CHAPTER 1

Identifying Problems in Treatment

As I was writing *Cognitive Therapy: Basics and Beyond*, I knew a "standard" cognitive therapy text could not cover the multiplicity of difficulties presented by many patients. Some patients just fail to progress when therapists use standard treatment. Some patients do not seem to grasp or are unable to implement standard therapeutic techniques. Some patients seem to be unwilling to engage sufficiently in treatment. Others seem to cling to their long-standing distorted beliefs about themselves, other people, and their worlds. Treatment must be varied for these patients. But how does a therapist know when and how to alter treatment?

When experienced cognitive therapists encounter a challenging therapeutic problem, they seem to understand intuitively what they need to do. After repeated requests for a book that deals with these kinds of problems, I began to more closely observe the moment-to-moment decisions I make during therapy sessions. What may appear to be an intuitive process of decision making is actually based on a continuous ongoing conceptualization of patients, their diagnosis, and their experience of the therapy session. In addition to observing my own work, I have also been very fortunate to be able to observe and closely analyze therapy sessions conducted by my father, Aaron T. Beck, MD, as well as those conducted by my colleagues and supervisees.

This book reflects what I have learned since the publication of *Cognitive Therapy: Basics and Beyond*. That book presents step-by-step methods for using cognitive therapy with patients who exhibit straightforward cases of depression and anxiety and is an important precursor to this book, which is designed to help therapists figure out what to do when the basics do not seem to work.

Many complex reasons account for the difficulties patients present in treatment. Some problems are outside a therapist's control—for example, a patient may not be able to come to treatment frequently enough due to financial constraints, or a patient's environment may be so deleterious that psychotherapy is of limited utility to him or her. But most problems are within, or at least partially within, a therapist's control. Difficulties may arise because of patients' distorted beliefs (e.g., "If I get better, my life will get worse") and/or because of therapist error (e.g., using a standard treatment for depression with a patient who is actually suffering from another disorder).

At literally hundreds of workshops that I have conducted in the past decade, I have asked mental health professionals to describe the specific problems they have experienced with their patients. I have reached two important conclusions. First, many therapists initially tend to describe difficulties in global terms that do not clearly define the problem, asserting, for example, that a patient is "resistant." Second, when therapists do specify problems, they tend to mention the same kinds of difficulties time and again: patients who do not do homework, patients who become angry at the therapist, patients who engage in self-defeating behaviors between sessions, and so on. I have discovered that many therapists need to learn to state patients' difficulties in behavioral terms, to understand relevant difficulties within a cognitive framework, and to devise strategies based on their specific conceptualization of an individual patient. This book teaches the therapist to:

- Specify problems (and determine the degree of control a therapist has to ameliorate them).
- Conceptualize individual patients, including those with Axis II disorders.
- Deal with patients' problematic reactions to therapists and vice versa.
- Set goals, structure sessions, do problem solving and enhance homework adherence (including behavior change) for patients with challenging problems.
- Identify and modify entrenched dysfunctional cognitions (automatic thoughts, images, assumptions, and core beliefs).
- Help patients reduce self-harming behavior.

Appendix A outlines opportunities for continuing professional growth in cognitive therapy. Sometimes there is just no substitute for hands-on training and supervision.

SPECIFYING PROBLEMS

Even the most experienced cognitive therapists have difficulty with some patients. It may be tempting to blame our patients for presenting challenging problems and to attribute their attitudes and dysfunctional behaviors to their own character flaws. It is usually not helpful, though, to view the problem broadly, labeling patients as "resistant," "unmotivated," "lazy," "frustrating," "manipulative," or "stuck." Global descriptions such as "The patient doesn't seem to want to be in therapy" or "The patient expects me to do all the work" are also too general to be useful. It is far more productive to *specify the behaviors* that interfere with therapeutic progress and to adopt a problem-solving stance. Therapists can precisely define the difficulty by asking:

> ■ "What specifically does the patient say or do (or not say or do) within the therapy session—or between sessions—that is a problem?"

