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4. The Therapeutic Relationship

I think it's an act of courage for most clients to enter treatment. Many have automatic thoughts such as "What is therapy going to be like?"; "Is it really going to work?"; "Could it make me feel even worse?"; "What am I going to have to do?"; "What if my therapist pushes me too hard?"; and "What if my therapist expects too much or criticizes me?" So while I am warm, kind, and realistically optimistic throughout therapy, I am especially so at the beginning of treatment. As far back as 1979, Aaron Beck and colleagues devoted an entire chapter to the therapeutic relationship in the first CBT treatment manual, *Cognitive Therapy of Depression*. They emphasized the Rogerian counseling skills of warmth, accuracy, empathy, and genuineness, along with basic trust and rapport. They also prescribed tailoring the relationship to the individual client, seeking agreement on the goals and tasks of treatment, sharing an interpersonal bond, and attending to clients' negative reactions to therapists and vice versa. You will find the answers to these questions in this chapter. What are four essential guidelines to keep in mind at every session? How do you demonstrate good counseling skills? How do you monitor clients' affect and elicit feedback? How do you collaborate with clients? How do you tailor the therapeutic relationship to the individual? How do you use self-disclosure? THE THERAPEUTIC RELATIONSHIP

How do you repair ruptures? How do you help clients generalize what have they learned to other relationships? How do you manage your negative reactions? FOUR ESSENTIAL GUIDELINES When I teach psychiatric residents at the University of Pennsylvania, we start our discussion on how to establish a good therapeutic relationship. Then I ask them to write themselves a virtual or actual card with four ideas, which they express in their own words. Here's a typical card: Treat every client at every session the way I'd like to be treated if I were a client. Be a nice human being in the room and help the client feel safe. Remember, clients are supposed to pose challenges; that's why they need treatment. Keep expectations for my client and myself reasonable. I ask the residents to read their card before every therapy session. It's essential to start building trust and rapport with your clients from your first contact with them. Research demonstrates that positive alliances are correlated with positive treatment outcomes (e.g., Norcross & Lambert, 2018; Norcross & Wampold, 2011; Raue & Goldfried, 1994). Your objective is to make your clients feel safe,

respected, understood, and cared for. Spend enough time on the relationship to make that happen, but ensure that you have sufficient time to help clients reach their goals, alleviate their distress, and enhance their functioning and positive mood. Research has demonstrated that the therapeutic alliance becomes strengthened when clients perceive improvement from one session to the next (DeRubeis & Feeley, 1990; Zilcha-Mano et al., 2019). So, roll up your sleeves and get to work.

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You will need to focus more heavily on the relationship when you treat clients with strong, dysfunctional personality traits or serious mental health conditions. They tend to bring the same extreme negative beliefs about themselves and others to treatment—and may assume, until strongly demonstrated otherwise, that you will view them negatively (J. S. Beck, 2005; Beck et al., 2015; Young, 1999). A good case conceptualization can help you avoid problems. For example, Abe believed that people would look down on him because he was unemployed. He was concerned that I would too. Fortunately, I noticed a change in his facial expression during the evaluation when he first told me he was unemployed. I asked him how he was feeling. He said, “A little anxious.” I asked him what was going through his mind. He told me he was afraid I was viewing him negatively. I praised him for telling me that and assured him that it made sense to me that he would have been having difficulty getting himself to look for a job, given his level of depression. He was relieved. I asked him if he’d be willing to let me know if he had any other thoughts about my being critical in the future. And I made a mental note to be on the lookout for future instances where that could happen. DEMONSTRATING GOOD COUNSELING SKILLS Norcross and Lambert (2018) have reviewed the research and drawn the following conclusions about the therapeutic relationship: • Collaboration, goal consensus, empathy, positive regard and affirmation, and collecting and delivering client feedback are effective. • Congruence/genuineness, emotional expression, cultivating positive expectations, promoting treatment credibility, managing countertransference, and repairing ruptures are probably effective. • Self-disclosure and immediacy are promising but have not yet been sufficiently researched. • Therapist humor, self-doubt/humility, and deliberate practice also lack sufficient research. In CBT, the Rogerian counseling skills of empathy, genuineness, and positive regard are especially important (Elliott et al., 2011). You will continuously demonstrate your commitment to and understanding of clients through your empathic statements, choice of words, tone Cognitive Behavior Therapy: Basics and Beyond

