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Doing CBT: A Comprehensive Guide to Working with Behaviors, Thoughts, and Emotions, Second Edition.
By David F. Tolin. Copyright © 2024.
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CHAPTER 1

Laying Out the Basics

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THE ESSENTIALS

- A good CBT therapist sets reasonable and meaningful goals for treatment.
- A good CBT therapist mixes science with the art of psychotherapy.
- A good CBT therapist looks beyond the diagnosis and tries to understand why this client's problem is persisting.
- A good CBT therapist always frames their ideas as hypotheses and is willing to be wrong.
- CBT is primarily a way of thinking about psychological problems.
- In general, CBT tends to be focused, time-limited, present oriented, active, and directive, emphasizing measurable goals and testable hypotheses.

I'd like to begin by setting the stage for the discussion that follows in the rest of this book. As much as possible, I'm going to show you how we develop a case formulation, interact with our clients, and intervene with problems using vignettes from several fictitious clients, whom you'll get to know over the course of the book. That way, in addition to hearing it from me, you'll be able to see examples of each principle in action.

I'm assuming that most readers of this book are either mental health professionals or are people who are moving toward a profession in mental health (if that's not you, it's OK, you're welcome too!). But beyond that, I'm going to try not to make too many assumptions. Some readers already have a deep background in psychology, and for them, many of the principles we discuss will be familiar. However, others might just be starting out, or might come from a different field, and so these concepts will be new. Similarly, some readers already have considerable experience working with clients who have psychological problems, whereas others might be learning these principles in advance of actual client work. I've paced things so that readers of all experience levels can get what they need from this book.

We're going to spend a fair amount of time discussing not just what CBTers *do*, but also how they *think*. As you'll see, cognitive-behavioral therapy (CBT) is not just a set of techniques but rather is a comprehensive way of conceptualizing cases. I'll describe the basic principles that underlie the CBT approach, and illustrate how these principles can be put into action. We'll see how CBT sessions typically go (though, of course, there can be a lot of variability here; CBT is a pretty diverse approach and your treatment will necessarily be tailored to the individual client). And at the end of the book, I've included an appendix directing you to more readings that can help you go further on your journey to becoming an expert CBTer.

Meet Our Clients

To start, let me introduce the people whose stories I will be using to illustrate the ideas I write about. Here are the clients we'll encounter throughout the book.

- *Scott* is a 50-year-old cisgender White heterosexual, socially anxious man seen in private practice. Although he can interact with his wife and children just fine, he becomes paralyzed by fear when talking to his supervisor at work or with people he doesn't know well.

- *Suzanne* is a 65-year-old cisgender White heterosexual woman, seen in an outpatient counseling clinic, who has symptoms of generalized anxiety disorder (GAD) characterized by excessive worrying and tension. To cope with this anxiety, Suzanne has been overusing her benzodiazepine medication and fears she has become "hooked" on it. She is also highly dependent on others and seems reluctant to make decisions for herself.

- *Melissa* is a 25-year-old cisgender Asian lesbian woman who is being treated in a community mental health center. A survivor of chronic sexual abuse during her childhood, Melissa is experiencing complex posttraumatic stress disorder (PTSD) characterized by nightmares, extremely low self-esteem, difficulty sustaining healthy relationships, and difficulty trusting others.

- *Christina* is a 46-year-old cisgender heterosexual African American woman with chronic depression. She feels depressed most of the time and often has difficulty even getting out of bed. Although she is being treated in an outpatient clinic, at times she has had thoughts of suicide, combined with difficulty taking care of herself, that were so severe that she had to be hospitalized.

- *Samantha* is a 10-year-old cisgender White girl with trichotillomania. She repetitively pulls the hair from her scalp, eyebrows, and eyelashes, resulting in visible and embarrassing bald patches. Her parents brought her to a private specialty clinic.

- *Anna* is a 20-year-old cisgender female Hispanic college student, seen in her university's counseling center, who suffers from panic disorder and agoraphobia. Ever since moving onto campus, she has been experiencing unpredictable panic attacks. Due to her fears that these attacks will keep happening, she has been missing classes, has stopped driving, and is spending more and more time in her dorm room. She has considered taking a leave of absence from school.

- *Blaise* is a 28-year-old White nonbinary client who has been attending a day treatment program for substance use recovery. They (Blaise's preferred pronoun) have been abusing cocaine for many years and have been arrested for a variety of drug-related

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charges, including possession, larceny, and prostitution. They finally decided to get sober this year. They are finding it difficult, however, and have experienced multiple lapses. They are becoming increasingly discouraged and depressed.

- *Johanna* and *Nick* are a cisgender married White couple in their early 40s who feel the love has gone out of their marriage. They seem to argue quite a bit and feel angry and resentful toward each other much of the time. Often, they go for long periods barely speaking to each other at all. Johanna and Nick are also having difficulty raising their 12-year-old son *James*, who has been showing increasingly oppositional behavior.

- *Elizabeth* is a 45-year-old cisgender White woman who has been hospitalized more than 10 times for self-injurious behaviors, such as cutting or burning herself. She has been diagnosed with borderline personality disorder and experiences unstable moods, volatile relationships with others, and chronic thoughts of suicide. Her treatment was conducted in both an inpatient unit and a partial hospitalization program affiliated with the hospital.

- *Bethany* is a 17-year-old cisgender White girl with obsessive–compulsive disorder (OCD). She has several irrational fears, such as that she will be contaminated by germs and contract a disease and that she will be seized with an uncontrollable urge to harm others. As a result, she engages in several compulsive rituals, such as washing, praying, and repeating actions.

- *William* is a 52-year-old cisgender White gay man whose husband insisted he see a therapist. For most of his life, William has been unable to initiate tasks on his own or make decisions for himself, constantly asking his husband for guidance and reassurance. His husband now has to do nearly all of the household decision making and management. William has also been diagnosed with fibromyalgia, and he experiences chronic physical pain that, in his view, severely limits his activities.

- *Lauren* is a 30-year-old cisgender African American woman diagnosed with schizophrenia, paranoid type. She experiences delusional thoughts that others are monitoring, harassing, or trying to harm her. At times, she believes she hears the voices of other people whispering threatening messages into her ear. She is chronically unemployed, and her self-care has been inconsistent. She is being seen in a day treatment program for the chronically mentally ill.

- *Samuel* is a 50-year-old cisgender Hispanic man attending a specialty sleep disorders clinic. For several years, he has struggled with severe insomnia, which leaves him chronically fatigued. He has difficulty concentrating, and his work performance has been inconsistent, leading him to fear losing his job.

