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The Process of Cognitive-Behavioral Therapy

The process of becoming a therapist can be daunting. Clients who are suffering with emotional and behavioral problems entrust their therapists with their deepest thoughts and feelings and perhaps share experiences with us that they have never shared with anyone else. They place hope in us that we will be able to fix what ails them. This is a great responsibility.

Given that psychotherapy is a human interaction, we must remember that our clients come into this situation with beliefs they held long before their interactions with us. Perhaps they had negative experiences with other therapists. Maybe they grew up with highly critical parents. Years of failure at school and work might have led them to believe that they can never succeed, even with great effort. We must accept our clients as they walk in the door. Whatever they bring with them becomes part of our work together.

Engaging in psychotherapy means being faced with emotions all day. Over the course of a typical day, a therapist might sit with anger, sadness, intense anxiety, or even steely silence that is hard to attach to any one emotion. We must learn how to react effectively to our clients' emotional states and how to leave work at the end of the day in a comfortable emotional place, rather than carrying the burden of our clients into our lives outside of work.

Moreover, being a therapist involves exposure to all sorts of different behaviors. Every day, we meet clients who engage in dysfunctional

behaviors like smoking, drinking, binge eating, and gambling. We encounter clients who fail to engage in the behaviors that might improve their lives—for example, a depressed client who stays in bed all day rather than getting up and doing things that might help him or her feel better. We see clients who miss out on participating in their lives because of fear and avoidance. It can also be challenging to regularly meet people who hold views we might personally disagree with (e.g., supporting a political view we find repugnant) or who engage in behaviors that we find morally wrong (e.g., shoplifting, child neglect). In our personal lives, we might choose to distance ourselves from such people, but in our professional lives, this might all be in a day's work. The range of behaviors that presents in our offices can seem overwhelming. We might wonder how we can even begin to help every person who walks through the door.

In this chapter, we discuss how you can gain confidence as a clinician. But, first, we offer a useful metaphor for the therapy process—going on a journey.

THERAPY AS A JOURNEY

Many people love to travel. Some people are "fly-by-the-seat of their pants" kinds of travelers, but more often than not people like to make a plan before leaving on a journey. After all, time and resources are limited when we travel, and we like to make the most of it!

Perhaps we begin planning a trip by choosing a general location. We can reach this decision based on who is going on the trip, what the weather is at the time of year we are traveling, consideration of cost, how much time we have, and so forth. Once a general location is selected, it can be helpful to print out a map of that area and trace a route from place to place that might end up on the itinerary.

It often makes sense to consider the beginning, middle, and end of a trip. On the first few days of a trip, we can get acquainted with the place we're visiting—maybe by walking around or taking a bus tour to get a sense of what would be interesting to see. The middle of the trip can be exciting—maybe a really long, strenuous hike in a national park, seeing and hearing an amazing concert, or having a meal at a special restaurant. And it's always nice to leave a day or two at the end of the trip to pack up your belongings and get things in order before heading back to "real" life.

The process of *treatment planning* in cognitive-behavioral therapy

(CBT) is like making an itinerary for our trip. This itinerary leads us from the beginning of our trip to its end—and spells out all the points in between. As with a trip, therapy ideally begins with an acquaintance period. Therapist and client get to know each other, learn about the style of therapy and the presenting problem together, and discuss particular therapeutic strategies that may be employed both during and between sessions. The "exciting" part of the voyage involves all the tools of CBT—cognitive work, exposures, relaxation exercises, mindfulness techniques, and so forth—all carefully selected to get the client to an end point, some agreed-upon goal. Along the way, we might face challenges. When we travel, we might get a flat tire, someone might get ill, or a long-awaited attraction or destination might be closed for renovation or other unforeseen reason. In therapy, we might encounter clients who are resistant to change, clients who lead chaotic lives, or we—as therapists—might bring our own issues into the interpersonal relationship that make the process less than ideal. All these challenges must be effectively worked through so that the client can attain his or her goals in some reasonable time frame.

In the same way that it can be nice to enjoy a calm ending to a trip, therapy also should not finish abruptly. There is a way to conclude, to consider gains, and to ensure that these gains are maintained into the future. In other words, before hopping on a plane back to "real life," we want to ensure that our clients have packed their souvenirs (CBT strategies) in their luggage. Throughout this book, we discuss how to travel the path of CBT successfully with our clients.

It is essential to note that mapping out a plan in advance of a trip does not mean we cannot deviate from it. Maybe the hotel that looked great online turned out to be a dump. Perhaps a place where we planned to spend 2 days was so wonderful that we decided to spend 5 days there instead. Or, maybe we met a local fellow in a far-off place who took us on an adventure we could never have planned with our tour books back home. The *case conceptualization* is just like our trip itinerary. We set our itinerary before we leave home, but we always need to allow room for adjustments. In CBT, we create a case conceptualization that helps us to understand the client, his or her problems, and how we will resolve them at the beginning of the therapeutic relationship. But this conceptualization cannot be static. We must constantly examine whether it needs to be adjusted to best serve our client's needs. Throughout this book, we also show you how to formulate and revise a case conceptualization so that our voyage together is rewarding and effective.

