01 - 2. Overview of Treatment

2. Overview of Treatment

I n this chapter, you'll read about CBT principles of treatment. While CBT is individualized for each person, there are certain commonalities that apply to most clients. But don't worry about remembering everything in this chapter because you'll be exposed to all the concepts at various points throughout the book. I just want you to have a sense of what CBT is like. You may want to watch a full therapy session and use the Principles of Treatment Checklist (you'll find both at beckinstitute.org/CBTresources) to note which principles below are illustrated in the video. PRINCIPLES OF TREATMENT 1. CBT treatment plans are based on an ever-evolving cognitive conceptualization. 2. CBT requires a sound therapeutic relationship. 3. CBT continually monitors client progress. 4. CBT is culturally adapted and tailors treatment to the individual. 5. CBT emphasizes the positive. 6. CBT stresses collaboration and active participation. 7. CBT is aspirational, values based, and goal oriented. 8. CBT initially emphasizes the present. 9. CBT is educative. OVERVIEW OF TREATMENT

10. CBT is time sensitive.
11. CBT sessions are structured.
12. CBT uses guided discovery and teaches clients to respond to their dysfunctional cognitions.
13. CBT includes Action Plans (therapy homework).
14. CBT uses a variety of techniques to change thinking, mood, and behavior. Principle 1: CBT treatment plans are based on an ever-evolving cognitive conceptualization. I base my conceptualization of clients on the data they provide at the evaluation, informed by the cognitive formulation (key cognitions, behavioral strategies, and maintaining factors that characterize their disorder[s]). From the beginning, I incorporate their strengths, positive qualities, and resources into my conceptualization too. I continue to refine this conceptualization throughout therapy as I collect additional data, and I use the conceptualization to plan treatment. My treatment plan for Abe initially focused on current cognitions and problematic behaviors that interfered with working toward his goals. We discussed increasing action in line with Abe's values and aspirations, and he began monitoring his positive experiences. Toward the middle of therapy, we added a focus on underlying beliefs that undermined his confidence. At the end of treatment, we added an emphasis on planning for the future, anticipating obstacles, and developing a plan to

overcome these obstacles. We also responded to maladaptive cognitions about termination and focused on cognitions and behaviors that are important for relapse prevention. I conceptualize Abe's difficulties in three time frames. From the beginning, I identify current cognitions that are obstacles to his aspirations ("I'm a failure"; "I can't do anything right"). I also identify behavioral obstacles that serve to maintain his depression (isolating himself, inactivity). Second, I identify precipitating factors that influenced Abe's perceptions at the onset of his depression. He struggled at work and then lost his job; his wife became increasingly critical and divorced him. These events led to his belief that he was incompetent. Third, I hypothesize about the key developmental events and his enduring patterns of interpreting these kinds of events that may have predisposed him to depression. As a preteen, Abe's mother expected him to take on significant responsibilities at home, for which he was developmentally ill equipped. Rather than seeing that his overwhelmed mother was expecting too much of him, he interpreted her criticism as valid.

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Principle 2: CBT requires a sound therapeutic relationship. Clients vary in the degree to which they are initially able to develop a good therapeutic alliance. It wasn't difficult to establish the relationship with Abe, though initially he was skeptical that I could help him. Using good Rogerian counseling skills, asking him for his reaction to the treatment plan, making collaborative decisions about treatment, providing rationales for interventions, using self-disclosure, eliciting feedback during and at the end of sessions, and working hard to achieve (and have him recognize) progress contributed to our alliance. In general, you spend enough time developing the therapeutic relationship to engage clients in working effectively with you as a team. You use the relationship to provide evidence that clients' negative beliefs, especially beliefs about the self (and sometimes about others), are inaccurate and that more positive beliefs are valid. If the alliance is sound, you can maximize the time you spend helping clients resolve obstacles they will face in the coming week. Some clients, particularly those with personality disorders, do require a far greater emphasis on the therapeutic relationship and advanced strategies to forge a good working alliance (J. S. Beck, 2005; Beck et al., 2015; Young, 1999). Principle 3: CBT continually monitors client progress. The earliest CBT treatment manual, Cognitive Therapy of Depression (Beck et al., 1979), advised therapists to use weekly symptom checklists and to elicit both verbal and written feedback from clients at the end of sessions. Various studies have since demonstrated that routine monitoring improves outcomes (Boswell et al., 2015; Lambert et al., 2001, 2002; Weck et al., 2017). Client outcomes are enhanced when both clients and therapists receive feedback on how clients are progressing. With an increased emphasis on a recovery orientation, many CBT therapists now also measure clients' general functioning, progress toward their goals, and sense of satisfaction, connection, and well-being. Principle 4: CBT is culturally adapted and tailors treatment to the individual. CBT has traditionally reflected the values of the dominant culture in the United States. Clients with different ethnic and cultural backgrounds, though, have better outcomes when their therapists appreciate the significance of cultural and ethnic differences, preferences, and practices (Beck, 2016; Smith et al., 2011; Sue et al., 2009). CBT tends to emphasize rationality, the scientific method, and individualism. Clients from other cultures may hold different values and preferences: for example, emotional reasoning, varying degrees of emotional expression, and collectivism or interdependence. Cognitive Behavior Therapy: Basics and Beyond

