Fundamentals of Cognitive Behavior Therapy for Depression and Anxiety

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Definition of Cognitive Behavior Therapy (CBT)
• CBT IS A FOCUSED FORM OF PSYCHOTHERAPY BASED ON A MODEL STIPULATING THAT A CENTRAL FEATURE OF PSYCHOPATHOLOGY IS DYSFUNCTIONAL OR UNHELPFUL THINKING.
• THE MANNER IN WHICH PEOPLE FEEL AND BEHAVE IS INFLUENCED BY THE MANNER IN WHICH THEY VIEW AND MAKE MEANING OF THEIR EXPERIENCES.
• MODIFYING DYSFUNCTIONAL OR UNHELPFUL THINKING PROVIDES IMPROVEMENT IN SYMPTOMS, AND MODIFYING BELIEFS THAT UNDERLIE DYSFUNCTIONAL THINKING LEADS TO MORE DURABLE IMPROVEMENT.

Automatic Thoughts About Workshop Participation
WHAT THOUGHTS RUN THROUGH YOUR MIND AS YOU CONTEMPLATE THREE DAYS OF DIDACTICS, DEMONSTRATIONS IN FRONT OF THE GROUP, AND ROLE-PLAYS?

– What evidence suggests that this thought is true? What evidence suggests that this thought is not true?
– What’s an alternative explanation or viewpoint?
– What’s the worst that could happen? How would I cope? What’s the best that could happen? The most realistic that could happen?
– What’s the effect of telling myself this thought? What’s the effect of changing my thinking?

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Goals of this Workshop

- **GAIN AN UNDERSTANDING OF THE THEORETICAL AND EMPIRICAL BASIS FOR CBT AND THE MANNER IN WHICH IT APPLIES TO INDIVIDUAL CLIENTS.**
- **IDENTIFY TECHNIQUES FOR IMPLEMENTING CBT STRUCTURE AND ORIENTING CLIENTS TO TREATMENT.**
- **ACQUIRE SKILLS TO IDENTIFY AND MODIFY UNHELPFUL COGNITIONS.**
- **ACQUIRE SKILLS TO IDENTIFY AND MODIFY UNHELPFUL BEHAVIORAL PATTERNS.**
- **APPLY CBT SKILLS TO SPECIFIC DEPRESSIVE AND ANXIOUS CLINICAL PRESENTATIONS.**

Workshop Schedule

**DAY 1: INTRODUCTION, OVERVIEW, & GETTING STARTED**
- Theoretical foundation
- Case conceptualization
- Session structure
- Psychoeducation and introduction to cognitive restructuring

**DAY 2: CBT FOR DEPRESSION**
- Modifying unhelpful thoughts and beliefs
- Modifying unhelpful behavioral patterns

**DAY 3: CBT FOR SUICIDALITY AND ANXIETY**
- Hopelessness and suicidality
- Anxiety disorders
- Relapse prevention

Day 1: Introduction and Theoretical Basis
Why CBT?

• MODELS AN ACTIVE PROBLEM SOLVING APPROACH TO LIFE'S CHALLENGES
• EXPECTATION THAT THE CLIENT WILL NOTICE MEANINGFUL CHANGE IN A REASONABLE PERIOD OF TIME
• VERSATILE IN THAT IT CAN BE TAILORED TO AN INDIVIDUAL CLIENT'S CLINICAL PRESENTATION
• EXTENSIVE EMPIRICAL BASE THAT SUPPORTS ITS EFFICACY AND EFFECTIVENESS

Notable Features of CBT

• TIME-SENSITIVE
• ACTIVE AND STRATEGIC
• PRESENT-FOCUSED
• COLLABORATIVE
• TRANSPARENT

Goals of CBT for Depression & Anxiety

• MODEL A SYSTEMATIC APPROACH TO ADDRESSING LIFE PROBLEMS BY MAINTAINING AN ORGANIZED SESSION STRUCTURE.
• ENSURE THAT CLIENTS UNDERSTAND THE RELATIONS AMONG THEIR THINKING, THEIR BEHAVIOR, AND THEIR MOOD.
• HELP CLIENTS TO ACQUIRE SKILLS TO IDENTIFY, EVALUATE, AND MODIFY UNHELPFUL THOUGHTS AND BELIEFS.
• HELP CLIENTS TO ACQUIRE SKILLS TO ENGAGE MORE FREQUENTLY IN PLEASURABLE AND MEANINGFUL ACTIVITIES AND/OR OVERCOME AVOIDANCE.
Goals of CBT for Depression & Anxiety

• Ensure that clients have practiced these strategies outside of session and that their practice has resulted in a noticeable decrease in their depression and anxiety.

• Ensure that clients understand how to apply these strategies to manage life problems after treatment has ended.

• Maintain a strong therapeutic relationship throughout the process, characterized by warmth, empathy, and respect.

Myths About CBT

MYTH #1: THERAPISTS MUST FOLLOW A CHECKLIST REGARDLESS OF CLIENTS’ WISHES.

MYTH #2: THE THERAPEUTIC RELATIONSHIP IS COMPROMISED WHEN THE THERAPIST FOCUSES ON CBT STRUCTURE AND STRATEGY.

MYTH #3: THERAPISTS MUST USE STANDARD CBT TOOLS (E.G., A THOUGHT RECORD).

MYTH #4: CERTAIN TOPICS ARE "OFF-LIMITS" IN CBT SESSIONS (E.G., THERAPIST’S REACTION TO THE CLIENT).
Theory Underlying Cognitive Interventions: Automatic Thoughts

- **QUICK, EVALUATIVE THOUGHTS THAT ARE SITUATION-SPECIFIC**
- **CAN TAKE THE FORM OF VERBAL THOUGHTS, IMAGES, AND/OR MEMORIES**
- **OFTEN ARISE SO QUICKLY THAT PEOPLE DO NOT REALIZE THEIR EFFECT ON THEIR MOOD**
- **OFTEN ACKNOWLEDGE ONLY ONE ASPECT OF THE SITUATION, IGNORING OTHER ASPECTS THAT MIGHT BRING MORE BALANCE TO ONE’S APPRAISAL**
- **GENERALLY ACCEPTED AS TRUE, WITHOUT REFLECTION**
Theory Underlying Cognitive Interventions

Stress  Core Beliefs

Situation  

Automatic Thought  

Emotional and Behavioral Reaction  


Theory Underlying Cognitive Interventions: Core Beliefs

Unlovability
I am unlikeable/unlovable.
I am undesirable.
People will reject me.
I will always be alone.

Inadequacy
I am inadequate.
I am incompetent.
I am a failure.

Helplessness
I am helpless.
I am powerless.
I am vulnerable.
I am trapped.

Source: J. S. Beck (2011)
From Theory to Intervention

ON THE BASIS OF THIS MODEL...

• ...THE THERAPIST WORKS WITH THE CLIENT TO IDENTIFY, EVALUATE, AND MODIFY AUTOMATIC THOUGHTS.

• ...THE THERAPIST WORKS WITH THE CLIENT TO IDENTIFY AND ARTICULATE BELIEFS THAT UNDERLIE AUTOMATIC THOUGHTS.

• ...THE THERAPIST WORKS WITH THE CLIENT TO MODIFY UNHELPFUL BELIEFS.

Theory Underlying Behavioral Interventions for Depression

Lack of active engagement in one's environment

Depressive symptoms (e.g., depressed mood, anhedonia, fatigue)


From Theory to Intervention

ON THE BASIS OF THIS MODEL...

• ...THE THERAPIST WORKS WITH THE CLIENT TO IDENTIFY HOW S/HE IS SPENDING HIS/HER TIME.

• ...THE THERAPIST WORKS WITH THE CLIENT TO ENGAGE MORE FREQUENTLY IN ACTIVITIES THAT PROVIDE A SENSE OF MASTERY AND PLEASURE.

