COBRA Trial CBT Protocol

Clinical Practice Manual

Cost and Outcome of BehaviouRal Activation:

A Randomised Controlled Trial of Behavioural Activation versus Cognitive Behaviour Therapy for Depression

COGNITIVE BEHAVIOURAL THERAPY CLINICAL PRACTICE MANUAL

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Manual Structure

This manual contains the necessary information you will need in order to initiate and undertake cognitive-behavioural therapy (CBT) with patients in the COBRA trial.

Section 1 has some information about the COBRA trial itself. Section 2 outlines some general principles of session timing, duration, frequency and safety. Sections 3 and 4 describe the two treatments being tested in the COBRA trial – BA and Cognitive Behavioural Therapy (CBT) in very broad terms.

Sections 5 and 6 will give you a very good summary of what a course of CBT treatment in the COBRA trial will look like, describing the phasic nature of the COBRA protocol and a summary of the content of each phase. Section 6, in particular, gives a schematic overview of a COBRA CBT treatment programme.

Section 7 then goes on to describe the core CBT techniques – assessment/orientation, activity scheduling, cognitive restructuring and relapse prevention. It also briefly describes some of the modular specific techniques you will be using for co-morbid presentations.

Section 8 then goes on to detail the structure of clinical sessions at all stages of a CBT treatment programme. You should follow these structures very closely as your adherence to the overall structure, sessional structure and specific therapeutic content will be critical in ensuring fidelity to the clinical protocol COBRA is testing. As part of assuring treatment integrity tapes from all therapists will be formally assessed by independent assessors from the Oxford Cognitive Therapy Centre, initially with formative feedback and across treatment as a whole summatively to describe the trial CBT.

Section 9 consists of a series of helpful ‘therapist notes’ on each of the principle techniques you will be asked to employ. Think of these as aide memoires. They will help you refresh your memory when it comes to employing these techniques.

Section 10 lists some of the key scientific references underpinning the COBRA trial. This is followed by Section 11 (Appendices), consisting of the therapeutic tools such as diaries that you will need to use throughout any treatment programme.

Please consult this manual frequently. Bring it with you to supervision and use it to help you become confident and competent at delivering the COBRA CBT clinical protocol. If you would like to personalise it, please do, and if you have any suggestions for additional materials, the trial team will be happy to listen.

Introductory Pages

COBRA Trial CBT Protocol

Clinical Practice Manual

Introduction to the COBRA trial

Clinical depression is one of the most common and debilitating of the psychiatric disorders. It accounts for the greatest burden of disease among all mental health problems, and is expected to become the second-highest amongst all general health problems by 2020.

COBRA is a Randomised Controlled Clinical Trial of two psychological interventions – Behavioural Activation (BA) and Cognitive Behaviour Therapy (CBT) – to establish if there are important clinical and cost differences between them. In detail, the COBRA programme of research seeks to answer two interlinked questions:

3. What is the clinical effectiveness of BA compared to CBT for depressed adults in terms of depression treatment response measured by the PHQ9 at 12 and 18 months?
4. What is the cost-effectiveness of BA compared to CBT at 18 months?

In addition, we will undertake a secondary process evaluation to investigate the moderating, mediating and procedural factors in BA and CBT that influence outcome.

BA and CBT are both active psychological treatments which have previously demonstrated positive effects for people with depression, and are recommended by NICE guidelines for the treatment of depression. Half the participants in the COBRA trial will receive BA and half CBT, allocated on a random basis.

Participants will be assessed for eligibility by a COBRA researcher using a structured clinical interview. If eligible, they will be asked to complete a number of questionnaires with the researcher. They will then be randomly allocated to one of the treatments by the Peninsula Clinical Trials Unit in Plymouth using a process concealed from the research team to ensure the team are blind to allocation. Participants will also be seen again for follow-up appointments with a researcher at six months, 12 months and finally at 18 months to complete a number of questionnaires. The research study will last for four years, but each participant's involvement in the study will be for eighteen months.

The study will be taking place in three sites; Devon Durham and Leeds with the lead centre being the University of Exeter's Mood Disorders Centre. COBRA will begin in March 2012, the first participant will start treatment in September 2012 and the study will end in April 2016. Participants will be recruited from August 2012 until April 2014.

The trial is funded by a UK National Institute for Health Research (NIHR) Health Technology Assessment Programme Clinical Evaluation and Trials grant.

COBRA Trial CBT Protocol

Clinical Practice Manual

COBRA Trial CBT Protocol

Clinical Practice Manual

General clinical procedures

d. Frequency and duration of appointments

Participants will receive a maximum of 20 sessions over 16 weeks with the option of four additional booster sessions.

Sessions will be face to face, of one-hour duration maximum.

Therapists and participants have the option of having sessions up to twice weekly over the first two months of the trial and weekly thereafter where this is clinically indicated (e.g., with a severely depressed client and twice weekly sessions would support initial behavioural work).

The final few sessions may be spaced out further if clincially appropriate to support relapse prevention.

e. Risk assessment and management

Risk will be assessed at every appointment. At the first appointment a full risk assessment will include enquiry on suicide, self-harm, neglect of self, neglect of others, harm to others and harm from others. Risk will be assessed in terms of thoughts, plans, actions taken in support of any plans, and preventative factors. At subsequent appointments risk will be reviewed against the assessment conducted in the first appointment to assess any change in the patient's risk status.
Where any factors are detected which leads the therapist or mental health worker to believe that there is a danger that the patient will harm themselves or others through action or neglect, a risk management plan will be initiated. This plan will follow the principles of the Mood Disorders Centre's policy on risk and any actions taken will be determined by the specific policies in place at the NHS clinical provider site. All risks identified and any actions taken will be documented and discussed in supervision and with the COBRA trial manager, site lead and chief investigator.

f. Collecting routine outcome measures

Over recent years, it has become standard practice for therapists and mental health workers to ask patients to complete short clinical outcome scales at every clinical encounter. Measures are used to assist both parties to track progress, identify setbacks and provide data for individual patient progress and overall service evaluation. In COBRA we use the same procedure at every session. In the CBT arm this will be the Beck Depression Inventory (BDI). Measures are collected from the patient during the early part of the appointment and discussed briefly before moving onto the main session content. Occasionally measures may lead to a change in the session agenda. A summary of all therapists' outcomes on the BDI is always discussed in supervision.

COBRA Trial CBT Protocol

Clinical Practice Manual

What is Behavioural Activation?

Behavioural Activation (BA) is a psychological treatment alleviating depression by focusing directly on changing behaviour based on behavioural theory. This theory states that depression is maintained by avoidance of normal activities. As people withdraw and disrupt their basic routines, they become isolated from positive reinforcement opportunities in their environment. They then end up stuck in a cycle of depressed mood, decreased activity and avoidance. BA systematically disrupts this cycle, initiating action in the presence of negative mood, when people's natural tendency is to withdraw or avoid. BA targets avoidance from a contextual, functional approach not found in CBT – i.e., BA focuses on understanding the function of behaviour and replacing it accordingly. BA also explicitly prioritises the treatment of negatively reinforced avoidance and rumination.

The overall goal of BA is to re-engage participants with stable and diverse sources of positive reinforcement from their environment and to develop depression management strategies for future use. BA sessions consist of a structured programme increasing contact with potentially antidepressant environmental reinforcers through scheduling and reducing the frequency of negatively reinforced avoidant behaviours. Treatment is based on a shared formulation drawn from the behavioural model in the early stages of treatment, thereafter developed with the patient throughout their sessions. Specific BA techniques include the use of a functional analytical approach to develop a shared understanding with patients of behaviours that interfere with meaningful, goal-oriented behaviours and include self-monitoring, identifying 'depressed behaviours', developing alternative goal oriented behaviours and scheduling. In addition the role of avoidance and rumination will be addressed through functional analysis and alternative response development.

COBRA Trial CBT Protocol

Clinical Practice Manual

What is Cognitive Behavioural Therapy?

The overall goal of CBT is to alter the symptomatic expression of depression and reduce risk for subsequent episodes by correcting the negative beliefs, maladaptive information processing and behavioural patterns presumed to underlie the depression. Sessions consist of a structured, partially didactic programme. Treatment begins with patients learning the model and behavioural change techniques, then moves on to identifying and modifying negative automatic thoughts, maladaptive beliefs and underlying core beliefs. In later sessions, learning is translated to anticipating and practicing the management of stressors that could provoke relapse in the future. Specific CBT techniques include scheduling activity and mastery behaviours, the use of thought records and modifying maladaptive beliefs. The behavioural elements in CBT focus on increasing activity together with practical behavioural experiments to test specific cognitive beliefs. CBT does not take the contextual, functional approach of BA, nor does CBT explicitly prioritise the targeting of avoidance and rumination.

COBRA Trial CBT Protocol

Clinical Practice Manual

General clinical principles of the protocol

CBT for depression (Beck et al., 1979) is a manualised approach that has been demonstrated to have proven efficacy and effectiveness in numerous treatment trials. In this trial, therapists will use two seminal treatment manuals in this area (A.T. Beck et al., 1979; J.S. Beck, 2011). Several innovations in CBT since the publication of the original manual have emphasised approaches that help to individualise treatment (Kuyken, Padesky & Dudley, 2009) and overcome cognitive and behavioural avoidance (Moore & Garland, 2003). Moreover, there has been much clinical innovation in CBT that has been about ensuring core behavioural and cognitive strategies are as acceptable and potent as possible (e.g., J.S. Beck, 2011; Westbrook, Kennerly & Kirk, 2011; Padeksy & Mooney, 1990). Therapists will make use of cognitive and behavioural tools or approaches that have become part of the mainstream tool kit of well-trained CBT therapists.

In addition, we anticipate that a significant proportion of patients will present with psychiatric co-morbidities. Based on our previous trials and the epidemiological data these are most likely to be generalised anxiety disorder, social phobia, panic disorder and simple phobia. As with real world CBT, therapists will need to address patients' presenting problems including any co-morbid presentations. Therapists will use CBT case conceptualisation to understand how beliefs and strategies link patients' presenting issues and use evidence-based CBT models and protocols appropriate to the individual patient's presentation. In line with recommended standard CBT practice, therapists will record patients' depressive symptoms at each session using the BDI to monitor treatment progress and amend their conceptualisation and treatment plan if patients do not progress as anticipated.

Primary CBT protocols and evidence summaries used by therapists in the trial:

- Depression (unipolar):
    - Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
    - Moore, R. G., & Garland, A. (2003). *Cognitive therapy for chronic and persistent depression*. Chichester: Wiley.

- Social Phobia:
    - Clark, D.M. (1997). Panic disorder and social phobia. In Clark, D.M. & Fairburn, C.G. (Ed.) *Science and Practice of Cognitive Behaviour Therapy (pp.119-154).* Oxford: Oxford University Press.

- Panic:
    - Clark, D. M. (1986). A cognitive approach to panic. *Behaviour Research and Therapy, 24*, 461-470.

- GAD:
  - Dugas, M.J. & Robichaud, M. (2006). *Cognitive-behavioral treatment for generalized anxiety disorder: From science to practice.* New York: Routledge.

- Post-traumatic Stress Disorder:
  - Ehlers, A., Clark, D. M., Hackmann, A., McManus, F., & Fennell, M. (2005). Cognitive therapy for post-traumatic stress disorder: development and evaluation. *Behaviour Research and Therapy, 43*(4), 413-431.
  - Harvey, A. G., Bryant, R. A., & Tarrier, N. (2003). Cognitive behaviour therapy for posttraumatic stress disorder. *Clinical Psychology Review, 23*(3), 501-522.

- Personality disorders:
  - Beck, A. T., Freeman, A., Davis, D., & Associates. (2003). *Cognitive therapy of personality disorders* (Vol. Second Edition). New York: Guilford.

- Eating disorders:
  - Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. *Behaviour Research and Therapy, 41*(5), 509-528.
  - No summary to date, but see Roth, A., & Fonagy, P. (2005). *What works for whom: A critical review of psychotherapy research* (Vol. Second Edition). New York: Guilford.

When addressing co-morbidities therapists may wish to use disorder specific measures to assess severity and to monitor progress. The manuals may suggest such measures or alternatively therapists may use bespoke tools for assessment / evaluation.

CBT normally progresses through several phases (A.T. Beck, 1979; J.S. Beck, 2011):

a. Phase I

Phase I represents the introduction of the core CBT methods. The first session is an assessment where the worker gathers information on the patient’s presenting issues and illustrates the CBT model with respect to the presenting issues. A list of collaboratively agreed presenting issues and SMART treatment goals is generated. Phase I then moves on to socialise the client to CBT and start to introduce some of the core therapeutic activities with the intention to achieve some early symptom gains. This typically includes linking mood, thinking and behaviour through a descriptive case formulation and setting up some behavioural monitoring/activation.

b. Phase II

Phase II moves into cognitive interventions focused first on automatic thoughts and then moving on to working with conditional assumptions, using thought records and other in-session and homework tools. Typically a theory driven cross-sectional case formulation would be used here. Behavioural experiments are central to testing and reframing conditional assumptions.

c. Phase III

Phase III is focused on planning to maintain progress and reduce relapse potential by working on beliefs and behaviours that will confer resilience in the face of future stress. If appropriate, a longitudinal case formulation is used to anticipate and plan for set-backs.

d. Booster phase

These appointments are optional with a very flexible content. Therapist and patient undertake a review of the difficulties experienced and identify specific therapeutic techniques from the core Phase I stage or any modules in Phase II which may need refreshing, practice or further work. Relapse prevention activities may also be undertaken.

e. Transition and review appointments

These sessions are an opportunity for therapist and patient to review progress, reflect on activities undertaken so far and move to the next Phase. The list of presenting issues and goals is reviewed and the formulation is revisited. A revised set of presenting issues and goals is developed for the next phase.

CBT Protocol Overall Session Chart

PHASE I						TRANSITION	PHASE II								TRANSITION	PHASE III				BOOSTER			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Assessment/rationale/ agreed presenting issues/shaping towards goals. Descriptive case formulation diagram																							
	Goal setting and first interventions					Progress to goals reviewed									Progress to goals reviewed								
Homework																							
Behavioural experiments																							
	Behavioural interventions: Activity and mastery and scheduling pleasurable /rewarding activities																						
		Identifying and responding to automatic thoughts																					
						Identifying conditional assumptions and using cognitive and behavioural strategies to reframe conditional assumptions and articulate and test out more adaptive beliefs. Cross-sectional case formulation.																	
															Longitudinal case formulation, only if necessary, identifying and working with core beliefs, again only if necessary.								
																Relapse Prevention/ Maintaining Progress							

Dark blue = core activities for these sessions; Light blue = non-core, but optional activities for these sessions

Summary of Core CBT Techniques

7. Summary of core CBT techniques

a. Socialisation to the CBT model

Socialising the client to the CBT model includes the development of a shared sense of the treatment rationale. This includes the understanding of depression in relation to the 5 areas approach (Padesky & Mooney, 1990; Kuyken et al., 2009), and that change is possible though working on this model. Doubts and concerns are openly discussed and can be tested as part of treatment. Formulation of a presenting issue can help to apply this directly to the client's situation and add a sense of face validity, cautious optimism, and begin to indicate treatment. This also helps to socialise the client to the style of CBT as one that is collaborative, Socratic and involves two experts in the room (the client as expert in their difficulties and the therapist as an expert in CBT).

