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PSYCHOTHERAPY FOR PSYCHOLOGISTS



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INTRODUCTION

PSYCHOTHERAPY FOR PSYCHOLOGISTS

This FreeBook brings together a selection of chapters from Guilford Press and Routledge covering key topics in psychotherapy. With chapters covering psychotherapy for anxiety, trauma, depression and suicidal behaviour this FreeBook is essential reading for all clinical psychologists.

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CHAPTER 1: DEFINING THE THERAPEUTIC RELATIONSHIP IN CBT

From leading cognitive-behavioral therapy (CBT) experts Nikolaos Kazantzis, Frank M. Dattilio, and Keith S. Dobson, *The Therapeutic Relationship in Cognitive-Behavioral Therapy* describes ways to tailor empirically supported relationship factors that can strengthen collaboration, empiricism, and Socratic dialogue and improve outcomes. *Defining the Therapeutic Relationship in CBT* explores how the therapeutic relationship is key to successful psychotherapy, how to define its parameters and explore the qualities of a successful relationship.

“The ‘therapeutic relationship’ might be best defined as an exchange between therapist and client that develops for the purpose of sharing intimate thoughts, beliefs, and emotions in an endeavor to facilitate change. This relationship is characterized by a safe, open, nonjudgmental atmosphere that imbues trust and confidence.”

CHAPTER 2: EVOLUTION OF COGNITIVE BEHAVIORAL THERAPY

Innovations in Cognitive Behavioral Therapy provides clinicians with a powerful arsenal of contemporary, creative, and innovative strategic interventions for use in CBT. This chapter looks at the evolution of CBT, the contributions by leading therapists and how CBT has expanded from being a treatment for depression and anxiety being used in treatment across a range of disorders.

“The fact is that CBT is currently a central, if not the dominant, psychotherapeutic approach in both the contemporary psychotherapy research literature and in clinical practice. It is



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the psychotherapeutic approach that has the most extensive empirical base, demonstrating that it is associated with positive outcome relative to receiving no treatment at all.”

CHAPTER 3: MOVING FORWARD FROM TRAUMA, ADDICTION, OR BOTH

Trauma and addiction are two of the most common and difficult issues that people face—but it truly is possible to heal. In *Recovery from Trauma, Addiction, or Both*, leading expert Lisa M. Najavits explains the link between trauma and addiction and presents science-based self-help strategies. Although written as a self-help book for patients, this is valuable reading for all mental health practitioners.

“Living with addiction [or trauma] is sort of like growing up on a boat. The ground is always moving underneath you, sometimes you learn to stay upright, when the water is gentle, but at times it’s completely impossible, and it’s all you can do to lie flat and hang on for dear life. Coming into recovery ... it’s like washing up on the shore and standing up.”

CHAPTER 4: STRATEGIES FOR SOCIAL ANXIETY

CBT Strategies for Anxious and Depressed Children and Adolescents by Eduardo L. Bunge, Javier Mandil, Andrés J. Consoli, and Martín Gomar provides 167 engaging full-color reproducible tools for use in cognitive-behavioral therapy (CBT) with 7- to 18-year-olds. Beautifully designed handouts and worksheets are presented for each phase of treating anxiety and depression and are set up as large format, for easy photocopying. *Strategies for Social Anxiety*, covers understanding social anxiety and catastrophic thoughts and how to approach these with your patients.

“‘Social anxiety’ is a special kind of anxiety that happens when we have trouble facing situations where we interact with others... Mind reading can be explained this way: Every time we get anxious in these situations, we believe we can guess other people’s thoughts. The strangest thing is that what we guess is always negative!”



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CHAPTER 5: ORIENTING ADOLESCENTS AND FAMILIES TO TREATMENT AND OBTAINING COMMITMENT

Filling a tremendous need, *Dialectical Behavior Therapy with Suicidal Adolescents* by Alec L. Miller, Jill H. Rathus, and Marsha M. Linehan adapts the proven techniques of dialectical behavior therapy (DBT) to treatment of multiproblem adolescents at highest risk for suicidal behavior and self-injury. *Orienting Adolescents and Families to Treatment and Obtaining Commitment* presents a set of strategies for orientating young people and gaining their commitment.

“The primary task at the start of DBT is beginning to develop a collaborative relationship with the adolescent. This is crucial as well as difficult. Many adolescents presenting for treatment initially believe that they do not need it. Even those who have made a recent suicide attempt often minimize it as an impulsive act and state that they ‘feel better now.’”

CHAPTER 6: ATTITUDES THAT UNDERMINE RESILIENCE

Some individuals emerge from grim experiences stronger in mind and spirit than others who suffered the same ordeal. In this updated and revised edition, Michael Neenan focuses on the meanings we attach to life’s adversities in order to understand how we respond to them. This book is essential mental health professionals looking for guidance in helping their clients to cope better with adversity.

“If developing resilience can help you to overcome adversity and find ways of creating a better life for yourself, then we need to identify the blocks to its development and what can be done to remove them.”

CHAPTER 7: OVERVIEW OF PTSD AND CPT

The culmination of more than 25 years of clinical work and research, *Cognitive Processing Therapy for PTSD* by Patricia A. Resick, Candice M. Monson, and Kathleen M. Chard is the authoritative presentation of cognitive processing therapy (CPT) for posttraumatic stress disorder (PTSD). *Overview of PTSD and CPT*, walks you through the first session for PTSD.



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“The overall goals for the first session of CPT are for clients to understand what PTSD is, how they got stuck in their recovery, and what CPT will do to put the clients on the path to recovery. However, the most important immediate goal is to engage them in treatment so that they don’t avoid it by quitting before or after the first session, which is not uncommon in PTSD treatments.”

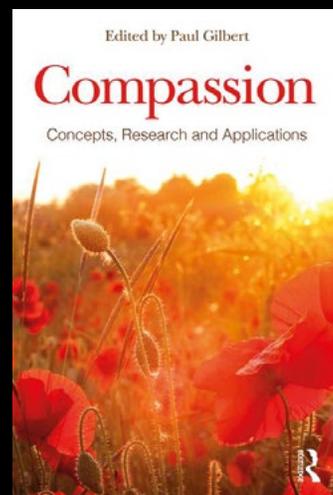
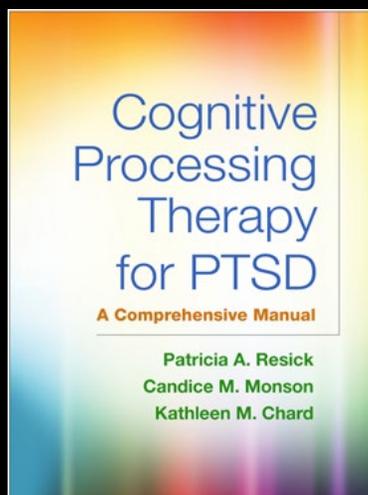
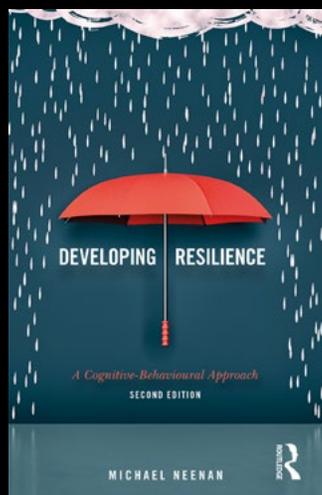
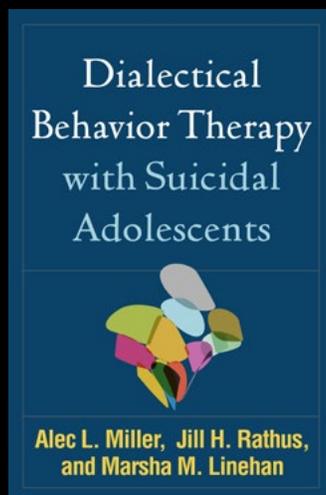
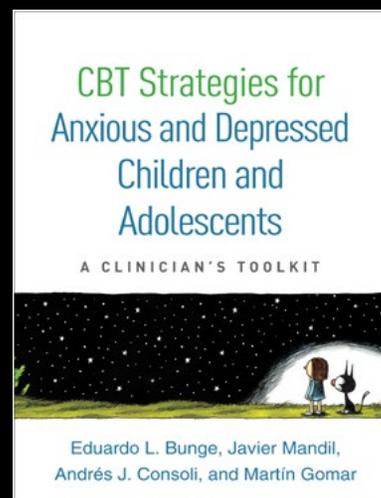
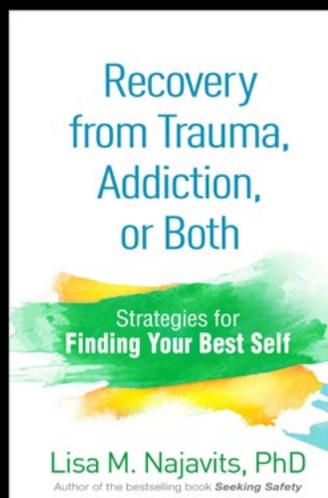
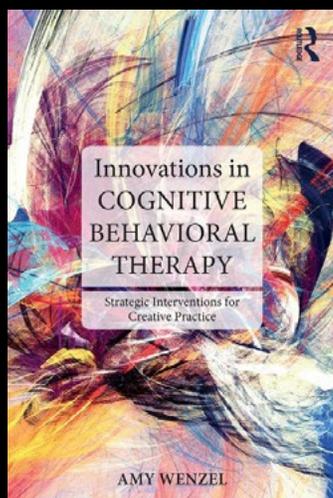
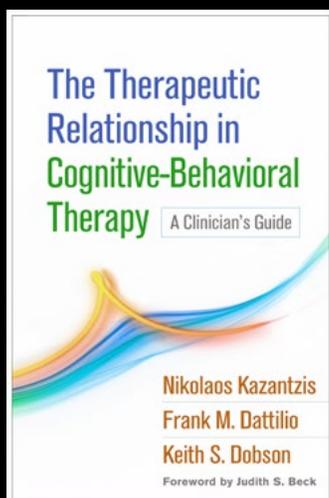
CHAPTER 8: THE EMERGENCE OF THE COMPASSION FOCUSED THERAPIES

In *Compassion*, Paul Gilbert brings together an international line-up of leading scholars and researchers in the field to provide a state-of-the-art exploration of key areas in compassion research and applications.

“CFT seeks to create the conditions in the therapy, *and within the patient*, to provide for the stabilising experiences of the secure base and safe haven, feeling valued (mirroring), with the competencies for empathy and intersubjectivity that enable individuals to understand their own minds and that of others.”

As you read through this FreeBook you will notice that some excerpts reference previous or further chapters. Please note that these are references to the original text and not the FreeBook.

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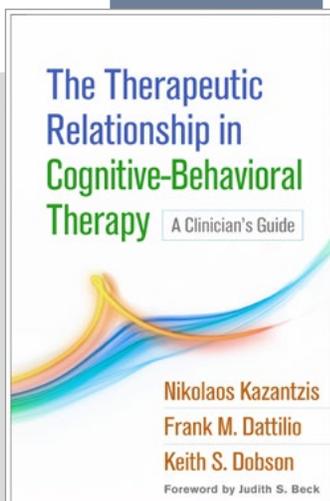
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CHAPTER

1

DEFINING THE THERAPEUTIC RELATIONSHIP IN CBT



This chapter is excerpted from
*The Therapeutic Relationship in Cognitive-
Behavioral Therapy*

By Nikolaos Kazantzis, Frank M. Dattilio, and
Keith S. Dobson

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DEFINING THE THERAPEUTIC RELATIONSHIP IN CBT

Nikolaos Kazantzis, Frank M. Dattilio, and Keith S. Dobson

Excerpted from *The Therapeutic Relationship in Cognitive-Behavioral Therapy*

The therapeutic relationship is more than a simple prerequisite for psychological intervention—it is crucial to effective work. Because the client–therapist interaction occurs within the context of therapeutic processes and interventions, one could even say that everything within the session is relational, without suggesting that all therapeutic effects are due to common factors (Kazantzis, Cronin, Norton, Lai, & Hofmann, 2015). Yet, a clear definition of the therapeutic relationship and its importance for CBT has been missing from our professional literature.

The “therapeutic relationship” might be best defined as an exchange between therapist and client that develops for the purpose of sharing intimate thoughts, beliefs, and emotions in an endeavor to facilitate change. This relationship is characterized by a safe, open, nonjudgmental atmosphere that imbues trust and confidence. This definition differs from that of the “therapeutic alliance” in that the alliance is a coalition that is built on the therapeutic relationship and involves the congruence of strategies and exchanges that facilitate change. The alliance evolves from the therapeutic relationship and constitutes the therapist’s knowledge and skill set, along with the provision of appropriate care. It combines a client’s will and motivation with a therapist’s passion to promote change.

During the early years of CBT’s evolution, the fields of psychology and psychiatry were dominated by psychoanalytic thinking. Psychoanalysis emphasizes the therapeutic interaction between client and therapist as the mechanism of change. Aaron T. Beck, who was a trained psychoanalyst himself, later went on to pursue research that supported the notion that clients could learn to make their own intentional changes to the content and process of their thinking, and that this method of conducting psychotherapy could alleviate emotional distress and improve client functioning. Beck was also influenced by the work of Carl Rogers and his therapeutic triad of empathy, genuineness, and positive regard. Those of us who have witnessed Beck’s work firsthand have noted those influences. Beck is kind and empathetic toward his clients and appropriately employs a sense of humor to convey positive regard and optimism for improved fulfillment and functioning. He also has a clear and steadfast belief in the client’s ability to be his or her own change agent.

In this chapter, we define the essential parameters of the therapeutic relationship in CBT and reflect on some of the aforementioned qualities that are critical to forming an effective therapeutic relationship.



DEFINING THE THERAPEUTIC RELATIONSHIP IN CBT

Nikolaos Kazantzis, Frank M. Dattilio, and Keith S. Dobson

Excerpted from *The Therapeutic Relationship in Cognitive-Behavioral Therapy*

GENERIC ELEMENTS

Any effective assessment or intervention in therapy relies on several components. First, clients need to feel respected, valued, and comfortable so that they can make themselves vulnerable and share their personal experiences, regardless of the emotional valence of their perspective. We may at times be confronted with a client's anger during the very first session, which may beckon us to become even better listeners as we recognize the client's hurt and fears. This difficult type of encounter requires a calm, steady, and sincere empathic response, which is not always easy to generate.

There are several generic elements of the therapeutic relationship in CBT (see **Figure 1.1**, on p. 12), including the therapist's counseling and listening skills, expressed empathy, and appropriate expressions of positive regard (e.g., encouragement and positive affirmations). Other generic elements include seeking client feedback, achieving congruence and genuineness, as well as the product of those efforts, which include the client's feelings of trust, mutual respect, and a positive relational bond.

We often provide our clients with a different relational experience from the ones they have previously encountered, and this new experience provides an opportunity for them to develop a broader lens to evaluate other people, relationships, and the world. The more information we have about the client and his or her relational history within the cognitive case conceptualization, the more effectively we can tailor these generic elements to begin the process of belief change. We often help our clients to develop a different perspective of the world by opening the door to new possibilities.

A perfect example of this relational process is a story conveyed to us by one of our senior colleagues who told of an experience he had several years ago. One day, while sitting in his office, he received a telephone call from a former patient whom he had treated 30 years earlier. The caller informed him that he had just received a raise to an executive position with his company and was cleaning out his desk in preparation for the move. He apparently came across our colleague's card and decided to take a risk and call him. "I don't know if you remember me, but you treated me decades ago while I was in college." Not too surprisingly, the therapist didn't remember him, but tried to be polite and cordial with the caller. The man was quite insistent in recalling how, while he was a college student, he had sought treatment with our colleague because he was suicidal. "I was very close to taking my life in those days, and you really helped me to turn my life around." The caller went on to talk about how well he had done in life and reported that he was now married with several grown children



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and had made a considerable success of himself in the business world. When our colleague asked selfishly, “Well, could you tell me a little bit about what it was that I did that helped you make such a monumental change?” the man thought for a minute and replied, “Oh, I don’t know, really it was just you being you.” Many of our clients value our genuineness, honesty, and connection. However, this valuation is more than simply being a “good person” as a therapist: our relational manner can radically shift our clients’ core beliefs about other people and the world.

The second major generic element of the therapeutic relationship is the working alliance. This concept has a long history within the psychotherapy literature, but the definition provided by Bordin (1979) has been broadly accepted and empirically supported. Bordin suggested that the alliance comprises the relational “bond” and features mutual respect and liking, as well as an overt statement of “agreement” regarding the priorities for the session work and the overall treatment. Any therapy session that fails to address the reasons the client enters therapy, or what troubles them the most, is simply not a good session. The relationship is strained if there is a mismatch in priorities, if the therapist’s ideas dominate those of the client, or if the client presses an agenda that the therapist does not share. Similarly, problems can arise if the stated goals of the session and the actual work of the session are misaligned.

The early therapy interaction described in the case of Johan introduced in Chapter 1 illustrates possible challenges to the therapeutic alliance. In that case, the therapist dutifully proceeded through the appropriate processes of informed consent and attempted to gain a more specific indication of the difficulties that had led Johan to therapy, even while Johan was trying to better understand the person he was meeting for the first time. Johan’s response of “Not really” to the therapist’s question “Would you like to start by telling me the things that bring you here today?” clearly indicated that his agenda for the session was different from the therapist’s. This response also characterized much of the anxiety that Johan experienced in the world, a difficulty in understanding himself in the context of his relationships with others and a persistent pattern of suspicion in considering the motives of others. The therapist’s thoughtful response to Johan was at odds with the response he usually elicited from others, and as it turned out, it was also at odds with the responses of his previous therapists who had all “thrown in the towel.” Johan also engaged in inappropriate behavior during the session, when he made the sardonic association of prostitution and the paid services of a psychologist; this link ultimately reflected Johan’s expectation of “falseness, insincerity, and unscrupulous motives of others.”



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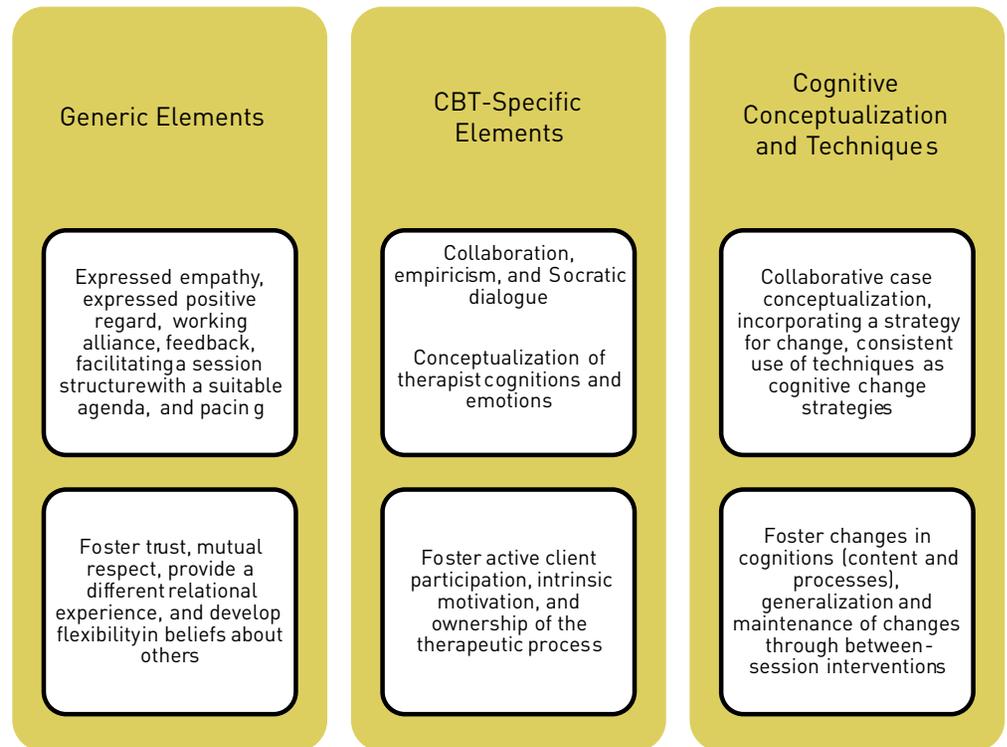


FIGURE 1.1. • Summary of specific therapist behaviors and intended products of generic and CBT-specific elements of the therapeutic relationship.

Effective therapists need to learn how to avoid taking their clients' discourteous or rude behaviors as a personal affront and instead should work with these clients to find a productive use for what is being shared. In the first session with Johan, the therapist made the wise suggestion to spend the session sharing values, which both changed the tone of the interaction to one of mutual sharing and enabled Johan to realize that his own values of "honesty, integrity, and consideration for others" were shared by the profession of psychology, even if the professionals might express these values in different ways. This discussion enabled the session work to begin the process of reaching a mutual understanding of Johan and his problems. It turned out that Johan not only believed he should proceed cautiously with others, but when they mistreated him (as, paradoxically, was often promoted by his own behavior toward others), he took this action as an indication that they should be "put in their place." The therapist articulated, "Well if it seemed to you that I would ultimately judge and reject you, no wonder you preempted that with some hostility— that is definitely one way of testing the waters."



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Other generic elements of the therapeutic relationship include the therapist's ability to work with the client to establish a structure for a session, to follow that structure with appropriate pacing, and to solicit feedback before, during, and after techniques and the session.

CBT-SPECIFIC ELEMENTS

The three major elements of CBT are collaboration, empiricism, and Socratic dialogue. These elements are highlighted consistently throughout this text, particularly in the cases illustrated in subsequent chapters.

With regard to the first element, collaboration, CBT invites clients to take an active role in the therapy process, while the therapist takes the primary posture of collaborator or guide—someone who can facilitate the client's progress toward his or her desired goal(s). This emphasis on the client as the agent of change is quite different from other therapies, in which the client may assume a more passive role. CBT places a priority on active participation, which is also different from modalities that involve the therapist in a passive role, serving as what may be described as a "reflective instrument of change," or in therapies wherein the therapist might tell or advise the client what to do (Kazantzis, Freeman, Fruzzetti, Persons, & Smucker, 2013). For example, we do not normally speak about treatment "compliance." Rather, we might think about "adherence" to the treatment plan that is co-developed, but we are also likely to consider "engagement" as the latter term reflects the shared therapeutic partnership. In fact, the term *collaboration* in CBT literally means "shared work" (Beck, 1995; Dattilio & Hanna, 2012; Tee & Kazantzis, 2011), and it fosters active client participation in the therapeutic exchange as a special feature of the therapeutic relationship in CBT. Although this relationship ideally reflects a balance in contributions, there are times when the therapist may take the lead and other times when the client is invited to spearhead the work in either the session or between sessions. We give collaboration special attention in the forthcoming chapters of the text, but for now, it is important to include it as the first CBT-specific element of the therapeutic relationship. We invite you to engage in a second self-reflection exercise on your own particular therapy style toward the end of the chapter.

The second element of the CBT relationship, empiricism, describes how we help the client to adopt a more "scientific" method to evaluate his or her experience. As opposed to the manner in which they may come to therapy, feeling pushed and pulled by different cognitions and emotions, we help the client to view these experiences as



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Excerpted from *The Therapeutic Relationship in Cognitive-Behavioral Therapy*

indirect gauges of events in their environment, and we especially guide them in how to appraise and cope with these events. It is important to recall that clients' emotions are valuable indicators of their initial distress and their progress in therapy. Just as changes in their thinking process is an important aspect of CBT, so too are changes in their emotional experiences. Indeed, an attentional focus on emotions helps CBT therapists to tailor interventions for each client and to keep them engaged in their therapeutic work, to tolerate tough times, and to view challenges as opportunities for growth. Use of the client's own experience as the measure for the effectiveness of interventions helps them to become curious, explorative, and reinforced for asking the difficult questions that might challenge the very fabric of their being.

Socratic dialogue, the third element of CBT, comprises a series of counseling skills that include questioning, summarizing, empathic listening, and providing the opportunity for the client to identify and resolve discrepant views. If clients can inquire about their own psychological processes in the same manner as the therapist does during treatment sessions, they can develop the ability to question and gain distance and perspective on their subjective experiences. If the therapist relies on Socratic dialogue as a means of fostering the discovery of ideas, then a client can gain a sense of ownership of their therapy. Chapter 5 delves into much more detail regarding the use of Socratic dialogue in guided discovery.

THERAPIST COGNITIONS AND EMOTIONS

The early interaction depicted in the case of Johan illustrates how the CBT therapist can communicate his or her personal values as a professional and, to some extent, those values that are generally important as a human being. This communication serves as part of the collaborative process in treatment. A therapist who possesses the personal values of being considerate, kind, and thoughtful will likely make a special effort to recall details about each of his or her client's lives, and then will incorporate these details into the therapy session when appropriate. This unique valuing of each client can be important for clients with long-standing relational problems, as these clients may otherwise feel exposed and vulnerable from a unidirectional sharing of information. Of course, the extent of the therapist's attention to the client's personal life is delimited by boundaries that are important to adhere for ethical reasons (see Chapter 12 on ethical and safety issues). Some therapists may elect to engage in appropriate self-disclosure in order to foster a different relational experience for the client. In many respects, development and maintenance of the focus on the client's problems requires great strength and fortitude.



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Excerpted from *The Therapeutic Relationship in Cognitive-Behavioral Therapy*

To maintain the focus on the client in therapy, we advocate a conceptualization of the therapist's belief system and attention to the activation of therapist beliefs in training and supervision. Clearly, the therapist's in-session emotions and physiology are often useful additional indicators. The elements of **Figure 1.2** link a particular therapist's positive and negative core beliefs of self and others with schema and values.

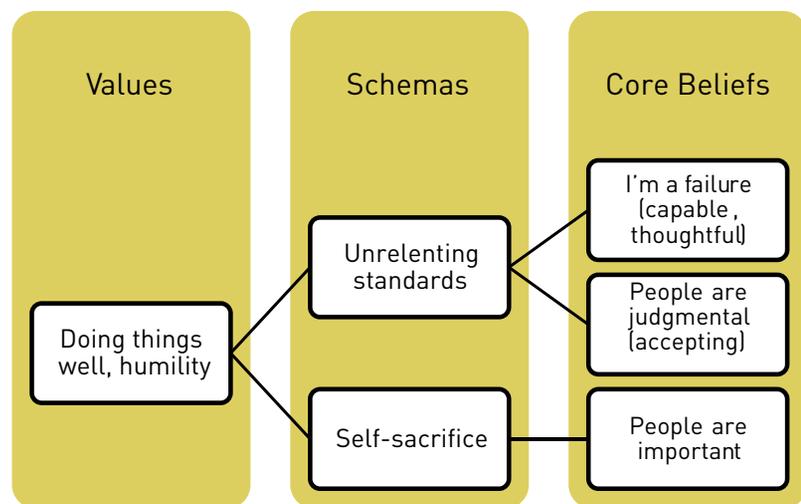


FIGURE 1.2 • Illustration of the links among values, schemas, and core beliefs in a therapist's belief system.

We recommend that our readers adopt two useful assumptions as they strive to maintain nonjudgmental acceptance of the client. First, we suggest that psychotherapy involves a relationship that is limited to discussions primarily about the client, the client's world, struggles, and ability to cope with life. Although there are different views regarding the extent to which therapist self-disclosure is useful and important in therapy, disclosure of the therapist's personal information may not always be helpful. In fact, in some cases it may even be countertherapeutic, depending on the timing and manner in which it is presented.



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SELF-REFLECTION EXERCISE

We invite you to consider some specific assumptions about forming therapy relationships with your clients:

- “If I have a negative thought and/or emotion about a client, he or she will likely detect this response and in turn respond to me negatively.”
- “I can serve as a point of difference for my clients in the world, as a kind, patient, and accepting person who prizes each individual who sits in the room with me.”
- “Accepting a client means not judging or trying to change them, but it’s my duty to support them if they want to change their perspective or behavior.”

Second, the style of the therapist warrants attention when he or she is considering his or her own cognitions and emotions. What may be normal for one therapist may be uncomfortable for another. Each therapist has his or her own strengths and limitations, and capacity to develop generic skills, such as empathic understanding. Many therapists who learn a model of psychotherapy will find themselves attempting to adopt the style of the therapy’s leading figure or proponent. While this strategy might be useful initially, we encourage practitioners to cultivate their own self-understanding and their own more comfortable personal style, as this manner is likely a better place from which to focus on the client’s needs.

In Chapter 1, you were encouraged to begin to identify your own values. We now encourage you to connect these values to your therapeutic style. For some therapists, a value of “doing things well” may represent taking a generally structured approach, while others will prefer fluidity and flexibility. For other therapists, not being controlled and not controlling others, or displaying a warm, generous, and encouraging demeanor, may be crucial to the therapeutic relationships. Again, the same values might lead therapists toward different interpersonal styles with their clients. These latter values might be expressed with a generally calm style, whereas others may prefer to be more reactive.

Therapists who elect to be more thoughtful, kind, tolerant, forgiving, determined, disciplined, analytical, efficient, patient, or humorous would likely demonstrate as many diverse meanings as to whoever identified them. Clearly, there are no “universal” definitions for these terms. We invite you to consider what makes your therapeutic practice unique to your own style with your specific caseload. This



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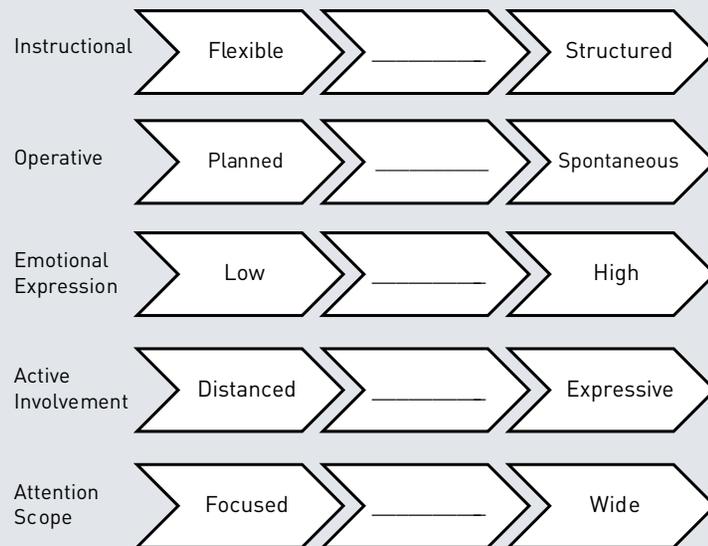
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process acknowledges that everyone practices CBT differently, and also that what we all identify today may be different in a year, or 20 years from now.

SELF-REFLECTION EXERCISE

We invite you to take 5 minutes to consider from which end of the continuum you prefer to work and to see how your values are translated into practice. For

example, you could mark on the “instructional” continuum to identify the extent to which your session agendas are flexible or structured, and consider what value underpins that behavior. The point of this exercise is to link your values with your therapeutic style—not to judge or evaluate it.



ADAPTING BASED ON CLIENT ATTRIBUTES

Just as every client is unique, every therapeutic relationship is unique. Our challenge is to ensure that our CBT interventions are adapted to each of our clients' particular strengths and abilities. With present-day knowledge and methods of investigation, we are limited to observational assessments of behavior during sessions. A client's smile or yawn in response to our own smile or yawn may lead to a hypothesis about activation of mirror neurons, but we ultimately have to depend on our mapping of the client's in-session behaviors to formulate a representation of his or her day-to-day interpersonal style.



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Excerpted from *The Therapeutic Relationship in Cognitive-Behavioral Therapy*

Many of the CBT techniques involve clients in the process of identifying thoughts and emotions, which is influenced by the understanding of their own emotional experience and being able to detect emotions in other people. CBT therapists need to attend to and accurately read in-session displays of emotion, or avoidance of emotion and to understand the relational difficulties our clients describe in other areas of their lives (Klumpp, Fitzgerald, Angstadt, Post, & Phan, 2014; Mayer, Salovey, & Caruso, 2008; Samoilov & Goldfried, 2000; Siegle, Carter, & Thase, 2006). Thus, in a very real sense, we help our clients to develop their emotional intelligence (Hezel & McNally, 2014; Muris, Mayer, Vermeulen, & Hiemstra, 2007; Spek, Nyklíček, Cuipers, & Pop, 2008). CBT also involves an elaborative processing of the present moment, which demands a certain amount of executive functioning so that aspects of experience are monitored during an interaction, while consciously inhibiting unhelpful strategies from the past (Johnco, Wuthrich, & Rapee, 2014; Mohlman, 2013; Snyder, 2013).