Typical problematic behaviors that some patients display *in* session include:

- Insisting they cannot change or that therapy cannot help them.
- Failing to set goals or contribute to the agenda.
- Complaining about, denying, or blaming others for their problems.
- Presenting too many problems or jumping from crisis to crisis.
- Refusing to answer questions or going off on tangents.
- Arriving late for or skipping sessions.
- Demanding entitlements.
- Becoming angry, upset, critical, or nonresponsive.
- Being unable or unwilling to change their cognitions.
- Being inattentive or continually interrupting the therapist.
- Lying or avoiding the disclosure of important information.

Many patients also display dysfunctional behavior *between* sessions, such as:

- Not doing homework.
- Failing to take needed medication.
- Abusing drugs or alcohol.
- Repeatedly calling the therapist while in crisis.
- Engaging in self-harming behaviors.
- Injuring others.

Suicide attempts require immediate crisis intervention and assessment at an emergency room (and are beyond the scope of this book).

CASE EXAMPLE

Andrea, a patient with bipolar disorder, posttraumatic stress disorder, and borderline personality disorder was recently released from hospital following a suicide attempt. She has just started treatment with a new outpatient therapist. From the beginning, Andrea distrusts her new therapist and is hypervigilant for harm. She is guarded, resists setting goals, and repeatedly states that therapy cannot help her. She often becomes upset with her therapist, attributing negative motives to her and blaming her for causing Andrea distress. She refuses to do homework assignments or to take the medication her psychiatrist has prescribed for her.

When trying to determine how best to treat patients who, like Andrea, present a host of challenging problems, it is important to assess whether difficulties in therapy are related to a number of different possibilities:

- Patient's pathology
- Therapist error
- Factors *inherent* in treatment (including level of care, format of therapy, and frequency of sessions), and/or
- Factors *external* to treatment (including the presence of organic disease, the toxicity of the patient's environment, or the need for adjunctive treatments)

Many of the problems described in this book are related to the first factor: patients' pathology. Patients who present a challenge in treatment often demonstrate long-standing difficulties in their relationships, in their work, and in managing their lives. They usually have very negative ideas about themselves, others, and their worlds—views that they developed in and have maintained since childhood or adolescence. When these beliefs dominate their perceptions, patients then tend to perceive, feel, and behave in highly dysfunctional ways, across time and across situations—including in the therapy session itself. It is important for therapists to recognize the activation of these beliefs and to determine when and how therapy should be adjusted in response to them. Patients may also present challenges because of the nature of their disorder—for example, due to the ego-syntonicity of anorexia or the biologically influenced mood swings of bipolar disorder. Specialized treatment is necessary for these patients, too.

Other problems arise, however, because of missteps in treatment, when therapists fail to implement standard therapy appropriately. And some problems are due to a combination of the two. Yet, before assuming that a difficulty stems primarily from the patient's pathology or from mistakes made by the therapist, it is essential to specify the problem, consider its frequency and breadth, and assess what other factors may be involved. The rest of this chapter describes how to:

- Determine the extent of a problem or problems.
- Consider factors external to the therapy session.
- Diagnose therapist error.
- Identify patients' dysfunctional beliefs.
- Distinguish therapist error from patients' dysfunctional beliefs.

The final section describes what therapists can do to avoid therapeutic problems in the first place.

CONSIDERING THE EXTENT OF A PROBLEM

Therapists need to analyze problems that arise in treatment, assessing the severity and frequency of a problem before deciding what to do. They should ask themselves:

- ◾ "Is this a problem that arises briefly within one session?"
- ◾ "Is it a problem that persists within a session?"
- ◾ "Or does the problem arise in many sessions?"

Mild problems may not need to be directly addressed, at least initially. George, a high school student, grimaced and rolled his eyes at the beginning of his first two therapy sessions. His therapist did not acknowledge George's behavior. Instead she took care to be appropriately empathic, with the goal of demonstrating to him that she was not going to be like other controlling adults in his life. She also helped him set goals that *he* wanted to reach, not necessarily those that others had laid out for him. By the middle of their second session, George was able to see that his therapist had much to offer him and his negative reactions ceased.