When clients’ cultures are different from your own, you may need to improve your cultural competency. You may, in fact, be largely unaware of your own cultural biases. You may also be unaware of the extent of cultural bias some clients experience in their community, especially if they are not part of the majority culture. Such biases and prejudice may play a significant role in your clients’ difficulties. Your clients may differ from you in many ways, in addition to culture. These include age, religious or spiritual orientation, ethnicity, socioeconomic status, disability, gender, sexual identity, and sexual orientation (Iwamasa & Hays, 2019). Make sure to educate yourself about your clients’ characteristics and anticipate how these differences might be relevant to treatment. Hays (2009) describes strategies to make CBT culturally responsive, including assessing the client’s and family’s needs, emphasizing culturally respectful behavior, identifying culturally related strengths and supports, and validating clients’ experiences of oppression. Of course, you still need to conceptualize the individual client and refrain from assuming that you’ll need to vary treatment for a given individual. Principle 5: CBT emphasizes the positive. Recent research demonstrates the importance of emphasizing positive emotion and cognition in treating depression (see, e.g., Chaves et al., 2019). You help clients actively work toward cultivating positive moods and thinking. It is also very important to inspire hope. Abe was like most depressed clients. He tended to focus on the negative. When he was in the depressive mode, he automatically (i.e., without conscious awareness) and selectively attended to negative experiences. He also misread neutral experiences as negative at times. In addition, he often discounted or failed to recognize more positive experiences. His difficulty in processing positive data in a straightforward manner led him to develop a distorted sense of himself. To counteract this feature of depression, you continually help clients attend to the positive. I want Abe to start engaging in experiences in which he concludes he is a resourceful person who can solve problems, overcome obstacles, and lead a satisfying life. Principle 6: CBT stresses collaboration and active participation. Both therapists and clients are active. I encourage Abe to view therapy as teamwork; together we decide what to work on each session, how often we should meet, and what Abe can do between sessions. At first, I’m more active in suggesting a direction for therapy sessions and for some Action Plans (therapy homework). As Abe becomes less depressed and more socialized to treatment, I encourage him to

become increasingly active in the session: deciding which steps to take toward his goals, problem solving potential obstacles, evaluating his dysfunctional cognitions, summarizing important points, and devising Action Plans. Principle 7: CBT is aspirational, values based, and goal oriented. In your initial session with clients, you should ask them about their values (what is really important to them in life), their aspirations (how they want to be, how they want their life to be), and their specific goals for treatment (what they want to accomplish as a result of therapy). Being responsible, competent, productive, and helpful to others were important values for Abe. He aspired to have a better life, to regain his sense of optimism and well-being, and to feel in control. His specific goals included being a better father and grandfather and getting a good job. But thoughts such as “I’m such a failure” and “I’ll never get a job” were obstacles. They had contributed to his avoiding steps he needed to take to reach his goals. Principle 8: CBT initially emphasizes the present. The treatment of most clients involves a strong focus on the skills they need to improve their mood (and their lives). Clients who use these skills consistently (during and after treatment) have better outcomes than those who don’t, even in the face of significant stressful life events (Vittengl et al.,

2019). When Abe viewed distressing situations more realistically, solved problems, and worked toward his goals, he felt less depressed. His mood became more positive as he focused his attention on what was going well in his life and what admirable qualities those experiences indicated about him as a person. You shift the focus to the past in three circumstances:

1. When the client expresses a strong desire to do so,
2. When work directed toward current problems and future aspirations produces insufficient change, or
3. When you judge that it's important for you and clients to understand how and when their key dysfunctional ideas and behavioral coping strategies originated and became maintained. Afterward, you'll discuss what your clients now understand about the past and how they can make use of their new understanding in the coming week. For example, midway through treatment, Abe and I briefly discussed some childhood events to help him identify a belief he learned Cognitive Behavior Therapy: Basics and Beyond

as a child: "If I ask for help, people will see how incompetent I am." I helped Abe evaluate the validity of this belief in both the past and the present. Doing so led him, in part, to develop a more functional, more reasonable belief. If he had had a personality disorder, I may have spent proportionally more time discussing his developmental history and childhood origin of beliefs and coping behaviors. Principle 9: CBT is educative. A major goal of treatment is to make the process of therapy understandable. Abe felt more comfortable once he knew what to expect from treatment, when he clearly understood what I wanted him to do, when he felt as if he and I were a team, and when he had a concrete idea of how therapy would proceed, both within a session and over the course of treatment. In our first session, I educated Abe about the nature and course of his disorder, the process of CBT, the structure of sessions, and the cognitive model. I provided him with additional psychoeducation in future sessions, presenting my ongoing and refined conceptualization and asking him for feedback. I used diagrams throughout treatment to help Abe understand why he sometimes had distorted thoughts and maladaptive reactions. (See Boisvert & Ahmed [2018] for many kinds of diagrams that are helpful in educating clients.) Throughout treatment, after using various techniques, I taught Abe how to use the techniques himself, so he could learn to be his own therapist. At each session, I encouraged Abe to record the most important ideas he had learned so he could review his new understandings daily. Abe also occasionally reviewed these notes after termination, when he found himself slipping back into old patterns of thinking and behavior. Principle 10: CBT is time sensitive. We used to say that CBT was a short-term therapy. Many straightforward clients with depression and anxiety disorders require between 6 and 16 sessions. But the treatment for some conditions needs to be much longer. We try to make treatment as short term as possible while still fulfilling our objectives: to help clients recover from their disorder(s); work toward fulfilling their aspirations, values, and goals; resolve their most pressing issues; promote satisfaction and enjoyment in life; and learn skills to promote resilience and avoid relapse. Abe initially had weekly therapy sessions. (Had his depression been more severe or had he been suicidal, I may have arranged more frequent sessions.) After 2½ months, Abe was feeling somewhat better and was able to use his skills between sessions. So, we collaboratively decided to experiment with every other week and then monthly sessions. Even after termination, we planned periodic "booster" sessions every 3 months for a year.

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Some clients need considerably more treatment over a longer period of time. Sometimes these clients have chaotic lives or face ongoing severe challenges such as poverty or violence. Some have chronic or treatment-resistant disorders. Others have personality disorders, entrenched substance use, bipolar disorder, eating disorders, or schizophrenia. A year or even two of therapy may be insufficient. Even after termination, they may need periodic sessions or additional (usually shorter) courses of treatment. Principle 11: CBT sessions are structured. CBT therapists aim to conduct therapy as efficiently as possible to help clients feel better as quickly as possible. Adhering to a standard format (as well as teaching the therapeutic techniques to clients) facilitates these objectives. You will tend to use this format in every session (unless your client objects, in which case you may need to negotiate the structure initially). I start planning Abe's treatment before he enters my office. I quickly review his chart, especially his goals for treatment and Action Plans (including therapy notes) from the previous session(s). My overarching therapeutic goal is to improve Abe's mood during the session and to create an Action Plan so he can feel better and behave more functionally during the week. What I do in any given session is influenced by Abe's goals and issues, my conceptualization, the strength of our therapeutic relationship, Abe's preferences, and the stage of treatment. Your goal in the first part of a therapy session is to reestablish the therapeutic alliance, review the Action Plan, and collect data so you and the client can collaboratively set and prioritize the agenda. In the second part of the session, you and the client discuss the issues or goals on the agenda. These kinds of discussions and interventions naturally lead to Action Plans. In the final part of the session, you or the client summarizes the session. You make sure the Action Plan is reasonable and then elicit and respond to clients' feedback. While experienced CBT therapists may deviate from this format at times, novice therapists are usually more effective when they follow the specified structure. Principle 12: CBT uses guided discovery and teaches clients to respond to their dysfunctional cognitions. In the context of discussing a problem or goal, you ask clients questions to help them identify their dysfunctional thinking (by asking what was going through their mind), evaluate the validity and utility of their thoughts (using a number of techniques), and devise a plan of action. With Abe, I use gentle Socratic questioning, which helps foster his sense that I am truly interested in collaborative empiricism, that is, helping him determine the accuracy and utility of his ideas through a careful review of the evidence. Note Cognitive Behavior Therapy: Basics and Beyond