Structural aspects of the treatment are also outlined including agenda setting, homework between sessions, the empirical nature of treatment, use of measures, confidentiality agreements, the treatment contract, and frequency and duration of appointments.

b. Goal setting

Goal setting involves the shared development and agreement with the client on the specific goals for treatment in each of the problem areas identified. This is a further aid to the collaborative nature of the work to ensure that both therapist and client have the same aims in mind for treatment. Goals are important in making the expectation of treatment explicit and appropriate (as opposed to the unrealistic goal of never feeling anxious or placing expectations on the behaviour of others). Setting goals is important in identifying explicitly the possibility of change, and can help focus the client upon this possibility. Goals also help to underline the active focused nature of CBT treatment and that progress can be evaluated and reviewed. Goals also serve an important motivational function in providing a point of focus against which current patterns of activities, changes and future patterns can be judged as helpful and/or worthwhile.

Goals developed should be consistent with the 'SMART' notion of goals in being; Specific, Measurable, Achievable, Realistic and Time limited. Goals may be developed further through being prioritised, graded and expressed in positive terms.

c. Activity scheduling

Physical and social inactivity is a key feature for many people with depression. Periods of inactivity may be seen to lead to reduced experience of mastery and pleasure and increased negative thinking, typically rumination and self-criticism. Activities or tasks which the depressed person may previously have completed with ease or with enjoyment become challenging and may be avoided. Cognitions related to performance (I will fail, I will not enjoy it) may reduce further the motivation and likelihood of engaging in tasks. Activity scheduling is a strategy aimed at addressing low levels of motivation, inactivity and rumination and increasing activity that is associated with mastery and pleasure.

By recording a person's activity on an hour by hour basis and tracking mood over this time a picture can be built up to see the impact of the level and range of activity (or inactivity) upon the person's level of depression. This is discussed with the client to identify those behaviours that impact negatively upon mood and those which help to improve mood. Where there is an absence of activity that improves mood this can be built into the person's day to maintain momentum.

This will allow the development of links between behaviour and emotion and subsequently cognition. Activities can be developed on the basis of increasing helpful activity, planning these at difficult times of the day and expanding the repertoire of behaviour. Prior activities that the person has enjoyed or selection of events from a pleasant events schedule (see J.S Beck, 2011) can be planned into the activity schedule.

Barriers to engaging in activities can be helped though a range of strategies including problem solving, challenging negative automatic thoughts, planning and grading activities and cognitive rehearsal.

Progress may be reviewed through a mood rating, scores for enjoyment (pleasure) and scores for achievement (mastery). The initial focus is upon changing the behaviour in advance of shifts in emotion. Small single point shifts in mood (up or down one point out of 10) are seen as significant and indicate future change. Changes in behaviour may need to be emphasised as having to reach a 'therapeutic dose' before improvements are noticed.

As changes in mood (however small) are noted, these provide evidence to challenge any negative automatic thoughts associated with the task (e.g. 'I can't do anything', 'nothing will make a difference,' 'these trivial events prove how pathetic I am').
It is important to keep this work focused on the collaboratively agreed presenting issues and goals.

d. Introduction to automatic thoughts – cognitive strategies

Depression is characterised by a number of cognitive features. This includes Beck et al's 'cognitive triad' that outlines depressive thinking in relation to the self, current experience and the future. Negative views of the self are often characterised by thoughts that one is defective, useless, or inadequate. In this way difficult experiences are attributed to the self. This can also then lead to strong self-criticism. The second component leads the person to interpret their current experience negatively, with insurmountable problems or difficulties leading to a sense of defeat. The final element is about the future as difficult, expectation of failure and hopelessness.

Automatic thoughts are an expression of this triad and occur habitually, automatically and involuntarily. A number of different categorisations of styles of automatic thinking have been developed, but all serve to fit perception with the negative triad. This then subsequently impacts upon the person's emotions, behaviour and physical experiences and vice versa. These will often be raised in relation to the effectiveness of therapy and out of session tasks proposed.

By practicing the identification and self-monitoring of these the client can become more aware of their presence and impact and begin to work to challenge these. Typically this may lead to the use of diary thought records and review of evidence to work towards a more balanced interpretation of events. This may well lead to planned behavioural experiments and the identification of patterns of thinking and behaviour that are more consistent with the client's smart goals. Other cognitive strategies may include the use of survey methods to check for accuracy of cognitions and may be collected by the client, therapist or both. It is important to keep this work focused on the collaboratively agreed presenting issues and goals.

e. Cognitive-Behavioural strategies – behavioural experiments

'The best way to increase the believability of your alternative or balanced thoughts is to try them out in your day to day life.' *(Greenberger & Padesky, 1995).*
Verbal challenging of thoughts is often followed by or developed through the use of behavioural experiments. This is often an important step in moving from an 'in the head' understanding through to a more felt sense of change by putting new or alternative understandings into practice; namely 'walking the talk.' Behavioural experiments are planned experiential activities based on experimentation or observation which the client does within or between therapy sessions.

The primary purpose is to obtain new information which may help to test the validity of the patients' existing beliefs, construct and test new more adaptive beliefs and contribute to the development and verification of the formulation. This will most often follow a process of identifying the cognition, developing an alternative and testing

these out on the basis of a clear prediction on how things will go according to these different perspectives. For an excellent overview of using behavioural experiments see Bennett-Levy et al. (2004). It is important to keep this work focused on the collaboratively agreed presenting issues and goals.

f. Underlying assumptions/rules

Underlying assumptions and rules represent the conditional level of belief and are typically captured in a cross-sectional case conceptualisation of the client's presenting issues. These are the highly individualised conditional and generalised rules or terms of reference a person may hold, are usually functional and which dictate behaviour. Padesky (1994) has proposed that these are often best expressed in an If ________ then _______ format. For example, in depression this may be, '**If** I make a mistake at work, **then** I am worthless' or '**If** my partner and I argue, **then** it means s/he will leave me.' A collaborative articulation of conditional assumptions is a pre-requisite for testing beliefs using behavioural experiments.

The same rule can be expressed negatively (If I don't do something) or positively (If I do something). **If** I don't make a single mistake and everyone says how well I am doing **then** I am okay; versus **If** I make a single mistake **then** I am worthless. Distress may be alleviated on a temporary basis by being able to meet the conditions for coping (the 'if' part of the rule). This however is seldom possible and does not normally support long-term change. The emphasis of intervention at this stage is therefore on the development of alternative more adaptive beliefs that provide a better fit with the person's goals for treatment (e.g. **If** I make a mistake at work, **then** I am just like everyone else, and I can learn from it and develop).

A possible example of an underlying assumption expressed as a rule is: 'I must do things perfectly.' This reflects the rigid, overgeneralised, absolute and extreme nature of problematic rules. Themes present within rules tend to be ones of achievement, acceptance, love or control. Violation of rules tends to be associated with extreme/excessive emotional reactions (anger, sadness, fear). Rules are likely to be activated in situations relating to individuals' specific vulnerability. However they are often not conscious and are uncovered through the development of cross sectional formulations and themes occurring across time and events, or through specific techniques, such as the downward arrow technique; e.g. 'if I can't provide for my family, then my wife will be cross'.

Socratic methods are used to review evidence for and against the belief, tracking the impact of the belief upon the person's goals, and the generation of an alternative belief. Further experimentation is then used to strengthen conviction in this alternative and support its use over and above the original rule. This will very likely require patients do a lot of practice within sessions and as homework. It is important to keep this work focused on the collaboratively agreed presenting issues and goals.

g. Relapse prevention

Relapse prevention is activity undertaken with the client to make explicit the learning and skills development that has taken place across the course of treatment. By helping the client to become aware of the specific skills used in self-formulation and which techniques are helpful, the chance of the client engaging with these skills and maintaining coping after treatment is enhanced. Explicit awareness of skills is typically identified alongside anticipated future difficulties and rehearsal of skills that would be helpful in this context. Relapse prevention can include further short, medium and long-term goals that the client will continue to work towards following the end of treatment, and a plan for how self-therapy will be continued.

The emphasis upon coping may also be enhanced with the use of resilience formulation. This is the application of the same Beckian formulation model, but populated with the thoughts, feelings, behaviours and physical sensations associated with progress, alleviation of distress and meeting the goals for therapy. This may well include alternative underlying assumptions or rules for living developed over the course of treatment (See Kuyken et al., 2009).

Session Guides

8. Session guides

The following pages detail the structure of individual sessions to be conducted as part of the COBRA trial. There are separate pages for: assessment, Phase I early, mid and late sessions, the Phase I to Phase II transition, Phase II sessions, the Phase II to III transition, the relapse prevention sessions and the booster sessions.

These session guides are the essential structure to the COBRA CBT protocol. Individual sessions have different session specific content, the details of which are described in the ‘therapist notes’ section of this handbook. Please use the technique specific instructions to tailor sessions but start and finish the sessions according to the session guides in the following pages.

Assessment Session Guide: Sessions 1-2

9. Introductions and orientation

10. Information gathering

a. Brief description of problems (problem list):
   Development: precipitants, time course, predisposing factors

b. Description of problem behaviour (typical example)
   Behavioural, cognitive, emotional, physical

c. Contexts and modulating variables: Situational, behavioural, cognitive, affective, interpersonal, physiological

d. Maintaining factors: Situational, behavioural, cognitive, affective, interpersonal, physiological

e. Avoidance

f. Coping resources

g. Sessional measures and feedback

h. Psychosocial situation: Family, relationships, accommodation, occupation, social relationships, hobbies/interests

i. Past history, previous treatments and response, other current treatments, alcohol and drug use, co-morbidities

j. Risk assessment

11. Information giving

a. CBT rationale

b. Treatment session, duration and content details, role of worker

c. Descriptive formulation of a typical presenting issue

12. Homework setting

a. Setting appropriate task: Further measures, complete activity record

13. Summarise and check out collaborative understanding of session

14. Appointment planning

15. Ending

Phase I Session Guide: Sessions 2 and/or 3

10. Setting the session agenda
11. Sessional measures – review of measure completed on arrival in waiting area
12. Risk review
13. Review goals – develop SMART elements

14. Session specific therapeutic content
    e. Review typical example of presenting problem
    f. Descriptive formulation of typical presenting issue
    g. Illustrate bi-directional nature of 5 areas approach
    h. Consider role of behaviour
    i. Talk through activity schedule and scoring (Mood overall, option of additional rating for achievement and enjoyment), and practice by completion of current day
    j. Set homework as activity recording for the week – problem solve any barriers to this

15. Manage any other business from agenda
16. Summarise (ideally client summarises), major feedback from client about therapy/therapist
17. End by agreeing next appointment time and place

Phase I Session Guide: Sessions 3 and/or 4

10. Setting the session agenda
11. Sessional measures
12. Risk review
13. Review of activity schedule

14. Session specific therapeutic content
    a. Review use of activity schedule
    b. Check for omissions and distortions
    c. Begin to demonstrate relationship between activity and affect
    d. Linking this to descriptive formulation of difficulty- beginning to note NATs linked to this
    e. Addressing NATs that have interfered with the homework
    f. Identification of behaviours that nurture and those that deplete
    g. Planning increase in nurturing behaviours
    h. Setting behaviour change as homework and problem solving barriers

15. Manage any other business from agenda
16. Major summary and feedback
17. End by agreeing next appointment time and place

Phase I Session Guide: Sessions 4-6

10. Setting the session agenda
11. Sessional measures
12. Risk review
13. Review of activity recording sheets

14. Session specific therapeutic content
    a. Development of role of NATs in activity and developing links between the 5 areas
    b. Identifying and recording NATs
    c. Considering thinking bias
    d. Developing diary thought record (DTR)
    e. Generating alternatives – linking DTR to Behavioural experiments (BE)
    f. Linking different responses to goals
    g. Homework linked to developing use of DTR and BEs

15. Manage any other business from agenda
16. Summarise and major feedback
17. End by agreeing next appointment time and place

Transition and Review Session A (Session 7)

10. Setting the session agenda
11. Sessional measures
12. Risk review
13. Review of DTR and BEs

14. Session specific therapeutic content
    a. Revisit formulation
    b. Check progress against goals
    c. Address remaining treatment interfering processes
    d. Consider cross sectional formulation from descriptive formulations developed
    e. Develop overall plan for next phase

15. Manage any other business from agenda
16. Summarise and major summary
17. End by agreeing next appointment time and place

10. Setting the session agenda
11. Sessional measures
12. Risk review
13. Review of DTR and BEs

14. Session specific therapeutic content
    a. Introduce role of cross sectional formulation
    b. Develop cross sectional formulation
    c. Link to conditional levels of belief (underlying assumptions)/rules for living
    d. Develop alternative conditional beliefs (underlying assumptions)/rules for living
    e. Linking different rules/assumptions to impact on goals
    f. Undertake specific exercises to challenge problematic conditional beliefs and build strength in alternatives
    g. Delivery of cognitive and behavioural interventions in line with the above

15. Manage any other business from agenda
16. Summarise and major summary
17. End by agreeing next appointment time and place

Transition and Review Session B (session 17)

10. Setting the session agenda
11. Sessional measures
12. Risk review
13. Review of homework/out of session task

14. Session specific therapeutic content
    a. Revisit formulation
    b. Check progress against goals
    c. Repeat rationales
    d. Identify remaining activities
    e. Consider need for longitudinal focus versus relapse prevention for progress to date

15. Manage any other business from agenda
16. Summarise and major summary
17. End by agreeing next appointment time and place

Phase III Relapse Prevention Session Guide: Session nos. <= 18-20

10. Setting the session agenda
11. Sessional measures
12. Risk review
13. Review of homework/out of session task

14. Session specific therapeutic content
    a. Introduce concept of maintaining progress and/or reducing relapse potential
    b. Acknowledge necessity to manage forthcoming therapeutic ending
    c. Develop coping blue print, consider inclusion of:
        i. High risk situations
        ii. Early warning signs
        iii. Formulation developed
        iv. Coping in line with goals
        v. Resilience formulation
        vi. Goals for the future (short, medium and long term)
    d. Plan Longitudinal formulation if appropriate
    e. Intervention strategies at conditional level of belief (continua methods, alternative conditional beliefs, point-counterpoint)

15. Manage any other business from agenda
16. Summarise and major summary
17. End by agreeing next appointment time and place

10. Setting the session agenda
11. Sessional measures
12. Risk review
13. Review of homework/out of session task

14. Session specific therapeutic content
    a. review of difficulties experienced
    b. review of formulation
    c. identification of specific therapeutic techniques to revisit
    d. relapse prevention activities

15. Manage any other business from agenda
16. Summarise and major summary
17. End by agreeing next appointment time and place/end

9. Therapist notes detailing core techniques

Assessment Session Guide

Assessment Session Guide

A number of sources provide information on the structure and focus of a CBT assessment. This information will focus upon the guidance developed from A.T. Beck at al (1979); J.S. Beck (2011); Kirk (1989) and Moore and Garland (2003).