UNDERSTANDING THE THEORY BEHIND CBT

It is beyond the scope of this book to provide you with an in-depth understanding of the theoretical assumptions that guide CBT case conceptualization and practice. Instead, we briefly offer some insights into its theoretical underpinnings. A clear understanding of this theory is essential while reading this book for two reasons. First, the book discusses the *process* of doing CBT. Understanding the theory behind CBT helps therapists to see what maintains problematic beliefs and behaviors, and what methods may be used to help clients change their lives. Second, this book moves *beyond technique* and uses CBT strategies to help therapists overcome difficulties that they might encounter in their day-to-day work with clients. The beauty of CBT is that we can use the theory and techniques to help ourselves as well as our clients.

CBT is an integration of two originally separate theoretical approaches to understanding and treating psychological disorders: the behavioral approach and the cognitive approach. The behavioral approach (at its strictest) focuses exclusively on observable, measurable behavior and ignores all mental events. It views the mind–brain as a "black box" that is not easily known and, therefore, not a suitable focus of attempts at therapeutic change. It focuses instead on the interactions of environment and behavior. The cognitive approach focuses on the role of mind and specifically on cognitions as determinants of feelings and behaviors.

The Behavioral Approach

John B. Watson (1913), often considered to be the "father of behaviorism," saw all behavior, and all behavior change, as a function of learning via *classical conditioning*. He posited that even complex behaviors could be broken down into component behaviors that had all been acquired through simple learning processes. There are four key elements of classical conditioning: (1) the unconditioned stimulus, (2) the unconditioned response, (3) the conditioned stimulus, and (4) the conditioned response. The "unconditioned stimulus" is any stimulus that is capable of producing a particular reflexive response. An example of an unconditioned stimulus is food—it naturally elicits salivation, an unconditioned response. The "conditioned stimulus" is one that is neutral prior to being paired with an unconditioned stimulus. For example, when a baby is shown a green light, he has no particular response to it (beyond looking at it). However, if the baby is repeatedly presented with the

green light immediately before his mother begins to feed him, he would eventually start to salivate in response to the green light alone. Salivation has now become a conditioned response—with repeated pairings, the conditioned stimulus (the green light) now elicits the same response, more or less (salivation), that occurred with the unconditioned stimulus alone (food). Watson believed that all learning (and thus all behavior change) occurred through these types of simple stimulus–response pairings.

Here are some more examples that clearly show classical conditioning at work in the kinds of problematic behavior that CBT therapists are interested in. Watson and his colleague (and later, wife) Rosalie Rayner Watson (see Watson & Watson, 1921) did a famous experiment with a little boy named Albert. Albert had never seen a white rat, and thus he had no learned response to it. In other words, the white rat was a "neutral stimulus" for Albert. Watson and Rayner showed Albert the rat, at the same time pairing it with a loud noise (unconditioned stimulus). The noise was known to elicit a startle or fear response (unconditioned response) in Albert. With just seven pairings of the white rat and the loud noise, Albert came to exhibit a fear response (conditioned response) to the rat alone (conditioned stimulus). Albert had "learned" to fear the rat. In fact, Albert came to fear many white, furry objects, including rabbits and a mask of Santa Claus. In behavioral terms, Albert's fear "generalized" to other white, furry objects. Another study, referred to as the case of Little Peter (Jones, 1924), demonstrated how fears could also be "unlearned." A young boy named Peter who was afraid of rabbits (the origin of his fear was not known) was exposed to a rabbit in its cage for many days while he was eating lunch. Peter gradually lost his fear of the rabbit, leading the experimenters to assume that Peter developed a new association between rabbits and the pleasure of eating lunch, rather than between rabbits and fear. These early experiments in learning and unlearning are important to our current understanding of how people acquire fears and how we can then help to extinguish these fears.

B. F. Skinner (1976) was another key figure in the rise of behaviorism. Skinner's theories of conditioning were more sophisticated than Watson's; they focused on *operant* rather than classical conditioning. In operant conditioning, stimuli are not thought of as eliciting responses. Instead, as organisms interact with their environments, they emit all sorts of responses (called operants); when the organism is rewarded for a particular response, the response is more likely to occur again; in behavioral terms, it has been "reinforced." Let's look at an example of operant conditioning at work in the kinds of problem we see as clinicians.

Consider a child who cries before school and is then permitted by his mother to stay home from school. He greatly enjoys his day at home, spending time alone with his mom (whom he usually has to share with his siblings), watching TV, and playing video games. This child is likely to continue crying each morning since he has learned that this behavior yields a desired consequence. If the mother then reads in a parenting magazine that she should make her child go to school regardless of his crying, the crying behavior will eventually be extinguished since the child will learn that crying no longer yields the desired outcome. In other words, he will unlearn the association between crying and being permitted to stay home from school.

The purely behavioral approach does apply to some of the problems that we see as cognitive-behavioral therapists. However, simple stimulus–response associations cannot explain all learned behaviors. As the complexity of behavioral phenomena increases, we require more complex explanations for behaviors. Knowing what people are thinking and feeling is also important to understanding their behavior.

The Cognitive Approach

The cognitive approach most clearly deviates from the strictly behavioral approach when contrasted to the staunch behaviorists' "black-box" view of the mind. The cognitive model is interested in the mind. Specifically, thoughts are considered important because they serve as intervening variables between stimuli and our responses to them.