• ...THE THERAPIST WORKS WITH THE CLIENT TO ACQUIRE PROBLEM SOLVING SKILLS TO OVERCOME OBSTACLES TO ENGAGING IN MEANINGFUL ACTIVITIES.
Theory Underlying Behavioral Interventions for Anxiety

Anxious symptoms (e.g., nervousness, shaking, racing heart) → Avoidance of feared stimuli or situations

From Theory to Intervention

ON THE BASIS OF THIS MODEL:

- THE THERAPIST WORKS WITH THE CLIENT TO IDENTIFY TRIGGERS FOR ANXIETY AND AVOIDANCE BEHAVIOR.
- THE THERAPIST WORKS WITH THE CLIENT TO SYSTEMATICALLY ENGAGE IN PROLONGED CONTACT WITH FEARED STIMULI OR SITUATIONS.
- THE THERAPIST WORKS WITH THE CLIENT TO ELIMINATE SUBTLE SAFETY MANEUVERS TO AVOID FULLY EXPERIENCING ANXIETY.

Interplay Between Cognition and Behavior

SITUATION: Negative life event (e.g., fired from job) → COGNITION: "I'm a loser," "Nothing ever works out"

BEHAVIORAL RESPONSE: Avoids social interaction; Procrastinate new job search → EMOTIONAL REACTION: Depressed, dejected
Day 1: CBT Case Conceptualization and Treatment Planning

CBT Case Conceptualization

- DESCRIPTION OF CLINICAL PRESENTATION
- EXPLANATION FOR CLINICAL PRESENTATION
- RELIANCE ON COLLABORATIVE EMPIRICISM
- GUIDES THERAPY IN ORDER TO RELIEVE DISTRESS AND BUILD RESILIENCE

Source: Kuyken, Padesky, & Dudley (2009)

CBT Case Conceptualization

Explanatory Conceptualization

- Longitudinal: Protective and Predisposing
- Cross-Sectional: Triggers and Maintenance
- Presenting Issues

Descriptive Conceptualization

Source: Kuyken, Padesky, & Dudley (2009)
CBT Case Conceptualization

- SYNTHESIZES CLIENT EXPERIENCE, RELEVANT CBT THEORY, AND RESEARCH
- NORMALIZES CLIENTS' PRESENTING ISSUES
- MAKES COMPLEX PROBLEMS SEEM MANAGEABLE
- PROMOTES CLIENT ENGAGEMENT
- GUIDES SELECTION, FOCUS, AND SEQUENCE OF INTERVENTIONS
- ANTICIPATES AND PROVIDES AN UNDERSTANDING OF PROBLEMS IN THERAPY

Source: Kuyken, Padesky, & Dudley (2009)

Cognitive Case Conceptualization Diagram

Conditional Assumptions/Beliefs/Rules

- ALSO CALLED INTERMEDIATE BELIEFS
- OFFER CROSS-SITUATIONAL RULES FOR LIVING THAT ARE CONSISTENT WITH CORE BELIEFS
- PROTECT THE PERSON FROM NEGATIVE AFFECT ASSOCIATED WITH THE ACTIVATION OF CORE BELIEFS
- OFTEN PHRASED AS "IF...THEN" STATEMENTS
Habitual Coping Strategies

• **LONG-STANDING BEHAVIORAL AND/OR COGNITIVE STRATEGIES IN WHICH THE CLIENT ENGAGES AS A RESULT OF THE ACTIVATION OF A CORE BELIEF**
  
  – **MAINTAINING STRATEGY:** Strategies that confirm the core belief
  – **OPPOSING STRATEGY:** Strategies that are aimed at proving that the core belief is wrong
  – **AVOIDING STRATEGY:** Strategies that help the client avoid the activation of a core belief

Cognitive Case Conceptualization Diagram: Application

Physical abuse by father
Combat experience where friends died
Difficulty adjusting to civilian life

I’m broken, a burden, worthless.

If I let others get close, I will be a burden to them.

Social isolation, Guardedness

Forthcoming holiday
Son gets a D.U.I.
Ex-wife getting remarried.

I’m broken, a burden.

I want to be with the family if we’d have been in line.

I’m worthless.

Guilty

Attend gathering for only a short period of time
Let son live with him rent-free and continue to abuse alcohol and drugs

I’m broken.

Depressed

Get drunk

I didn’t have what it took to hold onto her.

I didn’t have what it looked like from the start.

I’m broken, I’m worthless.

Depressed

I didn’t have what it took to hold onto her.

I didn’t have what it looked like from the start.

I’m broken, I’m worthless.

I’m broken.

Depressed

Get drunk

Attend gathering for only a short period of time
Let son live with him rent-free and continue to abuse alcohol and drugs
From Conceptualization to Treatment Planning

- Relevant Formative Experiences
- Core Beliefs
- Conditional Assumptions/Beliefs/Rules
- Habitual Coping Strategies

SITUATION ➔ Automatic Thought ➔ Meaning of AT ➔ Emotion ➔ Behavior

Treatment Goal #1

Treatment Goal #2

Treatment Goal #3

Treatment Goals

- Improve Depression
- Feel Better

Treatment Goals

SPECIFIC
MEASURABLE
ACHIEVABLE
REALISTIC AND RELEVANT
TIME-LIMITED

Source: Dobson & Dobson (2009)
Treatment Goals: Hints

• ASSOCIATE SPECIFIC BEHAVIORAL MARKERS WITH TREATMENT GOALS
  – What would it look like if you felt better?
  – What would others notice if you felt better?
• PRIORITIZE TREATMENT GOALS
• REVISIT TREATMENT GOALS PERIODICALLY THROUGHOUT THE COURSE OF TREATMENT TO ASSESS PROGRESS

Exercise:
Cognitive Case Conceptualization

Discussion
• WHAT ARE THIS INDIVIDUAL’S CORE BELIEFS? CONDITIONAL RULES AND ASSUMPTIONS?
• WHAT ARE THIS INDIVIDUAL’S HABITUAL COPING STRATEGIES?
• WHAT FORMATIVE EXPERIENCES CONTRIBUTED TO THE DEVELOPMENT OF THIS COGNITIVE BEHAVIORAL PROFILE?
• WHAT MIGHT BE APPROPRIATE TARGETS FOR TREATMENT?
• WHAT DID YOU LEARN FROM THIS EXERCISE THAT WILL IMPACT YOUR CLINICAL PRACTICE?
Day 1: CBT Structure

Socializing Clients into Session Structure

• EXPLAIN THE RATIONALE FOR EACH SESSION STRUCTURE COMPONENT IN THE FIRST SESSION.
• OBTAIN FEEDBACK FROM THE CLIENT TO ENSURE THAT S/HE UNDERSTANDS THE RATIONALE AND IS ON BOARD.
• MODEL SESSION STRUCTURE IN THE MANNER IN WHICH YOU APPROACH THE SESSION.

Brief Mood Check

• PURPOSES INCLUDE:
  – Communicate care and concern about the client’s current emotional state.
  – Track course of clinical presentation across sessions.
  – Identify important issues that should be addressed later in session.
  – Gather information about other important aspects of the client’s clinical presentation.

• METHODS INCLUDE:
  – Brief self-report inventories (e.g., BDI-II)
  – Subjective rating scales (e.g., 0 [no depression] – 10 [worst depression ever experienced])
Brief Mood Check

• SPECIFIC TOPICS FOR CHECK-IN (IF RELEVANT):
  – Mood
  – Alcohol and/or drug use
  – Suicidal ideation and intent
  – Compliance with medications and other treatment regime

• OBSTACLES INCLUDE:
  – General, open-ended discussion (e.g., excessive detail of the time in between sessions)
  – Launching into one specific topic before the agenda is set

Bridge from the Previous Session

• PURPOSES INCLUDE:
  – Consolidate learning that occurred in the previous session.
  – Determine whether client had an adverse reaction to anything that occurred in the previous session.
  – Orient the client to the current session and identify a thread that will run across sessions.

• OBSTACLES INCLUDE:
  – Client does not remember what occurred in the previous session.

Agenda

• PURPOSES INCLUDE:
  – Model a systematic approach to organizing life’s problems.
  – Ensure that the time in session is spent wisely and that there is time to cover all of the topics that are important to the client.
  – Ensure that there is an opportunity to implement a strategic intervention that has promise to address the client’s depression.