Some problems are fairly specific and isolated, and can be addressed through simple problem solving. Jerry became annoyed when his therapist asked him to complete weekly symptom checklists. He and his therapist compromised by having him rate his mood on a 10-point scale instead. Holly needed help figuring out how she could obtain

childcare for her young children so she could attend sessions regularly and on time.

Other, problems are more prominent in a session and may require various solutions. When Toni's therapist tried to help her evaluate a rigid belief, the patient was unable to see the situation in a different light. Her therapist simply said, "It doesn't sound as if this [discussion] is helpful right now. How about if we move on to [the next problem on the agenda]?" Bob looked distressed when his therapist interrupted him for the third time. Having ascertained that his distress was indeed related to the interruptions, his therapist apologized and suggested that he speak uninterruptedly for the next 5–10 minutes. In both cases, the therapist's change of plan solved the problem.

Sometimes the problem is with the session as a whole. Lucy felt worse toward the end of the session than when she first walked in. The therapist correctly attributed her distress to the continued activation of her core belief of worthlessness. They agreed to spend the last few minutes of each session talking conversationally about one of Lucy's interests (movies) so that Lucy could leave the session feeling less distressed. Margaret seemed irritable for the first part of her therapy session. In response to her complaint that her therapist had seemed unsympathetic, her therapist asked Margaret if she would like to express herself more fully while she, the therapist, listened carefully and refrained from problem solving until near the end of the session. Again, these problems were quickly dealt with.

An ongoing problem that cuts across sessions usually requires more time to discuss and problem-solve so the patient will be willing to continue and progress in therapy. Dean was continually annoyed with his therapist because he believed that she was trying to control him or put him down. His therapist needed to spend more time empathizing with him, eliciting and helping him to respond to dysfunctional ideas about *her* and doing problem solving in relation to the therapeutic relationship so that he could then focus his attention more fully on working on his everyday problems outside of therapy.

Most therapeutic problems can be resolved through problem solving, modifying patients' cognitions, or changing therapist behavior. When problems persist, it is important to assess a variety of factors that might be interfering with treatment, as described below.

CONSIDERING FACTORS EXTERNAL TO THE THERAPY SESSION

While some ongoing problems are related to the process and content of therapy sessions, others are influenced by external factors. The areas noted below are included in a checklist in Figure 1.1.

- Is the patient receiving an appropriate dose of therapy?

  Should the patient be seen more often? Less often?
  Should the patient be at a higher or lower level of care (outpatient vs. partial hospitalization vs. hospitalization)?

- Is the medication appropriate?

  If the patient is not taking medication, should he/she be?
  If the patient is taking medication, is he/she fully compliant?
  Is the patient having significant side effects?

- Could there be an undiagnosed organic problem?

  Should the patient have a physical checkup with a primary care physician or specialist?

- Is the format of therapy appropriate?

  Should the patient be in individual therapy?
  Group therapy?
  Couple therapy?
  Family therapy?

- Does the patient need adjunctive treatment?

  Should the patient be referred to a psychopharmacologist?
  Pastoral counselor?
  Nutritionist?
  Vocational counselor?

- Is the patient's current living or work environment too deleterious for him/her to progress?

  Should the patient seek another place to live for a period of time?
  Should the patient try to make significant changes in his/her job?
  Look for another job?

FIGURE 1.1. Factors to consider external to the therapy session.

Dose, Level of Care, Format of Treatment, and Adjunctive Treatment

Sometimes patients fail to make sufficient progress because the *"dose"* of therapy is not appropriate. Claudia, a highly symptomatic patient, improved considerably more quickly when her therapist encouraged her to come to therapy on a weekly, instead of every other week, basis. Janice, a patient whose anxiety disorder had remitted significantly, needed to be treated on a less frequent basis so she could put the skills she had learned in therapy into practice on her own, without relying so heavily on her therapist.

Patients may be receiving treatment at an inappropriate *level of care.* Larry, an unemployed patient with rapid-cycling bipolar disorder and frequent suicidal ideation, periodically deteriorated when treated on an outpatient basis and needed occasional hospitalization or a partial hospitalization program. Carol needed inpatient rehab to address her substance dependence before she could benefit sufficiently from outpatient treatment.