- *Shari* is an 18-year-old cisgender White woman who suffers from bulimia and is attending an intensive outpatient program for people with eating disorders. Nearly every day, she engages in binge eating, in which she eats a large amount of food rapidly, while feeling out of control. After these binges, she feels disgusted with herself and makes herself vomit. She often feels depressed and ashamed of herself.

As you can see, our clients represent a broad range of ages, backgrounds, presenting problems, symptom severity, level of functioning, and treatment settings. As you progress through this book, one thing I'd like you to notice is that the same principles can be applied (to greater and lesser degrees) across diagnoses. The principles are, in many cases, exactly the same. Of course, that doesn't mean CBT for schizophrenia will look exactly like CBT for social anxiety or couples' distress. But they have similar foundations, which we will discuss as we go.

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Thinking Like a CBTer

Before we can do good CBT, we need to get into a CBT state of mind. That means we make certain assumptions about psychological problems, why they occur, and how to treat them. Try these on for size.

A Good CBTer Sets Goals

Fundamentally, CBT aims to *do* something. Regardless of whom we're treating or why, it makes little sense to start treatment before we have a solid understanding of why we're doing it and what we hope to accomplish by doing it.

Of course, the desired outcome will vary depending on the client's presenting problem and goals. Clients can present with any number of treatment goals, such as:

"I'd like to feel less depressed."
"I'd like to stop drinking."
"I'd like to have better relationships."
"I'd like to be able to work again."
"I'd like to stay out of the hospital."

Sometimes the client has a hard time articulating their goals. Clarifying those goals therefore becomes part of our job as therapists. But regardless of whether the client comes into treatment with clearly stated goals or whether such goals have to be formulated during the therapy, we assume there are indeed desired outcomes—we're not here "just to talk." Our treatment is explicitly designed to accomplish something.

Furthermore, as CBTers, we hold ourselves accountable for those outcomes and monitor our progress toward those outcomes along the way. If the treatment does not seem to be helping in a demonstrable way, we change what we are doing—we don't just keep doing the same thing over and over.

A Good CBTer Uses the Best Evidence

Numerous clinical trials have investigated the efficacy of various psychological treatments for various psychological problems or disorders. A central principle of our work is that this scientific work should serve as a guide for our clinical practice. The use of research findings to inform clinical practice is a major part of **evidence-based practice**.[1] Evidence-based practice means we start with the best research evidence for the presenting problem and then tailor the treatment (as needed) based on clinical expertise and client characteristics. Importantly, it doesn't mean we have all of the answers, and it doesn't mean the treatments are perfect (or even as good as they're going to get).

So what is the best evidence? This is not necessarily connected to any particular theoretical orientation, as there are some studies suggesting that psychodynamic and other psychological treatments can be effective for certain presenting problems (e.g., E. Frank & Levenson, 2010; Leichsenring & Rabung, 2008; Leichsenring et al., 2015). So I'm not saying, "CBT or nothing." But I am saying to go where the best evidence takes you—and when it comes to the sheer volume of solid evidence, CBT is, more often than not, the way to

[1] Terms in **boldface** type are defined in the "Key Terms and Definitions" sections at the end of each chapter.

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go. CBT is derived from well-documented principles of behavior and behavior change. Over the last several decades, basic scientists have taught us a lot about why thoughts, feelings, and behavior go haywire and how they can be changed. CBT builds upon that understanding. CBT, and the fundamental assumptions of CBT, are readily testable and therefore modifiable. This means that over time CBT evolves as scientific evidence accumulates, showing us what works and what does not. We routinely toss out things that don't work—indeed, if CBT were a highway, the roadside would be littered with old ideas that didn't pan out and got discarded. That's a good thing. It means we improve over time. CBT today is quite different from CBT a generation ago, and, hopefully, CBT a generation from now will be different from what we practice today.

It's also worth noting that over time CBT has incorporated some elements of other forms of therapy, and it's important to be open to that. A good idea is a good idea, and if there's evidence to back it up, we'll use it as long as it's not contraindicated by the other things we're doing. When done right, CBT is a flexible treatment. First and foremost, a good CBT therapist has to be a good psychotherapist. There is no manual or set of principles that make up for a lack of therapeutic skill. Good therapy is good therapy, and a good therapist is a good therapist. In Chapter 7, we'll talk about the elements that should be present in any good therapy, CBT or otherwise.

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Should We Pick Elements from Various Schools of Psychotherapy?

I mentioned earlier that there are a lot of good aspects of non-CBT psychotherapy. So it may surprise you to learn that I have real reservations about some forms of eclectic therapy (in which elements from multiple theoretical orientations are merged into a unified treatment). I know a lot of people like to include "CBT techniques" into an otherwise psychodynamic or humanistic therapy. And I can see the appeal of doing so. After all, there are good things about psychodynamic and humanistic therapies, and there are good things about CBT, so sampling the best from each ought to be as great as combining peanut butter and jelly, right? Sometimes it is, but I have heard of a lot of cases in which it was more like peanut butter and ketchup. They're great separately, but together, not so much. Given the widespread adoption of integrated therapy among practitioners (e.g., Rihacek & Danelova, 2016), it's worth a bit of discussion here.

There are two ways of introducing eclecticism into psychotherapy. The first of these, identified by Arnold Lazarus (e.g., A. A. Lazarus, 1967; A. A. Lazarus, Beutler, & Norcross, 1992), is *technical eclecticism*, in which we use strategies derived from different models of psychotherapy without necessarily subscribing to their underlying theory. Strategies are selected solely because they work. You'll see examples of technical eclecticism throughout this book. As just a few examples, I'll borrow interpersonal strategies derived from Rogers's (1957) client-centered therapy and techniques from Perls's (1973) Gestalt therapy. In this book, you'll see elements of motivational interviewing (MI; Miller & Rollnick, 2024), cognitive therapy (J. S. Beck, 2021), behavior therapy (Wolpe, 1990), and mindfulness (Kabat-Zinn, 1994). This technical eclecticism is, in my opinion, helpful. I'm less concerned with who developed an idea, and whether they called it "CBT," than I am about whether it works within the overall framework of what I'm trying to accomplish.

But this kind of eclecticism works only because I'm always operating as a CBT therapist, no matter what strategy I am using. I have a coherent, evidence-based model of why the client is suffering, and from that model I derive hypotheses about what's likely to work for that client. Remember, CBT is more than a set of techniques. It's a comprehensive understanding of why people suffer, how to interact with them, and how to intervene.