• OBSTACLES INCLUDE:
  – Client has nothing for the agenda.
  – Client suggests vague items.
  – Client suggests items that are unrelated to treatment goals.
  – Client has trouble slowing down and provides excessive detail.
Discussion of Agenda Items

- AGENDA ITEMS ARE DISCUSSED SYSTEMATICALLY WHILE THE THERAPIST IS MINDFUL OF:
  - Time
  - A balance between fostering a collaborative therapeutic relationship and implementing a strategic intervention that will promote cognitive-behavioral change
  - Maintaining a thread that runs across sessions
  - The client’s treatment goals
- PERIODIC SUMMARIES CONSOLIDATE LEARNING AFTER THE DISCUSSION OF EACH AGENDA ITEM.

Homework

- PURPOSES INCLUDE:
  - Practice the skills/strategies in between sessions in order to consolidate learning.
  - Observe, experientially, the manner in which cognitive and behavioral strategies are useful in reducing depression and in improving quality of life.
- HINTS INCLUDE:
  - Be sure to adequately review the previous homework assignment in order to reinforce the importance of homework in treatment.
  - Develop a new homework exercise whenever it logically flows from the work being done in session and start in session.
  - Develop the homework collaboratively with the client.
  - Have the client commit to a certain time to do the homework.
  - Identify obstacles to completing homework.

Homework

- OBSTACLES INCLUDE:
  - Client does not complete the homework developed in the previous session.
  - Client repeatedly does not complete the homework developed in the previous sessions.
  - Client does not like the idea of homework or the word itself.
  - Client does not want to write things down for homework.
Final Summary and Feedback

• **PURPOSES INCLUDE:**
  - Review the main conclusions drawn from discussion of agenda items.
  - Consolidate learning.
  - Determine whether client had an adverse reaction to anything that occurred in the session.

• **OBSTACLES INCLUDE:**
  - Client introduces an important new issue.
  - Client is overwhelmed and has difficulty summarizing the main conclusions drawn from discussion of agenda items.
  - Client is experiencing acute negative effect and the session time is winding down.

Discussion

• **WHAT DO YOU SEE AS THE ADVANTAGES OF CBT SESSION STRUCTURE? THE DISADVANTAGES?**

• **WHAT PROBLEMS HAVE YOU ENCOUNTERED IN IMPLEMENTING CBT SESSION STRUCTURE?**

Demonstration & Experiential Role-Play: CBT Session Structure

Goal of the role play: Develop skill in conducting the brief mood check, in obtaining a bridge from previous session, and in setting the agenda.
CBT Treatment Structure

• EARLY SESSIONS
  – Develop sound therapeutic relationship.
  – Develop a cognitive behavioral understanding of the client’s clinical presentation (i.e., cognitive case conceptualization).
  – Develop treatment goals.
  – Socialize the client to the CBT model and the process of therapy.
  – Identify and address any factors that might decrease the client’s motivation for treatment.
  – Identify any attitudes toward or expectations for treatment that have the potential to interfere with treatment and use CBT strategies to address.
  – Begin the process of making cognitive and behavioral changes.

• MIDDLE SESSIONS
  – Continue to identify and modify unhelpful cognitions, moving from automatic thoughts to underlying beliefs.
  – Continue to identify and modify unhelpful behavioral patterns, focusing on developing coping strategies.
  – Monitor progress toward treatment goals and modify treatment goals if necessary.

• LATER SESSIONS
  – Consolidate gains made in treatment.
  – Review treatment plan to ensure that goals were met.
  – Develop a relapse prevention plan.
  – Work collaboratively with client to identify an end-point to treatment.
  – If indicated, begin to taper the frequency of sessions.

Day 1: Psychoeducation
Psychoeducation

DEFINITIONS
- Information communicated to clients in a therapeutic setting that is expected to move them forward in treatment (Wenzel, 2013)
- Teaching of relevant psychological principles and knowledge (Dobson & Dobson, 2009)

FORMATS
- Verbal discussion
- Pamphlets, worksheets, & books

Five Types of Psychoeducation

PSYCHOEDUCATION ABOUT...
- ...the presenting problem
- ...CBT’s structure and process
- ...the CBT model
- ...CBT’s evidence base
- ...concurrent CBT and pharmacotherapy


CT v. Antidepressant Medications: Outcome

Source: DeRubeis et al. (2005) © 2013 Beck Institute
CT v. Antidepressant Medications: Relapse

% of Patients who Relapsed

Source: Hollon et al. (2005) © 2013 Beck Institute

Discussion

- WHAT ARE THE IMPLICATIONS OF THESE EMPIRICAL FINDINGS FOR YOUR CLINICAL PRACTICE?
- WHAT OTHER RESEARCH FINDINGS ARE IMPORTANT TO COMMUNICATE TO YOUR CLIENTS?
Obstacle: When Clients Do Not Buy Into the CBT Model

- Ensure that clients can articulate the model in their own words
- Apply the model to a problematic situation from their own lives
- Assess the degree to which clients are responding to their problems in an accurate and relatively adaptive manner
- Assess for and address any adverse reactions


Day 1: Introduction to Cognitive Restructuring

Step 1: Identifying Automatic Thoughts

- Purpose includes:
  - Vivid illustration of the manner in which cognition affects mood
  - Practice in slowing down and identifying the cognitions that are most associated with emotional distress and, therefore, have the most promise in creating change
- Questions to assess for automatic thoughts include:
  - What was running through your mind in that situation?
  - Did you experience a mental image or a memory from the past?
  - What would you guess had been running through your mind?
  - Might you have been thinking _____ or _____?
  - What did that situation mean to you or about you?

Step 1: Identifying Automatic Thoughts

• OBSTACLES INCLUDE:
  – “I don’t know.”
  – Trouble distinguishing between thoughts and feelings
  – Identification of thoughts that are surface reactions but that do not account for the emotional reaction

Step 2: Evaluating Automatic Thoughts

• COLLABORATIVE EMPIRICISM VS. CHALLENGING
• ADOPTING AN INQUISITIVE, CURIOUS SPIRIT
• REFRAINING FROM ARGUING, PRESSURING, AND MAKING JUDGMENTAL OR EVALUATIVE COMMENTS
• EXAMINING BOTH ACCURACY AND USEFULNESS

AM I MAKING A THINKING ERROR?
  – All-or-nothing thinking
  – Overgeneralization
  – Mental filter
  – Disqualifying the positive
  – Fortune telling
  – Mind reading
  – Arbitrary inference
  – Catastrophizing
  – Emotional reasoning
  – Personalization
  – “Should” statements
Socratic Questioning: Accuracy

- What is the evidence that supports that thought? Is that evidence factual? What is the evidence that does not support that thought?
- What are some other explanations?
- Does _____ have to lead to or equal _____?
- What’s the worst that can happen? The best? The most realistic? If the worst were to happen, how would I cope?
- Is this true for everyone in this situation?
- What would I tell a friend if s/he were in this situation?

Socratic Questioning: Usefulness

- What’s the effect of believing this thought?
- How useful is it for me to be focusing on this thought?
- What are the advantages of focusing on this thought? The disadvantages?
- If I must be in this unfortunate situation, what wisdom can I gain? How can I grow as a person?

Step 3: Responding to Automatic Thoughts

- The goal is to provide guidance to the client as he or she creates an adaptive response to the automatic thought, taking care to formulate a new statement (or series of statements) on the basis of the evaluation facilitated by the Socratic questioning.
- Rate the level of emotional intensity associated with the old automatic thought and the new adaptive response.
- Identity other outcomes that result from the adaptive response.
### 3-Column Thought Record

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<thead>
<tr>
<th>Situation</th>
<th>Thought</th>
<th>Emotion (0-100)</th>
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### 3-Column Thought Record: Example

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thought</th>
<th>Emotion (0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team member messed up; I had to work after hours to fix the problem.</td>
<td>This is what my life will be like until I die.</td>
<td>Depressed (85)</td>
</tr>
</tbody>
</table>

### 5-Column Thought Record

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thought</th>
<th>Emotion (0-100)</th>
<th>Adaptive Response</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
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5-Column Thought Record

<table>
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<tr>
<th>Situation</th>
<th>Thought</th>
<th>Emotion (0-100)</th>
<th>Adaptive Response</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team member moved up; I had to work after hours to fix the problem.</td>
<td>This is what my life will be like until I die.</td>
<td>Depressed (85)</td>
<td>Although this is frustrating, I have a plan for transferring positions in the next year.</td>
<td>Depressed (80). More able to focus on getting it done as quickly as I can.</td>
</tr>
</tbody>
</table>

Obstacles in Cognitive Restructuring

- THE EVALUATION WAS IMPLAUSIBLE OR SUPERFICIAL.
- THERE ARE OTHER, MORE FUNDAMENTAL AUTOMATIC THOUGHTS THAT HOLD GREAT MEANING BUT WERE NOT IDENTIFIED.
- THE CLIENT EXPERIENCES A CLUSTER OF AUTOMATIC THOUGHTS, AND ONLY ONE WAS RESTRUCTURED.
- THE CLIENT EXPERIENCES SECONDARY, JUDGMENTAL AUTOMATIC THOUGHTS AS A RESULT OF COMPLETING THE EXERCISE.
- THE CLIENT GETS SOME GAIN FROM HOLDING ONTO THE AUTOMATIC THOUGHT.