The *format* of therapy may be inappropriate for some patients. Russell, a patient with depression and significant Axis II pathology, made faster progress when he agreed to move from individual therapy to group cognitive therapy. He perceived that the experience of others in the group had been similar to his; therefore they had a high degree of credibility for him and he was more amenable to testing his thoughts and changing his behavior. Elaine, who had mild depression and anxiety along with borderline traits, had received several sessions of individual therapy. She began to improve significantly once her boyfriend joined her for couple therapy. Lisa, an oppositional teenager, did not benefit much from individual therapy by itself, especially since she tended to blame others and to minimize her responsibility for problems. But when her therapist alternated individual sessions with family sessions, Lisa began to improve.

Sometimes therapists do not have the special expertise that patients need and *adjunctive treatment* might be indicated. Some patients benefit significantly from additional forms of treatment, such as pastoral, vocational, or nutritional counseling. Many patients are helped from support and education in groups such as Alcoholics Anonymous, one of its variations, or self-help groups.

Biological interventions

Many patients, especially those who have been taking medication for a period of time, benefit from a *medication consult* that may result in an increase, decrease, or change of medication. Joe, a severely depressed patient, was having a great deal of difficulty sleeping. Medication eased his sleep problem, allowing him to progress much better in therapy. Shannon, a patient with panic disorder, was taking a high dose of benzodiazapenes, which reduced her anxiety symptoms. She was not able to learn fully that these symptoms were not dangerous until she had tapered her medication. Nancy was experiencing sedating side effects from her antipsychotic medication and was unable to focus sufficiently in session (and while trying to do homework outside of session) until her medication was changed.

Patients can also have *undiagnosed medical problems* that need to be addressed. If they have not had a recent medical checkup, the therapist

should suggest one. Mark presented with anxiety, irritability, weight loss, emotional lability, and impaired concentration. Fortunately, his therapist pushed him to see his primary care doctor, who then determined through a blood test that Mark was not suffering from depression but instead had hyperthyroidism. Alexandra, too, seemed depressed. She had a significant loss of interest in nearly all her activities, felt physically and mentally slowed down, couldn't sleep, and had gained weight. Her physician diagnosed her with hypothyroidism and her symptoms abated once she was treated with appropriate medication.

Other patients may present with symptoms that look as if they stem from psychiatric disorders but are actually the result of endocrine disorders, brain tumors, traumatic brain injuries, seizure disorders, central nervous system infections, metabolic or vitamin deficiency disorders, degenerative dementias, cerebrovascular diseases, or other medical conditions (see Asaad, 1995, for in-depth information on this topic).

Environmental Changes

Sometimes patients' environments are so harmful that therapeutic intervention must be combined with a change in environment. Rebecca, a severely depressed teenager with an eating disorder, lived with her single mother and three siblings. The household was chaotic; her mother was alcoholic and emotionally abusive and her mother's boyfriend was physically abusive to Rebecca. Rebecca made little headway in solving her problems until her therapist facilitated her move out of the house and helped her establish residence with an aunt. Ken, a patient with rapid-cycling bipolar disorder, which was only partially controlled, struggled daily with a job that was beyond his capabilities when he was symptomatic. He became more and more anxious, depressed, and suicidal. It was not until he took a much less demanding job that he was able to progress in therapy.

When patients fail to improve or pose another challenge to the therapist, it is essential to determine whether external factors such as those outlined above are involved. Addressing such difficulties, as well as exploring the possiblity of therapist error or patients' dysfunctional beliefs, may be critical for patients to improve.

THERAPIST ERROR VERSUS PATIENTS' DYSFUNCTIONAL BELIEFS

Many problems that arise in therapy or between therapy sessions are related to mistakes the therapist has made, to patients' dysfunctional cognitions, or to both.

Is the problem related to therapist error?

