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A be1 is a 55-year-old divorced man of European heritage who became severely depressed over 2 years ago, following very significant difficulties at work and in his marriage. By the time I started treating him, he was fairly isolated and inactive, spending most of his time in his apartment, watching television and surfing the net, and occasionally playing video games. Abe and I met for a total of 18 sessions over 8 months, using both a traditional cognitive behavior therapy (CBT) and a recovery- oriented cognitive therapy (CT-R) conceptualization and corresponding interventions. You'll read more about the recovery orientation in this chapter and throughout the book. First, I conducted a diagnostic evaluation. In the next session, our first treatment session, I gave Abe information about his diagnosis, the theory of CBT, the process of therapy, and my proposed treatment plan. I asked about his aspirations (how he wanted his life to be) and values (what was really important to him) and then we set goals. Abe wanted to have a better life, to be productive and helpful to others, and to be optimistic, resilient, and in control. More specifically, it was important to him to manage better at home, find a job, improve the relationships with his ex-wife and children, reconnect with friends, start going to church again, and get in shape. We discussed how he could become more active in the coming week and agreed on an Action Plan (therapy "homework"). Then I elicited Abe's reaction to the session. 1 I've changed his name and some identifying characteristics. INTRODUCTION TO COGNITIVE BEHAVIOR THERAPY

The major part of each subsequent session focused on helping Abe identify his goals for the session, decide what steps he wanted to take in the coming week, create solutions to potential obstacles, reduce negative mood, and increase positive mood. We often did problem solving and skill building, especially skills related to changing his depressed thinking and behavior. I not only used various interventions with Abe but also taught him how to use these skills himself, to build resilience and prevent relapse. The structure and techniques we used were essential as was the development of a good therapeutic relationship. You'll be learning much more about Abe and his treatment throughout this book. You'll also follow Maria2 throughout this book. Maria is 37 years old. She has recurrent severe depression and traits of borderline personality disorder. Her treatment was much more complex and lasted a good deal longer. Maria saw herself as helpless, inferior, unlovable, and emotionally vulnerable. She viewed others as potentially critical, uncaring,

and likely to hurt her. These beliefs were often triggered during our sessions. Initially she was quite suspicious of me, on guard lest I harm her in some way. It was much more difficult to establish a strong therapeutic relationship with Maria. Her intense hopelessness and anxiety about therapy and about me interfered with her fully engaging in treatment for quite a while. While Abe's treatment exemplifies a standard approach, I had to adapt treatment considerably for Maria. In the rest of this chapter, you'll find answers to the following questions: What is CBT? What is the theory behind CBT? What does research tell us about its effectiveness? How was it developed? What is CT-R? What does a typical cognitive intervention look like? How can you become an effective CBT therapist? How can you best use this book? 2 I've changed her name and some identifying characteristics. Cognitive Behavior Therapy: Basics and Beyond

WHAT IS CBT? Aaron Beck developed a form of psychotherapy in the 1960s and 1970s that he originally named "cognitive therapy," a term that is often used synonymously with "cognitive behavior therapy" (CBT) by much of our field. Beck devised a structured, short-term, present--oriented psychotherapy for depression (Beck, 1964). Since that time, he and others around the world have successfully adapted this therapy to a surprisingly diverse set of populations with a wide range of disorders and problems, in many settings and formats. These adaptations have changed the focus, techniques, and length of treatment, but the theoretical assumptions themselves have remained constant. In all forms of CBT that are derived from Beck's model, clinicians base treatment on a cognitive formulation: the maladaptive beliefs, behavioral strategies, and maintaining factors that characterize a specific disorder (Alford & Beck, 1997). You will also base treatment on your conceptualization, or understanding, of individual clients and their specific underlying beliefs and patterns of behavior. One of Abe's underlying negative beliefs was "I'm a failure," and he engaged in extensive behavioral avoidance so his (perceived) incompetence, or failure, wouldn't be apparent. But his avoidance ironically strengthened his belief of failure. Originally trained as a psychoanalyst, Beck drew on multiple sources when he developed this form of psychotherapy, including early philosophers, such as Epictetus, and theorists, such as Karen Horney, Alfred Adler, George Kelly, Albert Ellis, Richard Lazarus, Albert Bandura, and many others. Beck's work, in turn, has been expanded by a host of researchers and theorists, too numerous to recount here, in the United States and abroad. Historical overviews of the field provide a rich description of how the different streams of CBT originated and grew (Arnkoff & Glass, 1992; Beck, 2005; Dobson & Dozois, 2009; Thoma et al., 2015). Some forms of CBT share characteristics of Beck's therapy, but their formulations 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 et al., 1999), exposure therapy (Foa & Rothbaum, 1998), cognitive processing therapy (Resick & Schnicke, 1993), cognitive behavioral analysis system of psychotherapy (McCullough, 1999), behavioral activation (Lewinsohn et al., 1980; Martell et al., 2001), cognitive behavior modification (Meichenbaum, 1977), and others. The form of CBT derived from Beck's model often incorporates techniques from all these

