BECK INSTITUTE | COGNITIVE BEHAVIOR THERAPY

CBT WORKSHEET PACKET

2020 EDITION

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Introduction

A more detailed description and further examples of each worksheet can be found in Beck, J. S. Cognitive Behavior Therapy: Basics and Beyond, 3rd ed. (2020), and Beck, J. S. Cognitive Therapy for Challenging Problems (2005). As noted in these books, the decision to use any given worksheet is based on the therapist's conceptualization of the client. The worksheets are inappropriate for some clients, especially those who are not intellectually equipped to understand them, who become easily confused, who do not read or write well, or who have an aversion to filling out forms. In reality, many experienced cognitive therapists do not use these forms as they are presented here; they adapt them to meet the needs of their individual clients.

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(TRADITIONAL) COGNITIVE CONCEPTUALIZATION DIAGRAM

Instructions

The (Traditional) Cognitive Conceptualization Diagram allows you to extract a great deal of information about clients' most central beliefs and key behavioral patterns; it helps you understand the connections between clients' childhood experiences, the development of core beliefs about the self, world and future, and the ways in which clients cope with and compensate for their fixed, global, negative beliefs.

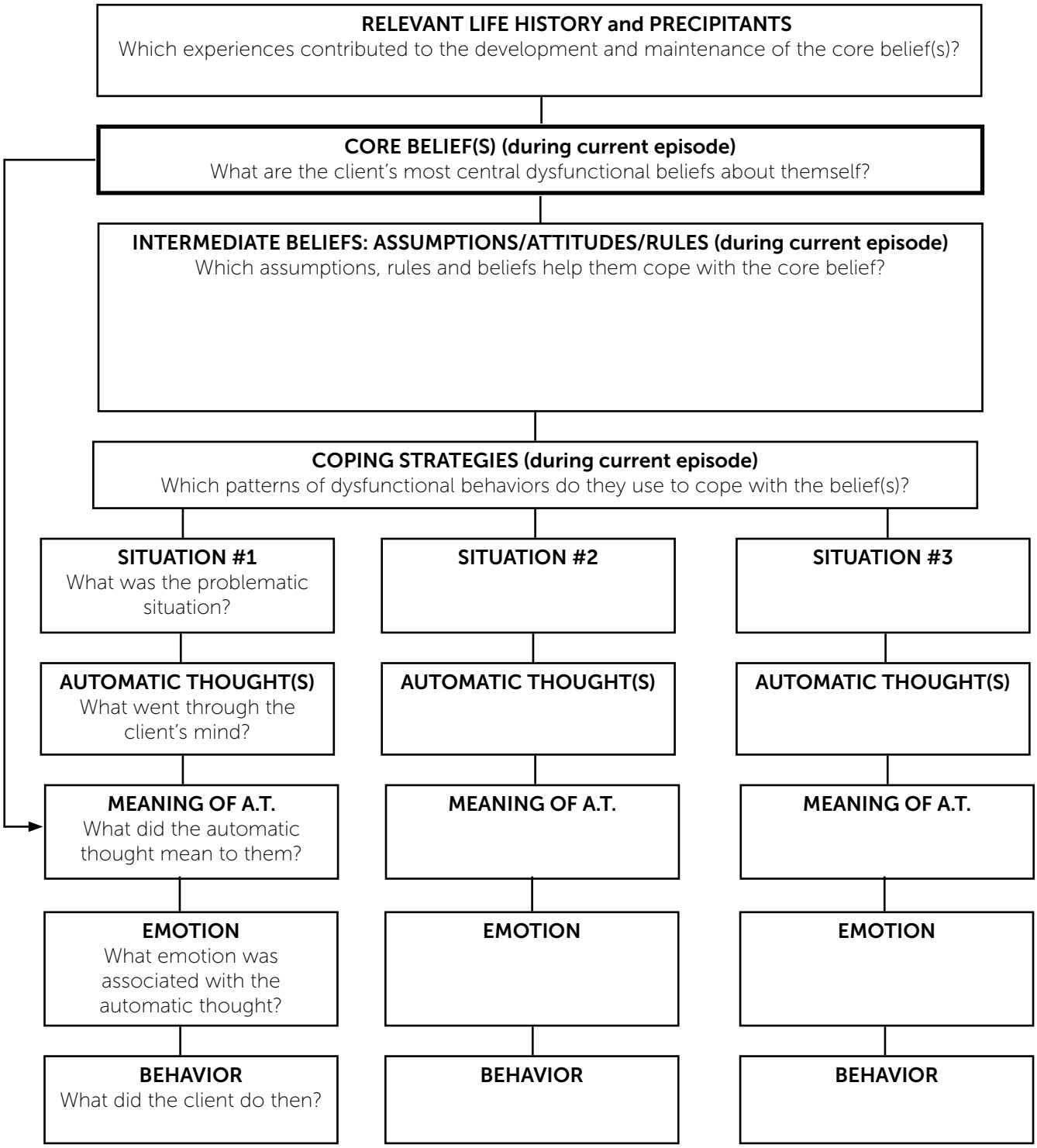
You should begin completing the cognitive conceptualization diagram between sessions as soon as you have collected pertinent data. The diagram is based on specific information that clients provide. Therefore, when you make hypotheses, you should indicate so (with a question mark, for example) and regard your hypotheses as tentative until directly confirmed by the client.

Generally, it is best to start midway down the page, recording problematic situations that are quite typical for the client. (It is important to note that three situations are insufficient to understand the complexity of some clients. You should add additional boxes across the bottom of the diagram, particularly when clients have several core beliefs.) Choose situations in which clients display a pattern of unhelpful hebavior or the clients' automatic thoughts show common themes. If there is more than one theme, make sure you include a situation that reflects it. Ascertaining the meaning of clients' automatic thoughts across representative situations should lead to hypotheses about their core beliefs. Using the questions on the next page, you can fill in the rest of the diagram.

This diagram is designed to help you conceptualize clients; it is too confusing for most clients. You can, however, draw simplified versions of it. In some cases, it may be appropriate to present the client with a blank diagram to complete with you. Again, it is generally best to fold the diagram in half and start with the lower portion. Developing the diagram with clients helps them to understand why they react (often dysfunctionally) in characteristic ways across situations.