Even well-experienced therapists inadvertently make mistakes. Typical errors, described throughout this book include:

- An erroneous diagnosis (e.g., misdiagnosing panic disorder as a simple phobia).
- An incorrect, formulation or conceptualization of the case (e.g., failing to recognize that anxiety, not depression, is primary for a particular patient or incorrectly identifying a patient's core beliefs).
- A failure to use one's formulation of the case and conceptualization of the patient to guide therapy (e.g., focusing on problems or cognitions that are not central to the patient's recovery).
- A faulty treatment plan (e.g., using principles of generalized anxiety disorder treatment for a patient with obsessive compulsive–disorder).
- A rift in the therapeutic alliance (e.g., the therapist has not recognized that the patient is becoming overly frustrated in the therapy session).
- An inadequate, list of behavioral goals (e.g., the patient's goals are too broad).
- Inappropriate structure or pacing (e.g., the therapist fails to interrupt the patient enough to address an important problem thoroughly).
- Inadequate focus on solving current problems (e.g., the therapist initially focuses on a depressed patient's childhood trauma instead of focusing on helping her become more functional in her daily life).
- Incorrect implementation of techniques (e.g., devising an exposure hierarchy in which the first few steps are too difficult).
- Inappropriate homework (e.g., the therapist suggests a homework assignment that the patient is unlikely to complete).
- A failure to maximize the patient's memory of the session (e.g., the therapist fails to record for the patient, in writing or on tape, the most important points of the session).

It is often difficult for therapists to identify their own mistakes. Listening to an audiotape of a therapy session, or having a colleague listen to it, sometimes reveals these kinds of therapist errors, especially if the listener uses the Cognitive Therapy Rating Scale (Young & Beck, 1980) to assess the tape. This scale, available at www.academyofct.org along with an accompanying manual, is used to measure therapist competency in 11 areas. Often review of an audiotape alone, while necessary, is by itself inadequate and the therapist also needs to thoroughly review the case with a colleague or supervisor.

Is the Problem Related to Patients' Dysfunctional Beliefs?

Identifying the beliefs that may underlie patients' problems in therapy is described more fully in the next two chapters. Briefly, it is helpful to hypothesize patients' assumptions, then check out the hypotheses with the patient. To do so, the therapist might put him- or herself in the patient's shoes and ask two questions:

- ■ "If I [do this dysfunctional behavior], then what good thing happens?"
- ■ "If I [don't do this dysfunctional behavior], what bad thing might happen?"

Andrea, the patient described at the beginning of this chapter, often blamed others for her problems. Her assumptions were:

"If I blame others, I won't have to change. But if I acknowledge that I had a part in my difficulties, I'll feel bad, let others off the hook, and be responsible for changing—which I feel incapable of, anyway."

Andrea was quite guarded in what she said during the session because of the following assumptions:

"If I avoid answering [my therapist's] questions directly or get her off track, I'll be okay. But If I reveal myself to [my therapist], I'll feel exposed and vulnerable and she will judge me harshly and reject me."

A third set of assumptions accounted for Andrea's continual rationalizations to justify her lack of behavioral change. Underlying her failure to follow through with reasonable homework assignments were the following assumptions:

"If I maintain the status quo, I won't open myself up to greater pain. But if I try to make my life better, it will actually get worse."

Understanding the assumptions that patients hold often clarifies the reasons for their dysfunctional behavior Testing and modifying these assumptions are often necessary before patients are willing to change.

Distinguishing between Problems Related to Therapist Error and Those Related to Patients' Dysfunctional Cognitions

The source of a problem is sometimes not readily apparent. Below are some typical difficulties that arise with patients who present challenging problems and examples of both therapist errors and patients' dysfunctional thoughts or beliefs.

- *The patient doesn't contribute to the agenda.*
  Therapist error: The therapist has not asked the patient (as part of a homework assignment) to think about which problems she most wants help in solving.
  Patient's cognition: "It is useless to discuss this because my problems are insoluble."
- *The patient becomes upset when the therapist interrupts.*
  Therapist error: The therapist is interrupting too much or too abruptly and the patient reasonably feels uncomfortable.
  Patient's cognition: "My therapist interrupts me because he wants to control me."
- *The patient vigorously negates the therapist's views.*
  Therapist error: The therapist has expressed his views too forcefully or too early in therapy or his views are erroneous.
  Patient's cognition: "If I adopt my therapist's viewpoint it means my therapist has won and I have lost."
- *The patient complains about problems instead of engaging with the therapist in solving problems.*
  Therapist error: The therapist has not sufficiently socialized the patient to the process of therapy or does not interrupt the patient to steer him toward problem solving.
  Patient's cognition: "I shouldn't have to change."
- *The patient is inattentive.*
  Therapist error: The therapist has not adjusted treatment for a patient who has attentional difficulties or for a patient who is experiencing high levels of distress that interfere with processing.
  Patient's cognition: "If I listen to my therapist, I'll get too upset."