Testing Your Thoughts Worksheet

WHAT IS THE EVIDENCE THAT SUPPORTS MY THOUGHT?

WHAT IS THE EVIDENCE THAT REFUTES MY THOUGHT?

WHAT ARE OTHER POSSIBLE EXPLANATIONS?

WHAT'S THE WORST THAT CAN HAPPEN? HOW WOULD I COPE?
Behavioral Experiments

- CLIENT EXPRESS A NEGATIVE PREDICTION, AND CLIENT AND THERAPIST DECIDE ON A WAY TO TEST OUT THE PREDICTION IN THE TIME BETWEEN SESSIONS.
- SPECIFICS OF THE “EXPERIMENT” ARE DESCRIBED IN DETAIL TO INCREASE THE LIKELIHOOD OF SUCCESS.
- CLIENT IS PREPARED TO COPE WITH THE “WORST-CASE OUTCOME.”
- RESULTS OF THE EXPERIMENT, AND THEIR IMPLICATIONS FOR THE CLIENT’S THOUGHTS AND BELIEFS, ARE CONSIDERED IN THE SUBSEQUENT SESSION.

Coping Cards

Automatic Thought: Other people will not be interested in hearing from me if I call them.

Adaptive Response: I have no evidence to support this prediction, as no one has ever indicated that they do not want to hear from me, nor have they cut phone calls short. In fact, the opposite might be true – that they are interested in hearing from me because I consistently get invitations to social gatherings.

Success Log

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<th>Dates of Flight</th>
<th>Destination</th>
<th>Panic Attack?</th>
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<td>N</td>
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<tr>
<td>8.1.10</td>
<td>Austin</td>
<td>N</td>
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<td>8.30.20</td>
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<td>N</td>
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<td>10.17.10</td>
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<tr>
<td>8.1.11</td>
<td>ISTANBUL</td>
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Maximizing Effectiveness

- ENSURE THAT THE CLIENT CAN ARTICULATE THE MAIN POINTS OF THE COGNITIVE MODEL.
  - Have a pre-prepared, compelling example of the cognitive model at work.
  - Review examples of negative or unhelpful thinking in the client’s own life.
- ENSURE THAT THE CLIENT BUYS INTO THE COGNITIVE MODEL.
- PRACTICE IN SESSION.
- COMPARE AND CONTRAST THE EMOTIONAL INTENSITY ASSOCIATED WITH OLD AND NEW WAY OF THINKING.

Cognitive Restructuring Homework

- COMPLETE THOUGHT RECORD WHENEVER CLIENT NOTICES A NEGATIVE SHIFT IN MOOD.
- COMPLETE THOUGHT RECORD AS CLOSE AS POSSIBLE TO THE MOMENT OF EMOTIONAL DISTRESS.
- ENSURE THAT SITUATIONS ON THOUGHT RECORDS ARE SPECIFIC RATHER THAN GENERAL PATTERNS THE CLIENT NOTICES.

Day 2: Cognitive Restructuring Part II
Discussion: What did you take away from yesterday’s presentation?

Cognitive Restructuring: Depression

- **AUTOMATIC THOUGHTS REFLECT THEMES OF:**
  - Hopelessness
  - Worthlessness
  - Failure
  - Being “less than”

- **HELPFUL TECHNIQUES FOR RESTRUCTURING INCLUDE:**
  - Examining evidence (especially historical evidence)
  - Addressing internal, global, and stable attributions

Cognitive Restructuring: Anxiety

- **AUTOMATIC THOUGHTS REFLECT THEMES OF:**
  - High likelihood of threat
  - Inability to cope
  - Discomfort with uncertainty

- **HELPFUL TECHNIQUES FOR RESTRUCTURING INCLUDE:**
  - Examining likelihood of best, worst, and most realistic outcomes, and if the worst case outcome were to occur, how bad that would be
  - DECASTROPHIZING PLAN
  - Acceptance of uncertainty
Demonstration and Experiential Role-Play: Working with Automatic Thoughts

Goal of the role play: Develop skill in working with the client to identify, evaluate, and respond to automatic thoughts associated with emotional distress.

Working with Beliefs: Modification Process

- **STEP 1:** IDENTIFY UNHELPFUL BELIEF
- **STEP 2:** CLEARLY DELINEATE A NEW, HELPFUL BELIEF THAT IS COMPPELLING AND ATTAINABLE
- **STEP 3:** USE CREATIVE COGNITIVE AND BEHAVIORAL STRATEGIES TO STRENGTHEN THE NEW BELIEF AND WEAKEN THE OLD BELIEF

Working with Beliefs: Downward Arrow

- Others will see that I’m red & blotchy.
- So what if others will see you are red & blotchy?
- What’s the worst part of others wondering what is wrong?
- What will it mean about you if others think you are weird?
- What does it mean to be exposed?
- Then others will wonder what is wrong with me.
- Then they’ll think I’m weird.
- Then I’ll be exposed.
- It means I’m weak, less of a man.

Identifying Underlying Beliefs

- CLIENT DEMONSTRATES SIGNIFICANT AFFECT.
- CLIENT AND THERAPIST RECOGNIZE THEMES THAT UNDERLIE THOUGHTS IDENTIFIED DURING COGNITIVE RESTRUCTURING.
- CLIENT ENDORSES BELIEF ON A SELF-REPORT INVENTORY.
  - Young Schema Questionnaire (YSQ)
  - Personality Belief Inventory (PBI)
  - Dysfunctional Attitudes Scale (DAS)

Working with Beliefs: Positive Data Log

New Belief: I am just as good as everyone else.

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Working with Beliefs: Cognitive Continuum

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Working with Beliefs: Modification

- ADVANTAGES-DISADVANTAGES ANALYSIS
- DEFINING THE "NEW SELF"
- ACTING "AS IF"
- EULOGY
- RESTRUCTURING EARLY MEMORIES
- SOLICITING SOCIAL SUPPORT AND CONSENSUS

Source: J. S. Beck (2011); Dobson & Dobson (2009)

Day 2: Behavioral Activation

Theory Underlying Behavioral Interventions for Depression

Lack of active engagement in one’s environment → Depressive symptoms (e.g., depressed mood, anhedonia, fatigue)

Behavioral Activation

AIMS
– Increase clients’ positive engagement with their environments
– Decrease behaviors that maintain emotional distress
– Solve problems that prevent clients from obtaining pleasure and mastery from their lives

Step 1: Activity Monitoring

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<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
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<tbody>
<tr>
<td>6-8 Breakfast &amp; paper</td>
<td>6-8 Get settled at work</td>
<td>6-8 Team meeting</td>
<td>6-8 Get settled at work</td>
<td>6-8 Meeting with boss</td>
<td>6-8 Get settled at work</td>
<td>6-8 Sleep</td>
</tr>
<tr>
<td>M=2 P=1</td>
<td>M=3 P=2</td>
<td>M=1 P=1</td>
<td>M=2 P=1</td>
<td>M=1 P=1</td>
<td>M=1 P=1</td>
<td></td>
</tr>
<tr>
<td>9-10 Get ready</td>
<td>9-10 Return phone calls</td>
<td>9-10 Deal with IT staff</td>
<td>9-10 Research for report</td>
<td>9-10 Meeting with client</td>
<td>9-10 Write report</td>
<td>9-10 Sleep</td>
</tr>
<tr>
<td>M=2 P=2</td>
<td>M=4 P=1</td>
<td>M=1 P=3</td>
<td>M=5 P=1</td>
<td>M=1 P=1</td>
<td>M=1 P=1</td>
<td></td>
</tr>
<tr>
<td>10-11 Church</td>
<td>10-11 Make employee schedule</td>
<td>10-11 Deal with IT staff</td>
<td>10-11 Write report</td>
<td>10-11 Prepare report for payroll</td>
<td>10-11 Write report</td>
<td>10-11 Sleep</td>
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<tr>
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Exercise: Complete Activity Monitoring Form for Monday, March 25
**Step 2: Activity Scheduling**