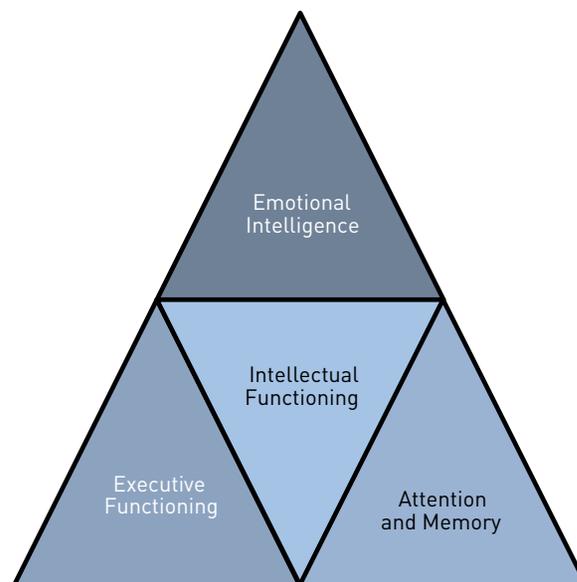


FIGURE 1.3 • Summary of client attributes that require attention in the adaptation of CBT.

CBT invites clients to attend to and sort out their thought processes, such as those that involve selective attention, memory biases, or other potentially dysfunctional ways to construct their experiences. Similarly, identifying and evaluating beliefs about thoughts, or thinking processes (i.e., meta-cognitions) requires certain aspects of intellectual functioning, such as receptive and expressive language, and abstract reasoning (Sasso & Strunk, 2013; Waters, Mogg, & Bradley, 2012). Clients with low



DEFINING THE THERAPEUTIC RELATIONSHIP IN CBT

Nikolaos Kazantzis, Frank M. Dattilio, and Keith S. Dobson

Excerpted from *The Therapeutic Relationship in Cognitive-Behavioral Therapy*

levels of intelligence, literacy challenges, fetal alcohol syndrome, attention-deficit/hyperactivity disorder, psychosis, or a history of traumatic brain injury or significant alcohol and drug use, or who may be experiencing the onset of dementia, will require the therapist's particular sensitivity and skill in providing CBT (see **Figure 1.3**).

COGNITIVE CASE CONCEPTUALIZATION AND ADAPTING RELATIONSHIPS

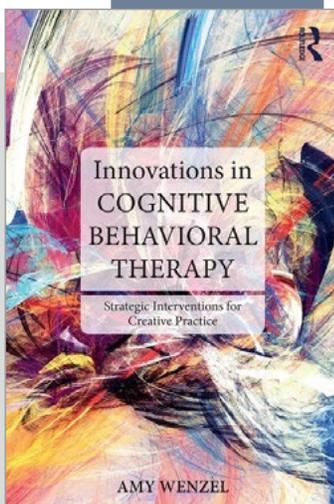
Although the competent practice of CBT depends on training and on the effective use of foundational counseling skills, these elements require skillful and sensitive adaptation for each client in each session. What may be experienced as empathic and supportive to one client could be interpreted as patronizing and demeaning by another. Every therapist's behavior is viewed through each client's set of values, beliefs, and assumptions. Hence, CBT therapists must walk a fine and constantly changing line, to ensure that their skills are appropriately adapted in a manner that is useful for their clients. In the next chapter, we discuss how the cognitive case conceptualization serves as a framework to adapt our generic therapeutic relationship skills for each client in each session.

"To thine own self [and thine own clients] be true."

CHAPTER

2

EVOLUTION OF COGNITIVE BEHAVIORAL THERAPY



This chapter is excerpted from
Innovations in Cognitive Behavioral Therapy

By Amy Wenzel

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EVOLUTION OF COGNITIVE BEHAVIORAL THERAPY

Amy Wenzel

Excerpted from *Innovations in Cognitive Behavioral Therapy*

Cognitive behavioral therapy, or *CBT* for short, is an active, semi-structured, time-sensitive approach to psychotherapy that aims to alleviate mental health and adjustment problems by addressing problematic cognitive and behavioral patterns that cause life interference and/or excessive emotional distress. By *active*, it is meant that the client and therapist both come prepared for the session, contribute to discussion, and work collaboratively together to address the client's life problems. By *semi-structured*, it is meant that the therapist typically brings some sort of flexible but organized scheme to each session, as well as to the course of treatment, in order to ensure that therapeutic work is targeted and efficient. By *time-sensitive*, it is meant that clients enter treatment with the anticipation that treatment will eventually end, that the work done in each and every session is meant to advance treatment and to make a difference in their lives in between sessions, and that they will have the ability to implement therapeutic tools on their own, without the need to have a therapist coaching them in doing so.

What does it mean to address problematic cognitive and behavioral patterns? From a cognitive perspective, therapists help clients to recognize aspects of their thinking that are unhelpful and that could be exacerbating their emotional distress. This thinking could be thoughts or images that run through clients' minds in particular situations, ways in which they interpret events in their lives, expectations that they hold for themselves or others, or underlying beliefs that developed from key developmental experiences. Intervention at the cognitive level can mean many things, from helping clients to modify their cognitions, to helping them to distance themselves from their cognitions and to live their lives the way they value in spite of their cognitions, or to coaching them to do something skillful to address their life problems so that a change in cognition will follow. From a behavioral perspective, therapists help clients to overcome avoidance, engage in healthy self-care habits, respond skillfully in the face of challenges and adversity, and participate in activities that they find meaningful and that give them a sense of positive reinforcement.

Many CBT strategies include both cognitive and behavioral components. For example, to implement effective problem solving, clients must have a centered cognitive orientation from which they approach problems, and they must enact effective behaviors in order to obtain a solution to their problems. As will be seen throughout the remainder of this volume, it is overly simplistic to limit cognitive behavioral interventions to only those that intervene at the level of cognition and behavior, as they are often targeted simultaneously as the session unfolds. Moreover, cognitive behavioral therapists are increasingly working at the level of emotion (e.g., Hofmann,



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2016; Thoma & McKay, 2015) as well as at the level of large-scale environmental forces, such as discrimination (e.g., Hays, 2008).

The term *cognitive behavioral therapy* often evokes a noticeable reaction in mental health professionals. Some clinicians, like myself, are passionate about it, believing that it is a therapeutic approach that brings rapid and sustained relief from emotional distress and that it arms people with tangible strategies for preventing future relapse and recurrence. Other clinicians roll their eyes, indicating that claims about the efficacy of CBT are overstated, that the cognitive behavioral approach is too simplistic and does not get at the “real” underlying issues, or that CBT is “old hat” and that the field has moved on. Of course, as the purpose of this book is on innovations in CBT, I hope to disabuse the reader of these notions.

Whatever a clinician’s reaction toward CBT may be, the fact is that CBT is currently a central, if not the dominant, psychotherapeutic approach in both the contemporary psychotherapy research literature and in clinical practice. It is the psychotherapeutic approach that has the most extensive empirical base, demonstrating that it is associated with positive outcome relative to receiving no treatment at all and relative to receiving placebo conditions, such as minimal contact with a mental health professional (Butler, Chapman, Forman, & Beck, 2006). Results from survey studies indicate that more clinicians identify themselves with a cognitive behavioral orientation than with any other therapeutic orientation (Jaimes, Larose-Hébert, & Moreau, 2015; Norcross & Karpiak, 2012; Thoma & Cecero, 2009) and that rates of identification with the cognitive behavioral orientation have increased over time, whereas rates of identification with other theoretical orientations have decreased over time (Norcross & Karpiak, 2012; Norcross & Rogan, 2013). It is the psychotherapy that is taught most often to graduate students in psychology doctoral training (Heatherington et al., 2013). It is increasingly being viewed as the treatment of choice for many mental health disorders by insurance companies because of its time-sensitive (and thereby cost-saving) nature. There are also massive efforts to disseminate CBT to large treatment agencies, such as Veterans Affairs Medical Centers (Karlín, Ruzek et al., 2010; Karlín, Brown et al., 2012; Wenzel, Brown, & Karlín, 2011) and community mental health agencies in large urban areas (e.g., Stirman, Buchhofer, McLaulin, Evans, & Beck, 2009). Thus, there is no question that CBT has a firmly established place in the fields of clinical psychology, psychiatry, and other mental health-related disciplines.



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This being said, the beauty of science and practice is that they evolve, and an approach that is stagnant runs the risk of becoming obsolete. Clinicians who practice from any theoretical orientation must have updated knowledge of relevant scientific findings, and they must translate that knowledge into their clinical practice. They must be in tune with societal trends that have the potential to affect the clinical presentations of their clients. They must have interaction with other professionals to obtain fresh perspectives on the way in which they approach complex cases. They must be open to consideration and evaluation of therapeutic approaches outside the mainstream of their typical practice.

Fortunately, cognitive behavioral therapists value these very points. Cognitive behavioral therapists consider themselves scientist-practitioners (or practitioner-scientists). This means that they truly value science, as evidenced by the fact that they keep up with the scientific literature and practice in a way that is consistent with what the literature says is efficacious. This also means that they use a scientific approach in their clinical work with clients, such that they find quantitative and observable ways to measure progress and to determine whether adjustments need to be made. In addition, cognitive behavioral therapists view environmental factors as important when they develop conceptualizations of clients' clinical presentations. For example, the well-known cognitive behavioral therapist Robert Leahy has written extensively about applying cognitive behavioral principles to cope with and thrive during unemployment in response to the economic woes experienced by many during the most recent recession (Leahy, 2014). Moreover, cognitive behavioral therapists place great value on consultation with other professionals, at times viewing it as an essential part of the treatment package for clients with chronic mental health problems or for those who are at risk for suicidal and self-harm behavior (Linehan, 1993a; Wenzel, Brown, & Beck, 2009). Finally, cognitive behavioral therapists integrate techniques from other therapeutic approaches into their practice. A terrific example of this is the cognitive behavioral schema therapy approach, spearheaded by Jeffrey Young and his colleagues (Young, Klosko, & Weishaar, 2003), who have integrated many Gestalt, psychodynamic, and social constructivist interventions into their treatment. More about schema therapy is found in Chapter 5.

The purpose of this book is to highlight innovations in the science and practice of CBT, painting a picture of the flexible and contemporary study and practice of CBT. As is likely evident from its name, this book will *not* simply be another description of traditional cognitive behavioral strategies and techniques that are outlined in countless other CBT texts. Instead, this book briefly describes these traditional



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strategies and techniques in order to set the stage for consideration of the innovations that have stemmed from those traditional strategies and techniques, as one can only appreciate innovations if they understand the traditional approaches from which they developed. However, much of the focus of the volume is on new treatment packages, strategies, and techniques that have been evaluated in the research literature as well as ideas of the application and adaptation of standard and innovative techniques that have been tested in clinical practice but that must be verified by empirical research. It is hoped that after reading this volume, the reader will be able to answer the questions: Where has CBT been, where is it now, and where is it going? Although a detailed how-to description of each individual technique is beyond the scope of this volume, the ensuing discussion will provide a framework for understanding the ways in which these techniques are implemented, evaluating their effectiveness, obtaining more detailed information when needed, and thinking broadly and creatively about cognitive behavioral change.

The remainder of this introductory chapter is devoted to a consideration of the historical context in which CBT developed. It describes the predominant climate that characterized the fields of psychology and psychiatry at the time of CBT's inception, and it highlights the independent contributions made by many giants in CBT's history. It describes the expansion of CBT from a treatment for depression and anxiety to a treatment for a vast array of mental health disorders and adjustment problems as well as to its delivery in varied formats, settings, and populations. This chapter concludes with a glimpse of the traditional and innovative strategies that will be discussed in the remainder of this volume.

ORIGINS OF CBT

Many forces converged to form the “perfect storm” that provided the impetus for the development of CBT. In 1952, Hans Eysenck published a now classic paper criticizing one prevailing model of psychotherapy—psychodynamic psychotherapy—and proposing behavior therapy as an alternative. Eysenck provocatively raised the notions that neurosis need not stem from a deep-seated psychological conflict and that it can be treated in full by intervening directly at the level of symptoms (Eysenck, 1960; Rachman, 1997). The late 1950s and 1960s, then, witnessed increased attention on behavioral approaches to treatment that relied on principles of behavior modification, with British researchers primarily focusing on classical conditioning-based approaches to target fear reduction, and American researchers primarily focusing on operant conditioning-based techniques to target severe



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psychopathology in institutionalized patients (Rachman, 1997, 2015; Thoma, Pilecki, & McKay, 2015). However, as time progressed, it became evident that a strictly behavioral conceptualization was insufficient to account for the full range of clinical presentations that therapists see in their practices and that strictly behavioral interventions often left major components of problems unaddressed (e.g., obsessions; K. S. Dobson & Dozois, 2010; Rachman, 1997, 2015). According to Rachman (2015), “the dependence on conditioning processes ... gradually ran out of steam” (p. 4).

Also happening at this time was that the field of psychology was going through a “cognitive revolution,” such that information processing models were being advanced (e.g., Neisser, 1967), and high-quality research was designed to measure many aspects of cognition, such as learning and memory. This is not to say that innovators developed cognitive behavioral approaches specifically to apply advances in cognitive psychology in clinical practice; in fact, a direct tie between the cognitive revolution and the incorporation of a focus on cognition into therapeutic intervention is often overstated (Rachman, 2015; Teasdale, 1993). Nevertheless, the field’s fresh focus on cognition created a climate that was ripe for the inclusion of cognition into traditional behavioral interventions. By the mid-1970s, scholar-practitioners were beginning to propose a mediational model, advancing the notions that cognition affects emotion and behavior and that intervening at the cognitive level would affect behavior change (e.g., Mahoney, 1974). According to Rachman (1997), “cognitive therapy [supplied] content to behaviour therapy,” and “cognitive concepts have widened the explanatory range of behaviour therapy and helped to fill in the picture” (p. 18). In the next sections, early cognitive behavioral treatment approaches are described.

ALBERT ELLIS’S RATIONAL EMOTIVE BEHAVIOR THERAPY

Beginning in the late 1940s and 1950s, Albert Ellis developed *rational emotive behavior therapy* (REBT, formally called *rational therapy* and then *rational-emotive therapy*) after questioning basic premises of the psychoanalytic model in which he was trained, observing that clients could develop sophisticated insight into their psychological problems but yet were still struggling (Ellis, 1962). The basic premise of REBT is that irrational cognition plays a large role in explaining people’s emotional and behavioral responses. Ellis developed the well-known ABC model, such that (A) inferences that people make about **a**ctivating events stimulate an (B) irrational **b**elief system, which leads to (C) **c**onsequences, which can be emotional (e.g., shame), behavioral (e.g., withdrawal), or cognitive (e.g., hopelessness) in nature (Dryden, 2012). The



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aim of REBT is to challenge (B) a person's irrational belief system, characterized by rigidity and extremity, and shape it into a flexible and non-extreme belief system indicative of psychological health (Dryden, 2011). Ellis assumed that a person would experience decreased emotional distress and behave in a more adaptive manner if he or she substituted irrational beliefs with more realistic beliefs. The primary process through which this change occurred was through disputation, including questioning, challenging, and debating (Ellis, 1979). During the course of this process, Ellis actively encouraged clients to address directly the (largely self-imposed) obstacles that were keeping them from meeting their goals (Backz, 2011).

Ellis was a colorful personality and prolific writer whose clinical acumen exerted tremendous influence in the field. At a time when the prevailing model of psychotherapy was one in which the therapist was nondirective and even passive, Ellis blazed new trails by developing active, direct interventions and by asking his clients to complete homework in between sessions (DiGiuseppe, 2011). At times, he was provocative and confrontational—characteristics that very well might have turned some clinicians away from embracing this approach—but, nevertheless, it was an approach that his clients came to appreciate due to the hard work he exerted on their behalf and the timely progress they made (Backz, 2011; DiGiuseppe, 2011). Importantly, Ellis assembled a conference at his institute of like-minded clinicians (many of whom are described in this section) who believed in the central importance of cognition in understanding and treating mental health problems. As a result, he played a large role in solidifying a movement that provided a viable alternative to the more dominant psychodynamic and humanistic approaches that pervaded the practice of psychotherapy at the time (DiGiuseppe, 2011). However, Ellis was first and foremost a clinician, and although he encouraged outcome research, he did not pursue it with the same vigor as some of the other innovators described in this section. Thus, though REBT was perhaps the first CBT approach that was described in print, it plays a smaller role in the evolution of modern CBT than Aaron T. Beck's cognitive therapy, described next (Backz, 2011; DiGiuseppe, 2011).

AARON T. BECK'S COGNITIVE THERAPY

Like Albert Ellis, Aaron T. Beck was trained in psychoanalysis and became disillusioned by it, observing that there was little empirical evidence for key unobservable psychoanalytic constructs and that a more parsimonious way to understand clients' emotional distress was to examine the role of the meaning they were making from their life circumstances (A. T. Beck, 2006). He developed a



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cognitive theory in which he mapped particular cognitive distortions onto various emotional disorders (A. T. Beck, 1976) and published a seminal treatment manual on cognitive therapy for depression (A. T. Beck, Rush, Shaw, & Emery, 1979). The term *cognitive therapy* suggests that A. T. Beck gave central importance to the role of cognition in understanding emotional and behavioral problems. In fact, he later stated that “cognitive therapy is best viewed as the application of the cognitive model of a particular disorder with the use of a variety of techniques designed to modify the dysfunctional beliefs and faulty information processing characteristic of each disorder” (A. T. Beck, 1993, p. 194). Nevertheless, the treatment included a broad array of strategies, many of which were behavioral in nature, in order to create cognitive change and enhance emotional well-being.

Unlike REBT, cognitive therapy was subjected to rigorous empirical research to establish its efficacy. As is described in the subsequent section on the evolution of CBT, A. T. Beck expanded the empirical investigation of cognitive therapy from the treatment of depression to a host of other mental health conditions. Moreover, he also pursued rigorous examination of the tenets of his cognitive theory, simultaneously advancing cognitive theories of various manifestations of psychopathology. At the time of the writing of this volume, A. T. Beck is one of the most highly cited scholars in psychiatry and psychology.

OTHER EARLY COGNITIVE BEHAVIORAL APPROACHES

The 1970s was clearly an exciting time for scholars who were moving beyond psychodynamic, humanistic, and strictly behavioral approaches to the treatment of mental health disorders. At the same time that Ellis and A. T. Beck were molding their cognitive approaches, other innovators were assembling treatment packages that focused on the modification of problem behavior and cognition. Though these cognitive behavioral approaches did not have as pervasive an influence on the field or were applied to as many clinical conditions, they nonetheless deserve mention for their place in the history of this dynamic field. For example, early in his career, Donald Meichenbaum discovered that teaching people with schizophrenia to engage in “healthy talk” was associated with significant improvements in adaptive behavior, such as less distractibility and better task performance (Meichenbaum, 1969). He reasoned that when a person internalizes verbal commands, he or she is better able to exert self-control over his or her behavior. Thus, Meichenbaum concluded that covert behaviors, like cognition, could be modified using the same behavioral modification principles as overt behaviors (Meichenbaum, 1973). He elaborated



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his approach into *self-instructional training* (SIT), which involved a process in which clients learned to generate internal coping statements, self-correct errors, and reinforce themselves for successful task completion (Kendall & Bemis, 1983; Meichenbaum, 1985). Although SIT is not generally used as a stand-alone CBT today, the SIT framework continues to be used in helping people focus on a sense of self-efficacy, such as youth with disabilities (K. S. Dobson & Dozois, 2010). Meichenbaum later continued his thoughtful integration of cognitive and behavioral approaches and developed *stress inoculation training*, a more elaborate approach to self-control, stress management, and the development of generalized coping skills (Meichenbaum, 1985, 1993, 2007). In fact, Meichenbaum's evolution as a scholar-clinician represents a microcosm of the evolution of the field as a whole, as he acknowledges overlap between SIT and stress inoculation training but states, "The stress inoculation training goes beyond SIT by including a psycho-educational training, imaginal training, behavioral training, and a greater focus on emotional and environmental interventions" (D. Meichenbaum, personal communication, July 27, 2016). As will be seen in the subsequent section, many other cognitive behavioral approaches followed a similar evolution.

Other innovative cognitive behavioral approaches were published in the early empirical literature as well. Suinn and Richardson (1971) described an *anxiety management training* approach, which aimed to help anxious clients develop coping skills (e.g., relaxation) that would help them achieve a greater sense of competence in managing their anxiety. Goldfried, Decentecio, and Weinberg (1974) developed an approach called *systematic rational restructuring* that combined cognitive restructuring and exposure to anxiety-provoking situations, reasoning that misinterpretation of stimuli as being threatening plays a key role in the maintenance of anxiety and that the aim of therapy is to help anxious clients enhance their ability to cope with anxiety. Rehm (1977) constructed an elaborate self-control model of depression, proposing that depression is associated with deficits in (a) selective monitoring of negative events, (b) accurate self-evaluation, and (c) self-reward (coupled with an excess in self-punishment). His model served as the basis for *self-control therapy* for depression (Fuchs & Rehm, 1977), which incorporated an array of behavioral and cognitive strategies to help depressed clients manage their emotions. The implications of this early body of research are that rich treatment packages could be assembled on the basis of behavioral and cognitive principles of change and that they held great promise for developing into efficacious treatments for mental health problems.



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EMERGENCE OF CBT

It is difficult to pinpoint the precise time at which the field of CBT solidified. Some scholars in the 1970s called their approach *cognitive behavioral modification* (e.g., Mahoney, 1974; Meichenbaum, 1977), and many of the treatment packages described in the previous section indeed included cognitive and behavioral components. According to Rachman's (2015) historical analysis, the true field of "cognitive behavioral therapy" was brought together by David M. Clark's (1986) elegant cognitive theory of panic. In this theory, D. M. Clark emphasized the importance of catastrophic misinterpretations as being central in the conceptualization of panic attacks—an idea that was quite innovative at the time, when panic was regarded as simply a by-product of agoraphobia and was expected to decrease with the successful behaviorally oriented treatment of agoraphobia. Other key figures who merged cognitive and behavioral constructs into theory and interventions into treatment were David Barlow in the cognitive behavioral understanding and treatment of anxiety disorders (Barlow, 1988, 2002) and Paul Salkovskis in the cognitive behavioral understanding and treatment of obsessive compulsive disorder (OCD; Salkovskis, 1985). According to Rachman (2015),

In the process of merging behaviour therapy and cognitive therapy, the behavioural emphasis on empiricism was absorbed into cognitive therapy. The behavioural style of conducting empirical outcome research was adopted, with its demands for rigorous controls, statistical designs, treatment integrity and credibility, and so forth. In turn, cognitive concepts were absorbed into behavior therapy, and cognitive therapists made greater use of behavioural experiments.

(p. 6)

Because of the speed at which CBT proliferated, as well as the number of separate but overlapping approaches that quickly emerged, it can be difficult to answer the question "What makes a treatment a cognitive behavioral therapy?" K. S. Dobson and Dozois (2010) indicated that a central assumption across all cognitive behavioral therapies is that cognition mediates behavior change. Other similarities include (a) the targets of change (i.e., cognition and behavior); (b) the emphasis on self-control; (c) the time-sensitive nature of treatment; (d) the problem-focused nature; (e) the structure; (f) the psychoeducation that is provided by therapists to clients; (g) the central role of homework; (h) collaborative empiricism (i.e., the therapist and client, together, drawing conclusions on the basis of actual evidence and experiences); (i)



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technical eclecticism; (j) the delivery of treatment with an eye on prevention; and (k) the emphasis on parsimony in theoretical explanation (K. S. Dobson, 2012; K. S. Dobson & Dozois, 2010; Herbert & Forman, 2011; Kendall & Kriss, 1983). Herbert and Forman (2011) further indicated that it is also helpful to characterize what CBT is *not*, such as a primary focus on the development of insight into intrapsychic conflicts or an exclusive focus on the therapeutic relationship as the curative factor, alone, for clients' problems. In the final chapter, I offer two additional observations from my own scholarship and clinical practice regarding key components of CBT as it is currently understood and practiced. On the basis of this analysis, I advance a definition of *integrative CBT*, which captures the contemporary, strategic, and comprehensive practice of CBT with the vast array of clients seen in everyday clinical practice.

EVOLUTION OF CBT

Since the 1970s, the family of CBTs has expanded greatly to the treatment of many mental health problems; to its delivery using various modalities; to a movement in which it is delivered with increasing flexibility; to its evaluation not only in tightly controlled academic laboratories but also in "real-world" settings with "real" clinicians and "real" clients who struggle with clinical presentations that do not neatly fit into a research protocol; to cultural adaptations that take into account important racial, ethnic, religious, socioeconomic, and other individual differences; and to an increased focus on acceptance. These expansions are considered in the following section.

EXPANSION IN STATUS FOR THE TREATMENT OF DEPRESSION

A. T. Beck's cognitive therapy was met with much skepticism when it was developed, as it was such a departure from the prevailing view of the way in which depression was conceptualized and treated (i.e., the psychodynamic approach, the humanistic approach, the pharmacological approach). However, he was committed to empirical scrutiny and ran clinical trials early on designed to demonstrate the efficacy of this treatment package. He made a notable impression with the publication of his first clinical trial (Rush, Beck, Kovacs, & Hollon, 1977), in which he compared the efficacy of cognitive therapy and imipramine in depressed out-patients. Results indicated that almost 80% of participants who received cognitive therapy showed marked improvement or complete remission of symptoms relative to approximately 23% of the participants who received imipramine. More clients dropped out of the



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imipramine condition than in the cognitive therapy condition. Moreover, 68% of the clients who received imipramine later reentered treatment for depression relative to only 16% of the clients who received cognitive therapy. For the first time, health-care professionals began to consider psychotherapy as being an alternative (not simply an adjunct) to medication in the treatment of depression.

However, debate continued as to whether it was seen as first-line treatment for depression, equal to antidepressant medications. To further address this question, the massive Treatment of Depression Collaborative Research Program (TDCRP; Elkin et al., 1989) was initiated, which compared cognitive therapy, interpersonal psychotherapy (IPT), imipramine plus clinical management, and placebo plus clinical management at five different sites around the United States. Contrary to the findings reported by Rush et al. (1977), results for cognitive therapy were disappointing: Only 36% of clients receiving cognitive therapy met study criteria for recovery posttreatment relative to 43% and 42% for IPT and imipramine, respectively. Moreover, all treatments, including placebo plus clinical management, performed similarly for less severely depressed clients, and imipramine plus clinical management outperformed the other conditions for severely depressed clients. On the basis of these findings, it was widely concluded that psychotherapy, including cognitive therapy, was appropriate for people with mild to moderate depression but that antidepressant medication was necessary for moderate to severe depression. This attitude persisted for many years, despite the preponderance of outcome studies demonstrating the efficacy of cognitive therapy that were accumulating and despite the fact that concern was raised about the quality of cognitive therapy that was delivered in some of the sites included in the TDCRP (N. S. Jacobson & Hollon, 1996).

This attitude shifted after the publication of research by Robert DeRubeis, Steven Hollon, and their colleagues (DeRubeis et al., 2005), in which clients with moderate to severe depression were randomly assigned to receive antidepressant medication (paroxetine, with the possibility of augmentation with lithium or desipramine in cases in which clients did not meet established response criteria by week 8), cognitive therapy, or pill placebo. At the 8-week assessment, both the medication (50%) and the cognitive therapy (43%) groups had higher response rates than placebo (25%), and at posttreatment, both the medication and the cognitive therapy groups had achieved response rates of 58%. Even more compelling are the results from their 12-month follow-up period, in which the investigators followed the clients who had completed cognitive therapy, the clients who had completed their medication trial, and a subset of clients who continued on with their medication trial (Hollon et al.,



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2005). Clients who had completed cognitive therapy had much lower relapse rates than clients who had completed their medication trial (31% vs. 71%, respectively), and they were no more likely to relapse than patients who were continuing to take medications (47%). These results suggest that cognitive therapy is indeed efficacious for moderate to severe depression and that its effects are much more enduring than the effects of taking medications (cf. Hollon, Stewart, & Strunk, 2006). Cognitive therapy, or CBT, is now seen as a viable alternative to antidepressant medication in the treatment of depression.

EXPANSION TO VARIOUS MENTAL HEALTH PROBLEMS

As has been seen to this point in the chapter, much of the early evaluation of CBT (A. T. Beck's cognitive therapy in particular) was focused specifically on the treatment of depression. Both A. T. Beck's cognitive therapy and Ellis's REBT have since been expanded to the treatment of anxiety disorders (A. T. Beck & Emery, 1985; Warren & Zgourides, 1991), anger (A. T. Beck, 1999; Dryden, 1990), substance abuse (A. T. Beck, Wright, Newman, & Liese, 1993; Ellis, McInerney, DiGieseppe, & Yeager, 1988), eating disorders (Fairburn, 2008), personality disorders (A. T. Beck, Davis, & Freeman, 2015; Ellis, 1999), and suicidal behavior (Brown et al., 2005; Ellis, 1989; Wenzel et al., 2009). More recently, CBT, broadly speaking, has been developed as an adjunctive treatment for serious psychiatric conditions, such as bipolar disorder (Basco & Rush, 2005) and schizophrenia (A. T. Beck, Rector, Stolar, & Grant, 2009). CBT has also been adapted for the treatment of clients whose salient feature is not necessarily a diagnosis of a mental health problem but other difficulties including (but not at all limited to) medical illnesses (Kyrios, 2009), chronic pain (Winterowd, Beck, & Gruener, 2003), obesity (Cooper et al., 2010), and sexual dysfunction (ter Kuile, Both, & van Lankveld, 2010).

Thus, it is very quickly becoming true that CBT has been adapted for the treatment of as many types of emotional distress, unhelpful approaches to coping, and adjustment difficulties that one can imagine. Similarities across these approaches include the active, problem-focused nature of treatment, the structure that cognitive behavioral therapists bring to each session and the overall course of treatment, the integration of both cognitive change and behavior change strategies, and some of the basic cognitive behavioral interventions (e.g., cognitive restructuring; see Chapter 4). What makes each of these approaches unique is not only the content focused on in session but also the inclusion of specific techniques that are tailored to the problem at hand. For example, clients with eating disorders who participate in CBT often weigh in at



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the beginning of each session; obviously, this practice would be unnecessary for a client who is being treated for anxiety or depression.

EXPANSION TO VARIOUS MODALITIES OF DELIVERY

Early forms of CBT were primarily delivered in the context of in-person individual psychotherapy. However, today, CBT is delivered in the context of a number of modalities. For example, cognitive behavioral group therapy is regarded as a treatment of choice for several clinical presentations (cf. Bieling, McCabe, & Antony, 2006; Norton, 2012a). One of the most rigorous and thoughtful adaptations of cognitive behavioral group treatment was advanced by Richard Heimberg and his colleagues in the treatment of social anxiety disorder (Heimberg & Becker, 2002). It is logical that a group treatment approach would be particularly attractive for socially anxious clients, as the group setting, itself, could provide a form of exposure and corrective learning experience for clients as they acquire other important cognitive behavioral tools. However, today, group CBT approaches can be found for nearly any clinical presentation; a subset of the group CBT approaches recently published at the time of this writing include but are not limited to group CBT for psychosis (Owen, Sellwood, Kan, Murray, & Sarsam, 2015), for comorbid anxiety disorders and personality disorders (Holas, Suszek, Szaniawska, & Kokoszka, 2015), for perfectionism (Handley, Egan, Kane, & Rees, 2015), for specific phobias as distinctive as emetophobia (Ahlen, Edberg, Di Schiena, & Bergström, 2015), and with male prison inmates (Brazão, Rijo, Pinto-Gouveia, & Ramos, 2015).