It's an anchor I am secured by, or a platform I stand on and return to, even as I draw on techniques from other theoretical models. Why do I need such an anchoring theory? Isn't it just OK to "do what works" and leave it at that? One important reason is that therapy often doesn't go as you initially planned it to. Unexpected stuff, crises, and wrinkles arise over the course of therapy. When you encounter something that makes you question how you have formulated the client and their situation, or reach what feels like a dead end in your progress with a client, having a theoretical platform to return to is necessary, so you can think clearly and critically about what's going on. And, if warranted, you might want to change tactics in a way that is guided by your theoretical model.

In addition, if I didn't have a coherent model underlying my treatment, I would be at risk of the other kind of eclecticism—*theoretical integrationism* (Norcross, 1986)—in which the clinician merges the theoretical models or worldviews of different schools of therapy, creating a new hybrid understanding of the client from (for example) a cognitive–psychodynamic–behavioral–Gestalt perspective. Theoretical integrationism is not a good recipe for successful therapy (A. A. Lazarus & Beutler, 1993). It can leave you thrashing around aimlessly, without a good sense of what you're doing and why. Indeed, there are times when the theory behind one approach directly conflicts with the theory behind another approach. As just one example, think of OCD. The psychoanalytic model of OCD posits that obsessive thoughts represent unresolved conflicts from early stages of psychological development and that the person's compulsive behaviors represent an unconscious struggle for control over drives that are unacceptable at a conscious level. The CBT model of OCD, on the other hand, posits that strange thoughts are entirely normal, occurring in most people, and that the problem in OCD stems from the fact that the person takes these thoughts seriously, believes them to be true or dangerous, tries unsuccessfully to suppress them, and feels a need to do something about them. Now imagine talking to Bethany, who is having obsessive thoughts about harming her family, and trying to somehow "blend" the psychoanalytic and cognitive-behavioral explanations for what's going on. Probably, you'll end up with a confusing mess.

Maybe you have the skill to pull off theoretical integrationism. I certainly don't. So I choose to do CBT and do it really well, even though I might include some technical eclecticism. As you go through this book, I encourage you to try doing the same. Jump in with both feet. We'll be open to new ideas and not unnecessarily dogmatic, but we'll keep our conceptualization firmly grounded in CBT—that is, we have good reason to believe psychological problems are maintained by certain processes, and we always have those processes firmly in mind.

A Good CBTer Mixes Art and Science

We've discussed how the best treatment choices are based on scientific evidence of efficacy. That assumption might have you wondering where we make room for the art of psychotherapy. I would suggest that our science and art are not mutually exclusive—in fact, they get along famously. Sometimes, people try to frame this as a conflict between the two, as if you have to choose one or the other. Rather, I suggest we think about science and art as being two important aspects of the complex task of psychotherapy, both of which are critical to success (see Figure 1.1). Artless science is probably not going to be helpful in providing psychotherapy, nor will scienceless art. The best practitioners use an artful application of scientifically derived principles. That's what we're shooting for here. Being a scientific artist (or an artistic scientist, whichever sounds best to you) is not an easy task, but it's an important one if you're going to do good CBT.

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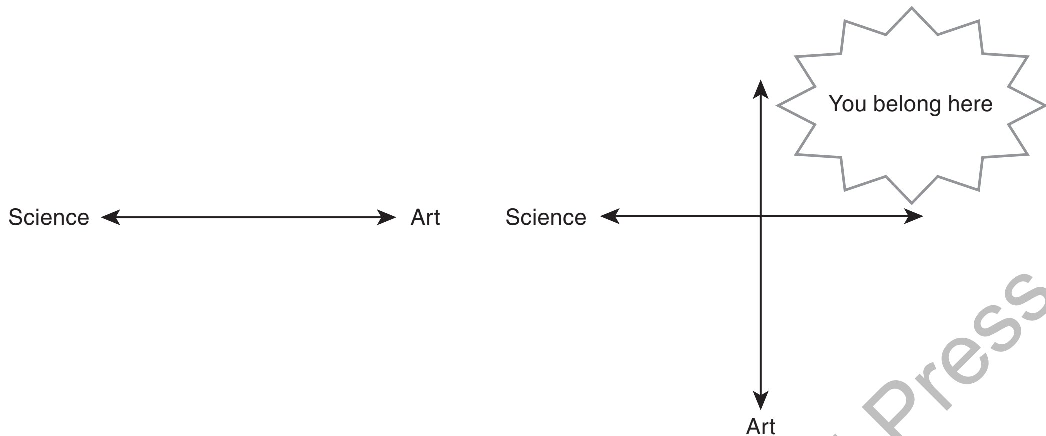

FIGURE 1.1. Science and art in psychotherapy. They are not opposite poles (left). Rather, they are two different constructs (right).

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Combining Evidence to Fit Your Client

It's important for us to recognize that, if you have a client in front of you, and you go to the scientific literature looking for explicit guidance about what to do with this exact client, you might come away disappointed. Much of the scientific evidence comes from tightly controlled clinical trials, the participants in which may or may not match your clients. For example, in most clinical trials only one diagnosis was being treated; there is usually little attention to the treatment of multiple problems simultaneously. You probably won't find, for example, much research that shows you clinical outcomes for clients who are simultaneously depressed and have drinking problems and personality disorders and chaotic living environments. And people from minoritized backgrounds are woefully underrepresented in clinical trials.

So how do we capitalize on the best available research evidence, given these limitations? We *start with the evidence* that seems to come closest to what we're trying to accomplish and make a (scientifically informed) best guess. Let's say I'm treating a client with a really bad case of panic disorder, who also suffers from a significant amount of depression. I know from the available literature that panic disorder can be effectively treated using the CBT interventions of *interoceptive exposure*, *in vivo exposure*, and *cognitive restructuring* (more on these interventions later). That research didn't really address depression, but at least it's a start. So I will use that as my basic platform of treatment. I also know from the literature that *activity scheduling* is an effective treatment for depression. So I will think of ways to incorporate elements of this intervention into my treatment package.

A Good CBTer Uses the Clinic as a Laboratory

As part of this science-based thinking, we *treat every client as an experiment*. That doesn't mean our clients are guinea pigs, nor does it mean we just try whatever comes to mind in hopes that something will work. It's really just an honest way of dealing with reality: There is always an open question as to whether any intervention or combination of interventions will work for any given client. Therefore, we must take a scientifically informed educated guess, test whether our guess is right, and modify the plan as needed.