therapies, as well as other evidence-based psychotherapies, within a cognitive framework. As time goes on, it will be useful for you to learn more about other evidence-based interventions. But it would be overwhelming to do so in any depth while you are still learning CBT. I would encourage

you to master the basics of CBT first and then learn additional techniques to implement within the framework of a cognitive conceptualization. CBT has been adapted for clients 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 hospitals and clinics, schools, vocational programs, prisons, and many other settings. It is used in group, couple, and family formats. While the treatment described in this book focuses on individual 45- to 50-minute sessions with outpatients, therapeutic interactions can be briefer. Full sessions are inappropriate for some clients, such as individuals who are hospitalized for treatment of severe schizophrenia. And many different health care and allied health care providers use CBT techniques, without conducting full therapy sessions, within brief medical or rehabilitation appointments or medication checks. Paraprofessionals and peer specialists, too, use appropriately adapted CBT techniques. THE CBT THEORETICAL MODEL In a nutshell, the cognitive model proposes that dysfunctional thinking (which influences the client'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 a decrease in negative emotion and maladaptive behavior. For example, if you were quite depressed and had difficulty concentrating and paying your bills, you might have an automatic thought, an idea (in words or images) that just seemed to pop up in your mind: "I can't do anything right." This thought then leads to a particular reaction: You might feel sad (emotion) and retreat to bed (behavior). In traditional CBT, your therapist would likely help you examine the validity of this thought, and you might conclude that you had overgeneralized and, in fact, you still do many things well, despite your depression. Looking at your experience from this new perspective would probably decrease your dysphoria and you might engage in more functional behavior (start paying bills). In a recovery-oriented approach, your therapist would help you evaluate your automatic thoughts. But the focus would be less on cognitions that have already arisen and more on cognitions that are likely to arise in the coming

week that could interfere with your taking steps to achieve a specific goal. Cognitions (both adaptive and maladaptive) occur at three levels. Automatic thoughts (e.g., "I'm too tired to do anything") are at the most superficial level. You also have intermediate beliefs, such as underlying assumptions (e.g., "If I try to initiate relationships, I'll get rejected"). At the deepest level are your core beliefs about yourself, others, and the world (e.g., "I'm helpless"; "Other people will hurt me"; "The world is dangerous"). For lasting improvement in clients' mood and behavior, you will work at all three levels. Modifying both automatic thoughts and underlying dysfunctional beliefs produces enduring change. For example, let's say you continually underestimate your abilities. If so, you might have a core belief of incompetence. Modifying this general belief (i.e., seeing yourself in a more realistic light) can alter your perception of specific situations that you encounter daily. You will no longer have as many thoughts with the theme of incompetence. Instead, in specific situations where you make mistakes, you will probably think, "I'm not good at this [specific task]." In addition, it's important in a recovery orientation to cultivate realistically positive automatic thoughts (e.g., "I can do a lot of things well") and intermediate and core beliefs (e.g., "If I persevere, I can probably learn what I need to" and "I have strengths and weaknesses like everyone else"). CBT RESEARCH CBT has been extensively tested since the first outcome study was published in 1977 (Rush et al., 1977). At this point, more than 2,000 outcome studies have demonstrated the efficacy of CBT for a wide range of psychiatric disorders, psychological problems, and medical problems with psychological components. Many studies have also shown that CBT helps prevent or reduce the severity of future episodes. A study by von Brachel and colleagues