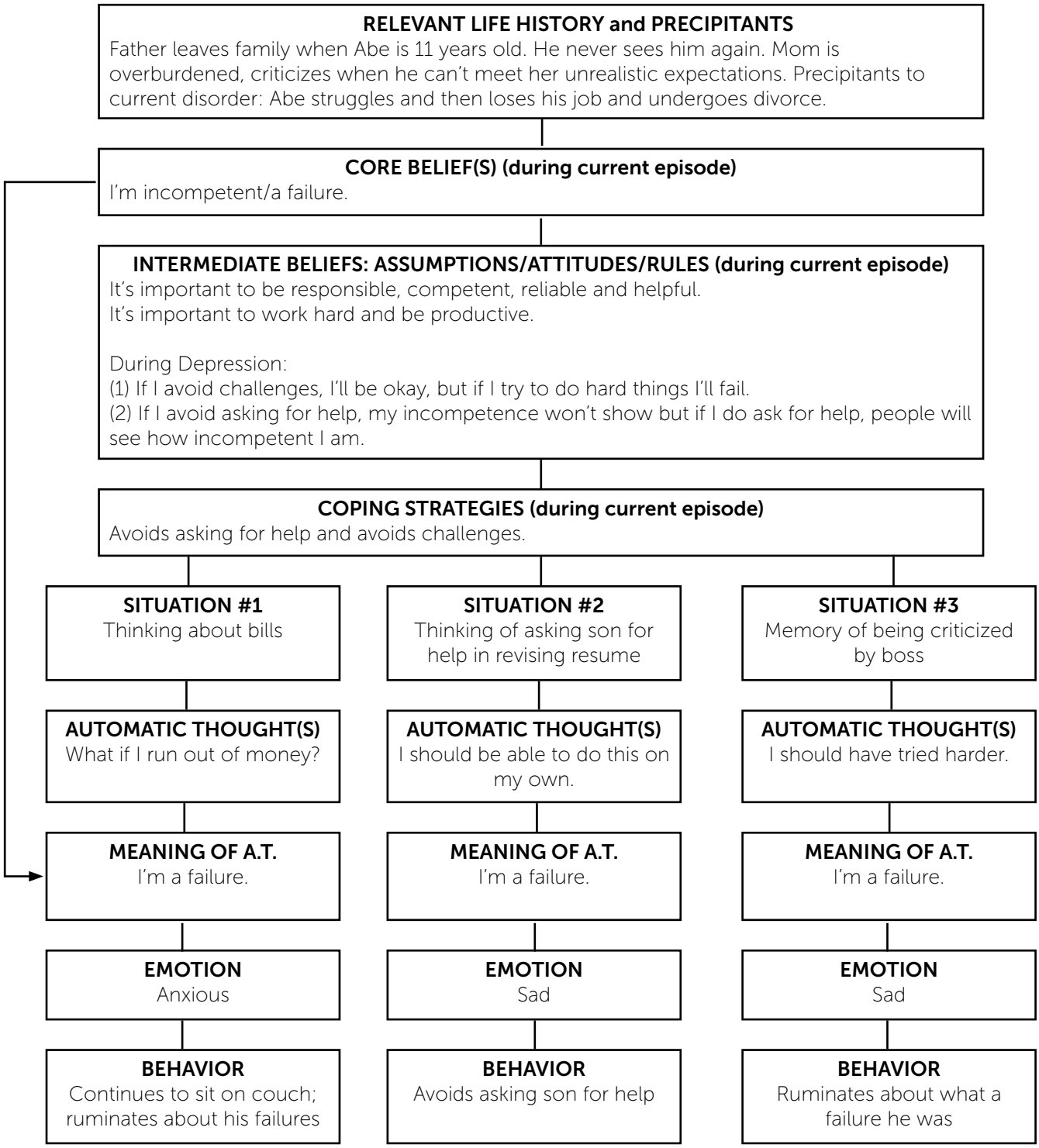
(TRADITIONAL) COGNITIVE CONCEPTUALIZATION DIAGRAM QUESTIONS

Name: _____ Date: _____ Diagnosis: _____



(TRADITIONAL) COGNITIVE CONCEPTUALIZATION DIAGRAM EXAMPLE

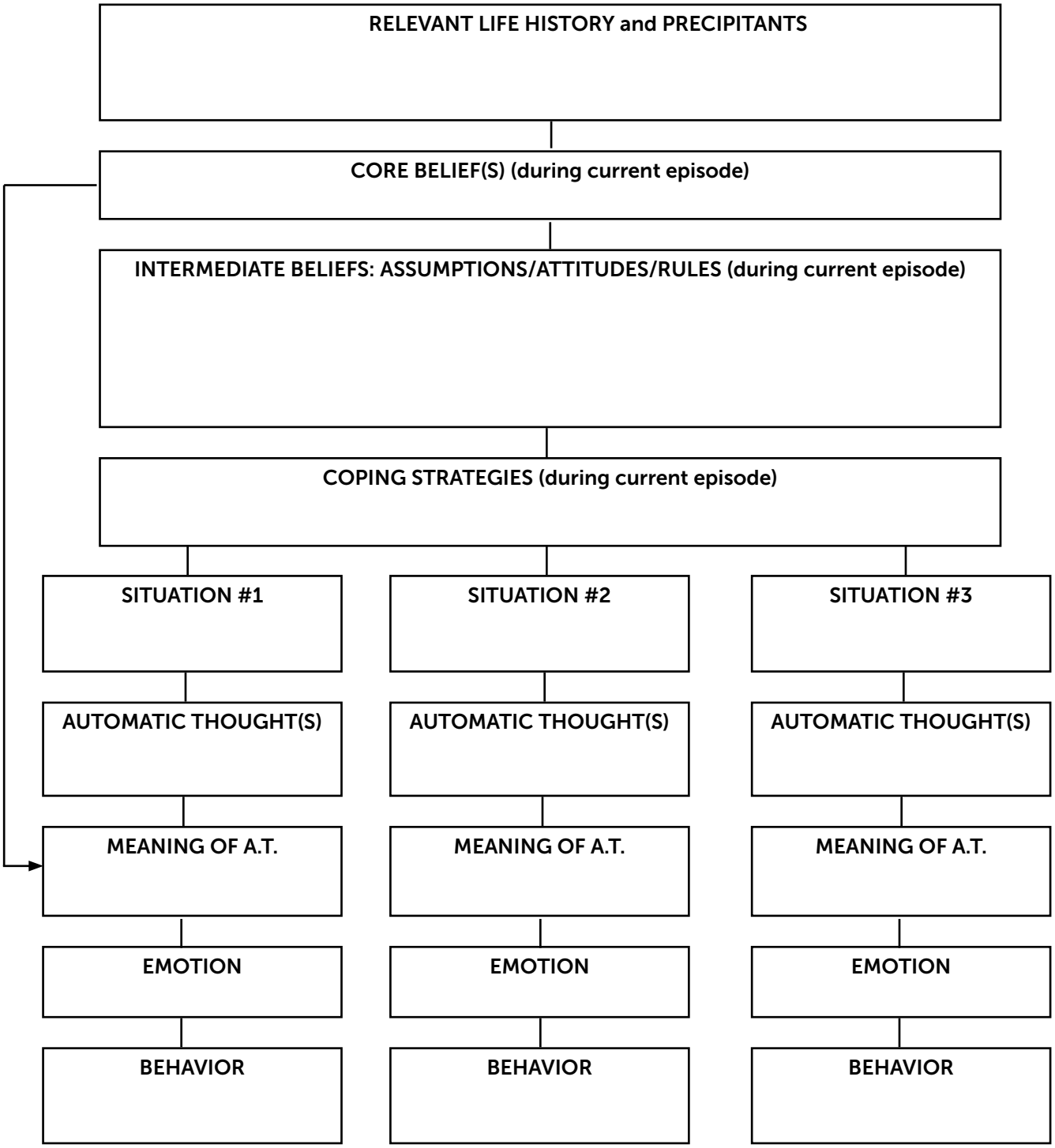
Name: _____ Date: _____ Diagnosis: _____



(TRADITIONAL) COGNITIVE CONCEPTUALIZATION DIAGRAM WORKSHEET

For a click-and-fill version of this worksheet, please visit: **beckinstitute.org/diagram**.

Name: _____ Date: _____ Diagnosis: _____



STRENGTH-BASED COGNITIVE CONCEPTUALIZATION DIAGRAM

Instructions

The Strength-Based Cognitive Conceptualization Diagram (SB-CCD) helps organize clients' patterns of helpful cognitions and behavior. It depicts, among other things, the relationship among:

- important life events and adaptive core beliefs
- adaptive core beliefs and the meaning of the client's automatic thoughts
- adaptive core beliefs, related intermediate beliefs and adaptive coping strategies
- situations, adaptive automatic thoughts and adaptive behaviors.

You'll elicit relevant data at the evaluation (e.g., when you ask clients to describe the best period in their life) for the top of the diagram and additional data for the whole diagram throughout treatment. The SB-CCD is too complex to present to many clients. If you do, show them a blank copy. You can fill it out together, choosing historical (premorbid) situations in which they had adaptive automatic thoughts and behaviors, especially how they adaptively dealt with challenging situations. And/or you can wait until the clients are currently perceiving themselves and their experiences more realistically and are engaging in helpful coping strategies.

STRENGTH-BASED COGNITIVE CONCEPTUALIZATION DIAGRAM QUESTIONS

Name: _____ Date: _____

RELEVANT LIFE HISTORY (including accomplishments, strengths, personal qualities and resources prior to current difficulties)

What experiences contributed to the development and maintenance of the adaptive core belief(s)? What have the client's strengths, skills, personal and material assets, and positive relationships been like? What are the client's skills, strengths and positive qualities? What internal and external resources does the client have?

ADAPTIVE CORE BELIEFS (prior to onset of current difficulties)

What are the client's most central adaptive beliefs about themself? others? the world?

ADAPTIVE INTERMEDIATE BELIEFS: ASSUMPTIONS, RULES, ATTITUDES (prior to onset of current difficulties)

What general assumptions, rules, attitudes and values does the client have?

ADAPTIVE PATTERNS OF BEHAVIOR (prior to onset of current difficulties)

What adaptive coping strategies and behaviors does the client display?

SITUATION #1	SITUATION #2	SITUATION #3
What was the problematic situation?		
AUTOMATIC THOUGHT(S) What went through the client's mind?	**AUTOMATIC THOUGHT(S)**	**AUTOMATIC THOUGHT(S)**
EMOTIONS What emotions were associated with the automatic thought?	**EMOTIONS**	**EMOTIONS**
BEHAVIOR What did the client do that was helpful?	**BEHAVIOR**	**BEHAVIOR**

STRENGTH-BASED COGNITIVE CONCEPTUALIZATION DIAGRAM EXAMPLE

Name: _____ Date: _____

RELEVANT LIFE HISTORY (including accomplishments, strengths, personal qualities and resources prior to current difficulties)

People described Abe as "a good kid." Some positive interactions with family, maternal uncle and coaches growing up. Took father's abandonment in stride. Tried hard when given age-inappropriate responsibilities at home at age 11. Good friends, average grades, above-average athlete, high school diploma. Strongly motivated, excellent work history, many interpersonal and supervisory skills; reliable, productive, responsible. Good problem-solver, good common sense. Had made a reasonable living; always budgeted and saved money. Likeable, a "good family man;" good relationships with children/grandchildren, a cousin, two male friends; made a reasonable living; always budgeted and saved money. Strongly motivated, good sense of humor, liked by most people. Sees two grown children and four grandchildren often, helps them out, close relationships with them, a cousin and several male friends.

ADAPTIVE CORE BELIEFS (prior to onset of current difficulties)

I'm responsible, considerate, competent, self-reliant, helpful, a good person, likeable, resourceful. Most people are neutral or benign. The world is potentially unpredictable but relatively safe and stable. I can cope (if bad things happen).

ADAPTIVE INTERMEDIATE BELIEFS: ASSUMPTIONS, RULES, ATTITUDES (prior to onset of current difficulties)

Family, work and community are important. It's important to work hard, be productive, self-reliant, responsible, and reliable, honor commitments, consider others' feelings, do the right thing; do what I say I'm going to do. I should figure things out for myself. If I persist on a difficult task, I'll probably succeed. If I perform highly, it means I'm competent; I'm okay.

ADAPTIVE PATTERNS OF BEHAVIOR (prior to onset of current difficulties)

Sets high standards for himself, works hard, tries to increase his competence, perseveres and solves problems himself; is kind and considerate to others, honors his commitments, does what he sees as "the right thing," helps others.

SITUATION #1	SITUATION #2	SITUATION #3
Thinking about meeting buddies for breakfast	Fixing neighbor's car	Surfing the web
AUTOMATIC THOUGHT(S)	**AUTOMATIC THOUGHT(S)**	**AUTOMATIC THOUGHT(S)**
I'm really tired but I don't want to disappoint them.	I don't know if I can get it to run.	I'd like a better TV but I have to cover my bills.
EMOTIONS	**EMOTIONS**	**EMOTIONS**
Neutral	Neutral	Mild disappointment
BEHAVIOR	**BEHAVIOR**	**BEHAVIOR**
Goes to breakfast	Keeps trying	Doesn't order TV

STRENGTH-BASED COGNITIVE CONCEPTUALIZATION DIAGRAM WORKSHEET

Name: _____ Date: _____

RELEVANT LIFE HISTORY (including accomplishments, strengths, personal qualities and resources prior to current difficulties)

ADAPTIVE CORE BELIEFS (prior to onset of current difficulties)

ADAPTIVE INTERMEDIATE BELIEFS: ASSUMPTIONS, RULES, ATTITUDES (prior to onset of current difficulties)

ADAPTIVE PATTERNS OF BEHAVIOR (prior to onset of current difficulties)

SITUATION #1	SITUATION #2	SITUATION #3
AUTOMATIC THOUGHT(S)	AUTOMATIC THOUGHT(S)	AUTOMATIC THOUGHT(S)
EMOTIONS	EMOTIONS	EMOTIONS
BEHAVIOR	BEHAVIOR	BEHAVIOR

CASE WRITE-UP EXAMPLE

The Case Write-Up is a conceptualization tool designed to help you formulate cases. It is not designed for client use.

PART ONE: INTAKE INFORMATION

IDENTIFYING INFORMATION AT INTAKE:

Age: 56
Gender Identity and Sexual Orientation: Male, heterosexual
Cultural Heritage: American with European heritage
Religious/Spiritual Orientation: Belongs to the Unitarian Church; was not attending church at intake
Living Environment: Small apartment in large city, lives alone
Employment Status: Unemployed
Socioeconomic Status: Middle class

CHIEF COMPLAINT, MAJOR SYMPTOMS, MENTAL STATUS, AND DIAGNOSIS:

Chief Complaint: Abe sought treatment for severe depressive symptoms and moderate anxiety.

Major Symptoms

Emotional: Feelings of depression, anxiety, pessimism and some guilt; lack of pleasure and interest

Cognitive: Trouble making decisions, trouble concentrating

Behavioral: Avoidance (not cleaning up at home, looking for a job or doing errands), social isolation (stopped going to church, spent less time with family, stopped seeing friends)

Physiological: Heaviness in body, significant fatigue, low libido, difficulty relaxing, decreased appetite

Mental Status: Abe appeared to be quite depressed. His clothes were somewhat wrinkled; he didn't stand or sit up straight and made little eye contact and didn't smile throughout the evaluation. His movements were a little slow. His speech was normal. He showed little affect other than depression. His thought process was intact. His sensorium, cognition, insight and judgment were within normal limits. He was able to fully participate in treatment.

Diagnosis (from the Diagnostic and Statistical Manual or International Classification of Disease): Major Depressive Disorder, single episode, severe, with anxious distress. No personality disorder but mild OCPD features.

CURRENT PSYCHIATRIC MEDICATIONS, ADHERENCE AND SIDE EFFECTS; CONCURRENT TREATMENT:

Abe was not taking psychiatric medication and was not receiving any treatment for his depression.

CURRENT SIGNIFICANT RELATIONSHIPS: Although Abe had withdrawn somewhat from his family, his relationship with his two grown children and four school-age grandchildren were good. He

sometimes visited them or attended his grandchildren's sporting events. He had a great deal of conflict with his ex-wife and he had completely withdrawn from his two male friends. He was relatively close to one cousin and less so to one brother. He saw and spoke to his other brother and his mother infrequently and didn't feel close to them.