that we refrain from challenging cognitions (by stating or trying to convince clients that their thoughts or beliefs aren't valid); rather, we help clients through cognitive restructuring, a process of assessing and responding to maladaptive thinking. In other sessions, I ask Abe about the meaning of his thoughts to uncover underlying beliefs he holds about himself, his world, and other people. Through questioning, I also guide him in evaluating the validity and functionality of his beliefs. And from the beginning of treatment, I help Abe fortify positive beliefs about himself by teaching him to give himself credit and guiding him to draw positive conclusions about the steps he has taken toward his goals. Depending on the kind of cognition you've agreed to address, you might substitute or add additional techniques to those above. When automatic thoughts are part of a dysfunctional thought process such as rumination, obsession, or continual self-criticism, you might help clients accept their thoughts nonjudgmentally and allow them to come and go on their own. To change cognitions at the emotional or gut level, you might use imagery, tell a story, offer analogies and metaphors, employ experiential techniques, do role-playing, or suggest behavioral experiments. Principle 13: CBT includes Action Plans (therapy homework). An important aim of treatment is to help clients feel better by the end of the session and to set them up to have a

better week. Action Plans usually consist of • identifying and evaluating automatic thoughts that are obstacles to clients' goals, • implementing solutions to problems and obstacles that could arise in the coming week, and/or • practicing behavioral skills learned in session. Clients tend to forget much of what occurs in therapy sessions, and when they do, they tend to have poorer outcomes (Lee et al., 2020). So here's our rule of thumb: Anything we want clients to remember is recorded. You or your client should write down therapy notes and Action Plans, either on paper or in the client's phone or tablet. Or you can

record therapy notes on a cell phone by using an app. Here's an example of a therapy note that Abe and I collaboratively composed: If I start to think that I can't sit down and pay bills, remind myself: · I'm only going to do it for 10 minutes. · It may be difficult but probably won't be impossible. · The first minute or two will probably be the hardest and then it's likely to get easier. · I should focus on the positive feeling I will get from accomplishing something I haven't been able to do. Action Plans naturally flow from the discussion of each goal or issue on the agenda. You'll need to craft them carefully with clients, based on the nature of the issue, your conceptualization of what will help most, practical considerations (such as time, energy, and opportunity), and client variables (e.g., level of motivation and concentration, and preferences). A frequent mistake of therapists is suggesting Action Plans that are much too difficult. Principle 14: CBT uses a variety of techniques to change thinking, mood, and behavior. In fact, we adapt strategies from many psychotherapeutic modalities within the context of the cognitive framework. For example, depending on my conceptualization of a client, I may use techniques from acceptance and commitment therapy, behavior therapy, compassion-focused psychotherapy, dialectical behavior therapy, Gestalt therapy, interpersonal psychotherapy, meta-cognitive therapy, mindfulness-based cognitive therapy, person-centered psychotherapy, psychodynamic psychotherapy, schema therapy, solution-based therapy, well-being therapy, or others. While you're still learning CBT, it will be difficult for you to incorporate a wider variety of interventions than the ones you'll read about in this book. 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. As you progress as a CBT clinician, it will be worthwhile to study these and other evidence-based treatments.

SUMMARY The basic principles described in this chapter apply to most clients. Guided by your cognitive conceptualization of each client, you will vary the techniques you use to tailor treatment to the individual. CBT treatment takes into account individuals' cultures, family history, and other important characteristics; the nature of their difficulties; their goals and aspirations; their ability to form a strong therapeutic bond; their motivation to change; their previous experience with therapy; and their preferences. The foundation of treatment is always a solid therapeutic relationship. REFLECTION QUES TIONS Which of the 14 principles of treatment did you already know were important elements of CBT? Which were new? Did any of them surprise you? PRACTICE EXERCISES Review the principles of treatment. Describe in your own words why each is important. Then think about what else you'd like to know about each principle and compose a relevant question. Consider watching an entire therapy session. Use the Principles of Treatment Checklist (beckinstitute.org/CBTresources) to note which principles are demonstrated in the video.

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