Chapter 1

INTRODUCTION TO COGNITIVE BEHAVIOR THERAPY

A revolution in the field of mental health was initiated in the early 1960s by Aaron T. Beck, MD, then an assistant professor in psychiatry at the University of Pennsylvania. Dr. Beck was a fully trained and practicing psychoanalyst. A scientist at heart, he believed that in order for psychoanalysis to be accepted by the medical community, its theories needed to be demonstrated as empirically valid. In the late 1950s and early 1960s, he embarked on a series of experiments that he fully expected would produce such validation. Instead, the opposite occurred. The results of Dr. Beck’s experiments led him to search for other explanations for depression. He identified distorted, negative cognition (primarily thoughts and beliefs) as a primary feature of depression and developed a short-term treatment, one of whose primary targets was the reality testing of patients’ depressed thinking.

In this chapter, you will find the answers to the following questions:

- What is cognitive behavior therapy?
- How was it developed?
- What does research tell us about its effectiveness?
- What are its basic principles?
- How can you become an effective cognitive behavior therapist?
WHAT IS COGNITIVE BEHAVIOR THERAPY?

Aaron Beck developed a form of psychotherapy in the early 1960s that he originally termed “cognitive therapy.” “Cognitive therapy” is now used synonymously with “cognitive behavior therapy” by much of our field and it is this latter term that will be used throughout this volume. Beck devised a structured, short-term, present-oriented psychotherapy for depression, directed toward solving current problems and modifying dysfunctional (inaccurate and/or unhelpful) thinking and behavior (Beck, 1964). Since that time, he and others have successfully adapted this therapy to a surprisingly diverse set of populations with a wide range of disorders and problems. These adaptations have changed the focus, techniques, and length of treatment, but the theoretical assumptions themselves have remained constant. In all forms of cognitive behavior therapy that are derived from Beck’s model, treatment is based on a cognitive formulation, the beliefs and behavioral strategies that characterize a specific disorder (Alford & Beck, 1997).

Treatment is also based on a conceptualization, or understanding, of individual patients (their specific beliefs and patterns of behavior). The therapist seeks in a variety of ways to produce cognitive change—modification in the patient’s thinking and belief system—to bring about enduring emotional and behavioral change.

Beck drew on a number of different sources when he developed this form of psychotherapy, including early philosophers, such as Epicetus, and theorists, such as Karen Horney, Alfred Adler, George Kelly, Albert Ellis, Richard Lazarus, and Albert Bandura. Beck’s work, in turn, has been expanded by current researchers and theorists, too numerous to recount here, in the United States and abroad.

There are a number of forms of cognitive behavior therapy that share characteristics of Beck’s therapy, but whose conceptualizations and emphases in treatment vary to some degree. These include rational emotional behavior therapy (Ellis, 1962), dialectical behavior therapy (Linehan, 1993), problem-solving therapy (D’Zurilla & Nezu, 2006), acceptance and commitment therapy (Hayes, Follette, & Linehan, 2004), exposure therapy (Foa & Rothbaum, 1998), cognitive processing therapy (Resick & Schnicke, 1993), cognitive behavioral analysis system of psychotherapy (McCullough, 1999), behavioral activation (Lewinsohn, Sullivan, & Grosscup, 1980; Martell, Addis, & Jacobson, 2001), cognitive behavior modification (Meichenbaum, 1977), and others. Beck’s cognitive behavior therapy often incorporates techniques from all these therapies, and other psychotherapies, within a cognitive framework. Historical overviews of the field provide a rich description of how the different streams of cognitive behavior therapy originated.

Cognitive behavior therapy has been adapted for patients with diverse levels of education and income as well as a variety of cultures and ages, from young children to older adults. It is now used in primary care and other medical offices, schools, vocational programs, and prisons, among other settings. It is used in group, couple, and family formats. While the treatment described in this book focuses on individual 45-minute sessions, treatment can be briefer. Some patients, such as those who suffer from schizophrenia, often cannot tolerate a full session, and some practitioners can use cognitive therapy techniques, without conducting a full therapy session, within a medical or rehabilitation appointment or medication check.