There are a number of features of group therapy that make it an attractive modality in which to deliver CBT. One obvious feature is the potential cost effectiveness of group treatment, as groups can be implemented for as little of half the cost of individual therapy (Morrison, 2001). Although meta-analytic work indicates that individual CBT is slightly more efficacious than group CBT (cf. Bieling et al., 2006), this difference is often seen at the level of a statistical trend, and its clinical significance is questionable. Another attractive feature of CBT groups is the ability to capitalize on the distinctive features of the group modality in general (cf. Yalom & Leszcz, 2005), including the promotion of a sense of universality, the ability to demonstrate altruism toward others, and a forum for corrective learning experiences to emerge as a function of interactions among fellow group members.

CBT is also readily delivered in the context of couples and family therapy (cf. Dattilio, 2010; Ellis, 1993; Ellis & Wilde, 2001). Cognitive processes often targeted in cognitive behavioral couples and family work include (a) selective attention, or the tendency



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to focus on certain aspects of relational behavior while ignoring other aspects; (b) malicious attributions that are used to provide an explanation for a partner's or family member's behavior; (c) probability overestimations for events that are predicted to happen in the relationship; (d) unrealistic assumptions about general characteristics of people and their relationships; and (e) unrealistic standards about characteristics that "should" operate in relationships (Baucom, Epstein, Sayers, & Sher, 1989). Common behavioral processes that are targeted in cognitive behavioral couples and family work include (a) communication skills deficits, (b) problem-solving skills deficits, and (c) excesses in negative behavior coupled with deficits in positive behavior (Epstein & Baucom, 2002). Dattilio (2010) also emphasized the importance of incorporating a focus on affect in cognitive behavioral couples and family work, allowing space for partners to experience and express emotion. Outcome research suggests that cognitive behavioral couples therapy is associated with significant improvement posttreatment, such that couples engage in more positive behaviors and report greater adjustment in the relationship (R. L. Dunn & Schwebel, 1995).

Since the turn of the century, a rapidly developing and innovative field of study has been the delivery of CBT via the Internet (iCBT; Andersson, 2014). iCBT includes standard content, such as psychoeducation; "lessons" that build progressively in a sequence to help clients acquire skill in modifying unhelpful thinking, emotions, and behaviors; and homework that serves to consolidate learning and allows the client to practice what has been learned (Andrews & Williams, 2014, 2015). Typically, iCBT programs are paced so that they mimic the course of progression in face-to-face CBT. Therapist support and guidance are provided through e-mail correspondence, video chat, and/or telephone consultations in order to promote treatment engagement and prevent dropout (Andersson, Rozental, Rück, & Carlbring, 2015; Andrews & Williams, 2014). There are many advantages of iCBT, including that it is available whenever an individual wants to access it, that it has an array of attractive interactive features (Andersson et al., 2015), and that fidelity, or the reliability and validity of the psychotherapeutic approach, is guaranteed (Andrews & Williams, 2014). Accumulating research suggests that iCBT is highly efficacious; for example, when iCBT is compared to either no treatment or treatment that consists of minimal support, effect sizes are moderate to large and comparable to effect sizes obtained in studies examining the efficacy of face-to-face CBT (Andersson, 2014; Andersson, Cujpers, Carlbring, Riper, & Hedman, 2014; Andrews & Williams, 2014, 2015). It has even been shown to be highly efficacious for clients with severe clinical presentations, such as severe depression with persistent suicidal ideation (A. D. Williams & Andrews, 2013).



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EXPANSION TO FLEXIBLE PROTOCOLS

As CBT garnered an increasing amount of attention and following, treatment manuals describing step-by-step CBT protocols for various mental health disorders were developed. This was a great accomplishment for the field, as it laid out the specific interventions that cognitive behavioral therapists deliver for specific mental health problems so that these interventions could be replicated and evaluated using scientific methods (Wenzel, Dobson, & Hays, 2016; Wilson, 2007). Manualized treatments were not without critics, however. For example, concerns were expressed that manualized treatments are stagnant and promote the delivery of psychotherapy in a robotic manner that leaves little room for clinical wisdom and collaboration with the client (Gaston & Gagnon, 1996; Westen, Novotny, & Thompson-Brenner, 2004). Furthermore, because most manuals focused on one particular mental health diagnosis (e.g., major depression, bulimia nervosa), there was concern that clinicians would have to learn an unwieldy number of protocols to treat the array of clients typically seen in clinical practice (Beutler, 2000).

Treatment manuals have significantly advanced the practice of CBT, and I anticipate that they will serve as essential resources for practitioners for many years to come. Nevertheless, even the protocols described in manuals, themselves, will continue to evolve. For example, many CBT protocols have moved away from session-by-session prescriptions and instead include “modules” that can be administered on the basis of the conceptualization of the client’s clinical presentation and the client’s needs (e.g., Dugas & Robichaud, 2007). Moreover, there is movement toward the development of transdiagnostic protocols that can be applied to clients that target the mechanisms that underlie related clinical presentations rather than the diagnosis per se (e.g., eating disorders, Fairburn & Cooper, 2014; emotional disorders, Barlow et al., 2011). Such developments in the field reflect recognition of the similar psychological processes that underlie many diagnoses of mental health disorders as well as the importance of customizing treatment for each client’s clinical presentation and circumstances and for incorporating essential ingredients that cut across therapeutic approaches (e.g., cultivation of a therapeutic alliance).

EXPANSION FROM EFFICACY TO EFFECTIVENESS

Efficacy is the degree to which the delivery of a treatment results in positive outcomes under optimal, tightly controlled circumstances, such as a high degree of homogeneity among clients enrolled in the study (e.g., no comorbidity), the use of highly trained therapists who receive extensive supervision (e.g., postdoctoral



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fellows or seasoned PhD-level therapists), or a setting like a principal investigator's research laboratory. *Effectiveness*, in contrast, is the degree to which the delivery of a treatment results in positive outcomes in real-world settings and under real-world circumstances, such as a community mental health center that uses master's level therapists and serves clients with a range of mental health problems and needs. It is typical for psychotherapy packages to first be evaluated using research methods that establish efficacy, and, once efficacy is established, to be subjected to research designs that target effectiveness.

Since the 1970s, a body of research has accumulated that clearly establishes CBT's efficacy (see Butler et al., 2006; Driessen & Hollon, 2010; and Epp & Dobson, 2010, for reviews). Nevertheless, critics have questioned the degree to which the efficacy research applies to "real-life" clients, reasoning that there is a difference between the types of clients who are enrolled in efficacy trials and the types of clients who therapists typically see in their clinical practices (Pagato et al., 2007; Persons & Silberschatz, 1998). Thus, it has been observed that there is a gap between psychotherapy researchers in academia and practicing clinicians, often manifesting in an us-versus-them mentality (cf. Lilienfeld, Ritschel, Lynn, Cautin, & Lutzman, 2013). To, in part, address this gap, whether real or perceived, researchers are increasingly turning their attention to effectiveness. Some researchers have compared outcome data obtained in community outpatient settings with results reported in efficacy studies (i.e., a benchmarking strategy) and found that rates of treatment gains and treatment maintenance are comparable (Björgvinsson et al., 2014; Merrill, Tolbert, & Wade, 2003; Stuart, Treat, & Wade, 2000; Wade, Treat, & Stuart, 1998). Others have conducted randomized controlled trials (RCTs) in clinical practice settings for mental health problems such as depression in older people (Serfaty et al., 2009), eating disorders (Byrne, Fusland, Allen, & Watson, 2011), and psychosis (Lincoln et al., 2012). Collectively, these data are demonstrating that CBT is generalizable to real-life clinical settings with real-life therapists and clients, which, through dissemination, will increase the accessibility of this psychotherapeutic approach to treatment-seeking individuals around the globe. More about dissemination is considered in the final chapter.

EXPANSION TO CULTURAL SENSITIVITY

Cognitive behavioral therapists have, traditionally, emphasized case conceptualization and the unique understanding of each client in the context of his or her environment, communicating a great respect for individual differences. At the same time, some



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have noted that CBT was developed from the basis of Western, individualistic values such as autonomy, independence, and achievement and questioned the degree to which the fundamental tenets of CBT are applicable across cultures (Hays, 2009). In fact, many empirically supported treatments for mental health disorders, including CBT, are evaluated using samples drawn from predominately white, middle-class backgrounds, making their relevance to individuals of ethnic minorities unclear (Bernal & Scharrón-del-Río, 2001).

Cultural sensitivity is increasingly receiving attention in the field. For example, Pamela Hays is a leading cognitive behavioral clinician whose scholarly work centers on culturally responsive cognitive behavioral treatment (e.g., Hays, 2008; Hays & Iwamasa, 2006). She developed the ADDRESSING framework to be aware of the multiple influences that affect clients' clinical presentations, including influences relevant to **a**ge/generation, **d**evelopmental and other **d**isabilities, **r**eligious and spiritual orientation, **e**thnic and racial identity, **s**ocioeconomic status, **s**exual orientation, **i**ndigenous heritage, **n**ational origin, and **g**ender (Hays, 2008, 2009). According to Hays (cf. Wenzel et al., 2016), cognitive behavioral therapists take care not to assume that clients' clinical presentations result solely from distortions or abnormalities in cognition and behavior but that they consider the ways in which environmental factors (e.g., racism, oppression) existing outside the individual contribute to the problems and stresses that clients are experiencing. She also encourages clinicians to use stories and metaphors from clients' cultural backgrounds to illustrate key cognitive and behavioral principles and ways for clients to incorporate those principles into their lives.

The program of research developed by Ricardo Muñoz exemplifies the adaptation of traditional CBT intervention strategies in a culturally sensitive manner to the Latino community. Muñoz studied under Peter Lewinsohn at the University of Oregon, and as will be seen in Chapter 6, Lewinsohn is a major figure in the development of behavioral activation, a central component in the cognitive behavioral treatment of depression. Muñoz applied his well-established expertise in CBT to the treatment of mental health problems, especially depression and tobacco dependence, in the Latino community in San Francisco. He developed treatment manuals that have been disseminated around the country for working with Latino clients (Muñoz & Mendelson, 2005). His approach incorporates four major CBT strategies: (a) cognitive restructuring, (b) behavioral activation, (c) social problem solving to manage personal relationships, and (d) social problem solving to manage physical health issues (Aguilera, Garza, & Muñoz, 2010).



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Of note, many constructs that resonate with Latino individuals are assimilated into his CBT approach (see Muñoz & Mendelson, 2005, for an extensive discussion). Muñoz and his colleagues sought feedback from Latino individuals when he was developing his treatment manuals. Vocabulary was modified to meet the typical education level of the ethnically diverse clients he served, and culturally relevant images, stories, and metaphors were included to communicate key points. For example, “la gota de agua labra la piedra” (translated to “drops of water can carve a rock”) was used to illustrate the fact that, over time, thoughts can shape the way in which we view the world and interact with it, thereby reinforcing depression. In addition, cultural values were acknowledged and modeled by Muñoz and his colleagues in treatment development and by therapists who executed the treatment, such as the importance of family (i.e., familism), respect (i.e., respeto), and an emphasis on spirituality and religion. Importantly, Muñoz demonstrates a commitment to science, and his approach has been evaluated in clinical research. For example, a series of studies have evaluated his Mothers and Babies (Mamás y Bebés) course, a CBT approach to prevent postpartum depression, and studies show that his approach outperforms usual care in the prevention of this mental health disorder (Le, Perry, & Stuart, 2011; Muñoz et al., 2007; Tandon, Perry, Mendelson, Kemp, & Leis, 2011).

The body of work developed by Muñoz and his colleagues demonstrates that not only does CBT have applicability broadly across ethnicity, culture, and social class but also that therapists can retain integrity with regard to CBT’s basic model and principles even when adaptations are made. This being said, much future research is needed to establish CBT’s efficacy with a number of cultural and ethnic groups as well as the efficacy of specific adaptations that would be hypothesized to enhance outcome.

EXPANSION TO THIRD-WAVE CBTS

The *third-wave* or *contextual* cognitive behavioral therapies have received a great deal of attention over the past 15 to 20 years, focusing on principles of acceptance, mindfulness, and nonjudgmental awareness (Hayes, 2004; Hayes, Villatte, Levin, & Hildebrandt, 2011). Examples of third-wave CBTs include acceptance and commitment therapy (ACT; Hayes et al., 2012), mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002, 2013), dialectical behavior therapy (DBT; Linehan, 1993a, 1993b, 2015), and metacognitive therapy (Wells, 2009). An important feature that distinguishes third-wave cognitive behavioral therapies from more traditional CBTs is the shift away from content to function. In other words, many



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therapists who practice contextual psychotherapies are less concerned with the overt modification of unhelpful cognitions and instead are more concerned with shifting the person's relationship with the cognition itself. Contextual cognitive behavioral therapies are generally more centered on the process by which a person lives his or her life rather than on what, specifically, is being thought or done (K. S. Dobson & Dozois, 2010). According to Hayes (2004), "The third-wave interventions are not a rejection of the first and second waves of behavioral and cognitive therapy so much as a transformation of these earlier phases into a new, broader, more interconnected form" (p. 660).

Experts in the field disagree about the degree to which these approaches truly represent a new wave and the degree to which they should be subsumed into the family of cognitive behavioral therapies versus the degree to which these approaches are distinct (cf. Hofmann & Asmundson, 2008; Öst, 2008). Nevertheless, these approaches have significantly influenced even the most traditional cognitive behavioral therapists. Discussions on the listservs of the Academy of Cognitive Therapy and the Association for Behavioral and Cognitive Therapies regularly focus on applications of mindfulness and acceptance techniques within the practice of CBT as well as the optimal delivery of these third-wave treatment packages. Chapter 9 describes third-wave treatment approaches that focus specifically on mindfulness and acceptance. In the final chapter, I advance my own reconciliation of CBT and the contextual approaches.

OVERVIEW OF THE CURRENT VOLUME

This chapter has provided a concise illustration of what CBT is and how it evolved. What it has not provided is a description of specific treatment strategies and techniques that are used by cognitive behavioral therapists. That is the purpose of the remaining chapters in the volume. Each chapter is structured in roughly the same manner. First, I define the basic parameters of a standard cognitive behavioral intervention strategy (e.g., cognitive restructuring). Next, I illustrate the traditional way in which the intervention strategy was translated to specific treatment techniques and implemented with clients (e.g., the thought record that can be used to achieve the aims of cognitive restructuring). Then, I summarize innovative ways that the intervention strategy has been adapted, either in terms of innovative techniques that can be used with clients, contemporary modalities for delivery, innovative modifications for particular types of clients, or innovative issues to consider when



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using the strategy. At the end of each chapter, I propose future directions for empirical research as well as clinical practice.

The main intervention strategies described in these chapters are as follows. In Chapter 2, traditional and innovative approaches to case conceptualization are described and applied to a single case. Chapter 3 describes an exciting development in the field—the use of motivational interviewing before and during the administration of standard cognitive and behavioral intervention strategies to address client ambivalence and increase motivation for change. Chapters 4 and 5 are devoted to traditional and innovative approaches to cognitive restructuring—Chapter 4 is focused on the restructuring of thoughts that people experience spontaneously in particular situations, and Chapter 5 is focused on the restructuring of underlying beliefs that develop on the basis of key experiences from previous times in a person’s life. In Chapter 6, traditional and innovative approaches to behavioral activation are considered, focusing on two contemporary behavioral activation treatment packages that have been subjected to rigorous empirical scrutiny. Chapter 7 is devoted to the intervention strategy of exposure and describes the historical trajectory by which exposure has been incorporated into cognitive behavioral treatment protocols for anxiety-based disorders, the dominant theoretical paradigm that has been used to guide the implementation of exposure since the late 1980s, and a new theoretical paradigm that emerged in the late 2000s. Chapter 8 focuses on traditional and innovative approaches to affect management (which I define as incorporating strategies for both emotion regulation and distress tolerance) and introduces ways to evaluate the degree to which affect management strategies are helpful or harmful in the short and long term. Chapter 9 shifts to a focus on the popular constructs of mindfulness and acceptance. Chapter 10 closes this volume with two main foci: (a) challenges that the field faces in the training and dissemination of CBT and (b) a reconsideration of the fundamental definition of CBT as well as a new perspective on what might be considered *integrative* CBT.

This book is by no means comprehensive. In fact, innovations will be developed and published just in the time that it takes for this finished product to go to press and to be released to the general public. I encourage readers to digest the material contained in this book with the “spirit” of innovation in mind. Too often, I encounter therapists who practice from a different theoretical orientation, or who are just beginning training in CBT, who have the idea that CBT must be delivered in a prescribed “cookbook” manner and that there is a “right” and a “wrong” way to do it. In the past, I have argued strongly against these notions (e.g., Wenzel, 2013).



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Therapists are, without a doubt, delivering CBT if they are implementing a strategic intervention that (a) follows logically from the case conceptualization of the client's clinical presentation; (b) is done so collaboratively with the client, taking into account his or her preferences and wishes; (c) moves treatment forward in some systematic way instead of proceeding without a clear plan or rationale; and (d) is seen through in its entirety without getting derailed by extraneous discussion of therapist reluctance.

In other words, just about any intervention strategy can be delivered by cognitive behavioral therapists, and they will still be "doing" CBT. In fact, cognitive behavioral therapists have license to integrate a tremendous amount of creativity into their clinical work. It is thoughtful consideration of the principles that underlie their intervention strategies that is the key issue. I invite the reader to allow the ideas presented in this book to stimulate critical and creative thought about innovations that they can use in their own clinical practice.

CHAPTER

3

MOVING FORWARD FROM TRAUMA, ADDICTION, OR BOTH

Recovery
from Trauma,
Addiction,
or Both

Strategies for
Finding Your Best Self

Lisa M. Najavits, PhD
Author of the bestselling book *Seeking Safety*

This chapter is excerpted from
Recovery from Trauma, Addiction, or Both
By Lisa M. Najavits

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Lisa M. Najavits

Excerpted from *Recovery from Trauma, Addiction, or Both*

I am not what happened to me. I am what I choose to become.
—Carl Gustav Jung, 20th-century Swiss psychiatrist and writer

You can heal from trauma and addiction. In the words of people who have done it:

Living with addiction [or trauma] “is sort of like growing up on a boat. The ground is always moving underneath you, sometimes you learn to stay upright, when the water is gentle, but at times it’s completely impossible, and it’s all you can do to lie flat and hang on for dear life. Coming into recovery ... it’s like washing up on the shore and standing up. Even though you’re on solid ground, it takes a while to stop reeling and constantly counterbalancing, because that’s all you know. People on land might look at you like you’re insane for hanging on to a railing, because they’ve always stood on solid ground and can’t understand being that involuntarily imbalanced. Over time, you start to gain your land legs, though, and stop having to reel back and forth just to stay upright. Then you wake up one day and realize that you can walk a straight line on dry land for the first time. You always remember the buck and roll and learning to walk again, but you learn to stay upright and walk among the ‘land people.’ ”

—From www.soberrecovery.com

“Living in recovery is like gradually waking up from a long, nightmare-filled sleep. It is discovering pale days slowly fading into warm, colorful transforming experiences rich with meaning and joy.”

Emotional pain that you’ve carried, even for a long time, can become the seed of growth.

TRAUMA AND ADDICTION

Throughout the world, trauma and addiction are two of the most difficult and common issues that people face.

TRAUMA MEANS “WOUND”

Trauma comes from the Greek word for *wound*, which vividly describes what it feels like. It’s a serious, unwanted, harmful event that can lead to lasting pain. The wounds



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may be physical, emotional, or both. Most people endure at least one in their lifetime and some have a lot of them.

The definition of *trauma* from the American Psychiatric Association (2013) refers to physical events such as the following:

- car accident
- sexual assault
- military combat
- physical violence
- fire
- hurricane, tornado, or other natural disaster
- terrorist incident
- life-threatening illness or injury
- sudden death of someone close to you
- industrial accident
- domestic violence

“Starting at the moment that the bomb went off, I had a mental video and audio of that day’s experiences that played 24 hours a day, along with everything else I was doing.”

—Paul Heath, survivor of the Oklahoma City bombing, in *Learning to Live Past 9:02 am, April 19, 1995*, by Kathryn Foxhall

Trauma can also refer to deeply disturbing experiences that are not physical in nature:

- emotional abuse • bullying • growing up with mentally ill parents • neglect
- abandonment • homelessness • major loss • severe social rejection • ongoing serious stress, such as chronic pain, poverty, or discrimination

◇ Have you had trauma?

How trauma occurs also matters. It can happen ...

- » *To a person or entire communities.* Whole cultures can suffer trauma as in genocide and slavery, which carries forward emotionally over generations.



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- » *Amid support or brutality.* Humiliation, silence, betrayal, and blame worsen the impact of trauma.
- » *Directly or threatened or witnessed.* For example, a child may see violence happening to a parent.
- » *Once or often.* Some people say there were “too many times to remember.”

Whatever your history of trauma, you can learn new ways to cope with it. The past can't be rewritten, but you can change how you relate to it.

ADDICTION MEANS “CAN'T STOP”

Addiction comes from Latin roots for *enslavement*, which perfectly describes what serious addiction feels like. But addiction can be mild, moderate, or severe. You don't have to fit the image of an addict to have a problem. It can creep up on you without your noticing. Others may see it before you do. Or you may have a problem that's not yet a full-blown addiction.

Broadly, addiction means that *you keep engaging in a behavior despite the harm it causes*. You keep drinking even though your doctor tells you to stop. You keep gambling despite your debt. You keep having affairs even if it costs you relationships. People without addiction would stop to preserve their health, finances, or relationships. People with addiction keep repeating the behavior. They may want to stop but can't. They feel more and more out of control. Or they may think it's not a problem, but the facts show that it is.

“In those rare times lately when I sit back and take stock of myself, I can see that I'm spending hour after hour, evenings and weekends, just sitting around staring at porn. Instead of actually having 'a life,' I've lost precious hours, days, weeks, months, even years in isolation and loneliness. Most days I can't wait for work to end so I can get home to my porn collection. Whoever says this problem doesn't exist should try walking in my shoes for a few days... I don't know what it is to have a real relationship because all I've ever experienced is webcam hookups and porn.”

—From *Always Turned On: Sex Addiction in the Digital Age*, by Robert Weiss and Jennifer P. Schneider

Substance addiction – alcohol or drugs – is one of the most common addictions and also the most studied. The formal term is *substance use disorder*, and 15% of



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people develop it in their lifetime. In the United States it's the second most common psychological problem after depression. Drug overdoses currently kill more Americans than cars or guns.

But people can get addicted to all sorts of behaviors, including gambling, pornography, sex, work, food, spending or shopping, electronics (such as television, Internet, texting, and gaming), rage, violence, self-harm such as cutting or burning, and body-related behavior such as plastic surgery, tattooing, tanning, or exercise. These *behavioral addictions* are becoming more and more recognized as they seem to have many of the same features as substance addiction.

◇ Are there any behaviors you want to reduce – alcohol, drugs, gambling, eating, spending, or any others?

A NEW PERSPECTIVE LINKING TRAUMA AND ADDICTION

A major breakthrough in recent years is the understanding of how common it is for *both* trauma and addiction to happen to the same person.

Sometimes trauma leads to addiction, sometimes addiction leads to trauma, and sometimes both occur at the same time. For most people trauma occurs first, then addiction – often through an attempt to try to cope with emotional or physical pain. This pattern has existed throughout history, including the description here by a famous 19th-century writer.

“I have absolutely no pleasure in the stimulants in which I sometimes so madly indulge. It has not been in the pursuit of pleasure that I have periled life and reputation and reason. It has been in the desperate attempt to escape from torturing memories ... from a sense of insupportable loneliness and a dread of some strange impending doom.”

—From the letters of Edgar Allan Poe

It makes perfect sense that people reach for something to try to feel better when they're distressed. A trauma survivor may drink to deal with nightmares or binge to soothe inner pain. People abuse substances, gamble away their money, overeat, work too hard, and spend too much because they want to shift feelings. They may want to feel *more* of something, such as energy, joy, or calm; or *less* of something, such as



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rage, hurt, loneliness, or self-hatred. Feelings get thrown off balance due to trauma. You may have no feeling (numb) or too much feeling (overwhelmed) or bounce back and forth between these. Addictive behavior can “solve” trauma problems in the short term even though it’s destructive in the long term.

To those who don’t understand, addiction is often judged as bad rather than seen at a deeper level as an attempt to cope. The truth is that even though addictive behavior causes problems, it may have been safer in the moment than the alternative. Some people say substance use calmed them enough to prevent suicide or helped them survive abuse they couldn’t escape.

Jennyfer: “I probably would have committed suicide if I hadn’t turned to drugs as a way to cope after my accident – that fateful moment when a stray bullet in the night altered the course of my life forever. I think a lot about my life since my traumatic brain injury – my choices, addictions, the insane risks I have taken, and my absolute lack of fear. I have hopped on planes and relocated to foreign countries where I didn’t know a soul, because I felt like there was an invisible driving force whispering in my ear, ‘All you have is today.’ ”

The goal now is to find ways to cope with trauma so that you won’t need addictive behavior. But you can honor that you may have used it to survive emotionally or physically.

BEFORE GETTING INTO RECOVERY VERSUS AFTER

Notice what people say before they get into recovery versus after.

Before recovery

- “I’m haunted by my memories.”
- “I drink to get to sleep at night.”
- “I have urges to hurt myself.”
- “I’m numb.”
- “I don’t take care of my body.”
- “I hate myself.”



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- “When I use, it decreases the rage.”
- “I’m with a partner who hits me.”
- “When I have flashbacks, I go to the casino to calm down.”
- “Cocaine gives me permission to feel sexual.”
- “I drink to keep from killing myself.”
- “Heroin is the only way I know to nurture myself.”
- “When I drink, I cry about all the things that happened to me.”
- “I can’t stop doing what I do.”
- “I feel scared a lot.”
- “Using drugs closes the door to my past.”
- “I feel like a failure.”
- “A food binge makes me feel better.”

◇ Do any of those statements sound familiar to you?

In recovery

- “I’m no longer afraid of my memories.”
- “When I get cravings to use, I can let them pass.”
- “I am better at choosing people who treat me well.”
- “I no longer feel angry all the time.”
- “Things that used to throw me – I’d be in bed for days, depressed – I can handle now.”
- “I can be sexual without getting triggered.”
- “I learned that I don’t have to rebel to be seen and heard.”
- “Now I view my addiction as a medical illness.”
- “For the first time, I can forgive myself. I really feel it – it’s not just words.”
- “I know who I am; I’m not a stranger to myself any- more.”
- “I take care of my body now.”
- “I became a good mother to my kids the more I became nurturing toward myself.”
- “I stopped keeping secrets.”



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- “I understand now that I don’t have to suffer so much.”
- “After being down for so long, hating myself, I don’t take for granted what it feels like to be up. There’s a sense of appreciation.”
- “I can say what I want rather than blowing up.”
- “Now other people are more important to me than drugs.”

◇ Which statements sound like what you want for yourself?

THE OLD WAY – SPLIT WORLDS: TRAUMA *OR* ADDICTION

Imagine that you’re seeking help for addiction plus a history of painful trauma – perhaps childhood physical, sexual, and emotional abuse; a serious car accident; or combat. In traditional addiction approaches, you might be told to “Get clean and sober first” or “Just work on your addiction recovery.” You may think, “No one wants to hear what happened,” “I’m weak for focusing on it,” or “Maybe what I went through wasn’t that important.” There may be caring people who want to help, but perhaps they were trained to avoid focusing on trauma.

So too if you have trauma problems, you might enter a mental health program where they never ask about addiction unless it’s severe, in which case they refer you to an addiction program. They may say, “Come back when you’ve gotten the addiction under control” – a message that can leave you stuck, unable to address the trauma or the addiction successfully. One young woman, Chandra, said, “I had to hide my addiction to get into a trauma program. I lied because I knew that if I didn’t get help for my PTSD I would never recover from substance abuse.”

The worlds of trauma recovery and addiction recovery have historically been separate and largely remain so today. The two worlds have separate workforces, cultures, and funding. People with both trauma and addiction problems can get lost in the gap, rejected from help in one domain because they’re too severe in the other.

Now imagine a new approach: you enter a program that’s both *trauma-informed* and *addiction-informed*. You’re asked about your trauma and addiction from the start, and the staff are trained to understand how each impacts the other. You’re able to be open about both and learn skills to work on both at the same time, not delaying one for the other. You might feel more understood and more motivated to work on recovery. “It feels like it’s a piece of the puzzle. There was a piece that was missing, and now it’s not missing anymore,” said one client in such a program.



MOVING FORWARD FROM TRAUMA, ADDICTION, OR BOTH

Lisa M. Najavits

Excerpted from *Recovery from Trauma, Addiction, or Both*

Notice the differences between the old and new ways:

Focus on trauma <i>or</i> addiction Traditional approach	Focus on addiction <i>and</i> trauma New approach
Addiction is the focus or trauma is the focus, not both.	If you have both, you can get help for both.
“One size fits all” – there’s one right way to heal.	“Many roads, one journey” – there are many ways to heal.
Attend one type of treatment.	Embrace all the help you can.
Work on addiction now and trauma later.	Work on both at the same time.
With addiction recovery you’ll feel better and better.	Trauma problems may flare up as you maintain addiction recovery; this needs attention too.
If you heal trauma, the addiction will go away on its own.	Healing trauma alone is not enough.
If you work on trauma and addiction at the same time, you’ll get worse.	It’s <i>how</i> you work on it that matters. Working on both shows positive results if it’s done well.
Addiction is just due to genes (biology).	Addiction is typically due to genes and environment (including trauma).
Lack of focus on gender or culture	Gender and culture play a role in trauma and addiction.
Addictive behavior is an attempt to <i>avoid</i> trauma memories.	There are many reasons why people have addictive behavior.

One of the big moments in recovery is when you can see how trauma and addiction are linked if you have both issues. You open your heart and find ways to move forward. You tell a new story of who you are.

AN UPWARD SPIRAL

Just as trauma and addiction are linked, so is their recovery. You can apply recovery skills to both at once, which is more powerful than working on each alone.

You can create an *upward spiral*: Improving one helps the other. In fact, people who have both issues prefer working on them together when they’re given that option, research shows.



MOVING FORWARD FROM TRAUMA, ADDICTION, OR BOTH

Lisa M. Najavits

Excerpted from *Recovery from Trauma, Addiction, or Both*

◇ What does the opening quote in this chapter mean to you?

◇ What feels hopeful for you right now?

RECOVERY VOICES

Lily – “. . . a life worth living”

Lily survived child abuse and had drug addiction that lasted into her 30s. “For so long I never thought about what I went through. Everything was a blur. All I lived for was to forget. Now I have a guiding light. When I crave a substance, it’s a sign that there’s something happening in my life that I need to pay attention to, a reminder of my past, a sign to change the story and practice taking care of me. It took me a long time to get to that. I didn’t see the connection between my trauma and addiction. It was really hard to see it when I was living it. I couldn’t escape the trauma when it was happening, and I wasn’t going to give up the substances because it felt like that’s what was saving my life at the time. I eventually landed in addiction treatment, and that helped, but it was silent about trauma. I was told that I shouldn’t talk about it till later, but for me ‘later’ never came. Eventually I found a counselor who helped me work on both. He was really caring and also gave me ideas of what to try, a lot like what’s in this book. I made it my mission to learn all I could. It wasn’t a straight path; I still kept secrets. I gave up alcohol but lied about using pills. Or I’d have trauma nightmares and go back to alcohol. But over time I got stronger and more honest. The opening quote in this chapter captures what recovery means to me – yes, there’s pain in life, but I can make choices that bring me more of what I want: love, good people, sobriety, and the adventure of life on life’s terms. I can’t change the past, but I have a life worth living.”

CHAPTER

4

STRATEGIES FOR SOCIAL ANXIETY

CBT Strategies for
Anxious and Depressed
Children and
Adolescents

A CLINICIAN'S TOOLKIT



Eduardo L. Bunge, Javier Mandil,
Andrés J. Consoli, and Martín Gomar

This chapter is excerpted from

*CBT Strategies for Anxious and Depressed Children
and Adolescents*

By Eduardo L. Bunge, Javier Mandil, Andrés J. Consoli,
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STRATEGIES FOR SOCIAL ANXIETY

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MODULE GOALS

- Understanding the factors that maintain social anxiety, specifically catastrophic thoughts and safety measures.
- Discussing the impact of a common thinking trap among clients with social anxiety: mind reading.
- Learning ways to challenge catastrophic thoughts and reduce safety measures.