PART TWO: HISTORICAL INFORMATION

BEST LIFETIME FUNCTIONING (INCLUDING STRENGTHS, ASSETS AND RESOURCES): Abe was at his best when he finished high school, got a job, and moved into an apartment with a friend. This period lasted for about six years. He did well on the job, got along well with his supervisor and co-workers, socialized often with good friends, exercised and kept himself in good shape, and started saving money for the future. He was a good problem-solver, resourceful and resilient. He was respectful to others and pleasant to be around, often helping family and friends without being asked. He was hard-working, both at work and around the house. He saw himself as competent, in control, reliable and responsible. He viewed others and his world as basically benign. His future seemed bright to him. He also functioned highly after this time, though he had more stress in his life after he married and had children.

HISTORY OF PRESENT ILLNESS: Abe developed depressive and anxious symptoms 2 ½ years ago. His symptoms gradually worsened and turned into a major depressive episode about 2 years ago. Since that time, symptoms of depression and anxiety have remained consistently elevated without any periods of remission.

HISTORY OF PSYCHIATRIC, PSYCHOLOGICAL OR SUBSTANCE USE PROBLEMS AND IMPACT ON FUNCTIONING: Abe became quite anxious about 2 ½ years ago when his supervisor changed his job responsibilities and provided him with inadequate training. He began to perceive himself as failing on the job and became depressed. His depression increased significantly when he lost his job six months later. He withdrew into himself and stopped many activities: helping around the house, doing yardwork and errands, seeing his friends. His wife then became highly critical and his depression became severe. He had not had any problems with alcohol or other substances.

HISTORY OF PSYCHIATRIC, PSYCHOLOGICAL OR SUBSTANCE ABUSE TREATMENT, TYPE, LEVEL OF CARE AND RESPONSE: Abe and his wife had three joint outpatient marital counseling sessions with a social worker about 2 years ago; Abe reported it did not help. He reported no other previous treatment.

PERSONAL, SOCIAL, EDUCATIONAL AND VOCATIONAL HISTORY: Abe was the oldest of three sons. His father abandoned the family when Abe was eleven years old, and he never saw his father again. His mother then developed unrealistically high expectations for him, criticizing him severely for not consistently getting his younger brothers to do homework and for not cleaning up their apartment while she was at work. He had some conflict with his younger brothers who didn't like him "bossing"

them around. Abe always had a few good friends at school or in the neighborhood. After his father left, he developed a closer relationship with his maternal uncle and later with several of his coaches. Abe was an average student and a very good athlete. His highest level of education was a high school diploma. Abe started working in the construction industry in high school and had just a few jobs in the industry between graduation and when he became depressed. He worked his way up in customer service until he became a supervisor. He got along well with his bosses, supervisors and co-workers and had always received excellent evaluations until his most recent supervisor.

MEDICAL HISTORY AND LIMITATIONS: Abe had a few sports-related injuries in high school but nothing major. His health was relatively good, except for moderately high blood pressure, which he developed in his late forties. He didn't have any physical limitations.

CURRENT NON-PSYCHIATRIC MEDICATIONS, TREATMENT, ADHERENCE AND SIDE EFFECTS: Abe was taking Vasotec, 10 mg, 2x per day with full adherence to treat high blood pressure. He had no significant side effects. He was not receiving any other treatment.

PART THREE: THE COGNITIVE CONCEPTUALIZATION DIAGRAM

See page 5 of this worksheet packet.

PART FOUR: THE CASE CONCEPTUALIZATION SUMMARY

HISTORY OF CURRENT ILLNESS, PRECIPITANTS AND LIFE STRESSORS: The first occurrence of Abe's psychiatric symptoms began 2 ½ years ago when Abe began to display mild depressive and anxious symptoms. The precipitant was difficulty at work; his new supervisor had significantly changed his job responsibilities, and Abe experienced great difficulty in performing his job competently. He began to withdraw from other people, including his wife, and started spending much of the time when he was home sitting on the couch. His symptoms steadily worsened and increased very significantly when he lost his job and his wife divorced him, about two years ago. His functioning steadily declined after that. At intake, he was spending most of his time sitting on the couch, watching television, and surfing the web.

MAINTAINING FACTORS: Highly negative interpretations of his experience, attentional bias (noticing everything he wasn't doing or wasn't doing well), lack of structure in his day, continuing unemployment, avoidance and inactivity, social withdrawal, tendency to stay in his apartment and not go out, increased self-criticism, deterioration of problem-solving skills, negative memories, rumination over perceived current and past failures, and worry about the future.

VALUES AND ASPIRATIONS: Family, autonomy and productivity were very important to Abe. He aspired to rebuild his life, to recapture his sense of competence and ability to get things done, to get back to work, to become financially stable, to re-engage in activities he had abandoned and to give back to

others.

NARRATIVE SUMMARY, INCORPORATING HISTORICAL INFORMATION, PRECIPITANTS, MAINTAINING FACTORS AND COGNITIVE CONCEPTUALIZATION DIAGRAM INFORMATION: For most of his life, Abe demonstrated many strengths, positive qualities and internal resources. For many years he had had a successful work history, marriage and family. He had always aspired to be a good person, someone who was competent and reliable and helpful to others. He valued hard work and commitment. His strongly held values led to adaptive behavioral patterns of holding high, but realistic, expectations for himself, working hard, solving his problems independently and being responsible. His corresponding intermediate beliefs were, "If I have high expectations and work hard, I'll be okay. I should solve problems myself. I should be responsible." His core beliefs about the self were that he was reasonably effective and competent, likeable and worthwhile. He saw other people and his world as basically neutral or benign. His automatic thoughts, for the most part, were realistic and adaptive.

But the meaning Abe put to certain adverse childhood experiences made him vulnerable to having his negative beliefs activated later in life. His father left the family permanently when Abe was 11 years old, which led him to believe that his world was at least somewhat unpredictable. His mother criticized him for failing to reach her unreasonably high expectations. Not realizing her standards were unreasonable, Abe began to see himself as not fully competent. But these two beliefs weren't rock solid. Abe believed that much of his world was still relatively predictable and that he was competent in other ways, especially in sports.

As an adult, when Abe began to struggle on the job, he became anxious, fearing that he wouldn't be able to live up to his deeply held values of being responsible, competent, and productive. The anxiety led to worry, which caused difficulties in concentration and problem-solving, and his work suffered. He started to view himself and his experiences in a highly negative way and developed symptoms of depression. His core belief of incompetence/failure became activated and he began to see himself as somewhat helpless and out of control. His negative assumptions surfaced: "If I try to do hard things, I'll fail." "If I ask for help, people will see how incompetent I am." So, he began to engage in dysfunctional coping strategies, primarily avoidance. These coping strategies helped maintain his depression.

Failing to be as productive as he thought he should be and avoiding asking for help and support from others, along with harsh criticism from his wife for not helping around the house, contributed to the onset of his depression. He interpreted his symptoms of depression (e.g., avoidance, difficulty concentrating and making decisions, and fatigue) as additional signs of incompetence. Once he became depressed, he interpreted many of his experiences through the lens of his core belief of incompetence or failure. Three of these situations are noted at the bottom of the Case Conceptualization Diagram.

Once Abe became depressed, he started to view other people differently. He feared that they would be critical of him, and he withdrew socially. Historically, he had seen his world as potentially unpredictable. After losing his job and being blindsided by his wife, he began to view his world as less safe (especially financially), less stable and less predictable.

PART FIVE: TREATMENT PLAN

OVERALL TREATMENT PLAN: The plan was to reduce Abe's depression and anxiety, improve his functioning and social interactions, and increase positive affect.

PROBLEM LIST/CLIENT'S GOALS AND EVIDENCE-BASED INTERVENTIONS

Unemployment/Get a job: Examined advantages and disadvantages of looking for a job similar to what he did before versus initially getting a different job (one that would be easier to obtain and perform); evaluated and responded to hopeless automatic thoughts, "I'll never get a job and even if I do, I'll probably get fired again," problem-solved how to update resume and look for a job; roleplayed job interview.

Avoidance/Re-engage in avoided activities: Scheduled specific tasks around the house to do at specific times; did behavioral experiments to test his automatic thoughts ("I won't have enough energy to do this," "I won't do a good enough job on this.") Evaluated and responded to automatic thoughts (e.g. "Doing this will just be a drop in the bucket.") Scheduled social activities and other activities that could bring a sense of pleasure. Taught Abe to give himself credit for anything he did that was even a little difficult and keep a credit list.

Social isolation/Reconnect with others: Scheduled times to get together with friends and family; assessed which friend would be easiest to contact, evaluated automatic thoughts ("He won't want to hear from me;" "He'll be critical of me for not having a job"), discussed what to say to friends about having been out of touch; did behavioral experiments to test interfering thoughts.

Ongoing conflict with ex-wife/Investigate whether improved communication skills can help/ Decrease sense of responsibility for divorce: Taught communication skills such as assertion and did behavioral experiments to test thoughts ("It won't make any difference. She'll never stop punishing me/being mad at me."). Did a pie chart of responsibility.

Depressive rumination and self-criticism/Reduce depressive rumination: Provided psychoeducation about symptoms and impact of depression; evaluated beliefs about deserved criticism; evaluated positive and negative beliefs about rumination and worry; did a behavioral experiment to see impact of mindfulness of the breath; prescribed mindfulness exercise each morning and during the day as needed.

PART SIX: COURSE OF TREATMENT AND OUTCOME

THERAPEUTIC RELATIONSHIP: At the beginning of treatment, Abe was concerned that I might be critical of him and he thought he should be able to overcome his problems on his own. I provided him with my view—that he had a real illness for which most people require treatment, that his difficulties stemmed from his depression and didn't indicate anything negative about him as a person, and that it was a sign of strength that he was willing to see if treatment could help. He seemed to be reassured. He demonstrated a level of trust in me from the beginning—he was open about his difficulties and collaborated easily. Initially, when he reported what he had accomplished on his Action Plans, he was skeptical when I suggested that these experiences showed his positive attributes. But he was able to recognize that he, too, would see these activities in a positive light if someone else in his situation had engaged in them. Abe mostly provided positive feedback at the end of sessions. He was able to appropriately let me know when I misunderstood something he said. In summary, he was able to establish and maintain a good therapeutic relationship with me.

NUMBER AND FREQUENCY OF TREATMENT SESSIONS, LENGTH OF TREATMENT: Abe and I met weekly for 12 weeks, then every other week for four weeks, then once a month for four months, for a total of 18 sessions over eight months. We had standard 50-minute CBT sessions.

COURSE OF TREATMENT SUMMARY: I suggested, and Abe agreed, that we work first on (1) getting Abe to get out of his apartment almost every day (2) spending more time with his family and (3) cleaning up his apartment. Doing these things increased his sense of connectedness and his sense of control and competence (and decreased his belief that he was incompetent and somewhat out of control). (Later we worked on spending more time with friends and volunteering). Increasing his social activities improved his social support and fulfilled his important values of close relationships and being helpful and responsible to other people. We also worked on decreasing his depressive rumination. Once he was functioning somewhat better, we worked on finding employment. He started off by doing construction for his friend's business. Our final goal was to see if he could improve his relationship with his ex-wife—but he could not.

MEASURES OF PROGRESS: Abe scored 18 on the PHQ-9 and 8 on the GAD- 7 at intake and his sense of well-being on a 0-10 scale was 1. I continued to monitor progress by using these three assessments at every session. At the end of treatment, his PHQ-9 score was 3, his GAD-7 score was 2 and his sense of well-being score was 7. Although he still had some days that were difficult, on more days than not, he felt much better.

OUTCOME OF TREATMENT: Abe's depression was almost in remission at the end of weekly treatment. He subsequently got a full-time job that he liked and did well in, was more engaged with friends and family, and he felt much better. When he returned for his last monthly booster session, his depression was in full remission and his sense of well-being had increased to an 8.