It is critical, therefore, to take repeated measures of the clients. We need to see, on an ongoing basis, whether they are getting better or not. Self-report is often just fine, and it's usually the most convenient thing we can do, although measurement need not be limited to self-report. For a given client, I could measure *outcomes*, such as symptoms of the disorder, daily functioning, quality of life, or other relevant variables (e.g., the number of drinks consumed per day). I could also measure hypothesized *mechanisms* of the problem—the variables I think influence the outcomes—using measures of emotions or distorted thought patterns, physiological measures (e.g., heart rate during symptom provocation), overt behaviors (e.g., performance-based tests in session), or other relevant variables (e.g., the number of arguments with their spouse).

A Good CBTer Looks beyond the Label

Many of us are accustomed to using the fifth edition, text revision, of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022) in our work. The DSM has its uses. We need diagnoses to get paid for our work, and a diagnosis can often serve as a useful "shorthand" to communicate information about a client. But as a guide for treatment, it leaves much to be desired. You don't treat a diagnosis; you treat a person. The treatment for two people with the same diagnosis might be different, whereas treatment for two people with different diagnoses might be quite similar. And the number of diagnoses in the DSM is so huge that there's no way we could hope to accumulate a decent scientific basis for the treatment of each diagnosis (let alone for combinations of diagnoses).

It's helpful, therefore, to focus less on diagnoses than on *syndromes of psychological problems*. Think of it this way: There are a limited number of syndromes (e.g., "depression," "fear") that may range from mild to severe and that may occur alone or in combination—that is, it's less important to know the name of the problem than it is to understand what's going on. This idea—that syndromes are more important than diagnoses—is consistent with recent moves in CBT toward dimensional, rather than categorical, models of psychopathology (e.g., Insel et al., 2010; Kotov et al., 2017). Some specific syndromes I look for in my own practice (which is generally with clients who have anxiety, depressive, or obsessive–compulsive and related disorders) include:

- *Avoidance*. It's natural to want to avoid situations or stimuli that elicit uncomfortable emotions, such as fear or sadness. However, for many clients, this avoidance becomes excessive, compounding their affective disturbance (e.g., Struijs et al., 2017), and needs to be addressed, perhaps using strategies such as *exposure* (see Chapter 11).

- *Rumination*. Rumination is described as a pattern of repetitive and prolonged thinking about one's self, one's feelings, and upsetting experiences (Watkins, 2008). Rumination exacerbates negative mood states, as well as stress responses (Watkins & Roberts, 2020).

- *Worry*. Worry is another form of repetitive, negative thinking, characterized by repeated thinking about potential negative events (Ruscio, Borkovec, & Ruscio, 2001). Worrying is associated with elevated depression, anxiety, and stress (Olatunji, Broman-Fulks, Bergman, Green, & Zlomke, 2010). In this book we'll address interventions for repetitive negative thinking, such as *cognitive restructuring* (Chapter 14) and *acceptance* (Chapter 15).

- *Insomnia*. Insomnia, defined as difficulty falling or staying asleep, is highly prevalent in the population (e.g., LeBlanc et al., 2009). In addition to its association with several psychiatric disorders, insomnia can have profound negative impacts on quality of life (Suh

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et al., 2014). We'll talk more about interventions for insomnia in this book, particularly in Chapter 8 when we'll talk about *stimulus control*.

To be clear, this is far from an exhaustive list of the syndromes of psychopathology you might see in your practice. It's just a sample from mine. But I want to point out that these syndromes are not limited to specific DSM-5-TR diagnoses. They are transdiagnostic, meaning they cut across diagnoses. So rather than treating "generalized anxiety disorder" as a diagnostic entity, for example, I frame my conceptualization such that I'm treating worry, avoidance, and insomnia.

My general dislike of labels extends to the labels slapped on CBT interventions as well. These days, it seems like everyone has come out with their own brand of CBT, all with different names and treatment manuals. I don't think a good CBTer needs to know every CBT package that has been developed or needs to memorize a treatment manual for everything. If you tried, your head would explode. What is important is that you understand the fundamental *ingredients* of these therapies, and the theoretical rationale behind each of them. You'll find, once you start looking, that the number of actual working ingredients is much smaller than the number of treatment packages out there.

So we have a finite number of interventions for a finite number of syndromes. When we do the necessary conceptualization work, we see that any presenting problem can be broken into component parts, and we have effective core interventions to address those parts. That's how this book is arranged. Of course, for specific presenting problems you might want to look at manualized treatments to get a better sense of how treatment can be implemented. There are a lot of good CBT manuals out there that are worth a look; Appendix A will direct you to some of my favorites. But with the information you learn here, you'll find you can anticipate what's going to be in most CBT manuals before even opening them. Should you opt to use treatment manuals in your practice, having a solid foundation in the principles and practice of CBT will help you use those manuals in a flexible manner, adapting them to meet the needs of your clients.

A Good CBTer Is Willing to Be Wrong

Thomas Huxley (1825–1895) wrote that "the great tragedy of science [is] the slaying of a beautiful hypothesis by an ugly fact." I can come up with a great conceptualization of the client's problem and think I have nailed down perfectly why it is happening . . . and then I learn more about the client, and my conceptualization falls apart. I don't like when that happens, and you probably won't, either. After all, being right feels a lot better. But central to thinking scientifically is a recognition that a lot of your ideas will turn out to be wrong. A good CBTer is open to the possibility of wrongness, even looking for signs of wrongness along the way. We can always modify our ideas as we learn new facts. We run into trouble when we start ignoring the facts that don't conform to our ideas. The tendency to do so is, unfortunately, human nature, and it applies as much to ourselves as to our clients. In Chapter 3 we'll talk about how these kinds of *information-processing biases* come into play in psychological problems.

What Is CBT?

Fundamentally, CBT is a way of *thinking* about psychological problems and their treatment. More than anything, it is an approach to case conceptualization that guides our

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understanding of *why* someone is suffering and *how* we can help them. Here are some elements that make CBT unique:

- As an intervention, CBT tends to be *focused*—that is, we spend most of our time discussing and working on the target problem.

- CBT tends to be *time-limited*, at least compared with many other treatments. Some CBTs are really short (e.g., one-session CBT for specific phobias; Öst, 1989), and some CBTs are quite long (e.g., 2-year CBT for borderline personality; Linehan et al., 2006), but generally speaking, CBT tends not to be a "forever" treatment.