WHEN TO USE THESE HANDOUTS AND WORKSHEETS

- When clients present with a diagnosis of social anxiety disorder, or of some other depressive or anxiety disorder that involves social fear.
- When clients have done psychoeducation for anxiety and learned some cognitive strategies for anxiety, and whenever clients present intense fear of judgment from others.

CLINICAL TIPS

- Therapists should highlight the frequent repetition of thoughts related to possible negative judgments from others in social situations.
- If clients are always “guessing” that others are having negative thoughts about them, it may be helpful to use “Typical Thoughts in Social Anxiety” and try to identify the typical thoughts these clients may have in social situations.
- If clients are consistently engaging in mind reading, therapists can provide examples of mind reading from other kids, ask the clients to think of some alternative thoughts, and then suggest how the clients could respond to their own instances of mind reading.

HOW TO COMBINE FORMS

- When clients present with social anxiety and depression together, they will have both catastrophic and negative thoughts. For these clients, the forms on cognitive restructuring from Modules 5, 10, and 11 may be used together.

CASE ILLUSTRATION

Keisha is 14 years old, suffers from social anxiety disorder, and is currently experiencing a depressive episode. She has difficulties interacting with her peers and believes people are judging her negatively. Although she has a small group of friends, she is occasionally bullied by another group of classmates. After doing psychoeducation for anxiety and depression, and after practicing some behavioral



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activation strategies with Keisha, the therapist begins to explore some of her social fears, and highlights the “mind reading” thinking trap.

THERAPIST: Keisha, may I see the thought record you made? You say that after walking into class, you thought, “They don’t like what I am wearing,” and you told me you decided not to discuss this thought. Am I right?

CLIENT: Yes. I know that they were looking at me with that look, plus they are always criticizing everybody.

THERAPIST: Let me ask you something: Did they criticize you? Or was this based on their look?

CLIENT: Well, I supposed . . . Oh, come on! You know when someone is looking at you with that look.

THERAPIST: You may think so, based on what happened in the past. But if we are continually experiencing social fears, do you think that believing 100% of what we are saying to ourselves is a good idea?

CLIENT: Hmm . . .

THERAPIST: Is there any risk of doing so?

CLIENT: You don’t understand. You just don’t know them.

THERAPIST: Well, that is true; I don’t know them. What I am wondering is this: Is it useful to take our thoughts as certain? What do you think?

CLIENT: Probably, in some cases, it won’t be useful.

THERAPIST: Considering that you tend to feel anxious in social situations, what type of thoughts would you have?

CLIENT: Yeah, I know, all bad thoughts.

THERAPIST: Can we check this worksheet (*showing Keisha “Worksheet: Mind Reading”*)?

CLIENT: (*Reading it*) I see, but I don’t read minds. I come up with things based on their attitudes.

THERAPIST: So the question now is this: Do you really know what they are thinking, or are you making inferences about their thoughts?

CLIENT: Hmm . . . Aha. I see. I don’t know for sure what people are thinking.

THERAPIST: Actually, none of us knows for sure. We may be right or wrong, but when we are constantly anxious in social interactions, it is worth it to be aware of this. What do you think?



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CLIENT: Probably, yes.

THERAPIST: Would you like to see if you can challenge some typical “mind readings” that other kids usually have? *(Continues working on the worksheet with Keisha)*

TROUBLESHOOTING

- What if clients have difficulties finding alternative interpretations to their catastrophic thoughts? Or what if a client’s thoughts are too rigid?
- Therapists should be aware that other disorders (e.g., high-functioning autism) may have a presentation similar to that of social anxiety. If difficulties are frequent and intense, it may be wise to review the assessment and diagnosis.
- Adolescents with dysthymia or severe depression may also have difficulties in changing their perspective; in these cases, therapists should consider working on improving mood before continuing with this module.

CULTURAL CONSIDERATIONS

- It is important to consider the types of social interactions that clients’ families and cultural reference groups commonly engage in, to appreciate the impact that social anxiety disorder may have on clients, and to be able to agree on treatment goals that are culturally responsive and congruent.
- Therapists are encouraged to keep in mind that some families and cultural groups may expect a reserved and deferential attitude in most social contexts, while others may expect an open expression of personal emotions.
- The comic strip in the “Mind Reading” handout shows a behavior that may be inappropriate for some cultural groups. Therapists are encouraged to check in with clients consistently and systematically throughout treatment, in order to tailor the tools offered here appropriately, and as a way to get to know their clients even better.

ACKNOWLEDGMENT FOR FORM

“This problem feeds on catastrophic thoughts . . .” in “What Is Social Anxiety?”: Botella, Baños, and Perpiñá (2003).



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WHAT IS SOCIAL ANXIETY?



“Social anxiety” is a special kind of anxiety that happens when we have trouble facing situations where we interact with others, such as these:

- Public speaking.
- Taking oral exams.
- Meeting new friends.
- Expressing how we feel and what we need.

We all suffer shyness or anxiety to some extent, every now and then. But when this fear is repeated often and with great intensity, it may be useful and necessary to work on it.

Here is one of the keys to this problem:

“I am constantly thinking about what they think of me.”

This problem feeds on catastrophic thoughts, such as these:

“Everybody else is better than me.”

“I’m not as good as they are.”

“They’ll be aware of how I do things.”



STRATEGIES FOR SOCIAL ANXIETY

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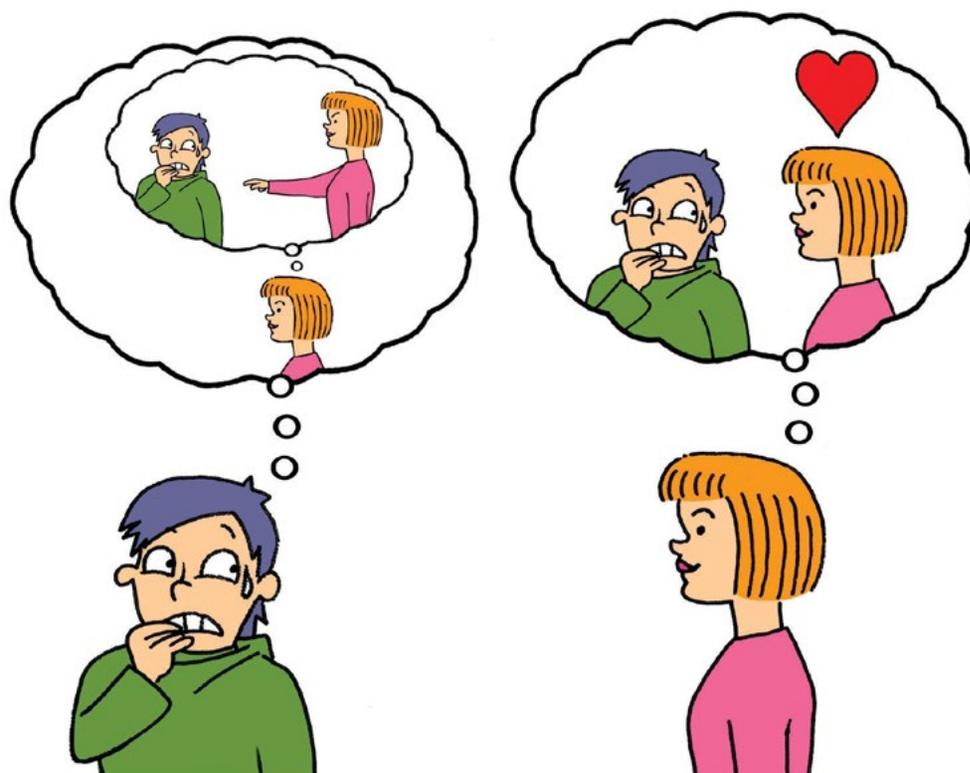
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"It'd be very difficult to please them."

"I'll be in trouble if they don't like me."

"I could look ridiculous."

These thoughts are based on an unhelpful way of seeing things, which we call "mind reading."



Mind reading can be explained this way: Every time we get anxious in these situations, we believe we can guess other people's thoughts. The strangest thing is that what we guess is always negative!

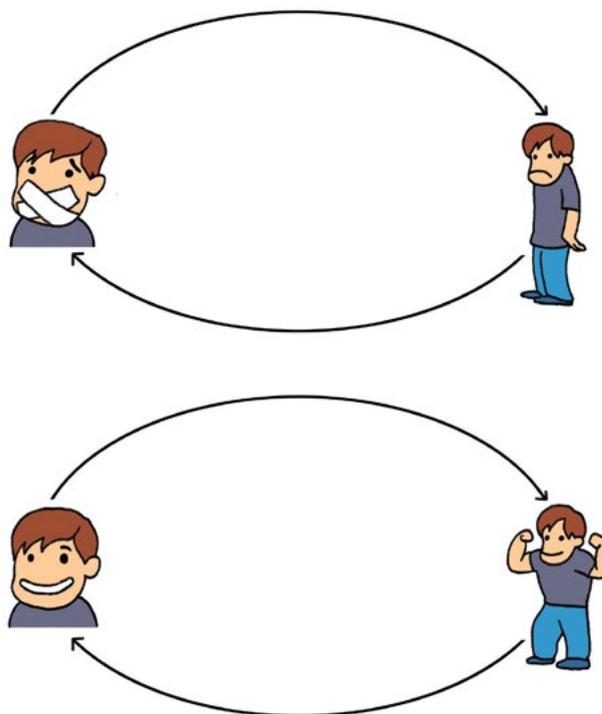
As you already know, our usual reaction when we try to face this fear is to avoid or escape, which only makes problems worse.



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TYPICAL THOUGHTS IN SOCIAL ANXIETY

These are some examples of typical thoughts we have when we get nervous in front of other people.



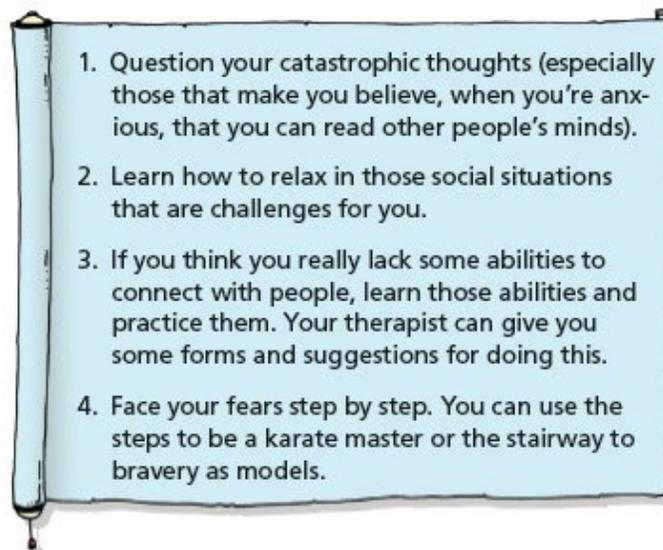


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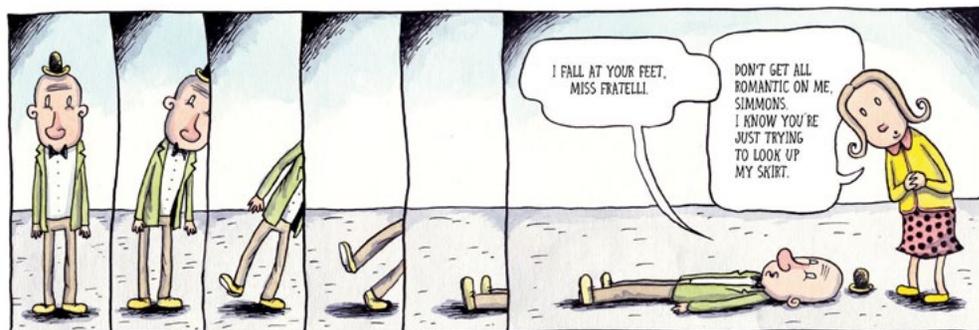
Excerpted from *CBT Strategies for Anxious and Depressed Children and Adolescents*

Do you usually think these kinds of things? What other types of thoughts do you have? How do they make you feel? Would you like to defeat them? If so, here are some ideas.



MIND READING

Let's take a closer look at mind reading—the unhelpful way of seeing things that produces catastrophic thoughts in social situations.



Miss Fratelli thinks Simmons's intention is to look up her skirt. We call this type of thinking "mind reading." Mind reading can be wrong, be right, or have a little bit of both. But here's what we know for sure:

- We can't really know what's going on inside someone else's mind, unless this person tells us.
- Generally, we imagine that what others think about us is exactly what we also think about our own selves.



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Mind reading can be the reason we feel afraid to do some things in the presence of other people (and so we keep quiet or stay home). It can also be why we find it more difficult to make friends.

WORKSHEET: MIND READING

Here are some mind-reading examples. Use these to come up with ways you could defend yourself from these thoughts. Fill in the last two "Situation" and "Thought" spaces with examples of your own.

<i>Situation</i>	<i>Thought (mind reading)</i>	<i>Alternative thought</i>
I'm giving a speech at school.	"The kids are thinking that I stutter too much."	
People are dancing at a party.	"They think I'm bad at dancing."	
I'm speaking on the phone at home. Other family members are in the next room.	"For sure, they're all listening to check how I talk."	
My friend is hanging out with a guy I don't know.	"They want to play without me."	
My friend tells me I'm pretty.	"She's saying it so I won't feel bad."	

Get ready to respond to mind reading the next time you need to!

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CHAPTER

5

ORIENTING ADOLESCENTS AND FAMILIES TO TREATMENT AND OBTAINING COMMITMENT

Dialectical
Behavior Therapy
with Suicidal
Adolescents



Alec L. Miller, Jill H. Rathus,
and Marsha M. Linehan

This chapter is excerpted from

Dialectical Behavior Therapy with Suicidal Adolescents

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The pretreatment stage of orientation and commitment to DBT begins once suicide risk and diagnostic assessments are complete and the adolescent has been found to meet the inclusion criteria for the DBT program (see Chapter 6). As discussed in Chapter 3, the key goals of this stage are for the client and therapist to arrive at a mutually informed decision to work together and to make explicit their agreed-on expectations about that work. The process involves the primary therapist's helping the adolescent identify his or her long-term goals, orienting him or her to the treatment, and obtaining the teen's commitment to treatment. These therapeutic actions are considered "pretreatment targets." This chapter presents a set of strategies to use with adolescents and families to orient them and obtain their commitment. These are outlined in **Table 5.1**. In outpatient adolescent programs, an additional orientation to DBT often occurs in a multifamily skills training group format. (See Chapter 10 for orientation to skills training.)

Orientation and commitment to DBT begin with the adolescent alone first. Once the process has been initiated with the adolescent, the therapist can bring in the parents and/or other participating family members and repeat some of the key elements (this can occur late in the first session or in the second session). Even in more restrictive treatment settings (e.g., inpatient, forensic, and residential), we suggest following this same format, despite the fact that the adolescent may not have any choice whether to participate in the DBT program or not. It is important to foster some sense of control over the teen's participation. For example, the therapist might say,

"We know right now that you do not want to be here. So you can remain miserable, stay in your room, not participate in DBT group or individual sessions, and keep talking to your friend— or you can try to get to know some new people, participate in the treatment, and maybe figure out what you need to do to build a life worth living outside of this place and we'll help you do it."

The development and maintenance of a therapeutic alliance with the adolescent are of critical importance in this initial stage and throughout treatment. Other key orientation tasks are (1) to introduce the treatment in terms of how it fits, and can help solve, the individual teen's problems; (2) to link work on Stage 1 treatment targets with the adolescent's long-term goals; and (3) to present an overview of the treatment and its requirements. Orientation is not simply a description of the treatment; rather, it aims to build motivation. It is a discussion of what the particular teen can (and can't) realistically hope to get out of the treatment, and of how the treatment works to fulfill



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those hopes. The process clarifies the adolescent's specific goals and the specific DBT procedures used for reaching those goals. This becomes the basis for an explicit treatment agreement to which all parties are asked to commit themselves. Strategies for obtaining client commitment are discussed later in this chapter.

Table 5.1 • Orientation and Commitment Strategies for Adolescents and Families

1. Begin to establish a therapeutic alliance:
 - a. Use friendly, egalitarian, down-to-earth, and open demeanor, while simultaneously earning respect and conveying credibility.
 - b. Convey realistic degree of confidence in oneself as therapist, the client, and the treatment.
 - c. Establish active stance while collaboratively setting the agenda.
2. Fold adolescent's specific problems into areas of dysregulation (and explain corresponding skills developed to address each problem area):
 - a. Confusion about self
 - b. Impulsivity
 - c. Emotional instability
 - d. Interpersonal problems
 - e. Adolescent–family dilemmas
3. Define adolescent's specific problems as primary target behaviors:
 - a. Life-threatening behaviors
 - b. Treatment-interfering behaviors (based on prior treatment history)
 - c. Quality-of-life-interfering behaviors
 - d. Skills capabilities and deficits
4. Elicit client's long-term goals, and link these to work on Stage 1 targets.
5. Introduce the biosocial theory.
6. Introduce the treatment's format and characteristics.
7. Introduce DBT diary cards.
8. Review treatment agreements:
 - a. Client agreements
 - b. Therapist agreements
 - c. Client–therapist relationship agreement
 - d. Family agreements
9. Use commitment strategies with adolescent to obtain and strengthen commitment.
10. Use commitment strategies with family members to obtain and strengthen commitment.



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Jessica, the 15-year-old introduced in Chapter 6, is typical of adolescents in our outpatient clinic. When her assessments were complete, she met the criteria for the DBT program. She then met alone with the person who was to become her primary (individual) therapist. This began the orientation process.

ORIENTING ADOLESCENTS TO DBT

BEGINNING TO ESTABLISH A THERAPEUTIC ALLIANCE

The primary task at the start of DBT is beginning to develop a collaborative relationship with the adolescent. This is crucial as well as difficult. Many adolescents presenting for treatment initially believe that they do not need it. Even those who have made a recent suicide attempt often minimize it as an impulsive act and state that they “feel better now.” These adolescents often have had conflictual relationships with their parents as well as other adults. Being told that they must talk to a therapist, a stranger, because “something is wrong” makes many teenagers angry, resistant, and noncompliant. Given that up to 77% of suicidal adolescents either do not attend follow-up therapy appointments or drop out of treatment prematurely, it becomes important for therapists to equip themselves with a variety of techniques and strategies to engage such adolescents (Trautman et al., 1993).

A key strategy to working with adolescents involves conveying a down-to-earth, friendly, egalitarian, and open demeanor, while maintaining an understated degree of expertise and credibility. The challenge for therapists entails getting teens both to like and to respect them. In our experience, therapists who have had more experience with adult clients at times approach teenagers with an authoritarian, doctor-like, “one-up-one-down” stance. This approach consistently alienates adolescents. In working with an adolescent, it is also important to communicate a high level of confidence in one’s own ability as a therapist, in the client’s ability to improve, and in the efficacy of the treatment. Feigning confidence in oneself, in the client, or in the treatment will inevitably prove ineffective; a teenager will see through the act and disengage from the treatment. This may pose a challenge for a therapist who is new to the treatment and feels less competent. Thus the therapist should strive for a balance between genuinely communicating confidence in all three domains (self, client, and treatment) and not overpromoting them.

It is important to take an active stance in work with adolescents, especially early in treatment. Therapists who work within other treatment orientations often take a



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less active stance at the beginning of treatment and allow clients to choose freely what to discuss. In standard DBT, as well as in DBT with adolescents, the therapist uses these early sessions to get to know the client and to allow the client to get to know the therapist. This active stance is part of a dialectic, however, since one of the biggest mistakes that a novice DBT individual therapists tends to make is forcing an agenda on the client instead of letting the session unfold and skillfully weaving in the necessary components identified below. Thus taking an active stance involves the therapist's developing a plan for the session content with the client and then guiding the client through this content, as well as adhering to DBT principles. Setting an agenda at the beginning of the session is a customary part of most forms of CBT. Although DBT does not require agendas, it can often be helpful to lay out at the beginning of a session which tasks and topics need to be covered. It also gives the adolescent a chance to say what topics he or she wants to cover. In the first or second session, which may include assessment, orientation, and commitment, the therapist will set the agenda by stating, "Jessica, I want to get some history and hear what problems you may currently be having before we decide what is the appropriate treatment for you." Some beginning therapists feel compelled to tell clients everything they are supposed to cover in the first session, as opposed to skillfully weaving the material into the first couple of sessions.

One stylistic strategy in DBT is the use of irreverence—a style characterized by calling a spade a spade, as well as by using humor, sarcasm, or confrontation. Whereas some therapists are wary that being "too" irreverent early in therapy might alienate teens, we believe exactly the opposite. We recommend weaving irreverence into treatment immediately, since it functions to get adolescents' attention in a manner different from most others with whom they discuss their problems. For example, when Jessica nonchalantly discussed her suicidal behaviors and her ambivalence about discontinuing them, the therapist stated, "Jessica, you realize that this treatment will not work if you are dead." Irreverent communication strategies are discussed further in Chapters 3 and 8 as well as in Linehan's (1993a) text.

FOLDING ADOLESCENT'S SPECIFIC PROBLEMS INTO AREAS OF DYSREGULATION

The orientation session begins with asking for a recap of the client's problems. Hence it is important to validate the client's potential frustration at having to repeat his or her story to yet another mental healthcare provider. This is relevant only if the primary therapist is different from the initial evaluator. For example, the therapist might say,



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“Jessica, I know you already told a lot of this information to Liz, who spent 3 hours with you last week during the diagnostic evaluation. She did share much of that information with me; however, if I am going to be your individual therapist, I want to get to know you, your strengths, and your weaknesses, and I will probably be asking at least some of the same questions. So bear with me.”

As the session proceeds, the therapist folds the client’s problems into the five major problem areas identified on **Figure 5.1**. These problem areas correspond directly to the areas of dysregulation associated with BPD (i.e., emotional, behavioral, cognitive, interpersonal, and self; see Chapter 3). We describe the five problem areas as follows: (1) confusion about self, (2) impulsivity, (3) emotional instability, (4) interpersonal problems, and (5) teenager–family dilemmas. For example, if a teen identifies sudden and apparently baseless anger as a problem, the therapist might say,

“Jessica, when you are feeling OK one minute and then angry for seemingly no reason, DBT therapists call that a ‘problem with regulating emotion’ or ‘emotional instability’ (Problem 3 on the handout). Since you don’t know why your emotions shift sometimes, you probably experience some confusion about yourself (Problem 1 on the handout). If you then start cutting yourself or purging without thinking about the consequences, we consider that impulsive behavior (Problem 2 on the handout).”

The therapist will review the other problem domains if the adolescent does not raise them naturally during the first session. Typically, adolescents referred to our program endorse at least four out of the five problem areas.

“Jessica, do you find that your relationships—with your boyfriend, your parents, your sister, your friends—run hot and cold? That is, even though you have friendships, do you find it hard to keep these relationships stable? Is it hard to get what you want from these relationships? If so, that would be Problem 4—interpersonal problems. And Problem 5 relates to teenagers who feel that they don’t see eye to eye with their family members. Do you feel you’re on one side of the Grand Canyon and your family members are on the other side, and it is difficult to understand one another



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and come to an agreement on issues, such as curfew, dating, homework, or body piercing?”

The DBT therapist then tells the teen that although having these problems may feel overwhelming, there is some good news:

“For each of these problems, the skills group will teach you specific skills that will target and reduce your specific problems.

DIALECTICAL BEHAVIOR THERAPY	
PROBLEMS (What to decrease)	SKILLS (What to increase)
I. Confusion about yourself (Not always knowing what you feel or why you get upset; dissociation)	I. Mindfulness
II. Impulsivity (Acting without thinking it all through)	II. Distress tolerance
III. Emotional instability (Fast, intense mood changes with little control; or, steady negative emotional state)	III. Emotion regulation
IV. Interpersonal problems (Pattern of difficulty keeping relationships steady, getting what you want, or keeping your self-respect; frantic efforts to avoid abandonment)	IV. Interpersonal effectiveness
V. Teenager–family dilemmas (Polarized thinking, feeling, and acting—e.g., all-or-nothing thinking)	V. Walking the middle path

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FIGURE 5.1. • Handout on DBT for adolescents and family members.



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For example, in regard to impulsivity, we are going to teach you distress tolerance skills so that you will learn how to distract and soothe yourself when you have urges to kill yourself, cut yourself, overdose, drink alcohol, or purge. When you say you have interpersonal problems, we are going to teach you a set of interpersonal effectiveness skills in order to help you keep your self-respect; you're your relationships stable; and get what you want from your boyfriend, your girlfriends, and your parents. Do those skills sound helpful?"

In addition to what takes place in individual therapy, the skills trainer briefly reviews each problem area as it relates to each individual client and then describes the corresponding skills module, one by one. This review typically instills hope in the adolescent and family.

DEFINING ADOLESCENT'S SPECIFIC PROBLEMS AS PRIMARY TARGET BEHAVIORS

The individual therapist (who may or may not be the same clinician as the diagnostic interviewer, as noted earlier) is responsible for eliciting the information relevant to the DBT Stage 1 targets. Much of this information may have already been gathered during the diagnostic evaluation. The therapist connects the client's specific problems with DBT's primary target behaviors. The therapist might say, "So those overdoses are considered life-threatening behaviors, and your depression, your bingeing and purging, your school problems, and your intense conflicts with your parents are what we call 'quality-of-life-interfering behaviors.' Is it your belief that these problems interfere in the quality of your life?" Reframing these problems in DBT language enables the therapist to explain how DBT will be able to target these problems, while also beginning (unobtrusively) to teach the client this language.

Once the primary target behaviors are identified, the DBT therapist is then able to review the Stage 1 treatment target hierarchy and informs the client that individual sessions will be organized accordingly from that day forward. To make this point clear, the therapist may draw a pyramid and list the client's problem behaviors from top to bottom in a fashion corresponding to the Stage 1 hierarchy (see [Figure 5.2](#)). It is explained to the adolescent that if in the past week there have been any self-injurious behaviors or increases in suicidal ideation, those behaviors will need to be analyzed first. The therapist goes on to explain that it does no one any good if the therapist and client spend the session talking about issues unrelated to the self-injury, since the client may intentionally or accidentally kill him- or herself by the next



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visit if they do not understand what is going on and how to deal with it differently. The remaining targets are then discussed, in hierarchical order.

ELICITING CLIENT'S LONG-TERM GOALS, AND LINKING THESE TO REDUCING STAGE 1 TARGET BEHAVIORS

In obtaining a commitment to reducing such Stage 1 target behaviors as suicide and self-injury, drug use, and truancy, as well as increasing behavioral skills, it is critical for the therapist to link them to the adolescent's long-term goals. Thus it is always important to elicit these goals. Jessica's goals included graduating from high school and starting college, continuing her cheerleading activities, joining a band as a singer, getting married, having kids, and finding a high-paying job. Jessica agreed not to kill herself, but was initially reluctant to reduce her self-cutting, since the behavior helped distract her from her intense anxiety and sadness. The therapist then queried Jessica as follows:

THERAPIST: You mentioned that you are self-conscious about the marks on your arms and legs. If we could figure out a way for you to reduce your anxiety and sadness without leaving cuts and scars on your body, would you choose another method?

JESSICA: I don't know ... I know this works.

THERAPIST: I get that ... and if you want to continue your cheerleading next year, I imagine it may be hard to wear long sleeves and pants to cover those marks. And I also know that while you initially experience relief when you cut, you also often experience shame later. This becomes a vicious cycle for many people and makes them more vulnerable to cutting again ... Does that happen to you?

JESSICA: Yes, I often feel worse. I know I have to work on this, but I am so scared to give it up.

THERAPIST: That makes perfect sense to me, given how effective this behavior has been for you in the short term at reducing certain negative emotions. I feel confident, though, that if I can teach you some new skills and we try them out, we'll find some of them will help you in similar ways to cutting, without leaving those marks or creating the negative emotions that perpetuate the problem as well.



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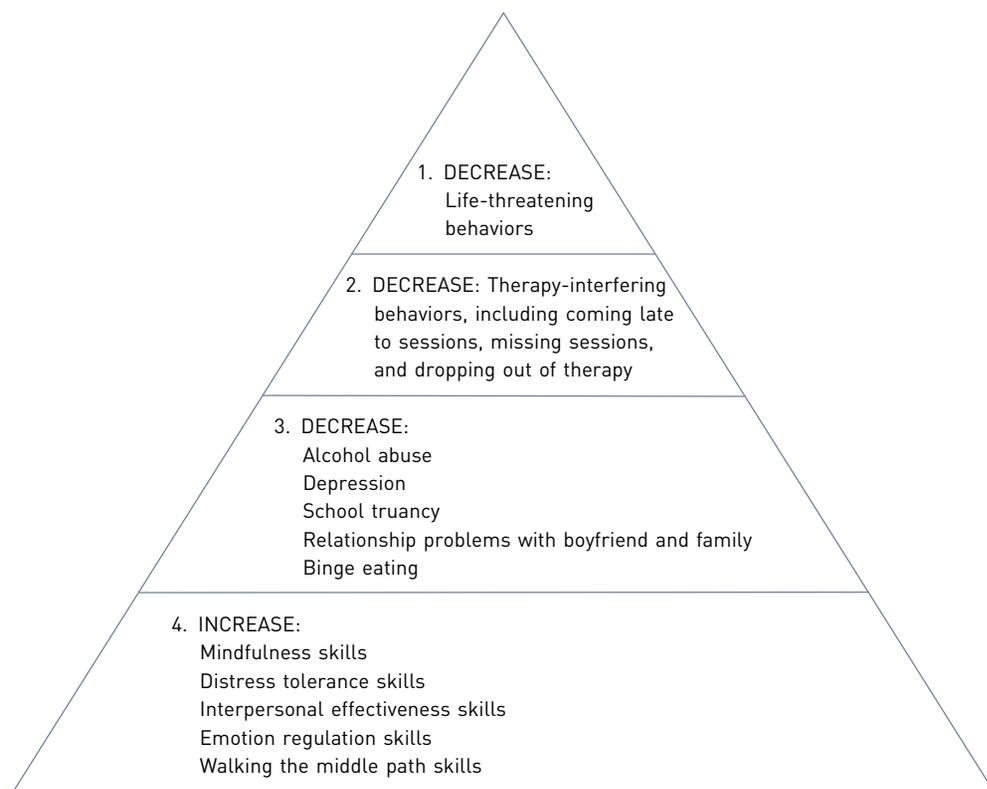


FIGURE 5.2 • Jessica's Stage 1 target pyramid drawn in session.

INTRODUCING THE BIOSOCIAL THEORY

Referring back to the five problem areas listed on [Figure 5.1](#), the therapist asks the adolescent rhetorically, “How do you think you developed these types of problems?” Typically, the adolescent is baffled and somewhat demoralized by the rhetorical question. To help answer this question, we explain that Marsha Linehan, the originator of DBT, developed a theory that helps explain why some people have these types of problems (Linehan, 1993a; see Chapter 3 for a full discussion of the biosocial theory). Using visual aids such as a handout can help adolescents better understand this abstract theory. The therapist first reviews and defines the two components of the theory: “bio” and “social.” “Bio,” derived from the word “biology,” involves the biochemistry of one’s brain. The therapist might ask, “Jessica, have you ever experienced yourself as more emotionally sensitive, quicker to react, and slower in returning to your emotional baseline once you get upset than your siblings or friends?” Indeed, most of these adolescents admit that little things seem to



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“get under their skin easily” and affect them more than their peers. Moreover, they acknowledge that when they get upset, their emotional reactions are more intense and reactive (e.g., not just a little sad, but feeling very depressed; not mildly anxious, but having panic attacks; not merely irritated, but experiencing angry outbursts). The third characteristic—slow return to emotional baseline—is explained by drawing a graph on a piece of paper, with a line halfway up the bell curve to represent the adolescent’s moderate to high level of emotional arousal. Instead of returning back to 0, the line remains elevated at this level for an extended period (sometimes hours or even days). Many teens endorse this characteristic as true of themselves as well. Jessica reported, “Sometimes when I get really angry, it takes me almost a whole day to chill.”