CASE WRITE-UP WORKSHEET

For a click-and-fill version of this worksheet, please visit: **beckinstitute.org/casewriteup**.

PART ONE: INTAKE INFORMATION

IDENTIFYING INFORMATION AT INTAKE:

Age:

Gender Identity and Sexual Orientation:

Cultural Heritage:

Religious/Spiritual Orientation:

Living Environment:

Employment Status:

Socioeconomic Status:

CHIEF COMPLAINT, MAJOR SYMPTOMS, MENTAL STATUS AND DIAGNOSIS:

Chief Complaint:

Major Symptoms:

Emotional:

Cognitive:

Behavioral:

Physiological:

Mental Status:

Diagnosis (from the Diagnostic and Statistical Manual or International Classification of Disease):

CURRENT PSYCHIATRIC MEDICATIONS, ADHERENCE AND SIDE EFFECTS; CONCURRENT TREATMENT:

CURRENT SIGNIFICANT RELATIONSHIPS:

PART TWO: HISTORICAL INFORMATION

BEST LIFETIME FUNCTIONING (INCLUDING STRENGTHS, ASSETS AND RESOURCES):

HISTORY OF PRESENT ILLNESS:

HISTORY OF PSYCHIATRIC, PSYCHOLOGICAL OR SUBSTANCE USE PROBLEMS AND IMPACT ON FUNCTIONING:

HISTORY OF PSYCHIATRIC, PSYCHOLOGICAL OR SUBSTANCE ABUSE TREATMENT, TYPE, LEVEL OF CARE AND RESPONSE:

PERSONAL, SOCIAL, EDUCATIONAL AND VOCATIONAL HISTORY:

MEDICAL HISTORY AND LIMITATIONS:

CURRENT NON-PSYCHIATRIC MEDICATIONS, TREATMENT, ADHERENCE AND SIDE EFFECTS:

PART THREE: THE COGNITIVE CONCEPTUALIZATION DIAGRAM

See pages 3-6 of this worksheet packet.

PART FOUR: THE CASE CONCEPTUALIZATION SUMMARY

HISTORY OF CURRENT ILLNESS, PRECIPITANTS AND LIFE STRESSORS:

MAINTAINING FACTORS:

VALUES AND ASPIRATIONS:

NARRATIVE SUMMARY, INCORPORATING HISTORICAL INFORMATION, PRECIPITANTS, MAINTAINING FACTORS AND COGNITIVE CONCEPTUALIZATION DIAGRAM INFORMATION:

PART FIVE: TREATMENT PLAN

OVERALL TREATMENT PLAN:

PROBLEM LIST/CLIENT'S GOALS AND EVIDENCE-BASED INTERVENTIONS (INCLUDE UP TO FIVE):

Problem/Goal #1:
Interventions:

Problem/Goal #2:
Interventions:

Problem/Goal #3:
Interventions:

Problem/Goal #4:
Interventions:

Problem/Goal #5:
Interventions:

PART SIX: COURSE OF TREATMENT AND OUTCOME

THERAPEUTIC RELATIONSHIP:

NUMBER AND FREQUENCY OF TREATMENT SESSIONS, LENGTH OF TREATMENT:

COURSE OF TREATMENT SUMMARY:

MEASURES OF PROGRESS:

OUTCOME OF TREATMENT:

GRAPH FOR OBJECTIVE SCORES

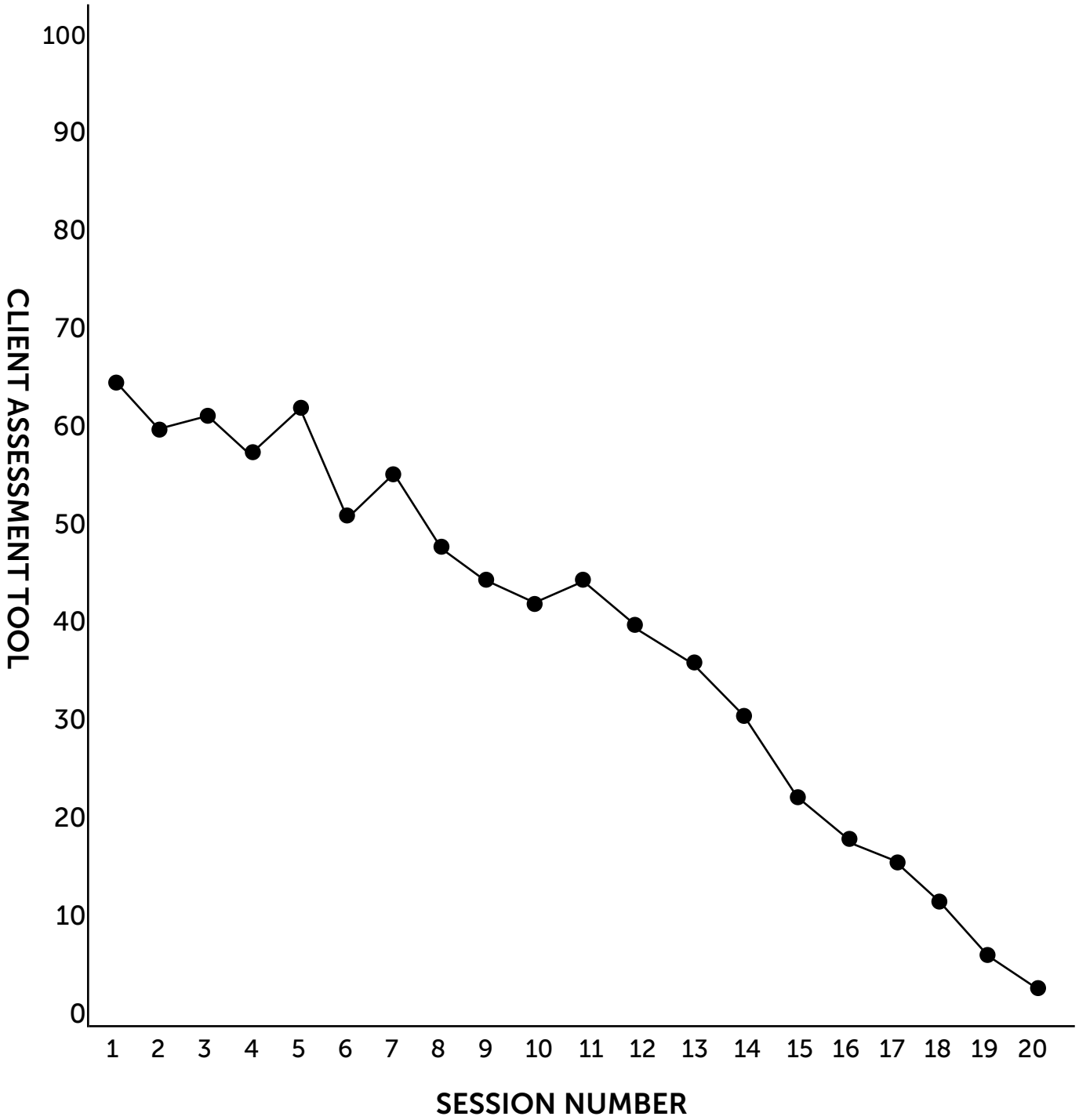
Instructions

In addition to subjective reports of clients' progress in therapy, it is helpful to obtain weekly measures of depression, anxiety, hopelessness, etc. Some clients like the idea of graphing their scores on these measures; it can also be helpful for you to have a visual depiction of how scores vary over time, especially for longer- term clients.

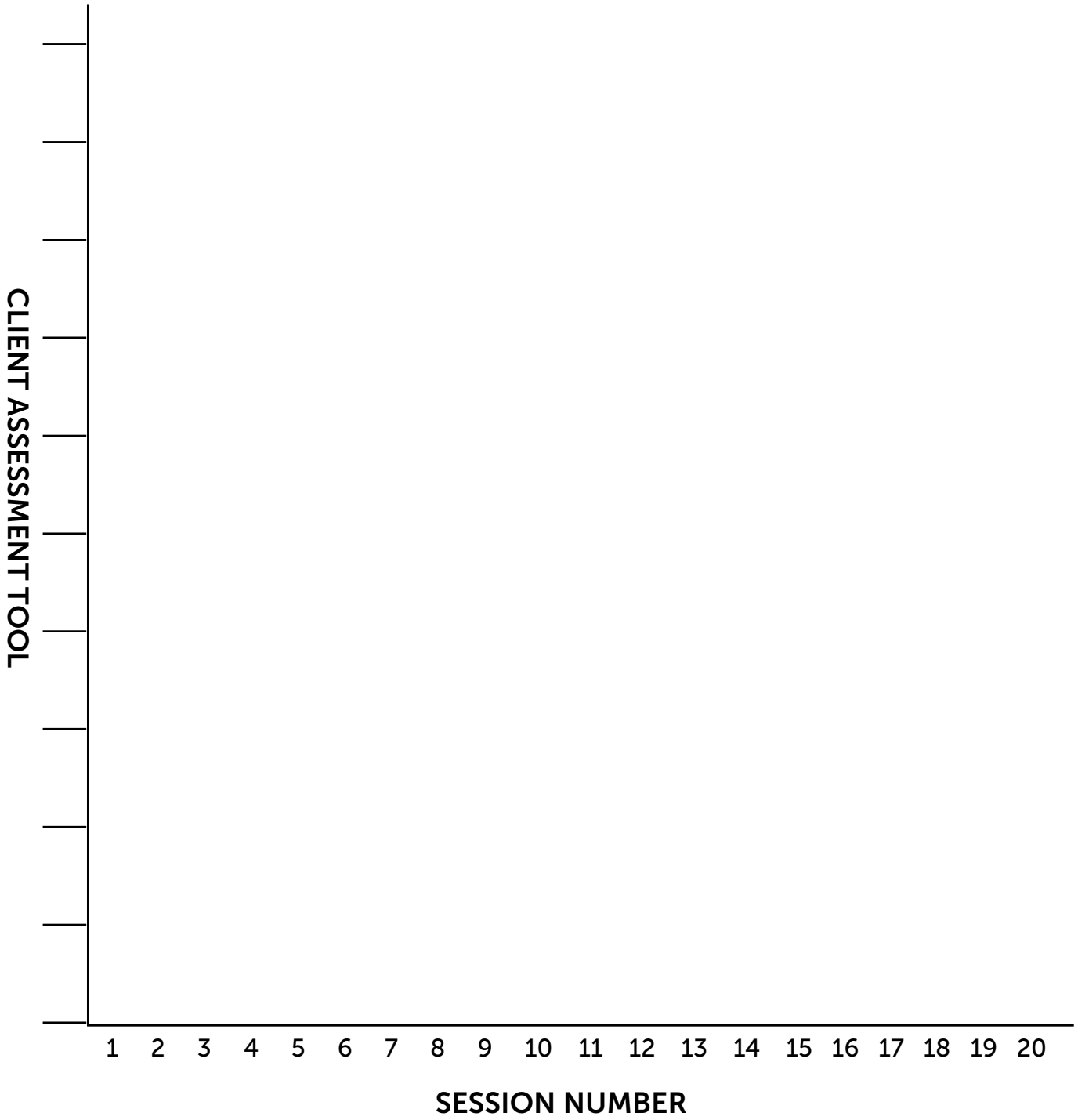
You could use the Beck Depression Inventory-II, Beck Anxiety Inventory and Beck Hopelessness Scales, all of which can be ordered from Pearson Assessments: www.pearsonassessments.com. You could also use a scale in the public domain, such as the GAD-7 or the PHQ-9; or you could simply ask the client to rate their anxiety or depression on a scale of 0-100 or 0-10. Or you can ask them to rate their sense of well-being on a similar scale. Fill in the points along the y-axis to correspond to the assessment tool you have chosen. In the example on the next page, the client was asked to rate her depression on a scale of 0-100, with 100 being the most depressed she's ever felt and 0 being no depression at all.