of voice, facial expressions, and body language. You will try to impart the following implicit (and sometimes explicit) messages, when you genuinely endorse them: “I care about you and value you.” “I want to understand what you are experiencing and help you.” “I’m confident we can work well together and that CBT will help.” “I’m not overwhelmed by your problems, even though you might be.” “I’ve helped other clients with issues like yours.” If you cannot honestly endorse these messages, you may need help from a supervisor or colleague to respond to your automatic thoughts about the client, about CBT, or about yourself. And you may need additional training and supervision to increase your competence. Important basic counseling skills, along with examples, are below. • Empathy (“It must be so difficult for you when your ex-wife is angry”). • Acceptance of client (“It makes sense to me, given how upset you were, that you [engaged in a dysfunctional coping strategy] this week”). • Validation (“It can be really hard to start difficult conversations with people”). • Accurate understanding (“Did I get this right? She said, ; you felt ; you then [did]”). •

Inspiring hope (“The reason I’m so hopeful for you is ”). • Genuine warmth (“I’m glad you were able to get out of your apartment so many times this week!”). • Interest (“Tell me more about your grandsons”). • Positive regard (“Offering to help your neighbor was such a kind thing to do! I’m not sure everyone would be willing to put themselves out the way you did”). • Caring (“It’s really important to me that I make this therapy right for you”). • Encouragement (“You know, the fact that you felt a little better when you spent some time with your friends is such a good sign”). • Positive reinforcement (“How great that you finally got your taxes done!”).

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• Offering a positive view of the client (“It sounds like it was so complicated to figure out what was wrong with your cousin’s car. You’re so good at things like that”). • Compassion (“I’m sorry you had such an upsetting conversation with your ex-wife”). • Humor (“You should have seen me when I ”). As described later on, you’ll need to figure out when and to what degree to use these basic counseling skills. But the using the right amount at the right times, can help clients • feel likeable, when you are warm, friendly, and interested; • feel less alone, when you describe the process of working together as a team to resolve their issues and work toward their goals; • feel more optimistic, as you present yourself as realistically hopeful that treatment will help; and • feel a greater sense of self-efficacy, when you help them see how much credit they deserve for solving problems, completing Action Plans, and engaging in other productive activities. **MONITORING CLIENTS’ AFFECT AND ELICITING FEEDBACK** You will be continuously alert for your clients’ emotional reactions throughout the session. You’ll observe their facial expressions and body language, their choice of words, and tone of voice. When you recognize or infer that clients are experiencing increased distress, you will often address the issue right at the moment—for example: “You’re looking a little upset. [or ‘How are you feeling right now?’] What was just going through your mind?” Clients often express negative thoughts about themselves, the process of therapy, or you. When they do, make sure to positively reinforce them. “It’s good you told me that.” Then conceptualize the problem and plan a strategy to resolve it. You’ll read more about how to do this later in the chapter. I hope you won’t let a concern about getting negative feedback prevent you from eliciting clients’ responses. If there’s a problem, you need to know what it is so you can solve it! If you aren’t sure what to say, try this: “It’s good you told me that. I’d like to think more about it. Is it okay if we discuss it at our next session?” **Cognitive Behavior Therapy: Basics and Beyond**

Then get advice from your supervisor or colleague and practice role-playing your response. If you don’t address clients’ negative feedback, they will probably be less able to focus on the work of the session. They may even decide not to return to therapy the following week. Even when you discern that your alliance with clients is strong, elicit feedback from them at the end of sessions. For the first few sessions, you might ask, “What did you think about the session? Was there anything that bothered you, or you thought I misunderstood? Is there anything you want to do differently next time?” After several sessions, when you believe clients will give you honest feedback, you can just ask, “What did you think of the session?” Asking these questions can strengthen the alliance significantly. You may be the first health or mental health professional who has ever asked the client for feedback. I find that clients usually feel honored and respected by our genuine concern for their reactions. You won’t necessarily elicit feedback every time you infer the client has had a negative reaction. For example, you may be able to ignore teenage eye-rolling the first couple of times your young client engages in it. I remember an adult client of mine who often sighed.