The “social” part of the theory is described as the “invalidating environment.” Once “validation” and then “invalidation” are defined, an example is provided immediately to help illustrate the concept of invalidation. The therapist attempts to use examples offered by the adolescent during the first session if possible:

“Jessica, you told me that whenever you feel depressed and you feel you have less energy to do your chores in the house, your mother calls you a crybaby and tells you to snap out of it, or you’ll get a beating. You also told me that when you travel with your father to visit your relatives in Puerto Rico, your father insists that you put on a smile even if you are not in a smiling mood. These experiences are examples of ‘invalidation’—in other words, communications indicating that your thoughts, feelings, or actions are wrong, inappropriate, and invalid. ... Who’s to say how you should feel and act and what you should think? Those are your thoughts and feelings, not theirs!”

Jessica responded, “I’m so used to it, I guess I never thought of it that way.” The therapist emphasizes that invalidation occurs frequently, to varying degrees, and can often be inadvertent. The therapist also explains the transactional nature of the biosocial theory (see Chapter 3), emphasizing a nonjudgmental and nonblaming attitude. For example, a mother and child may have different temperaments, as in the case of a quiet, shy, mellow toddler unmatched temperamentally with a gregarious, high-energy, demanding mother, or a highly emotional child with an emotionally controlled parent. Some teens tend to protect their parents in response to this explanation of an invalidating environment. The therapist can suggest that



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parents who invalidate often learned it as children from their own parents and do not know any way to communicate more effectively. If this is applicable, the therapist might state, “It makes perfect sense that your parents invalidate you, since that is what they learned growing up.” The therapist then has an opportunity to point out the intergenerational transmission of invalidation. Additionally, teens sometimes invalidate their family members as well.

Regardless of the intent, the therapist targets the invalidation experienced in the family, in order for the adolescent to feel better understood by the family and for the family members to feel better understood by the adolescent. (The biosocial theory review, like other aspects of orientation to treatment, typically occurs first with the adolescent alone and then is reported with the entire family.) The therapist then continues, “Here’s the good news: Now is the time for you (and your family) to learn how to validate one another properly, and to put an end to the inadvertent invalidation that occurs in your household each day. You, Jessica, and each member of your family have to take responsibility for becoming more aware of this behavior and practicing the skill of validation.”

For many adolescents, hearing the biosocial theory explained is the first time they understand why they act and feel the way they do. Some adolescents are literally moved to tears by the experience.

INTRODUCING THE TREATMENT’S FORMAT AND CHARACTERISTICS

The therapist reviews the treatment format next, consistently checking in with the client to ensure that he or she understands what is being said. Then the therapist attempts to obtain initial commitment to the various treatment modalities (see the later discussion of commitment strategies), using a conversational yet didactic style. A therapist would introduce the 16-week Montefiore program as follows:

“Jessica, our DBT program is two sessions per week for 16 weeks.¹ The treatment consists of one individual session (for 60 minutes) and one multifamily skills training group (for 2 hours) per week. So since you live with your mom, and you and she have a lot of conflicts, I think it makes sense to invite her as the family member who will attend the multifamily skills group with

¹ The most important issue is to set a treatment time period (e.g., 16 weeks, 6 months, 1 year) for the client to commit to. The therapist and client can then either renew the agreement at the “initial” endpoint for a specified period of time, or consider referring the client to a different therapist or therapy if sufficient progress is not being made.



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you. Don't you agree? Also, the individual session is periodically divided in half, so that we can have some time to address family issues with your mom, your dad, and even your sister. How does that sound to you? The bottom line is that you and your family will be treated by a team made up of your individual therapist, two skills trainers, your prescribing psychiatrist, and other DBT therapists in our program.

"The first phase of treatment lasts 16 weeks. When you finish that, you could be eligible for the graduate group, which involves a lot of fun activities and is only for people who graduate from the first phase. Another important component of the treatment is the telephone coaching. There are three reasons I would like you to call me. First, I want you to page me before you engage in a problem behavior, like cutting, overdosing, purging, or drinking. It doesn't help to call me afterwards, since you already decided how to handle that situation. Second, I want you to call me with good news. I love to hear good news— and you can leave a message on my machine and I will be thrilled to get it. Finally, I want you to call me if you feel that we have to repair our relationship [see Chapter 3 for further explanation]. Some teens have trouble with this pager idea ... they say, 'I didn't want to call you and bother you on the weekend.' Jessica, let me be crystal-clear: I wouldn't be instructing you to call me if I thought it was a problem. If I am tied up with something else when you page me, I'll tell you so and let you know how soon I can call you back. Does that seem reasonable? Good. So I'd like to have you practice paging me this week, at some point when you're not in crisis, just to see how this whole thing works. Don't worry, I won't keep you on long—just to say hello. Can you we do a practice page on Tuesday night?"

The practice page helps the client add this new skill to his or her behavioral repertoire during an undistressed period, with the hope that he or she will be more likely to use it when actually faced with a stressor.

The therapist then says to the client enthusiastically, "If we work together as a team, I can help you solve your problems. There are several key points you need to understand as we move ahead." The therapist describes seven characteristics of DBT



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to the adolescent in the first or second individual therapy session. We list them below, with sample therapist descriptions for the client:

1. *DBT is not a suicide prevention program, but rather a life enhancement program.* Although the therapist acknowledges the client's misery and concedes that suicide provides one way out of suffering, he or she emphasizes that the alternative is to make life more livable. "The bottom line is that I cannot keep you from killing yourself if you are intent on doing so, but I can help you create a life worth living."
2. *DBT is supportive of clients' attempts to improve the quality of their lives.* "Jessica, I want to support you to achieve your goals in any way I can."
3. *DBT is behavioral.* "In order for you to change your life and achieve your goals, you are going to have to decrease some of your old problem behaviors, and begin to increase new skillful behaviors that you're going to learn in DBT. Given your depression and anxiety, I think you will find it interesting to know that by changing your behavior, you can actually change your emotions."
4. *DBT teaches skills.* "As you know from your cheerleading and piano lessons, it will take practice to get good at these new skills."
5. *DBT is collaborative.* "We're going to work as a team to help you achieve your goals. Clearly, you haven't been able to get there yet without help, and I know that I will not be able to help you if you don't pull some of the weight ... so I feel confident that if we work together, we can do it."
6. *DBT employs telephone consultation.* In the first session, the therapist gives the client his or her phone number or pager number and explains the three reasons for phone calls in DBT (see above). To emphasize this point, the therapist can use the metaphor of a basketball player and coach. "Jessica, you're a basketball player [the therapist identifies Jessica's favorite player and calls her by that name]. You're dribbling down the court, your team is down by 1 point, and there are 20 seconds left. As you dribble past half-court, the other team sets up a defense, and you feel stuck. What do you do? You call a time out and check in with your coach to figure out how to get unstuck, instead of getting trapped and turning the ball over. Similarly, in life, when faced with a very tough or unfamiliar situation, I want you to call a 'time out' and call your coach—that's me—so that I can help you get out of sticky situations without making things worse."
7. *DBT is a team treatment.* "Here's more good news: I am not treating you alone. I have a team I talk to every week. The team is made up of me, your individual therapist; the skills trainers; and other DBT therapists who work in this program. Their job is to make sure I deliver the best possible treatment to you. You've got me to help you, and I have the team to help me."



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INTRODUCING DBT DIARY CARDS

Introduction of the diary card (see **Figure 5.3**) typically occurs at the end of the first session or during the second session. (The two-page card can be photocopied and trimmed down to fit on one 8½ × 11 page.) The client is told that the diary card is a crucial component of the therapy, and that he or she is expected to complete it and return it to the therapist each week. The therapist explains the rationale for the diary card by explaining its several extremely important functions.

First, filling out the diary card daily requires the client to self-monitor target behaviors, emotions, and skills. In and of itself, this is an intervention that may help reduce problem behaviors while also serving as a consistent mindfulness skills practice exercise. Second, the card functions as a general overview of the client's week, so the therapist and client have a "week at a glance." This helps reduce the risk of overlooking any primary target behaviors. Third, the card functions as a "diary," in that it helps keep a more accurate record of the adolescent's daily emotions and behaviors than would the adolescent's memory alone, especially 7 days later. Fourth, the diary card enables the client and therapist to perceive potential links between emotions and maladaptive as well as adaptive behaviors. Fifth, the diary card is the primary tool used at the beginning of every individual session to help focus the session content. The therapist states,

"I really hope we can figure out a way for you to remember to complete and return your diary card each week ... because if you forget your diary card, I will have to ask you to fill out a blank one in session, and then we'll have to figure out what interfered in your ability to complete and return it. That will take up a good portion of our session time, and I would much rather use your time to discuss other issues happening during the week. Wouldn't you?"

In order for the adolescent to learn how to complete the diary card, the therapist asks the client in session to remember the previous day and to rate any maladaptive behaviors and emotions listed on the card, starting from left to right. The therapist clarifies the difference between "self-harm urges and actions" and "suicidal thoughts and actions" by highlighting the presence of suicidal intent as the sole criterion. Typically, the adolescent is instructed to complete only a portion of the diary card for the subsequent week. This helps the adolescent avoid feeling overwhelmed by the fairly complex card and potentially helps to build mastery. Moreover, the door-in-the-face commitment strategy (see below) is effectively used around this issue.



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week?” Usually the adolescent sees this as a bargain. Furthermore, it constitutes a relatively easy homework assignment and thus provides the therapist with something to positively reinforce at the beginning of the next session.

In addition to standard behaviors, such as suicide attempts, NSIB, and risky sexual behaviors, the diary card for adolescents should also include age-appropriate targets and should be tailored to each individual client. Hence we have added to the adolescent diary card a “Cut class/school” column, along with some blank columns. For some teens, we track binge and purge urges and behaviors. For other teens, we track assaultive urges, dissociative behaviors, and/or invalidating statements toward self and others. When teens rate these behaviors (and emotions) on a 0–5 scale, they are instructed to rate the “most intense” urge or affect, instead of the “average.” Often, for example, the average anger on a given day might fall at about 3 on the 0–5 scale, and it becomes difficult to assess those days when anger was clearly most intense. For those clients who report high urges and emotions all day nearly every day (5’s), the therapist might encourage the client to track the “average” as well as the “most intense” rating each day, in order to differentiate one day from another.

A common mistake made by a new DBT therapist is forgetting to troubleshoot after obtaining initial commitment that the adolescent is going to fill out the diary card during the week. The therapist should say something like this:

“Jessica, now that you have agreed to complete the diary card, what might interfere with your getting it done and then bringing it back here next week? Let’s think about some potential obstacles. ... For starters, what time of the day do you think you might fill it out? Where will you keep it each day and night? How will you remember to leave home with it next Wednesday, so that you can bring it to our session?”

We often suggest to teenagers who do not have an opinion that filling out the diary card before bed, and leaving it in a place near the bed or desk, is a good idea. Also, we suggest that they write a note and leave it on the refrigerator or bathroom mirror so that they cue themselves to (1) fill out the diary card each day and (2) bring the diary card to therapy.

Many teens exhibit initial noncompliance with completing their diary cards. Common reasons for this noncompliance include, but are not limited to, (1) not understanding the rationale for the diary card; (2) not understanding how to fill out the diary card



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properly; (3) feeling as though they do not have the time to complete the diary card; (4) feeling angry about having more “homework”; and (5) worrying about their parents’ sneaking a peek at their diary cards (which are supposed to remain confidential). Understanding what is interfering with completion of the diary card is crucial.

Because some teens have initial difficulty with completing the diary card, therapists must remember to employ the principle of shaping. Getting the teens to bring in a portion of the diary card filled out is a good start. For those who have trouble with that, sometimes simplifying the diary card is indicated. In addition, it is often necessary for a therapist to ask a client after a week or two of noncompliance, “Remind me again why I am assigning this work for you to do at home. Am I doing this to be a pain in your neck, or are there other reasons?” A more thorough behavioral analysis may be indicated at this point to assess the function of the non-compliance. Therapists must be careful not to be shaped by their clients’ noncompliance into not asking for and obtaining a diary card each and every week! It is equally important for therapists to remember that clients may feel shame when they do not complete the diary card, just as they may experience shame when they do—since completing the diary card “forces” them to acknowledge certain behaviors and emotions that they have been trying to avoid.

REVIEWING TREATMENT AGREEMENTS: CLIENT, THERAPIST, CLIENT-THERAPIST RELATIONSHIP, AND FAMILY AGREEMENTS

Orientation cumulates in a set of agreements that spell-out the responsibilities and goals for all parties involved, including families. Client, therapist, and family agreements are typically presented and discussed during the second or third session. Client agreements, which may overlap with but are not necessarily the same as addressing the specific target behaviors identified on the treatment plan, are made orally and include the following: (1) to enter and stay in therapy for a specified length of time (e.g., 16 weeks, 6 months, or 1 year, depending on the program); (2) to attend both individual therapy and group skills training (the therapist should review the attendance policy); (3) to work on reducing specific life-threatening, therapy-interfering, and quality-of-life-interfering behaviors that have been identified during the initial assessment and orientation, while increasing behavioral skills; and (4) to page the therapist for coaching as needed.

Implicitly and explicitly, the therapist agrees (1) to make every reasonable effort to be effective; (2) to act ethically; (3) to be available to the client (both for sessions and



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by pager]; (4) to show respect for the client; (5) to maintain confidentiality, with the exceptions of (a) suicidal or homicidal ideation with plan and intent (to be reported to the clients' legal guardian) and (b) suspected physical or sexual abuse or neglect (to be reported to child protective services as mandated by state law); and (6) to obtain consultation as needed from supervisors and colleagues attending the therapist consultation team meetings.

The client–therapist agreement with adolescents is introduced by dialectically highlighting omnipotence and impotence:

“Jessica, I know as a DBT therapist that I am pretty darn good. However, I am not perfect. I make mistakes. I am confident, therefore that I will do something during treatment that will bother you, piss you off, and maybe even cause you to question continuing in therapy. Now let’s be clear: I expect you will make mistakes, you may do things that piss me off, and so on. The point I am making here is that if you are going to get the help you need, we *both* need to be sure that we keep the therapeutic relationship strong. That requires both of us to be honest with the other if we feel there is a problem. If one of us upsets the other (even accidentally), we have to say to the other person, “Hey, when you said that, you pissed me off,” or “Hey, why didn’t you call me when you said you would?”

Given that suicidal adolescents typically drop out of treatment at very high rates, it is imperative for the therapist to raise these relationship issues on Day 1, and to obtain commitment from the teen and demonstrate personal commitment to attend to them as the treatment progresses.

Lastly, when families are involved in DBT, it is equally important to review agreements pertaining to them as well. We develop an oral agreement with family members that includes the following (1) to attend and actively participate in a multifamily skills training group (or family skills training); (2) to participate in family therapy sessions on an as-needed basis; (3) to facilitate transportation for the teen, either by driving him or her to scheduled appointments or by providing money for public transportation; and (4) to observe rules of confidentiality by not asking the primary therapist to provide specific information gleaned from individual sessions. Parents are told that they can feel free to leave messages on the primary therapist’s answering machine or speak to the therapist directly to *give* relevant information.



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Parents are also reminded about conditions for therapists to break confidentiality. At times, the therapist may choose to tell the client that the parents left a message and share the contents of that message, especially when there is a serious concern (such as a suicide attempt, suicidal ideation, or increasing depressive symptomatology). When less dire messages are left, the therapist uses his or her judgment concerning whether to bring that information into the session or not. We provide further discussion of handling confidentiality between teens and their parents in Chapter 9 (see especially Table 9.4).

OBTAINING COMMITMENT TO TREATMENT WITH ADOLESCENTS

In our experience, inadequate commitment by the client, therapist, or both leads to many therapy failures and early terminations. The client may make an insufficient or superficial commitment in the initial stages of the change process—or, more likely, events both within and outside of therapy may conspire to reduce strong commitments previously made. This last point particularly relates to working with adolescents, since they are usually residing in their invalidating environments and often feel hopeless about any improvement in their situations. Client commitment in DBT serves as both an important prerequisite for effective therapy and a goal of the therapy. Thus a therapist does not assume a client's commitment. DBT views commitment as a behavior itself, which can be elicited, learned, and reinforced. The therapist's task thus includes figuring out ways to help this process along. When working in a clinic in which treatment is potentially short-term, the therapist must figure this out quickly (Miller, Nathan, & Wagner, in press).

In-session behaviors that are inconsistent with an initial degree of commitment and collaboration include refusing to work in therapy, avoiding or refusing to talk about feelings and events connected with target behaviors, and rejecting all input from the therapist or attempts to generate alternative solutions. At these moments, the commitment to therapy itself should be targeted and discussed, with the goal of eliciting a recommitment. The therapist cannot proceed further without it. Remember, problems other than commitment may underlie these behaviors; thus, a behavioral analysis is indicated.

STRATEGIES FOR OBTAINING COMMITMENT

Often adolescents have not come voluntarily for treatment. They may be forced into treatment by parents or schools (which may not allow the adolescents to return if



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they are not in therapy), or treatment may be mandated by courts or child welfare agencies. Thus obtaining a commitment can be a particular challenge; however, without it treatment cannot begin.

Eliciting commitment necessitates a certain amount of salesmanship. The product being sold is new behavior and sometimes life itself. When treatment is mandated by the courts or by an adolescent's parents, sometimes the therapist's only course of action is to say, "OK, I know you don't want to be here. Would you feel any better if we could figure out a way to get the court [or your parents] off your back? Yes? Great. So what has to happen before they get off your back? Let me help you with that." Although we hope to obtain a full, enthusiastic commitment to any and all target behaviors, we often settle for a partial commitment to one or two target behaviors, with the hope of obtaining a deeper and broader commitment as the treatment progresses. It is useful here to remember a key DBT maxim: "DBT therapists get what they can take and take what they can get."

To obtain commitment to DBT, the therapist needs to be flexible and creative while employing one or more of the following commitment strategies: (1) selling commitment: evaluating pros and cons; (2) playing devil's advocate; (3) the foot-in-the-door and door-in-the-face techniques; (4) connecting present commitments to prior commitment; (5) highlighting freedom to choose and absence of alternatives; and (6) cheerleading (Linehan, 1993a).

Selling Commitment: Evaluating Pros and Cons

In evaluating the pros and cons of proceeding with treatment, the therapist wants (1) to review the advantages of the decision to proceed, as well as (2) to develop counterarguments based on reservations that are likely to arise later, when the client is alone and has no help in diffusing doubts. For example, the therapist might say,

"Jessica, by making a commitment to treatment, we will work together to help you achieve your goals of reducing your suicidal and self-injurious behaviors; reducing your drinking, depression, bingeing, and purging; decreasing your problems with your boyfriend and parents; and helping you stay in school so that you can graduate. Now let's think together about the cons of making this kind of commitment. It is going to take a huge effort to change some of your long-standing behavioral patterns. Plus the time commitment necessary for group and individual sessions, as



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well as therapy homework assignments and phone consultations, may be too much for you right now ... so we should think about both the pros and cons before you make a final commitment. Whenever I have to make an important decision, I try to weigh the pros and cons."

Often therapists start with the cons and then identify the pros, since many teens are already starting from the "con" side of participating in treatment. The therapist may want to highlight cons to treatment if the adolescent has forgotten some standard ones, such as having less free time, doing homework for therapy, and stirring up intense emotions. It is important for the therapist to highlight the short- and long-term nature of each pro and con, since participating in treatment often looks less compelling in the short term. Many teens have trouble considering the "long term." Some teens are unable to visualize their lives 2 or 3 years from now; therapists may have to help such clients "stretch" their imaginations to weeks and months, and visualize the pros and cons from that vantage point.

Playing Devil's Advocate

In the devil's advocate approach, the therapist poses arguments against making a commitment to treatment, with the intent that the client will make his or her argument for participating in treatment. The therapist might say, "Jessica, this treatment requires a huge time commitment and a good deal of work ... and I am not sure that you are up to it right now" or "... wouldn't you rather be in a treatment that wasn't so demanding?" This technique becomes quite useful with teenagers who are more likely to offer simplistic "blanket" agreements, such as, "Oh, yeah, I definitely want to do this therapy ... And, yes, I will never cut myself again." Therapists want adolescents to argue for the therapy by building a strong case for themselves: "I do want therapy now, because my life is a wreck, my parents are going to kick me out of the house, I am already on probation at school, and my drug problem is getting really out of control. I don't know if I'll have another chance before it's too late. I gotta get help and get it now."

Foot-in-the-Door Technique

The foot-in-the-door and door-in-the-face techniques are well-known procedures from social psychology that enhance compliance with requests. In the foot-in-the-door technique (Freedman & Fraser, 1966), the therapist makes a request that seems easy, followed by a more difficult request. For instance, a therapist first got a client



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with social phobia to agree to attend group skills training. Then the therapist said, “OK, now that you are there, can you volunteer to report on your homework, or at least read something from the skills notebook when the skills trainers ask for volunteers?” Here is another example: In the first session, after the therapist gets the adolescent to commit to participate in treatment and work on all target behaviors, the therapist then says, “Oh, by the way, there’s one more little thing I would like you to do for next week ... it’s called a diary card.” At that point, the therapist reviews the card.

Still another example of the foot-in-the-door technique involves maladaptive behaviors that the client does not want to address. One therapist said to a suicidal adolescent with alcohol abuse and marijuana use, “OK, I understand you do not think marijuana is a problem for you. I am not clear one way or another. So let’s not have you try to reduce it. How about if you merely track your use on the diary card like you do your alcohol use, which we agree you *are* trying to reduce. OK?” As previously discussed, self-monitoring is the first step to ultimately reducing any behavior.

Door-in-the-Face Technique

In the door-in-the-face technique (Gialdini et al., 1975), the therapist first makes a harder request, and then solicits a more easily performed behavior. This strategy proves helpful in obtaining early commitment to treatment and to reducing suicidal behavior and NSIB. For example, with one teen who was angry about being “dragged to a shrink,” this strategy was helpful: the therapist slowly reduced the length of his commitment from 16 weeks to 2 weeks, and it was agreed that treatment would focus on “how to get your parents off your back.” Regarding a commitment to stop suicidal behavior, Jessica would not agree to stay alive for the entire length of the program (i.e., 16 weeks), but she could make a commitment not to end her life for the next week. The therapist said, “Jessica, how about if you agree to stay alive this week, and we will reevaluate next week to see if you are willing to renew your agreement?”

Another example of the door-in-the-face technique is often used with the diary card (see [Figure 5.3](#)). This strategy can also be useful in the skills training group as well. For example, one afternoon one of the group members entered the group room 2 minutes early—but he chose to sit away from the table (where everyone else sits), looking agitated, with the hood of his jacket covering his face. The skills trainer asked, “Alan, would you please come sit at the table, pull your hood off your face, and lead us in a mindfulness exercise?” Alan said, “I ain’t doing all that!” The therapist seemingly relented by saying, “How about if you just come to the table and lower your hood, then?” The client said, “All right.” In this case, the therapist never expected the



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client to agree to all of those requests and lead the mindfulness exercise. But making an additional, more challenging request at first led to increased compliance when the therapist then asked Alan for less.

Connecting Present Commitments to Prior Commitments

When the therapist has a sense that the commitment is fading, or when the client's behavior is incongruent with previous commitments, the therapist can remind the client of commitments made previously. For instance, when Jessica threatened at one point to use laxatives again, the therapist said, "But I thought you were going to try your best not to do that ever since you made that commitment 6 weeks ago? That's one of the commitments you made upon entering therapy with us."

Highlighting Freedom to Choose and Absence of Alternatives

The strategy of highlighting freedom to choose and absence of alternatives is particularly useful for working with all teenagers, but especially for those who are in treatment involuntarily or who are not particularly interested in treatment at this point. The idea behind this strategy is that commitment and compliance are enhanced when people, especially adolescents, believe that they have chosen freely and when they believe there are no alternatives to reach their goal. Hence the therapist should enhance the feeling of choice, while at the same time stressing the lack of effective alternatives. For example, in developing or redeveloping a client's commitment to stop attempting suicide, the therapist may emphasize that the client is free to choose a life of coping by suicide—but that if he or she makes that choice another treatment should be found, since DBT requires reduction of suicide attempts and NSIB as a goal. When using this strategy to strengthen commitment to the treatment program, the DBT therapist attempts to list in graphic form all of the problems the teen is currently experiencing and then says,

"Jessica, you can try to manage your suicidality, depression, substance use, disordered eating behaviors, school problems, and huge conflicts with your boyfriend and parents on your own as you have been doing. The other option is to try this therapy twice per week and see if we can get these problems under control, so that you can stay alive, get your parents off your back, and remain at home and school instead of being sent to residential treatment. ... Of course, it's totally your choice, since this is your life! What do you think?"



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Cheerleading

The purpose of cheerleading is to generate hope. One of the major problems confronting suicidal adolescents with BPD or borderline features is their lack of hope that they can effect change in their lives. In cheerleading, the therapist encourages the client, reinforces even minimal progress, and consistently points out that the client has the qualities needed to handle his or her problems. For example, Jessica was raised in a family in which the primary coping and problem-solving style was to attempt suicide. This became a learned response that seemed to be passed from generation to generation. Another client was raised by an emotionally abusive, alcoholic father who continued to demean and insult her. Both of these clients needed extensive amounts of cheerleading and encouragement to help build a sense of hope that they could actually change themselves and alter (somewhat) their oppressive home environments.

Instilling hope is intimately connected to getting an initial commitment to treatment and recommitment when needed. Cheerleading may also be required when the devil's advocate technique falls flat. With Jessica, the therapist aggressively employed the devil's advocate technique by saying, "This does not seem to be the right time for you to work on these problems ... maybe you can recontact the program when you feel more ready to work on all of your problems." Jessica started to agree with the therapist and looked dejected. The therapist quickly responded with "You know, however, I do get the impression that when you do put your mind to something you can do extremely well, as you used to do in school, choir, and cheerleading. Is that true? If so, then if you really and truly put your mind to working at this treatment, like you do in other areas of your life, I bet you will start to feel better. What do you think?" Jessica was buoyed by these last comments and was more able to make a firm commitment to the treatment program. The devil's advocate technique and cheerleading can be used in a dialectical fashion to build commitment.

The periodic and intense hopelessness of these clients can overwhelm a therapist. At these times, the therapist consultation meeting becomes critical in helping the therapist reestablish commitment, perspective, and balance. Many therapist teams make good use of cheerleading to enable their weary colleagues to continue treatment effectively.

ORIENTATION AND COMMITMENT WITH FAMILY MEMBERS

After orienting and obtaining commitment from the adolescent, the therapist invites the family members in for the latter portion of the first session (or a portion of the



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second section) to begin orientation and commitment with them as well. First, the therapist reviews the handout illustrating the five problem areas and corresponding skills modules (**Figure 5.1**), and asks the adolescent to identify which of the five problem areas applies to him or her. Then, in order to instill hope in the family members just as was done with their child, the therapist makes the connection between the problem areas and the corresponding skills modules specifically developed for those behavioral problems and taught in skills sessions (e.g., multifamily skills group, family skills training, individual skills training). Depending on the particular family issues as well as time remaining in the session, the therapist may choose to ask the parents whether they believe the skills being taught in the multifamily skills training group may be helpful to them as well (see Chapter 9 for an extended discussion), especially given the heightened stress in the household. In many cases, identifying parents' own current and/or past problem areas occurs in the family skills training sessions.

The therapist then orients the family members to the treatment format, including the modes of treatment. Parents are strongly urged to participate in the 2-hour multifamily skills training group for the duration of treatment. Exceptions are made when certain employment and language barriers exist. If a parent is at risk of losing his or her job if time is taken off even after a medical letter is provided, we will make an exception. In addition, exceptions are made for parents who are monolingual in a language other than English, since we cannot translate the entire skills group content in a 2-hour time period. In either of these cases, parents unable to attend the skills group are expected to spend extra time in family sessions reviewing skills and having their own child teach them some of the content when appropriate. The other modes of treatment are briefly reviewed: weekly individual therapy, family therapy as needed, telephone consultation, and the therapist consultation/supervision group. Permission is obtained from the parents at this point for their adolescent to use the telephone to page the primary therapist for skills coaching as needed. Parents are told that they too can receive skills coaching when they need it by paging the multifamily group skills trainer. Also, the DBT therapist informs parents of the adolescent diary card and kindly requests that they do not ask to look at or ask their teens to share the contents of the card, since the card is intended for the therapist only. Again, the therapist attempts to preempt any intentional or inadvertent breaches of confidentiality or pressure from the parents.

Addressing issues of confidentiality is an important part of orienting the family to the DBT program. A DBT therapist typically explains the rules of confidentiality to the



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adolescent alone first, and then repeats them with the parents present. Although variations exist, many practitioners apply similar “rules” for breaking confidentiality: (1) if the adolescent informs DBT staff that he or she has a specific suicide plan and intent; (2) if the adolescent informs DBT staff that he or she has a specific plan and intent to harm someone else; and (3) if the adolescent suggests that any physical or sexual abuse or neglect is occurring.² It is explained that the therapist will encourage the client to tell the parents about any of these aforementioned situations (with the possible exception of abuse/neglect if it is occurring in the household); however, the therapist will not hesitate to notify the parents if the adolescent does not.

One of the more sensitive confidentiality issues involves the issue of NSIB and whether to report that to families. Our recommendation is that DBT therapists validate parents’ concerns regarding the behavior, while at the same time saying they will not notify them of such behaviors unless they become life-threatening. The rationale for this is that adolescents may be less likely to disclose the very behaviors that bring them to treatment if they believe their parents will be notified. Many families understand this dilemma and comply with the confidentiality regarding NSIB. The exception is that if a client’s self-injury becomes increasingly dangerous and nonresponsive to DBT interventions, a therapist will break confidentiality. Other sensitive issues include substance use and sexual activity. Unless these behaviors are apparent at the outset, confidentiality about them is maintained (i.e., they are not discussed explicitly with families). Although some families probe the primary therapist for this information, we employ the same rationale for maintaining confidentiality regarding these behaviors as we do regarding NSIB. The exception also remains the same: “If I believe that your daughter [or son] is doing anything that puts her [or him] at grave risk, I will certainly let you know.”

Finally, the same commitment strategies used with the adolescent are used with the family members as needed. Typically, fewer commitment strategies are necessary to engage families in the DBT program. There are times, however, when family members exhibit insufficient commitment by suggesting that the treatment providers need to “fix” their kid without their participation, or state hopelessly that “nothing can help” the adolescents. In these cases, as well as others that are less obvious, the therapist validates the family members by suggesting how concerned and frustrated they must be to say those things. In addition, it is apparent that these problems are affecting everyone in the family. The therapist can mention recent data suggesting

² Mental health professionals are mandated by state law to report any suspicion of child abuse or neglect.



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that those adolescents whose parents maintain a positive attitude about their treatment are more likely to have a more positive outcome (Halaby, 2004). In addition, at some point in the orientation, it behooves the therapist to mention the wealth of DBT effectiveness data for suicidal multiproblem adults and the promising pilot data with adolescents (Rathus & Miller, 2002).

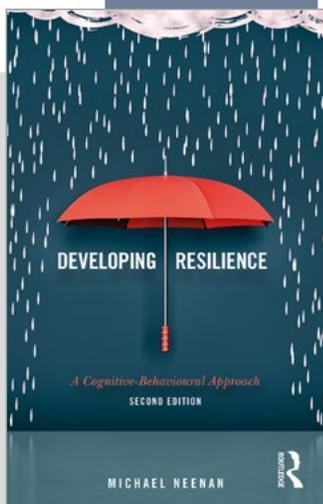
When parents express their unwillingness to participate actively in the treatment, the therapist must first assess the reason. If it is not a logistical problem that needs to be solved, but rather a psychological one, the therapist may need to employ several of the commitment strategies discussed earlier. If the parents are still unwilling or unable to participate, the therapist should discuss with the consultation team how to proceed. There are times, unfortunately, despite the therapist's and the team's best efforts, when a family does not actively participate and an adolescent is treated alone. To date, we have no empirical data to suggest that these outcomes are necessarily any worse. Clinically, it is important for the therapist to validate the adolescent's feelings of disappointment and rejection, while at the same time cheerleading the teen and conveying the belief that he or she can do this treatment with the therapist's help, even if it must be done without the family's participation.