The cognitive model, and the therapy associated with it, is most closely associated with Aaron T. Beck (1979; see also Beck, Rush, Shaw, & Emery, 1979). Beck developed cognitive therapy in the early 1960s as a treatment for depression, but it has since been applied to virtually every psychiatric disorder, as well as to general "problems of daily living." Cognitive therapy is based on the cognitive model, which proposes that distorted or dysfunctional thinking underlies all psychological disturbances. Furthermore, dysfunctional thinking has an important effect on our emotions and behavior. The key concept of the cognitive model, which dates back to the writings of the ancient Greeks, is that *it is not events themselves that affect our behavior, but rather how we perceive events* (see J. S. Beck, 2011, p. 31).

The cognitive model starts with a situation or event. Consider this situation: Emily makes plans to meet a friend for a movie at 7:00 P.M. It is now 7:30; Emily's friend has not arrived and the movie is about to begin. At this point, Emily experiences *automatic thoughts*. These are "quick, evaluative thoughts [that are] not the result of deliberation or reasoning"

(J. S. Beck, 2011, p. 31). Beck points out that automatic thoughts can be so quick that we might not even be aware of them. Rather, we might only notice the emotions or behaviors that follow from them.

When Emily's friend does not arrive for the movie, her automatic thoughts are as follows: "She must have had a car accident" and "Something terrible has happened." Emily also has images of her friend in a totaled car in the middle of the freeway.

This interpretation of the initial event (her friend being late for the movie) leads to several reactions. Emily feels terribly anxious and worried (emotional reaction). She begins to repeatedly text her friend (behavioral reaction). When she does not get a text back, she notices her heart racing and her hands sweating (physiological reaction).

Another person might have a different reaction. José's automatic thoughts in the same situation are "She doesn't like me" and "She's out with other friends instead." These thoughts lead to sadness and anger (emotional reaction), and José goes home alone and drinks far too much (behavioral reaction). Taylor, also in the same situation, assumes her friend just forgot to meet her, as she has often done in the past. This might leave Taylor feeling annoyed (emotional reaction), and she might then decide to head into the theater on her own (behavioral reaction). Kevin might think that maybe *he* got the time or date wrong ("I'm so stupid"; *automatic thought*). This would leave him feeling rather sad (emotional reaction), and he might head to the store on his way home to buy the appointment book that he has been meaning to get for weeks (behavioral reaction). A single situation can elicit various emotional, behavioral, and physiological responses, depending on how the person *perceives* the situation. This is really the crux of the cognitive model.

Why do people experience such different automatic thoughts in the same situation? Taking a step further back from automatic thoughts, the cognitive model further posits that our core beliefs play an important role. These beliefs about oneself, other people, and the world develop during childhood based on the experiences that we have as we are growing up. Core beliefs are "understandings so fundamental and deep that . . . the person regards these ideas as absolute truths, just the way things 'are'" (J. S. Beck, 2011, p. 32). Core beliefs are global and apply to situations in general. This is in contrast to automatic thoughts, which are described as "the actual words or images that go through a person's mind" (J. S. Beck, 2011, p. 34) and which are situation-specific. In between core beliefs and automatic thoughts are intermediate beliefs, which consist of "attitudes, rules and assumptions" (J. S. Beck, 2011, p. 35). Let's return to our example of Emily to illustrate these concepts. It is certainly possible that Emily holds a core belief that "I'm an unlucky

person." In between this core belief and her automatic thought ("My friend was in an accident"), Emily might hold a variety of intermediate beliefs, including "Bad things will happen to people I am close to" and "The world is full of danger."

The cognitive model posits that when people find themselves in situations, automatic thoughts are activated that are directly influenced by their core beliefs and their intermediate beliefs. Automatic thoughts then influence our reactions. Because our most fundamental beliefs impact our thoughts in any given situation, different people have very different reactions to the same situations. Figure 1.1 illustrates the cognitive model and Figure 1.2 shows a cognitive conceptualization based on Emily.

How Does the Cognitive Model Inform Treatment?

So, how does CBT work? We discuss the workings of CBT throughout this book, but, on the most basic level, techniques that fall under the umbrella of CBT work to change parts of this chain of events from situation to interpretation (automatic thoughts) to reaction. As illustrated in Figure 1.3, CBT involves both cognitive and behavioral treatment tools. It would be overly simplistic, though, to think that cognitive techniques only target cognitions and behavioral techniques only target behaviors. As Figure 1.3 shows, change in one of these systems undoubtedly results in change in the other system.

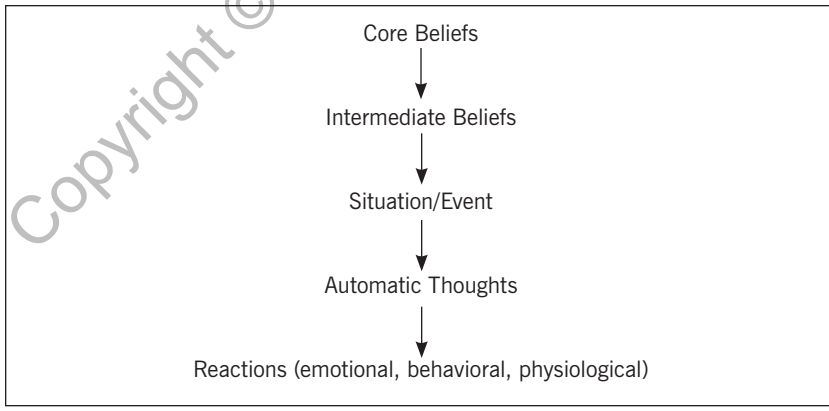

FIGURE 1.1. The cognitive model. Adapted from J. S. Beck (2011, p. 36). Copyright © 2011 Judith S. Beck. Adapted with permission from The Guilford Press.