- Unlike some other forms of psychotherapy, CBT, in most cases, is *present oriented*—that is, we spend more time talking about the current situation than about historical events. When we ask the question "Why is this person suffering?," that question could be interpreted as asking about *etiology* ("How did this person begin suffering?") or about *maintenance* ("Why, on a day-to-day basis, does this person continue to suffer?"). We are interested in etiology, but our therapy is most effective when we identify the factors that maintain the problem and then work to change those factors. That's true even when the etiology is really striking. Take, for example, our client Melissa, who has PTSD. Her childhood traumas were really awful and clearly were the initial source of her psychological suffering. And we are indeed interested in that and want to talk to Melissa about that. But ultimately what's going to get her feeling better is addressing the day-to-day factors that cause her suffering to persist.

- CBT tends to be *active*. CBT is about doing things, and the client will have new things to try throughout the course of therapy. In many cases, the therapist does these things right along with the client, sometimes outside of a traditional office setting.

- CBT is *directive*. Unlike some more humanistic and supportive forms of psychotherapy, in CBT the therapist takes a leadership role and helps set an agenda for the therapy and for each session. In many respects, the CBT therapist acts as a coach for the client.

- In keeping with its scientific foundations, CBT emphasizes *measurable gains* and *testable hypotheses*. We set clear goals for our desired outcomes, we take educated guesses about what will work, and then we check in a systematic fashion to see whether it actually did work.

Let me also make a comment about what CBT isn't. Some people have misconceptions about this kind of treatment, so let's get them on the table.

- *CBT as a toolbox, manual, or set of techniques*. There are a lot of unique interventions in CBT, and I've often heard people use a "toolbox" or "clinical armamentarium" analogy (e.g., "Hey, this book is great because it'll give me more tools in my toolbox!"). It is true that the interventions we discuss here are effective, and I have no doubt that they'll be useful for you and your clients. But the toolbox analogy misses the point. Think about the difference between a cook and a chef. A cook can follow a recipe and come up with something delicious. But a chef can actually create the recipe, adapting what they are doing to meet the specific needs of the diner. A good CBTer is a chef, not a cook. Following a published therapy manual is one thing; knowing how to figure out why any given client is suffering and coming up with an interventional strategy that is tailored to that client's individual needs is another thing altogether. The intervention is most helpful if it's applied within the broader theory of why the problem is there.

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- *CBT as a Band-Aid*. First of all, let's not disparage the Band-Aid. It reliably stops bleeding, prevents infection, and promotes rapid healing, all for a few cents, and can be obtained virtually anywhere by anyone. We should be so lucky as to have something that good in mental health! More substantively, when people use this analogy they are implying that CBT does not address the *cause* of the problem, only the *symptoms* of the problem. This is not accurate. CBT does address the cause—the reason *why*—but our conceptualization of the cause—the *why*—is different from those used in other disciplines. We do not chalk psychological problems up to a chemical imbalance, as in pharmacotherapy, nor do we attribute them to unconscious conflicts rooted in early childhood, as in classic psychoanalytical theory (not that such things don't exist; they're just not all that helpful for our purposes). Rather, CBT posits that psychological problems are caused and maintained by a mixture of factors, both internal and external to the person, that include emotions and physiological sensations, thoughts and beliefs, behaviors, information-processing biases, behavioral contingencies, and behavioral skill deficits. Understanding how those factors interact to cause the problem is at the core of developing effective interventions.

- *CBT as a set of techniques independent from relationship*. This is a little bit like the (false) science and art distinction described earlier. There are some who will tell you CBT therapists are all about doing a certain technique and don't care about the relationship. It may be true that early basic research on behavioral interventions left something to be desired, relationship-wise. But when we're talking about modern CBT, technique and relationship are not mutually exclusive (see Figure 1.2). The bottom line here is that the best practitioners apply proper techniques in the context of a positive relationship. In many ways, the therapeutic relationship is central to the CBT. As one example, **collaborative empiricism** forms the basis of the therapeutic relationship, in which the client and therapist collaboratively form and test hypotheses (more on this in Chapter 7). As another example, the therapeutic relationship is used as a vehicle for shaping and reinforcing healthy behaviors in session (see Chapter 9).

I view good CBT as having three basic ingredients: (1) *good therapy*, (2) a *good CBT conceptualization*, and (3) specific *CBT techniques* (see Figure 1.3). All three ingredients are important; good CBT cannot occur unless each is present. Good therapy forms the

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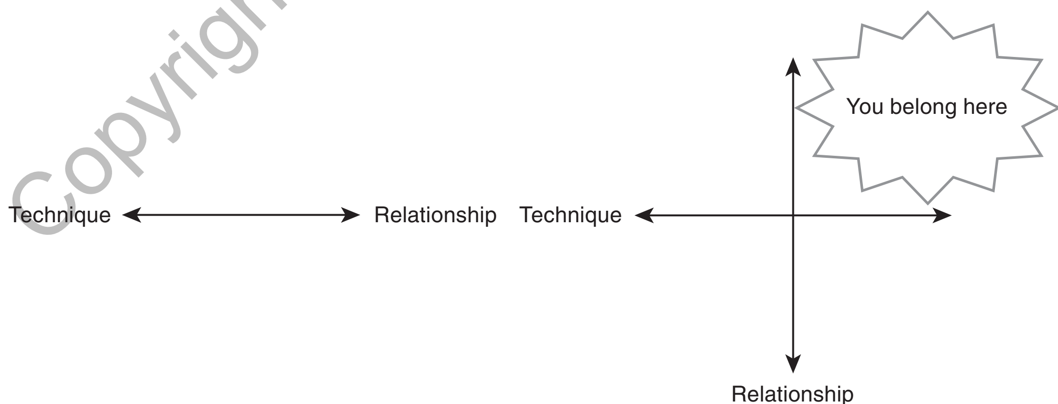

FIGURE 1.2. Technique and relationship in psychotherapy. They are not opposite poles (left). Rather, they are two different constructs (right).