This graph, like the other diagrams and worksheets in this packet, is optional.

GRAPH FOR OBJECTIVE SCORES EXAMPLE



GRAPH FOR OBJECTIVE SCORES WORKSHEET



ACTIVITY CHART & PLEASURE AND MASTERY RATING SCALE

Instructions

The activity chart can be used for either monitoring or scheduling. You and your clients can complete it together in session or clients can complete it at home.

As a monitor, the chart allows you and your clients to collect important data. For example, the chart can help gauge how clients are spending their time and assess which activities they are spending too much and/or too little time on. It is also useful for some clients to predict, then measure, their sense of pleasure and/or mastery they receive from various activities. You can use the Pleasure and Mastery Rating Scale Worksheet to help clients create their own scale for rating pleasure and mastery.

The chart can facilitate monitoring in other ways as well:

1. Clients can record their activities and measure the degree of a specific mood (for example, anxiety) during each activity.

2. Or they can record only those instances in which they experience more intense emotion, for example, writing down activities during which their anger was above a 5 on a 0-10 point scale.

3. Alternatively, clients can record only positive events or behaviors, such as identifying when their partner does or says something nice or when they begin a task without procrastinating.

As a monitor, the activity chart can reveal important information. With depressed clients, it may be important to identify activities in which they experienced little mastery or pleasure, as a prelude to eliciting their dysfunctional thinking in these situations. A review of the chart may also reveal that a client has been avoiding important activities or, conversely, that a client's schedule is too demanding.

As a schedule, the chart can be used to help clients commit to specific times and days to engage in important activities. For example, depressed clients often need to schedule several activities per day which have the potential for increasing their sense of mastery or pleasure, connection or control. Procrastinating clients may need to schedule "must-do" activities.

Alternatively, clients can use the chart to keep track of activities they deserve credit for participating in or activities in which they felt even a little better. Doing this focuses their attention on the positive.

PLEASURE AND MASTERY RATING SCALE EXAMPLE

PLEASURE SCALE (P)		MASTERY SCALE (M)	
0	Paying bills	0	Bouncing a check
1		1	
2		2	
3		3	
4		4	
5	Having lunch with a friend	5	Cleaning the kitchen
6		6	
7		7	
8		8	
9		9	
10	Trip to the beach with husband	10	Finishing a major work project

Note: 0 - 10 ratings of pleasure and mastery recorded on the activity chart that follows are represented by P = _____ and M = _____

PLEASURE AND MASTERY RATING SCALE WORKSHEET

PLEASURE SCALE (P)	MASTERY SCALE (M)
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10	10

Note: 0 - 10 ratings of pleasure and mastery recorded on the activity chart that follows are represented by P = _____ and M = _____

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ACTIVITY CHART EXAMPLE

	MON.	TUE.	WED.	THU.	FRI.	SAT.	SUN.
MORNING							
6-7	Morning routine P=0 M=2						
7-8	Prepare breakfast Kitchen clean up P=1 M=4						
8-9	TV Newspaper P=5 M=2						
9-10	Call sister P=6 M=3						
10-11	Rest P=5 M=0						
11-12	Prepare lunch P=0 M=5						
AFTERNOON							
12-1	Straighten apartment P=1 M=7						
1-2	Rest P=1 M=0						
2-3	TV P=4 M=0						

continued...

BECK INSTITUTE

ACTIVITY CHART EXAMPLE

	AFTERNOON					EVENING				
	3-4	4-5	5-6	6-7	7-8	8-9	9-10	10-11	11-12
MON.	Rest P=1 M=0	Call friend P=8 M = 3	Prepare dinner P=2 M = 3	Kitchen clean up P=0 M = 5	Email Facebook P=6 M = 3	Read Get in bed P=3 M = 1	Sleep	Sleep	Sleep
TUE.									
WED.									
THU.									
FRI.									
SAT.									
SUN.									

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ACTIVITY CHART WORKSHEET

	MON.	TUE.	WED.	THU.	FRI.	SAT.	SUN.
MORNING							
6-7							
7-8							
8-9							
9-10							
10-11							
AFTERNOON							
11-12							
12-1							
1-2							
2-3							

continued...

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ACTIVITY CHART WORKSHEET

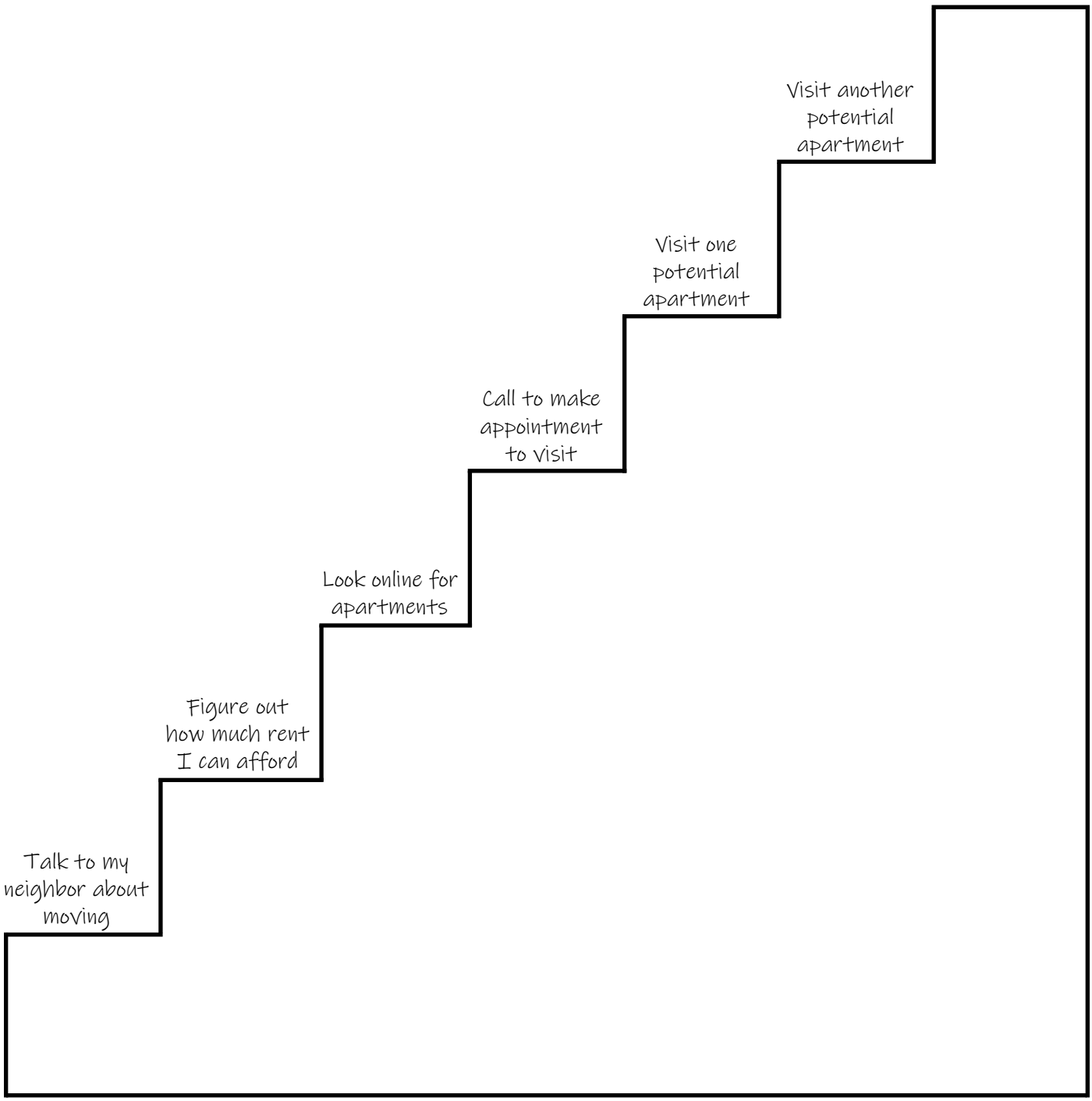
	AFTERNOON				EVENING				
	3-4	4-5	5-6	6-7	7-8	8-9	9-10	10-11	11-12
MON.									
TUE.									
WED.									
THU.									
FRI.									
SAT.									
SUN.									

GRADED TASK ASSIGNMENT

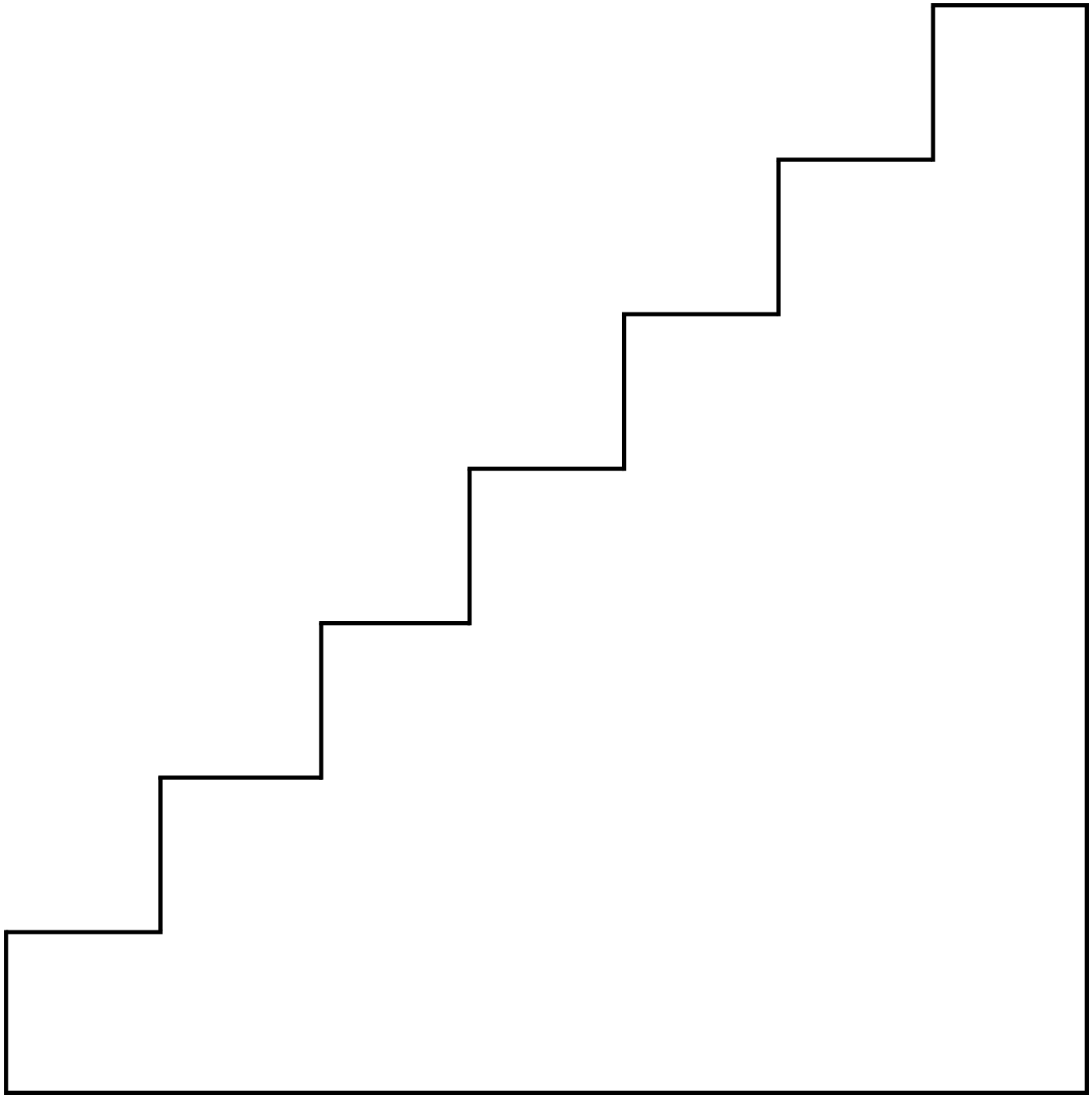
Instructions

To reach a goal, it is usually necessary to accomplish a number of steps along the way. Clients tend to become overwhelmed when they focus on how far they are from a goal, instead of focusing on their current step. A graphic depiction of the steps is often reassuring. You can use the form provided or draw, free-hand, the graphic depiction on the following page. While it is not necessary to label each step, you should label the first few steps, the penultimate step and the last step.