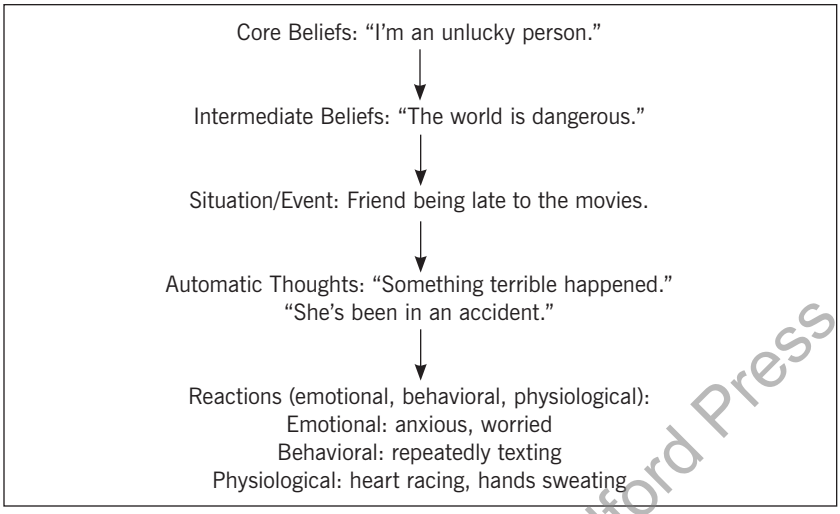

FIGURE 1.2. The cognitive model as applied to Emily. Adapted from J. S. Beck (2011, p. 37). Copyright © 2011 Judith S. Beck. Adapted with permission from The Guilford Press.

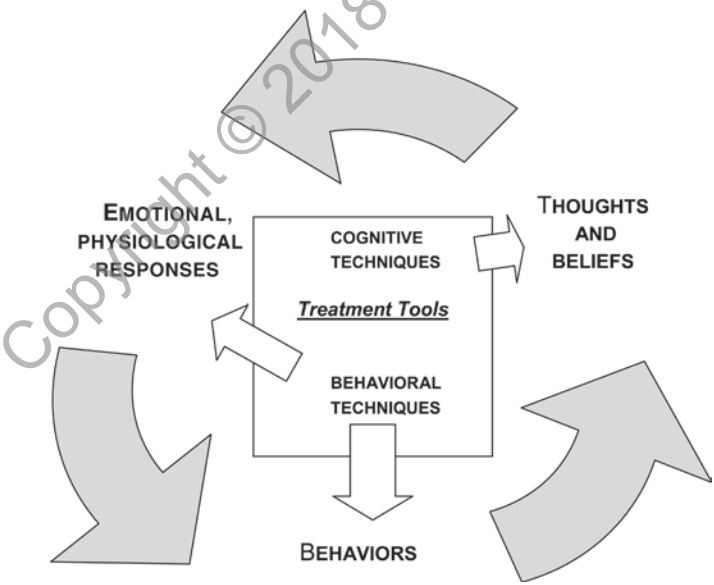

FIGURE 1.3. Basic model for cognitive-behavioral case conceptualization.

Let's consider first how this applies to cognitive techniques. Our primary cognitive tool is cognitive restructuring, which involves identifying and reframing maladaptive thoughts. Rather than treating automatic thoughts as "truths," cognitive restructuring involves questioning our thoughts and reframing them if they are irrational, inflexible, or otherwise unhelpful. Let's return to Emily, but imagine that this same scenario plays out when Emily is just starting CBT. Early in treatment, Emily might still experience the same automatic thoughts in response to her friend being late—"Something terrible has happened" and "She's been in a terrible accident." However, given her newfound CBT skills, she is now able to question these thoughts. Emily asks herself, "Do I know for certain that something bad happened?" and "Is there another way of looking at this situation?" By responding to these key questions, Emily quickly realizes that she has jumped to conclusions and that it is unlikely that her friend is seriously injured. Furthermore, Emily recognizes that there are all sorts of possible reasons why her friend has not arrived yet—she might be running late, might have gotten lost, might have had something come up at work, and might have also forgotten to turn her cell phone on. These realizations may lead to a very different behavioral response. Emily decides to text her friend, saying she is going to go in and see the movie and telling her friend to either come in and meet her if she is running late or text later to let her know what happened. This is a very different behavioral outcome than standing outside the movie theater, repeatedly texting her friend. Emily is also likely to have different emotional and physiological reactions. As she settles in to the theater and begins to enjoy the movie, she will likely feel calm and relaxed rather than terribly anxious.

What did Emily learn from using the skills she had been taught in her first few sessions of CBT? Her most important lesson was that a single situation has many possible interpretations. She also learned that there are various ways to react to a single situation. She learned that texting her friend in a panic would not have been of any benefit (to her, or to her friend!), and she learned that going to see the movie turned out to be pleasant and had no negative consequences (e.g., her fear of being unavailable to a friend in need was not realized). The act of cognitive restructuring positively affected Emily's beliefs (as we would expect), her behavioral responses, and her emotional and physiological responses to a potentially stressful situation.