Initially, I helped her respond to her unhelpful thought, “I wish I didn’t have to do that.” When she sighed in subsequent sessions, I judged that we could continue with the issue we were discussing without needing to address the automatic thought associated with her sighing. **COLLABORATING WITH CLIENTS** As mentioned previously, collaboration is a hallmark of CBT. In chapter 6, you’ll read more about how to start the collaborative process in the first session, and you’ll see collaboration in action in many of the videos. Throughout treatment, you will foster collaboration in many ways. For example, you and your client will jointly make decisions such as • which goals to work toward during a session; • how much time to spend on various goals and obstacles; • which automatic thoughts, emotions, behaviors, or physiological responses to target; • which interventions to try; • which self-help activities to do at home; • how often to meet; and • when to start tapering sessions and ending treatment.

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You’ll explain to clients in the first session that you and they will act as a team. You’ll be transparent and ask for feedback about your goals, the process of therapy, the structure of sessions, and your conceptualization and treatment plan. Throughout this book, you’ll find examples of collaborative empiricism where you and clients act as scientists, looking for evidence that supports or disconfirms their cognitions and, when relevant, seeking alternative explanations. **TAILORING THE THERAPEUTIC RELATIONSHIP TO THE INDIVIDUAL** While the counseling skills we discussed earlier are essential, so is your ability to assess and adjust the degree to which you use these skills with each client. Most clients respond positively to your use of these behaviors. But you need to be careful not to overdo it or underdo it with individual clients. For example, some clients may view warmth and empathy in a negative light and feel suspicious, patronized, or uncomfortable. Too little can lead other clients to believe that you don’t value or like them. Watching for clients’ emotional reactions in the session can alert you to a problem so you can change how you present yourself and help the client feel more comfortable working with you. Your clients’ cultures and other characteristics (such as age, gender, ethnicity, socioeconomic status, disability, gender, and sexual orientation) can influence the therapeutic relationship (Iwamasa & Hays, 2019). Clients may differ in the way they view you, your role, and their role. Clients from one culture, for example, may feel more comfortable when they perceive you as an expert who takes charge in the session, while clients from another culture may perceive you as dominating the session in a disrespectful way. Some clients value your suggestions of alternative perspectives or behaviors. Other clients may be disturbed when these same suggestions are in conflict with their culturally influenced beliefs and practices. It’s important to recognize that your own background and culture exert an influence on your beliefs and values and on how you perceive, speak to, and behave toward your clients. Understanding the impact of your cultural biases helps you respond to clients in a culturally sensitive way. You may, for example, need to vary how you introduce yourself to and address clients, how you maintain eye contact, what words you choose, how you express respect, and how much self-disclosure you use, depending on the client’s culture. Of course, each client is an individual for whom you develop an individualized conceptualization and an individualized treatment plan. You may find that despite significant cultural differences, any given client may respond well, without the need for you to adapt your general style. **Cognitive Behavior Therapy: Basics and Beyond**

USING SELF-DISCLOSURE I know some therapists are taught in graduate school not to use self-disclosure. This prohibition may stem from the psychoanalytic concept of the therapist as a “blank screen.” But in CBT, you don’t want to be a blank screen. You want clients to accurately perceive you as a warm, authentic person who wants, and is capable, of helping them. Judicious self-disclosure can go a long way in fortifying this perception. Of course, self-disclosure should have a definite purpose, for example, strengthening the therapeutic relationship, normalizing the clients’ difficulties, demonstrating how CBT techniques can help, modeling a skill, or serving as a role model. I’ve found that most clients are curious about me as a person. These days, your clients may be able to find out about you through social media—so be careful what you post and what your friends and family post about you. I’m happy to answer questions about my age, how long I’ve been married, how many children and grandchildren I have, where I went to school, and what my training and experience have been. If clients ask me additional questions, I gently turn the discussion back to them—for example: “We could keep on talking about me, but then we won’t have as much time to talk about what’s important to you, how you can have a better week. Is it okay if we turn [or get back] to ?” It’s also acceptable and sometimes important to reveal less about yourself than I do. It is usually inappropriate, for example, to answer questions about subjects such as your dating life or alcohol use. You might say something like the following: “I’m sorry not to answer your question, but I want to focus on how I can help you.” I tend to use some self-disclosure in most sessions with most of my clients. For example, when clients are perfectionistic, I often tell them that I keep a sticky note on my desk that says, “Good enough.” When they are overly responsible and say yes too often, I tell them about my sticky note that says, “Just say no.” I generally do mild self-disclosures when clients are giving me an update of their week, especially when they tell me about an experience in which they felt better. For example, when Abe told me he watched a baseball game with his son and grandsons, I asked, Judith: Which team are you rooting for? The Phillies? Abe: Yes. Judith: I didn’t watch the game, but who won? Abe: Unfortunately, it was the Braves. Judith: Oh, too bad. How are the Phillies doing this season?