GRADED TASK ASSIGNMENT EXAMPLE



GRADED TASK ASSIGNMENT WORKSHEET



IDENTIFYING THOUGHTS

Instructions

The cognitive model suggests that the interpretation of a situation (rather than the situation itself), expressed in automatic thoughts or images, influences one's emotion, behavior and physiological response. It's important to help clients respond to their unhelpful or inaccurate thoughts. But first, they must learn to identify their thoughts. The following worksheet can help clients ask the most important question to identify their thoughts: What was just going through my mind? This worksheet is helpful for clients who are either just beginning to learn to identify their automatic thoughts or who have trouble remembering what they were thinking after the fact.

IDENTIFYING THOUGHTS WORKSHEET

PART 1:

REMEMBER: JUST BECAUSE I THINK SOMETHING, DOESN'T NECESSARILY MEAN IT'S TRUE. WHEN I CHANGE MY UNHELPFUL OR INACCURATE THOUGHTS, I'LL LIKELY FEEL BETTER.

Instructions: When my mood gets worse or I'm engaging in unhelpful behavior, ask myself: ***"What was just going through my mind?"*** Write down my thoughts below.

PART 2:

REMEMBER: IT'S IMPORTANT TO CATCH MYSELF THINKING IN A HELPFUL WAY.

Instructions: When I'm engaging in helpful behavior, ask myself, ***"What was I thinking that allowed me to do this?"*** Write down my thoughts below.

QUESTIONS TO IDENTIFY AUTOMATIC THOUGHTS

Instructions

Sometimes clients just don't know how to answer the question "What was just going through my mind?" If clients get stuck on this question, the following worksheet has additional strategies clients can use, including:

- Supplying thoughts that are probably the opposite of what they're thinking
- Asking for the meaning of the situation
- Determining if they are predicting something that may happen in the future, or remembering something that happened in the past

QUESTIONS TO IDENTIFY AUTOMATIC THOUGHTS WORKSHEET

REMEMBER: JUST BECAUSE I THINK SOMETHING, DOESN'T NECESSARILY MEAN IT'S TRUE. WHEN I CHANGE MY UNHELPFUL OR INACCURATE THOUGHTS, I'LL LIKELY FEEL BETTER.

1. WHAT'S GOING THROUGH MY MIND? OR "WHAT AM I THINKING?"

2. WHAT AM I DEFINITELY NOT THINKING? (IDENTIFYING AN OPPOSITE THOUGHT CAN HELP PROMPT YOU TO IDENTIFY THE ACTUAL THOUGHT.)

3. WHAT DOES THE SITUATION MEAN TO ME?

4. AM I MAKING A PREDICTION? OR REMEMBERING SOMETHING?

THOUGHT RECORDS

Instructions

Thought Records provide a structured format for clients to monitor their thoughts and emotions, evaluate their thinking and respond in an adaptive way. They should be introduced after clients firmly grasp that their thinking in specific situations affects their mood and behavior and that at times their thinking is distorted. Otherwise it doesn't make sense to clients to use such a form. Also, the worksheet is inappropriate for clients who would find it too confusing or who have an aversion to worksheets.

You should introduce just the first four columns initially and make sure clients understand the differences among situations, automatic thoughts, and emotions and can successfully record them in session. Then, you can collaboratively set an assignment to complete these columns at home when clients notice their mood changing. Advise clients to identify the worst part of an experience. Was it before, during or after a given situation? Then they should note their thoughts during that time.

When clients demonstrate good ability with the first part of the Thought Record (TR), explain the final two columns. Ensure that clients understand how to use the questions at the bottom of the TR to develop an alternative response and can remeasure the intensity of their belief in the automatic thought and of their emotion in session before they try to do so at home.

You should alert clients that TRs may appear deceptively simple but may be more difficult than they appear in session. Any problems, however, can be solved at the subsequent session.

THOUGHT RECORD SIDE ONE: WORKSHEET

Remember, thoughts may be 100% true, 0% true or somewhere in the middle.

JUST BECAUSE YOU THINK SOMETHING, DOESN'T NECESSARILY MEAN IT'S TRUE.

Spend just 5-10 minutes to complete the Thought Record. Noe that not all questions will apply to every automatic thought. Here's what to do:

1. When you notice your mood getting worse, or you find yourself engaging in unhelpful behavior, ask yourself, **"What's going through my mind right now?"** and as soon as possible, jot down the thought or mental image in the Automatic Thought(s) column.
2. The situation may be external (something that just happened or something you just did) or internal (an intense emotion, a painful sensation, an image, daydream, flashback or stream of thoughts—e.g., thinking about your future)
3. Then fill in the rest of the columns. You can try to identify cognitive distortions from the list below. More than one distortion may apply. Make sure to use the questions at the bottom of the worksheet to compose the adaptive response.
4. Spelling, handwriting and grammar don't count.
5. It was worth doing this worksheet if your mood improves by 10% or more.

Cognitive Distortions

All-or-nothing thinking	Example: "If I'm not a total success, I'm a failure."
Catastrophizing (fortune telling)	Example: "I'll be so upset, I won't be able to function at all."
Disqualifying or discounting the positive	Example: "I did that project well, but that doesn't mean I'm competent; I just got lucky."
Emotional reasoning	Example: "I know I do a lot of things okay at work, but I still feel like I'm a failure."
Labeling	Examples: "I'm a loser." "He's no good."
Magnification/minimization	Example: "Getting a mediocre evaluation proves how inadequate I am. Getting high marks doesn't mean I'm smart."
Mental filter (selective abstraction)	Example: "Because I got one low rating on my evaluation [which also contained several high ratings], it means I'm doing a lousy job."
Mind reading	Example: "He's thinking that I don't know the first thing about this project."
Overgeneralization	Example: "Because I felt uncomfortable at the get-together, I don't have what it takes to make friends."
Personalization	Example: "The repairman was curt to me because I did something wrong."
"Should" and "must" statements	Example: "It's terrible that I made a mistake. I should always do my best."
Tunnel vision	"My son's teacher can't do anything right. He's critical and insensitive and lousy at teaching."

THOUGHT RECORD: SIDE TWO EXAMPLE

Date/time	Situation	Automatic Thought(s)	Emotion(s)	Adaptive Response	Outcome
	1. What event (external or internal) is associated with the unpleasant emotion? Or what unhelpful behavior did you engage in?	1. What thought(s) and/or image(s) went through your mind (before, during or after the event or unhelpful behavior)? 2. How much did you believe the thought(s)?	1. What emotion(s) (sad/ anxious/ angry/ etc.) did you feel (before, during or after the event or unhelpful behavior)? 2. How intense (0–100%) was the emotion?	1. (optional) What cognitive distortion did you make? 2. Use questions below to compose a response to the automatic thought(s). Indicate how much you believe each response.	1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0–100%) is the emotion? 3. What would be good to do?
6/23	1. Thinking about the job interview	1. I'll be so nervous, I won't know what to say, and then I won't get the job. 2. 80%	1. Anxious 2. 75%	1. Fortune telling 2. I'm nervous now but I can practice more with [my therapist]. When I was nervous in the past, like when I got a new boss, I didn't have trouble talking. (80%) If I don't get the job, I can apply for other ones. The best outcome would be that the interviewer will offer me the job on the spot. The most realistic outcome is that I'll have to apply for several jobs before I get one. (90%) Thinking I won't get the job just keeps me anxious. Realizing that it's not the end of the world if I don't get it makes me feel better. (100%) I'd tell Gabe that it isn't the end of the world if he's nervous and doesn't get the job. But the more he practices, probably the less nervous he'll be. (100%) I should practice what I want to say and then act as if I'm not nervous. (100%)	1. 50% 2. Anxious (50%) 3. Practice
Questions to help compose an alternative response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) If the worst happened, how could I cope? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of my changing my thinking? (5) If [person's name] was in this situation and had this thought, what would I tell them? (6) What would be good to do?					

THOUGHT RECORD: SIDE TWO WORKSHEET

Date/time	Situation	Automatic Thought(s)	Emotion(s)	Adaptive Response	Outcome
	1. What event (external or internal) is associated with the unpleasant emotion? Or what unhelpful behavior did you engage in?	1. What thought(s) and/or image(s) went through your mind (before, during or after the event or unhelpful behavior)? 2. How much did you believe the thought(s)?	1. What emotion(s) (sad/ anxious/ angry/ etc.) did you feel (before, during or after the event or unhelpful behavior)? 2. How intense (0–100%) was the emotion?	1. (optional) What cognitive distortion did you make? 2. Use questions below to compose a response to the automatic thought(s). Indicate how much you believe each response.	1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0–100%) is the emotion? 3. What would be good to do?
Questions to help compose an alternative response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) If the worst happened, how could I cope? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of my changing my thinking? (5) If [person's name] was in this situation and had this thought, what would I tell them? (6) What would be good to do?					

TESTING YOUR THOUGHTS

Instructions

The Testing Your Thoughts Worksheet is similar to the Thought Record, but the questions are worded more simply and it's easier to record responses. This worksheet also provides a structured format for clients to monitor their thoughts and emotions, evaluate their thinking and respond in an adaptive way. It should be introduced after clients firmly grasp that their thinking in specific situations affects their mood and behavior and that at times their thinking is distorted. Otherwise, it doesn't make sense to clients to use such a form. As with all worksheets, make sure clients can complete it in session with you before suggesting it as a self-help item on their Action Plan.

This worksheet is inappropriate for clients who would find it too confusing or have an aversion to worksheets. Alert clients that the worksheet can be difficult. If they do run into any problems, they should bring it back to the next session so you can help them with it.

TESTING YOUR THOUGHTS: SIDE ONE WORKSHEET

Remember, thoughts may be 100% true, 0% true or somewhere in the middle.

JUST BECAUSE YOU THINK SOMETHING, DOESN'T NECESSARILY MEAN IT'S TRUE.

1. When you notice your mood getting worse, or you find yourself engaging in unhelpful behavior, ask yourself the questions on the reverse side of this worksheet and write down the answers. It will probably take about 5-10 minutes.
2. Not all questions apply to all automatic thoughts.
3. If you'd like, you can use the list below to identify cognitive distortions. You may find that more than one distortion applies.
4. Spelling, handwriting and grammar don't count.
5. It was worth doing this worksheet if your mood improves by 10% or more.