Anecdotally, whether a client remains in treatment beyond the first session depends largely on how effective the therapist applies the orientation and commitment strategies. Although we describe these strategies here in the early phase of treatment, most clinicians need to refer back to the majority of them, because the client's motivation and commitment inevitably wax and wane as the treatment progresses. The next three chapters—describing individual therapy, family work, and skills training, respectively—also make use of these orientation and commitment strategies.

CHAPTER

6

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING



This chapter is excerpted from

Developing Resilience

By Michael Neenan

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ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

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INTRODUCTION

Resilience is one of the subjects studied by positive psychologists. Positive psychology was launched in the late 1990s and focuses on identifying and building on your strengths and virtues (what's right with you), rather than looking at your deficits and weaknesses (what's wrong with you) which is the usual remit of traditional psychology. However, some psychologists argue (and I agree) that we don't need to separate psychology into types, as psychology 'spans the whole of the human condition, from disorder and distress to well-being and fulfilment' (Linley et al., 2006: 6).

If developing resilience can help you to overcome adversity and find ways of creating a better life for yourself, then we need to identify the blocks to its development and what can be done to remove them. What follows are some attitudes that keep people trapped in responding poorly to the difficulties they face; these attitudes are not the only ones that interfere with resilience building, just the common ones I encounter in my practice. These attitudes are not set in stone, so ways to change them are also presented. It's important to point out that some people, for whatever reason, don't reach out to learn resilience. They're overwhelmed and demoralized by their unsuccessful attempts to cope with adversity and happiness continually eludes them. A few will see suicide as the only option to end their suffering. Such individuals require a compassionate understanding of their plight, not condemnation because they fail to overcome the challenges they face. As I pointed out in Chapter 1, resilience is not about dividing people into winners or losers, quitters or fighters but offered as a capacity open to all to learn.

IT'S NOT MY FAULT I'VE BEEN MADE A VICTIM'

This means feeling helpless and angry in the face of adverse events, continually blaming others for your misfortunes and seeing the world divided into victims and villains. Anyone who questions your victim status is accused of victim blaming. Leahy (2001) suggests that when a therapist attempts to help such clients by encouraging them to focus on problem solving, this too invites accusations of victim blaming and making light of their suffering: 'I see, I'm just supposed to get on with my life as if being viciously mugged is of no account whatsoever; in other words, I'm making too much of a fuss about it'.

The victim's story can become the only story in your life, forever ready to relate to others – if they're still listening to you – your tales of suffering and helplessness.



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Being a victim has become your identity; this often leads to a state of infantilization where you can't be expected to take responsibility for dealing with your difficulties ('How can I? I'm still hurting'). If you mix with others who have similar stories to tell, you're likely to become involved in a competition to establish whose suffering is the worst. The longer you justify your victim status, the harder it will become to break free of it and develop other facets of your personality and life. Incidentally, this competition in suffering can also be seen in grief: 'Look how much I loved her/him and with these tears I prove it (and win the trophy)' (Barnes, 2014: 114). Competitive mourning has been called the narcissism of grief (Oates, 2011) where my loss is the most devastating, heart-rending and I remain utterly inconsolable (unlike my friend who'll get over her loss).

While you may have been treated unfairly at the hands of others and not received the redress you were seeking, it's still your inescapable responsibility to decide if you want to remain dependent upon your pain in order to attract sympathy or put boundaries around the pain and escape from the victim trap (Wolin and Wolin, 1993). For example, Peter was bullied by his boss and eventually took sick leave having been worn down by the experience: 'Nobody took my complaints seriously. They just said "it's a tough environment we work in and you've got to get on with it"'. He left his job but couldn't let go of how he'd been treated by his boss who, he later learned, had been promoted. He saw this promotion as his boss being rewarded for treating him badly.

In our sessions, he spent some time venting his understandable anger at his boss's mistreatment of him and the company culture that 'turned a blind eye' to such behaviour. But more importantly, we focused on how his continuing anger and sense of helplessness about correcting this injustice were having corrosive effects on his life; principally, his reluctance to find another job in case the bullying happened again.

I argued there were two forms of injustice: first, what his boss did to him and, second, the injustice he would do to himself if he didn't pursue his desired goals, forever blaming the bullying for holding him back in life. He considered the second one, the self-inflicted injustice, as the truly destructive one. He saw the sense in regarding the bullying as a time-limited event (it occurred over a six-month period) that would not adversely affect the rest of his life. I taught him some techniques for standing up to a bullying boss (see Chapter 8). Looking beyond the bullying, he felt he was beginning to regain control over his life.



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Before I leave this section, I'd like to make some comments on helplessness which is a key feature of victimhood. When people say they 'feel helpless' they really mean 'I believe I'm helpless' (an assumption, not a feeling or a fact). Believing you're helpless is a choice you make. The late philosopher Isaiah Berlin observed:

Action is choice; choice is free commitment to this or that way of behaving, living, and so on; the possibilities are never fewer than two: to do or not to do; be or not to be ... it is always possible, though sometimes painful, to ask myself what it is that I really believe, want, value, what it is that I am doing, living for; and having answered as well as I am able, to continue to act in a given fashion or alter my behaviour.

[2013: 96]

It may seem to you that it's equally painful if you stay the same or change, but the pain associated with change carries with it the possibility of a brighter future, whereas staying the same sees only a bleak one. Finally, a choice is a choice whether it's straightforward or hard to make, so don't become trapped by thinking that choices should only be easy and painless.

'I'LL NEVER GET OVER IT'

The 'it' may be a traumatic event, troubled childhood or any misfortune you believe has robbed you of any future happiness or irreparably damaged your life. Some clients describe the 'it' as having 'left me in pieces'. From this viewpoint, it's reasonable to ask: can a broken Humpty Dumpty be put together again? (Some writers use the nursery rhyme character to introduce this discussion.) Flach (2004) argues that falling apart in the face of significant stress is a normal – even necessary – part of the resilience response as, during this period of disruption, new ways of reacting to tough times can be developed so that the pieces of ourselves can be reassembled in sturdier ways. Our old ways of dealing with things have become obsolete, forcing us to find new ways to cope. However, this period of disruption is not without its risks. The pieces can be reassembled successfully or fail to cohere into a meaningful whole that leaves you 'forever more or less destabilized' (Flach, 2004: 13). Going through a period of severe stress can either be grasped as a valuable learning experience for both present and future benefit or thrown away because, for example, you refuse to accept that anything good can ever come from anything bad.



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I saw an executive, Roger, who'd been overwhelmed by the relentless pressures placed upon him. He felt depressed ('I'm a failure, washed up at 42'), angry ('What were they trying to do, kill me?') and ashamed that he couldn't cope with the pressure ('I'm weak for the whole world to see'). He believed his life was in pieces. When he seemed receptive to the message, I pointed out to him that 'Humpty Dumpties' can be made whole again. He was intrigued that he could reconfigure the pieces of himself and move his life in a different direction. However, despite this interest, he remained unyielding in his view that he should've been able to handle the pressure and that he would be 'stained with the mark of weakness for the rest of [his] life'. He dropped out of therapy after several sessions and I never saw him again.

Sometimes the process of self-repair can take a long time. In a famous long-term study (from youth to old age) of socially disadvantaged men (one of three groups studied), Professor George Vaillant and his team at Harvard University tracked their progress and came up with some surprising and welcome conclusions (as Vaillant (2012) says, to investigate adult development properly requires lifelong study). A poor start in life doesn't have to mean that a happy and fulfilling existence cannot eventually be achieved:

The disadvantaged youth becomes a loving and creative success; the child who 'did not have a chance' turns out to be a happy and healthy adult. We have much to learn from these once-fragmented Humpty Dumpties who ten – or even forty – years later become whole.

(Vaillant, 1993: 284)

If you study someone's life at a particular point, you might see her struggling unsuccessfully against the odds and this snapshot might lead you to make gloomy predictions about how her life is going to turn out. Revisit her life in 5, 10 or 15 years' time and these predictions may have proved inaccurate. I worked in the National Health Service for 20 years and saw many clients who led chaotic, self-destructive lives. Some died, some seemed forever trapped in a cycle of despair, and some pulled through. If I was a betting man I would've lost a lot of money predicting who would and who wouldn't eventually make it.

'I CAN'T STAND IT!'

Also called low frustration tolerance (LFT; Ellis, 2001), this attitude refers to your perceived inability to endure frustration (e.g. delaying gratification), boredom,



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negative feelings, hard work (e.g. tackling your procrastination), inconvenience, setbacks – if something cannot be easily and quickly attained you give up. The cognitive core of LFT is ‘I can’t stand present discomfort in order to achieve future gain’. LFT is a key reason why some clients drop out of therapy or coaching when the hard work of change begins; that is, putting into daily practice the CBT skills they’ve learnt. LFT is a deceptive outlook because it encourages you to think that you’re winning by avoiding difficulty, whereas your life is actually becoming much harder to manage in the longer term as your unresolved problems pile up and opportunities for self-development aren’t grasped because they seem like too much hard work.

Helen wanted to learn French but left the course after two sessions as she found it embarrassing having to practise in front of others and realized she wasn’t going to become fluent in French *immediately*. She’d tried to learn Spanish and classical guitar the previous year but gave up for the same reasons. She kept vowing to get fit, seek a new job, find a relationship, make life more exciting, but all to no avail. Ironically, in avoiding the discomfort of persevering with change, she ended up suffering the greater discomfort of a dull and unfulfilled life. Which is more unendurable, the discomfort of maintaining the status quo in your life or the discomfort of changing it in order to arrive at a brighter future?

To make matters worse, she frequently became angry and depressed for giving up too easily (‘What’s wrong with me? Why can’t I stick at things?’). She had a triple dose of discomfort – a dull life plus being angry and depressed for not persevering with her efforts to change. In therapy, she kept demanding instant answers to understand her problems and easy solutions to solve them.

When you make LFT statements such as ‘I can’t stand it when there’s a long queue in the shops’, what does ‘I can’t stand it’ actually mean? Will you die as a result of having to put up with frustration or go into psychological meltdown because you have to stick with doing boring tasks? Or you may think that you can’t be happy if you have to deal with disagreeable events. In fact, many people actually do stand what they believe they can’t stand. The challenge is to find better ways of standing it; namely, choosing to seek out the avoided tasks and situations in order to prove to yourself that frustration is indeed tolerable, nothing terrible will happen to you while you’re feeling frustrated and that future gain is worth fighting for. In Helen’s case, the challenge was to persevere with her efforts, among other things, to learn French and classical guitar. Frustrations in life are inevitable; disturbing yourself about these frustrations doesn’t have to be (Hauck, 1980).



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'WHY ME?'

People often ask this question when they've experienced a traumatic event. The answer is usually implicit in the question: 'It shouldn't have happened to me. I've done nothing to deserve this.' (The word 'should', when used by clients throughout this book, is meant in the imperative sense of expressing commands and demands.) 'Why me?' suggests you believe in immunity justification; that is, offering reasons why bad events shouldn't happen to you. Your assumption of a just and fair world has been shattered by a traumatic event (Janoff-Bulman, 1992). As de Botton observes: 'The continuing belief that the world is fundamentally just is implied in the very complaint that there has been an injustice' (2001: 93).

For example, John was involved in a multiple car crash and sustained some significant injuries. He was very angry about this happening to him. He kept on insisting that he was a 'very conscientious person'. The connection between this virtue and the car crash initially seemed puzzling. However, in teasing out John's sense of logic, it became clear that being a very conscientious person should have given him an exemption from 'anything horrible in life'. He said, 'I could understand it if I'd been a lazy, work-shy kind of person or someone who's a liar and a cheat, an unpleasant person, but I'm not that kind of person'. His idea of how the universe worked had been 'mocked and destroyed'. He now saw himself as the victim of cruel, uncontrollable forces and couldn't see how any constructive meaning or order could be restored to his life. He even wondered at times if he'd been deceiving himself and was, in fact, a bad person who deserved punishment (if a person believes prior to the trauma that she is bad, this view is likely to be confirmed when it happens).

'Why me?' introspection is unlikely to yield any useful answers that will help you in your time of distress (this is my experience in working with such clients). For what answers would satisfy you? That the world can be random and capricious; therefore, what happened to you is not actually about *you*. Goodness is no protection against experiencing adversity. What happened was completely unseen, a bolt out of the blue; the driver had a heart attack, his car swerved across the road and hit you. (Some clients will say or think, 'Why couldn't he have hit the car in front of or behind me instead of mine?' implying that they were singled out in some way by the driver or fate.) 'Why me?' is an unappeasable question. To keep on searching for answers that will only prove unsatisfactory prevents you from starting to process the trauma in a constructive way; accepting the grim reality of events and learning how to adapt to them in order to start getting your life back to some form of normality.



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A very different perspective might provide an answer, 'Why not me?' This question states an unpalatable truth: that no one is exempt from experiencing the possibility of tragedy or trauma, no matter how well you lead your life. Obviously the timing of such a question is crucial. The therapist is likely to be seen as callous if he asks it before the client has been given the space to explore her reactions to the trauma. When the question is eventually asked, in a sensitive, non-accusatory way, it can take a different form such as 'Have you ever considered that everyone is likely to experience some misfortune in their life?'

Mary had been mugged and listed her own immunity justification, 'Bad things shouldn't happen to good people', but came round to the idea of 'Why not me?' She said the idea made sense to her (unlike John) and began to break free from the restraints of 'why meism' However, her new belief was 'Now that I've had my one [mugging], I'll be safe. It's someone else's turn.' The philosophy of 'Why not me?' also includes the possibility that it could happen again, which Mary hadn't considered. She was reinstating immunity justification into her new outlook. We discussed the trap she might be setting for herself and she removed the justification. Two years later Mary was robbed on the London Underground. She said that what stopped her 'from completely disintegrating' was her acceptance that horrible things could happen to her again.

'YOU CAN'T ESCAPE THE PAST'

The past maintains its unshakeable and malign grip on your present behaviour ('It's like being chained for ever to what happened earlier in my life'), depriving you of any real happiness or feeling of freedom. It's not the past itself that maintains this grip but the beliefs you've constructed about these past events which you still believe today. It's the beliefs that are the chains. The past is unalterable; your beliefs about it are not (breaking the chains). In his teenage years, Darren found out that he'd been adopted and jumped to the conclusion that he must be unloveable because his real parents had abandoned him. I met him when he was 30 and he still believed this:

MICHAEL: Before you found out you'd been adopted, how did you see yourself?

DARREN: I saw myself as okay, just normal.

MICHAEL: What was life like with your adoptive parents?

DARREN: It was happy. I liked it.

MICHAEL: Why did you think you were unloveable when you found out your biological parents put you up for adoption?



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Michael Neenan

Excerpted from *Developing Resilience*

DARREN: It's obvious. Everybody would think like that if it happened to them.

MICHAEL: Could you explain the obvious to me?

DARREN: Well, if you're a loveable baby then your parents would want to keep you. That makes sense, doesn't it?

MICHAEL: Could you be a loveable baby but still be put up for adoption?

DARREN: I suppose so.

MICHAEL: What reasons might there be for doing that?

DARREN: Well, I know about that. I've discussed that with my adoptive parents. My real parents had lots of problems, some of them psychiatric, and they couldn't really cope with their own lives let alone bring up a child, so they wanted the best for me because they couldn't provide it themselves.

MICHAEL: Presumably you don't find that a convincing explanation.

DARREN: No, I don't. What continues to anger me all these years later is that if they really wanted me then they would have found a way to keep me. They just would have found a way. It's as simple as that.

MICHAEL: And because they didn't find a way to keep you, the only answer can be that you were and remain unloveable. And you're stuck with that view of yourself.

DARREN: That's right. What else am I supposed to think then?

MICHAEL: Well, given what you know about your parents' struggles and their inability to cope with their problems, you expected them to somehow become superhuman, fight to keep you and win. In other words, to be the kind of people you wanted them to be. But they couldn't be anything other than the people they were at that time: individuals struggling unsuccessfully to overcome their problems.

DARREN: I suppose that's true. I never saw it that way. I suppose my parents couldn't be anything else other than how they were, though it's hard to get my mind round that.

MICHAEL: Another thing to try and get your mind around is that you keep labelling yourself as unloveable because you were adopted. Being adopted didn't make you unloveable, if you were truly unloveable then how could your adoptive parents love you to bits? Being adopted isn't the problem, maintaining this negative view of yourself is. Every day you can decide to keep it or begin to change it.



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Michael Neenan

Excerpted from *Developing Resilience*

DARREN: How do I do that then?

MICHAEL: By what we've been doing today: stepping back from this belief that you're unloveable and starting to examine it critically. It's as if you've been brainwashing yourself for fifteen years that you can't be anything else other than unloveable.

Eventually, Darren was able to see and accept the following points: that he'd rejected himself when told he'd been adopted and, in consequence, had been perpetuating this self-rejection for fifteen years; that the quality of his life with his adoptive parents was probably far better than his real parents could've provided if they'd kept him; and that who his real parents are isn't determined biologically, but by the people who provided a loving environment for him to grow up within and who continue to stand by him through thick and thin.

'IT SHOULDN'T HAVE HAPPENED'

How many times have you said that? You were hoping for a different outcome to the one that occurred. For example:

- You're low on petrol and keep passing petrol stations. You're not prepared to queue in your eagerness to get home after a tiring day at the office. You eventually run out of petrol several miles from home and ask incredulously, 'How could this have happened?'
- You've no skills or interest in DIY but decide reluctantly, at the urging of your partner, to 'have a go' and end up with a host of problems which require the services of a professional to put right. You shake your head in disbelief at the large fees you have to pay for his services.
- Your car has faulty brakes and is going into the garage for repairs in several days' time, but you think you'll be safe if you continue to drive but only at night when there's less traffic on the road. You crash the car and are off work for several weeks. You can't believe how reckless and stupid you've been.

As Edelman observes: 'Everything that we say and do, including those things that turn out to have negative consequences, happens because all the factors that were necessary for them to occur were present at the time' (2006: 74). From this perspective, these events should have happened, not shouldn't have happened, based upon your wishful thinking which ignored inconvenient truths. Warburton defines wishful thinking as 'believing that because it would be nice if something were true,



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then it must actually be true' (2007: 160). In the first example, your overriding concern was to get home, not to get petrol, and you thought you could achieve it even though the petrol gauge was indicating otherwise. In the second, you believed you would be able to do a reasonable job, not a badly botched one, without having any DIY skills. In the third, you took a chance that your faulty brakes wouldn't put you in danger if you were cautious by going out only at night, and that your brakes would 'be aware' of your caution and not let you down by failing (assuming the brakes have a mechanical intelligence that understands and responds to your apprehension).

So it's futile to keep telling yourself that 'it shouldn't have happened' (as if this will change the outcome of past events) when all the conditions were in place for it to have happened in the way it did. While we all engage in wishful thinking sometimes, it's important to subject such thinking to logical scrutiny to see if it really does make sense to you (conclusion: 'My brakes can fail at any time, so don't drive the car'). Or, to put it another way, such scrutiny is like throwing a bucket of cold water over yourself, waking you up to the possibility – likely probability – that you're deceiving yourself in some way. Acting on this probability should realistically lead to fewer instances of 'it shouldn't have happened' and head-shaking disbelief.

'I'M A FAILURE'

Such self-devaluation keeps you in a state of demoralized inertia as you act in accordance with your self-image; it's as if you've surrendered to the belief and declared 'This is how I am and this is how I'll stay'. Even though you probably see both of these statements as unchangeable facts, they're actually assumptions that you're making about yourself and your life which are open to examination and change. For example, if you're a genuine failure as a person then all you can ever do – past, present and future – is fail; even if you wanted to succeed, your essence or identity as a failure wouldn't allow it. A review of your life to this point will definitely not support the idea that you're a failure if you're open to finding disconfirming evidence, and your future is still to be revealed.

However, what's likely to stop you from seeing this disconfirming evidence is your negative belief functioning as a self-prejudice (Padesky, 1994); that is, your 'I'm a failure' belief rejects any evidence that might contradict it and seeks evidence only to confirm it. Think of a belief you don't agree with such as 'all women are bad drivers'. While listening to the person holding this belief, you might make yourself incensed: 'Why can't he see that women, just like men, are both good and bad drivers? Women



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have a better safety record than men, they're more careful. He's such a pig-headed git!' He won't be able to hear you because he has a fixed attitude and no amount of contrary evidence is going to shift it (at least not yet).

So, if we come back to your view that you're a failure, then you're doing exactly the same thing that he's doing; namely, discounting any evidence that doesn't fit in with your point of view. Some of my clients give this belief-as-self-prejudice a name such as 'ratbag', 'Bill' or 'the whisperer' (e.g. 'That ratbag is talking again but I'm listening to her less and less'). And the reason you're paying less attention is because you're looking at all the evidence about yourself and your life, not just focusing on examples of failure.

All self-devaluation beliefs are illogical because they are based on the part = whole error. An aspect of the self, such as a failed relationship, can never capture the complexity of the whole (you) or the totality of your life. There are other aspects of you that also contribute to making up the whole, but these are overlooked in your rush to self-condemnation. For example, when something goes right in your life does this make you a success? Can you be a failure yesterday and a success today? Neither label can do justice to the complexity of a person. Would you attach labels to your children and announce to the world that you've captured their essence as human beings? The inevitable failures and setbacks that we experience are part of the story of our life, but certainly not the whole story.

'I'M NOT ME ANYMORE. I FEEL LIKE A PHONY'

Clients sometimes complain, when tackling their problems, of feeling strange or unnatural as they start to think, feel and act in new and unfamiliar ways: 'This doesn't feel like me. I'm very uncomfortable with all this.' This dissonant state – the conflict or disharmony between old and new ways of doing things – can lead to some clients dropping out of therapy or coaching in order to feel natural again (i.e. returning to the status quo in their lives which they were keen to change a few weeks or months earlier). This dissonant state is a natural part of the change process and will need to be tolerated until it passes; old habits may now seem unfamiliar. Thinking, feeling and acting differently indicates newness, not phoniness. Hauck (1982) likens this dissonant state to wearing in a new pair of shoes.



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'WHY CAN'T I FIND HAPPINESS?'

This plaintive enquiry is often heard in therapy with clients hoping that the therapist will come up with a happiness formula for them. No matter what the person tries, happiness continues to elude her, so each new activity undertaken (e.g. yoga) is interrogated, 'Will *this* make me happy?' Another person achieves the success he's been chasing (e.g. gaining a much sought-after position in the company), but experiences post-success disillusionment as he believed all his discontents would disappear once his dream was realized. He sets himself and achieves another goal in his attempt to capture happiness but it remains out of reach. As Grayling remarks: 'It has wisely been said that the search for happiness is one of the main sources of unhappiness in the world' (2002: 71).

If the search for happiness does indeed end in unhappiness, then how are we to be happy? Auschwitz survivor Viktor Frankl explained thus: 'Happiness cannot be pursued; it must ensue. One must have a reason to "be happy". Once the reason is found, however, one becomes happy automatically' (1985: 162). What he meant by this is that happiness is a by-product or the result of an interesting and meaningful life (ensue), not the central goal of your life (pursue). I believe that Frankl's message is an eminently wise one and the 'formula' I teach my clients if they're receptive to it. Some of them say they're now seeking a more meaningful and interesting life, not pursuing happiness, but, alas, a few are still holding on to the old attitude (e.g. 'I've always wanted to do choir singing, so I joined a choir, but it's not making me happy!').

NOT FACING REALITY

In Chapter 1, I discussed the popular but unrealistic view that resilience is bouncing back from adversity. Such a view encourages what might be called resilience perfectionism; for instance, rising immediately to the challenge of adversity and overcoming it with faultless determination which elicits the admiration of others. Struggling to recover from misfortune departs from this ideal response and you angrily condemn yourself for failing to act 'in the right way'. Effort and struggle are to be despised as they point to deficiencies of character, 'It means I'm not in complete control of myself'.

I once saw a senior manager who was a formidable problem solver, the more intractable the problem, the more he liked it – 'Bring it on' – until one day at work he experienced a panic attack and discovered, to his horror, that his problem-solving prowess was ineffective with panic (he thought some tough self-talk would



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do the trick). In fact, his panic attacks were getting worse and, in consequence, his performance and concentration were suffering. He was angry and dumbfounded by this state of affairs and kept asking incredulously, 'How could this happen to *me*?' He had a fixed view of his character and believed it would function in the way he told it to as if it was an obedient dog. I explained to him that he could deal with the panic attacks relatively quickly if he allowed me to show him how. His usual response was, 'You don't understand. This is not *me*.'

His panic attacks undoubtedly belonged to him but, in his mind, they were the mark of a weak person; as he never saw himself as weak, they therefore couldn't be part of him. Why couldn't I understand that? He feared his character was beginning to unravel as he couldn't see a solution to a problem that he shouldn't have. After a few sessions, he left therapy none the wiser and berated himself for coming in the first place as this was another worrying sign of the weakness he was forbidden to have.

Needless to say, this is a self-defeating, self-deluding response to dealing with panic attacks or other problems because there will come a time when your expected (or in his case fixed) way of responding to events isn't working; new ways need to be explored if there's going to be a favourable outcome. Your way may have been the right way so far, but it doesn't have to remain the only way.

Another means of not dealing with the reality facing you is spending too much time daydreaming about or regretting not pursuing the unlive life (i.e. the road not taken) – 'I should've married Mary all those years ago' – which you believe would have undoubtedly led to great happiness and fulfilment as opposed to the lived life of frequent struggle, intermittent happiness and unrealized potential. As Phillips observes: 'We discover these unlive lives most obviously in our envy of other people, and in the conscious (and unconscious) demands we make on our children to become something that was beyond us. And, of course, in our daily frustrations' (2013: xii–iii).

While brooding about the road not taken, it's also worth remembering that it could have led to discontent and disillusionment if taken: 'I wish I'd never met and married Mary. It was a disaster.' While the unlive life is part of the lived life, as our visits there demonstrate, too much mental wandering in the land of what could have been reduces the time, effort and concentration we require to improve the quality of the lived life.



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Excerpted from *Developing Resilience*

'I NEED TO KNOW'

Intolerance of uncertainty is the core issue for most people who worry (Leahy, 2006). You believe you have to know *now* what's going to happen. Not knowing will leave you feeling on edge and you won't be able to focus on anything else. You can't enjoy life with this uncertainty hanging over you and you continually dwell on 'What if' imaginings (e.g. 'What if she's having an affair?'), which generate more 'What ifs' such as 'What if she leaves me?', 'What if I can't cope on my own?' and 'What if I can't pay the mortgage?' These proliferating 'What ifs' lead you to conclude that you've many more problems than you actually do and that you're losing control of your mind.

For example, Stanley had been suspended from work pending a disciplinary hearing and brooded endlessly on losing his job, the shame involved in being sacked, finding another job at 45, never being happy again – whatever could go wrong in his life would now go wrong. He kept on insisting in our sessions:

If they could just tell me today whether they're going to keep me or kick me out, then at least I would be put out of my misery. This disciplinary process is going to go on for another few months. It's mental torture. They should bloody well give me a decision instead of dragging it out!
(Stanley)

The mental torture was largely self-inflicted as Stanley demanded that the disciplinary process run to his timetable, not the company's. He kept on assuming that the outcome of the hearing would mean the loss of his job, rather than the possibility he might keep it, and that he couldn't focus on anything else in his life until he had a decision.

Instead of demanding to know the unknowable before a decision was announced, Stanley focused on what he did know and could do, such as re-engaging in daily family activities. Additionally, Stanley flooded himself with uncertainty every day (Leahy, 2006) by saying to himself many times 'I could possibly lose my job'. In order to tolerate this thought without distress, he focused on developing contingency plans in case this did happen (he'd been avoiding doing this), and realized that any shame he may experience would be time-limited, not lifelong. By undertaking these activities, Stanley felt in control of himself in the face of uncertainty. He did lose his job, but the shock was moderate and he found another one within three months. Learning to tolerate uncertainty can bring forth some unexpected strengths, even



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if the results you were looking for from the situation don't materialize (i.e. keeping your job).

'I DON'T FEEL CONFIDENT'

How many times have you said this before trying anything new? Why should you feel confident if you haven't done it before? I see clients with performance anxiety (e.g. running a workshop or engaging in public speaking for the first time) who want to be articulate, witty, insightful, calm and cool, answer every question with impressive authority and get wonderful evaluations from the audience for their performance; in other words, they want to deliver a perfect performance. Yet their fear is falling well below this standard and being revealed as hopelessly incompetent, a laughing stock.

They always start in the wrong place in assessing their performance: they're beginners, not accomplished performers; so it's important to have beginner's expectations, not those of a star performer. If they do want to become star performers, then they need to realize it could be a long road before they get there rather than, in their minds, achieving instant acclaim. Feeling confident before you do something new and potentially risky is putting the cart before the horse. Furthermore, courage usually comes before confidence; you're prepared to take the risk of putting yourself in your discomfort zone and staying there without knowing how the situation will turn out. Your legs shake, your heart pounds, your voice falters and your stomach churns, but you force yourself into the limelight. Talk of confidence at this stage is premature. Also, your view of confidence is one-sided as it only envisages a successful outcome. Being resilient means that real confidence embraces both success and defeat – neither is taken too seriously – and that learning from whatever happens is the true focus of self-development.

'I'M A PESSIMIST BY NATURE'

This usually means that when you've a setback you believe the consequences will be catastrophic, wiping out any present or future happiness. You're unlikely to persevere when the going gets tough ('What's the point?') and you slip back into a state of helplessness and self-blame, believing that you've no control over events in your life. Seligman (1991) states that this pessimistic outlook consists of three key elements when a negative event occurs:

- *permanence* – 'It's going to last for ever';



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- *pervasiveness* – ‘It’s going to undermine everything I’ve tried to achieve in my life’;
- *personalization* – ‘It’s my fault’.

When my clients say that pessimism is part of them, they usually mean it’s inborn and therefore unchangeable. Some clients declare at the beginning of therapy that ‘you won’t be able to help me’. I see this as a hypothesis to be talked about and tested, not an accurate prediction of how therapy will unfold.

Optimists, by contrast, see negative events as temporary (‘It will blow over soon’), specific (‘It only affects one area of my life’), and place responsibility for the event on an external cause (‘My boss was in a foul mood today’), or take personal responsibility without self-condemnation (‘I was rather slow on this occasion in getting the report in on time’). Pessimists dwell on their problems whereas optimists seek constructive ways of dealing with them.

How we explain events to ourselves is called explanatory style. As you can see, optimists and pessimists have very different explanatory styles. These two styles are habitual ways of thinking, but habits can be changed. You can learn to become more optimistic in your style of thinking. Martin Seligman, an eminent psychologist and author of *Learned Optimism* (1991), has to battle with his own pessimistic outlook:

I am not a default optimist. I am a dyed-in-the-wool pessimist; I believe that only pessimists can write sober and sensible books about optimism, and I use the techniques that I wrote about in *Learned Optimism* every day. I take my own medicine, and it works for me.

(2003: 24)

One of the techniques he uses to start changing his pessimistic explanatory style is the ABC model that I discussed in the previous chapter.

- **A = activating event or adversity**
- **B = beliefs**
- **C = consequences** – emotional and behavioural.

For example, if you fail to successfully assemble a flat-pack bookcase (A) and feel despair and anger, and throw the pieces into the dustbin (C), you might believe (B) ‘I can never do anything right. I’m completely useless.’ This belief puts you in the dustbin along with the self-assembly pieces. In contrast, optimistic beliefs are



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balanced, flexible and realistic (not feel-good bromides), and point out the dangers of using words like 'never' and 'useless' in assessing yourself and/or your abilities as they create the dispiriting impression of unchangeability in your life.

Seligman (1991) made the case for flexible optimism because there might be specific situations where a pessimistic explanatory style might be more appropriate than an optimistic one, helping you to avoid the high risks you may be running. For example, if you've been drinking, you'd be wise to assume that you'll be stopped by the police and take a cab instead; if you're tempted to plagiarize material to put into your college assignment, you'd assume you'll be found out by your tutor; and if you lie about your achievements on your CV, you'd assume this will be discovered by your prospective employer. And, on a grimmer note, James Stockdale, the POW we met in Chapter 2, pointed out that those prisoners who didn't return from the camps were optimists. Year after year, their hopes that release was just around the corner, such as at Christmas or Easter, were continually dashed. 'I think they all died of broken hearts' (quoted in Coutu, 2003: 7).