How does this reciprocal relationship apply to behavioral techniques? There are many behavioral tools under the umbrella of CBT, such as *in vivo* exposure, social skills training, relaxation training, and

structured problem solving. However, a commonality of all these tools, as with cognitive restructuring, is that they are based in learning theory and involve unlearning old, maladaptive associations between stimuli and our responses while also learning new ones. *In vivo* exposure, for example, involves helping people to confront harmless stimuli that cause them to feel anxious. The purpose of repeated exposure to such triggers is to help the client to learn that his or her fears are unfounded, or at least exaggerated. Take, for example, Stan, a man with a terrible phobia of snakes. For as long as he could remember, Stan was terrified of all snake-related stimuli (e.g., pictures of snakes, snakes in movies). He recently purchased a house and relished the idea of gardening. However, he soon learned that his garden contained small garden-variety snakes. The few times that he saw one, he had terribly frightening thoughts (e.g., "It's going to bite me"; "I'm going to die from its venom"; "I can't cope with this"). These thoughts led him to feel very anxious (emotional reaction) and experience a racing heart and profuse sweating (physiological reactions). Each time he saw one of these tiny snakes in his garden, he ran away and would not come outside until someone could come over to his house and confirm that the snake was no longer in the garden, sometimes days later (behavioral response). His garden soon became overgrown from neglect, and the neighbors started to complain. Furthermore, Stan was missing out on the fun experience of gardening.

Stan decided to get some treatment and chose to see a behavior therapist. Treatment involved repeated exposure, first to snake-related stimuli, and gradually to real snakes. With repeated exposure, Stan slowly came to exhibit a neutral response to snakes and, later, was able to return to gardening. On the rare occasions that Stan did see a snake in his garden, he simply noticed it and moved on with his task, rather than reacting with fear and terror.

It seems as if Stan's treatment was purely behavioral—with repeated exposure, he set up a new stimulus–response association. Yet, how did this new association become established? It certainly seems that Stan developed some new *beliefs* about snakes. As he learned more about them through exposure, he learned that most snakes where he lived do not bite and are not poisonous. He learned that snakes do not feel slimy (as he predicted before his first exposure), but that they are actually dry, smooth, and quite nice to touch. And he also learned that it could be enjoyable and interesting to watch snakes move through various habitats and engage in their natural behaviors, like eating and burrowing under the sand. These learning experiences led to an extinction of one stimulus–response pairing (snakes–fear) and the formation of a new

stimulus–response pairing (snakes–interest). This new association led to a shift in beliefs ("Snakes aren't scary") and a shift in behavior (e.g., gardening, spending more time outside), even though treatment—on the surface—appeared to be focused simply on "behavior."

GETTING READY TO DO THERAPY

Now that we have introduced the theory underlying CBT, let's return to our trip metaphor. When we go on a trip, it is ideal to do some preparation before we depart. It can be interesting to read about the history of a place, sleuth out the best sights and restaurants, and talk to friends who have been there. Beginning therapists must also prepare before seeing their first clients. Following a cognitive-behavioral model, the "Getting Ready" section of this chapter is divided into two parts: "Managing Our Thoughts" and "Engaging in Helpful Behaviors." Beginning clinicians have many beliefs about their ability to do therapy, and managing these beliefs is perhaps the first step to getting into the room with a client.

Managing Our Thoughts

We asked a group of beginning therapists to reflect back on the first client they had seen. What did they remember thinking and feeling? What were their worries and concerns? We noted a number of common themes. We have tried to articulate these themes as typical automatic thoughts, using the downward-arrow technique (see J. S. Beck, 2011, pp. 206–207), to get at the beliefs underlying these thoughts. We discuss ways for beginning therapists to counter them, using CBT techniques.

1. *I don't know what I'm doing.* → *The client will find out.* → *He/she will drop out/ask for another therapist/won't get better.* Many beginning clinicians mentioned experiencing "the imposter syndrome"—feeling concerned that the client would find out he or she was their "first" client and, related to this worry, that the clinician really had no idea what he or she was doing. Underlying this notion is the belief that, without "boots on the ground" experience, we are *incompetent*.

In cognitive therapy, we can probe for a deeper thought by asking "So what?" or "What would this mean for you?" or "What would the consequence of this be?" If the client did know you were a new, inexperienced therapist, what then would happen?

Our novice therapists expressed worries that their clients would

drop out of therapy or request a different (older, better, more experienced) therapist. Presumably, this would reflect badly on the trainee and also deprive the trainee of getting the experiences he or she would need to become a better therapist. Perhaps most importantly, an incompetent therapist would simply not be able to help the client get better.

One way to address these assumptions is to turn to the data. Research examining the relation between clinician experience and therapy outcome is surprisingly inconsistent—even within single data sets (e.g., Huppert et al., 2001). Some studies have found a positive correlation between experience and outcome (e.g., Crits-Christoph et al., 1991; Driscoll et al., 2003; Smith & Glass, 1977), which is what beginning clinicians and their supervisors generally expect, but in general these correlations have been modest. It is possible that therapist experience really matters with complex cases but that it does not influence the outcome of more straightforward cases (see Beutler, Bongar, & Shurkin, 1998). Other studies have found clinician experience to be unrelated to treatment outcome (e.g., Shapiro & Shapiro, 1982) or to therapy dropout rates (Wierzbicki & Pekarik, 1993). Interestingly, there is actually little evidence that age or similarity of therapist and client attributes contributes to treatment outcome (Beutler et al., 2004).