WHAT IS THE THEORY UNDERLYING COGNITIVE BEHAVIOR THERAPY?

In a nutshell, the cognitive model proposes that dysfunctional thinking (which influences the patient’s mood and behavior) is common to all psychological disturbances. When people learn to evaluate their thinking in a more realistic and adaptive way, they experience improvement in their emotional state and in their behavior. For example, if you were quite depressed and bounced some checks, you might have an automatic thought, an idea that just seemed to pop up in your mind: “I can’t do anything right.” This thought might then lead to a particular reaction: you might feel sad (emotion) and retreat to bed (behavior). If you then examined the validity of this idea, you might conclude that you had overgeneralized and that, in fact, you actually do many things well. Looking at your experience from this new perspective would probably make you feel better and lead to more functional behavior.

For lasting improvement in patients’ mood and behavior, cognitive therapists work at a deeper level of cognition: patients’ basic beliefs about themselves, their world, and other people. Modification of their underlying dysfunctional beliefs produces more enduring change. For example, if you continually underestimate your abilities, you might have an underlying belief of incompetence. Modifying this general belief (i.e., seeing yourself in a more realistic light as having both strengths and weaknesses) can alter your perception of specific situations that you encounter daily. You will no longer have as many thoughts with the theme, “I can’t do anything right.” Instead, in specific situations where you make mistakes, you will probably think, “I’m not good at this [specific task].”
WHAT DOES THE RESEARCH SAY?

Cognitive behavior therapy has been extensively tested since the first outcome study was published in 1977 (Rush, Beck, Kovacs, & Hollon, 1977). At this point, more than 500 outcome studies have demonstrated the efficacy of cognitive behavior therapy for a wide range of psychiatric disorders, psychological problems, and medical problems with psychological components (see, e.g., Butler, Chapman, Forman, & Beck, 2005; Chambless & Ollendick, 2001). Table 1.1 lists many of the disorders and problems that have been successfully treated with cognitive behavior therapy. A more complete list may be found at www.beckinstitute.org.

Studies have been conducted that demonstrate the effectiveness of cognitive behavior therapy in community settings (see, e.g., Shadish, Matt, Navarro & Philips, 2000; Simons et al., 2010; Stirman, Buchhofer, McLaulin, Evans, & Beck, 2009). Other studies have found computer-assisted cognitive behavior therapy to be effective (see, e.g., Khanna & Kendall, 2010; Wright et al., 2002). And several researchers have demonstrated that there are neurobiological changes associated with cognitive behavior therapy treatment for various disorders (see, e.g.,

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<td>Habit disorders</td>
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<td>Schizophrenia (with medication)</td>
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Goldapple et al., 2004). Hundreds of research studies have also validated the cognitive model of depression and of anxiety. A comprehensive review of these studies can be found in Clark and colleagues (1999) and in Clark and Beck (2010).

**HOW WAS BECK’S COGNITIVE BEHAVIOR THERAPY DEVELOPED?**

In the late 1950s and early 1960s, Dr. Beck decided to test the psychoanalytic concept that depression is the result of hostility turned inward toward the self. He investigated the dreams of depressed patients, which, he predicted, would manifest greater themes of hostility than the dreams of normal controls. To his surprise, he ultimately found that the dreams of depressed patients contained fewer themes of hostility and far greater themes of defectiveness, deprivation, and loss. He recognized that these themes paralleled his patients’ thinking when they were awake. The results of other studies Beck conducted led him to believe that a related psychoanalytic idea—that depressed patients have a need to suffer—might be inaccurate (Beck, 1967). At that point, it was almost as if a stacked row of dominoes began to fall. If these psychoanalytic concepts were not valid, how else could depression be understood?