AVOIDING PROBLEMS IN THERAPY

Therapists can minimize the occurrence of problems by ensuring that they continuously follow some of the central precepts of cognitive therapy (described more fully in J. Beck, 1995):

1. Accurately diagnose and formulate the case.
2. Conceptualize the patient in cognitive terms.
3. Use the cognitive formulation and the individual conceptualization to plan treatment within and across sessions.
4. Build a strong therapeutic alliance.
5. Set specific behavioral goals.
6. Employ basic strategies.

7. Use advanced strategies and techniques.
8. Assess the effectiveness of interventions and of therapy.

These elements are briefly described below and illustrated throughout the book.

Diagnosis and Formulation

Since the focus of cognitive therapy treatment for one disorder may be significantly different from that of another, it is essential to conduct a thorough clinical assessment of patients that yields an accurate diagnosis. For example, the treatment for posttraumatic stress disorder differs in some important ways from the treatment of generalized anxiety disorder.

It is also important to formulate the case correctly. The most important cognitions in the treatment of panic disorder, for example, are the patient's catastrophic misinterpretation of symptoms (Clark & Ehlers, 1993). In depression, negative thoughts about the self, the world, and the future are most important to target (Beck, 1976). In obsessive compulsive–disorder, it is important not to focus heavily on modifying the *content* of patients' obsessive thoughts or images, but instead to modify their *appraisal* of their obsessive cognitions (Frost & Stekettee, 2002; Clark, 2004; McGinn & Sanderson, 1999). If a therapist employs a generic approach for patients, without varying it according to an individual patient's disorder, the patient is unlikely to make sufficient progress. Additional information about treatment manuals can be found at www.beckinstitute.org.

Therapists also must be aware of key issues affecting patients and their treatment, for example, their age, developmental level, intellectual level, cultural milieu, spiritual beliefs, gender, sexual orientation, physical health, and stage of life. Mia, for example, was Asian. Her therapist unwittingly alienated her by questioning her extremely strong cultural belief about the need to obey one's parents. Janet's therapist did not understand the grief she felt when her youngest child left home, and instead of empathizing and supporting her, tried to modify her thinking, which left Janet believing she was defective for having a normal, human reaction. Keith's therapist failed to take into account his aging patient's difficulty with mobility and memory and suggested homework assignments that were doomed to failure.

At times it becomes apparent even at the evaluation or first therapy session that treatment will need to be varied. Understanding that Andrea, described above, had borderline personality disorder with strong paranoid features helped her therapist think about how therapy with Andrea might have to be different from therapy with a patient who was experienc-

ing a first episode of depression and who had no significant Axis II pathology.

Diagnosis and formulation of the case needs to be ongoing. A comorbid diagnosis may not, for example, be obvious at the start of treatment. Eleanor, a patient with depression and panic disorder, made some progress in therapy but then became stuck. It was not until her therapist realized that she also had a significant case of social phobia, and began treating her for it, that Eleanor began to improve again. The same was true for Rodney, who initially minimized the extent of his drug use.

Cognitive Conceptualization

Therapists need to develop and continually refine a cognitive conceptualization of the individual patient. The conceptualization, described in Chapter 2, helps therapists (and patients) understand why the patient currently reacts to situations and problems in a particular way and to identify the central cognitions and behaviors that are important to target in therapy. Patients may have any number of problems and problematic behaviors, thousands of automatic thoughts, many dozens of dysfunctional beliefs. Therapists must quickly identify the specific cognitions and behaviors most needing—and most amenable to—change.

Planning Treatment Across and Within Sessions

An accurate diagnosis and formulation of the case enables the therapist to devise a general treatment approach for the patient across sessions. An accurate, continuously evolving cognitive conceptualization enables the therapist to focus on the patient's most central problems, dysfunctional cognitions, and behaviors in each session. Treatment planning within sessions is illustrated throughout this book.