In light of these findings, beginning clinicians can be open to the possibility that their lack of experience will not negatively affect their clients. In reality, most clients who work with therapist trainees see benefits in this arrangement. Trainees tend to be attentive and committed to helping. Many clients who work with trainees cannot afford therapy with more experienced clinicians. They are often grateful to receive the help they are getting.

So, if therapist experience does not affect outcome, then what does? Another body of literature from which novice therapists can draw when faced with self-doubt focuses on the therapeutic alliance. Many individuals choose to become therapists at least in part because they naturally possess the qualities that Carl Rogers (1957) identified as being essential to the effective clinician. These qualities are *empathy* (the ability to see clients' worlds from their point of view), *genuineness* (allowing what we say and how we behave to be congruent with what we think and feel), and *nonpossessive* warmth (caring for clients, treating them with respect). Rogers also encouraged a stance of *unconditional positive regard,* in which clients are accepted and valued for who they are. This idea of unconditional positive regard fits well with the stance of CBT clinicians, who typically do not blame clients for their symptoms. Symptoms are thought to be maintained via cognitive and behavioral pathways, not

by laziness, lack of motivation, or weakness. Taken together, these Rogerian qualities have been found quite reliably to be associated with positive treatment outcomes in many forms of therapy, including CBT (see review by Keijsers, Schaap, & Hoogduin, 2000).

According to Hardy, Cahill, and Barkham (2007), "a good relationship between client and therapist is, at the very least, considered to be the base from which all therapeutic work takes place" (p. 24). In fact, across diverse therapy approaches, a significant relationship has been found between the quality of the therapeutic relationship and treatment outcome (Lambert & Bergin, 1994), particularly when the quality of the therapeutic relationship is based on ratings made by the client rather than by the therapist him- or herself or independent raters (see Hardy et al., 2007). Interestingly, the relationship between the therapeutic alliance and treatment outcome tends to be stronger than the relationship between specific therapy techniques and treatment outcome (Hardy et al., 2007). Norcross (2002) estimated that the therapeutic relationship accounts for approximately 30% of change in psychotherapy. Martin, Garske, and Davis (2000) conducted a comprehensive meta-analysis of the relationship of the therapeutic alliance to therapy outcome and found that the average weighted correlation between alliance and outcome was $r = .22$.

Unfortunately, when beginning clinicians focus too much on how they are coming across to their clients, their empathy, warmth, and genuineness can get lost. To ameliorate this problem, beginning clinicians should make every effort to focus their attention outward toward the client. Pay attention to what the client is saying and how the client is reacting to what you are saying. As you focus attention on the client and his or her difficulties rather than on yourself, it is likely that he or she will feel more comfortable, supported, and understood.

2. *There is so much to teach in CBT.* → *I will leave important stuff out/make mistakes.* → *The client won't do well.* Many novice clinicians expressed worry about getting through all the psychoeducational material at the beginning of most CBT treatment manuals. They believed they had to cover every last bit of material, perfectly, without boring the client. They often felt guilty about talking too much and not letting the client talk. One beginning clinician expressed the belief that he or she was "pushing an agenda" and had to communicate it "just so" in order for CBT to "work."

There is undoubtedly a bit of a conflict operating here. In many training programs, trainees are evaluated on how closely they adhere to manuals (e.g., a supervisor might note that point 5 on page 23 was

forgotten!). For the purposes of training (or if one is serving as a therapist in a randomized controlled trial), it might be important to get all the information across in a specific way. This can make it hard to focus on the client and how he or she is reacting to the material. As clinicians become more comfortable with the CBT model, they will develop their own style for communicating the essentials of CBT to their clients. The process will become more interactive and more relevant to each individual client. As we gain confidence, this will shine through in our interactions. Time is a really great teacher in this regard!

The bottom line is that there is key material we must communicate to our clients—but the importance of a lot of the accompanying detail has not been studied. We do want our clients to know what is maintaining their current difficulties, in a way that is tailored to their own situation. And we want to them to understand what we are going to do to help them break these patterns. For example, let's take a client with a phobia of dogs. It is important to teach this client about the three components of anxiety—thoughts, feelings, and behavior—and how these components interact to maintain his phobia. It is also essential that we teach the client that we can help him reduce his fear of dogs by targeting these components. We can challenge his beliefs about the danger of dogs, and even more importantly, we must help him change his behaviors around dogs (which will feed back into his beliefs about them and the feelings he has in their presence). Although it might be interesting to share our knowledge of the incidence of dog phobias, and the causes of dog phobias, and the age of onset of dog phobias, skipping this material or making an error here or there will likely not affect the clinical outcome of the case.

3. *I have a lot of knowledge about X disorder, but the client has Y disorder.* → *I have no idea what to do.* → *I will not be able to help/I will make the client worse.* One of our favorite "first therapy experience" stories came from a clinician who was primarily interested in anxiety disorders. She had read extensively on the topic and had watched therapy sessions by more experienced therapists. Then she was assigned her first client, and he turned out to have schizophrenia! This therapist panicked. She knew tons about anxiety disorders, but not about schizophrenia.

This brings us back to beliefs we hold about our abilities. Just because we have not treated a client with *Y* disorder, or even read much about it, does not mean we have no skills to aid us. First, we possess listening skills and warmth. Second, CBT affords us an amazing toolbox of skills that can be applied to a vast array of situations, mental

disorders, and behavior problems. In the case of the client with schizophrenia, for example, a skilled CBT therapist could hone in on the environmental factors that prevent the client from taking his medication on a daily basis. She could then put a behavioral plan into place to increase the likelihood that the client will take his medication.

We will not be able to successfully treat every client who comes through our doors. Many of us have focused during our training on particular areas of expertise and simply do not have the experience (or interest) to treat some other problems. That is OK! We can do an amazing service for clients by simply assessing them, figuring out what ails them, and then referring them to other professionals who specialize in those particular concerns.

Engaging in Useful Behaviors

A great deal of learning about the process of therapy can occur before we even set foot in the room with a client. In the next section of the chapter, we talk about the background learning that should occur before therapeutic encounters begin. As with examining and correcting faulty cognitions, engaging in useful behaviors can work wonders in alleviating the anxiety experienced by novice clinicians.

Doing Coursework

In an ideal world, you will have completed a host of relevant coursework before seeing your first client—courses on the nature and treatment of a range of mental disorders; courses on testing and assessment; courses on professional conduct. In reality, however, this often does not occur. In many training programs, students are expected to work with clients before having completed all of these courses. This makes it all the more important that students take the initiative to adequately prepare themselves via the methods outlined below.

Reading

Many of our memories of graduate school involve hauling around immense piles of articles—and reading, and reading, and reading. If you are particularly interested in CBT (as we hope you are, if you are reading this book), you should supplement your course work with further reading. We suggest here a selection of books that will help you to gain an understanding of the theory underlying CBT and how to conduct

CBT (see Appendix A for further reading). This is not meant to be an all-inclusive list, but certainly these books are "must-reads" for people who work in the field of CBT.

A great place to start is with the classics, Aaron Beck's *Cognitive Therapy of Depression* (Beck et al., 1979) and *Cognitive Therapy and the Emotional Disorders* (Beck, 1979). To learn the basics of CBT, we also recommend:

- *Cognitive-Behavioral Therapy: Basics and Beyond* (2nd ed.) by Judith S. Beck (2011).
- *Feeling Good: The New Mood Therapy* (rev. ed.) by David Burns (2008).
- *Mind Over Mood: Change How You Feel by Changing the Way You Think* (2nd ed.) by Dennis Greenberger and Christine Padesky (2016; see also Padesky and Greenberger's [1995] *Clinician's Guide to Mind Over Mood*).
- *Cognitive Therapy Techniques: A Practitioner's Guide* by Robert L. Leahy (2003a).
- *Core Competencies in Cognitive-Behavioral Therapy: Becoming a Highly Effective and Competent Cognitive-Behavioral Therapist* by Cory F. Newman (2013).
- *Evidence-Based Practice of Cognitive-Behavioral Therapy* (2nd ed.) by Deborah Dobson and Keith Dobson (2017).
- *Clinical Practice of Cognitive Therapy with Children and Adolescents: The Nuts and Bolts* (2nd ed.) by Robert D. Friedberg and Jessica M. McClure (2015) and *Cognitive Therapy Techniques for Children and Adolescents: Tools for Enhancing Practice* by Robert D. Friedberg, Jessica M. McClure, and Jolene Hillwig Garcia (2009).

Once beginning clinicians have a handle on the core techniques of CBT, they must acquire knowledge about cognitive-behavioral theories and therapy for specific psychological problems. A good place to start is with a broad book like the fifth edition of David H. Barlow's (2014) *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual*. The book includes chapters on a number of specific psychological problems that outline the nature of each problem, offer cognitive-behavioral models for understanding them, and describe how to use CBT to treat them from initial assessment to termination. The book provides an excellent model of how CBT is applied to different psychological problems and a balanced blend of data (prevalence rates,

findings from treatment outcome studies) and practical knowledge (case examples, sample dialogues, forms for clients to complete, etc.).

When you begin to treat clients with specific difficulties, more in-depth reading in specific areas is also important. This in-depth reading should include research-oriented books (e.g., books that discuss epidemiology, etiology, diagnostic issues, approaches to treatment), as well as treatment manuals (see Appendices B and C). Some manuals include brief overviews of research on the specific problem, but are, of course, most specifically focused on guiding clinicians through the treatment process. Although it might make most sense to only read manuals focused on the disorders you are most likely to treat, it can be very interesting to explore more widely. A useful technique can sometimes be found in a CBT manual designed for a disorder you are not focusing on in your studies.

Unfortunately, simply reading books and treatment manuals will not allow you to keep up to date on cutting-edge knowledge in our field. Practicing clinicians should make a habit of keeping up to date on influential treatment outcome studies, as well as studies that help us to better understand the nature of various psychological disturbances. There are too many excellent journals in our field to list them all here, but we have included the names of some that beginning clinicians might want to start keeping up with in Appendix D. It can also be helpful to sign up for blogs, newsletters, and listservs that summarize important, current research in your areas of interest (see Appendix D).

From Memory (or, Almost)

There are certain skills that become easier with practice, but it is a good idea to become familiar with certain information before getting into the room with clients. As we discuss in Chapter 3, diagnostic interviews and assessment measures can be complicated to administer. Therefore, be familiar with them (how they are administered, what page to flip to after a skip-out, etc.) before actually doing them with clients. Similarly, it is important to have a good working knowledge of the diagnostic criteria for the most common psychiatric disorders. In this way, the correct questions can be asked to make differential diagnoses and, therefore, get treatment off to a well-thought-out start. Finally, cognitive-behavioral therapists (even beginning ones) should be able to explain what CBT is, how cognitive-behavioral theory helps us to understand the maintenance of problematic thoughts and behaviors, and how CBT works to change these behaviors. In effect, people who do CBT need to be cheerleaders for CBT. When we first meet with clients, we need to communicate that

CBT is worth the time, money, and effort. If we are flipping through notes, taking painfully long pauses to answer questions, or saying "I don't know" to basic questions, our clients might come away with serious doubts about our competency, as well as the effectiveness of CBT.