As Dr. Beck listened to his patients on the couch, he realized that they occasionally reported two streams of thinking: a free-association stream and quick, evaluative thoughts about themselves. One woman, for example, detailed her sexual exploits. She then reported feeling anxious. Dr. Beck made an interpretation: “You thought I was criticizing you.” The patient disagreed: “No, I was afraid I was boring you.” Upon questioning his other depressed patients, Dr. Beck recognized that all of them experienced “automatic” negative thoughts such as these, and that this second stream of thoughts was closely tied to their emotions. He began to help his patients identify, evaluate, and respond to their unrealistic and maladaptive thinking. When he did so, they rapidly improved.

Dr. Beck then began to teach his psychiatric residents at the University of Pennsylvania to use this form of treatment. They, too, found that their patients responded well. The chief resident, A. John Rush, MD, now a leading authority in the field of depression, discussed conducting an outcome trial with Dr. Beck. They agreed that such a study was necessary to demonstrate the efficacy of cognitive therapy to others. Their randomized controlled study of depressed patients, published in 1977, established that cognitive therapy was as effective as imipramine, a common antidepressant. This was an astounding study. It was one
of the first times that a talk therapy had been compared to a medication. Beck, Rush, Shaw, and Emery (1979) published the first cognitive therapy treatment manual 2 years later.

Important components of cognitive behavior therapy for depression include a focus on helping patients solve problems; become behaviorally activated; and identify, evaluate, and respond to their depressed thinking, especially to negative thoughts about themselves, their worlds, and their future. In the late 1970s Dr. Beck and his postdoctoral fellows at the University of Pennsylvania began to study anxiety, and found that a somewhat different focus was necessary. Patients with anxiety needed to better assess the risk of situations they feared, to consider their internal and external resources, and improve upon their resources. They also needed to decrease their avoidance and confront situations they feared so they could test their negative predictions behaviorally. Since that time, the cognitive model of anxiety has been refined for each of the various anxiety disorders, cognitive psychology has verified these models, and outcome studies have demonstrated the efficacy of cognitive behavior therapy for anxiety disorders (Clark & Beck, 2010).

Fast-forward several decades. Dr. Beck, his fellows, and other researchers worldwide continue to study, theorize, adapt, and test treatments for patients who suffer from an ever-growing list of problems. Cognitive therapy or cognitive behavior therapy is now taught in most graduate schools in the United States and in many other countries.

WHAT ARE THE BASIC PRINCIPLES OF TREATMENT?

Although therapy must be tailored to the individual, there are, nevertheless, certain principles that underlie cognitive behavior therapy for all patients. Throughout the book, I use a depressed patient, Sally, to illustrate these central tenets and to demonstrate how to use cognitive theory to understand patients’ difficulties and how to use this understanding to plan treatment and conduct therapy sessions. Sally is a nearly ideal patient and allows me to present cognitive behavior therapy in a straightforward manner. I make some note of how to vary treatment for patients who do not respond as well as she, but the reader must look elsewhere (e.g., J. S. Beck, 2005; Kuyken, Padesky & Dudley, 2009; Needleman, 1999) to learn how to conceptualize, strategize, and implement techniques for patients with diagnoses other than depression or for patients whose problems pose a challenge in treatment.

“Sally” was an 18-year-old single female when she sought treatment with me during her second semester of college. She had been
feeling quite depressed and anxious for the previous 4 months and was having difficulty with her daily activities. She met criteria for a major depressive episode of moderate severity according to DSM-IV-TR (the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision; American Psychiatric Association, 2000). A fuller portrait of Sally is provided in Appendix A.