Initial contact with the client can serve a number of purposes, not least of which is to develop an individual formulation of how the cognitive model applies to this client's difficulties. This necessitates an understanding of how problems have developed and how they are maintained. This will help to devise the treatment plan and may help to predict difficulties in treatment. The development of assessment and formulation is also used to develop the collaborative sense of treatment and to convey that the therapist understands the difficulties the client describes. Through this approach the therapist aims to inspire a sense of hope and to start to form a good therapeutic alliance. Formulation of a client's presenting issue from information gathered is also an optimal way of socialising the client to the model and the expectations for treatment.

The main aims of a CBT assessment may therefore be considered as:

- Generating a 'list of presenting issues (problem list)'
- Identifying SMART goals for treatment
- Assessment of factors maintaining the problem(s)/current situation
- Socialising to the model and treatment
- Generating a descriptive formulation (5-part model or hot cross bun)
- Assessment of the development of presenting issues
- Assessment of the client's view of presenting issues and treatment

Setting the boundaries and expectations:

The structural elements and expectations of treatment should be explicit and transparent. This includes discussion of arrangements with regard to:

- Consent to treatment, recording and information collection (measures) and sharing.

- Confidentiality arrangements, with particular respect to storing of materials (notes, recordings), supervision arrangements, information sharing, and when the law requires information to be shared (e.g. risk to self or others) and how this will happen.

- Treatment as an active process with an expectation upon out of session work between meetings, and an active collaborative experimental approach.

- Arrangement for timing, frequency and location of meetings, including the setting of a treatment contact and any limitations in terms of the maximum length of treatment and non-attendance.

Assessment and generating the presenting issues list:

Current symptoms and problems are assessed in order to develop the list of presenting issues (sometimes known as the 'problem list'). This requires the collection of information about what the client feels they are intending to gain help with. Basic information is then collected regarding the onset, duration and course of difficulties.

During this phase it is particularly important to use the client's words, to listen carefully and communicate caring concern to the client, with validation of the difficulty that the client is experiencing. This is placed alongside instilling optimism for the possibility of change. Validating statements such as 'This is obviously very difficult/upsetting for you' and summarising the client's discussion and checking for understanding are important.

To generate the list of presenting issues it is helpful to ask the client what he/she sees as the main problems. These can then be explored subsequently in greater detail once a brief description of each has been elicited. Difficulties may then be prioritised by the client in order of difficulty and focus. The area of greatest concern can then be explored in greater detail by discussion of a typical example.

The presenting issues list can then be added to over the course of the assessment and reviewed as the client discusses each of their presenting issues in turn. These may be added to and revised over the course of treatment.

Development of the problem:

Assessment of developmental factors in CBT is focused upon information that is of direct relevance to the development and maintenance of the presenting issue which is being focused upon.

Onset, duration and course:

Difficulties may have a clear onset, or may be more likely to have developed gradually over a succession of events and time. The course of events may also vary for the individual, perhaps persisting steadily or coming in waves with marked fluctuation. It may be helpful to track long standing fluctuations on an event time chart. Changes in presentation may also be considered in light to any treatment or intervention entered into. It may also be the case that the factors leading to the onset of difficulties may vary from those that are now maintaining it. Any clear predisposing factors that made the client more vulnerable to the difficulties currently presenting may also be noted from the perspective of understanding why difficulties have developed and to aid what that may mean for treatment now.

Description of the problem behaviour: typical example

Once an overview of the presenting issues has been identified, it is helpful to consider a detailed example of the main (highest priority) presenting issue. It is important to check that the example to be discussed is typical of the presenting issue.

Ask the client to then give you detail regarding that example. If this is difficult for the client to explain, it may be helpful for the person to close their eyes and imagine the scene as it was happening.

The therapist can then assess the example from the 5 areas approach by considering:

The context or environment:
Where was the client, when was it, what were they doing, who else was involved, how were you feeling physically, how where you feeling emotionally?

Emotions:
Clients will most often be feeling aware of how they are feeling emotionally in situations. People will often seek to avoid or control their experience of emotions which can play a large part in their maintenance. The emotions the person experiences will therefore need to be assessed. A person with a diagnosis of depression will typically not only be feeling a strong sense of sadness, but may also experience anxiety, anger and shame amongst other emotions. How did that person's emotional state impact upon their thinking, behaviour and physical sensations?

Behaviour:
Within depression as noted above, the behaviours that a person engages with will be aimed at managing or avoiding certain emotion experience (but then becomes maintaining of this). What is it that the client is doing to manage his or her situation?

Common behavioural responses to depression are withdrawal, isolation and rumination. Avoidance is common within depression and can serve to maintain the person's sense of failure or self-criticism.

Within the specific example: How did the person react in that situation? What did they do in order to manage how they are feeling? What was the impact of that behaviour? What did they hope to achieve by that behaviour? How does the person feel about responding in this way; do they see it as a problem or something that is helpful? How does it fit with their hopes for the future?

Thoughts:
What are the NATs or other cognitions that were maintaining of the person's difficulty? What was going through your mind at that point? Is that typical for you? How much do you believe this? How does this thought make you feel? What do you want to do when you have this thought?

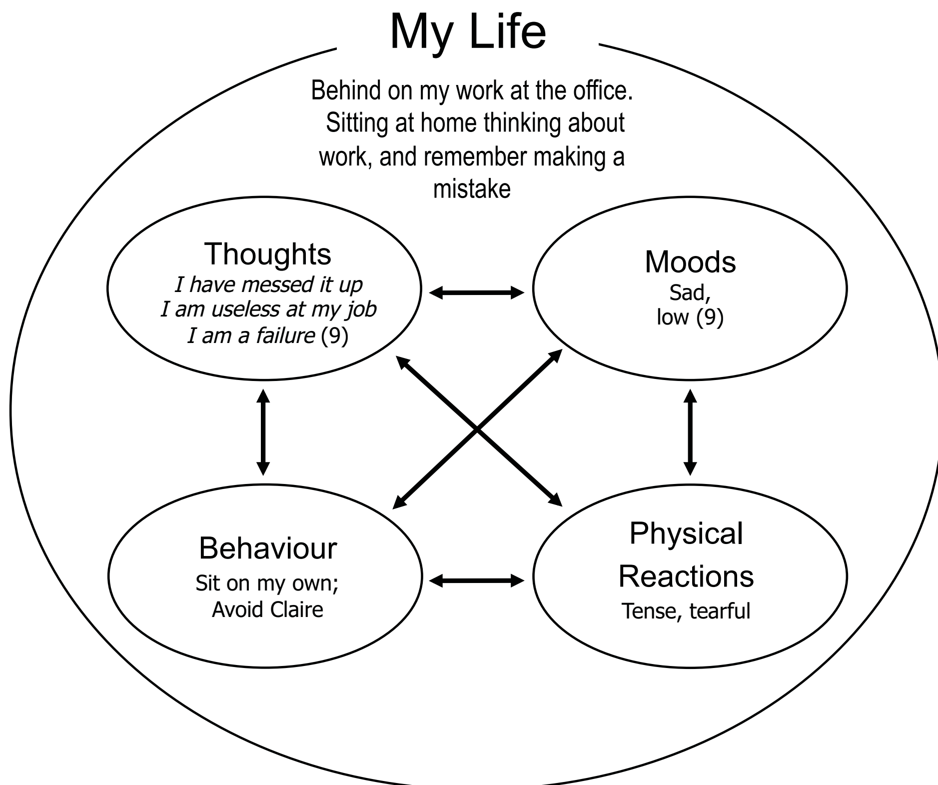
Physical sensations:
How does the person feel physically in this situation? Does this typical pattern of events led to other physical difficulties, such as poor concentration, poor sleep, poor memory, lethargy, shaking, numbness, pain or other physical sensations. Physical embodiment of depression is not uncommon and may even impact upon your client's presentation in the room in terms of their posture, eye contact or level of engagement and energy.

Socialising to the model (CBT rationale) and the bidirectional relationships between areas:

This information can then be collaboratively used to develop a descriptive formulation of this presenting issue to provide some psycho-education regarding the focus of CBT work. Socratic exploration of the impact of each area upon another and that this relationship is bidirectional is important.

- When you were in this situation what was going through your mind?
- When you were thinking this way how did that make you feel?
- The more you had these feelings what happened to these thoughts?
- When you were thinking and feeling this way what did you do in order to manage this?
- What was the impact of this upon these thoughts and these feelings, etc?
- What do you think this might mean about what is important for you to move forward?

Below is an example of descriptive conceptualisation for a man who experienced depression and anxiety that was impacting his work and home life.



Once a typical example had been explored other examples or presenting issues could be explored with exploration around the 5 areas to consider other modulating and maintaining factors.

Modulating variables and maintaining factors:
It may be important to assess for other factors outside of the typical example which impact upon the person's presentation.

Are there contexts when the difficulties are more or less present, or when the client had been able to show increased coping in the past. Are difficulties more prominent in the presence of others? What are the relationships like with key others in the person's life and how do these impact upon the person's presentation? Are there short and long term impacts upon the person's pattern of behaviour?

Moore and Garland (2003) provide some useful questions to elicit further information regarding emotions, cognitions cognitive processes and behaviour.

Coping resources:

It is also important in the assessment of depression to be able to see and build upon the coping resources and resilience that a person has. These may well provide a good platform for further competence and may be the starting point for expansion into alternative coping in line with the persons preferred sense of their future.

These may also be considered from the same five areas approach. Has the person had times when he/she has been able to engage in difficult events and find that he/she was able to cope? What activities, roles or friendships has the person been able to maintain despite the difficulties he/she is experiencing? It is important to keep these explicit and these may even be formulated.

Psychosocial situation:

Consider the broader context within which difficulties are occurring; some of which it may be possible to help access professional support for and other may be facilitated through problem solving. This broader context includes; family, relationships, accommodation, occupation, debt, unemployment, social relationships, and physical health concerns.

Goals:

As part of the assessment and formulation it is important to have a developing sense of the client's goals for treatment. Initially this may be broad and is shaped up further over time. Goals can be helpful to provide a clear shared sense of what the client and therapist are both working towards through treatment and how they will know if this is being achieved. What would the client like to be different by the end of treatment? How would things look if the difficulties were no longer present, and how would others know about or see this change? This beginning will be shaped into SMART goals at this or subsequent sessions.

Phase I Session Guide: Sessions 2-4

Goal Setting and Behavioural Scheduling

Phase I: Sessions 2 - 4

Goal Setting and Behavioural Scheduling

Goal setting:

The collaborative setting of goals for treatment should be developed in SMART terms. SMART stands for:

Specific: what would that look like?

Measurable: how would you know, what would have changed?

Achievable: does this goal involve changing things that are under your control?

Realistic: is this something you can see happening? Would other people say this is a realistic goal?

Time constrained: when would you like this to have changed by?

Goals should also be expressed in positive terms (what will be present) rather than negative terms (things being absent). In other words, rather than 'feeling less depressed' (negative statement of goal) the therapist might enquire, 'So if you were feeling less depressed, how would you be feeling instead', and 'how would you know that this had happened, what would others notice?'

On this last question goals may also be best expressed in concrete operational terms. In other words, how would this impact upon the person's behaviour, what would we see them doing. By expressing goals in these terms they can be easier to measure.

Goals developed may also be prioritised:

- Do you need to tackle any of these goals right away to avoid a crisis?
- Which goal would make the most immediate improvement to your life?
- Is there another goal you need to reach first before you can accomplish this one?
- Which of these goals is most important to you?
- Which of these goals would be the easiest?

Goals may also be broken down into smaller steps to shape performance in approximating towards goals with manageable steps helping to increase the possibility of engagement.

Questions for eliciting goals (Moore & Garland, 2003):

- What goals would you like to work towards in treatment?
- In what ways would you like things to be different?
- What would you like to change most about your current circumstances?
- What things have you stopped doing since you became depressed which you would like to resume?
- Are there things that you have started doing since you became depressed which you would like to change?
- What would you be doing differently if you were not depressed?

On a recent trial with a depressed population (Thomas et al. 2011), difficulties related to goal setting were often cognitive in nature, such as;

'I can't set goals, or things will go wrong'
'If I set goals then I'll only fail and feel worse'
'I can only cope 1 day at a time'.

There are cognitive responses which are amenable to the same interventions as other thoughts. It has been helpful to conduct behavioural experiments on these thoughts, to break goals down further into smaller more manageable steps and to consider the impact of these thoughts on the possibility of change.

Homework setting

Why set homework?

Homework is set in CBT to develop alternative understandings, provide a structure for gathering data and testing hypotheses (used in sessions) and the transfer of in-session skills to a real world setting. Homework is also focused upon maintaining skills use and preventing relapse. It also reflects the stance in CBT of developing skills in order to develop the client's autonomy rather than reliance. Perhaps most importantly, setting and completing homework makes progress in treatment more likely, more rapid and longer lasting (Kazantis et al., 2000).

How do we set homework?

In setting any homework tasks, it is important that the therapist provides a clear rationale for tasks undertaken, and that this rationale is checked and understood. Tasks must be developed through negotiation and collaboration. Tasks which are empowering and jointly developed rather than imposed are more likely to be completed. A clear description of tasks with precise goals should be developed and the content of these should flow naturally from material in the session.

The nature of the rationale should include the idea of this as a no lose or win-win scenario. If an experiment is undertaken and positive changes take place as a result then we win. If homework is undertaken and difficulties emerge, then through

discussing these difficulties, understanding them and developing skills to manage and overcome them we really win.

Homework should be explored with sufficient time in the session to work with the client to explore potential obstacles and how these may be overcome. This includes open discussion to elicit client reactions, and to take feedback on this. Does the task seem useful, meaningful, purposeful, manageable and clear?

What to set as homework?

At the beginning of treatment this may well be set by the therapist to begin to form the expectation of homework as a weekly occurrence. The homework developed should be a continuation of the content of the session. As an intervention and development of understanding, this should be linked to the formulation and help to develop the client's skills.

Initially homework tasks may be more psycho-educational, including reading materials provided, listening to a recording of the session or working up to goals for treatment. These may then develop as the work progresses towards testing new beliefs, exploration of beliefs and alternatives, experiments with new behaviours and the use of strategies to overcome obstacles.