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<thead>
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<th>Tues</th>
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<td>8-9</td>
<td>8-9</td>
<td>9-10</td>
</tr>
<tr>
<td>Make pancakes</td>
<td>Bagels with co-worker</td>
<td>Research for report</td>
<td>Eat cereal with fresh fruit</td>
<td>9-10 Walk dog</td>
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</tbody>
</table>

**Step 3: Complete Activity Scheduling Form**

<table>
<thead>
<tr>
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<th>Wed</th>
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<td>9-10</td>
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<tr>
<td>Make pancakes M=5 P=8</td>
<td>Bagels with co-worker M=3 P=8</td>
<td>Research for report M=5 P=2</td>
<td>Eat cereal with fresh fruit M=1 P=3</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

| 9-10 Get ready M=2 P=2 |
| Get ready M=2 P=2 |
| 9-10 Return phone calls M=6 P=2 |
| 9-10 Meeting with supervisor M=1 P=1 |
| 9-10 Research for report M=5 P=2 |
| 9-10 Meeting with client M=5 P=1 |

| 9-10 Write report M=3 P=1 |
| 9-10 Write report M=3 P=1 |
| 10-11 Ate cereal with fresh fruit M=3 P=6 |

| 10-11 Ate cereal with fresh fruit M=3 P=6 |
| 10-11 Ate cereal with fresh fruit M=3 P=6 |

**Activity Monitoring and Scheduling: Tips**

**MASTERY**
- 10 = Remodeling the kitchen
- 5 = Mowing the lawn
- 0 = Receiving a reprimand at work

**PLEASURE**
- 10 = Vacation
- 5 = Dinner with wife
- 0 = Arguing with wife
Activity Monitoring and Scheduling: Tips

- HONOR THE FACT THAT THIS EXERCISE REQUIRES SUSTAINED WORK.
- DO NOT FOREGO THE MASTERY AND PLEASURE RATINGS.
- ALLOW CLIENT TO DRAW HIS OR HER OWN CONCLUSIONS FROM ACTIVITY MONITORING BEFORE COMMUNICATING YOUR OWN CONCLUSIONS.
- ALLOW FLEXIBILITY WITH ACTIVITY SCHEDULING.
- DEVELOP "BACK-UP" PLANS FOR ACTIVITY SCHEDULING SO THAT CLIENTS DO NOT BECOME DISCOURAGED IF THEY MISS AN ACTIVITY THAT THEY HAD SCHEDULED.

Alternative Activity Log

<table>
<thead>
<tr>
<th>Pleasure or Mastery Activity</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
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<tbody>
<tr>
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<tr>
<td>Walking the dog</td>
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<tr>
<td>Planning a vacation</td>
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<td></td>
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<tr>
<td>Reading for pleasure</td>
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<tr>
<td>Listening to music</td>
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<tr>
<td>Going to a museum</td>
<td></td>
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<tr>
<td>Meeting someone for lunch</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Attending kids’ sporting event</td>
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<tr>
<td>Completing a household task</td>
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OVERALL DEPRESSION RATING

Summarizing Results of Behavioral Activation

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Identifying Pleasurable Activities

PLEASANT EVENTS SCHEDULE

- Soaking in the bathtub  F ___  P ___
- Planning my career  F ___  P ___
- Collecting things  F ___  P ___
- Going to a movie  F ___  P ___
- Reading magazines  F ___  P ___
- Spending time with friends  F ___  P ___
- Practicing yoga  F ___  P ___
- Taking care of plants  F ___  P ___

Behavioral Homework

• LESS ADEQUATE: GO TO THE GYM THREE TIMES IN THE NEXT WEEK.

• MORE ADEQUATE: GO TO THE GYM THREE TIMES IN THE NEXT WEEK.
  – Which days will you commit to going to the gym?
  – When in the day will you go to the gym?
  – How long will you stay at each visit?
  – What exercises will you do at each visit?
  – What obstacles might get in the way of going to the gym on any one day?
  – How will you overcome those obstacles?
  – If you don’t make it on a day you had planned, what is the “back-up plan”?

Problem Solving

• IDENTIFY AND DEFINE THE PARAMETERS OF THE PROBLEM.

• BRAINSTORM POSSIBLE SOLUTIONS.

• EVALUATE THE PROS AND CONS OF THE POSSIBLE SOLUTIONS.

• DECIDE UPON A SOLUTION (OR A COMBINATION OF SOLUTIONS).

• IMPLEMENT THE SOLUTION FOR HOMEWORK.

• EVALUATE THE SUCCESS OF THE SOLUTION.
Demonstration and Experiential Role-Play: Activity Scheduling

Goal of the role play: Develop skill in working with a depressed client to draw conclusions from activity monitoring and to use those conclusions in the service of activity scheduling.

Day 2: Discussion of the Cognitive Therapy Rating Scale

Day 2: DVD Demonstration of CBT for Depression

Goal of the demonstration: Apply your knowledge of the Cognitive Therapy Rating Scale to rate Dr. Judith Beck's session.
Day 3: Depression with Hopelessness & Suicidality

Slides developed in conjunction with Dr. Gregory K. Brown, University of Pennsylvania

Traditional Approach to Treating Suicidal Clients

DEPRESSION + HIGH RISK MANAGEMENT
- Treating depression may not focus on suicide-relevant cognitive processes.
- Treating depression may not address other modifiable risk factors.
- Treating depression may not help clients develop skills to manage future suicidal crises.
- Lack of randomized controlled trials indicating that depression treatment prevents suicide or suicide attempts.

New Approach to Treating Suicidal Clients

- Assessment of Risk and Protective Factors
- Cognitive Conceptualization and Treatment Plan
- Cognitive and Behavioral Strategies
- Relapse Prevention Task
Conceptual Underpinnings

- SUICIDAL BEHAVIOR IS VIEWED AS A PROBLEMATIC COPING BEHAVIOR.
- SUICIDAL BEHAVIOR IS VIEWED AS THE PRIMARY PROBLEM RATHER THAN A SYMPTOM OF A DISORDER.
- CBT FOR SUICIDAL CLIENTS IS ONE OF SEVERAL INTERVENTIONS THE CLIENT MAY BE RECEIVING.
- TREATMENT IS BRIEF AND FOCUSED (10 SESSIONS).

Integrative Cognitive Model of Suicidal Acts

Dispositional Vulnerability Factors

- Stress
- Cognitive Processes Associated With Psychiatric Disturbance
- Cognitive Processes Associated With Suicidal Crises

Cognitive Processes Associated With Psychiatric Disturbance

- Impulsivity
- Impulsive Aggression
- Inability to Generate Solutions
- Low Problem Solving Self-Efficacy
- Inability to Execute Solutions
- Tendency to Make Cognitive Distortions
- Perfectionism
- Overgeneral Memory Style
- Personality (e.g., neuroticism)

Goals of Early Phase of Treatment

- DISCUSSION OF INFORMED CONSENT
- COMPLETION OF A SUICIDE RISK ASSESSMENT
- COMPLETION OF A SAFETY PLAN
- BEGINNING OF THE NARRATIVE DESCRIPTION OF EVENTS SURROUNDING THE RECENT SUICIDAL CRISIS
- DEVELOPMENT OF A SENSE OF HOPE

Discussion

- WHAT ARE THE RISKS AND PROTECTIVE FACTORS FOR SUICIDAL ACTS?
- HOW DO YOU ASSESS FOR THEM?
Early Phase: What is a Safety Plan?