(2019), for example, showed that outpatients with a range of psychiatric disorders who were treated with CBT in routine care continued to improve between 5 and 20 years after the end of therapy, more so than those who received medical treatment. (For meta-analyses and reviews of CBT, see Butler et al., 2006; Carpenter et al., 2018; Chambless & Ollendick, 2001; Dobson et al., 2008; Dutra et al., 2008; Fairburn et al., 2015; Hanrahan et al., 2013; Hofmann et al., 2012; Hollon et al., 2014; Linardon et al., 2017; Magill & Ray, 2009; Matusiewicz et al., 2010; Mayo-Wilson et al., 2014; Öst et al., 2015; and Wuthrich & Rapee, 2013. (For lists of

conditions for which CBT has been shown to be effective, see www. div12.org/psychological--treatments/treatments and www.nice.org.uk/about/ what-we-do/our-programmes/nice--guidance/nice-guidelines. For research on CT-R, see Beck et al., in press; Grant et al., 2012, 2017.) THE DEVELOPMENT OF BECK’S CBT In the late 1950s, Dr. Beck was a certified psychoanalyst; his clients free-associated on a couch while he made interpretations. Beck recognized that the concepts of psychoanalysis needed to be experimentally validated if this school of psychotherapy were to be taken seriously by scientists. In the early 1960s, 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 clients, which, he predicted, would manifest greater themes of hostility than the dreams of psychiatric clients without depression. To his surprise, he ultimately found that the dreams of depressed clients contained fewer themes of hostility and far greater themes of defectiveness, deprivation, and loss. He recognized that these themes paralleled his clients’ thinking when they were awake. The results of other studies Beck conducted led him to believe that a related psychoanalytic idea—that depressed clients 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 weren’t valid, how else could depression be understood? As Dr. Beck listened to his clients on the couch, he realized that they occasionally reported two types of thinking: a free-association stream and a stream of quick, evaluative thoughts, especially about themselves. One woman, for example, detailed her sexual exploits. At the end of the session, she spontaneously reported that she had been feeling anxious. Dr. Beck made an interpretation: “You thought I was criticizing you.” The client disagreed: “No, I was afraid I was boring you.” When he questioned his other depressed clients, Dr. Beck recognized that all of them experienced “automatic” negative thoughts that were closely tied to their emotions. He began to help his clients 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 clients responded well. The chief resident, A. John Rush, MD, who became 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. Their randomized controlled study of depressed clients, 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. In a follow-up study, cognitive therapy was shown to be much more effective than imipramine in preventing relapse. Beck and colleagues (1979) published the first cognitive therapy treatment manual 2 years later. Starting in

the late 1970s, Dr. Beck and his postdoctoral fellows at the University of Pennsylvania began to study anxiety, substance use, personality disorders, couples' problems, hostility, bipolar disorder, and other conditions, using the same process. First, they made clinical observations about the disorder; they outlined the maintaining factors and key cognitions (thoughts and underlying beliefs, emotions, and behaviors). Then they tested their theories, adapted treatment, and undertook randomized controlled trials. Fast-forward several decades. Dr. Beck and I and researchers worldwide continue to study, theorize, adapt, and test treatments for clients who suffer from an ever-growing list of problems. CBT is now taught in most graduate schools in the United States and in many other countries. It is the most broadly practiced therapy in the world (David et al., 2018; Knapp et al., 2015). RECOVERY-ORIENTED COGNITIVE THERAPY In recent decades, there has been an innovation in the field of mental health: the recovery movement, which was started as an alternative approach to the medical model for individuals diagnosed with a serious mental health condition. Aaron Beck, our colleagues at the Beck Institute for Cognitive Behavior Therapy, and I are now refining recovery- oriented cognitive therapy (CT-R) for individuals diagnosed with a wide range of conditions. CT-R, an adaptation of traditional CBT, maintains the theoretical foundation of the cognitive model in conceptualizing individuals and planning and delivering treatment. But it adds an additional emphasis on the cognitive formulation of clients' adaptive beliefs and behavioral strategies, and factors that maintain a positive mood. Rather than emphasizing symptoms and psychopathology, CT-R emphasizes clients' strengths, personal qualities, skills, and resources. Taking a recovery orientation, I elicited and conceptualized Abe's aspirations and values to plan treatment. Family, for example, was very important to Abe, and despite his deep depression, he was willing to push himself to increase his interaction with them. We set up many potentially rewarding activities for Abe to engage in between sessions