Homework should be adjusted according to the difficulty that the client has in completing the task, and care should be taken not to overload clients. During a more acute phase of depression small and specific tasks are likely to be more appropriate. As symptoms relief is achieved, then more complex tasks may be negotiated.

Within depression the client may often report feeling unsure as to what the homework task was. Tasks should therefore be simple, explicit and concrete. This may also be helpful where the client may have worries regarding not completing the task correctly. For example, asking a client to keep a thought diary of negative automatic thoughts may be aimed at recording 5 examples of this, rather than the client feeling that they needed to capture every experience of this. This should be rehearsed within the session, with the client having a clear understanding of the rationale for this.

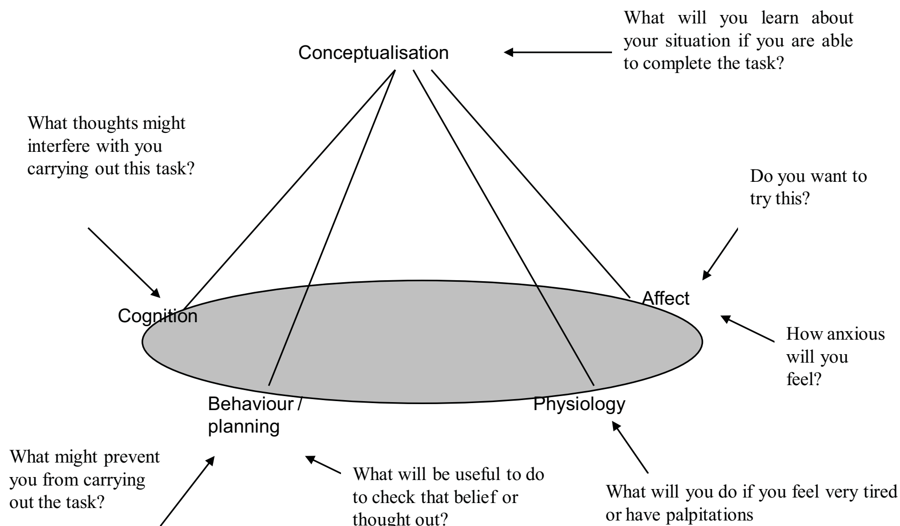
Review of homework should always be a priority for the next session. Failure to do this may result in reduced motivation for work between sessions, a feeling of disinterest or disrespect on the therapist's behalf, or a sense of having done this work or being unworthy of this interest. Learning developed from experiments should ideally be recorded by the client and related to the formulation.

Tips for homework setting:

- Ensure homework is collaboratively set
- Check the client understanding of both the task and the rationale
- Rehearse the task wherever possible
- Elicit client reactions to the task
- Identify together any possible barriers to completion and problem solve these (the win-win approach)

- Formulate barriers to completion
- Don't give up setting homework
- Consider any therapist interfering cognitions in effective homework setting (e.g. 'there's no point', 'I'll just give a task, there isn't time to set one together').
- Relate the task to the formulation (see diagram below)

Consider from CTS-R



Useful questions to ask yourself:

- Did I give a rationale underpinning the assignment?
- Did I check the client was confident in being able to take on the task?
- Did the client see the relevance of the task?
- Was the homework adequately planned within the session?
- Were obstacles to the homework discussed?
- Was the most appropriate task set?
- Was it consistent with the content of the session?
- Will the client learn something useful from engaging in this task?

Obstacles to homework:

Client does not do homework. How could you respond?

- Use this as the focus of the session.
- Assess what led to difficulties in completion
- Were there any practical difficulties (cost, opportunity, other priorities)?

- Beliefs or emotional response to the task?
- Did the client understand the task?
- Did the client understand the rationale?

Partial completion of homework; how do you respond?

- Reinforcement/shaping
- Problem solving

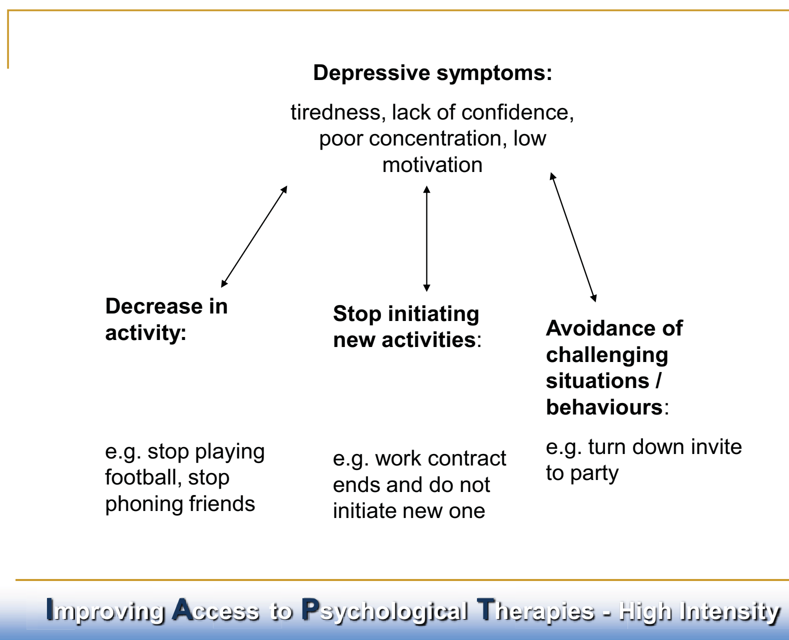
Activity Scheduling

Activity Scheduling

Depression is characterised by long periods of inactivity and rumination. Reduced levels of activity with negative thinking and low mood are conceptualised as forming a vicious cycle for depression. Once the client has been socialised to the model, standard treatment within CBT leads to behavioural activation.

Impact of depression upon behaviour:

- Reduction in activity, increase in withdrawal/avoidance
- Increased engagement with rumination
- Reduction in sense of enjoyment and achievement
- Energy often focused upon maintaining chores and duties
- Loss of contact with support network and protective factors
- Activities maintained may become aversive (I did it poorly, no-one was interested, I'm much worse at it).



Step 1: The first stage of activity scheduling is to monitor the client's level of activity.

This involves asking clients to record their activity on an hour by hour basis and to rate their mood at that time. This may be broken down further into rating of achievement (a sense of mastery) and enjoyment, though for many clients this may remain as a global rating of mood overall. Typically these will be given a rating out of 10 where 0 amounts to none at all and 10 being the highest level. One of the key points to emphasise here is that a client is never doing 'nothing'. When you are sitting in a chair thinking things over and over, this is your activity. In depression it may be important to rate 'mood' overall out of 10 where the client is unable to break this down further, and may experience strong NATs about their ability to complete the task.

The therapist and client then consider this recording to consider the activities that help to improve mood and are more consistent with the client's goals and those which deplete the client further. This can help to emphasise the links between activity and emotion; and may well be helpful in identifying cognitions that are maintaining difficulties (e.g. none of this will do any good') as well as helping to challenge this thought as activation progresses. The capacity to change behaviour and experience a direct impact on mood is also important in developing a sense of agency as being the agent for change.

This will be best rehearsed in the session and the brief nature of description and scoring can help to overcome client concerns about the level of difficulty in completing the task.

	Monday	**Tuesday**	**Wednesday**
8 – 9am	*Get up, shower and dress* *E = 3* *A = 3*	*Lie in and watch TV* *E = 2* *A = 1*	*Get up, shower and dress* *E = 2* *A = 2*
9 – 10am	*Eat breakfast and read paper* *E = 5* *A = 2*	*Get up, shower and dress* *E = 2* *A = 3*	*Answer emails and drink coffee* *E = 4* *A = 5*

Step 2: Monitor and review. Identifying activities that promote positive mood and nurture the client in line with their treatment goals and activities that deplete the client and lead to lower mood ratings.

This means being sensitive to activities that raise or lower mood by a single point and that planning and developing positive activities at key times for vulnerability can increase a sense of agency and the possibility of change.

Once the client has completed the activity record, this data is then used to provide a baseline for the overall level of activity and mood. The therapist and client review those activities completed and consider:

- Which activities increased the rating of mood (and enjoyment and achievement) or maintained improved mood levels?
- Which activities reduced mood or maintained low levels of mood (and enjoyment and achievement)?
- Were there times of the day when mood was most vulnerable?
- Which patterns were most consistent with the person's goals?
- And on the basis of the above, what would be important in the coming week?

In essence, step 2 includes steps to increase frequency and intensity of rewarding behaviour:

- Identify sources of reward
- Increase rewarding behaviour
  - Intensify/increase existing behaviours
  - Enhance skills in behaviours that bring reward
- Decrease avoidance behaviour
- Enhance self-reinforcement

Additional behaviours that may help promote positive mood may be drawn from prior experience/activity, be activities that the person has recently withdrawn from, may be activities that the person has previously considered, may be drawn from lists of suggested possible activities.

Helpful Questions/Considerations

- How is time being used?
- Are activities planned or spontaneous?
- Are activities rewarding? Monotonous? 'Shoulds'? Alone/with others? Ruminative?
- Which activities are associated with most/least E and A? – list
- How do activities relate to life goals?
- What did you learn from this?

Step 3: Scheduling & review: During this stage the therapist is working to engage the client in activities of daily living and tackle biological symptoms of depression (e.g. concentration and memory deficits, lack of energy, procrastination). This stage may also include addressing those cognitions that prevent engagement with the task. A model of looking at TICs (Task Interfering Cognitions) and TOCs (Task Orienting Cognitions) has been developed by Burns (1989).

The concept of TICs and TOCs is aimed at addressing the negative thoughts that clients' may have when planning tasks. This approach helps to identify the process and impact of negative thoughts and in this way awareness and alternative responses can be facilitated. Some thoughts (TICs) are tracked as obstacles to the task in hand (e.g. 'I can't do it') and the consequences of them made explicit. The validity of these thoughts can then be tested through activity and experimentation. TOCs represent the thoughts that are helpful in allowing the person to attempt the task in hand (e.g. 'I can give this a try').

Common problems in activity scheduling:

Moore and Garland (2003) provide guidance on managing challenges in monitoring activity levels in clients with depression. Below is a summary of some of the issues considered.

<u>The client has difficulty in completing an activity schedule:</u>

Don't

- Give up in monitoring of activities
- Conclude that the client is too unmotivated to make progress
- Pressurise or lecture the client that not doing tasks will stop them from getting better (as this is likely to lead to thoughts that trying only leads to failure and therefore future engagement is reduced further)

Do:

- Find out about the reasons for difficulty
- Simplify the monitoring procedure (e.g. rate mood overall rather than enjoyment and achievement, simplify the recording form to am and pm).
- Monitor activity monitoring in the session
- Frame the task as an experiment to find out more about the difficulties

<u>The client gets no sense of mastery or pleasure (or enjoyment) from their activities:</u>

Activities previously performed may have become less satisfying through a number of possibilities including tiredness, applying a high standard of expectation for performance, being duty-focused activities or the sense of anhedonia.

Don't:

- Try to persuade the client that the things that they are doing are in fact satisfying
- Make numerous suggestions of activities that the person may find pleasurable

Do:

- Check that ratings accurately reflect satisfaction gained when performing the activity
- Identify if previously satisfying activities are being overlooked or may have become unsatisfying
- Elicit and highlight thoughts which may deprive the client of potential satisfaction
- Use graded task assignment to simplify tasks
- Test ratings of mood, enjoyment and pleasure on reducing excessive activity levels

Graded task assignment refers to increasing the likelihood of success in setting new behaviours by breaking down tasks into small, manageable steps. Each small step is reinforced in its own right. The moving through steps is aided by identifying and challenging barriers to completion. This may lead to cognitive challenging or strategies to manage anxiety provoking situations such as exposure response prevention. Graded task assignment aims to reduce the client's experience of difficulty (and the chances of taking this as evidence of failure) by encouraging progress towards goals with manageable steps, to increase the frequency of rewards through repeated completion of these steps, and to judge progress in light of the difficulties that they are facing (Fennell, 1989).

The therapist is confronted by a barrage of negative automatic thoughts as to why graded task assignment is not going to work

Clients may often report thoughts in relations to activity scheduling on themes of: 'it won't do any good' or 'it will make me feel worse'. A sense of low expectation for the task may relate to rules applied by the person for them to be effective, i.e. task perfectly completed.

Don't:

- Attempt to modify a barrage of automatic thoughts
- Accept the person's assertion (e.g. this won't do any good)

Do:

- Remain focused upon the task in hand
- Draw the client's attention to the negative thoughts
- Use the TICs/TOCs technique
- Formulate the consequences of the negative thinking

Engaging in the task results in a worsening of depressive symptoms

Whilst in general terms engagement in activity leads to some alleviation of depressive symptoms, it is also possible that clients will report feelings of exhaustion and lowering of mood when engaging with tasks.

Don’t:

- Disbelieve the client or dispute that they feel worse
- Press on with assigning activities as though everything was going well
- Give up on assigning activities

Do:

- Take the limitations imposed by depressive symptoms fully into account
- Break down tasks into smaller chunks or less demanding tasks
- Draw attention to the effects of deprecatory thoughts about starting with small activities
- Weigh up the pros and cons of engaging in small activities

The effects of depressive symptoms on energy levels, concentration and pain levels are all too real and have physical effects that could perhaps be measured. It may be important for clients to acknowledge this difficulty. This may highlight the client to see the difficulties in aiming for an immediate non-depressed level of activity and functioning. This is replaced by breaking down tasks into feasible steps forward. The role of the therapist therefore includes helping to strike the balance between what is an appropriate level of demand when goal setting in the context of the constraints imposed by depressive symptoms.

The client’s hopelessness and avoidance are so entrenched that suggesting any activity provokes a hostile reaction

The level of difficulty and hopelessness that a client may experience in depression could lead to any suggestions for engagement in activity being experienced by the client as a failure of the therapist to understand their difficulties. Therapist suggestions may be seen as attacking or insulting.