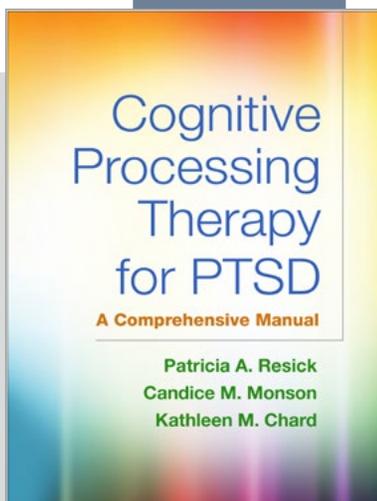
UNDERMINED, BUT NOT FOR EVER

In this chapter, I've looked at some of the attitudes that undermine resilience building and suggested ways of replacing them with resilience-oriented attitudes. This transition can be slow and difficult and it's easy to give up and fall back into familiar, but self-defeating, attitudes and actions. Change is possible no matter how long you've been stuck in your ways, but the starting point is a willingness to be open to discussing new ideas and trying out some different behaviours if you want to develop a resilient outlook. This is the subject of the next chapter.

CHAPTER

7

OVERVIEW OF PTSD AND CPT



This chapter is excerpted from

*Cognitive Processing Therapy for PTSD:
A Comprehensive Manual*

By Patricia A. Resick, Candice M. Monson, and
Kathleen M. Chard

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OVERVIEW OF PTSD AND CPT

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SESSION 1

GOALS FOR SESSION 1

The overall goals for the first session of CPT are for clients to understand what PTSD is, how they got stuck in their recovery, and what CPT will do to put the clients on the path to recovery. However, the most important immediate goal is to engage them in treatment so that they don't avoid it by quitting before or after the first session, which is not uncommon in PTSD treatments. First, therapists describe the symptoms of PTSD and engage clients in describing examples of their symptoms. Next, therapists explain what happens to the body and thinking during traumatic events. Therapists then move into the cognitive theory of PTSD; they explain how people attempt to maintain their prior beliefs about prediction and control, and their faith in the just-world myth. Finally, therapists explain how CPT teaches clients to become their own therapists by giving them tools to examine their thoughts and label their emotions in ways they were not taught previously, with the goals of feeling the natural emotions arising from the trauma and changing thoughts that are keeping them stuck.

PROCEDURES FOR SESSION 1

1. Set the agenda.
2. Describe the symptoms of PTSD and the theory of why some people get stuck in recovery.
3. Describe cognitive theory.
4. Discuss the role of emotions in trauma recovery.
5. Briefly review the index trauma.
6. Describe the overall course of therapy.
7. Give the first practice assignment.
8. Check the client's reactions to the session.

SETTING THE AGENDA

Therapists should explain to clients that the first session of CPT is somewhat different from the rest of the sessions, because the therapists will be educating the clients about the symptoms of PTSD, explaining how PTSD is a problem of nonrecovery, discussing the role of avoidance in maintaining PTSD symptoms, and describing how CPT works. The session ends with the first assignment. Therapists



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tell clients that they (the therapists) will do most of the talking in the first session, but that this will change over time, with clients doing more of the talking while the therapists serve as consultants regarding any problems with practice assignments. The therapists will ask questions to guide the clients to think about their trauma differently.

DISCUSSING THE SYMPTOMS OF AND A FUNCTIONAL MODEL OF PTSD

PTSD for Therapists: Diagnostic Criteria

Rather than just listing the symptoms and clusters of PTSD, a therapist needs to help a client understand why some people are later diagnosed with PTSD. Therefore, it is important for the therapist not just to know the list of DSM-5 or ICD-10 symptoms, but to understand how they interact to prevent some people from recovering. Several major changes have been made to the diagnosis and classification of PTSD in DSM-5 (American Psychiatric Association, 2013). One of the most important is that PTSD is no longer considered an anxiety disorder, as it was from DSM-III to DSM-IV-TR (American Psychiatric Association, 1980, 2000). The various negative emotions that clients with PTSD experience, such as guilt, anger, shame, disgust, and sadness, have been demonstrated sufficiently well that PTSD is now considered much more than an anxiety disorder. PTSD has been included in a new DSM-5 category called “trauma- and stressor-related disorders.”

Criterion A for PTSD (the definition of traumatic experiences) has been tightened up to exclude media-related exposures as traumas (unless such an exposure occurred as part of one’s job), and learning about a traumatic event is considered a traumatic experience only if the event occurred to a close friend or relative. In addition, there are now four rather than three symptom clusters. According to DSM-5, the Criterion B cluster should be described not as thinking about the event repeatedly, but as unexpected, intrusive memories that are either cued by something in the environment or emerge when individuals are not keeping their minds preoccupied with other matters (e.g., chronic working). When they are tired, sick, or not busy, clients may have memories of their traumatic events that emerge in the form of images, sounds, or flashbacks—or, during sleep, in the form of nightmares about the traumatic events. More severe flashbacks may include dissociative responses, in which an individual becomes lost in an event and loses the sense of present time. Even without full recall of the traumatic event, it is possible to have emotional or physiological reactions upon reminders of the event. The Criterion B symptoms are thus largely sensory and brief, but highly distressing.



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Criterion C, the avoidance criterion, is now composed of just two avoidance items: avoiding internal memories of the event, and avoiding external reminders. However, these two types of avoidance can be manifested in myriad ways. For example, the most common types of avoidance related to therapy are for clients not to come to sessions, to come late, or not to do their out-of-session practice. They may also attempt to change a distressing topic to something more mundane in a session. The use of substances or other self-harm behaviors to numb memories and emotions or to sleep without nightmares are other forms of avoidance. All these types are effective in the short run, but prevent processing of the traumatic event. There are probably as many forms of avoidance as there are clients; therapists must always be vigilant for avoidance, label it as a symptom, and emphasize that it is not an effective form of coping in the long term. Criterion C does not appear in the graphic at the top of [Handout 7.1](#) because this figure illustrates the process of natural recovery. The graphic at the bottom of [Handout 7.1](#) includes the avoidance criterion in PTSD, and should be discussed last rather than in the order in which it appears in DSM-5.

Criterion D is new to DSM-5, but includes a range of cognitive and emotional responses that have been found repeatedly in the literature. Although the cognitive symptoms are described as part of the cognitive theory of PTSD later in the session, it is good to elicit clients' responses at this point for reference. Cognitive symptoms include persistent negative expectations about oneself, others, or the world; persistent distorted blame of self or others for a traumatic event; and even dissociative amnesia for parts or all of the event. Although it is usually quite easy for clients to blame themselves for causing or failing to prevent traumatic events, they may not recognize that blaming other people who did not cause or intend the events might not be accurate. For instance, clients who were abused as children may blame their mothers for not protecting them from perpetrators, without understanding that (1) their mothers might not have known about the abuse, or (2) the mothers might have been abused themselves and unable to extricate themselves and their children from the situation. Military service members may have been taught implicitly or explicitly that if all personnel do their jobs correctly, all will come home unharmed. If service members or veterans cannot find any way in which they made a mistake—for example, if their units were ambushed—they may look to blame other service members, superior officers, or the military itself, rather than recognizing that the nature of an ambush is a surprise and that perhaps no one could have foreseen the event except the person(s) who planned the attack.



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Emotional reactions in DSM-5 no longer focus only on fear and anxiety, because PTSD is no longer classified as an anxiety disorder. Disrupted emotions can include any kind of pervasive negative emotional states (e.g., fear, horror, anger, guilt, disgust, shame); markedly diminished interest or participation in significant activities; or feelings of detachment or estrangement from others. In DSM-IV/DSM-IV-TR, there was an emphasis on emotional numbing. However, it has since become clear that despite their attempts to numb their emotions, people with PTSD have breakthroughs of negative emotions when reminded of their traumatic events. The only emotions that they are truly successful at numbing are positive emotions, such as joy, happiness, and love. The lack of positive emotions and the presence of negative emotions also contribute to diminished interest in previously enjoyed activities or estrangement from others.

Criterion E includes the arousal items that were present in DSM-IV/DSM-IV-TR, and some behavioral reactions have been added. So, in addition to hypervigilance, pronounced startle responses, problems with concentration, sleep difficulties, and irritability/anger, DSM-5 now also includes aggression as the typical expression of irritability/anger, as well as reckless or self-destructive behavior. The latter can include self-harm behaviors, driving erratically or too fast, driving a motorcycle without a helmet, indiscriminate sexual behavior, or other risk-taking behavior suggesting that clients may not care whether they live or die.

Therapists who are using the ICD-10 (World Health Organization, 1992) classification system should note that ICD-10 also includes five criteria, but that the focus is slightly different from that of DSM-5. These differences should be taken into account in discussing how a client's PTSD symptoms are affecting the client today. Criterion A in ICD-10 still refers to experiencing a stressful event, but clarifies that the event must have been "exceptionally threatening or catastrophic" and would be likely to cause ongoing distress in almost everyone. Like its counterpart in DSM-5, Criterion B focuses on experiencing intrusive flashbacks or dreams and/or feeling distressed when exposed to trauma triggers. Criterion C is also similar to that in DSM-5, its focus on avoidance of stimuli that are either related to or resemble the stressor event(s). ICD-10 Criterion D offers a departure from DSM-5, in that an individual needs to have either (1) the inability to remember important aspects of the event, or (2) persistent arousal that is shown by any two of the following symptoms: sleep difficulties, irritability/anger, difficulty concentrating, hypervigilance, or exaggerated startle response. Finally, Criterion E in ICD-10 requires that the onset of symptoms must occur within 6 months of the stressor, unlike DSM-5, which specifies only that



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the symptoms must have a duration of greater than 1 month (although the label “with delayed expression” is used if full diagnostic criteria are not met within 6 months of the event).

The preparation of ICD-11 is well underway, with a projected release date of 2018. Initial comparisons of ICD-11 drafts with DSM-5 indicate that ICD-11 is moving to a narrower definition of PTSD that focuses on it as a fear-based, stress-induced anxiety disorder. The ICD-11 system also includes complex PTSD as a separate diagnosis, whereas DSM-5 does not. Studies of the two systems (O’Donnell et al., 2014; Stein et al., 2013) suggest that ICD-11 PTSD prevalence, comorbidity with depression, and disability rates are all lower than those obtained in research using the DSM-5 classification system. Practitioners who will be using ICD-11 may find that fewer individuals in their practice will meet full criteria for PTSD than when they were using either the DSM-5 or the ICD-10 system.

PTSD for Clients: A Functional Model

In reviewing **Handout 7.1** with a client, a therapist should refer to the top portion of the handout as a description of normal recovery, noting that if a trauma is severe enough or if a person has experienced repeated traumas, PTSD symptoms are normal rather than abnormal, at least for a period of time. Once the trauma has ended, it becomes a memory that people have to integrate in a balanced way into their understanding of experiences and why they happen, as well as into their view of themselves, others, and the world. A review of the PTSD symptom clusters, and a discussion of which symptoms a client is experiencing and when they occur, is a good starting place. As an example of such a review, the therapist could say something like the following (in his or her own words, not in a verbatim reading):

“One set of PTSD symptoms has to do with intrusive memories, or memories that ‘intrude’ on you in an unwanted way. They come at you when you don’t expect or want them to—maybe when you are falling asleep or aren’t feeling well. They can come as images, sounds of the event, or physical or emotional reactions when you encounter something that reminds you of [the index event]. Can you give me any examples of the types of intrusive symptoms you have? When you have these experiences intrude on you, it is natural to experience strong feelings as well. These emotions need to run their course. When you think about the trauma, what emotions do you experience?”

“You also have thoughts about why the event happened, and, in an attempt to prevent future events, you may blame yourself or look for mistakes you think you made.



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Those kinds of thoughts are also associated with emotions, but different emotions from those that come from the event naturally. Your natural emotions about the event might be fear, anger, or sadness. If you blame yourself, however, you may feel guilt or shame, which is not a natural emotion but one based on your thoughts. Have you had any of these kinds of thoughts or feelings?

“If your intrusive symptoms, emotions, or thoughts are unbearable to you, you may attempt to escape or avoid them. There are many ways that people avoid thinking about or feeling their emotions about a traumatic event. Keeping very busy, drinking or using drugs, not coming to therapy sessions, coming late, or not doing your practice assignments are all examples of avoidance. Although it is understandable that you would want to avoid dealing with the traumatic event, and you may have been doing that for a long time, the avoidance prevents you from recovering.”

When describing natural recovery from a traumatic event, the therapist should point out that when intrusive memories, strong emotions, arousal, and so forth are triggered, individuals are more likely to hear corrective feedback about the actual causes of the events and receive support for their natural emotional reactions if they allow themselves to feel their emotions, think about the trauma, and talk to supportive people about their thoughts. Natural emotions that emerge directly from the flight–fight–freeze response (e.g., fear, anger) are likely to decrease rather quickly, along with other emotions that are not based on thoughts (except grief, which is an ongoing process). As emotions decrease, individuals become more receptive to other points of view and acceptance of the traumatic event. The top portion of **Handout 7.1** shows how thoughts, emotions, and arousal interact in natural recovery, and how they decrease and disconnect from one another over time. After a while, the survivor may be able to say, “I remember how awful that event was and how bad I felt at the time,” rather than continuing to feel strong emotions and needing to push away the memories. It becomes part of his or her life history.

The lower portion of **Handout 7.1** shows how people can get stuck in these symptoms and be diagnosed with PTSD. Instead of feeling natural emotions, talking about their traumatic events with other people and taking in others’ perspectives, and approaching rather than avoiding their symptoms in order to integrate their experiences appropriately into memory (the process of accommodation; see Chapter 1), persons with PTSD stop the natural recovery process by avoiding any or all emotions, thoughts, and other reactions to the traumatic event, at all costs. Unfortunately, although avoidance is not an initial part of posttraumatic reactions, it



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ultimately prevents recovery. Also unfortunately, most forms of avoidance (such as aggression, substance abuse, and withdrawal from others) work in the short term—but because they do not work in the longer term, the persons increase their use, often to such an extent that these behaviors can become comorbid disorders in their own right. In fact, if clients had a tendency to engage in any of these dysfunctional behaviors before the trauma, they may worsen after the trauma. As depicted in the lower portion of **Handout 7.1**, the symptoms of PTSD may appear smaller because the avoidance is larger. However, if a person with PTSD stops engaging in the avoidance behavior, the symptoms of PTSD reemerge. For example, it is well known that people with PTSD and substance abuse are more likely to relapse than people with substance abuse alone. As soon as these clients stop drinking or using drugs, they may experience more flashbacks or nightmares, and then are more likely to relapse into using substances to diminish these PTSD symptoms.

It is important for clients receiving PTSD treatment to understand the role of avoidance in maintaining PTSD symptoms, and to accept that in order to recover, they need to cease the forms of avoidance in which they are engaging. Furthermore, one of therapists' major roles is to help clients identify avoidance behaviors when these occur so that they can stop the behaviors. Therefore, the importance of attending sessions on time, completing practice assignments, and not relying on other forms of avoidance is emphasized and included in a therapy contract (see Handout 4.1 in Chapter 4).

Therapists will also assist clients in examining their thoughts about the causes and consequences of their traumatic events, help them differentiate thoughts from facts, facilitate their learning how specific thoughts lead to different emotions, and help them learn the skills involved in examining their experiences in a balanced way. After reviewing the symptoms of PTSD, therapists then give clients an explanation of cognitive theory, with an emphasis on the role of thoughts in PTSD and on how changing thoughts can change PTSD symptoms.

DESCRIBING COGNITIVE THEORY

Part of engaging clients in CPT is helping them to understand the cognitive model of emotional and psychological disorders. Clients may have heard nothing about cognitive theory or the cognitive model, or they may have misconceptions of the model—for example, that it is superficial, or cold, or a form of mind control. Therapists will provide a good start to treatment if they give their clients a clear working model of the conceptual underpinnings of CPT and the rationale for the approach.



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Below is a typical explanation of cognitive theory as presented by a therapist. (Again, this is *not* meant as a script to be followed word for word, but simply as an example of how to introduce these concepts to clients.)

“From the time we are born until the time we die, we are bombarded with information. Information comes in through our senses, through our experiences, and through what people teach us. All this information would be completely overwhelming if we didn’t find a way to organize it, and to figure out what to pay attention to and what we can ignore. As human beings, we have a strong desire to predict and control our lives, and we often believe we have more control over other people and events than we really have. Without organizing all the incoming information, we would have difficulty determining what is dangerous or safe, what we like and what we don’t like, or how we want to spend our time and with whom.

“As small children, we begin to learn language as a way to organize information. In the beginning, our environment and experiences are very limited, and we have only a few words to describe them. A child may call an animal with four legs, a tail, and a nose a ‘dog,’ because that is the only word the child knows—even if the animal is a cat, a pig, a horse, or a lion. As we grow older, we develop more categories that are more fine-tuned, so that we can communicate with others and so that we have a greater sense of control over our world.

“The ‘just-world myth’ is taught to children by parents, teachers, religions, or society in general, because as small children we are too young to understand probabilities or more subtle outcomes to behaving or misbehaving. The just-world myth goes something like this: ‘People get what they deserve. If something bad happens to someone, then that person must have committed some wrong previously and is being punished. If something good happens, then the person must have done something courageous or smart or kind before, or must have followed the rules. In other words, good things happen to good people, and bad things happen to bad people.’

“Parents don’t usually announce to their children that if they behave, they may or may not be rewarded. They don’t say, ‘If you misbehave, you may or may not be punished.’ It is only through the course of time and greater learning that people realize that good things can happen to criminals (for instance, they may get away with crimes), or that bad things can still happen to people who follow the rules and are kind to others. Unfortunately, early learning is not erased, and people often revert to the ‘Why me?’ question when they experience a negative event. They believe that they are being punished for something they did, and if they can figure out what they did wrong, then



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they can prevent bad things from happening in the future. This is probably one of the reasons why we hear so much self-blame following traumatic events.

“The flip side of the ‘Why me?’ question is the ‘Why not me?’ question. This is the source of survivor guilt. We have often heard service members say something like this: ‘It is not fair that my buddy was killed. He was a great guy who was married with two small kids. I’m single and don’t have kids. Why was I spared?’ Or someone may wonder why the tornado spared his or her house but destroyed every other house on the street. The person may feel guilty about being spared when so many other people were not. Both questions (‘Why me? Why not me?’) are assuming that all life events are explainable, fair, and potentially controllable.

“When a traumatic event occurs, it is a big event, and there are very natural emotions like being terrified, angry, grief-stricken, or horrified that accompany the event. Your mind also has to find some way to reconcile what happened with your previous beliefs and experiences. If you have never experienced a traumatic event before, your expectation might be that only good things should happen to you. The traumatic event pulls the rug out from under you, and you have to figure out a way to take in this new information that bad things can happen to you. Another thing that people often do is to try to change the event so that it matches previous positive beliefs about the world and the sense of control over future events. They may distort their memory of the event like saying to themselves that they made a mistake, it was a misunderstanding, or they should have prevented the event. If they can just figure out what they did wrong, they think that they can prevent bad things from happening in the future. [Therapist note: This is assimilation.]

“If someone came from an abusive or neglectful home, the event may not be so difficult to accept. That person already has negative beliefs about him- or herself, and this new traumatic event is used as proof of the prior beliefs. The person may think, ‘I am a trauma magnet,’ or ‘Bad things always happen to me.’ In fact, if the person already has PTSD, and negative beliefs stemming from prior traumas, these negative beliefs may be activated after a new trauma event even if they don’t quite fit the new event. An example would be a rape victim who is assaulted by a stranger and says afterward, ‘I don’t trust anyone in my life in any way.’ Why would a stranger’s actions affect one’s beliefs about trust? That belief probably arose from earlier events and is now being reactivated.

“One thing that people with PTSD try to do is distract themselves or avoid memories of a traumatic event, as we talked about earlier. But it is pretty difficult to ignore an event so important, and the avoidance is not successful in the long run.



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“Recovery from traumatic events consists of changing negative beliefs about the self and the world enough to include this new information. It means learning and accepting that traumatic events can happen. A new thought might go something like this: ‘I didn’t do anything wrong. Maybe bad things can happen to good people, and the person who harmed me is the one who is at fault.’ For some people, this thought is frightening, because if it is not their fault, then perhaps all bad things cannot be prevented. If other people blamed you for your traumatic incident, it would also reinforce the idea that you must have done something wrong for the event to occur to you. In fact, if you were abused a lot as a child, you may come to believe an extreme and unhelpful version of the just-world myth: Bad things will always happen because of something about you as a person. Instead of self-blame regarding a single incident, you may experience shame and a deep belief that you are a bad person or deserve only mistreatment. “If you were not alone during the event, and had someone else to blame besides the perpetrator and yourself, you might blame someone nearby who didn’t actually cause the event or intend harm. This is another way some people think, to try to get a false sense of control that blaming a perpetrator does not give them. In the military, it is often taught that if all personnel do their jobs correctly, then everyone will come home unhurt. But what if there is an explosion and people are killed, and you cannot see anything you did wrong? In order to keep the idea that your side has control, you might blame someone else in your unit or someone higher up the chain of command. Similarly, a child who is abused by one parent may blame the other parent the most, even if the other parent didn’t know about it.

“Another way to cope with a traumatic event is to change your beliefs about yourself and the world to extremes. Here are some examples: ‘I used to trust my judgment and decision-making ability, but now I can’t make decisions,’ ‘I must control everyone around me,’ ‘The world is always dangerous, and you must stay on guard at all times,’ ‘People in authority will hurt you.’ Such extreme negative beliefs may come from flipping from one belief to the exact opposite, or from attending only to negative events and people and deciding that avoiding these is the best way to protect and control your future. Instead of saying, ‘That person hurt me, so I will stay away from that person in the future,’ a trauma victim may blame everyone who falls into a shared class with that person (such as men, women, the military, or people in authority). So the person may conclude that people cannot be trusted in any way, and withdraw from anyone who reminds him or her of the presumed cause of the event. Beliefs can go overboard after a trauma in many ways, but common ones are related to the themes of safety, trust, power and control, esteem, or intimacy. These themes may be related to yourself or to others. [Therapist note: This is overaccommodation.]



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The more you say something to yourself, the more you may come to believe that it is a fact, and you may stop noticing any evidence that contradicts what you have decided. The problem is that these kinds of beliefs have serious negative effects on your life and continued PTSD symptoms. You have to ignore or distort anything or anybody who doesn't fit the new beliefs, and you end up isolating yourself from others. We call these thoughts that prevent recovery 'Stuck Points.' "

At this point, therapists should give clients **Handout 7.2** and review with them what a Stuck Point is and isn't.

DISCUSSING THE ROLE OF EMOTIONS

After discussing the role of thoughts in impeding recovery from traumatic events, therapists turn to the role of emotions. A major negative life event should naturally generate intense emotions. These may be generated during the event itself as part of the fight-flight-freeze response. If one has been trained to fight, as in the military or other first-responder positions (e.g., firefighters, police), one might expect an approach response to threat, and fight may be accompanied by anger. The flight response is to run away and is accompanied by fear. The freeze response may be one of two types. At the first perception of danger, the person may freeze briefly to orient to the situation, determine whether there is a threat, and decide what is going on or what to do. Sometimes clients who have done this blame themselves for having frozen for a few seconds, as if that could have changed the outcome of the event. The other type of freezing may be associated with tonic immobility and dissociation. If threat continues and neither fight nor flight is working, the freeze response may be the survival response; this may be accompanied by dissociation, a flattening of affect, or a complete sense of objectivity about the event, as if watching it from outside (i.e., derealization, depersonalization). The emotions that are paired with automatic responses are all perfectly natural emotions generated directly by the event without the need for time-consuming appraisal. Humans are hard-wired to have natural emotions in response to threat, loss, something disgusting, or even something pleasant. From an evolutionary perspective, they provide important information about how to respond in a situation. However, once the danger is over, a person should return to a steady state. In the case of PTSD, people bottle up their emotions and do not allow them to run their natural course. In fact, therapists often use the example of a carbonated beverage bottle that has been shaken. If a person starts to lift off the lid, there may seem to be an enormous eruption that is perceived as never-ending, and the person immediately puts the lid back on. However, if the person left the lid



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off, the energy would abate after the initial eruption, and the beverage would become flat fairly quickly.

Biologically, what happens in the brain during the fight–flight response is that when danger is detected, the amygdala activates emotions (fear or anger) and sends out neurotransmitters to the brain stem, which start the emergency response to fight or flee (see Chapter 1). In the process, unnecessary functions are turned off. The prefrontal cortex (the reasoning center, abbreviated here as the PFC) is quiet, as well as the immune system, digestion, and other functions that are not relevant to fighting or fleeing. There is a circular relationship between the amygdala and the PFC: When one is responding strongly, the other is relatively weak. A person who is calm can think clearly, and the amygdala is kept in check. If the amygdala is highly active in an emergency, the person does not need to be engaged in higher-order thinking, “What is my philosophy of life?” or “Do I want to change jobs?”, so the PFC is less active. However, in a normal fight–flight response, the PFC detects when the danger is over; it sends a message to the amygdala to stop the fight–flight response; and in turn the amygdala lowers the levels of neurotransmitters being sent to the brain stem. The PFC comes back online, and balance is restored. In someone with PTSD, the PFC shuts off too much, and there is no message to the amygdala to stop the high-level response. It takes much longer to calm down. A client may experience “speechless horror” because Broca’s area, the brain’s speech center (which is part of the PFC), is turned off. Talking may bring the PFC back online. Labeling ones’ emotions and keeping the PFC active by talking about the trauma rather than reliving it may be the most effective means of teaching the client affect regulation.

Emotions of the other kind are generated by the client’s thoughts following the event. These emotions produced by thoughts are what we call “manufactured emotions” in CPT (and what others might call “secondary emotions”). For instance, instead of being angry with the perpetrator of an assault—which leaves the victim wondering whether such an event could happen again—the victim engages in self-blame and feels either guilt or self-directed anger. With new information, and with help in looking at the event in different ways, the person can learn to change the manufactured emotions quickly. The analogy we often use to make the distinction is that of a fire. We may say something like this:

“A fire in a fireplace has a lot of heat and energy, like emotions, and you may not want to get too close. If you just sit there and watch the fire and do nothing to it, what happens? [A client usually says, “It burns out.”] Yes, it can’t keep burning forever



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unless it is given more fuel. That's what natural emotions from the traumatic event do: They burn out if you just feel them until the energy has burned out of them. But what if you throw 'thought logs' on this emotion fire, like 'It's all my fault,' 'I'm so stupid,' or 'I should have known it was going to happen'? You can keep that fire blazing as long as you keep throwing thought logs on that fire. The problem is that these are not the natural emotions from the event. The fire does not burn out, because it is being fueled by different thoughts like self-hatred, blaming people who weren't responsible for that particular event, thinking that all people are bad or untrustworthy, and so on.

"In this therapy, what we want to do is allow the natural emotions to burn down naturally, which does not take very long, and to take away the fuel that has been keeping the other emotions burning hot by changing any extreme or inaccurate thoughts. Does this make sense?"

REVIEWING THE INDEX TRAUMA

After a therapist has answered any questions a client has about the cognitive theory of PTSD and natural versus manufactured emotions, the therapist and client agree on the index event (the traumatic event causing the most distress and impairments to be addressed first in the therapy). In some cases, an assessor has met with the client before the first session, has gone through the trauma history, and has picked what the client considered the most troubling trauma to use as the index event for conducting the clinical interview (preferably the Clinician-Administered PTSD Scale for DSM-5; see Chapter 3) to determine whether the person has PTSD and, if so, how severe it is. Even if this has been done, however, the therapist should review the trauma history and help the client decide on the index event in the first session, because a client may be afraid during a first interaction in assessment to discuss the actual most distressing trauma, may worry about being judged, or may confuse "distress" or "worst life event" with "worst traumatic event and PTSD symptoms" (e.g., "When my father died of cancer, that was the worst event of my life. Everything changed after that"). Grief and PTSD are not the same, and the client may report an event that has not actually produced the symptoms of PTSD. The therapist should review the events reported as traumatic and ask about any that the client has thought about since the assessment. Sometimes it is helpful for the therapist to ask questions such as these: "Is there any other event that you left out or thought of since the assessment?", "Is there an event that you hope I don't ask about or doesn't come up in therapy?", or "Which event do you have the most nightmares about or most often pops into your head when you least expect it?"



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The reason for starting CPT with the most distressing traumatic event is that other events are likely to have the same Stuck Points attached to them, and if treatment starts with a lesser event, a client may have to begin again with the most difficult event, prolonging the therapy unnecessarily. Once clients learn that they can tolerate their emotions about the most distressing events, the other traumas can be dealt with during the course of therapy by completing Challenging Questions Worksheets and listing any unique Stuck Points on the Stuck Point Log.

Once the index trauma has been determined, the therapist asks the client to give a brief description (no more than 5 minutes long) of the trauma, if this was not done during the pretreatment assessment. The purpose for this short description is for the therapist to hear a few facts about what happened, in order to start generating a plan for how to guide the therapy. It is important that this description not become a detailed description with lots of emotion. At this point in therapy, clients occasionally have an urge to speak about the trauma, but if they become too emotional, they may well flee from therapy and may assume that their therapists are judging them as they have been judging themselves. At this early point in the therapy, they have no reason to trust that their therapists will be supportive, and no sense that there may be other ways to look at their traumatic event than how they have been viewing the events since they happened. If a client starts to get too detailed, a therapist can help keep the session on course by asking questions, moving the client on to describe the next part of the event, and asking how it ended. However, we have found that most clients do give brief versions of their events, because they have likely developed short, emotionless versions for public consumption.

DESCRIBING THE THERAPY

A therapist should now give a brief overview of the therapy course. If the therapist and client have not agreed before the first session on whether to do CPT+A or CPT, this is the time to decide. Some people like to write, but other people would quit therapy if they had to do so. This issue is discussed at greater length in Chapter 6. If clients can choose the version of therapy they want to do, they will be more empowered and more likely to engage in the treatment. The only instances in which therapists may recommend the addition of written accounts are (1) when clients are highly dissociative, and thus would benefit from writing the accounts to put events back into proper order with a beginning, middle, and end and to stay more engaged with their trauma memories; or (2) when clients are particularly emotionally numb, because sometimes the written accounts can elicit natural emotions that talking



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about the traumatic events cannot. If clients are extremely emotional, or have severe comorbid mental illness and are at risk of decompensation, it would probably be better to do CPT, which helps with affect regulation through the activation of the PFC and speech areas of the brain, and corresponding inhibition of the amygdala. Writing the accounts, with the associated imagery and emotions, may be unnecessarily distressing for these latter clients and as reviewed in Chapter 2, do not add to the outcomes of therapy.

The brief overview of the therapy can be as simple as saying something like this:

“As with every skill we learn, practice is necessary. And, as with most new things you learn, the more you put into something, the more you will get out of it. These facts may seem in stark contrast to your desire to avoid thinking about or talking about your traumas, and to escape feeling the emotions that emerge when you do. However, what you have been doing—avoiding—has not been working for you, as we have determined. Therefore, this treatment is going to be asking you to take the opposite stance, and approach dealing with the traumas. CPT will do this by teaching you new skills a step at a time, to help you look at your thoughts, tell the difference between a fact and a thought, ask yourself questions about the thought, and decide how you feel when you think it. You will be given handouts that will help you put your thoughts down on paper, and will show you new skills to question the facts surrounding your trauma and to determine how you might think about it differently. Ultimately, you may come up with different, more effective ways to think about the trauma and its effects, and you will notice a change in your emotions.