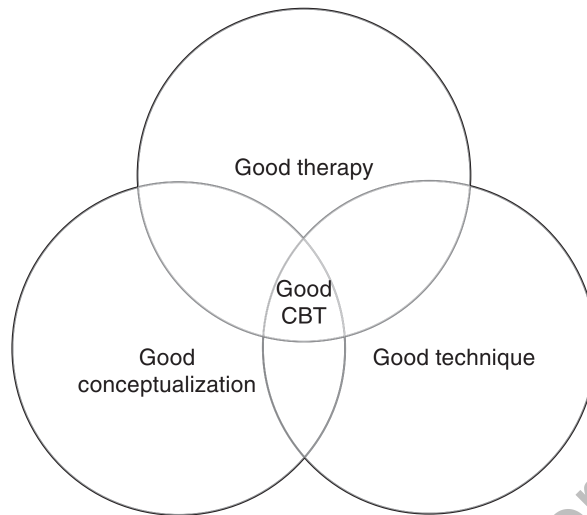

FIGURE 1.3. Elements of good CBT.

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foundation of the CBT. It represents a minimal set of criteria that must be present for therapy to be effective. A good CBT conceptualization is critical. Specifically, the therapist and client need to have a good working model of why the person is suffering. Technique is also critical. Often, if you have developed a good CBT case conceptualization within the context of good therapy, the specific techniques to be used become self-evident.

We'll spend a lot of time talking about the ins and outs of good CBT therapy in Chapter 7. Briefly, however, many of the elements of good therapy are independent of therapeutic orientation (e.g., J. D. Frank, 1974). As just one example, recent data from a large sample of clients seen in private practice demonstrated that a written case formulation, a list of treatment goals, and a plot of symptom scores are all independently associated with improved therapy outcomes (Gates, Hsiao, Zieve, Courry, & Persons, 2021). These are not necessarily limited to CBT, but we emphasize those elements here.

Good therapy means *paying careful attention to the client.* That means we take the time to inquire about the person's symptoms, take a thorough history, learn about what is important to them, and understand their quality of life. It also means we pay close attention to behaviors the client exhibits in session, including how they interact with the therapist.

Good therapy means a *solid clinical relationship*. Carl Rogers (1957) was one of the first people to emphasize relationship factors in psychotherapy, and his ideas are still useful today. He suggested that good therapists display the following behaviors:

- *Empathy.* Good therapists routinely demonstrate, in words and in nonverbal cues, that they care about the clients' well-being and feel compassion for what they are going through.
- *Genuineness.* Good therapists act like themselves. They share, when clinically appropriate, their thoughts, ideas, and emotional reactions.
- *Unconditional positive regard.* Good therapists display a basic liking of their clients. They do not pass judgment or appear critical (though this does not preclude confronting the client when clinically appropriate). They respect the client as a person and believe the client has the right to feel better.

Good therapy means *facilitating positive expectations and hope*. Of course, we should not oversell the benefits of therapy or lead clients to believe we can perform miracles. But if we don't think things will get better, then there's little reason for us to be doing therapy in the first place. So, using the best clinical judgment we have, we convey the message that the client's problem can be improved.

A good CBT conceptualization, which we'll address in detail over the next several chapters, means we develop and share with the client a clear understanding of what is wrong and why. The importance of case conceptualization can't be overstated. In an analysis of 225 recordings of therapy sessions for clients with depression, therapist competence in case conceptualization explained 40% of within-patient variance and 19% of between-patient variance associated with significant and positive change in depression (Easden & Fletcher, 2020). So having a solid case conceptualization, and sharing that conceptualization with your client, matters a lot.

So what do I mean by "competence" in case conceptualization? Persons (2008) addresses this issue in detail, and we'll go over the specifics of our case conceptualization approach in the next few chapters. Briefly, for each of our clients, our conceptualization is grounded in the idea that psychological problems consist of *cognitive* elements, *emotional* elements, and *behavioral* elements (see Table 1.1) and that the problem can be examined (and potentially addressed) by way of each of these elements and the interactions among them. Cognitive elements refer to the person's thoughts, beliefs, interpretations, and information-processing styles, as well as effortful mental strategies the person uses to try to cope. Emotional elements refer to subjective feeling states (e.g., sad, angry, scared) and associated physiological processes and sensations. Behavioral elements refer to the client's overt responses.

So as CBT therapists, we're looking for these elements when we meet with our clients. From the start of therapy, the therapist is constantly asking questions (which we discuss in detail later), such as:

- Under what circumstances does this problem occur?
- What are the *behavioral* elements of the problem (see Chapter 2)?
  - How do external and internal *contingencies* (e.g., reward and punishment) influence this person's behavioral responses?
  - Does this person lack the specific *behavioral skills* needed to adapt successfully to the environment?
  - What are the negative effects of this person's behaviors?

TABLE 1.1. Possible Cognitive, Emotional, and Behavioral Elements of Selected Psychological Problems

	Cognitive	Emotional	Behavioral
Depression	Belief that I am worthless	Sadness, heavy sensation, low energy	Spend excessive time in bed
Mania	Belief that I am all-powerful	Excitement, high energy, decreased need for sleep	Impulsive sex, spending
Panic	Belief that I am dying	Fear, increased heart rate, dizziness	Avoidance, seeking reassurance

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- What are the *cognitive* elements of the problem (see Chapter 3)?
  - To what extent does this person have *interpretations* that are unhelpful?
  - To what extent do this person's *intermediate and core beliefs* shape their thinking in difficult situations?
  - To what extent do *information-processing biases* distort how information is attended to and remembered?
  - To what extent does this person engage in *maladaptive mental coping strategies*?
- What are the *emotional* elements of the problem (see Chapter 4)?
  - What are the subjective feeling states experienced?
  - What physiological sensations are associated with those emotions?
  - To what extent have emotional responses been *classically conditioned* through paired associations?
- How has this person's *learning history* shaped their thoughts, emotions, and behaviors?

Good conceptualizations make use of **Ockham's razor**, also known as the *principle of parsimony*. William of Ockham (c. 1285–1349) said, "One should not increase, beyond what is necessary, the number of entities required to explain anything." In plainer language, Ockham was telling us that we should avoid assumptions that cannot be examined, tested, or falsified, especially if our conceptualization works fine without them. So as we try to understand why a client is suffering, we'll be most effective if we start with the simplest and most straightforward explanation, trying our best to avoid making assumptions about unconscious processes that we'll never be able to evaluate. I'm talking to you, Freud.