Don’t:

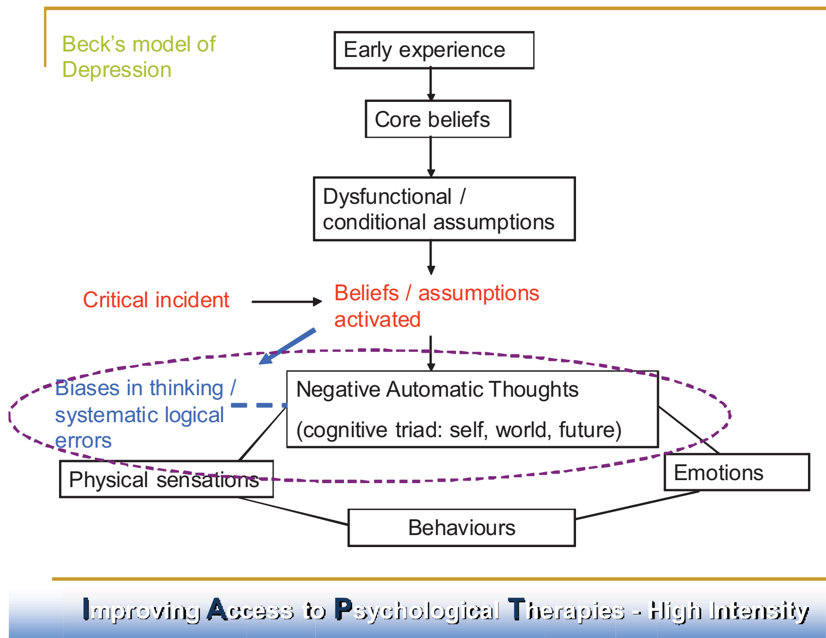
- Give up or become quiet and withdrawn
- Insist that the client carry out the suggested task
- Rely solely on questioning
- Retaliate or become angry or critical of the client

Do:

- Try to maintain activity and structure in the session
- Focus on understanding the client’s reaction
- Make educated guesses about this reaction and share them with the client
- Return to formulating and socialising the client to the cognitive model

Phase I Session Guide: Sessions 4-6

Much of CBT intervention is focused on developing the client's skills to identify, test and challenge negative automatic thoughts (NATs). The focus of techniques designed to develop these skills is on symptomatic relief and the management of difficulties in life. Negative automatic thoughts are the situation-specific thoughts of which patients are often largely unaware. They are automatic, habitual and plausible for the recipient.



The first step in managing NATs is to be able to catch and identify them. This is the first step of cognitive skills developed in treatment. Typically the experience of unpleasant emotions is taken as a trigger to consider the situation in which the emotions occur and then to identify the associated negative automatic thoughts.

Changes in mood are a signal to the presence of NATs. The client can be helped to begin the process by rating (0-10) and becoming aware of changes in emotion. Socialising clients to rating their emotions can also help to increase their sensitivity to changes in strength and nuances of emotions when challenging NATs. Then ask the client to consider in what situation these feelings were occurring. What were they doing, or thinking, who were they with, where were they and what were they doing? Clients should then be asked to consider what was going through their mind when they began to feel this way and to rate how much they believe this thought (0-10). This can lead into further descriptive formulation (hot cross bun) and homework based upon practising this skill. Recording of NATs identified will typically be completed with the use of a thought diary, such as those provided by Greenberger and Padesky (1995).

These skills may be facilitated by the therapist in noticing shifts in emotion as they occur during the session and exploring the above steps with the client through the Socratic Method.

Questions to help elicit NATs:

- What was going through your mind just before you started to feel this way?
- What does this say about you?
- What does this mean about you? Your life? Your future?
- What are you afraid might happen?
- What is the worst thing that could happen if this is true?
- What does this mean about how the other person thinks/feels about you?
- What does this mean about the other person(s) or people in general?
- What images or memories did you have in this situation?
- What images went through your mind?

Beck at al (1979) highlight strategies for the detection of automatic thoughts as:

1. Catching thoughts as they occur and recording them at the time that they occur.
2. Setting aside some time each evening to replay events that led to the thoughts as well as the thoughts themselves.
3. Identifying specific environmental events leading to feelings of depression; are there times or events that often lead to low mood and what is the meaning of these events to the person? This may even lead to deliberate engagement with these environmental events to help to identify cognitions, which are then focused upon in treatment to work to symptomatic relief.

Fennell (1989) identifies some common difficulties in working with clients to identify NATs including:

a) Client avoids recording thoughts:

Strong feeling of depression may make it difficult for the client to diffuse from the emotional experience in order to identify their thoughts. Awareness may at time increase the level of negative affect. Therefore for those who find this difficult the development of behavioural interventions to alleviate low mood may be critical. Additionally, it is important for clients to have a clear sense from socialisation of the rationale for this approach to facilitate engagement. Awareness however, may be particularly helpful for clients to begin to address those distressing thoughts in order to move forward.

b) Therapist and client find it difficult to identify the NATs:

Where clients are unable to identify any NATs it may be helpful to socratically question the personal significance of events (e.g. 'what does this mean to you, what does it say about you/your situation/your future?') Moore and Garland (2003) also identify this difficulty when working with depression and suggest that therapists:

Don't:

- Become abstract and try to describe the definitive features of an automatic thought
- Assume there is necessarily avoidance or resistance at work

Do:

- Consider words, images and meanings
- Persist with standard techniques, including review of upsetting events, mood changes occurring in session and automatic thought records

Among further difficulties and strategies identified by Moore and Garland (2003) is the challenge that:

<u>The client refuses to discuss upsetting situations</u>

Avoidance may take many forms in depression, including intentional cognitive avoidance as a strategy to try to manage distress. It may therefore be particularly challenging for clients using this strategy to be asked to deliberately focus upon and record their thoughts.

Don't:

- Insist that the client discusses the upsetting situation
- Change focus to an unrelated area

Do:

- Identify the client's thoughts about discussing upsets
- Use these thoughts to illustrate the cognitive model
- Discuss the pros and cons of not thinking about upsetting things
- Approach discussion of upsetting situations in a graded fashion
- Point to the possibility that particular underlying beliefs may be magnifying upsets.

By developing awareness of NATs, clients may also be helped to identify patterns in their thinking which can help to increase their awareness, create distance from them and manage them.

Systematic logical errors: Reasoning biases

- Mind reading is making assumptions about what others are thinking.

- Emotional Reasoning is using how you feel to infer what is going on.

- Discounting is ignoring evidence that contradicts your view.

- Labelling is putting a global label on an incident of a certain type without responding to what is specific and different about that incident.

- Arbitrary inference is drawing a specific conclusion in the absence of evidence or when the evidence is contrary to the prediction. Jumping to conclusions.

- Selective abstraction is focusing on a detail out of context whilst ignoring other important features of the situation. Mental filter/tunnel vision.

- Overgeneralisation is drawing a general conclusion on the basis of one or more isolated incidents and applying across the board to related and unrelated situations.

- Magnification/catastrophisation is exaggerating the significance or importance of an event in a negative direction. Fortune telling.

- Personalisation is inappropriately relating external events to oneself.

- Dichotomous thinking is judging events as either good or bad, black and white thinking. All-or-nothing thinking.

- Making 'should' or 'must' statements is having an over-precise idea of how you or others should behave, not taking into account situational factors.

Further examples of thinking errors are available, one example being Moore and Garland (2003, p.389).

Once the client has identified NATs the next step is to question the thoughts and track their impact upon the person's mood, how they fit with the client's SMART goals, and the validity of the thoughts. There are a number of methods to help the client test automatic thoughts.

Methods:

- Reviewing evidence for and against (thought records)

- Behavioural experiments – this will be expanded further in relation to underlying/conditional assumptions

- Responsibility pies - Attribution of blame/responsibility beliefs

- Surveys – ‘everyone thinks/does this don’t they?’

- Looking at the origins of the thought
    - Can you remember when you began to hold this view?
    - Are there times in the past when X happened and you did not think this?
    - What experiences have led you to think this?

- Role playing the thought
    - Client argues FOR the thought, therapist argues AGAINST it.
    - Then swap roles

Thought records

Thought records as identified below are typically worked through with the client to begin to challenge the NATs identified. The example below is based on Greenberger and Padesky (1995) and provides prompting questions that the therapist and client can work through together in the session, prior to use between sessions.

The client is asked to consider current and historical factual evidence that is consistent with both the 'hot thought' (the thought with the most emotion attached) and evidence that is not consistent with the thought. This information may be currently available, or experiments may need to be carried out in order to test the thoughts. The use of thinking bias may be helpful in considering how information that is not consistent with the hot thought is excluded, or processes such as 'emotional reasoning' ('I feel it therefore it must be true') that may treat emotions as if they were facts.

THOUGHT RECORD

1. Situation	2. Emotions	3. Automatic thoughts	4. Evidence that supports the hot thought	5. Evidence that does not support the hot thought	6. Alternative / balanced thoughts	7. Re-rate moods now	8. What should I do now?
Brief description of what was happening, what you were doing at the time?	Describe each emotion in one word. Rate the intensity of the emotion from 0-100%	What was going through your mind? What does this say about you? What is the worst that could happen?	Write factual evidence to support his conclusion. Try to avoid mind reading / emotional reasoning.	Write factual evidence that does not support this conclusion.	Based upon the evidence what would be a balanced alternative thought? Rate how much you believe this thought 0-100%	Copy the emotions from column 2. Re-rate their intensity from 0-100%	What should you now do based upon the balanced thought?

Useful questions:

- What evidence do you have that supports this thought? Are there other times/experiences that have made you think this?
- Is there any evidence that does not support this thought? Before you got anxious/depressed…, when you were younger?
- Are there any experiences that show the thought is not completely true all the time?
- What would I say to a friend?
- What would a friend say to me?
- When I’m not feeling like this do I think about this situation in a different way?
- When I felt this way in the past, what did I think about to help me feel better?
- What have I learnt in my prior experience that might help me now?
- Action plan – does the new thought suggest any action?

In many situations the alternative evidence for thoughts will not be immediately available. In this instance, intervention will be focused on setting up experiments in order to gather information to test thoughts and assumptions. Behavioural experiments may be set up in relation to NATs or underlying/conditional assumptions.

Transition and Review Session (Session 7)

Transition and Review Session (Session 7)

This session is used to review work to date, revisit the presenting issues and goals agreed at assessment and plan the next phase of work. The intention is to support patient learning up until this point, celebrate any positive change, ensure the focus for therapy remains collaboratively agreed and appropriate and map out the work that will take place in Phase II.

Normally at this stage the client will be socialised to the model, comfortable with the therapy format and therapist, able to use behavioural skills and identify and challenge automatic thoughts. The next phase turns to beliefs that underpin automatic thoughts and behavioural repertoires involved in maintaining depression.

However, every client is different and the rate of progress will be different for every client.

Phase II Session Guide: Sessions 8-16

Once the client can skilfully and effectively challenge NATs the focus of cognitive intervention shifts to the level of underlying/conditional assumptions. In this stage the therapist works to identify the rules or assumptions that the client holds. This level of focus is more consistent with a cross-sectional level of formulation (Kuyken, Padesky & Dudley, 2009). This is focused on identifying the typical themes and patterns that repeatedly occur across different situations.

Underlying assumptions may be explored by the therapist and client by considering the themes in thinking that occur across time and different situations. A further approach is the downward arrow technique where the client is asked specifically about the meaning of NATs or what NATs say about them e.g.:

- What does this mean to you?
- If this was true, what does this say about you as a person?
- What is the worst thing about that?

Underlying assumptions may be best identified in the 'if_________ then __________' format as identified by Mooney and Padesky (2000). These are the rules or assumptions that the person makes in different situations (e.g. if 'I don't do things perfectly or make a mistake then I am worthless'). Underlying/conditional assumptions expressed in this format are more amenable to experimentation. Behavioural experiments are one method for challenging such beliefs.

Underlying assumptions should be integrated into the formulation and considered in terms of their impact upon the client and how they fit with the client's goals for treatment. It is also important to consider with the client the context of the development of these rules and assumptions, which they may have needed in order to survive difficult or toxic situations. However the invitation in treatment is to now consider whether these rules are optimal for the client's goals and current life situation.

The therapist also aims to assist the client in identifying that the underlying/ conditional beliefs are beliefs rather than facts. One approach for this is to consider the prejudice model outlined by Padesky (1990).

Steps involved in working with underlying/conditional assumptions:

- Formulation of the conditional belief - what is the belief held by the client?
- Observation of the belief in action in everyday situations – what is the impact of this belief? Formulate this and consider this in relation to treatment goals.
- Socratic questioning/discussion of evidence for and against belief(s)
- Consequences of beliefs: self-fulfilling?

- Is change seen as advantageous?
    - Advantages and disadvantages of conditional belief
- Identifying alternative rule
- Behavioural experiments

Socratic Qs of conditional beliefs

- Are there times when this rule does/does not work for you?
- What experiences have you had that support this belief?
- What experiences have you had that don't support this belief?
- How does this belief fit with what is realistic or possible for you/for other people?
- How does this belief fit with the rules you expect other people to fit to (are you setting very tough standards for yourself)?

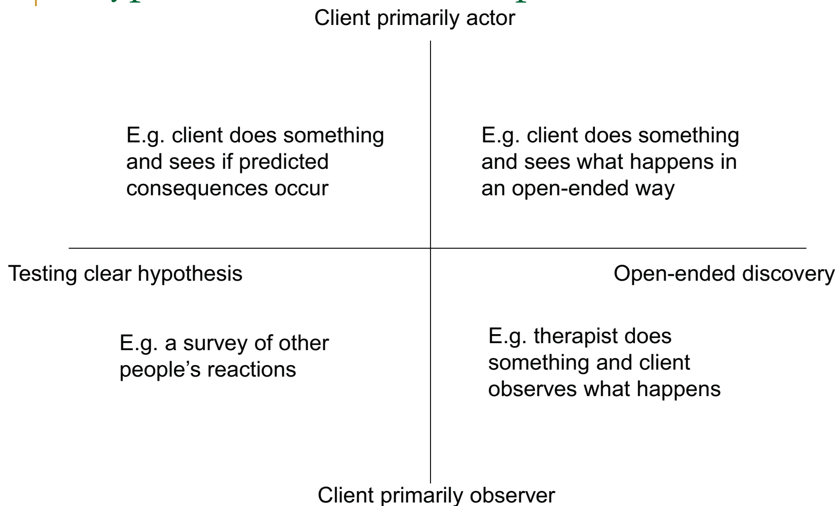
Exploring the consequences of CBs

- What are the consequences of having this rule?
    - Compensatory behaviours
    - Feelings/reactions when the rule is activated

Generating an alternative, balanced conditional belief

- What might be a more helpful rule to have?
- What sort of new rule could you come up with that would better reflect the realities of your situation?
- What sort of alternative rule could you have which would help you have the sort of life/relationships that you want? E.g. my value as a father and a husband depends on more than just the amount I am paid.
- Flashcards for modifying conditional beliefs.

There are different types of behavioural experiments (Figure below). It is important to take in to account when designing behavioural experiments how much the activity is driven by the conditional belief and how often the behavior occurs in the client's normal repertoire of behavior.



Planning and Implementing Behavioural Experiments

- Collaborative, logical, planned, rationalised

Behavioural experiments should be developed in partnership with the client and make sense to the client both in terms of why the experiment is being undertaken and how the client will carry this out.

- Be clear about the belief you are testing (e.g., "So your prediction is that you go to this party you will end up standing by yourself most of the time and you believe this 95%")

The behavioural experiment should be clearly focused on a specific belief.

- Design experiment collaboratively 'how could we test this out?'