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When Abe told me he took his granddaughters to an amusement park, I said, “My grandchildren aren’t quite old enough to go there. But I did take my kids there when they were teenagers. I wonder if it’s changed much over the years.” I also often use self-disclosure when a client tells me about a problem that I have experienced myself. Abe related that he was having trouble cleaning out a closet because he couldn’t figure out what to throw away and what to keep. Judith: I sometimes have that problem too. Should I tell you what I do? Abe: Yes. Judith: Instead of two piles, I make three. One is for things I definitely want to keep. A second is for things I definitely want to get rid of. The third is for things I’m uncertain about. I put all the uncertain things in a box for a few months. Then I go through it again. Anything I haven’t used in that time probably means I can get rid of it. (pause) Do you think that could work for you, too? As with any technique, pay attention to your clients’ verbal and nonverbal reactions to your self-disclosures. I learned early on, for example, that many clients with narcissistic personality disorder didn’t particularly appreciate hearing anything about me. Finally, be judicious in revealing your own automatic thoughts and reactions. Timing is everything! Saying something like “It makes me feel sad when I hear about what your father did when you were a child” may be inappropriate at the first session, before the client trusts your genuineness. It might be better to say, “I’m so sorry that happened to you.” Expressing your genuine sadness can really strengthen your bond, though, after you’ve established

a trusting relationship. Your clients may also benefit from your reactions to their unhelpful behaviors. Here's something nonpejorative you can say when an angry client has calmed down a little. "When you get really passionate about something and yell, it makes it harder for us to figure out what to do about the problem we've been discussing." If the client takes your feedback well, you can ask him (at the time or at a later time) whether he yells loudly outside of session. If he does, you can inquire whether yelling is inconsistent with a value he holds or if it fails to produce the long-term outcome he desires.

REPAIRING RUPTURES

Why do difficulties in the relationship arise with some clients and not others? Clients bring their general beliefs about themselves, other people, and relationships to the therapy session, as well as their Cognitive Behavior Therapy: Basics and Beyond

characteristic behavioral coping strategies. Many clients enter treatment with the beliefs "Other people are generally trustworthy and helpful" and "Problems in a relationship can usually be resolved." If so, they tend to assume that you will accurately understand, empathize with, and accept them. They feel free to reveal their difficulties, faults, weaknesses, and fears and to express their preferences and opinions. It's relatively easy to form a collaborative team with them. But some clients believe "Other people will hurt me" and "Problems in relationships can't be solved." These clients tend to feel vulnerable and are on guard when they start therapy, assuming you may be critical, uncaring, manipulative, or controlling. They may resist revealing what they see as their negative qualities or behaviors, either avoiding certain topics or insisting on controlling or dominating the session. A problem obviously exists when clients give you negative feedback (e.g., "I don't think you understand what I'm saying" or "You're treating me like everyone else"). Many clients, however, allude indirectly to a problem, sometimes taking responsibility themselves, for example, saying, "Maybe I'm not expressing myself clearly" when they really mean, "You're not understanding me." If so, you'll need to question the client further to find out whether a problem does indeed exist and whether it's had a negative impact on the alliance. It's important to use your conceptualization of the client to prevent or repair problems. Let's say your client has given you negative feedback (e.g., "This isn't helping") or you have inferred an affect shift and elicited an important automatic thought (e.g., "You don't care about me"). First, you provide positive reinforcement ("It's good you told me that" or the equivalent); then, you conceptualize the problem and plan a strategy. The first question to ask yourself is "Is the client right?" If so, model good apologizing and discuss a solution. Typical mistakes include introducing a worksheet that is confusing to your client, offering a suggestion that your client finds inappropriate, proposing Action Plan items that are too difficult, misunderstanding what your client has said, or being too directive or too nondirective. Another common problem is interrupting too much (see p. 194). At one particular session, I noticed a negative affect shift on Abe's face. Judith: You're looking a little distressed. What were you thinking when I asked you about the Action Plan? Abe: I don't think I can talk to my ex-wife about our daughter. She'd just criticize me. Judith: It's good you told me. I think I made a mistake to suggest it. Should we try to figure out another way to help your daughter?