and helped him draw positive conclusions about these experiences. We cultivated positive cognitions and memories and used the therapeutic relationship and a variety of techniques to strengthen an adaptive core belief about the self and to experience positive emotion in and out of session. One difference between traditional CBT and CT-R is the time orientation. In traditional CBT we tend to talk about problems that arose in the past week and use CBT techniques to address them. In CT-R, we focus more on clients' aspirations for the future, their values, and steps they can take each week toward their goals. The usual CBT techniques are used in overcoming challenges or obstacles clients will face in taking these steps. A TYPICAL COGNITIVE INTERVENTION Below is an excerpt from a therapy session with Abe. It provides the flavor of a typical CBT intervention. First, we agree to talk about a goal Abe wants to work on. We discuss steps he can take and the obstacles that could get in the way. Judith: Okay, did you want to start by talking about your goal to get a job? Abe: Yeah, I really need the money. Judith: What's one step you'd like to take this coming week? Abe: (Sighs.) I guess I should update my résumé. Judith: That's important. [starting problem solving] How will you go about doing that? Abe: I don't know. I haven't even looked at it in years. Judith: Do you know where it is? Abe: Yeah. But I'm not sure what to put on it. Judith: What are some ways you could figure this out? Abe: I guess I could go online. But my concentration hasn't been too good lately. Judith: Would you be better off talking to someone who knows more about résumés than you do? Abe: Yeah. (Thinks.) I could talk to my son. Judith: What would you think about calling him today? Could anything get in the way? Abe: I don't know. I should be able to figure out what to do myself, without bothering him. Cognitive Behavior Therapy: Basics and

Judith: That’s an interesting idea—that you should be able to figure it out. Have you had a lot of experience looking at other people’s résumés? Abe: No, I don’t know that I ever saw one from someone else. Judith: How much bother do you think it would be for your son? Abe: Not that much, I guess. Judith: So, what would be good to remind yourself before you call him? Abe: That he’s had much more recent experience with résumés than I’ve had. That he’d probably be okay with helping me. Judith: (Praising Abe.) That’s excellent. Could you call him today? Abe: Tonight would be better. Abe was easily able to identify and respond to an unhelpful thought that could have posed an obstacle to taking a step toward achieving a valued goal. I asked him to imagine that, with his son’s help, he had successfully revised his résumé. Then I asked him how he felt emotionally in the image and helped him experience some of the positive feeling right in our session. (Some clients, facing a similar problem, might require a greater therapeutic effort before they’re able to follow through behaviorally.) BECOMING AN EFFECTIVE CBT THERAPIST I hope you have an aspiration to become an excellent therapist and help hundreds or thousands of individuals in your career. Keeping this aspiration in mind can help you persevere if you become anxious while reading this book. If you do feel nervous, remember that the cognitive model proposes you’ve had some negative thoughts. You’ll be learning tools throughout the book to address these kinds of unhelpful thoughts. Meanwhile, it helps to think about a specific reading goal each week and the obstacles you might face in taking the steps you need to. And make sure your expectations for yourself are reasonable. I’d like you to know that I wasn’t a very good therapist when I first began doing CBT. How could it have been any different? I had never done therapy before. So, give yourself a break if you’re just starting out or if you’re fairly new to CBT. You’re in good company. Recognize and give yourself credit for each chapter you read. Also give yourself credit for answering the reflection questions and doing the practice exercises you’ll find at the end of each chapter. Compare yourself to your peers, not to expert CBT therapists.