- PRIORITIZED WRITTEN LIST OF COPING STRATEGIES AND RESOURCES FOR USE DURING A SUICIDAL CRISIS
- USES A BRIEF, EASY-TO-READ FORMAT THAT USES THE CLIENT’S OWN WORDS
- COMPLETED BY THE THERAPIST AND CLIENT, SITTING SIDE-BY-SIDE
- INVOLVES A COMMITMENT TO TREATMENT PROCESS (AND STAYING ALIVE)

Sources: Stanley & Brown (2012); Wenzel, Brown, & Beck (2009)

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Step 1: Recognizing Warning Signs

- SAFETY PLAN IS ONLY USEFUL IF THE CLIENT CAN RECOGNIZE THE WARNING SIGNS.
- ASK, “HOW WILL YOU KNOW WHEN THE SAFETY PLAN SHOULD BE USED?”
- ASK, “WHAT DO YOU EXPERIENCE WHEN YOU START TO THINK ABOUT SUICIDE OR FEEL EXTREMELY DISTRESSED?”
- WRITE DOWN THE WARNING SIGNS (THOUGHTS, IMAGES, THINKING PROCESSES, MOOD, AND/OR BEHAVIORS) USING THE CLIENT’S OWN WORDS.

Sources: Stanley & Brown (2012); Wenzel, Brown, & Beck (2009)

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Step 2: Using Internal Coping Strategies

- LIST ACTIVITIES THAT CLIENTS CAN DO WITHOUT CONTACTING ANOTHER PERSON.
- ACTIVITIES FUNCTION AS A WAY TO HELP CLIENTS TAKE THEIR MINDS OFF THEIR PROBLEMS AND PROMOTE MEANING IN CLIENTS’ LIVES.
- COPING STRATEGIES PREVENT SUICIDE IDEATION FROM ESCALATING.
- USE A COLLABORATIVE, PROBLEM SOLVING APPROACH TO ADDRESS POTENTIAL ROADBLOCKS.

Sources: Stanley & Brown (2012); Wenzel, Brown, & Beck (2009)
Step 3: Socializing with Others

• COACH CLIENTS TO USE STEP 3 IF STEP 2 DOES NOT RESOLVE THE CRISIS OR LOWER RISK.

• IDENTIFY FAMILY, FRIENDS, OR ACQUAINTANCES WHO MAY OFFER SUPPORT AND DISTRACTION FROM THE CRISIS.

• ASK CLIENTS TO LIST SEVERAL PEOPLE IN CASE THEY CANNOT REACH THE FIRST PERSON ON THE LIST.

Sources: Stanley & Brown (2012); Wenzel, Brown, & Beck (2009)

Step 4: Contacting Others for Help

• COACH CLIENTS TO USE STEP 4 IF STEP 3 DOES NOT RESOLVE THE CRISIS OR LOWER RISK.

• ASK, “HOW LIKELY WOULD YOU BE WILLING TO CONTACT THESE INDIVIDUALS?”

• IDENTIFY POTENTIAL OBSTACLES AND PROBLEM SOLVE WAYS TO OVERCOME THEM.

Sources: Stanley & Brown (2012); Wenzel, Brown, & Beck (2009)

Step 5: Contacting Professional Help

• COACH CLIENTS TO USE STEP 5 IF STEP 4 DOES NOT RESOLVE THE CRISIS OR LOWER RISK.

• IDENTIFY POTENTIAL OBSTACLES AND DEVELOP WAYS TO OVERCOME THEM.

• LIST NAMES, NUMBERS AND/OR LOCATIONS OF:
  – Clinicians
  – Local Emergency Department
  – National Suicide Prevention Lifeline: 800-273-TALK (8255)

Sources: Stanley & Brown (2012); Wenzel, Brown, & Beck (2009)
Step 6: Reducing the Potential for Use of Lethal Means

- **ASK CLIENTS WHAT MEANS THEY WOULD CONSIDER USING DURING A SUICIDAL CRISIS.**
  - Always ask whether the client has access to a firearm.

- **FOR METHODS WITH LOW LETHALITY, CLINICIANS MAY ASK CLIENTS TO REMOVE OR RESTRICT THEIR ACCESS TO THESE METHODS THEMSELVES.**

- **FOR METHODS WITH HIGH LETHALITY, COLLABORATIVELY IDENTIFY WAYS FOR A RESPONSIBLE PERSON TO SECURE OR LIMIT ACCESS.**


Middle Phase: Behavioral Strategies

- **INCREASING PLEASURABLE ACTIVITIES**

- **IMPROVING COMPLIANCE**
  - Assess reasons for noncompliance or road blocks.
  - Monitor compliance with other treatments at each session.
  - Role play communication skills for making appointments.

- **INCREASING SOCIAL SUPPORT**
  - Attending to existing relationships
  - Building new relationships
  - Modifying reactions toward others
  - Utilizing family support


Middle Phase: Affective Coping Strategies

- **PHYSICAL SELF-SOOTHING**
  - Exercise, muscle relaxation

- **COGNITIVE SELF-SOOTHING**
  - Distraction

- **SENSORY SELF-SOOTHING**
  - Engaging senses (e.g., touch, sound, smell)

Middle Phase: Cognitive Coping Strategies

- IDENTIFYING REASONS FOR LIVING
  - Hope Kit
- MODIFYING SUICIDE-RELEVANT BELIEFS
  - Socratic questioning, Future time-imaging
- ENHANCING PROBLEM SOLVING SKILLS
- DEVELOPING COPING CARDS
- REDUCING IMPULSIVITY

Later Phrase: Relapse Prevention Protocol

1. PREPARATION PHASE
2. REVIEW OF RECENT SUICIDAL CRISIS
3. REVIEW OF RECENT SUICIDAL CRISIS USING SKILLS
4. REVIEW OF FUTURE SUICIDAL CRISIS USING SKILLS
5. DEBRIEFING AND FOLLOW-UP

Efficacy: Repeat Suicide Attempts

Day 2: DVD Demonstration of CBT for Depression

Goal of the demonstration: Apply your knowledge of the Cognitive Therapy Rating Scale to rate Dr. Aaron Beck’s session.

Day 2: Exposure for Anxiety

Theory Underlying Behavioral Interventions for Anxiety

Anxious symptoms (e.g., nervousness, shaking, racing heart) -> Avoidance of feared stimuli or situations -> Anxious symptoms (e.g., nervousness, shaking, racing heart)
Types of Exposure

- **IN VIVO**: ACTUAL ENCOUNTER WITH A FEARED STIMULUS OR SITUATION
  - • Primary = direct confrontation of distressing thoughts or images
  - • Secondary = augments worst-case scenarios associated with in vivo exposures
  - • Preliminary = initial step before in vivo exposure

- **IMAGINAL**: USE OF VIVID IMAGERY TO IMAGINE AN ENCOUNTER WITH A FEARED STIMULUS OR SITUATION
  - • Primary = direct confrontation of distressing thoughts or images
  - • Secondary = augments worst-case scenarios associated with in vivo exposures

- **INTEROCEPTIVE**: PROVOCATION OF A FEARED PHYSIOLOGICAL SYMPTOM OF ANXIETY
  - • Primary = actual physiological symptoms
  - • Secondary = situations that produce physiological symptoms

Source: Abramowitz, Deacon, & Whiteside (2011)

Exposure’s Mechanisms of Change

- Habituation
- Cognitive Restructuring
- Adaptive Coping

Exposure: Expected Results

[SUDs Rating vs Time in Minutes graph]
Developing a Fear Hierarchy

**Order of Sequence of Feared Stimuli or Situations That Represent Progressively More Difficult Encounters**

Step 1: Brainstorm the full array of feared stimuli/situations, using the self-monitoring form as a guide.
Step 2: Assign SUDs (Subjective Units of Discomfort) ratings.
Step 3: Order list from lowest to highest SUDs ratings.

**Sample Hierarchy: Vomit Phobia**

1. Use downstairs bathroom where family members have vomited. (30)
2. Sit on couch where family member vomited. (35)
3. Watch episode of ER. (40)
4. Go to previous place of employment where someone vomited. (50)
5. Watch YouTube clip of college student vomiting. (65)
6. Go to church where someone vomited on Easter Sunday. (75)
7. Go to bar where person vomited outside. (85)
8. Go to crowded bar on a weekend. (90)
9. Eat spicy food that might upset stomach. (95)

**Fear Hierarchy: Tips**

- Choose items that are associated with no more than everyday levels of risk.
- Worst fear must be incorporated.
- Use very specific (vs. general) descriptors.
- As much as is possible, identify feared stimuli and situations that the client can create at any time.
- Record in a Microsoft Word file so that it can be altered as new feared stimuli/situations are identified.
- Spend time defining the SUDS anchors.
Exercise: Work with a partner to develop a fear hierarchy for one of your clients.