As well as developing the experiment collaboratively it is important to consider the opportunity to learn and develop whatever the outcome. In this sense the experiment is a no lose experiment, as whatever the outcome we learn more about how to cope.

- Make clear prediction(s) and rate conviction

In advance of completing the experiment the client should be able to state clearly what the outcome of the experiment will be if the assumption is true and what will illustrate that the rule may not be true. In this way disconfirmatory experience upon completion of the experiment is less like to be discounted.

- Open-minded approach

All parties should consider the experiment in an empirical way, with all outcomes being seen as possible.

- Anticipate negative outcomes and rehearse coping strategies

Consider how the client will cope if there is difficulty in completion of the experiment. Can any barriers be anticipated and problems solved or planned for?

- Experiment can be in-session too!

Reviewing behavioural experiments:

- What actually happened: thoughts, feelings, outcomes? Match to prediction(s) – review the specific outcome of the experiment in light of the prediction made

- Integrating meaning of BE:
    - What new information does this give us?
    - How can we make sense of what happened?
    - What does this mean for similar situations in the future?
    - Attending to 'yes, but…'
    - What is the next step (extend or generalise conclusions? Improve design of current experiment?)
    - Re-rate belief in cognition(s)
    - Consider a new conditional belief (theory A, theory B)
    - Using behavioural experiments to test out conditional beliefs
- Test old versus new conditional beliefs – complete further experiments designed.

(See BE experiment sheet in clinical tools section, potentially include example).

Responsibility pie chart:

Responsibility pie charts are useful when the person attributes a higher than appropriate level of responsibility for a negative outcome or event to him or herself, leading to mood based difficulties. This may well touch on an underlying/conditional assumption that they hold, which predisposes them to hold a high level of responsibility for negative events.

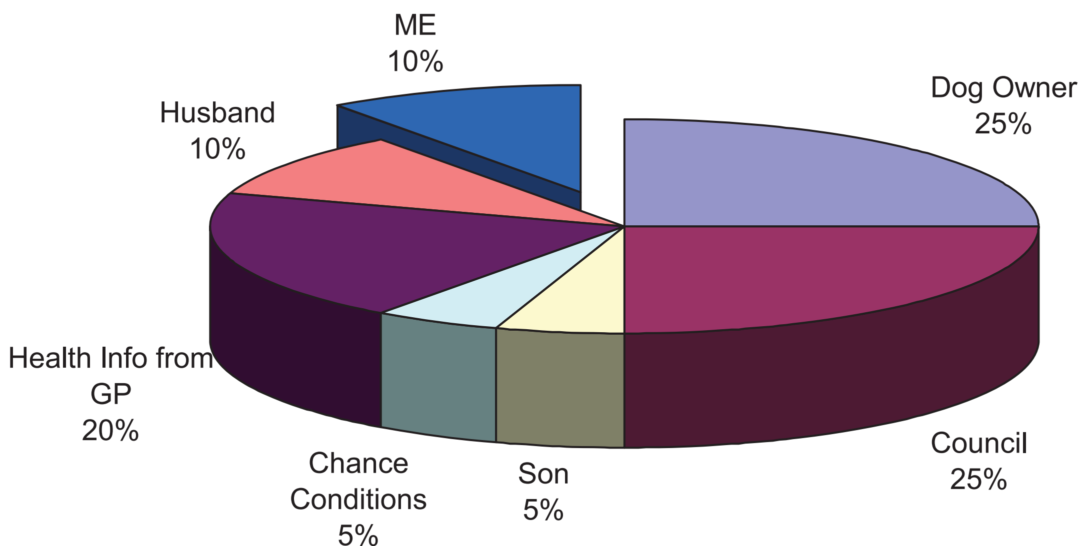
In this instance the level of responsibility for such events or outcomes can be elicited from the client (e.g. I am 100% responsible) which then forms the basis for intervention.

Steps in creating a responsibility pie chart:

I am 100% responsible for . . .

- Gather as much information as possible on who or what else may share this responsibility - list these (theirs first).
- Get the client to rate how much each item on the list is responsible as a percentage, in reverse order (leaving the client as the last item).
- Place these in the responsibility pie chart as you go.
- The slice that is left is their responsibility.

If my son contracts toxoplasmosis it will be my fault.



Surveys

Survey methods can provide a good way to judge whether the 'normal' beliefs or experiences that a client has are also normal and typical for others. This can help to normalise concerns and reduce the strength of belief in metacognition in relation to these beliefs ('the fact that I have this belief means....').

In this method the client and the therapist draw up a list of questions to test whether others have similar experiences/thoughts. The client and therapist then work together to identify the client's expectations on how others will respond to these questions (based on their beliefs, what do they expect people will say?). It is also considered what it would mean about the client's belief if people do not respond in the way that the client predicts. Then either the client or the therapist (or both) ask people they come into contact with to respond to the questions and responses are recorded. These responses are then discussed in the session and considered against the prediction the client made and what this may mean in terms of alternative beliefs.

Identifying and working with core beliefs

For the main part, intervention will be at the level of underlying/conditional assumptions. There may be some occasions, however, when it is necessary to consider working at the level of unconditional belief (schema/core belief).

What are core beliefs?

Core beliefs are unconditional beliefs that a person may hold about themselves. They reflect our understanding of our early experiences and statements about the self that are of an absolute, global and stable nature.

- I am unlovable; I am worthless; I am a failure.

Core beliefs may lie dormant until activated by a situation that matches with them. Once activated they work to filter out all information that is not consistent with them and focus attention on the information that supports and maintains the core belief.

Core beliefs are at times the least accessible thoughts helped by a person and may not be available in a precise verbal form.

Identifying core beliefs

- Core beliefs may be expressed as NATs at times, e.g. 'I am _____' statements made by the client in relation to specific events.
- Downward arrow technique using guided discovery –
    - 'What's the worst that could happen?'
    - 'What does that say/mean about you/other people/the future?'
    - 'As we are talking about this, do you have any images in your mind?' (describe and use downward arrow technique)
    - 'If you play that image forwards, what happens?'
- Working back 'have you felt like this before / found yourself thinking this about yourself before?'
- Can be 'then……' part of conditional beliefs
- Looking out for themes, e.g. in thought record – themes in meaning of different situations and contexts
- Completing three phrases (Padesky, 1994):
    - I am……
    - Others are….

    - The world is……

- Following strong and pervasive emotion, especially shame, guilt or feelings of self-hatred.

<u>When Do I Use a Longitudinal Conceptualisation?</u>

Use when:

- Longstanding issues are part of the presenting issues

- The client needs a sense of 'why?' At times clients will express a desire to understand why their difficulties are present. A longitudinal formulation gives the opportunity to develop this understanding of onset, to normalise and validate the ways of understanding the world as necessary in a difficult or toxic situation, and to consider alternative rules or coping that may fit the person's current life situation and goals better.

- There is an inadequate response to well-delivered therapy – where schemas or core beliefs held by the client are treatment-interfering if left unaddressed.

- It strengthens resilience and reduces the chances of relapse – developing understanding, coping and alternative responses through continua methods can help reduce vulnerability and promote resilience.

<u>Identifying positive core beliefs</u>

Identify alternative (positive) core beliefs: creating/re-accessing alternative 'file drawer' for experience

- Look at negative belief and look for exceptions: what alternative belief would fit these exceptions?

- 'How would you like to be?'

- Should be inconsistent with negative belief (but not necessarily the opposite). However, positive alternative schemas should also be expressed in absolute terms. Whilst negative schemas imply total absence (unlovable meaning never being loved) a positive schema contains greater flexibility (some experience show it is possible for me to be lovable).

- Careful attention to wording

Exploring beliefs to weaken negative schemas and build positive alternatives is explored by Padesky (1993) through the use of continua methods.

1. A continua is developed focused upon the positive alternative schema (e.g. I am lovable). This is scaled from 0 to 100%. This focus automatically seeks the focus of attention on to discovery of instances of the positive quality. This also immediately moves the person to a more balanced midpoint between unlovable and lovable. In other words rather than starting from 100% unlovable, the start point is halfway to lovable at 0% lovable.

Endpoints of the scale can be defined in absolute terms to help shift the person's perception of themselves (e.g. 100% unlovable must mean never ever being liked in the slightest by anyone ever in the history of their life). Friends may also be plotted on the scale, followed by disliked people (e.g. a cruel boss, an abusive family member or neighbour, even figures from history). This is also helpful in anchoring the end points of the scale.

2. Behavioural sub-continua of the global scale are then developed. What are the behavioural qualities that show someone is loveable; what are the qualities that embody this? This can be facilitated by considering someone they know that represents the alternative belief (i.e. who is someone you know you would consider lovable) and by identifying what the qualities they possess are that demonstrate this. The attention to wording is important in helping to reframe these beliefs. Also, the therapist needs to explain the rationale for the start point of the continuum scale not being opposite to positive belief as progress may be hampered by thinking errors, e.g., black or white thinking, negative bias etc. Therapists may have covered thinking errors in earlier sessions, but progress in therapy may not be linear and thinking errors are probably likely to still be problematic when tackling core beliefs and this work provides an opportunity to build on earlier work.

3. These qualities are developed in sub-continua, with clearly defined endpoints. The person is then asked to rate themselves on these specific criteria, as people will rate themselves less negative on specific items than global criteria.

4. The differences between specific and global ratings are discussed to shift global ratings.

5. Experiments are based on meeting sub-continua and developing competence in these, or having the opportunity to do so (e.g. contacting other friends).

6. These help to create a positive data log.

Positive data log

- Positive data logs are a form of behavioural experiment.

- Evidence consistent with positive beliefs is clearly recorded. This is then reviewed in order to consider the client's confidence rating (0-100%) in this alternative belief.

- Positive data does not need to fit with the positive belief 100% and the positive belief may not need to reach a 100% rating either.

- One of the main aims of this log is to help the client become increasingly alert for prejudice or negative filtering of information at work.

- The therapist will need to be alert to instances consistent with the alternative belief and help the client to identify these, particularly in the early stages. It can be difficult to identify evidence unprompted. Therefore adding structure to the collection of this evidence as identified below may be important.

What sort of evidence might you look out for?

Category	Example	%
I didn't 'cave in' to an unreasonable request		
I organised myself in advance for activities		
People trusted me with responsibility		

<u>Behavioural change</u>

A clear goal of developing these alternatives is to translate this into behaviour, which will further increase the collection of evidence in support of them.

- Acting/living according to the new belief:
  - Identify occasions in past week when client acted according to new belief.
  - Identify opportunities to act in accordance with new belief in next week 'if you really believe X, how would you approach this situation?'
  - 'What would someone who believed X about themselves do in this situation?'
  - Review outcomes: not just the outcome itself but also how well the client's action fitted with the new belief.

Transition and Review Session B (Session 17)

Transition and Review Session B (Session 17)

This session consolidates all the gains thus far against the previous list of presenting issues and goals and maps out the final phase which is focused on relapse prevention and building long-term resilience.

Phase III Relapse Prevention Session Guide: Sessions 18-20

Relapse prevention

Doing a relapse plan or blueprint for change can make a difference in long-term outcomes (Hollon et al., 2005). This work involves working with the patient using all that has been learned in therapy to devise a relapse signature that will support the patient in:

- Detecting early warning signs for relapse
- Accessing action plans for tackling setbacks

A blueprint for change typically includes:

- What have I learnt in cognitive therapy?
- How do I plan to build on what I have learnt in everyday life?
- What obstacles are there for building on my gains?
- How am I going to overcome these?
- What might lead to a setback for me?
- If I did have a setback what would I do about it?

Typically this phase of therapy involves very explicitly planning further behavioural experiments that will expose the client to situations that will activate old conditional/underlying beliefs and provide an opportunity to challenge these, activate new more functional conditional/underlying beliefs and behave more functionally. They can use their relapse signature and blueprints for change and have the knowledge that ongoing therapy sessions are available to support them in this work.

It is really important in this phase of therapy to support patients become more self-sufficient in using the tools of CBT, including setting time aside for self-therapy and reviewing their therapy folder.

Finally, in this phase of therapy, the focus of formulation moves to a formulation of the client's resilience. That is to say applying the formulations developed so far, but now the explicit focus is on thoughts, feelings, behaviours, physical sensations and underlying assumption that are supportive of progress made in therapy. This is best linked to explicit skills that will help to move the client towards coping resiliently with challenges.

Booster Session Guide

Booster Session Guide

The booster sessions are used very flexibly and have the main aim of supporting clients in maintaining gains, practising skills they learned in therapy and staying well in the long term. A model that works best is offering these sessions to clients on an as-needed basis during the trial follow-up period, so they can phone up and make an appointment when they need it. However, some clients may prefer the security of having a session in the diary and with others the therapist may judge that it would be best for whatever reason to pre-schedule these appointments.

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11. Appendices: Clinical Tools

Appendix A: Introduction to CBT 79
Appendix B: Descriptive Case Conceptualisation 83
Appendix C: Weekly Activity Schedule 84
Appendix D: How to Activate Yourself 86
Appendix E: How to Become Aware of your Automatic Thoughts 93
Appendix F: Thought Record 94
Appendix G: Record Sheet for Behavioural Experiments 95
Appendix H: Coping Worksheet 96

Appendix A: Introduction to CBT

What is depression?

"My partner doesn't care about me anymore. I'm not good enough for him, but I could never survive without him"

"I'm going bald and losing my looks. No-one will care about me anymore"

"I can't cope with my job. My boss and workmates only put up with me because they feel sorry for me. *Nothing* I do ever turns out right"

"I just can't make myself do the housework. My marriage is falling apart"

These are some thoughts that are typical of people with depression. These sorts of thoughts can happen to anyone, and usually the individual would be able to challenge them and move on. However, when someone has depression, these sorts of thoughts become more common, and they also become harder to deal with.

People who are depressed often think about themselves and the world in a different and more negative way compared with how they thought before their illness. Their thoughts, their feelings, and even their actions have *changed.* Often the change comes on gradually, so it is not always noticed for a while. But it is a big change; people who are depressed often stop enjoying things that used to be fun, they may lose interest in things and people that are important to them. They may even feel hopeless and want to end their life.

Depression affects people in different ways. Often the most obvious sign of depression is a sad mood. Depressed people may often cry, but aren't sure why. They may feel isolated and find it difficult to respond to others as they used to. They could have trouble sleeping and might wake very early in the morning, feeling miserable. They can feel tired and lack energy. They can be irritable with others and find it more difficult than usual to concentrate and make decisions. They may feel scared and lose all their confidence. People with depression often become less active and sometimes avoid work and social activities.

What does the research say?

We know that people with depression often think of themselves as 'worthless', bad or failing - perhaps not even fit to live. Why are these feelings so common?