We often use analogies and metaphors in CBT (Stott et al., 2010). Here’s a common one we use with clients that you may find useful yourself. “Do you remember learning how to drive or to play a musical instrument? 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 CBT therapist. Keep your goals small, well defined, and realistic. Compare your progress to your ability level before you started reading this book or to the time you first started learning about CBT. Be careful not to undermine your confidence by contrasting your current level of skill with your ultimate objective. If you feel anxious about starting to use CBT with clients, make yourself a “coping card,” a physical or virtual index card on which you have written statements that are important to remember. You’ll be using coping cards or their equivalents with your clients (because we make sure that anything we want clients to remember is written down). My psychiatric residents often have unhelpful thoughts before they see their first outpatients. After a discussion, they create a card that addresses these thoughts. The card is individualized but generally says

something such as follows: My goal is not to cure this client today. No one expects me to. My goal is to establish a good relationship, to inspire hope, to identify what's really important to the client, and perhaps to figure out a step the client can take this week toward achieving his or her goals.

Reading a card like this can help you reduce your anxiety so you can focus on your clients and be more effective. To the untrained observer, CBT sometimes appears deceptively simple. The cognitive model, the proposition that one's thoughts influence one's emotions and behavior (and sometimes physiology), is quite straightforward. Experienced CBT therapists, however, seamlessly accomplish many tasks at once: building rapport, socializing and educating the client, collecting data, conceptualizing the case, working toward clients' goals and overcoming obstacles, teaching skills, summarizing, and eliciting feedback. As they're accomplishing these tasks, they sound almost conversational. If you're new to the field, you will need 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, you first need to learn skills to develop the therapeutic relationship and to conceptualize clients. You'll also learn the techniques of CBT (and other modalities), all of which is best done in a step-by-step manner. You can view the development of expertise as a CBT therapist in four stages. (These descriptions assume that you are already proficient in basic counseling skills: listening, empathy, concern, positive regard, and genuineness, as well as accurate understanding, reflection, and summarizing.) 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 learn how to develop a strong therapeutic relationship. You learn how to structure the session and use your conceptualization of the client and good common sense to plan treatment, considering your clients' values, aspirations, and goals. You help clients develop solutions to the obstacles they face and view their dysfunctional thoughts in a different way. You learn to use basic cognitive and behavioral techniques and to teach your clients how to use them. 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 objectives of treatment and more skillful at conceptualizing clients, refining your conceptualization, and using the conceptualization to make moment-to-moment decisions about interventions. You expand your repertoire of strategies and become more proficient in selecting, timing, and implementing appropriate techniques and in strengthening the therapeutic relationship. 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 client. You vary the structure and techniques of basic CBT as appropriate, particularly for clients with personality

disorders and other difficult disorders and problems. You become more skilled at preventing and also repairing ruptures in the therapeutic alliance. In Stage 4 you continue learning CBT for the rest of your professional life. I keep learning from every client I treat. I participate in weekly case conferences, consult on clinical matters with colleagues and supervisees, and stay current with CBT research and practice by reading books and articles and regularly attending conferences. I'm a much better therapist today than I was 5 years ago. And I hope to be a better therapist 5 years from now. I hope you will adopt a similar attitude about the importance of lifelong learning. If you

already practice in another psychotherapeutic modality but are new to CBT, you will likely be more effective if you start implementing it with new clients. If you decide to implement it with existing clients, it will be important for you to do so collaboratively. You should describe what you would like to do differently, provide a rationale, and seek the client's agreement. Most clients agree to such changes when they are phrased positively, to the client's benefit. When clients are hesitant, you can suggest a change (such as setting an agenda) as an "experiment," rather than a commitment, to motivate them to try it. Therapist: I was reading an important book on making therapy more effective and I thought of you. Client: Oh? Therapist: Yes, and I have some ideas about how you might be able to feel better faster. [being collaborative] Is it okay if I tell you about it? Client: Okay. Therapist: One thing I read was called "setting the agenda." That means at the beginning of sessions, I'd like to ask you which goals or issues you want to work on in the session. For example, you might say that you'd like to work on socializing more or getting more done around the house. This will help us figure out how to spend our time in session better. (pause) How does that sound? MAKING THE BEST USE OF THIS BOOK This book is intended for students and clinicians at any stage of experience and skill development who lack mastery in the fundamental building blocks of cognitive conceptualization and treatment—or who want to learn how to incorporate principles of CT-R into treatment. It's critical to master the basic elements of CBT (and CT-R) so you can Cognitive Behavior Therapy: Basics and Beyond