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After we came up with another solution, I questioned Abe further, to increase the likelihood that he'd be willing to tell me about other misunderstandings: Judith: Abe, are there any other things you think I don't understand? Abe: (Thinks.) No, I don't think so. Judith: If I do make another mistake, do you think you could let me know right away? If you haven't made a mistake, the

problem is likely to be related to your client's inaccurate cognitions. After positively reinforcing your client for expressing the feedback, you might do the following:

- Express empathy.
- Ask for additional information in the context of the cognitive model.
- Seek agreement to test the validity of the thought.

I did this with Maria.

Judith: Can we talk for a moment about phone calls? Maria: (guardedly) Okay.

Judith: It seems to me that at least once this week when you called me, it wasn't really a crisis.

Maria: You don't understand! I was so upset!

Judith: It's good you told me that. What does it mean to you that we're even talking about phone calls?

Maria: Well, obviously, you don't care about me or a few phone calls wouldn't bother you.

Judith: That's an interesting thought, that I don't care. How much do you believe it?

Maria: 100%.

Judith: And how does that thought make you feel?

Maria: Upset. Really upset.

Judith: It would be so important for you to find out whether that thought is 100% true, or 0% true, or somewhere in the middle. (pause) Other than phone calls, do you have other evidence that I don't care about you?

Maria: (Thinks; mutters.) I can't think of anything.

Judith: Okay, is there any evidence on the other side, that maybe I do care about you?

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Maria: Not really.

Judith: [offering evidence] Well, do you see how I always start our sessions on time? Do I seem glad to see you? Do I seem sorry when you're upset? Do I work hard to help you?

Maria: I guess so.

Judith: Could there be another explanation for why I've brought up phone calls, other than I don't care?

Maria: I don't know.

Judith: Is it possible I brought it up because I know you get upset and I want to teach you some skills to reduce your distress—so you won't even have to call?

Maria: I guess so. But when I'm upset, there's nothing I can do!

Judith: Which is exactly why I brought up the phone calls. I want you to build your skills so you can be confident that you can help yourself. That way, when I'm out of the picture, you'll have the choice about whether to call someone immediately—or whether to help yourself and then either call or not.

Maria: (Sighs.) Okay.

HELPING CLIENTS GENERALIZE TO OTHER RELATIONSHIPS

When clients have an incorrect view of you, they may very well have a similarly incorrect view of other people. If so, you can help them draw a conclusion about your relationship and then test it in the context of other relationships.

Judith: Maria, can you summarize what you just learned?

Maria: I guess you do care.

Judith: That's right. Of course I care. (pause) Maria, have you had this idea about anyone else lately?

Maria: (Thinks.) Yeah. My friend, Rebecca.

Judith: What happened?

Maria: Well, this was yesterday. We were supposed to go to a movie together, but she texted me at the last minute and said she wasn't feeling well and didn't want to go. But she could have invited me over! We could have watched a movie at her apartment! We've done that before.

Judith: And when she cancelled and didn't offer to get together in another way, what went through your mind?

Maria: That she didn't care.

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Judith: You know, we can use the same questions as a few minutes ago: What other evidence do you have that she doesn't care? And what's the evidence on the other side, that maybe she does care, or does care somewhat? (pause) But I wonder if you could just think about the next question: Is there another explanation for why she did that?

Maria: (Sighs.) I don't know. Maybe she felt too sick.

Judith: Or she was just too tired?

Maria: Could be.

Judith: Looking at it now, what do you think is most likely? Does she have a history of cancelling on you and not caring?

Maria: (Thinks.) No, I guess not.

Judith: It's so important that you recognized that! I wonder if you have a certain vulnerability to assuming that people don't care when they actually do. (pause) Do you think that's possible?

Maria: I'm not sure.