Building the Therapeutic Alliance

To engage fully in treatment, most patients need to feel that their therapists are understanding, caring, and competent. Yet even when their therapists display these characteristics, some patients react negatively—for example, they may become suspicious of their therapist's motives. Sometimes therapists need to vary their style, becoming more or less empathic, structured, didactic, confrontive, selfdisclosing, or humorous. An autonomous patient, for example, may prefer his therapist to be business-like and slightly removed, while a sociotropic patient may respond better if his therapist is warm and friendly (Leahy, 2001). The ability to pinpoint, conceptualize, and overcome difficulties in the therapeutic relationship is

essential to helping patients progress—and may help them improve other relationships as well, as described in Chapters 4 and 5.

Setting Specific Behavioral Goals

It is important for therapists to guide patients to identify specific goals they would like to reach as a result of therapy. Many patients initially state that they would like to feel happier or less dysphoric. These long-term goals are too broad to easily work toward and achieve. Therapists often have to ask patients what they would be *doing differently* if they were happier; the behaviors they state then become the short-term goals toward which patients work at each session.

Employing Basic Strategies

It is important to have patients engage in fundamental therapy tasks: identifying and responding to their automatic thoughts, completing homework assignments, scheduling activities (this task is especially important for depressed patients), and exposing themselves to feared situations (this task is especially important for patients with anxiety disorders). Therapists whose patients are highly resistant to doing such tasks may drop their focus on these essential activities altogether, when instead they should negotiate with their patients about improving adherence or help their patients respond to associated dysfunctional cognitions.

Using Advanced Techniques

Therapists often need to use a wide variety of techniques with patients. These techniques are typically cognitive, behavioral, problem solving, supportive, or interpersonal. Some techniques are emotional in nature (e.g., teaching emotional regulation skills to highly reactive patients or heightening affect in avoidant patients). Some are biological (e.g., ruling out an organic cause of symptoms, helping patients cope with medication side effects or a chronic medical condition). Some are environmental (e.g., helping an abused patient find another living situation). Some are experiential (e.g., restructuring the meaning of early trauma through imagery). Some are psychodynamic-like (e.g., helping patients correct their distorted beliefs about the therapist).

Therapists often need to devise new techniques on the spot to deal with the activation of patients' emotionally charged beliefs or, conversely, their avoidance of emotionally charged material (Newman, 1991; Wells, 2000). Nonstandard techniques are sometimes essential, for example, to maintain a strong therapeutic alliance or to help patients gain an emotional or gut-level change in belief.

Assessing the Effectiveness of Interventions and of Therapy

To gauge progress and plan treatment across and within sessions, it is essential to conduct a mood check at the beginning of each session (J. Beck, 1995), preferably accompanied by self administered scales such as the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) or Beck Youth Inventories (J. Beck, Beck, & Jolly, 2000). In addition, it is important to assess progress during the therapy session itself. Standard techniques should be employed, such as asking patients to summarize periodically during the session or checking on the degree of negative emotion patients feel *before* and after discussing a problem in therapy (as well as the degree to which they believe their dysfunctional cognitions).

Change in the therapy session itself, however, is insignificant if patients return to the same negative thinking and mood once the session is over and/or they fail to make necessary behavioral change between sessions. An important part of gauging how well therapy is going is determining what constitutes reasonable progress for a patient. For many of the patients described in this book, progress was quite slow, but fairly steady, with setbacks along the way.

SUMMARY

Part of the art of conducting cognitive therapy lies in identifying problems in treatment, assessing the severity of the problems, then specifying the source of the problems. Difficulties may be related to factors external to treatment (e.g., a deleterious environment), factors inherent in the treatment (e.g., an insufficient level of care), therapist error (e.g., incorrect implementation of techniques), and/or the patient's pathology (e.g., deeply entrenched beliefs). Outside consultation is sometimes necessary to diagnose a problem adequately. Creative solutions to typical difficulties are presented throughout this book. The next chapter, which addresses cognitive conceptualization, lays the groundwork for understanding why problems related to patients' pathology arise.