understand how and when to vary standard treatment for individual clients. The chapters of this book are designed to be read in the order presented. You might be eager to skip over introductory chapters and jump to the "how-to" chapters. The sum of CBT, however, is not merely the use of cognitive and behavioral techniques. Among other attributes, it entails the artful selection and effective use of many different kinds of interventions based on your conceptualization of the client. Visit beckinstitute.org/CBTresources to find videos of Abe's treatment and downloadable worksheets. You'll find a list of additional CBT resources in Appendix A. A note about worksheets: You'll need to print out some worksheets, such as the Thought Record and the Testing Your Thoughts Worksheet (from Chapter 15), because they contain a great amount of information. And you may need to print out additional worksheets when you're first starting to use CBT. But once you become familiar with the material, it's often preferable to hand draw worksheets as you sit in the session with a client. Doing this allows you to individualize them as necessary, and you are more likely to avoid a negative reaction from clients who don't like formal worksheets. Your growth as a CBT therapist will be enhanced if you start applying what you learn to yourself. Make sure to do all the practice exercises. For example, in the practice exercise at the end of this chapter, you'll be directed to identify your own automatic thoughts as you read this book. You can note them and refocus on your reading. Or after identifying them, you could use the questions on the next page to create a coping card for yourself. By turning the spotlight on your own thinking, you can boost your CBT skills, modify your dysfunctional thoughts, and positively influence your mood (and behavior), making you more receptive to learning. Other practice exercises ask you to role-play with a peer, friend, colleague, or family member. If you can't find a role-play partner, you can write a transcript with an imaginary client. Or you might do both. The more you practice the vocabulary and concepts of CBT, the better your treatment will be. Teaching yourself the basic skills of CBT using yourself as the subject will enhance your ability to teach your clients these same skills. As an added bonus, when you use skills that are helpful, you can do some relevant self-disclosure with clients—which can encourage them to practice the skill too. An online course also provides you with many opportunities to practice using CBT skills on yourself; it's one of the best ways to really

grasp and practice this kind of therapy. It’s also important for you to know what this book doesn’t cover. Its focus is depression, and important variations are needed to treat

other disorders. It doesn’t include how to adapt treatment for youth or older adults. And it doesn’t address the very important topics of self-harm, substance use, suicidality, or homicidality. You will need to supplement your learning to be effective with individuals who vary substantially from our major client example, Abe. SUMMARY CBT was developed by Dr. Aaron Beck in the 1960s and 1970s and has since been demonstrated to be effective in more than 2,000 published outcome studies. Today, it is considered the “gold standard” of psychotherapy (David et al., 2018). It’s based on the theory that people’s thinking influences their emotions and behavior. By helping their clients evaluate and change dysfunctional or unhelpful thinking, CBT therapists can bring about lasting change in mood and behavior. CBT therapists employ techniques from many different psychotherapeutic modalities, applied within the context of the cognitive model and of their individualized conceptualizations of their clients. A recovery orientation focus has recently been added to traditional CBT, emphasizing values and aspirations, drawing positive conclusions from their day-to-day activities, and experiencing positive emotion in and outside of the therapy session. REFLECTION QUES TIONS What new ideas have you learned about CBT or CT-R in this chapter? How could CBT techniques help you? What thoughts could readers have that would deter them from applying CBT skills to themselves? What would be good responses to those thoughts? PRACTICE EXERCISE As of right now, start noticing when • your mood has changed or intensified in a negative direction, • you are having bodily sensations associated with negative emotion (such as your heart beating fast when you become anxious), and/or • you are engaging in unhelpful behavior or avoiding engaging in helpful behavior.

Ask yourself what emotion you are experiencing, as well as the cardinal question of cognitive therapy: “What was just going through my mind?” This is how you’ll teach yourself to identify your own automatic thoughts. Pay particular attention to automatic thoughts that get in the way of achieving your goals, especially the ones that interfere with reading this book and trying techniques with clients. You may recognize thoughts such as these: “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 help my client?” Experienced therapists whose primary orientation has not been CBT may be aware of a different set of automatic thoughts: “This won’t work.” “The client won’t like it.” “It’s too superficial/structured/unempathic/simple.”

Introduction to Cognitive Behavior Therapy