Cognitive Distortions

All-or-nothing thinking	Example: "If I'm not a total success, I'm a failure."
Catastrophizing (fortune telling)	Example: "I'll be so upset, I won't be able to function at all."
Disqualifying or discounting the positive	Example: "I did that project well, but that doesn't mean I'm competent; I just got lucky."
Emotional reasoning	Example: "I know I do a lot of things okay at work, but I still feel like I'm a failure."
Labeling	Examples: "I'm a loser." "He's no good."
Magnification/minimization	Example: "Getting a mediocre evaluation proves how inadequate I am. Getting high marks doesn't mean I'm smart."
Mental filter (selective abstraction)	Example: "Because I got one low rating on my evaluation [which also contained several high ratings], it means I'm doing a lousy job."
Mind reading	Example: "He's thinking that I don't know the first thing about this project."
Overgeneralization	Example: "Because I felt uncomfortable at the get-together, I don't have what it takes to make friends."
Personalization	Example: "The repairman was curt to me because I did something wrong."
"Should" and "must" statements	Example: "It's terrible that I made a mistake. I should always do my best."
Tunnel vision	"My son's teacher can't do anything right. He's critical and insensitive and lousy at teaching."

TESTING YOUR THOUGHTS: SIDE TWO EXAMPLE

1. What is the situation? You might be having thoughts about something that just happened in the environment or something that happened inside of you (e.g., an intense emotion, a painful sensation, an image, a daydream, a flashback or a stream of thoughts, such as thinking about my future). I got a parking ticket.

2. What am I thinking or imagining? I'm so stupid.

3. What is the cognitive distortion? (optional) Labeling, overgeneralizing

4. What makes me think the thought is true? I shouldn't have lost track of time.

5. What makes me think the thought is not true or not completely true? Other people get parking tickets. It doesn't necessarily mean they're stupid.

6. What's another way to look at this? I just made a mistake.

7. If the worst happens, what could I do then? Just keep paying parking tickets, but it would be better to set an alarm on my phone so it doesn't happen again.

8. What's the best that could happen? I'll never get a parking ticket again.

9. What will probably happen? I could get another ticket but I'll probably remember what happened this time and make sure I don't.

10. What will happen if I keep telling myself the same thought? I'll keep being upset with myself.

11. What could happen if I changed my thinking? I'd feel better.

12. What would I tell my friend or family member [think of a specific person] Gabe if this happened to him or her? It's not that big a deal. So you forgot and made a mistake. You know how to avoid doing this in the future.

13. What would be good to do now? Get my mind off of this. Go for a walk.

TESTING YOUR THOUGHTS: SIDE TWO WORKSHEET

1. What is the situation? You might be having thoughts about something that just happened in the environment or something that happened inside of you (e.g., an intense emotion, a painful sensation, an image, a daydream, a flashback or a stream of thoughts, such as thinking about my future).

2. What am I thinking or imagining?

3. What is the cognitive distortion? (optional)

4. What makes me think the thought is true?

5. What makes me think the thought is not true or not completely true?

6. What's another way to look at this?

7. If the worst happens, what could I do then?

8. What's the best that could happen?

9. What will probably happen?

10. What will happen if I keep telling myself the same thought?

11. What could happen if I changed my thinking?

12. What would I tell my friend or family member [think of a specific person]_____if this happened to him or her?

13. What would be good to do now?

ADVANTAGE/DISADVANTAGE ANALYSIS

Instructions

Clients may find it helpful to learn the skill of analyzing the advantages and disadvantages in a variety of contexts:

1. IN DECISION MAKING

a. Weighing attributes. (Should I take job A or job B?)

b. Deciding whether to take a certain step. (Should I leave my partner? Go back to school? Take medication?)

c. Determining whether this is a reasonable time to take a certain step. (Given that I'll eventually have to change jobs, should I do so now or later?)

2. IN CHANGING CERTAIN BELIEFS

a. What are the advantages and disadvantages of continuing to hold this belief?

b. What might be the advantages and disadvantages of changing the belief?

3. IN ENHANCING MOTIVATION

a. What are the advantages and disadvantages [of engaging in this behavior]?

b. What are the advantages and disadvantages [of not engaging in this behavior]?

ADVANTAGE/DISADVANTAGE ANALYSIS EXAMPLE

ADVANTAGES OF VOLUNTEERING	**DISADVANTAGES OF** VOLUNTEERING
1. Get me out of the apartment 2. Make me feel useful, productive 3. Help people 4. Good step before I get a paid job 5. Learn new skills?	1. Might be too tired 2. Might not like it 3. Thinking about it makes me anxious
ADVANTAGES OF NOT VOLUNTEERING	**DISADVANTAGES OF** NOT VOLUNTEERING
1. Don't have to feel anxious about it 2. Can save my energy for other things 3. Don't have to face potential failure	1. Doesn't help my depression 2. Doesn't get me out of the house 3. Doesn't give me potential opportunity to feel useful and productive 4. Doesn't help me practice for a paid job 5. Doesn't increase my skillset

ADVANTAGE/DISADVANTAGE ANALYSIS WORKSHEET

ADVANTAGES OF	DISADVANTAGES OF
ADVANTAGES OF	**DISADVANTAGES OF**

PROBLEM SOLVING

Instructions

Associated with or in addition to their psychological disorders, clients face real life obstacles to taking steps toward valued action or fulfilling their aspirations. At every session, you'll encourage clients to look ahead to the coming week or weeks, think about what they can do to improve their experience, and identify potential obstacles or problems. There are several approaches you can take, depending on the nature of the predicted difficulties. When clients are deficient in problem-solving skills, they may benefit from direct instruction in problem solving, where they learn to specify a problem, devise solutions, select a solution and implement it. The following worksheet can help clients with problem solving. You can start by filling out the worksheet together, in session. If the client seems to understand how to fill it out, you can encouage them to use the worksheet on their own to deal with problems that come up between sessions.

PROBLEM SOLVING EXAMPLE

1. PROBLEM

Boyfriend says he's going away to California to visit his aunt for a week.

2. SPECIAL MEANING: AUTOMATIC THOUGHTS AND BELIEFS

He doesn't care about my feelings.

3. RESPONSE TO SPECIAL MEANING

Not necessarily true. He often shows that he cares. His aunt is getting up in age and she's always been like a second mother to him— he ought to spend some time with her.

4. POSSIBLE SOLUTIONS

1. Arrange to call and text him or have him call and text me several times when he's away.

2. Spend the weekend together when he gets back, even if it's just catching up on errands and chores together.

3. Explain to him that I acted angry toward him because I felt hurt but now I realize he does care about my feelings.

PROBLEM SOLVING WORKSHEET

1. PROBLEM

2. SPECIAL MEANING: AUTOMATIC THOUGHTS AND BELIEFS

3. RESPONSE TO SPECIAL MEANING

4. POSSIBLE SOLUTIONS

CORE BELIEFS ABOUT THE SELF

Beginning in childhood, people develop certain ideas about themselves, other people and their world. These "core beliefs" are so fundamental and deep that many do not articulate them, even to themselves. Individuals regard these ideas as absolute truths—just the way things "are." Many individuals primarily hold realistically positive beliefs much of the time. But we all have latent negative beliefs that can become partially or fully activated in the presence of thematically-related vulnerabilities or stressors.

ADAPTIVE (POSITIVE) CORE BELIEFS ABOUT THE SELF

EFFECTIVE CORE BELIEFS

I am reasonably competent, effective, in control, successful, useful.
I can reasonably do most things, protect myself, take care of myself.
I have strengths and weaknesses (in terms of effectiveness, productivity, achievement).
I have relative freedom.
I mostly measure up to other people.

LOVABLE CORE BELIEFS

I am reasonably lovable, likeable, desirable, attractive, wanted, cared for.
I am okay and my differences don't impair my relationships.
I am good enough to be loved by others.
I am unlikely to be abandoned or rejected or end up alone.

WORTHY CORE BELIEFS

I am reasonably worthwhile, acceptable, moral, good, benign.

UNHELPFUL (NEGATIVE) CORE BELIEFS ABOUT THE SELF

HELPLESS CORE BELIEFS

I am ineffective in getting things done.
I'm incompetent, ineffective, helpless, useless, needy; I can't cope.
I am ineffective in protecting myself.
I am powerless, weak, vulnerable, trapped, out of control, likely to get hurt.
I am ineffective compared to others.
I am inferior, a failure, a loser, defective, useless.
I'm not good enough (in terms of achievement); I don't measure up.

UNLOVABLE CORE BELIEFS

I am unlovable, unlikeable, undesirable, unattractive, boring, unimportant, unwanted.
I won't be accepted or loved by others because I am different, a nerd, bad, defective, not good enough, have nothing to offer, there's something wrong with me.
I am bound to be rejected, abandoned, alone.

WORTHLESS CORE BELIEFS

I am immoral, morally bad, a sinner, worthless, unacceptable.
I am dangerous, toxic, crazy, evil.
I don't deserve to live.

BELIEF CHANGE

Instructions

The Belief Change Worksheet is designed for clients to use once they begin evaluating and modifying a core belief, so that they can do so in a continual, consistent manner. First, help clients identify their most central core beliefs and hypothesize that they quickly process negative data consistent with the core belief but disregard or discount positive data inconsistent with it.

Work together with clients to measure the strength of the old unhelpful belief and of the new, more functional belief at the beginning of each session. Throughout the session and throughout the week, clients should monitor their interpretations of events to fill out the worksheet.

BELIEF CHANGE EXAMPLE

EVENT/EXPERIENCE THAT SUPPORTS MY NEW BELIEF "I AM COMPETENT."

WHAT DOES THIS SAY ABOUT ME?

- Figured out how to work [son's] drone which shows I'm competent.
- Fixed bookshelf for daughter which my son-in-law couldn't—evidence of competence.
- Balanced checkbook—most people can do this but it's still a sign of competence.
- Helped put up drywall for Charlie—I was competent.

EVENT/EXPERIENCE WITH REFRAMES OF MY OLD BELIEF "I AM INCOMPETENT."

- Had trouble understanding article on economic trends but most people probably would.
- Couldn't figure out how to fix the brakes in my car but I'm not a trained mechanic.
- Got a parking ticket but the sign was ambiguous.
- Dinner I made tasted terrible but that means I'm incompetent at cooking that meal, not that I'm incompetent as a person.

BELIEF CHANGE WORKSHEET

EVENT/EXPERIENCE THAT SUPPORTS MY NEW BELIEF "I AM COMPETENT."

EVENT/EXPERIENCE WITH REFRAMES OF MY OLD BELIEF "I AM INCOMPETENT."

WHAT DOES THIS SAY ABOUT ME?

PREPARING FOR THERAPY

Instructions

It's important to collect a significant amount of data early in the session to set a full agenda and prioritize items. When asked for agenda items, clients do not necessarily name the most important goals or problems on which to work (e.g., the problems they need help with in order to progress). If they think about the questions on this sheet before they enter your office, they will be much better able to quickly supply the information needed to set goals and plan a strategy for the session. Clients can be asked to complete this sheet either mentally or in writing immediately before a therapy session (or during the previous day). While helpful for most clients, this worksheet is particularly helpful for clients who avoid thinking about therapy between sessions or who have difficulty summarizing the gist of their week.

PREPARING FOR THERAPY WORKSHEET

WHAT DID WE TALK ABOUT LAST SESSION THAT WAS IMPORTANT? HOW MUCH DO I BELIEVE MY THERAPY NOTES?