The basic principles of cognitive behavior therapy are as follows:

**Principle No. 1. Cognitive behavior therapy is based on an ever-evolving formulation of patients’ problems and an individual conceptualization of each patient in cognitive terms.** I consider Sally’s difficulties in three time frames. From the beginning, I identify her current thinking that contributes to her feelings of sadness (“I’m a failure, I can’t do anything right, I’ll never be happy”), and her problematic behaviors (isolating herself, spending a great deal of unproductive time in her room, avoiding asking for help). These problematic behaviors both flow from and in turn reinforce Sally’s dysfunctional thinking. Second, I identify precipitating factors that influenced Sally’s perceptions at the onset of her depression (e.g., being away from home for the first time and struggling in her studies contributed to her belief that she was incompetent). Third, I hypothesize about key developmental events and her enduring patterns of interpreting these events that may have predisposed her to depression (e.g., Sally has had a lifelong tendency to attribute personal strengths and achievement to luck, but views her weaknesses as a reflection of her “true” self).

I base my conceptualization of Sally on the cognitive formulation of depression and on the data Sally provides at the evaluation session. I continue to refine this conceptualization at each session as I obtain more data. At strategic points, I share the conceptualization with Sally to ensure that it “rings true” to her. Moreover, throughout therapy I help Sally view her experience through the cognitive model. She learns, for example, to identify the thoughts associated with her distressing affect and to evaluate and formulate more adaptive responses to her thinking. Doing so improves how she feels and often leads to her behaving in a more functional way.

**Principle No. 2. Cognitive behavior therapy requires a sound therapeutic alliance.** Sally, like many patients with uncomplicated depression and anxiety disorders, has little difficulty trusting and working with me. I strive to demonstrate all the basic ingredients necessary in a counseling situation: warmth, empathy, caring, genuine regard, and competence. I show my regard for Sally by making empathic statements, listening closely and carefully, and accurately summarizing her thoughts and
feelings. I point out her small and larger successes and maintain a realistically optimistic and upbeat outlook. I also ask Sally for feedback at the end of each session to ensure that she feels understood and positive about the session. See Chapter 2 for a lengthier description of the therapeutic relationship in cognitive behavior therapy.

**Principle No. 3. Cognitive behavior therapy emphasizes collaboration and active participation.** I encourage Sally to view therapy as teamwork; together we decide what to work on each session, how often we should meet, and what Sally can do between sessions for therapy homework. At first, I am more active in suggesting a direction for therapy sessions and in summarizing what we’ve discussed during a session. As Sally becomes less depressed and more socialized into treatment, I encourage her to become increasingly active in the therapy session: deciding which problems to talk about, identifying the distortions in her thinking, summarizing important points, and devising homework assignments.

**Principle No. 4. Cognitive behavior therapy is goal oriented and problem focused.** I ask Sally in our first session to enumerate her problems and set specific goals so both she and I have a shared understanding of what she is working toward. For example, Sally mentions in the evaluation session that she feels isolated. With my guidance, Sally states a goal in behavioral terms: to initiate new friendships and spend more time with current friends. Later, when discussing how to improve her day-to-day routine, I help her evaluate and respond to thoughts that interfere with her goal, such as: *My friends won’t want to hang out with me. I’m too tired to go out with them.* First, I help Sally evaluate the validity of her thoughts through an examination of the evidence. Then Sally is willing to test the thoughts more directly through behavioral experiments (pages 217–218) in which she initiates plans with friends. Once she recognizes and corrects the distortion in her thinking, Sally is able to benefit from straightforward problem solving to decrease her isolation.

**Principle No. 5. Cognitive behavior therapy initially emphasizes the present.** The treatment of most patients involves a strong focus on current problems and on specific situations that are distressing to them. Sally begins to feel better once she is able to respond to her negative thinking and take steps to improve her life. Therapy starts with an examination of here-and-now problems, regardless of diagnosis. Attention shifts to the past in two circumstances. One, when patients express a strong preference to do so, and a failure to do so could endanger the therapeutic alliance. Two, when patients get “stuck” in their dysfunctional thinking, and an understanding of the childhood roots of their beliefs can potentially help them modify their rigid ideas. (“Well, no wonder you
still believe you’re incompetent. Can you see how almost any child—who had the same experiences as you—would grow up believing she was incompetent, and yet it might not be true, or certainly not completely true?”