Our conceptualization also hinges on the idea that the emotional, cognitive, and behavioral elements of psychological problems can mutually influence each other. An example of this interaction for our client Anna, who has panic disorder, is shown in Figure 1.4. As you can see, when she's feeling panicky, Anna has an *emotional response* (increased heart rate and a subjective feeling state of fear), a *cognitive response* (the thought "I'm dying!"), and a *behavioral response* (avoidance and seeking reassurance from others). These three elements—cognitive, emotional, and behavioral—all fuel each other, causing the entire process to get worse and worse. The reciprocal escalation of these factors forms what I call the **core pathological process**. It's a snowball effect, such that as one element gets worse, the others get worse, too. Fortunately, this can also work the other way—which is what we strive to do in therapy (see Figure 1.5). In this case, Anna's decrease in physiological sensations (slower heart rate and less dizziness), decreased belief that she is dying, and decreased avoidance and reassurance-seeking behavior all deescalate each other, causing the entire process to get better and better. We can push the snowball in a healthy direction.

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What Does a CBT Session Look Like?

As you might guess, there's no formula set in stone, and so one CBT session may not look much like another. However, in many CBT sessions you're likely to see several elements, including the following:

- The therapist actively listens to the client, expressing empathy, genuineness, and unconditional positive regard.
- The therapist collaboratively sets an agenda for the session with the client.
- The therapist reviews the events since the past session, with particular emphasis on any homework the client was to complete.

- The therapist makes liberal use of praise, congratulating the client on their efforts to get better or on behaviors in the session that signal improvement.
- The therapist and client discuss an aspect or instance of the problem by breaking it down into cognitive, emotional, and behavioral features.
- The therapist uses psychoeducation to help the client better understand the problem and why it is occurring.
- The therapist and client work together on a strategy or exercise that aims to help improve the problem.

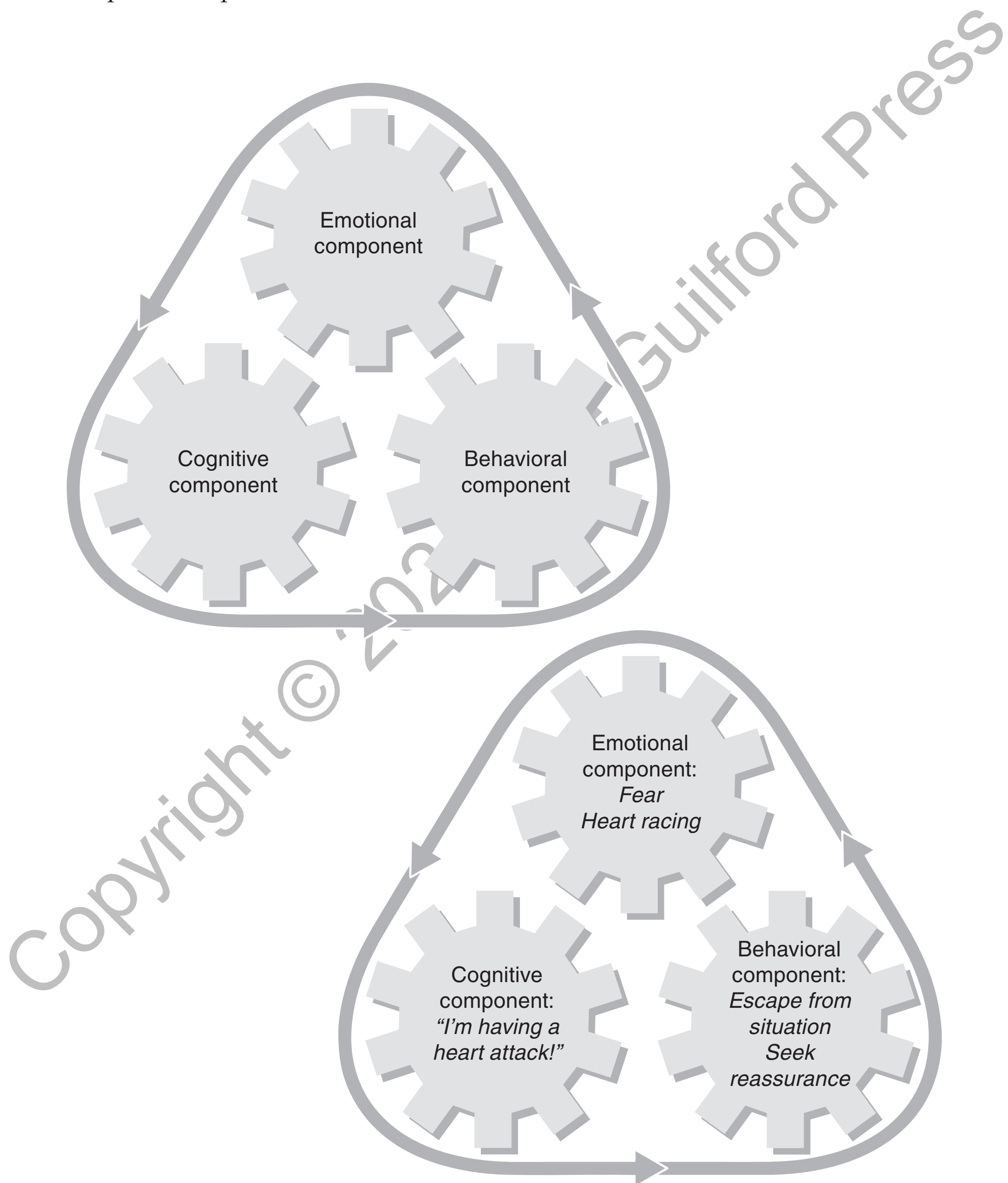

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FIGURE 1.4. Reciprocal influence of cognitive, physiological, and behavioral elements of the core pathological process, in general (top) and for Anna, our client with panic disorder (bottom).