WHAT HAS MY MOOD BEEN LIKE, COMPARED TO OTHER WEEKS?

WHAT POSITIVE EXPERIENCES DID I HAVE THIS WEEK? WHAT DID I LEARN? WHAT DO THESE EXPERIENCES SAY ABOUT ME?

WHAT ELSE HAPPENED THIS WEEK THAT'S IMPORTANT FOR MY THERAPIST TO KNOW?

WHAT ARE MY GOALS FOR THIS SESSION? THINK OF A BRIEF TITLE FOR EACH (E.G., CONNECTING MORE WITH PEOPLE; GETTING MORE DONE AROUND THE HOUSE; CONCENTRATING BETTER AT WORK).

WHAT DID I DO FOR MY ACTION PLAN? (IF I DIDN'T DO AN ITEM, WHAT GOT IN THE WAY?) WHAT DID I LEARN?

SESSION NOTES

Instructions

You should take notes during sessions to refine you conceptualization, keep track of what is being covered in session and plan for future sessions. It is useful, even for experienced therapists, to note the goals/ problems discussed, dysfunctional thoughts and beliefs written verbatim (and the degree to which the client initially believed them), interventions made during session, newly restructured thoughts and beliefs (and the degree of belief in them), the Action Plan (formerly called homework) and potential topics for the agendas of future sessions.

SESSION NOTES EXAMPLE

PREPARATORY NOTES: Continue activity scheduling and evaluating automatic thoughts; check on credit list

PATIENT NAME: Abe K. **DATE:** 6/10 **SESSION#:** 5 **DIAG./CPT CODE:** F 32.3

MOOD RATING/OBJECTIVE MEASURES (SPECIFY): Feeling "a little better" PHQ-9=15; GAD-9=6; Well-being=3

MEDS (CHANGES/SIDE EFFECTS/OTHER TREATMENT): None

RISK ASSESSMENT (SUICIDAL/SELF-HARM/HOMICIDAL IDEATION): No longer has thoughts of death; low risk

UPDATE/ACTION PLAN REVIEW/CONCLUSIONS DRAWN: Got more done in apartment/ changing thinking and behavior affects mood/shows taking more control; out of apartment every day/sees he's starting to take a "little more control;" felt best at concert/shows he values family/worth it to push self; read therapy notes daily; got out daily; babysat for granddaughters; dinner with son and family/ good to get out/good to be with them/deserves credit; identified ATs; gave self credit.

AGENDA ITEMS: "Hard stuff" in apartment, ~~volunteering/tiredness~~, working for Charlie, evaluate automatic thoughts, schedule activities

AGENDA ITEM #1 (PROBLEM OR GOAL): Working for Charlie
CONCEPTUALIZATION (AUTOMATIC THOUGHTS/(MEANING/BELIEFS, IF IDENTIFIED)/ EMOTIONS/ BEHAVIORS): Situation: Thinking about working a full day AT: "I don't have the stamina." → Emotion: "Worried" → Behavior: Avoided calling Charlie back.

INTERVENTIONS OR THERAPIST SUMMARY: (1) Taught the "What makes me think..." question to evaluate "I don't have the stamina..." (2) Significant evidence AT is true. (3) Evaluated options when talking to Charlie. (4) Roleplayed what to say to Charlie.

ACTION PLAN: Ask Charlie to keep him in mind for future work. Remind self that stamina will improve as depression improves.

AGENDA ITEM #2 (PROBLEM OR GOAL): Sorting mail, paying bills, filling out forms
CONCEPTUALIZATION (AUTOMATIC THOUGHTS/(MEANING/BELIEFS, IF IDENTIFIED)/ EMOTIONS/ BEHAVIORS): Situation: Thinking about getting started AT: "It's too hard." → Emotion: "Depressed" → Behavior: Avoided mail

INTERVENTIONS OR THERAPIST SUMMARY: (1) Skills training (divide mail in four categories); (2) Evaluated AT (Response: "I don't have to do everything. The first step is just sorting. I should be able to do the sorting. If unsure, immediately put items in "unsure" pile and discuss next session.") Also discussed what to do with the piles next session. (3) Covert rehearsal (4) Imagine completing task (5) Response to AT ("I should have done it sooner."): "The depression got in the way." (6) Set alarm on phone for tomorrow morning.

ACTION PLAN: Read relevant therapy notes, imagine completing task, sort mail for tomorrow morning.

OTHER ACTION PLAN ITEMS: Keep credit list; get out of apartment every day; see family, take grandsons to baseball game; identify automatic thoughts and ask, "What makes me think this thought is true? What makes me think it's untrue, or not completely true?"

SUMMARY/CLIENT FEEDBACK: Feeling better linked to changed thinking, behavior and giving self credit; importance of taking control; very likely to complete Action Plan. Feedback—"good"

THERAPIST'S SIGNATURE: Judith S. Beck, PhD

NOTES FOR NEXT SESSION: Discuss volunteering? Increasing stamina? Assess self-criticism; continue activity scheduling and teaching evaluation of automatic thoughts.

SESSION NOTES WORKSHEET

PREPARATORY NOTES:

PATIENT NAME: _____DATE: _____SESSION#: _____DIAG./CPT CODE: _

MOOD RATING/OBJECTIVE MEASURES (SPECIFY):

MEDS (CHANGES/SIDE EFFECTS/OTHER TREATMENT):

RISK ASSESSMENT (SUICIDAL/SELF-HARM/HOMICIDAL IDEATION):

UPDATE/ACTION PLAN REVIEW/CONCLUSIONS DRAWN:

AGENDA ITEMS:

AGENDA ITEM #1 (PROBLEM OR GOAL):
CONCEPTUALIZATION (AUTOMATIC THOUGHTS/(MEANING/BELIEFS, IF IDENTIFIED)/ EMOTIONS/ BEHAVIORS):

INTERVENTIONS OR THERAPIST SUMMARY:

ACTION PLAN:

AGENDA ITEM #2 (PROBLEM OR GOAL):
CONCEPTUALIZATION (AUTOMATIC THOUGHTS/(MEANING/BELIEFS, IF IDENTIFIED)/ EMOTIONS/ BEHAVIORS):

INTERVENTIONS OR THERAPIST SUMMARY:

ACTION PLAN:

OTHER ACTION PLAN ITEMS:

SUMMARY/CLIENT FEEDBACK:

THERAPIST'S SIGNATURE:

NOTES FOR NEXT SESSION:

FEEDBACK FORM

Instructions

The final element of each therapy session, at least initially, is feedback. Eliciting feedback strengthens rapport by providing the message that you care about what the client thinks. It also provides clients with an opportunity to express, and for you to resolve, any misunderstandings. Asking clients whether there was anything that bothered them gives them the opportunity to state and then to test their conclusions. In addition to verbal feedback, you may decide to have clients complete a written Feedback Form.

FEEDBACK FORM WORKSHEET

Name: _____ Date: _____

WHAT DO YOU WANT TO REMEMBER FROM THE THERAPY SESSION TODAY?

WAS THERE ANYTHING THAT BOTHERED YOU ABOUT THE THERAPIST OR ABOUT THERAPY? IF SO, WHAT WAS IT?

HOW LIKELY ARE YOU TO DO THE NEW ACTION PLAN? HOW IS IT RELATED TO YOUR ASPIRATIONS AND VALUES? IF YOU DO IT, WHAT WILL THAT SHOW YOU (ESPECIALLY ABOUT YOURSELF)?

WHAT DO YOU WANT TO MAKE SURE TO COVER NEXT SESSION?

SELF-THERAPY SESSION

Instructions

Many clients benefit from a structured plan to continue therapy work on their own while therapy is being tapered to less frequent sessions and after termination. This guide is designed for clients to read and reflect on, jotting just a few notes. Providing written answers to each question would probably be too laborious and unproductive. You should review this guide in session, predict with clients how long a self-therapy session might take (about five minutes), and ask them to say their answers aloud and motivate them to implement their plan at home (which they can do at their leisure, without charge or traveling inconvenience) to assess the degree to which it is beneficial.

SELF-THERAPY SESSION WORKSHEET

THINK ABOUT THE PAST WEEK(S):

- What positive things have happened? What did these experiences mean to me? About me? What do I deserve credit for?

- What problems came up? If they're not resolved, what do I need to do?

- Did I complete the Action Plan? What could get in the way of completing it this week?

LOOK FORWARD:

- How do I want to feel by this time next week? What do I need to do to make that happen?

- What goals do I have for this week? What steps should I take?

- What problems could get in the way? Should I consider
    - Doing worksheets?
    - Scheduling pleasure, mastery, self-care, or social activities?
    - Reading therapy notes?
    - Practicing skills such as mindfulness?
    - Keeping a credit list or positive experience list?

- What should I do?

GUIDE TO BOOSTER SESSIONS

Instructions

Ideally, therapy is gradually tapered from weekly sessions to sessions that are held every two, three and then four weeks, with clients doing their own self-therapy between sessions. Booster sessions are advisable even after therapy is terminated, for example, after three, six and twelve months. Clients are encouraged to consider whether a booster session could be advantageous, even if they are feeling relatively well, in order to ensure that they are maintaining their progress.

The guide to booster sessions is designed to help clients take responsibility for the productive use of these sessions. Clients should read and reflect on the questions, with brief notes to remind them of what would be helpful to discuss in session with their therapist.

GUIDE TO BOOSTER SESSIONS WORKSHEET

1. **SCHEDULE AHEAD. MAKE DEFINITE APPOINTMENTS, IF POSSIBLE, AND CALL TO CONFIRM.**

2. **CONSIDER COMING AS A PREVENTIVE MEASURE, EVEN IF YOU HAVE BEEN MAINTAINING YOUR PROGRESS.**

3. **PREPARE BEFORE YOU COME. DECIDE WHAT WOULD BE HELPFUL TO DISCUSS, INCLUDING:**

    a. What has gone well? What do these experiences imply about you? About how others see you? About the future?

    b. How much do you believe your new core beliefs—at both an intellectual and emotional level? How can you keep strengthening them?

    c. To what degree are you living in accordance with your values? What goals do you have now? What obstacles might arise? How can you handle them?

    d. What CBT techniques have you been using? Did you have self-therapy sessions? Would they be useful to have in the future?

CBT RESOURCES

Beck Institute

The nonprofit Beck Institute for Cognitive Behavior Therapy was established in 1994 by Dr. Aaron T. Beck and Dr. Judith S. Beck as a setting for state-of-the-art psychotherapy and professional training in CBT. In our 25-year history, Beck Institute has built exceptional in-person and online trainings in CBT, trained thousands of professionals from around the world, and created a global community of CBT practitioners.

Beck Institute offers a full range of CBT training opportunities for professionals across disciplines, experience and skill levels. Over the past 25 years, we have worked to extend access to high-quality CBT training through innovative programs, such as in-person trainings at our home office in suburban Philadelphia, onsite trainings for organizations focused on specific issues and populations, and virtual workshops, webinars and online courses for individuals and organizations around the world.

CBT TRAINING THROUGH BECK INSTITUTE:

- Workshops in Philadelphia or online
- Comprehensive training programs for organizations
- Supervision and consultation
- CBT certification

ONLINE RESOURCES:

- Visit beckinstitute.org for webinars, video clips and multimedia resources
- Read the Beck Institute blog (beckinstitute.org/blog)
- Shop for books, DVDs and more in our CBT Store (beckinstitute.org/store)
- Sign up for the Beck Institute Newsletter (bit.ly/beckinstitute)
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