For example, I briefly turn to the past midway through treatment to help Sally identify a set of beliefs she learned as a child: “If I achieve highly, it means I’m worthwhile,” and “If I don’t achieve highly, it means I’m a failure.” I help her evaluate the validity of these beliefs both in the past and present. Doing so leads Sally, in part, to develop more functional and more reasonable beliefs. If Sally had had a personality disorder, I would have spent proportionally more time discussing her developmental history and childhood origin of beliefs and coping behaviors.

**Principle No. 6. Cognitive behavior therapy is educative, aims to teach the patient to be her own therapist, and emphasizes relapse prevention.** In our first session I educate Sally about the nature and course of her disorder, about the process of cognitive behavior therapy, and about the cognitive model (i.e., how her thoughts influence her emotions and behavior). I not only help Sally set goals, identify and evaluate thoughts and beliefs, and plan behavioral change, but I also teach her how to do so. At each session I ensure that Sally takes home therapy notes—important ideas she has learned—so she can benefit from her new understanding in the ensuing weeks and after treatment ends.

**Principle No. 7. Cognitive behavior therapy aims to be time limited.** Many straightforward patients with depression and anxiety disorders are treated for six to 14 sessions. Therapists’ goals are to provide symptom relief, facilitate a remission of the disorder, help patients resolve their most pressing problems, and teach them skills to avoid relapse. Sally initially has weekly therapy sessions. (Had her depression been more severe or had she been suicidal, I may have arranged more frequent sessions.) After 2 months, we collaboratively decide to experiment with biweekly sessions, then with monthly sessions. Even after termination, we plan periodic “booster” sessions every 3 months for a year.

Not all patients make enough progress in just a few months, however. Some patients require 1 or 2 years of therapy (or possibly longer) to modify very rigid dysfunctional beliefs and patterns of behavior that contribute to their chronic distress. Other patients with severe mental illness may need periodic treatment for a very long time to maintain stabilization.

**Principle No. 8. Cognitive behavior therapy sessions are structured.** No matter what the diagnosis or stage of treatment, following a certain
structure in each session maximizes efficiency and effectiveness. This structure includes an introductory part (doing a mood check, briefly reviewing the week, collaboratively setting an agenda for the session), a middle part (reviewing homework, discussing problems on the agenda, setting new homework, summarizing), and a final part (eliciting feedback). Following this format makes the process of therapy more understandable to patients and increases the likelihood that they will be able to do self-therapy after termination.

**Principle No. 9. Cognitive behavior therapy teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs.** Patients can have many dozens or even hundreds of automatic thoughts a day that affect their mood, behavior, and/or physiology (the last is especially pertinent to anxiety). Therapists help patients identify key cognitions and adopt more realistic, adaptive perspectives, which leads patients to feel better emotionally, behave more functionally, and/or decrease their physiological arousal. They do so through the process of guided discovery, using questioning (often labeled or mislabeled as “Socratic questioning”) to evaluate their thinking (rather than persuasion, debate, or lecturing). Therapists also create experiences, called behavioral experiments, for patients to directly test their thinking (e.g., “If I even look at a picture of a spider, I’ll get so anxious I won’t be able to think”). In these ways, therapists engage in collaborative empiricism. Therapists do not generally know in advance to what degree a patient’s automatic thought is valid or invalid, but together they test the patient’s thinking to develop more helpful and accurate responses.

When Sally was quite depressed, she had many automatic thoughts throughout the day, some of which she spontaneously reported and others that I elicited (by asking her what was going through her mind when she felt upset or acted in a dysfunctional manner). We often uncovered important automatic thoughts as we were discussing one of Sally’s specific problems, and together we investigated their validity and utility. I asked her to summarize her new viewpoints, and we recorded them in writing so that she could read these adaptive responses throughout the week to prepare her for these or similar automatic thoughts. I did not encourage her to uncritically adopt a more positive viewpoint, challenge the validity of her automatic thoughts, or try to convince her that her thinking was unrealistically pessimistic. Instead we engaged in a collaborative exploration of the evidence.