One of the most important research findings is that people with depression often interpret situations wrongly or unhelpfully. They focus on the bad or upsetting things, for example, things they haven't done and might criticise themselves for not having done anything. How they think of themselves affects how they feel, and they often mistakenly believe that they are inadequate and no one cares about them. Unhelpful thinking of this sort can lead to a

vicious cycle in which negative thoughts reduce confidence, which in turn leads to not doing things and so on.

Cognitive behavioural therapy (CBT) is a way of helping people with depression change the way they think in order to improve how they feel and to change what they do. Learning how to change upsetting negative thinking can help people with depression start to feel better about themselves and improve their mood.

How are thinking and depression related?

People with depression often notice more unpleasant thoughts. With every negative thought, the depressed feeling gets worse and worse, and their mood plummets down. But often these negative thoughts are not based on real facts, and so people with depression feel sadder than the situation warrants. For example, negative thoughts that “I won’t enjoy it” may keep an individual with depression from joining in activities with others. They may then criticise themselves and think they are “lazy” or “useless” and this makes them feel even worse.

Consider this example: Suppose you are walking down the street and you see a friend who appears to ignore you completely.

Naturally you feel sad. You may wonder how you have upset your friend. Perhaps he wasn’t wearing his contact lenses. Sometimes, if you are depressed you might think that your friend has rejected you. You may not even mention it to him and assume this rejection is true. You may come home and mull over this hurt again and again. In future you may avoid him because you no longer trust that he likes you. However, if you later mention the incident to him he might tell you that he was so preoccupied that he didn’t even see you! Jumping to the wrong conclusion might have upset your friend.

Research evidence suggests that people with depression make mistakes like this over and over again. They often do not check their negative interpretations of events and therefore don’t discover that many of their concerns are unfounded.

What are typical thinking errors?

Here are some typical errors of thinking that may apply to people with depression:

Exaggeration: everything seems extreme, difficulties turn into disaster. Problems, and the harm they can cause, are exaggerated. The individual underestimates their ability to deal with problems. For example, “Now I have upset her, our friendship is over and I’ll end up with no friends”.

Bias against themselves*:* the individual makes strong statements that emphasise the negative. For example, if someone criticises them, they may think “I am a failure” and “Nobody likes me”.

Ignoring the positive/focusing on the negative: The individual only seems to remember and dwell on negative events. They dismiss good experiences as 'unimportant', "So what if I finished my work? It's what I'm supposed to do".

Black or white/All or nothing thinking: The individual sees things in black and white. If something falls short of perfection it is a failure.

Jumping to the worst conclusions: The individual interprets what happens in a negative way without any facts to support their view. For example, they indulge in *mind reading* (they assume someone feels or thinks badly of them without checking it out). For example, "He thinks I'm a bore" or "She's really laughing at me". Or they may be sure that things will turn out badly without any evidence. "This is never going to work".

Labelling: The individual deals with their mistakes (and other people's) by using general labels. For example, "I'm a bad mother". This is very demoralising when the person keeps doing it.

Taking things to heart: The individual assumes responsibility for things that aren't really under their control. For example, "It's my fault he started drinking again".

Saying should/must/ought thoughts: The individual tells themselves how they ought to act, feel or think. For example, "I should please everyone" or "I shouldn't have to put up with this".

Working with a CBT therapist

The CBT therapist will help the individual to identify and correct their unrealistic and unhelpful negative thoughts and work out ways to deal more effectively with day-to-day problems. A course of CBT usually lasts between 12 and 18 sessions, each lasting just under one hour. It is an educational approach in which the individual will receive suggestions of things to do and they can then try these out for themselves to see what works.

What happens in CBT?

CBT encourages the individual to plan changes in their activity/behaviour to help them get back to enjoyable and meaningful activities.

CBT focuses on helping the individual change their thoughts, beliefs and unhelpful thinking patterns.

It deals with the here and now, although it also looks at the influence of past events. It helps the individual change step by step using a clear plan.

The patient and therapist work together. Therefore, a good relationship is an important part of therapy.

The therapist will suggest new ways of dealing with situations, but the individual will only benefit if they try these out themselves to work out what helps. *This is the key to progress,*

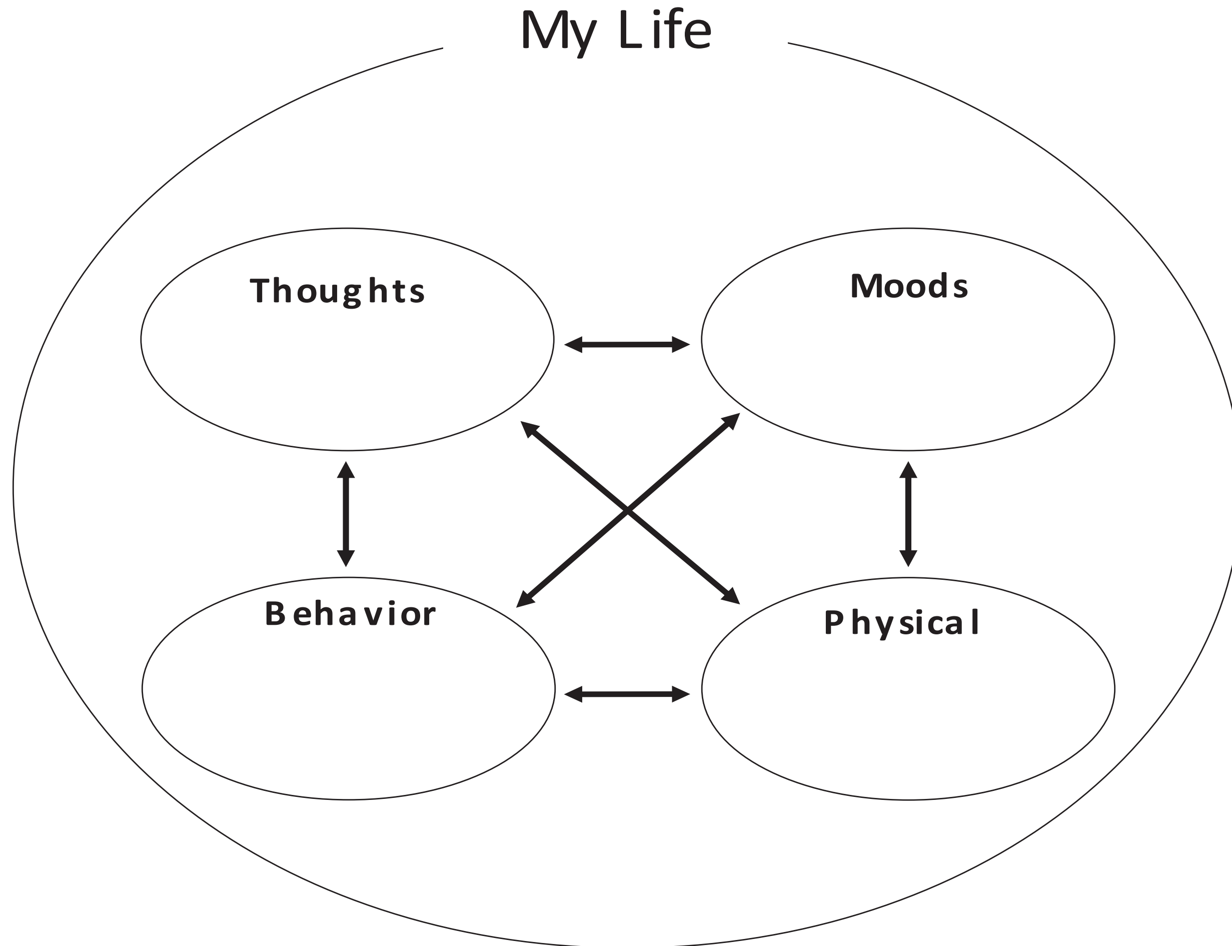
as evidence shows that people who do this and reflect a lot on their thoughts between sessions do the best.

The therapist will use questions to help the person identify their thoughts and problems, and help them come up with solutions.

The therapist is not a “guru” who has special insight into the patient’s deepest feelings. He or she will not “interpret” the patient’s thoughts or feelings, but will work with the individual to see how their thoughts are affecting their life and show how they can learn to feel differently. For the therapist to know what worries, fears or concerns the individual has, they will need to tell their therapist.

The therapy is educational and the individual will learn skills to deal with their problems, skills that they will be able to use when the therapy is finished.

Appendix B: Descriptive Case Conceptualisation



Descriptive case conceptualization. © Kuyken, Padesky & Dudley, 2009

Appendix C: Weekly Activity Schedule

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM 6-7							
7-8							
8-9							
9-10							
10-11							
11-12							
PM 12-1							
1-2							

2-3							
3-4							
4-5							
5-6							
6-7							
7-8							
8-9							
9-10							
10-11							
11-12							

Appendix D: How to Activate Yourself

The Problem

Depression is a vicious circle. It slows you down, mentally and physically. Everything becomes an effort and you tire easily. You do less and then blame yourself for doing less. You come to believe that you can do nothing and that you will never get over your depression. Then you feel even more depressed. It becomes even more difficult to do anything. And so it goes on.

Overcoming the problem: Activity scheduling

Becoming more active is one way of breaking the vicious circle. It has a number of advantages:

Activity makes you feel better. At the very least, it takes your mind off your painful feelings. It can give you the sense that you are taking control of your life again, and achieving something worthwhile. You may even find that there are things you enjoy, once you try them.

Activity makes you feel less tired. Normally, when you are tired, you need rest. When you are depressed, the opposite is true. You need to do more. Doing nothing will only make you feel more lethargic and exhausted. And doing nothing leaves your mind unoccupied, so you are more likely to brood on your difficulties, and to feel even more depressed.

Activity motivates you to do more. In depression, motivation works backwards. The more you do the more you feel like doing.

Activity improves your ability to think. Once you get started, problems which you thought you could do nothing about come into perspective.

In spite of these advantages, getting going again is not easy. This is because the gloomy, pessimistic thoughts which are typical of depression stand in your way. When you are depressed, you may think that you are doing nothing, achieving nothing, and enjoying nothing. It may be difficult to organise your time productively, or to involve yourself in things you normally enjoy. When you are faced with something you want to do, you may find yourself thinking, "I won't enjoy it", "I'll only make a mess of it" or "It's too difficult". Thoughts like these stop you from taking action and help to keep you in the vicious circle.

Later on in therapy, you will learn how to work directly on depressing thoughts which stop you from getting down to what you want to do. Your goal will be to notice and challenge the thoughts, so that they no longer stand in your way. First of all, though, you need to get a detailed idea of exactly what you are doing, and how much pleasure and satisfaction you get from what you do. What you discover will help you to plan your time so as to get the most out of each day's activities. This is called "activity scheduling" and you will find details of how to do it below. There are two steps involved: self-monitoring and planning ahead.

Step I: Self-Monitoring

'Self-monitoring' simply means observing your pattern of activities. It involves keeping a detailed record of what to do, hour-by-hour. You can do this in a notebook or diary, or your therapist will give you a special record sheet.

Your record will show you in black and white how you are spending your time and will make your aware of how much satisfaction you get from what you do. This will allow you to test thoughts like "I'm not doing anything" or "I don't enjoy anything I do", and to see if they hold water when compared with facts. You may well find that you are more active and competent than you assumed, and that you are enjoying yourself more than you thought. Even if this is not the case, you will have a factual record to help you find out more about what is getting in your way, and to form a basis for changing how you spend your time.

How to do it

For the next few days, in your diary or on your record sheet write down:

1. Your activities. Record exactly what you do, hour by hour.
2. Pleasure and mastery. Give each activity a rating between 0 and 10 for pleasure (P) and for mastery (M). 'P' refers to how much you enjoyed what you did. So 'P10' would mean that you had enjoyed something very much. 'P0' would mean that you had not enjoyed it at all. You could use any number between 0 and 10 to show how much you had enjoyed a particular activity. 'M' refers to how much mastery you experienced in what you did. How much of an achievement was it, given how you felt? 'M10' would mean that what you did was a real achievement. 'M0' would mean that it was not an achievement at all. Again, you could use any number between 0 and 10 to show how much mastery was involved in a particular activity.

Common problems in self-monitoring

- Thinking you are doing nothing. Sitting in a chair in front of the television is an activity. So are going to bed, and staring out of the window brooding. You are never doing 'nothing'. But some activities may be less helpful to you than others. It will help you to identify these if you specify on your record sheet what they are, rather than simply writing 'nothing'.
- Underestimating your achievements. 'M' should be rated for how difficult an activity is for you now, not how difficult it was for you before you got depressed, or how difficult another person might find it. When you are depressed, things which would normally be very easy become difficult. Even getting out of bed, or making a slice of toast, can be a major achievement, given how you feel. Beware of thoughts like 'But I should be able to do this better' or 'So what? Any fool could do this'. They will only keep you trapped in depression's vicious circle. Take a stand against them by making sure that you give yourself credit for what you do.
- Delaying your ratings. It is important to rate your activities for P and M at the same time. If you wait until later, your depression will colour how you see your day and may well cause you to ignore or devalue good things you have done. When people are depressed, bad things that happen are easily noticed and remembered. In contrast, good things are often blotted out or discounted. If you make your ratings at the time this bias in how you see things is less likely. Immediate ratings will also help you to become sensitive to even small degrees of pleasure and mastery, which might otherwise go unnoticed.

Step II: Planning Ahead

Now that you can see how you are spending your time; the next step is to plan each day in advance, making sure that you include activities which will give you a sense of pleasure and mastery.

Planning ahead will allow you to feel that you are taking control of your life, and will give you a sense of purpose. The framework you give yourself will prevent you from sinking into a swamp of minor decisions ('What shall I do next?'), and will help you to keep going even when you feel bad. Once the day's activities are laid out in writing, they will seem less overwhelming. You will have broken the day

down into a series of manageable chunks, rather than a long shapeless stretch of time which you must somehow fill.

How to do it

1. Plan your activities. Every evening, or first thing in the morning, set aside time to plan the day ahead. Find out what time suits you best to do this, remembering that you are likely to be able to plan more realistically and constructively when you are feeling relatively well and clearheaded. If you find it difficult to remember to make time to plan ahead, give yourself reminder cues. Put up signs around the house, for example, or ask someone to remind you that 7.30 is your time for planning tomorrow. As far as possible, try to ensure that your planning time is not interrupted, and that there are no other pressing demands to distract you. Turn off the television and take the phone off the hook.

   Aim for a balance between pleasure and mastery in your day. If you fill your time with duties and chores, and allow no time for enjoyment or relaxation, you may find yourself feeling tired, resentful and depressed at the end of the day. On the other hand, if you completely ignore things you have to do, you may find your pleasure soured by a sense that nothing has been achieved, and your list of necessary tasks will mount up. You may find it helpful to aim for the pattern of activities you found most rewarding in the past. There is a fair chance that, once you get going, you will find this pattern works for you again.