Judith: Well, let's keep it in mind. I'm going to put it in my notes in

case it comes up again. Maria: Okay. **MANAGING NEGATIVE REACTIONS TOWARD CLIENTS** You and your clients have a reciprocal influence on each other (Safran & Segal, 1996). You, too, will likely bring your general beliefs about yourself, other people, and relationships to the therapy session, as well as your characteristic behavioral coping strategies. If your negative core beliefs get triggered during a session, you may react in an unhelpful way and your client may then engage in an unhelpful coping strategy. For example, one therapist I supervised believed he was incompetent. During therapy sessions, he had lots of thoughts such as “I don’t know what I’m doing,” and he became quite passive and quiet. His client became uncomfortable with the silences and criticized him, which intensified his belief of incompetence. Another therapist who believed she was incompetent became angry at a client who disagreed with her, perceiving that he was implying that she didn’t know what she was talking about. The client then blamed himself and became quite distressed. So, it’s important to have an accurate cognitive conceptualization of both your clients’ and your own beliefs and behaviors and their reciprocal interaction. Here’s something I’d like you to do at the start of every workday. Look at your schedule. Ask yourself: Cognitive Behavior Therapy: Basics and Beyond

“Which clients do I wish would not come in today?” Then use CBT techniques on yourself if any client comes to mind. Identify your cognitions about this client and do one or more of the following:

- Evaluate and respond to your cognitions about the client; create a coping card to read.
- Check on your expectations for your clients. Work on accepting them and their values as they are.
- Check on your expectations for yourself. Make sure they’re realistic.
- Specify your concern and conceptualize: What might the client do or say (or not do or not say) in session (or between sessions) that could be a problem? Which beliefs might underlie this behavior?
- Cultivate nondefensiveness and curiosity.
- Problem-solve by yourself or with a colleague/supervisor.
- Set appropriate limits with clients.
- Work on accepting your own emotional discomfort.
- Do good self-care throughout the day (e.g., deep breathing, taking a walk, calling a friend, doing a short mindfulness practice, eating in a healthy way).

I remember having to do some work on myself when, for the first time, I started treating a client who had narcissistic personality disorder. I was nervous before our sessions and sometimes wished she would skip a week. My thought was “She’s going to say something provocative and I won’t know how to respond.” I had a fair amount of evidence that she was likely to put me down in some way. In previous sessions, she had questioned my experience and expertise. She had told me she thought she was smarter than I was. She had even criticized how my office was decorated. I had to remind myself that her provocative statements were a coping strategy because she was a relatively new client who hadn’t yet learned that I wouldn’t put her down or make her feel inferior. In other words, she didn’t feel safe enough with me. I recognized that I could respond to some provocative statements by saying, “It’s good you told me that.” And/or I could ask, “If it’s accurate, what would be so bad about that?” If she said, “Oh, nothing,” I could make a mental note of what happened and then bring the discussion back to the issue at hand. If she continued with a provocative

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statement, such as “I want my therapist to be smarter than I am,” I could ask, “Could we continue working together for a few more sessions until you have more information?” In any case, I was alert that my own belief of incompetency could get activated and so I prepared myself to react in a nondefensive way. Making these mental preparations allowed me to approach our sessions with curiosity (“I wonder what she’ll do today to feel safe?”) instead of with dread. It’s important to

observe your negative reactions, accept your emotional reactions nonjudgmentally, and then figure out what to do. Once clients feel safe with you, you can address the maladaptive coping strategies they use with you—and likely with others as well. Monitor your level of empathy, and be on the alert for your own unhelpful reactions. Assess your skill deficits, engage in continual self-reflection and self-improvement (Bennett-Levy & Thwaites, 2007), get additional training, and regularly consult with others or seek supervision to increase your competence. And, when indicated, consider personal therapy.

SUMMARY It's essential to have a good working relationship with clients. You facilitate this objective by adapting treatment to the individual, using good counseling skills, working collaboratively, eliciting and responding appropriately to feedback, repairing ruptures, and managing your own negative reactions. Clients who are in distress may have strong negative core beliefs about themselves that they bring to the therapy session. If they also have strong negative beliefs about other people, they may assume you will mistreat them in some way. That's why it's important to help clients feel safe.

REFLECTION QUESTIONS How can you help clients feel safe in session? What automatic thoughts might interfere with your asking clients for feedback? How can you respond to those thoughts?

PRACTICE EXERCISE Write a coping card about the therapeutic relationship that would be helpful for you to read just before your therapy sessions.

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