**Principle No. 10. Cognitive behavior therapy uses a variety of techniques to change thinking, mood, and behavior.** Although cognitive strategies such as Socratic questioning and guided discovery are central to cognitive behavior therapy, behavioral and problem-solving techniques
are essential, as are techniques from other orientations that are implemented within a cognitive framework. For example, I used Gestalt-inspired techniques to help Sally understand how experiences with her family contributed to the development of her belief that she was incompetent. I use psychodynamically inspired techniques with some Axis II patients who apply their distorted ideas about people to the therapeutic relationship. The types of techniques you select will be influenced by your conceptualization of the patient, the problem you are discussing, and your objectives for the session.

These basic principles apply to all patients. Therapy does, however, vary considerably according to individual patients, the nature of their difficulties, and their stage of life, as well as their developmental and intellectual level, gender, and cultural background. Treatment also varies depending on patients’ goals, their ability to form a strong therapeutic bond, their motivation to change, their previous experience with therapy, and their preferences for treatment, among other factors.

The emphasis in treatment also depends on the patient’s particular disorder(s). Cognitive behavior therapy for panic disorder involves testing the patient’s catastrophic misinterpretations (usually life- or sanity-threatening erroneous predictions) of bodily or mental sensations (Clark, 1989). Anorexia requires a modification of beliefs about personal worth and control (Garner & Bemis, 1985). Substance abuse treatment focuses on negative beliefs about the self and facilitating or permission-granting beliefs about substance use (Beck, Wright, Newman, & Liese, 1993).

WHAT IS A THERAPY SESSION LIKE?

The structure of therapy sessions is quite similar for the various disorders, but interventions can vary considerably from patient to patient. (The website of the Academy of Cognitive Therapy [www.academyofct.org] posts a list of books that describe the cognitive formulation, major emphases, strategies, and techniques for a wide range of diagnoses, patient variables, and treatment formats and settings.) Below is a general description of treatment sessions and the course of treatment, especially for patients who are depressed.

At the beginning of sessions, you will reestablish the therapeutic alliance, check on patients’ mood, symptoms, and experiences in the past week, and ask them to name the problems they most want help in solving. These difficulties may have arisen during the week and/or they may be problems patients expect to encounter in the coming week(s). You will also review the self-help activities (“homework” or
“action plan”) patients engaged in since the previous session. Then, in the context of discussing a specific problem patients have put on the agenda, you will collect data about the problem, cognitively conceptualize patients’ difficulties (asking for their specific thoughts, emotions, and behaviors associated with the problem), and collaboratively plan a strategy. The strategy most often includes straightforward problem solving, evaluating patients’ negative thinking associated with the problem, and/or behavior change.

For example, Sally, the college student, is having difficulty studying. She needs help evaluating and responding to her thoughts (“What’s the use? I’ll probably flunk out anyway”) before she is able to fully engage in solving her problem with studying. I make sure Sally has adopted a more accurate and adaptive view of the situation and has decided which solutions to implement in the coming week (e.g., starting with relatively easier tasks, mentally summarizing what she has read after every page or two of reading, planning shorter study sessions, going for walks when she takes breaks, and asking the teaching assistant for help). Our session sets the stage for Sally to make changes in her thinking and behavior during the coming week that, in turn, lead to an improvement in her mood and functioning.

Having discussed a problem and collaboratively set therapy homework, Sally and I turn to a second problem she has put on the agenda and repeat the process. At the end of the session we review important points from the session. I make sure that Sally is highly likely to do the homework assignments, and I elicit her feedback about the session.

DEVELOPING AS A COGNITIVE BEHAVIOR THERAPIST

To the untrained observer, cognitive behavior therapy sometimes appears deceptively simple. The cognitive model, the proposition that one’s thoughts influence one’s emotions and behavior, is quite straightforward. Experienced cognitive behavior therapists, however, accomplish many tasks at once: conceptualizing the case, building rapport, socializing and educating the patient, identifying problems, collecting data, testing hypotheses, and summarizing. The novice cognitive behavior therapist, in contrast, usually needs to be more deliberate and structured, concentrating on fewer elements at one time. Although the ultimate goal is to interweave these elements and conduct therapy as effectively and efficiently as possible, beginners must first learn the skill of developing the therapeutic relationship, the skill of conceptualization, and the techniques of cognitive behavior therapy, all of which is best done in a step-by-step manner.

Developing expertise as a cognitive behavior therapist can be viewed in three stages. (These descriptions assume that the therapist
is already proficient in basic counseling skills: listening, empathy, concern, positive regard, and genuineness, as well as accurate understanding, reflection, and summarizing. Therapists who do not already possess these skills often elicit a negative reaction from patients.) In Stage 1 you learn basic skills of conceptualizing a case in cognitive terms based on an intake evaluation and data collected in session. You also learn to structure the session, use your conceptualization of a patient and good common sense to plan treatment, and help patients solve problems and view their dysfunctional thoughts in a different way. You also learn to use basic cognitive and behavioral techniques.

In Stage 2 you become more proficient at integrating your conceptualization with your knowledge of techniques. You strengthen your ability to understand the flow of therapy. You become more easily able to identify critical goals of treatment and more skillful at conceptualizing patients, refining your conceptualization during the therapy session itself, and using the conceptualization to make decisions about interventions. You expand your repertoire of techniques and become more proficient in selecting, timing, and implementing appropriate techniques.

In Stage 3 you more automatically integrate new data into the conceptualization. You refine your ability to make hypotheses to confirm or revise your view of the patient. You vary the structure and techniques of basic cognitive behavior therapy as appropriate, particularly for patients with personality disorders and other difficult disorders and problems.

If you already practice in another psychotherapeutic modality, it will be important for you to make a collaborative decision with patients to introduce the cognitive behavior therapy approach, describing what you would like to do differently and providing a rationale. Most patients agree to such changes when they are phrased positively, to the patient’s benefit. When patients are hesitant, you can suggest the institution of a change (such as setting an agenda) as an “experiment,” rather than a commitment, to motivate them to try it.

THERAPIST: Mike, I was reading an important book on making therapy more effective and I thought of you.

PATIENT: Oh?

THERAPIST: Yes, and I have some ideas about how we can help you get better faster. [being collaborative] Is it okay if I tell you about it?

PATIENT: Okay.

THERAPIST: One thing I read was called “setting the agenda.” That means at the beginning of sessions, I’m going to ask you tell me the names of problems you want my help in solving during the session. For example, you might say that you’re having a problem with your
boss, or with getting out of bed on weekends, or that you’ve been feeling really anxious about your finances. (pause) By asking you the names of problems up front, we can figure out how to spend our time in session better. (pause) [eliciting feedback] How does that sound?

HOW TO USE THIS BOOK

This book is intended for individuals at any stage of experience and skill development who lack mastery in the fundamental building blocks of cognitive conceptualization and treatment. It is critical to have mastered the basic elements of cognitive behavior therapy in order to understand how and when to vary standard treatment for individual patients.

Your growth as a cognitive behavior therapist will be enhanced if you start applying the tools described in this book to yourself. First, as you read, begin to conceptualize your own thoughts and beliefs. Start paying attention to your own shifts in affect. When you notice that your mood has changed or intensified in a negative direction (or when you notice that you are engaging in dysfunctional behavior or are experiencing bodily sensations associated with negative affect), ask yourself what emotion you are feeling, as well as the cardinal question of cognitive behavior therapy:

“What was just going through my mind?”