Watching the Masters

In addition to reading, beginning clinicians can also prepare to conduct CBT by watching more experienced clinicians. It can be quite informative (and fun) to watch the "masters" of CBT. The Association for Behavioral and Cognitive Therapies (ABCT) has created a series called the "Clinical Grand Rounds" that shows world-renowned cognitive-behavioral clinicians treating mock clients. These DVDs afford the opportunity to see excellent CBT, often from the individuals who created the treatments for specific problems.

Even easier to access than these DVDs are YouTube and other Internet-based resources. A caveat is worth mentioning—as with everything on the Internet, the quality of videos discussing or demonstrating CBT varies widely. Try to seek out well-known clinicians, centers, or professional organizations. As an example, the Beck Institute for Cognitive Behavior Therapy has its own YouTube channel that includes many clips of Dr. Aaron Beck explaining CBT concepts and demonstrating CBT techniques.

These aforementioned resources all show an abridged version of therapy with mock clients. Although they are extremely valuable to the beginning clinician, he or she should also try to secure recordings of entire cases with real clients. Many training clinics maintain recordings of interesting cases for trainees to watch. By watching a case from start to finish, you will not only to be exposed to many different therapy techniques but also to issues that can come up at different stages of the therapy process. Whenever possible, novice clinicians should discuss their observations with a more experienced clinician, ideally the clinician who did the treatment. In this way, you can ask the clinician to explain why he or she made the decisions that were made as the therapy progressed.

Therapy sessions can also be observed in real time from behind a one-way mirror or in the room with the clinician and client. This is an excellent way to learn, particularly if you can spend some time with the clinician after each session to discuss the case and ask questions. If you are able to be in the room with the clinician and client, you might also be able to take a gradually more active role, depending on the style of the clinician and the willingness of the client. These parameters should

be discussed with the clinician, and also with the client, prior to the beginning treatment so that everyone is clear on the nature of your role.

Making Good Use of Supervision

Beginning clinicians can ease some of the anxiety they experience by making good use of supervision (we discuss supervision in greater detail in Chapter 10). Beginning clinicians might *feel* alone when they start to see clients, but in fact they are not. Because developing clinicians are not yet self-sufficient and independently competent, they require monitoring by a clinical supervisor whose job is to provide support and feedback during the training process. From a didactic perspective, there are multiple goals of supervision. The most obvious goal is to teach students the skills they require to offer psychological services. Supervisors also teach trainees about *being* clinicians. They help trainees learn how to manage unanticipated difficulties that can arise with clients over the course of therapy. They also teach beginning clinicians how to practice psychology ethically and responsibly by introducing them to the ethical codes that govern our work and helping them to resolve ethical dilemmas as they arise. Finally, supervisors often serve as mentors, helping trainees to chart their career paths, including developing their own supervisory skills (For more on the topic of supervision of CBT, see Newman & Kaplan, 2016; Sudak et al., 2015, and other books listed in Appendix A).

Perhaps the biggest concern for trainees in the context of the supervisory relationship is the prospect of evaluation by supervisors. This concern is not unfounded since supervision typically involves receiving "constructive criticism." Furthermore, in supervision, we tend to bring in segments of therapy sessions that were problematic. If a supervision meeting comes off as negative in tone, trainees might become anxious about the next one. This can have an adverse effect on therapy, since trainees will be so focused on doing the "right thing" for fear of being reprimanded during supervision that they will not be able to attend to the client.

One way to deal with fear of negative evaluation is to reframe the way in which you perceive the supervisory experience. Supervision, both from supervisors and from peers, can be amazingly educational, even if at times it is hard to swallow. Beginning clinicians need to develop a thick skin and remember that feedback is not intended as a personal affront, but rather as a means to help them grow. When beginning clinicians learn to be in supervision meetings and not take feedback personally, they get a great deal more out of it.

Becoming Part of a Community

As a beginning CBT clinician, it is also advisable to join international, national, or local organizations (see Appendix D for more information). Membership in these organizations allows you to keep informed about current developments in cognitive-behavioral research and practice. These organizations also sponsor conferences where you can learn by attending workshops and talks and where you can meet other individuals who are also interested in CBT. These organizations include the ABCT and the International Association of Cognitive Psychotherapy (IACP), as well as more specialized organizations like the Anxiety and Depression Association of America (ADAA). The Academy of Cognitive Therapy (ACT) is another excellent resource. The ACT offers certification to individuals with advanced expertise in CBT and offers resources pertinent to beginning clinicians, including listings of clinical psychology doctoral programs, internships, and postdoctoral fellowships that have a CBT focus.

Being a clinician is an exciting career choice. Most of us embark on this path because we want to help people. The process of doing so is never boring. Each client we see is unique, both in terms of his or her clinical presentation and in terms of the alliance he or she forms with the clinician. Even clients who progress through treatment quite uneventfully present interesting challenges to think through. Starting out as a clinician can indeed be stressful, but we encourage you to embark upon this path with a spirit of curiosity.

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