   Encourage yourself by starting the day with an activity which will give you a sense of mastery or pleasure, and which you have a good chance of completing successfully. This is particularly important if you have trouble getting going in the morning. And plan to reward yourself with a pleasurable or relaxing activity when you tackle something difficult. You might, for example, set aside time to have a cup of coffee and listen to your favourite radio programme when you have spent an hour doing housework. Avoid bed. Beds are for sleeping in, not for retreating to during the day. If you need rest or relaxation, plan to achieve it in some other way.

   To begin with, you may find that trying to plan a whole day at a time is too much for you. If so, break the day down into smaller chunks, and deal with them one at a time.

2. Record what you actually do. Put your plan into practice. Write down how you in fact spend your time on your record sheet, just as you did at the self-monitoring stage. Rate each activity out of 10 for mastery and pleasure.

3. Review what you have done. At the end of each day, review what you have done. Take the time to sit down and examine how you spent your day, how much pleasure and mastery you got from what you did, and how far you managed to carry out the activities you had planned. This will help you to see clearly how you are spending your time, what room there is for improvement, and what changes you might like to make in the pattern of your day.

   If you have managed overall to stick to your plan, and have found what you did reasonably satisfying, this gives you something positive to build on. If on the other hand, you did not stick to your plan and you got little satisfaction from what you did, this will give you valuable information about the kind of things that are preventing you from making the most of your time. What exactly was the problem? Did you overestimate what you could do in the time available? Did you feel too tired to carry out everything you had planned? Did you aim too high, forgetting to take into account how you feel at the moment? Did you spend your day doing things that you felt you ought to do, rather than things that would give you pleasure and help you to relax? Were your best efforts

blocked by pessimistic thoughts? If you can find out what went wrong, you can learn from these experiences. Use what you have found out to help you plan in future.

Coping with practical tasks

Depression often leads people to put off practical tasks they need to carry out. The pile mounts, and in the end they feel completely overwhelmed. You can help yourself to get started on things you need to do by following these steps:

1. Make a list of all the things you have been putting off, in whatever order they occur to you.
2. Number the tasks in order of priority. Which needs to be done first? If you cannot decide, or it genuinely does not matter, number them in alphabetical order. The important thing at this stage is to do something.
3. Take the first task and break it down into small steps. What exactly do you have to do in order to complete it?
4. Rehearse the task mentally step by step. Write down any practical difficulties you may encounter, and work out what to do about them.
5. Write down any negative thoughts that come to you about doing the task and answer them if you can (see below). If you cannot find answers, simply note the thoughts down (recognising them for what they are), put them to one side for later discussion with your therapist, and concentrate on what you are doing.
6. Take the task step by step, dealing with difficulties and negative thoughts as they occur, just as you did in your mental rehearsal.
7. Write down what you have done on your activity schedule, and rate it out of 10 for P and M, as soon as you have completed the task.
8. Focus on what you have achieved, not on all the other things you still have to do. Watch out for negative thoughts that will make you devalue or discount what you have done. Write these thoughts down, and answer them if you can. If not, note them and put them to one side for later discussion with your therapist.
9. Take the next task and tackle it in the same way.

Common problems with planning ahead

Not being able to get going

If you have difficulty getting down to a particular activity, tell your body in detail what to do. 'Get on with it' is too vague. 'Legs, walk. Hand, pick up pen. Now write' will give you the impetus to begin. As soon as you have told yourself what to do, do it. Do not allow any pause for doubts to creep in.

Being too rigid

Your plan is a guide, not a god. It is not carved on stone tablets. It is there to help you, not to rule your life. So, for example, something unexpected may happen to throw you off schedule. A friend drops in unexpectedly, or the washing machine breaks down. At this point, you may feel that your efforts to plan your day have been wasted: unless you can stick to what you have planned, you might just as well not bother.

There are a number of things you can do to cope with the unexpected:

- Accept the disruption. Accept that things have not worked out the way you thought they would, and continue with your original plan when you can. Your friend leaves at 4 o'clock. What did you have scheduled for that time?
- Think of alternatives. Some of the activities you have planned may depend on factors beyond your control, such as the weather or other people's health. Supposing, for example, you plan a picnic,

have something up your sleeve in case it rains. Or supposing you had planned to spend the weekend with an old friend and at the last minute she comes down with flu, look for an alternative that you will enjoy, rather than giving up and doing nothing in particular.

- Do not try to make up things you have missed. If for some reason you cannot do what you had planned at a particular time (you wanted to clean the bedroom and ended up talking to your son about his holiday plans), do not go back and try to do it later. Move on to the next activity on your plan, and re-schedule what you missed for the next day. Similarly, if you find that you finish an activity sooner than planned; leave your next activity until the time you had scheduled. Fill the gap with something you enjoy. You may find it useful to have a list of pleasurable activities handy so that you have something to choose from.

Being too specific or too general

You need to write down what you intend to do in nit-picking detail. Listing every piece of furniture and ornament you have to dust is too specific. Equally, do not be so general. 'Housework', for example, is too general for you to feel clear about what it is that you are aiming to do. So you will not know when you have achieved your goal. Schedule your activities roughly by the hour or half hour. Experience will tell you how long each activity is likely to take.

Planning for quality, not quantity

Write down the amount of time you are going to spend on a particular activity, not how much you are going to do in that time. When the time is up, stop. How much you do in a given period may depend on factors outside your control (e.g. interruptions, machines breaking down), or on other problems (e.g. concentration difficulties, fatigue). If you tell yourself you must weed the whole garden this afternoon and you do not do it, you will probably think of yourself as a failure and give yourself no credit for what you *have* done. If on the other hand, you set yourself to weed for an hour, then how much you do is neither here nor there. Reward the effort, not the outcome.

Expecting miracles

Your immediate goal is to carry out what you have planned as best you can, not to get over your depression. You will probably feel less depressed when you are doing some things than when you are doing others. And if you work steadily at becoming more active, you will eventually feel better. But no single thing you do is likely to produce a miracle cure. Don't expect to be over your depression after an hour's television, or cleaning out the cupboard under the stairs. If you do, you will only disappoint yourself.

Stopping when the going gets tough

Quit an activity when you are winning, not when you have exhausted yourself, or when things are going badly. This will leave you feeling good about what you have achieved, and ready to carry on.

Thoughts that stop you activating yourself

We have already discussed how pessimistic, gloomy thinking can get in the way of your attempts to activate yourself, and trap you in the vicious circle of depression. The most powerful way to overcome your depression is to identify your depressing thoughts when they occur, and to challenge them. You will learn how to do this later in therapy. In the meantime, monitoring what you do and planning ahead will give you a good opportunity to start becoming more aware of depressing thoughts that block progress and get in your way.

In the last section of this handout, you will find some examples of the kind of thoughts that may be preventing you from becoming more active, together with some possible answers to them. These are not the right answers, nor the only answers. They are just some suggestions. The answers which work for you personally might be quite different. With practice you will learn to find effective answers, which change how you feel and help you to tackle your difficulties constructively, for yourself.

Automatic thoughts

I can't do anything – there are too many practical difficulties.

I can't keep a schedule – I've never been a record keeper.

There's too much to do – I won't be able to cope.

It's too difficult.

I won't know how to go about it.

I don't want to.

I'm not up to it just now; I'll wait till I'm feeling better.

It's too late; I should never have done it before.

I can't decide what to do first.

There's no point in trying. I'll only make a mess of it and feel worse.

Possible answers

There are many practical difficulties involved in doing anything – it's a part of life. What would I do about them if I wasn't depressed? Is there anyone who could give me advice with things I don't know how to handle?

Keeping written records is a skill that I may not have done before, but that doesn't mean to say I can't do it. After all, I've used lists before, for shopping and to remember what to take on holiday. I could start by listing all the things I have to do.

Believing that is all part of depression. It may not be true. If I write down what I need to do, it won't seem so overwhelming. I don't have to do it all at once. I can take things on at a time.

It only seems difficult because I'm depressed. I've done more difficult things than this in the past.

The idea is to have a go, not to produce a perfect performance. It's better to try and find out how I do, than not do anything at all.

That's true. But whether I want to or not, what is in my best interests? Which will make me feel better and more in control of things? Doing it? Or not doing it?

I won't know if I'm to it until I try. If I wait till I'm feeling better, I'll never do it. Doing it will make me feel better.

Maybe it would have been better if I'd done it before. But the fact is I didn't. Feeling guilty is not going to help me. Better later than never – do it now instead of wasting time in regrets.

I won't enjoy it.

I won't be able to do everything I've planned.

I'm not doing anything.

I don't do anything worthwhile.

I don't deserve to enjoy myself. I should get on with all the things I've got to do.

So I cleaned the car. So what?

It really doesn't matter. The important thing at this stage is to do *something.* Take the thing that comes first in the alphabet. Once you get going, it will probably be clearer what to do next. If not, just go on down the alphabet.

I don't know that till I try. Nobody's asking for a five-star performance. Even if I do make a mess of it, it's not the end of the world – I can learn from my mistakes if I don't take them too seriously.

How do I know? I'm not a fortune-teller. I might enjoy it more than I think, once I get involved in what I'm doing. That has happened before.

No one does everything they've planned all the time, so there's no need to feel badly about it. Before I got depressed, if I didn't get everything done, I just put it forward to next day. Do what you can, and forget what you can't. The world won't end because I don't clean out the attic today.

Am I sure of that? Or is it that I'm not giving myself credit for what I do? Why not keep a record for a few days, and see. Maybe I just *think* I'm not doing anything.

I didn't see it that way before I got depressed. I was doing much the same then as I am now, but I could see that it was worthwhile, even though none of it was very dramatic or exciting. If I discount everything I do I will only get discouraged.

Doing things I enjoy will help me feel better. That's what I want. Also, if I'm more relaxed and feeling better, I'm likely to do what I've got to do more efficiently, instead of getting in a muddle and dashing from one thing to another. I know that from experience; I get more done when I give myself breaks than when I plough on non-stop.

Normally, cleaning the car would be nothing very special. But given the way I feel, it is in fact very difficult. So doing it is an achievement. I deserve to give myself credit for that.

Appendix E: How to Become Aware of Your Automatic Thoughts

The aim in cognitive therapy is to reduce the effect of your negative thoughts on how you feel. The first step is to recognise these thoughts.

What are negative automatic thoughts (NATs)? Negative automatic thoughts are:

1. *Negative:* they make you feel even worse about yourself (e.g. I'm useless) and your life (e.g. it's all hopeless). They also stop you from helping yourself (e.g. there's no point).
2. *Automatic:* they just pop up into your mind, you don't decide to think them. In fact, you may find it hard not to think them, as they are like a habit.
3. *Believable:* they seem to be right; they seem to be facts and you will tend to accept them.
4. *Biased:* although they seem right, they are likely to be distorted or inaccurate. They may have some support from how you feel or things that may have happened but ignore many other facts which do not fit such a negative view.

How to catch NATs. This will be quite hard at first. They may have become a habit or you may think that they are not thoughts but reality. To learn to catch these thoughts:
1. *Use your feelings as a cue.* Whenever you notice feeling upset or your mood takes a downturn, as yourself "What was going through my mind just then?"
2. Look out for *pictures* as well as words. Sometimes the NATs take the form of pictures or images in your mind's eye. It is important to watch out for these images.
3. If you seem to be upset by an event rather than a thought, ask "How did I view this situation?" or "What did this mean to me?"

Counting NATs. With breaking any habit, catching yourself at it is the first hurdle. Counting the thoughts is one way of doing this. At first, "tuning in" to the negative things you are saying to yourself can make you feel bad. However, you will soon find that you are more able to stand back from them. Try to catch and observe them as they come to mind. You might try putting ticks on a piece of paper or card, or counting them using a golf or knitting counter. Then you can see easily how many you had that day. At first, the daily tally will go up as you get better at catching them.

Writing down your NATs. The best way to become aware of your NATs is to write them down. It is best to do this as soon as you notice your mood going down. However, sometimes it may be necessary just to make a mental note and jot it down later. You may find that some thoughts come to mind over and over again. Sometimes, just catching them and jotting them down can take out some of the sting or help you see things differently. At other times, you will need to use the ways of answering back these thoughts that you will learn during therapy.

Beware: There are a number of reasons or excuses for not catching or writing down your thoughts. It may seem like a lot of effort when you are already finding it hard to cope. You may worry that writing the thoughts will only make you feel worse. You may think that it is stupid having such thoughts. Although identifying NATs may involve effort and upset at first, remember that *it will get easier with practice.* On the other hand, not tackling these thoughts leaves them free to bother you just as much in the future. There is no pain free way of overcoming depression, but as your skills improve, <u>your efforts will help you to feel better.</u>

Appendix F: Thought Record

1. Situation	2. Moods	3. Automatic thoughts	4. Evidence that supports the thought	5. Evidence that does not support the thought	6. Alternative / balanced thoughts	7. Rate moods now	8. What should I do now?
Brief description of what was happening; what you were doing at the time.	Describe each emotion in one word. Rate the intensity of the emotion from 0-100%	What was going through your mind? What does this say about you? What is the worst that could happen?	Write factual evidence to support this conclusion. Try to avoid mind reading/interpretation of facts.	Write factual evidence that does not support your conclusion.	Based on the evidence what would be a balanced alternative thought? Rate how much you believe this thought 0-100%	Copy the emotions from column 2. Re-rate their intensity from 0-100%	What should you now do based on the balanced thought?

Appendix G: Record Sheet for Behavioural Experiments

DATE	SITUATION	PREDICTION (What exactly did you think would happen? How would you know? Rate belief 0-100%)	EXPERIMENT (What did you do to test the prediction?)	OUTCOME (What actually happened? Was the prediction correct?)	WHAT I LEARNED 1. Balanced view? (Rate belief 0-100%) 2. How likely is what you predicted to happen in future? (Rate 0-100%)

Appendix H: Coping Worksheet

What have you learned?

What has been useful to you?

How can you build on why you have learned?

What will make it difficult to do so?

How will you overcome the difficulties?

What might lead to a setback for you?

What would you do about a setback?

What gains have I made in therapy?

What is different now from before therapy?

What have I done to make this happen?

What skills do I want to take with me after finishing?

How can I continue to use the therapy in my everyday life?

What are the early warning signs that I need to be aware of?

What do I need to do if I experience this?

What are the possible high-risk situations for me in terms of slip backs?

What do I need to do if I encounter these situations?

What is my emergency plan in the event of a lapse / slip back?

What will be the most adaptive way to think about a lapse?

What are my specific goals for the next month / 3 months?

What could sabotage my plans?

What could I do to prevent this?

Any other potential setbacks that can be anticipated?

What are the warning signs to becoming unwell?
Thoughts:

Feelings:

Behaviours:

What are your thoughts about how it is now?

How do you identify ‘feeling better’?
Thoughts:

Feelings:

Behaviours: