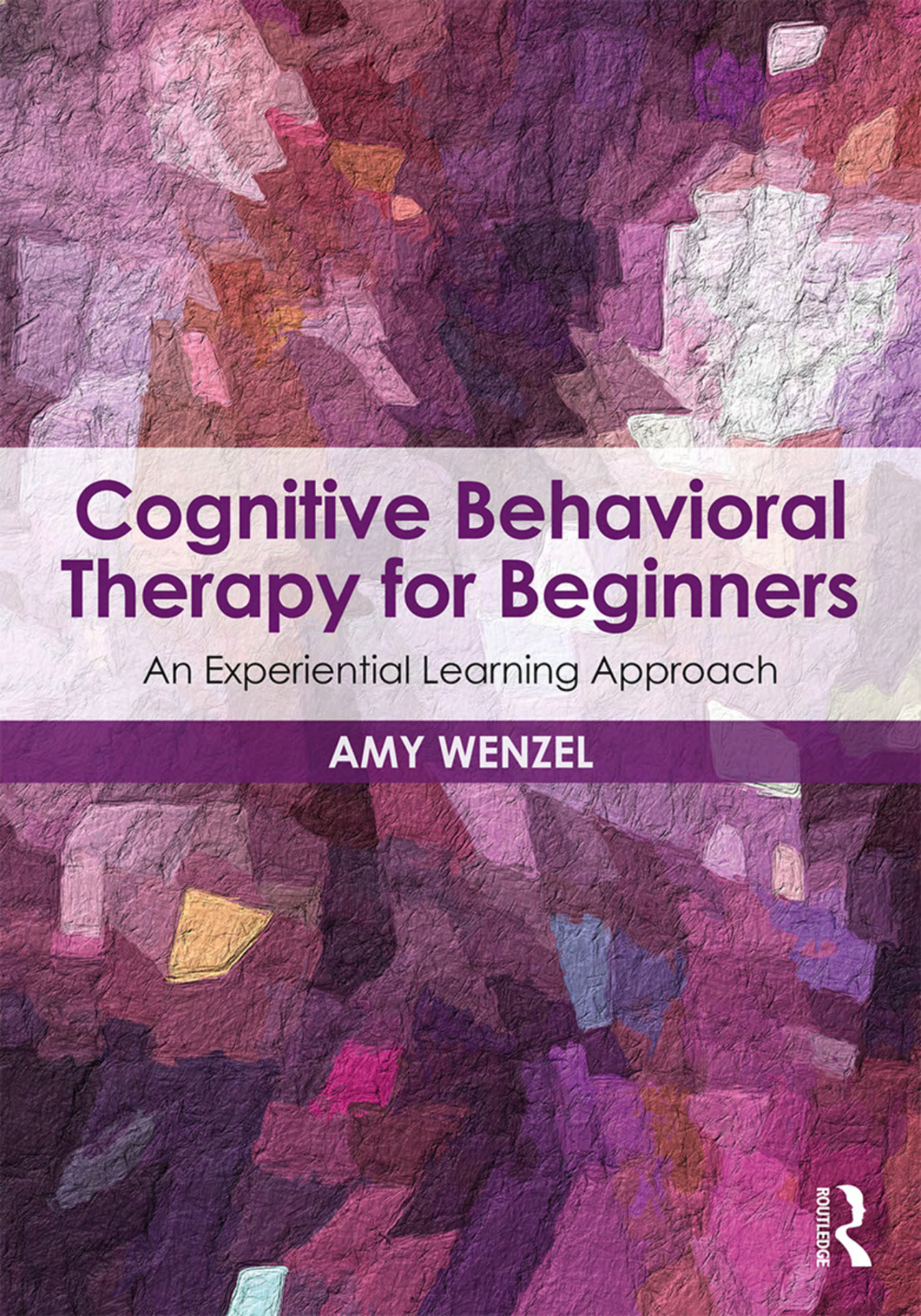
Cognitive Behavioral Therapy for Beginners
An Experiential Learning Approach
AMY WENZEL
ROUTLEDGE

# Cognitive Behavioral Therapy for Beginners

*Cognitive Behavioral Therapy for Beginners* lays out an experiential learning program replete with exercises to guide new clinicians, as well as more experienced therapists re-specializing in CBT, through the process of systematically implementing successful CBT interventions both for themselves and their clients. Each chapter examines a key construct in understandable terms, presenting an overarching view of how clinicians put these concepts and techniques into practice in typical as well as in difficult or unexpected scenarios. Readers will come away with a deep understanding, not just of the standard principles of CBT, but also of the real decisions and strategies that allow seasoned therapists to implement these principles in a way that maximizes the benefit to clients.

**Amy Wenzel, PhD, ABPP** is owner and president of Wenzel Consulting, LLC, and a clinical assistant professor of psychology in psychiatry at the University of Pennsylvania. She has authored or edited 21 previous books, many of which are on cognitive behavioral therapy (CBT).

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# Cognitive Behavioral Therapy for Beginners

## An Experiential Learning Approach

*Amy Wenzel*

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# Contents

# Series Editor's Foreword

*Cognitive Behavioral Therapy for Beginners: An Experiential Learning Approach* is the latest volume in one of Routledge's most popular series, Clinical Topics in Psychology and Psychiatry (CTPP). The overarching goal of CTPP is to provide mental health practitioners with practical information on psychological and psychopharmacological topics. Each volume is comprehensive but easy to digest and integrate into day-to-day clinical practice. It is multidisciplinary, covering topics relevant to the fields of psychology and psychiatry, and appeals to the student, novice, and senior clinician. Books chosen for the series are authored or edited by national and international experts in their respective areas, and contributors are also highly respected clinicians. The current volume exemplifies the intent, scope, and aims of the CTPP series.

Over the past several decades, cognitive and behavioral models of psychological care have grown at a breakneck pace. Previous surveys have revealed that approximately eight out of ten behavioral health professionals list these approaches as primary with regard to patient care. Considering the popularity of these models, it is reasonable to assume that a variety of training aides have come into existence. This is in fact the case. There are a number of cognitive behavioral therapy (CBT) "how to" books, videos, and websites dedicated to teaching the theoretical framework of CBT as well as its techniques. Although many therapists find these teaching aides useful in the development of their psychotherapeutic skills, a number of limitations are noted. For example, as discussed in the present volume, some therapists new to CBT find existing books and videos lacking with regard to managing patient's issues in the "moment". Although these sources of training are informative, for some, they do not capture the "spirit" of CBT. They provide little opportunity for reflection and contemplation, particularly when it comes to more complex and challenging patients.

In *Cognitive Behavioral Therapy for Beginners: An Experiential Learning Approach,* Dr. Amy Wenzel provides a superb overview of not only the "how" of CBT, but the "why" as well. Dr. Wenzel draws on her nineteen years of experience as a supervisor for hundreds of therapists, and her work at the Beck Institute for Cognitive Behavior Therapy, to help the new CBT therapist understand the key elements of CBT in easy-to-understand terms and provides relevant examples throughout the volume. In addition, she provides a number of reflective exercises that help

the therapist develop a deeper understanding of the model. This book goes well beyond teaching terms and techniques. It is a book that teaches one how to be an effective CBT therapist.

I am convinced that *Cognitive-Behavioral Therapy for Beginners* will become one of the lead textbooks in training future psychotherapists in cognitive behavioral therapy. It will also function as an excellent review for experienced practitioners looking for an easily digestible presentation of basic but crucial components of effective delivery of this evidence-based approach.

Bret A. Moore, PsyD, ABPP
Series Editor
Clinical Topics in Psychology and Psychiatry

## CHAPTER 1 BACKGROUND AND RATIONALE

# Background and Rationale

CHAPTER 1

When psychotherapists hear the term, *cognitive behavioral therapy* (or CBT for short), they usually have a noticeable reaction. After all, CBT was quite a change from the traditional approaches to psychotherapy—psychodynamic psychotherapy and client-centered therapy—that were the dominant psychotherapeutic approaches in the 1950s and 1960s. Beginning in the 1970s, behavioral and cognitive psychotherapeutic approaches began to make a "splash" (or perhaps, I should say that they created more of a "tsumani") in the empirical research literature, when they were demonstrated to be efficacious in the treatment of a wide, wide range of emotional, adjustment, and behavioral problems. Landmark studies demonstrated that CBT is just as efficacious as psychotropic medications for moderate to severe instances of mental health disorders (e.g., Barlow, Gorman, Shear, & Woods, 2000; DeRubeis et al., 2005)—a notion that went against conventional thinking, which was that psychotherapies such as CBT are efficacious for mild clinical presentations but that psychotropic medications are essential when clinical presentations go beyond the mild. Moreover, data from naturalistic follow-up studies provided even more interesting and compelling evidence supporting CBT's impressive effects, as these studies found that relapse rates were lower for people who received CBT than people who took psychotropic medication for emotional disturbances (Barlow et al., 2000; Hollon et al., 2005).

If you are reading this book, then it is likely that you are about to embark on a journey in which you hope to develop competence in CBT. Of course, I hope that you are excited about this notion and that there is something about CBT that inherently draws you to it. However, it is entirely possible that you are reading this book for a course, or that the agency that employs you is requiring you to develop competence in CBT, and that you are not particularly keen on being told that you must learn (and presumably deliver) CBT. Before we move on further, I would like you to provide a reflection on what you think of when you hear the term, *CBT*. This will be one of many, many reflections in which you will engage as you work through this program. When responding to the questions below, please indicate the first things that come to mind when you think about CBT.

**BOX 1 INITIAL REFLECTION ON CBT**

**What do you know about CBT that you find attractive?**

**What do you know about CBT that concerns you?**

In the next several pages, allow me to describe the fundamental tenets of what I call *contemporary CBT*, or CBT that is practiced in a way that is informed by up-to-date theory, practice, empirical research, and scholarship. I outline stereotypes about CBT that I have encountered over the course of years of practice, training, supervision, and scholarship, and I share my view of the truths and misconceptions associated with these stereotypes. I describe some examples that I have witnessed first-hand in my clients, supervisees, trainees, and even in myself that illustrate the power that can be harnessed from CBT. Then, I will invite you to revisit the "first impressions" that you just described above and reconsider them in light of the information that I have presented.

## Pre-test: Self-assessment of CBT Skills

Before proceeding, I would like you to first collect "baseline" information about your knowledge of, and skill in, CBT. The rationale underlying my request is that cognitive behavioral therapists conduct themselves as *practitioner-scientists*, meaning that they incorporate a scientific approach into their clinical work. Being a practitioner-scientist means two things: (a) that you use the scientific literature to inform your practice, and (b) that you collect data in session to evaluate the degree to which your interventions are achieving their desired aims. Those data could be scores on questionnaires, dimensional ratings (e.g., 0–10 Likert-type ratings) on constructs such as depression or anxiety, or observations of clients' behavior. Practitioner-scientists adjust their clinical work on the basis of these data, and in addition, the data inform clinicians of the degree to which clients are meeting their treatment goals and can move toward the completion of treatment.

We can apply the same framework to the acquisition of learning how to deliver a system of psychotherapy. That is, you can see where you stand in your knowledge of, and skill in, the psychotherapy to be learned before you begin the experiential learning program in earnest. When you have completed the experiential learning program, you can again see where you stand in these

***Table 1.1*** Pre-test: Self-assessment of CBT Skills

Please use the following scale to rate your perceived ability to deliver aspects of CBT.
0 = Not At All (0%)
1 = A Little (25%)
2 = Somewhat (50%)
3 = A Good Deal (75%)
4 = Extremely (100%)

| | | |
|---|---|---|
| 1. | I have a sound understanding of the fundamental tenets of CBT. | 0 1 2 3 4 |
| 2. | I have a sound understanding of cognitive behavioral theory. | 0 1 2 3 4 |
| 3. | I am confident in my ability to develop a case formulation and treatment plan with clients. | 0 1 2 3 4 |
| 4. | I have a sound understanding of the fundamentals of the therapeutic relationship in CBT. | 0 1 2 3 4 |
| 5. | I am confident that I can cultivate a strong therapeutic relationship while simultaneously implementing CBT structure and strategy. | 0 1 2 3 4 |
| 6. | I have a sound understanding of CBT session structure. | 0 1 2 3 4 |
| 7. | I am confident in my ability to implement CBT session structure. | 0 1 2 3 4 |
| 8. | I have a sound understanding of ways to implement cognitive restructuring with clients. | 0 1 2 3 4 |
| 9. | I am confident in my ability to implement cognitive restructuring with clients. | 0 1 2 3 4 |
| 10. | I have a sound understanding of ways to implement behavioral activation with clients. | 0 1 2 3 4 |
| 11. | I am confident in my ability to implement behavioral activation with clients. | 0 1 2 3 4 |
| 12. | I have a sound understanding of ways to implement problem solving with clients. | 0 1 2 3 4 |
| 13. | I am confident in my ability to implement problem solving with clients. | 0 1 2 3 4 |
| 14. | I have a sound understanding of ways to implement exposure with clients. | 0 1 2 3 4 |
| 15. | I am confident in my ability to implement exposure with clients. | 0 1 2 3 4 |
| 16. | I have a sound understanding of ways to implement mindfulness and acceptance skills with clients. | 0 1 2 3 4 |
| 17. | I am confident in my ability to implement mindfulness and acceptance skills with clients. | 0 1 2 3 4 |
| 18. | I have a sound understanding of ways to implement relapse prevention with clients. | 0 1 2 3 4 |
| 19. | I am confident that I can implement relapse prevention with clients. | 0 1 2 3 4 |

domains and evaluate the degree to which you have changed. In this spirit, I encourage you to take this self-assessment of your CBT skills as a "pre-test." I will ask you to take this test again in the final chapter of the book, so that you can evaluate the ways in which this experiential learning program allowed you to grow as a cognitive behavioral therapist.

What did you notice about your responses? Did you tend to score differently on the questions assessing understanding than the questions assessing your confidence in delivering aspects of CBT? Don't worry if you gave yourself low ratings (or even if you did not fully understand some of the terminology included in the questions). The purpose of this book is to guide you through, step-by-step, so that you can learn core CBT strategies to use with your clients, and along the way, gain some practice in applying them to your own life in an experiential manner. This pre-test is just a starting point. My hypothesis is that you will be pleasantly surprised to observe the change in your ratings when you retake this test at the end of the book. In fact, low scores on many of these items can be viewed in a positive light, as they allow for tremendous growth to be achieved throughout out the course of this experiential learning program.

## CBT's Fundamental Tenets

Let's begin with some of the most basic, fundamental tenets of CBT. These general principles serve almost as "meta-guidelines" that will help you to steer the overall course of your practice with clients. Read through these tenets and my commentary about them.

### *CBT is Active, Problem-focused, and Time-sensitive*

CBT emerged in a time in which it was common for clients to attend psychotherapy for years, often scheduling more than one appointment per week. The idea underlying many psychotherapeutic approaches of the time was that clients needed space in a safe environment to develop insight into their emotional distress, unhealthy relationships, poor decision making, and so on, and once insight was achieved, they would be able to readily translate it into meaningful change. The activities that were pursued in these sessions included exploration of childhood relationships and events, discussion of emotional experiences, analysis of dreams, and examination of clients' reactions to their therapist (i.e., transference) and their therapists' reactions to them (i.e., countertransference).

This is not at all to say that the exploration of childhood relationships and events, discussion of emotional experiences, analysis of dreams, and examination of clients' reactions to their therapist and their therapists' reactions to them are *unimportant* in psychotherapy. In many instances in this book, I provide examples of ways in which some of these activities are pursued within a CBT framework. Instead, cognitive behavioral therapists believe that therapeutic work focused *solely* on developing insight, exploring the past, and cultivating the therapeutic relationship is insufficient and inefficient, and that the aims of psychotherapy could be achieved more directly with a more active, problem-focused approach.

What does an active, problem-focused approach look like? In the research literature, many CBT protocols that are 10, 12, 16, or 20 sessions in length have been evaluated (e.g., Elkin et al., 1989; Safren et al., 2009). This is not to say that these are "magic numbers." When I explain this point to my clients, I say that it was a necessity for researchers to define a specific number of sessions as comprising a CBT protocol, so that they could be sure that each research participant was given the same amount of therapy. In reality, in "real life" clinical practice with "real life" clients, therapists are not limited to an exact number of sessions (unless an insurance company indicates that it will only reimburse a maximum number of sessions, but that is a different story). I have seen some clients for only four or five sessions, but they left satisfied with the "product" that they received, and they gave me the feedback that, not only did they view the problems that they brought to treatment as being resolved, but they also had confidence that they would be able to continue implementing what they had learned into their lives even if we were no longer meeting regularly. In contrast, I have other clients on my caseload who I have seen for more than 100 sessions. Usually, these are clients who have relatively complicated clinical presentations, such as a history of trauma, a personality disorder, chronic depression, or "bad luck" that results in them facing recurrent stressors that are out of their control. Am I still doing quality CBT with these longer-term cases? Absolutely, because I am implementing an active, problem-focused approach no matter how many sessions I have worked with them.

In Chapter 4 of this volume, you will learn more about CBT's session structure. Session structure is one aspect of CBT that makes it active and problem-focused. Rather than allowing their clients to meander into a session of "unloading" or providing endless detail about their life problems (unless clients specifically express a desire to do so), cognitive behavioral therapists gracefully and sensitively structure the session, so that clients think carefully about what they would like to accomplish in session, and so that there is space for something to be done to address their life problems. My motto, then, is for each of my clients to leave each session with something more than they came with, whether that "something more" is a solution to a problem, a new way of viewing a problem, acceptance, a skill or a tool to implement between sessions, and so on. Psychotherapy requires a large investment of time, energy, and (often) money, so it is my belief that the efficient delivery of services shows sensitivity and respect for this investment.

## *The "Heart" of CBT is the Case Formulation*

CBT's *case formulation* is the application of cognitive behavioral theory to the individual client's clinical presentation. You will learn much more about cognitive behavioral case formulation when you read the next chapter, Chapter 2 of this volume. Although case formulation is important in any therapeutic approach (Eells, 2007), the role it plays in CBT cannot be underestimated. In fact, in a 2016 lunch meeting I had with Dr. Aaron T. Beck, who is regarded by most as the "father" of CBT, we concluded that the CBT case formulation is the "heart" of CBT. The reason case formulation plays such a central role in CBT is because (a) it provides a coherent framework for understanding the development, maintenance, and exacerbation of a client's mental health problems; (b) it provides a template for integrating disparate pieces of information about a client's history; (c) this understanding, in turn, provides clear pathways for intervention; and (d) it makes events that transpire throughout the course of therapy, especially those that impact the therapeutic relationship, understandable.

Thus, cognitive behavioral therapists do not simply "jump" into psychotherapy and see what direction it takes. Rather, they are mindful of cognitive behavioral theory, and in the early sessions when they are getting to know their client, they are assimilating what they are learning about the client into their formulation, while simultaneously developing hypotheses about how the client got to where he or she is and where to go from here. They are thinking critically about the most salient aspects of the client's clinical presentation (in light of cognitive behavioral theory) and formulating a plan for intervention. All the while, they are cognizant of the fact that this formulation will evolve over the course of treatment, as they continue to get to know their client, observe the way in which their client responds to positive and stressful events in his or her life, and develop a felt sense of what it is like to form a relationship with the client.

## *CBT is Collaborative and Transparent*

When I first meet with my clients and educate them about CBT, I say the following: "I want you to know that by initiating a course of CBT, we are embarking on a collaboration. I have knowledge and expertise about psychology, psychotherapy, and CBT, specifically. But you are the expert on your own life circumstances. It would be presumptuous of me to think that I know exactly what it's like to be in your shoes at work, at home, or in other circumstances in which

you find yourself. So, when we work together, we bring our respective areas of expertise to the table, we put our heads together, and we figure out ways to make progress in addressing the problems that you would like to address in psychotherapy." As will be discussed further in Chapter 4 of this volume on session structure, part of the collaborative process is obtaining feedback from clients to ensure that they are "on board" with the direction in which the session is going. If a client expresses hesitation or ambivalence, such a response is taken seriously, and the cognitive behavioral therapist does not proceed further until the client's concerns have been resolved, and the client is either more in agreement with the intervention, or another intervention is decided upon.

In addition to its collaborative nature, CBT is also transparent. Transparency in CBT means that the client is "kept in the loop," such that he or she is educated about CBT principles and the rationale underlying recommendations made by the therapist. Cognitive behavioral therapists live by the somewhat humorous adage that we want to "put ourselves out of business," such that we want our clients to become their own cognitive behavioral therapists. Thus, cognitive behavioral therapists provide their clients with explanations about theory, expected mechanisms of change (i.e., the way in which we expect our interventions to work), and, when relevant, results from empirical research, so that they can begin to put their own words onto the principles that they are learning.

## *CBT is Conducted from a Stance of* Collaborative Empiricism

We just finished a section emphasizing the collaborative nature of CBT. Here, we add the focus on empiricism. *Empiricism* means that we base the conclusions that we draw on facts, observations, or data, rather than on conjecture, hearsay, or speculation. *Collaborative empiricism* refers to a stance in which the therapist and client, together and as equal members of the team, examine all of the facts, data, evidence, observations, and so on that contribute to a situation in the client's life being as it is, and then draw the most logical, balanced, and helpful conclusion on the basis of those facts, data, evidence, and observations. Analogies that are frequently used by expert cognitive behavioral therapists are that the therapist and client are serving as co-detectives on a case, evaluating the evidence before making an accusation about a crime, or as co-scientists, analyzing the data before drawing a conclusion and disseminating results from the experiment.

Another way to understand collaborative empiricism is from a "just the facts ma'am" perspective. Cognitive behavioral therapists encourage their clients to put the greatest weight on factual information in making sense of upsetting situations. Too often, when we are faced with upsetting situations, we make many assumptions about what is happening or reasons underlying what is happening, and we base our decisions about how to address the situation on these assumptions, which may or may not be true. CBT helps people to recognize when assumptions are being made and to slow down and verify them before acting on them. At the same time, cognitive behavioral therapists do not want their clients to discount their emotional responses; in fact, in *dialectical behavior therapy* (DBT), one seminal treatment approach within the family of cognitive behavioral therapies, clients are encouraged to pay close attention to their emotional responses, because negative emotions provide important information that something is not right or needs to be adjusted (Linehan, 1993, 2015). In other words, emotional responses

are a signal that something in our lives needs to be addressed, and we gather factual evidence to understand what is happening and what needs to be done. This overlap between the factual mind and the reasonable mind is called the *wise mind* by therapists who practice DBT.

## *CBT is Strategic*

A few years back, I wrote a book on strategic decision making in CBT (Wenzel, 2013). I define a *strategy* as a thoughtful intervention that is delivered in psychotherapy that has its basis in theory, empirical research, and clinical experience. In my book, I outlined four principles of CBT strategy: (a) that it follows directly from the case formulation; (b) that it is implemented in collaboration with the client; (c) that it is delivered in a way that is meant to move treatment forward; and (d) that it is seen through in its entirety, rather than abandoned partway through on the basis of assumptions that the therapist may be making. Points (a) and (b) have been described in previous sections. However, allow me to expand upon the latter two points.

Some scholars who reviewed my 2013 book did not "get" what I meant by point (c)—that the intervention the therapist selects must move treatment forward. Isn't that the point of any intervention in treatment? Why wouldn't a therapist do something that would move treatment forward? Obviously, this point requires some explanation. This point, as well as many additional ones that I will describe in this book, arises from my experience as a supervisor of therapists in programs designed to achieve competency in CBT. To facilitate the supervisory experience, I regularly listen to CBT sessions and rate them according to the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980). At this point in my career, I have had the privilege of working with several hundred supervisees who aimed to acquire competency in CBT, which means that I have reviewed around 2,000 recordings of CBT sessions. Thus, I have gathered a great deal of "data" on the efficient and effective delivery of CBT.

There were times when I reviewed these recordings of CBT sessions that it seemed as if the therapist selected an intervention strategy "out of thin air." It did not seem to follow from the formulation, nor did it seem relevant to the material that was being discussed in session. When I would gently question therapists in this position about the rationale for the strategy that was chosen, in most cases, they would respond sheepishly that they did not know why they chose the intervention. In some cases, they wondered whether they thought that they should be doing something, simply because they were attempting to "do" CBT; in other cases, they assumed that their client would *not* respond to a particular CBT strategy and were proceeding forward in a vague, general manner, trying not to do anything for which the client might not be ready. These sessions were almost invariably rated lower on the CTRS than sessions in which I heard a coherent strategy that advanced the client's treatment goals. This principle of strategy, then, encourages therapists to be thoughtful about and have a clear rationale for the interventions that they deliver—so that the intervention advances treatment. When I supervise therapists who hope to achieve competency in CBT, the most frequent question I ask is, "What strategy were you delivering in this session?" If they have difficulty succinctly articulating the strategy, then in many cases the intervention that they have delivered is not cogent enough to move treatment forward in that session.

I can imagine that the novice cognitive behavioral therapist might be having quite a reaction to these two paragraphs, entertaining thoughts, such as "I'll never get this" or "This is not what I

expected." If these are your reactions (or if you are having a similarly aversive reaction), please take heart. CBT trainers want you to be successful. CBT trainers feel passionately about the approach being disseminated. The last thing we want is for CBT to be inaccessible to therapists or to clients. I liken the acquisition of skill in CBT much as I do to learning how to drive a car. When we are in our teenage years, and our parents are driving with us, we are encouraged to focus solely on the "nuts and bolts" of driving—paying attention to the road and to the core aspects of driving without engaging in superfluous activities, such as talking to others or listening to the radio. Over time, however, the "nuts and bolts" of driving become automatic, freeing up our cognitive resources to devote to other things. Such is the same with CBT. Once the basic "flow" of the session has been practiced, it will become second nature to the therapist-in-training, freeing up cognitive resources to think conceptually and strategically, such that the intervention chosen will, indeed, be associated with a distinct expected mechanism of change. In fact, ways to implement strategic CBT will be discussed in all of the subsequent chapters, so after reading this book in its entirety, I expect the reader to emerge with a sense of confidence about implementing interventions that will, indeed, move treatment forward.

The final piece of CBT strategy—the fact that it is seen through in its entirety without being abandoned—also deserves some comment. Again, on the basis of my experience supervising therapists who hope to become certified cognitive behavioral therapists, I have seen on many occasions that therapists can get "cold feet" when they are trying to deliver a strategic intervention. In other words, they start to wonder if the client is having a negative reaction to the intervention, or the client goes in a different direction (as clients often do), and they conclude that the intervention is no longer appropriate and instead decide to follow the client's lead. Let me state at the outset that I am *not* suggesting that a cognitive behavioral therapist should ignore a client's lead; indeed, following the client's lead is an important part of a client-centered approach, which I believe unequivocally that CBT is, and is a point on which I elaborate further in Chapter 3 of this volume. Rather, before veering off in a direction other than the one in which you and the client agreed, collaboratively, to pursue, I suggest that you pause, and then continue thoughtful collaboration, saying something such as "We'd been talking about [insert topic], but I notice that [insert topic] is coming up here. What do you think is best—should we table what we are discussing about [insert topic] and shift our attention to [insert topic]?"

The results of asking such a question are usually striking. In the vast majority of the cases, clients will express gratitude for "keeping them on track," saying something such as "This is exactly what I need—someone to step in when I start to veer off in a different direction. That's part of my problem and why I'm looking for help." What I take such a comment to mean is that, if I had not thoughtfully posed the question of the direction to take when the client began to veer in a direction that was different than the one that formed the basis for the strategic intervention, then I would have assumed that I should abandon the intervention, thereby reinforcing what very well might be a quintessential example of the client's unhelpful way of addressing his or her life problems. We cannot evaluate whether a therapeutic intervention is successful unless we implement it fully and evaluate the degree to which it is effective. If we implement it "half way," or abandon it part-way through, then we set up a "self-fulfilling prophesy" for it to be unsuccessful, and our actions will have inadvertently contributed to the lack of efficacy associated with the intervention.

Thus, strategic cognitive behavioral therapists see their interventions through in their entirety. If the client veers off in a different direction, they ask the client directly whether he or she thinks that the new direction is more appropriate to take. If the client maintains that the new direction takes precedence, from a collaborative stance (see previous CBT tenet), they follow where the client is going, though they make a note of the intervention that they were delivering, so that they can revisit it in the future. This latter point is important (i.e., revisiting the intervention in the future), so that it does not model a haphazard approach to life's problems. However, if the client agrees that the new direction is a tangent that is less important than the topic at hand, then the therapist has modeled a new way of maintaining focus and organization in addressing the client's life problem.

### *Work Done Between Sessions is Just as Important as Work Done In Session*

If we do not want our clients to be in therapy indefinitely, then it is important that they develop the ability to generalize the learning that they achieved in session to their lives outside of sessions. The most direct way to achieve this aim is for clients to do some systematic work between sessions. Historically, this between-session work has been called *homework*, although many CBT experts are moving away from this term and are instead using language such as *action plan* or *practice*. Research shows that there is a tight association between the degree to which therapists emphasize homework in session, as well as the degree to which clients embrace homework, and, ultimately, outcome in CBT (Kazantzis, Whittington, & Dattilio, 2010). Much more discussion about (and tips for maximizing!) between-session work will be described in Chapter 4 of this volume.

### *Summary*

CBT is a psychotherapeutic approach that is meant to help clients achieve substantial (and positive) changes in their ability to regulate emotion, solve problems, and live a quality life. When they deliver CBT, cognitive behavioral therapists are mindful of these six tenets and use them to guide the decisions that they make during the session. Some therapists-in-training find that these tenets are very sensible and that they are generally already living their lives according to them. In these cases, they generally experience a smooth transition to delivering CBT with their clients. Other therapists-in-training find these tenets to be a bit foreign and different than their view of what psychotherapy should be. If you are in this latter group, it is okay. In fact, by working through this CBT for Beginners program, you will be accomplishing a very important goal of CBT—that of *psychological flexibility*. Psychological flexibility is defined as "the ability to contact the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends" (Hayes, Luoma, Bond, Masudam, & Lillis, 2006; p. 7). In other words, by giving CBT a "fair shot," working through this workbook, and gaining practice in the delivery of CBT to clients, you will be exemplifying an open stance to learning something new that is a bit inconsistent with your preferences and proclivities. Regardless of whether you choose to continue practicing CBT when you are done with the program, you will have bettered yourself as a clinician by truly immersing yourself into an approach to theory and practice that has significantly influenced the field and by developing a tolerance for trying something that is out of your comfort zone.

## Common Misconceptions About CBT

Although I regularly encounter many therapists who are eager to learn and acquire skill in CBT, I encounter a fair number of therapists who have reservations. Oftentimes, these reservations have their basis in stereotypes that have emerged about this approach, and they are surprised when I give them a different perspective. In this section, I outline some of the most common misconceptions that I have encountered, and I supply alternative perspectives that have their basis in my clinical and scholarly experience.

### *CBT is Superficial and is not "Deep" Enough for Complex Clinical Presentations*

As you will see as you work through this book, CBT provides a framework for therapists to deliver many skills and tools to clients, which are expected to lessen their emotional distress and improve their ability to engage in proper self-care, solve problems, and follow through with action plans. Most clients believe that the acquisition of these skills is invaluable and remark that they wished they would have been taught these skills by their parents or teachers when they were children.

However, some people believe that this is where CBT's usefulness ends, such that CBT is a sound approach for clients who need concrete tools, but for those who have "deeper" issues or complex clinical presentations, it falls short. In reality, CBT, indeed, goes far, far beyond the simple delivery and acquisition of skills and tools. As mentioned previously in the discussion of case formulation, the underlying theory provides a rich framework for understanding the development, maintenance, and exacerbation of clients' clinical presentations. As you will see when you read Chapter 2 of this volume, this theory allows for an understanding not only of the typical thoughts, emotions, and behavioral responses that clients exhibit when they are faced with a situational stressor in their lives, but it also provides a framework for understanding beliefs and habitual behavioral patterns that underlie these situational responses. Many cognitive behavioral therapists believe that clients realize the greatest amount of change when these underlying beliefs and habitual behavioral patterns serve as the ultimate target of treatment (Wenzel, 2012). Such underlying beliefs and behavioral patterns are, indeed, quite "deep," having been molded over time by previous experiences and that often feel as though they are the very core of the individual. You will not learn a great deal about belief modification in this book. Nevertheless, as you acquire skill in the "basics," there is a wealth of resources available for you to gain competence in the delivery of belief modification techniques.

In addition, cognitive behaviorally-based treatment packages have been developed *specifically* to address complex and chronic clinical presentations, many of which are assumed by people unfamiliar with CBT to be a better match for insight-oriented psychotherapies. For example, *schema therapy* is a treatment approach developed by Jeffrey Young, who had trained and collaborated with Aaron T. Beck (Young, Klosko, & Weishaar, 2003). In his clinical experience, clients with personality disorders, chronic depression, and/or a history of trauma are often characterized by distinct cognitive orientations called *schemas* (e.g., mistrust, abandonment) that create enough rigidity that it is difficult for them to form a strong therapeutic relationship or

otherwise embrace what "traditional" CBT had to offer. Using traditional CBT as a foundation, Dr. Young integrated approaches and techniques from other types of psychotherapies, such as *Gestalt therapy* and *object-relations therapy*, to activate and reshape these schemas. Research shows that it is highly efficacious in treating clients with personality disorders, including borderline personality disorder (Masley, Gillanders, Simpson, & Taylor, 2012). Although a full description of schema therapy is beyond the scope of this book, it is introduced here as one example of a cognitive behavioral approach that is "deep" and is efficacious and appropriate for complex clinical presentations.

### *There is a Checklist of Things I "Must" Do if I am to be Doing CBT the "Right" Way*

Many of my supervisees worry about whether they are doing CBT the "right" way, and conversely, they wonder if they forgot to implement an aspect of session structure or a cognitive behavioral intervention, that they have then implemented CBT the "wrong" way. In reality, there is very little that "must" be done in any one session for it to be a CBT session. Instead, CBT structure and cognitive and behavioral strategic intervention serve as guidelines or heuristics to make sessions (and the overall course of treatment) run more or less effectively. In my experience, there are really only a few core features of CBT that are present in almost all courses of therapy with clients:

1. The therapist attempts to understand the client's clinical presentation in light of cognitive behavioral theory (i.e., develops some sort of a case formulation).
2. The therapist and client work together to decide how best to use the time in session, as well as the goals to focus on across the courses of treatment (i.e., the active, organized, and systematic approach to addressing the client's life problems).
3. The therapist and client work together to decide how best to translate the work done in session to the client's life (i.e., between-session work).

In other words, therapists deliver in their intervention in a thoughtful and systematic manner—one of the principles of strategy that I introduced in the previous section. Even so, I can think of select instances in which a therapist was, indeed, "doing" CBT even if one of these three features was not in place, such that even when one or more of these features was not in place, CBT was not necessarily being done the "wrong" way.

For example, even the most seasoned cognitive behavioral therapists will have instances in which a client is in crisis, or a client expresses a need to unload, and the "agenda" of therapy is put on hold. In other words, the active, organized, and systematic approach to addressing the client's life problems does not always occur in every single CBT session. I vividly remember a time when I found myself in this position, when a client with whom I was delivering CBT for panic disorder with agoraphobia presented for session in tears, indicating that a close friend had committed suicide the previous day and left him a "good-bye" voice mail. We, of course, put our CBT work on hold, and at the client's request, he spent the session remembering fondly shared experiences with this friend. We resumed our CBT work in the following session, though for a number of subsequent sessions I took care to check in on how he was feeling about the loss

of his friend. At the close of treatment, the client and I both viewed the session discussing his friend's suicide as an especially powerful shared experience, and he provided feedback to me that the processing of his grief was one of the most important therapeutic gains that he made during the course of treatment, even beyond the tangible gains he made in reducing the symptoms of anxiety and avoidance for which he sought treatment.

Moreover, there will undoubtedly be instances in which clients explicitly indicate that they are uninterested in between-session work (I certainly have had a few across the course of my career!). In all of these instances, CBT can still be "done" and done well, even if it is not done according to the format described in textbooks. The key, as you will see throughout this workbook, is to ask clients to think critically about the learning that they are acquiring and the way in which they will generalize this learning to their lives, even if it is not through "formal" homework exercises.

In addition, many therapists-in-training equate certain specific tools or strategies to "doing CBT." This most commonly occurs with the strategy, cognitive restructuring, and a tool called the *thought record*, which can be used to facilitate cognitive restructuring. As will be described in much more detail in Chapter 5 of this volume, *cognitive restructuring* is a strategy in which the therapist works with the client to identify, evaluate, and if necessary, modify unhelpful thinking. An example is when a client concludes that a person does not like her, because the person did not say hello to her when they crossed paths at the grocery store. Although there is certainly a possibility that the person with whom the client crossed paths does not like her, there are many other possible explanations, such as the possibility that the person did not recognize her, the possibility that the person's mind was preoccupied with something else, the possibility that the person was in a hurry, and so on. When people focus only on the most negative possibility (in this case, that the person with whom the client crossed paths does not like her), they usually experience unpleasant and unnecessary emotional distress, and there is an increased likelihood that they will do something self-defeating (e.g., give the cold shoulder to the person the next time their paths cross). Cognitive restructuring helps clients to soften their interpretation of perceived negative events that they experience, which should help them to make sounder decisions regarding ways to handle these events. The *thought record* is a tool in which clients record situations like this that prompt negative emotions, the way in which they were interpreting the situation, and an alternative, more balanced view of the situation.

Cognitive restructuring is, indeed, a central strategy that cognitive behavioral therapists use in treatment. However, it is by far not the *only* strategy. Many of the chapters of this book describe and will give you practice in other core strategies associated with CBT, such as behavioral activation, exposure, problem solving, communication skills training, mindfulness, and acceptance. In fact, a client could go through an entire course of CBT and participate only in behavioral interventions, rather than cognitive interventions, and his therapist would still be "doing" CBT. Moreover, if a therapist implements cognitive restructuring, it need not be executed using a *thought record*; the aims of cognitive restructuring can be achieved simply through conversation between the therapist and client, using a mobile phone application, or in other creative ways that I will describe in Chapter 5 of this volume.

A major "take-home" point with which I hope you will leave after reading this book is that CBT is extremely versatile. The delivery of CBT is driven by theory and the case formulation, not by

any specific structural feature, technique, or tool. In fact, unless you are following a treatment manual for a very specific and singular clinical presentation, no two courses of CBT will look alike. You will be able to implement CBT on the basis of your client's needs and preferences, your own personal style, and the creativity and ingenuity that emerges from the synergy inherent in the collaborative therapeutic relationship that develops between the two of you.

### *Certain Aspects of CBT are Off-putting to or "Too Much" for Clients*

Some therapists-in-training worry that the structure of CBT will be off-putting to clients. For example, as you will see in Chapter 4 of this volume on session structure, one way to encourage organization and efficiency in session is for you and the client , together, to set an agenda, or an expectation of the topics and issues that will be addressed in the session. Over my years of supervision in CBT, I have heard therapists express concern that agenda setting will stifle spontaneous discussion of issues that unexpectedly arise in the course of discussion, or that clients will view agenda setting as so rigid that it will prevent them from feeling comfortable with their therapist and developing a strong therapeutic alliance. Other therapists-in-training express concern that their clients are too fragile for the more "directive" aspects of CBT, such as a "formal" intervention strategy like cognitive restructuring of behavioral activation, or for a homework exercise between sessions.

In my experience, these concerns most often reflect assumptions inherent in the therapist him- or herself, rather than truth. Of course, we do not want to dismiss these concerns, as if realized, they have the potential to affect the therapeutic relationship and the degree to which clients embrace the interventions we offer them. But, from the perspective of collaborative empiricism, it is important to check out these concerns with the client. Much more often than not, when cognitive behavioral therapists say something, such as "I'm wondering if what I'm suggesting doesn't seem right to you, or is rubbing you the wrong way?" clients respond by saying that they actually appreciate the spirit of the intervention, and while it might be a bit uncomfortable or different than the way they are accustomed to living their lives, they value the learning experience.

### *Cognitive Behavioral Therapists are Uninterested in the Therapeutic Relationship*

I hope that you have already seen in my writing to this point that this sentiment is, indeed, a misconception and that cognitive behavioral therapists place great importance on the therapeutic relationship. Over 40 years ago, Dr. Aaron T. Beck published his seminal book, *Cognitive Therapy of Depression* (Beck, Rush, Shaw, & Emery, 1979), and in this book, he devotes a full chapter to the importance of a strong therapeutic relationship. Nevertheless, this misconception is perpetuated. Perhaps the following anecdote will clarify why this situation has come to pass.

When I was writing this book, I delivered a three-day lecture on CBT for Anxiety-Related Disorders at the Beck Institute for Cognitive Behavior Therapy, a non-profit institution founded by Dr. Beck and his daughter, Dr. Judith S. Beck, that serves as the premier training organization

in CBT. As he often does, Dr. Beck attended a portion of the workshop, so that he could meet workshop participants, answer their questions about CBT, and consult on difficult cases. One of the workshop participants asked a question about the importance of the therapeutic relationship. Dr. Beck sighed and admitted that he made a mistake in his early writings about CBT. Elaborating upon this provocative statement, Dr. Beck indicated that he had, indeed, carefully read the works of seminal mental health providers, such as Carl Rogers, about the centrality of the therapeutic relationship in psychotherapy. Moreover, he agreed wholeheartedly with these writers that a strong therapeutic relationship is essential for successful psychotherapy. However, his mistake was that when he wrote about CBT, he assumed that the reader would already have this knowledge and training, so that the reader could build from a client-centered foundation and add the specific CBT framework and strategic approach to his or her clinical work. Unfortunately, over time, the absence of extensive discussion about the therapeutic relationship in his books was interpreted as a stance that cognitive behavioral therapists believe that the therapeutic relationship of minimal importance. As you will see in Chapter 3 of this volume, the CBT literature is now addressing this misconception with several published books and innovative research designs that illustrate the important role that a strong therapeutic relationship plays in CBT.

## *Certain Topics are "Off-limits" in CBT*

I cannot tell you the number of times I have had a supervisee say something to me, such as "I really have a strong reaction to the client. But I'm not allowed to address that, right? Because focusing on transference is off-limits in CBT, right?" My unequivocal response to this sentiment is, "Nothing further from this is the truth. In my opinion, the *best* CBT is often done in the context of something that is happening between you and the client right there in the therapy session." The ensuing discussion illustrates yet another way that the therapeutic relationship plays a central role in the course of psychotherapy.

I have many reasons for my stance on this issue. First, research shows that the strength of the therapeutic alliance accounts for 20% to 25% of the variance in outcome in psychotherapy (Martin, Garske, & Davis, 2000). Although these data are often used by cognitive behavioral therapists to support the notion that the therapeutic relationship is insufficient to fully influence outcome in psychotherapy, at the same time, these data also suggest that a strong therapeutic relationship is of crucial importance and should be cultivated. In other words, attending to what is happening in the therapeutic relationship is not the only task at hand in CBT, but it is an important one not to be dismissed.

Second, one intriguing research study (Strauss et al., 2006) discovered a "V-shape" association between tension in the therapeutic relationship and outcome in CBT. Moreover, it found that when a *rupture* (i.e., "a tension or breakdown in the collaborative relationship between patient and therapist" [p. 80]; Safran, Muran, & Eubanks-Carter, 2011; see also Safran, Crocker, McMain, & Murray, 1990) in the therapeutic relationship occurred, if it was repaired successfully, outcome was better than had a rupture not occurred at all. The eminent cognitive behavioral therapist, Cory Newman (who was also an author on this study) shed further light on these findings to suggest that too little tension in the therapeutic relationship means that

therapy is too easy, and that the client will likely not achieve the maximum benefit. Too much tension, in contrast, means that the therapeutic relationship has been compromised, and that the fundamental foundation of psychotherapy is not in place for gains to be made in session (Newman, 2007).

Third, the "real-time" unfolding of an issue in the therapeutic relationship has the potential to illustrate the CBT model and its associated strategies first-hand to clients. Take, for instance, a true story that occurred in my practice many years ago. I was seeing a single, female client who was involved in a romantic relationship that most of her friends and family believed was not good for her. She and I were preparing to break for eight weeks of my maternity leave, and she indicated that she had planned to end the relationship. I saw her the week I returned from maternity leave, and during that session she indicated that she had, indeed, ended the relationship, but that she resumed it a few weeks later. My initial response was, "Oh, I'm surprised" (admittedly not my best therapeutic moment).

This client's reaction to me at the time of the subsequent session, however, was telling. During my bridge from the previous session (see Chapter 4 of this volume for more on this aspect of session structure), I asked the client what "stuck with" her from the previous session. She looked at me harshly and said, "I felt so judged by you." I immediately acknowledged her reaction, thanked her for being so forthright, and asked if we could make this the first topic of discussion (meaning that I did not abandon agenda setting; see Chapter 4). When we discussed the issue from a compassionate but factual standpoint, the client realized that I did not, inherently, say anything judgmental (though we both laughed that my "I'm surprised" reaction might not have been the savviest). Rather, she realized that she had an array of negative self-judgments about resuming the relationship, and she attributed those to my ambiguous "I'm surprised" reaction. It was only after she checked out the facts (per collaborative empiricism) and was able to draw a more accurate and balanced conclusion on the basis of her fact-checking that she was able to see that I was not at all judging her with my reaction. Moreover, in my view, it ultimately, strengthened our relationship and the cognitive behavioral work we were doing together, as we sometimes lightheartedly referenced this moment during the course of therapy as a reminder that I would not pass judgment on her, and that it is important to check out the facts before assuming that we know what others think of us.

In addition to therapists' concerns about addressing issues that arise in the therapeutic relationship (or in their reactions toward their clients), I have also heard therapists-in-training assume that issues associated with "the past" are "off-limits." It is true that CBT was developed as a "here-and-now" approach to psychotherapy, with the rationale that cognitive behavioral therapists want their clients to feel the benefit of psychotherapy as immediately as possible, and that it is often unnecessary to dig deep into the past when current life problems are what have prompted the client to pursue services. Nevertheless, this does *not* mean that the past is *not* important. As you will see in greater detail in Chapter 2 of this volume, as they develop the case formulation of their clients' clinical presentations, cognitive behavioral therapists pay close attention to past formative life experiences that shape clients' core beliefs and habitual behavioral patterns. Furthermore, when a client has experienced a past trauma, the trauma is, of course, discussed in the process of implementing exposure, a strategy described in more detail in Chapter 6 of this volume. Moreover, some clients present to therapy with the observation