Response Prevention

• RITUALISTIC BEHAVIOR
  - Overt compulsive rituals
  - Subtle mental maneuvers
  - Reassurance seeking
  - Safety signals

• PEOPLE WHO ENGAGE IN RITUALISTIC BEHAVIOR BELIEVE THAT THEIR RITUALS PREVENT CATASTROPHES.
  - Restricts learning that the feared stimulus or situation is associated with a low probability of harm.

Maximizing Effectiveness

IDEAL MODEL IS TO CONDUCT AN EXPOSURE IN SESSION AND FOR THE CLIENT TO CONTINUE PRACTICING THE SAME OR SIMILAR EXPOSURES OUTSIDE OF SESSION FOR HOMEWORK.
  - Take the time to create a compelling in-session exposure.
  - Take the time to solicit the client's commitment to continue with exposures outside of session and identify potential obstacles.
  - Frame the exposure as a behavioral experiment.
  - Consider having sessions more than once a week (or longer than 50 min).
Maximizing Effectiveness

• EXPOSURE SHOULD END WHEN SUDS HAVE DECREASED TO 50-60% OF THEIR INITIAL PEAK – NO MORE THAN MILD DISTRESS.

• ENCOURAGE MASSED EXPOSURE (VS. SPACED EXPOSURE)—AT LEAST 3-4 TIMES PER WEEK FOR 1-2 HOURS.

• CONSIDER "EXPANDING SPACED" SCHEDULE OF EXPOSURE SESSIONS.

• DO NOT REASSURE CLIENT THAT "EVERYTHING WILL BE OK."

Sources: Abramowitz, Deacon, & Whiteside (2011); Antony, Craske, & Barlow (2006)

Maximizing Effectiveness

• EXPOSURES SHOULD BE PRACTICED IN VARIED SETTINGS TO ACHIEVE GENERALIZATION.

• DEVELOP ACCURATE EXPECTATIONS FOR THE SEQUENCE OF EVENTS THAT WILL OCCUR DURING THE EXPOSURE (I.E., PREDICTABILITY).

• BEFORE AND DURING THE EXPOSURE, USE COGNITIVE RESTRUCTURING TO ADDRESS ANY UNHELPFUL COGNITIONS.

• ENCOURAGE "LIFESTYLE EXPOSURES."

Sources: Abramowitz, Deacon, & Whiteside (2011); Antony, Craske, & Barlow (2006)

Discussion

DESCRIBE SOME SUCCESSES AND CHALLENGES YOU HAVE HAD IN THE DELIVERY OF EXPOSURE FOR CLIENTS WITH ANXIETY DISORDERS.
Day 3: Anxiety Disorders

Cognitive Similarities Among Anxiety Disorders

- **PROBABILITY OVERESTIMATION**
  - Regarding a negative event as probable when, in reality, it is very unlikely
- **CATASTROPHIC THINKING**
  - Viewing an event as unbearable when, in reality, it is not
- **MIND READING**
  - Assuming that one knows what another is thinking (and, usually, that the other's thoughts are negative)
- **LACK OF SELF-EFFICACY**
  - Assuming that one is unable to cope with threat, danger, or adversity

Behavioral Similarities Among Anxiety Disorders

<table>
<thead>
<tr>
<th>AVOIDANCE</th>
<th>ESCAPING BEFORE ANXIETY FULLY DISSIPATES</th>
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<tbody>
<tr>
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<td>FREEZING</td>
</tr>
<tr>
<td>AVOIDANCE</td>
<td>ACTING OUT</td>
</tr>
<tr>
<td>AVOIDANCE</td>
<td>SAFETY-SEEKING (E.G., RELIANCE ON THE PRESENCE OF A PARTNER)</td>
</tr>
<tr>
<td>AVOIDANCE</td>
<td>DIFFICULTY STAYING IN THE PRESENT MOMENT</td>
</tr>
</tbody>
</table>
What works in managing anxiety?

What DOES NOT work in managing anxiety?

CBT for Anxiety: Breathing Retraining

- OVERBREATHING CAUSES AND/OR EXACERBATES MANY OF THE PHYSIOLOGICAL SENSATIONS OF PANIC.
  - Reduces the amount of oxygen that goes to certain parts of the brain, which can cause dizziness
  - Reduces the amount of oxygen that goes to certain parts of the body, which causes numbness and tingling
  - Increases one's perception of uncontrollability

- GOALS OF BREATHING RETRAINING
  - Decrease physical cues for panic
  - Reduce physical sensations during a panic attack
  - Facilitate general relaxation

Source: Barlow & Craske (2007)

CBT for Anxiety: Breathing Retraining

1. COMFORTABLE, QUIET LOCATION.
2. COUNT ONE BREATH IN AND THINK RELAX ON BREATH OUT.
3. FOCUS ATTENTION ON BREATHING AND COUNTING.
4. NORMAL RATE AND DEPTH OF BREATHING.
5. EXPAND DIAPHRAGM ON BREATH IN AND KEEP CHEST STILL.
6. COUNT UP TO 10 AND BACK TO 1.
7. PRACTICE 2X/DAY, 10 MIN EACH TIME.

Source: Barlow & Craske (2007)
CBT for Anxiety: Muscle Relaxation

1. QUIET LOCATION, COMFORTABLE CHAIR OR BED.
2. LOOSEN TIGHT CLOTHING.
3. TENSE FOR 10 SECONDS AND RELAX FOR 20 SECONDS THE MAJOR MUSCLE GROUPS:
   - Lower legs
   - Upper forehead
4. COUNT FROM 1 TO 5 TO DEEPEN RELAXATION, BREATHE SLOWLY FOR 2 MIN, AND COUNT FROM 5 TO 1 TO BE MORE ALERT.
5. PRACTICE 2X/DAY FOR 7 DAYS.

Source: Barlow & Craske (2007)

CBT for Anxiety: Breathing and Relaxation Tips

- PRACTICE IN SESSION.
- PRACTICE, PRACTICE, PRACTICE OUTSIDE OF SESSION.
- ENCOURAGE CLIENT TO PLAY AN AUDIO FILE TO GUIDE HIM OR HER THROUGH THE EXERCISE, RATHER THAN READING FROM A BOOK.
- USE COGNITIVE STRATEGIES TO ENSURE THAT CLIENT HAS ACCURATE EXPECTATIONS.


CBT for Anxiety: Decatastrophizing

<table>
<thead>
<tr>
<th>DECATASTAPHIZING PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worry: That this lump on my neck is thyroid cancer.</td>
</tr>
<tr>
<td>Plan: If I do have cancer, I will:</td>
</tr>
<tr>
<td>• Remind myself that I have access to top doctors.</td>
</tr>
<tr>
<td>• Remind myself that thyroid cancer is one of the most treatable forms of cancer.</td>
</tr>
<tr>
<td>• Use the sick and personal time I have saved from work to consult with doctors and have surgery.</td>
</tr>
<tr>
<td>• Follow all doctor’s orders during recovery.</td>
</tr>
<tr>
<td>• Attend regular follow-up visits.</td>
</tr>
<tr>
<td>• Have my mother stay to help take care of the kids if necessary.</td>
</tr>
</tbody>
</table>

Source: Clark & Beck (2010)
CBT for GAD: Can worry be helpful?