In this way, you will teach yourself to identify your own automatic thoughts. Teaching yourself the basic skills of cognitive behavior therapy using yourself as the subject will enhance your ability to teach your patients these same skills.

It will be particularly useful to identify your automatic thoughts as you are reading this book and trying techniques with your patients. If, for instance, you find yourself feeling slightly distressed, ask yourself, “What was just going through my mind?” You may uncover automatic thoughts such as:

“This is too hard.”
“I may not be able to master this.”
“This doesn't feel comfortable to me.”
“What if I try it and it doesn’t work?”
Experienced therapists whose primary orientation has not been cognitive may be aware of a different set of automatic thoughts:

- "This won’t work."
- "The patient won’t like it."
- "It’s too superficial/structured/unempathic/simple."

Having uncovered your thoughts, you can note them and refocus on your reading, or turn to Chapters 11 and 12, which describe how to evaluate and respond to automatic thoughts. By turning the spotlight on your own thinking, not only can you boost your cognitive behavior therapy skills, but you can also take the opportunity to modify dysfunctional thoughts and positively influence your mood (and behavior), making you more receptive to learning.

A common analogy used for patients also applies to the beginning cognitive behavior therapist. Learning the skills of cognitive behavior therapy is similar to learning any other skill. Do you remember learning how to drive or how to use a computer? At first, did you feel a little awkward? Did you have to pay a great deal of attention to small details and motions that now come smoothly and automatically to you? Did you ever feel discouraged? As you progressed, did the process make more and more sense, and feel more and more comfortable? Did you finally master it to the point where you were able to perform the task with relative ease and confidence? Most people have had just such an experience learning a skill in which they are now proficient.

The learning process is the same for the beginning cognitive behavior therapist. As you will learn to do for your patients, keep your goals small, well-defined, and realistic. Give yourself credit for small gains. Compare your progress to your ability level before you started reading this book, or to the time you first started learning about cognitive behavior therapy. Be cognizant of opportunities to respond to negative thoughts in which you unfairly compare yourself to experienced cognitive behavior therapists, or in which you undermine your confidence by contrasting your current level of skill with your ultimate objectives.

If you feel anxious about starting to use cognitive behavior therapy with patients, make yourself a “coping card,” an index card on which you have written statements that are important to remember. My psychiatric residents often have unhelpful thoughts before they see their first outpatient. I ask them to create a card that addresses these thoughts. The card is individualized but generally says something such as:
My goal is not to cure this patient today. No one expects me to.
My goal is to establish a good working alliance, to do some problem
solving if I can, and to sharpen my cognitive behavior therapy skills.

Reading this card helps reduce their anxiety so that they can focus
on their patients and be more effective.

Finally, the chapters of this book are designed to be read in the
order presented. You might be eager to skip over introductory chapters
in order to jump to the sections on techniques. The sum of cognitive
behavior therapy, however, is not merely the employment of cognitive
and behavioral techniques. Among other attributes, it entails the artful
selection and effective utilization of a wide variety of techniques based
on one’s conceptualization of the patient. The next chapter provides
an overview of treatment, followed by an initial chapter on conceptual­
ization. Chapter 4 describes the evaluation process, and Chapters 5–8
focus on how to structure and what to do in therapy sessions. Chapters
9–14 describe the basic building blocks of cognitive behavior therapy:
identifying cognitions and emotions and adaptively responding to auto­
matic thoughts and beliefs. Additional cognitive and behavioral tech­
niques are provided in Chapter 15, and imagery is discussed in Chap­
ter 16. Chapter 17 describes homework. Chapter 18 outlines issues of
termination and relapse prevention. These preceding chapters lay the
groundwork for Chapters 19 and 20: planning treatment and diagnos­
ing problems in therapy. Finally, Chapter 21 offers guidelines in pro­
gressing as a cognitive behavior therapist.