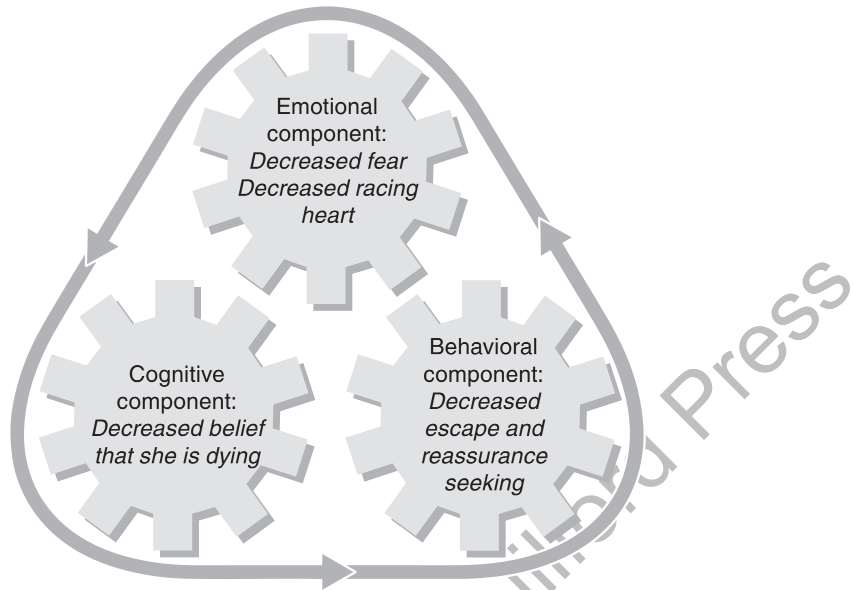

FIGURE 1.5. Reciprocal influence of cognitive, emotional, and behavioral elements during Anna's recovery from panic disorder.

- The therapist takes time to ensure that the client understands and agrees with the conceptualization and interventions.
- The therapist assigns homework for the client to continue to work on the problem until the next session.

What Does CBT Look Like over Time and across Sessions?

The course of therapy will necessarily vary from client to client. However, one fairly typical progression might proceed as follows:

- The therapist assesses the client, gaining an understanding of the target problem(s).
- The therapist collaborates with the client to develop a cognitive-behavioral conceptualization (see Chapter 5) of the problem(s).
- The therapist and client agree on the goals of therapy, stated as explicitly as possible. They also agree on general principles such as the duration and frequency of treatment, expectations of the therapist and the client, time frame for reassessment and reevaluation of the plan, and so forth.
- The therapist works with the client on ways to improve the problem(s) effectively and efficiently. Depending on the problem(s) and the client characteristics, initial steps might involve directed behavioral change, skill training, cognitive restructuring, acceptance, emotion regulation, or other strategies.
- The therapist and client routinely track progress and modify the treatment plan as needed. They openly discuss how the treatment is going, and whether changes need to be made.

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- As therapy progresses, the discussion might turn to broader issues such as *intermediate* or *core beliefs* (see Chapter 3) or long-standing maladaptive behavioral patterns.
- As the client nears their treatment goal, the therapist and client begin to discuss termination and relapse prevention.
- When it is agreed that the goals have been met and no additional treatment is needed, the treatment ends with the understanding that the client may initiate treatment again if needed in the future.

Tailoring CBT to the Individual

It's critical to emphasize that no CBT protocol should be treated as a "one-size-fits-all" strategy. You can use a diagnosis-specific treatment manual, and that might be fine, but many authors have pointed out significant limitations of that approach.

The diagnosis-specific, manualized approach to CBT is based largely on randomized controlled trials (RCTs) in which CBT was tested in a specific client population against a control condition. The use of RCTs is a vital part of the scientific process, and helps us feel confident that the treatments we're using actually work. However, it can sometimes be difficult to translate the results of RCTs to your clients. Whereas RCTs often exclude patients with certain "comorbid" psychiatric conditions (Westen & Morrison, 2001), clinical clients frequently meet DSM criteria for multiple disorders, or subdiagnostic symptoms of multiple disorders, making it difficult to isolate a single diagnosis (Goldfried & Eubanks-Carter, 2004; Wachtel, 2010; Westen, Novotny, & Thompson-Brenner, 2004). In addition to the presenting diagnoses for which empirically supported treatments (ESTs) have been developed, many clients in clinical settings also present with problematic personality characteristics, chaotic life situations and interpersonal difficulties, and the extant list of RCTs provides little guidance for such complex clients (Fensterheim & Raw, 1996; Westen et al., 2004). That doesn't mean we should ignore the RCTs. But it does suggest we need to be able to think flexibly and always rely on our individualized care formulation.

Similarly, many of our clients have diverse backgrounds that are not well captured by the existing RCTs. In particular, we see clients from minoritized backgrounds, such as racial, ethnic, and cultural minorities, sexual and gender minorities, and more. Fortunately, a recent review of meta-analyses (Cougle & Grubaugh, 2022) suggested that clients from racial and ethnic minority backgrounds fare as well in psychosocial treatment as do majority clients; however, these authors point out that there are still significant gaps in our understanding of how best to treat clients from diverse backgrounds—for example, how to manage premature dropout, which might be elevated in clients from racial and ethnic minority backgrounds (A. A. Cooper & Conklin, 2015), or how to deal with "real-world" barriers to treatment and comorbidity. Research into the efficacy and effectiveness of CBT for sexual- and gender-minority clients is still in its infancy (Pachankis, 2018). In Chapter 7 we'll talk more about potential adaptations of CBT for minoritized clients.

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Learning CBT by Applying It to Yourself

As you go through this book, you might find it helpful to try out some of our concepts and interventions on yourself. As a learning exercise, I invite you to select a *personal target* you'd like to work on. Ideally, your personal target would be an analogue (perhaps subclinical) of something for which people might seek treatment. A fear of spiders or public

speaking, moodiness, irritability or crankiness, difficulty getting along with someone, overuse of caffeine or nicotine, perfectionism, nail biting, and overeating are all fairly common concerns that have some overlap with more severe clinical problems.

After many of these chapters, I'll encourage you to try out what we've been discussing on your personal target. Try to understand why the target is there, based on the principles in the chapter, and try various interventions to get a feel for how to implement them and how they work for you.

KEY TERMS AND DEFINITIONS

Case formulation approach: A hypothesis-testing approach to clinical assessment, formulation, and intervention.

Collaborative empiricism: An approach to the therapeutic relationship in which the therapist and client act as partners, forming and testing hypotheses about the causes of the problem and how to address it.

Core pathological process: An interaction of cognitive, emotional, and behavioral responses that become maladaptive or unhelpful.

Evidence-based practice: A treatment approach based on scientific evidence, filtered through clinical expertise and client characteristics.

Ockham's razor: The idea that simpler explanations are preferred over more complex ones, as long as they can explain the phenomenon adequately.

QUESTIONS FOR FURTHER DISCUSSION

1. What do you think about applying scientific principles to psychotherapy? Is this a good idea? A bad idea? What are the pros and cons of such an approach?
2. What preexisting assumptions do you have about CBT? What have you heard about it? Do you subscribe to any of the beliefs described above (e.g., that it is a set of techniques, that it is a Band-Aid, or that it ignores the therapeutic relationship)?

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