<table>
<thead>
<tr>
<th>Productive Worry</th>
<th>Unproductive Worry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focused on immediate, realistic problems</td>
<td>Focused on distant, abstract problems</td>
</tr>
<tr>
<td>Can exercise control</td>
<td>Feels out of control</td>
</tr>
<tr>
<td>Greater focus on the problem</td>
<td>Greater focus on negative emotion</td>
</tr>
<tr>
<td>Can try out solutions and shift if not successful</td>
<td>Cannot accept solution because it is not a guarantee of success</td>
</tr>
<tr>
<td>Willingness to tolerate risk and uncertainty</td>
<td>Relentless pursuit of safety and certainty</td>
</tr>
<tr>
<td>Higher level of self-efficacy in coping</td>
<td>Perceived helplessness to cope with outcome</td>
</tr>
<tr>
<td>Lower anxiety</td>
<td>Higher anxiety</td>
</tr>
</tbody>
</table>

Source: Clark & Beck (2010) © 2013 Beck Institute

CBT for GAD: Uncertainty Recognition and Exposure

- DEVELOP AWARENESS OF STRATEGIES CLIENTS USE TO AVOID UNCERTAINTY.
  - Approach strategies (e.g., excessive reassurance seeking; obtaining excessive information)
  - Avoidance strategies (e.g., procrastination)
- ENGAGE IN IN VIVO EXPOSURE TO UNCERTAINTY-INDUCING SITUATIONS.

Source: Dugas & Robichaud (2007) © 2013 Beck Institute

CBT for GAD: Imaginal Exposure

- APPLIED TO WORRIES ABOUT HYPOTHETICAL SITUATIONS.
- GOAL IS TO OVERCOME COGNITIVE AVOIDANCE BY FULLY EXPERIENCING THREATENING MENTAL IMAGES AND EMOTIONAL AROUSAL.
- INCORPORATION OF UNCERTAINTY-INDUCING ELEMENTS IS FUNDAMENTAL.
- CREATE EXPOSURE SCENARIO.
  - Remove elements that neutralize the anxiety.
  - Use present tense, as if the event were happening.
  - Make the scenario frightening but believable.

Source: Dugas & Robichaud (2007) © 2013 Beck Institute
CBT for GAD: Problem Solving Training

- **APPLIED TO ACTUAL CURRENT PROBLEMS**
- **IMPROVING PROBLEM ORIENTATION**
  - Overcoming intolerance of uncertainty
    - Recognizing problems before it is too late
    - Seeing problems as a normal part of life
    - Seeing problems as opportunities rather than as threats
- **APPLYING PROBLEM SOLVING SKILLS**
  - Overcoming intolerance of uncertainty and the need to have the "perfect" solution

Source: Dugas & Robichaud (2007)

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CBT for GAD: Reevaluation of Worry

- **RATIONALE: CLIENTS WITH GAD OFTEN BELIEVE THAT...**
  - ...worry helps them to find a solution to their problems.
  - ...worrying serves a motivating function.
  - ...worry serves as a buffer for negative emotions.
  - ...worry can prevent negative outcomes from happening.
  - ...worrying about others shows that they are caring.
- **LAWYER-PROSECUTOR ROLE-PLAY**
  - Clients present arguments for and against the usefulness and value of their worries.
- **CONSIDERATION OF A LIFE WITHOUT WORRY**

Source: Dugas & Robichaud (2007)

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CBT for Social Anxiety: Exposure Ideas

- **ORDERING TAKE-OUT FROM AN ETHNIC FOOD RESTAURANT**
- **ORDERING THROUGH A DRIVE-THROUGH**
- **SENDING AN ORDER BACK AT A RESTAURANT**
- **PURCHASING SOMETHING AT A STORE THAT Sells UNFAMILIAR ITEMS OR ITEMS THAT CAN MAKE ONE UNCOMFORTABLE**
- **WALKING IN STORES THAT SELL EXPENSIVE ITEMS**
- **ASKING QUESTIONS OF A SALES CLERK**
- **USING COMPLEX EQUIPMENT AT THE GYM**
CBT for Social Anxiety: Exposure to Social Mishaps

- **TARGETS** THE HIGH COST THAT SOCIALLY ANXIOUS CLIENTS ATTRIBUTE TO FAILED SOCIAL INTERACTIONS
- **GOAL** IS TO CREATE EXPOSURES THAT ELICIT NEGATIVE AND AVOIDED CONSEQUENCES
- **EXAMPLES**
  - Ask 20 random women on the street out on a date.
  - Exaggerate a perceived deficit (e.g., pouring a pitcher of water under one's arm).
  - Buy something embarrassing from the store (e.g., Preparation H).
  - Sit in someone else’s seats at a sporting event.

Source: Hofmann (2010) © 2013 Beck Institute

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CBT for Panic Disorder: Panic Sequence

- **CLIENT BECOMES AWARE OF A BODILY (OR MENTAL) SENSATION.**
  - Panic clients are much more aware of uncomfortable sensations than most people.
- **CLIENT INTERPRETS SENSATIONS INCORRECTLY**, BELIEVING A BODILY (OR MENTAL) CATASTROPHE IS HAPPENING OR WILL HAPPEN IN THE NEXT FEW SECONDS.
- **CLIENT’S ANXIETY TURNS INTO PANIC.**
- **“FEAR OR FEAR” CYCLE PERPETUATES CLIENT’S PANIC DISORDER.**

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CBT for Panic Disorder: Catastrophic Misinterpretations

- PALPITATIONS OR OTHER CARDIAC SENSATIONS = HEART ATTACK
- FEELING OF UNREALITY = LOSING CONTROL, GOING CRAZY, OR ENDING UP IN A MENTAL INSTITUTION
- TIGHTNESS IN CHEST PLUS BREATHLESSNESS = SUFFOCATION
- DIZZINESS = FAINTING
- NUMBNESS OR TINGLING = STROKE
- MUSCLE SORENESS = TUMOR

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CBT for Panic Disorder: Therapeutic Hypotheses

“Either you really are in danger of [having an immediate heart attack] when you experience [chest pain and shortness of breath]

OR

The problem is that you believe you are in immediate danger.”

CBT for Panic Disorder: Coping Card

IF YOU DO HAVE A PANIC ATTACK, YOU HAVE A CHOICE.

You can think:
“Oh no, it’s horrible! I’ve had one panic attack and may have more. I can’t stand this!”

Or you can think:
“OK, I’ve had a panic attack. No big deal. Let me learn from it, see how it happened, and discover why I didn’t cope with the anxiety effectively before it grew into panic. At the very least, I can see once again that all my catastrophic predictions didn’t come true.”

CBT for Panic Disorder: Interoceptive Exposure

- **CARRYING OUT EXERCISES THAT PRODUCE PHYSICAL SENSATIONS OF PANIC**
  - Shake head loosely from side to side for 30 seconds => dizziness and disorientation
  - Place head between legs for 30 seconds and lift quickly => lightheadedness and blood rushing
  - Step-ups for 1 minute => racing heart and shortness of breath
  - Hold breath for 30-45 seconds => chest tightness and sensation of smothering
  - Tense every part of body for 1 minute => muscle tension, weakness, and trembling

Source: Barlow & Craske (2007)
CBT for Panic Disorder: In Vivo Exposure for Agoraphobic Behavior

- DISTANCE FROM HOME
- PROXIMITY TO AN EXIT OR EASE OF ESCAPE
- TIME OF DAY
- NUMBER OF PEOPLE
- ACCOMPANIED OR ALONE

Source: Barlow & Craske (2007)

Day 3: Relapse Prevention

CBT’s Later Stage

- ASSESSMENT OF PROGRESS IN TREATMENT
- CONSOLIDATION OF LEARNING
- RELAPSE PREVENTION
- PROMOTE A LIFESTYLE THAT FACILITATES PSYCHOLOGICAL HEALTH AND WELL BEING
- TAPERING OF SESSIONS IN ANTICIPATION OF COMPLETION OF TREATMENT
- BOOSTER SESSIONS
Relapse Prevention Plan

- **Warning signs:**
- **Coping plan:**
- **Other people who can help me:**
- **When I should contact a professional:**
- **Professional contacts:**

Discussion

**WHAT OTHER RELAPSE PREVENTION COMPONENTS DO YOU USE WITH YOUR CLIENTS?**

Further Reading

Certification and Referrals in Cognitive Behavior Therapy
WWW.ACADEMYOFCT.ORG

Beck Scales for Adults and Youth
WWW.BECKSCALES.COM

Cognitive Therapy Worksheet Packet
Designed for therapists to use with Cognitive Behavior Therapy: Basics and Beyond. This packet contains thirteen instruments used in that book, instructions, filled-in examples, and blank copies.
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