“We are going to spend the first half of this therapy focusing on the trauma or traumas themselves and determining what you have been saying to yourself. Together, we will ask questions to help you figure out what the facts were in that situation and whether your conclusions about them are accurate. If they are not, then we will work to find more factual statements you can learn to think. People can change their minds, and if you have been thinking the same things ever since the trauma happened without really reconsidering them, these thoughts might have become habits that could use a bit of exploration. We will use a series of informational handouts and worksheets to help you learn some skills for examining your thoughts that you were never taught in school. If you are thinking in certain ways that have become habits, it could take some practice to change your mind and make the new, more factual ways of thinking into new habits. The handouts and worksheets will help you do this. In fact, we are going to keep a list of these kinds of thoughts



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that have interfered with your recovery on a log, which we call the Stuck Point Log. A Stuck Point is a thought that you probably formed during or shortly after the trauma about why the trauma happened or what it means about yourself, others, and the world. It serves to keep you stuck in place and stops your recovery and growth. These Stuck Points will be examined throughout therapy, and you will learn new ways of dealing with them by using the Stuck Point Log and the other worksheets.

“Because your PTSD is out in your life and not only in this room, it is important that you practice these new skills with the worksheets every day, where they will do the most good. There are 168 hours in a week, and if you practice the new way of thinking only in 1 or 2 hours of therapy each week and the old way the other 166 or 167 hours, you will make little progress.

“Toward the end of the therapy, we will touch base on some specific themes of thoughts that are often affected by traumatic events: safety, trust, power/control, esteem, and intimacy. I mentioned these themes earlier, and each theme may relate to yourself or others. You will be given handouts to help you think about whether you have changed your beliefs too much as a result of the trauma(s) and haven’t considered all the exceptions to these negative beliefs in your life.”

GIVING THE FIRST PRACTICE ASSIGNMENT

In order to start to understand how the index trauma has affected a client’s thinking, the therapist asks the client to complete the first practice assignment, called an Impact Statement (see [Handout 7.3](#)). The Impact Statement consists of a short (typically one-page) essay describing the *reasons* why clients currently believe the traumatic event happened, and the *consequences* of the trauma in terms of their beliefs about themselves, others, and the world. In determining the effects of the trauma on their thinking, clients are encouraged to consider each of the themes (see above and Chapter 1) with regard to themselves and others.

Therapists should not only describe the assignment and give it to clients in writing; they should also encourage clients to start on it as soon as possible, to add to it over the days until the next session, and not to avoid it. The therapist may need to problem-solve when and where they can do their practice assignments if they don’t have much privacy. Clients should be reminded that they are not being asked to write about *what* happened, but what they think about *why* it happened and *how* it has affected their thinking and behavior. This may be the first chance that a therapist has to ask a client some clarifying questions. If the client expresses apprehension about



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writing at all, or about writing about the meaning of the event (e.g., “I’m afraid you will judge me and throw me out of therapy,” or “I might feel too many emotions and become overwhelmed”), the therapist can label these as Stuck Points and ask a few questions. Here are some examples of such questions:

“So you are wondering if I think just like you? ... In CPT we call that ‘mind reading.’ Why don’t you ask me under what conditions I would throw you out of therapy?”

“What happens when you feel emotions? ... And then what happens? ... And then what happens?”

“What are too many emotions? Have you ever seen anybody whose emotions never stopped?”

“What emotions are you likely to feel if you think about what the event means to you?”

“What could you do so that you don’t feel overwhelmed?” “What could you do if you feel overwhelmed?”

It is important for the therapist to stay calm and reassuring but firm that the client can do the assignment. For example, the therapist can say:

“I wouldn’t have suggested this therapy if I didn’t think you could handle it. In talking with you and doing the assessment, I can see that you have the ability to benefit from CPT. In fact, once you get over the hump of the first few sessions, you may enjoy it.”

A common therapist error is to scare clients by saying that they may get worse before they get better, or by overemphasizing how much work they have to do. Many clients, especially in CPT, have an immediate decrease in symptoms. Those who do have an increase in nightmares or flashbacks at the beginning of treatment may do so because they are not avoiding for the first time. Therapists can actually help such clients notice that this is a good start and that the flashbacks and nightmares will decrease over time. An increase in PCL-5 scores by a few points is not clinically significant.

Therapists can also remind clients that most of the out-of-session therapy assignments do not take a lot of time and are geared to helping them to take over as their own therapists by the end of treatment with a new set of skills. Moreover, therapists can remind clients that they have been having memories of their traumatic events for a long time, and that the goal of CPT is to relieve them of the pain of those intrusive memories and find a satisfactory way to accept what happened without all of the symptoms of PTSD.



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CHECKING THE CLIENT'S REACTIONS TO THE SESSION

A therapist should end Session 1 by asking about a client's reactions to the session and answering any questions the client may have about the session content or the practice assignment. Normalizing any negative emotions and praising the client for taking this important step toward recovery are both essential. The therapist should remind the client that he or she may have the urge to avoid both doing the practice assignment and coming to the next session, but that both are important for the recovery process.



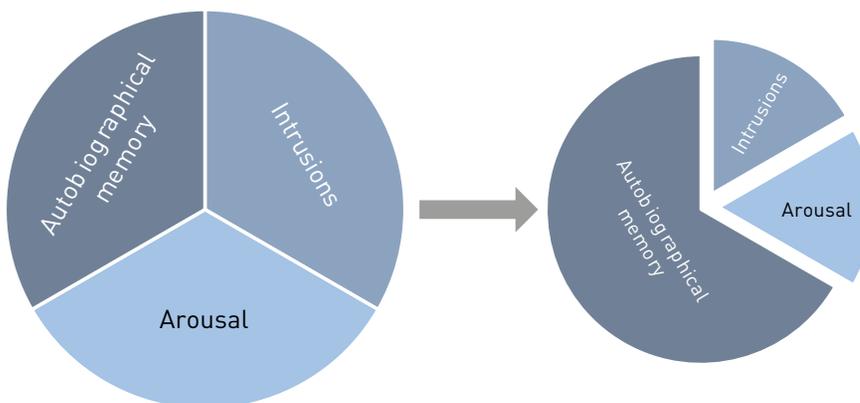
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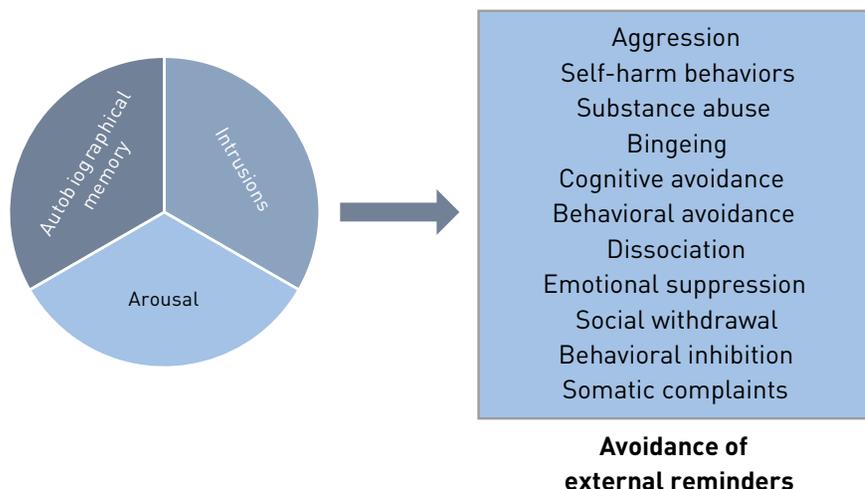
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Handout 7.1 • Recovery or Nonrecovery from PTSD Symptoms Following Traumatic Events

In normal recovery, intrusions and emotions decrease over time and no longer trigger each other.



When intrusions occur, natural emotions and arousal run their course and thoughts have a chance to be examined and corrected. It is an active “approach” process of dealing with the event.



However, in those who don't recover, strong negative emotions lead to escape and avoidance. The avoidance prevents the processing of the trauma that is needed for recovery, and it works only temporarily.

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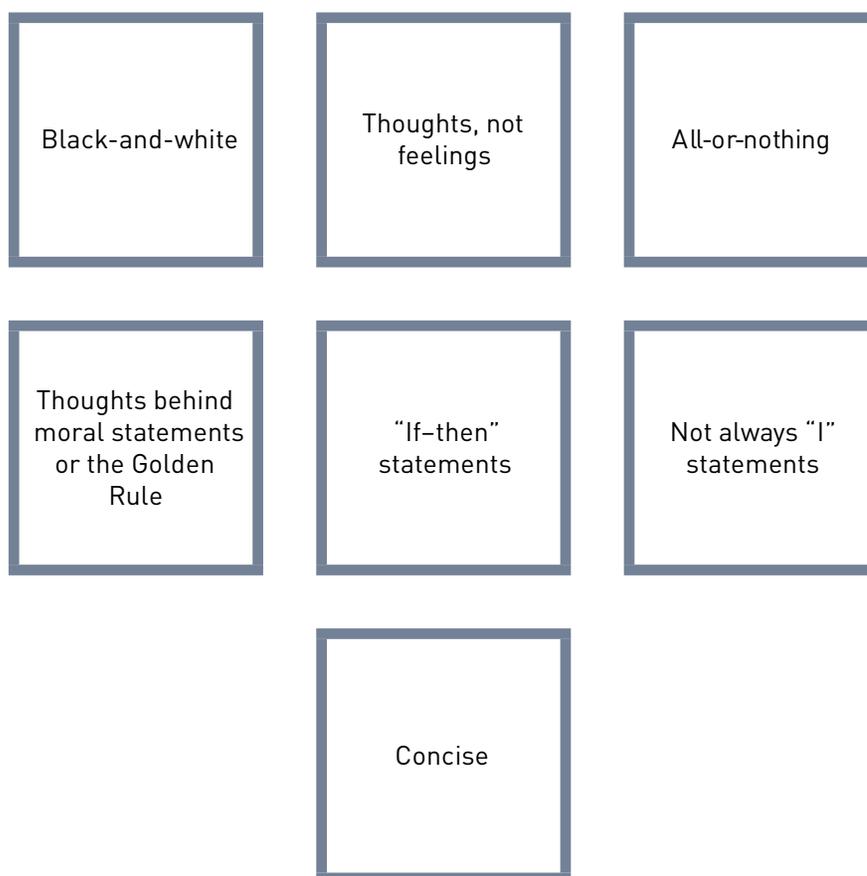
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Handout 7.2 • What Are Stuck Points?

Stuck Points are:



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Handout 7.3 • Practice Assignment after Session 1 of CPT

Date: _____ Client: _____

Please write at least a one-page statement on *why* you think your most distressing traumatic event occurred. You are *not* being asked to write specific details about this event. Write about what you have been thinking about the *cause* of this event.

Also, consider the effects this traumatic event has had on your beliefs about yourself, others, and the world in the following areas: safety, trust, power/control, esteem, and intimacy.

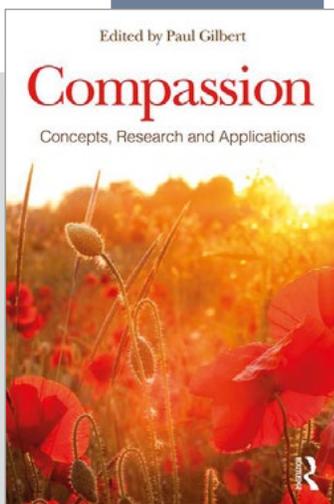
Bring this statement with you to the next session. Also, please read over the two handouts I have given you on PTSD symptoms and Stuck Points (**Handouts 7.1** and **7.2**), so that you understand the ideas we are talking about.

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CHAPTER

8

THE EMERGENCE OF THE COMPASSION FOCUSED THERAPIES



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Compassion

By James N. Kirby and Paul Gilbert

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THE EMERGENCE OF THE COMPASSION FOCUSED THERAPIES

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WHERE FROM AND WHERE TO?

Two and a half thousand years ago, an Indian Prince, Siddhartha, had been closeted in a golden palace by his father, with all the pleasures on hand to protect him from the realities of suffering outside the palace walls. One day, dissatisfied with this limited life, Siddhartha persuaded a servant to sneak him outside the palace. To his shock he encountered disease, ageing and death for the first time (what is traditionally called the 'four messengers', the fourth being a meeting with a holy man who was seeking answers to suffering and set Siddhartha on the path to enlightenment). For most of us these fearful discoveries would have sent us back to the wine, sex and songs, but he was so taken by the suffering all around him, and aware this was his destiny too, that he became preoccupied with the nature of human suffering and was determined to find a solution for the human condition (Leighton, 2003; Vessantara, 1993). On his quest he encountered many philosophies, insights, yoga and contemplative practices to address suffering, eventually arriving at the famous Bodhi tree. For many hours, if not days, he sat quietly observing the rising and falling of his own, different mental phenomena. From this deep, personal experience he became aware that our minds can be filled with conflicting and difficult motives and passions – ones of not-wanting (aversions) and wanting (grasping after what is impermanent). Emotions and passions bounce us about like corks on a restless sea, causing suffering to ourselves and others as they control our preoccupations and actions. Sitting in silent but intense observation, he realised it was possible to focus on his own *observing knowing consciousness* itself, observing its arising and falling, to become mindful. He made a very clear distinction between the experience of observing (consciousness of consciousness; the awareness of awareness) and the mind's content – the 'what' is observed. Moving attention increasingly into the observer position creates mindful wisdom, discernment and insight, not only into the contents of mind (created by our biological forms) but also the subtleties of mind and consciousness. He recognised that without mindful clarity and insight we are easily taken over by whatever motives and passions happen to be stimulated within us (Vessantara, 1993). Mindfulness opens the potential for a 'mindful brake' on the link of feeling into action. Without this we can be non-mindful actors for the archetypal dramas of life, acting out their scripts.

His solution was twofold. First, train the conscious, deliberate, observational competencies of mind, cultivating sharp awareness of our mind's contents as they arise, so that we can become mindful rather than 'mindless' in our thoughts and actions. The practices of mind-settling mindfulness also give insight into the subtle



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levels of mind and ultimately allow us to see into the illusions of the separate self, the snowflake that mistakes its individual separateness until it hits the sea. The Buddha's second solution was *motivation training*; of all the motives, passions and desires in us, the one that can offset grasping, greed and aversion, and balance the mind and bring true calmness and transformation is the motive of *compassion* – the desire to see all beings free of suffering and the causes of suffering – and then work for that outcome (Ricard, 2015). So the contents of mind can be given a focus. Mindfulness can bring stability to mind and compassion transforms it, freeing us from egoistic pursuits (Dalai Lama & Ekman, 2009; Germer & Siegel, 2012; see Germer & Barhofer, Chapter 4, this volume).

Over 2,000 years later Freud's observations, from encouraging free association in his patients, and analysing his own thoughts and dreams, married with the then rise of Darwinian thinking, generated similar insights (Ellenberger, 1970). Freud recognised, as had Siddhartha, that our minds are beset by complex and conflicting desires and passions, especially in the domains of yearnings, sex and violence. Unlike Siddhartha however, he argued that many of the darker sides of our minds are kept hidden by processes of defence (e.g. repression, denial, dissociation, sublimation) that can serve useful purposes but also make us vulnerable to mental distress. His solutions were quite different to Siddhartha's. He argued for the need to bring these conflicts into consciousness and resolve them, not via mindfulness or cultivating compassion (indeed, he viewed compassion with suspicion) but via therapist-guided free association. Indeed, both Freud and Jung argued that simply allowing unconscious contents to emerge without guidance or a therapeutic relationship could be dangerous for some people (Clark, 1994; Jung, 1984; see Farias & Wikholm, 2015). So for Siddhartha, without concepts of evolved motives and emotions, unconscious processes and defence mechanisms, the problem was a lack of insight-awareness of the nature of mind, for which training in 'observing the mind' was part of the solution. Today we can make a distinction between how to pay attention moment by moment, *mindfulness* in contrast to *mind awareness* which arises from scientific study of mind, various psychotherapies, and everyday interactions with people who provide feedback to us.

As the years unfolded an increasing varied *mélange* of therapies for mind awareness, insight and change emerged – some seeing the mind as 'meaning seeking', especially around the existential life issues of loneliness, freedom, meaning and death (Yalom, 1980). Others moved from Freud's focus on (thwarted) drives to a focus on interpersonal psychodynamic processes (Greenberg & Mitchell, 1983), and the



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role of attachment (Bowlby, 1960, 1973, 1980; Holmes, 2001). Gestalt and emotion focused therapists concentrated on emotion processing (Greenberg & Safran, 1987). Others, such as George Kelly (1963), saw the human mind like a scientist constantly generating and testing theories about the world and developing 'personal constructs'. Albert Ellis (Ellis, 1962) and Aaron Beck (1985), both trained psychoanalysts, made a different set of observations. It is not unconscious conflicts, a lack of mindful insight/enlightenment, compassion, or existential struggles that cause us problems, but the conscious interpretations we make, and beliefs we hold. Their focus was on the processes of reasoning, 'stream of conscious thinking', automatic thoughts, beliefs and interpretations as responsible for mental distress and harmful behaviour. One could therefore intervene on these directly and *alter their content*; central to this was evidence testing. With the innovations of computers, our minds became described as information-processing systems, with feedback and feed-forward loops. Subsequently new therapies arose that focused on changing our relationship with our thoughts, rather than the contents, with increased body awareness noted particularly in mindfulness approaches, such as Acceptance Commitment Therapy and Dialectical Behaviour Therapy (Hayes, Follette, & Linehan, 2004).

The other major tradition, behaviourism, disavowed the internal world altogether, exploring instead the contingencies of behaviour. Both classical and operant conditioning approaches were interested in how animals adapt to their environments in order to better survive and exploit them, and, especially for classical conditioning, are physiologically changed in the process of adapting. We now know that adapting to environments can even influence the expression of genes (see Conway & Slavich, Chapter 9, this volume). The way our physiologies are changed via associative learning, especially classical conditioning, is now central to many therapies, especially body-based therapies (e.g. Van der Kolk, 2015) and Compassion Focused Therapy (CFT). What's also important is the social context in which classical conditioning takes place, for example, whether we experience fear in the context of aloneness or in the context of receiving soothing support and care it is easier to face things we are frightened of whom we feel supported by others than when we feel completely alone. For example, when veterans return from combat situations they are conditioned to be sensitive to the presence of their 'buddies' as safeness signals and when they are not present (as in the home environment) this can create feelings of disconnection and vulnerability.



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THE MEDICAL MODEL

Many Western psychotherapies are also located within medical approaches to mind (Gilbert, 1995). These convey the idea that there is nothing fundamentally wrong with our mind as designed (i.e. nothing inherently bad or tricky about its evolved construction) and it is only 'when things go wrong' that we have a mental 'disorder', requiring therapies 'to correct' and 'fix' (Brune et al., 2012). So the therapies tended to cluster around 'disorders' of anxiety, depression and paranoia; with thoughts being 'distorted' and attitudes and behaviours being 'dysfunctional'. Whereas the Buddha highlighted that our *normal unenlightened* states were problematic – that the mind is, in a way, inherently crazy (Vessantara 1993), especially if it lacks compassion (Dalai Lama, 1995), the medical model took a different view, and psychotherapy to some degree followed this, particularly with the rise of DSM classifications and empirically supported treatments (Gilbert, 1995).

Evolution approaches to both physical and mental health problems have been critical of the medical model for failing to understand the difference between genuine pathology, reactions and evolved adaptations of innate strategies (Brune et al., 2012; Gilbert 1998a; Nesse & Ellsworth, 2009; Nesse & Williams, 1995). Indeed, we have known for a long time that in certain social contexts humans are naturally and easily prone to irrationalities, riddled with conscious and unconscious conflicts, tribal violence, nepotism and mental health problems (Buss, 2014; Gilbert, 1989/2016, 2009; Nesse & Williams, 1995). We are now beginning to understand why, and as we better understand why we can better understand 'how' to change things.

Today psychotherapy stands at an important developmental point. Before medicine understood the sophisticated physiology of how the heart works or how cells become cancerous, it relied on observations and engaging in 'trial and error' interventions. But as the scientific understanding of basic physiological systems improved, so did our capacity to develop improved interventions that target specific physiological processes. Psychotherapy is beginning to grapple with our better understanding of how humans evolved as biological, gene-built systems that (phenotypically) adapt to their environments and operate a range of evolved strategic and motivation- and emotion-processing systems (Barash, 2013; Conway & Slavich, Chapter 9, this volume; Gilbert, Chapter 3, this volume; Narvaez, Chapter 10, this volume). We recognise that as an evolved species (Siddhartha did not know this) many of our basic motives and emotions, and their genetic polymorphisms, are products of the challenges of survival and reproduction (Conway & Slavich, Chapter 9, this volume). This has important implications not only for our understanding of mental health



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difficulties but for their prevention and alleviation. It also warns us that assumptions like ‘*all is well until something goes wrong*’ are unhelpful, misleading and basically often wrong (Brune et al., 2012; Gilbert, 1998a; Nesse & Williams, 1995). Crucial too is that we’re moving away from the idea of humans as ‘autonomous minds’ to ones of ‘information flow’ and mutual influence (see Gilbert, Chapter 3, this volume; Frederickson & Siegel, Chapter 12, this volume; Siegel, 2016).

Rooting ourselves in our evolved minds, **Table 8.1** provides a few basic building blocks showing some of its problematic trade-offs and glitches (Gilbert, 1998a). Establishing the origins of how our brains have evolved can help us identify and focus on core evolutionary archetypal themes and motives, such as status, attachment, sense of belonging and connectedness, fears of rejection and shame. These are important for humans because of our evolved history and how the brain evolved to be choreographed.

Viewing mental distress through an evolutionary lens, particularly the evolution of social connectedness, mutual influence and our social intelligences, supports many of the basic tools of psychotherapy, such as the importance of the therapeutic relationship, the value of guided discovery and reflection and behavioural (exposure) practices which will remain the bedrock of therapeutic interventions. However, new models of how to facilitate change are also working out how to change neurophysiological pathways directly due to neurogenesis and neuroplasticity (Klimecki, Leiberg, Ricard, & Singer, 2013) and epigenetics (Conway & Slavich, Chapter 9 this volume; Fredrickson et al., 2013). We are moving towards a kind of ‘psycho-physiotherapy’. These approaches themselves, however, are contextualised in greater appreciation of the sociality of our species, and that our neuroplasticity and phenotypic variations are especially sensitive to social relationships, and are the cornerstone for understanding mental distress and its healing. It has been the research highlighting how prosocial, caring, supportive, helpful, altruistic and compassionate behaviour, both given and received (explored in the chapters of this book), impacts on such a wide range of physiological and psychological processes, that underpins CFT (Gilbert, 2000, 2009, 2014). So there is growing awareness of the importance of understanding how and why recruiting and cultivating evolved, care-focused motivational systems and affiliative emotions need to become central to the therapeutic process (Gilbert, 2000, 2014, 1989/2016; Chapter 3, this volume). Tibetan Buddhism has always placed the cultivation of compassion (Bodhicitta) central to the integration and organisation of mind, but science is beginning to show how and why this is so important (see Gilbert, Chapter 3, this volume). Indeed, much of this book,



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especially Part II, is dedicated to exploring how powerful compassion-focused social mentalities are in actually organising, choreographing and patterning the brain and body – even at the genetic level (see also Seppala & Doty, in press).

Table 8.1 • Evolution informed psychotherapy in CFT

	Description	Implications	Therapy
1. Human brain as an evolved organ	<ul style="list-style-type: none"> Like all living beings we are part of the flow of life. We have a human brain we did not design, but evolved through millions of years of evolution, which has inbuilt emotion and motivational systems. 	<ul style="list-style-type: none"> Our evolved brains' primary motivations are to survive and reproduce. Our brains have inbuilt motives and motive conflicts: <ul style="list-style-type: none"> ◇ Harm avoidance, food, sex, competitive, caring, status Motives organise our minds: <ul style="list-style-type: none"> ◇ Attention, thinking, behaviour, imagery, emotion, sensory. 	<ul style="list-style-type: none"> As therapists, with the help of our clients, we aim to discover how our clients are primarily motivated to be in the world, and how that changes/shifts in different social contexts (e.g. work, family, friends, romantic partner). <ul style="list-style-type: none"> ◇ For example, guided discovery, Socratic questioning. Over the course of therapy the therapist then focuses on exploring how particular motives impact and organise our minds.
2. Brain capacities	<ul style="list-style-type: none"> As a result of evolution, our brain has; 'trade-offs', constraints and many built-in biases. Old Brain Functions are focused on survival and reproduction. New Brain Functions, especially those supporting social intelligence (see Gilbert, Chapter 3, this volume), are focused on awareness and meta-awareness. 	<ul style="list-style-type: none"> Old Brain Functions: <ul style="list-style-type: none"> ◇ Motives: harm avoidance, food, sex, caring, status. ◇ Emotions: anger, anxiety, sadness, joy. ◇ Behaviours: fight, flight, shut down, courting, caring. New Brain Functions and competencies: <ul style="list-style-type: none"> ◇ Language/symbols, self-monitoring/awareness, self-criticism, imagination, planning, rumination, worry, shame, integration. We get caught in 'old brain–new brain' loops. <ul style="list-style-type: none"> ◇ We have the new capacity of thinking, but run on 'old' psychological systems, whereby external 'threat' stimulus is brought inside our minds (e.g., imagination, rumination, worry, self-blame). 	<ul style="list-style-type: none"> Psychodynamic and Jungian therapies focused on old-brain capacities (e.g. motives and archetypes, sex, aggression). Cognitive therapies focused on new-brain capacities (e.g. automatic thoughts, reasoning). As therapists we can focus on both, as in reality it is a two-way street, where we can attend to the interaction between old brain–new brain processing loops. <ul style="list-style-type: none"> ◇ For example, this could be demonstrated with the analogy of the 'Zebra in the Savannah'. If the Zebra senses a predator it will run away for safety (better safe than sorry), then go back to eating. Put a human brain in the Zebra, despite being safe, thoughts will continue such as "suppose I get caught tomorrow, dying would be terrifying!" Thus, external threat stimulus taken into the mind, and continues physiological threat response in the body, an 'old brain–new brain' loop. Therapists then focus on developing a case formulation of the client based on Evolutionary Functional Analysis (EFA, see Gilbert, 2014; Chapter 3, this volume).
3. Brain/mind shaped by social contexts	<ul style="list-style-type: none"> A genetic lottery for how our brains are built. The environments in which we grow and the parenting we receive influence our genetic expression and our developing phenotypes. Phenotypes are the expressed or manifest traits/outputs that are observable or measurable (e.g., styles of language or attachment). 	<ul style="list-style-type: none"> Born with a pre-determined set of genes we have inherited from parents. Epigenetics and the process of methylation influences genetic expression. Stressful environments, in contrast to safe and predictable environments, turn genes on and off in different ways as the child is developing his/her phenotypes that prepare them for the environmental niche in which s/he is growing. We are socially shaped, from gene expressions to our sense of self and values. 	<ul style="list-style-type: none"> This permits a de-shaming for our clients, as so much of what has happened to them is not of their choosing, and is not their fault. <ul style="list-style-type: none"> ◇ For example, ask yourself, "Would you be the same person if you had been kidnapped as a three-day old baby and raised by the Mafia?" Focus of therapy becomes what version of ourselves have we become and in what contexts, and what versions of ourselves are possible that we wish to cultivate (e.g., compassionate self, angry self, anxious self; for more see Gilbert, 2010, 2014).



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Table 8.1 • Evolution informed psychotherapy in CFT (continued)

	<i>Description</i>	<i>Implications</i>	<i>Therapy</i>
4. Brain and biases	<ul style="list-style-type: none"> • We have biases that shape how we see the world. 	<ul style="list-style-type: none"> • Biased learning (e.g., fear of snakes but not electricity). • Self-focused (grasping and aversion). • Kin preferences (nepotism). • In-group preferences (tribalism). • Negativity (better safe than sorry) bias. 	<ul style="list-style-type: none"> • These biases can lead to inner (mental anguish, such as self-criticism) and outer conflicts (interpersonal), which can lead humans to engage in great cruelty, bringing suffering to ourselves and to others (both mentally and physically). • Therapists can explore with their clients how these biases were not 'chosen' by them, and how they operate in their daily life, which informs the ongoing EFA for the client, then how to counteract them with different forms of compassion focusing. <ul style="list-style-type: none"> ◇ To indicate threat, therapists could provide clients the example of the 'Christmas Shopper'. The person who goes into 10 shops, in 9 of which he/she is greeted in a friendly and helpful manner, but in the 10th shop he/she is greeted by a rude and unhelpful shop assistant. When the Christmas Shopper gets home, what does he/she tell their partner about? The negative experience: an example of negativity bias.
5. Brain and caring motivation	<ul style="list-style-type: none"> • Parental investment (care for offspring – supporting allies). • Distress Signal/Distress Response. • Humans mammals evolved for forming (and needing) attachment and social lives 	<ul style="list-style-type: none"> • Humans are have few offspring, cared for many years. Parental care involves moving towards distress signals from young to soothe and calm (emotion regulation for child), and this forms attachments. • Attachment system: <ul style="list-style-type: none"> ◇ Proximity seeking – desire closeness. ◇ Secure base – source of security and guidance to explore. ◇ Safe haven – source of comfort and emotion regulation. ◇ Later in life, close friends and partners take on these roles and suffering can arise if they don't. 	<ul style="list-style-type: none"> • The therapist aims to create an internalised, secure base and safe haven for the client by activating the compassionate self as an organising process and focus for self-identity. • The therapist also acts as a model for compassion to the client in therapy, and seeks to create a secure base and safe haven enabling clients the opportunities to explore difficult memories, situations, thoughts, emotions in a therapeutic context of safeness. <ul style="list-style-type: none"> • Understanding how the client has developed safety behavioural strategies is crucially important at this stage, which also informs the EFA. • Therapist makes the distinction between safety (threat focused/preventive) and safeness (open, explorative and growth focused) (see Gilbert, 2014).
6. Brain and affect system	<ul style="list-style-type: none"> • The brain has emotion regulation systems that impact how we interact with the world and ourselves. 	<ul style="list-style-type: none"> • Threat and self-protect system: <ul style="list-style-type: none"> ◇ Focus on protection and safety-seeking, it activates and inhibits. ◇ Emotions: anger, anxiety, disgust • Drive and achievement system: <ul style="list-style-type: none"> ◇ Incentive/resource focused, wanting, pursuing, achieving, activating. ◇ Emotions: drive, excite, vitality. • Affiliative/soothing system: <ul style="list-style-type: none"> ◇ Non-wanting, affiliative focused, safeness-kindness, soothing. ◇ Emotions: content, safe connected. 	<ul style="list-style-type: none"> • The therapist with the client explore how we can operate from various emotion systems, and how each system can impact how we view ourselves and interact with others. <ul style="list-style-type: none"> ◇ Process of psycho-education, guided discovery, Socratic questioning. • The information ascertained further informs ongoing EFA for client. • The therapist with the help of the client, aims to develop a balance between these affect systems.



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Most psychotherapies follow unfolding and progressive (not necessarily linear) stages. For example, assessment, developing a formulation and building a therapeutic relationship for collaborative work are central components. Beyond these common themes, different therapies will structure their tasks and goals around their models. One core feature that varies is psychoeducation. Different therapies have different psychoeducations. For example, behaviour therapists educate about contingencies of behaviour and how to change those with action; cognitive therapists teach the link between our appraisals and interpretations to feeling and behaviours; body-based therapies focus on postures and body awareness. Some therapists prefer hardly any psychoeducation, believing it should all be via direct experience. As an evolution-informed therapy, CFT focuses psychoeducation a lot on the fact that the human brain 'evolved' in a piecemeal fashion and is riddled with trade-offs, compromises and quite serious 'glitches', whilst also being inherently social, and socially needy (Gilbert, 1998a, 1998b); we call it 'tricky brain' (described in [Table 8.1](#)). Part of the reason for focusing on the problems nature has handed us, with how our brain evolved is not only to provide a framework for the work to be constructed, but also as a process of de-shaming (Gilbert, 2007, 2009, 2010). As people begin to see their human mind as riddled with complexities, conflicts and competencies – that they did not choose and often do not want, but which can be sources of suffering to themselves and others – they can begin to gradually depersonalise. We are all just 'one' of many possible versions (see [Table 8.1](#)). As this process unfolds individuals are able to recognise that at the core of what we want: food, love, sex and status, what we feel if we achieve them or do not achieve them (happy, or sad, anxious and angry) and what threatens us (physical harm and social harms), is an evolutionary setup, and that is not our fault! The senses and bodily functions we have, and the contents and preoccupations of our minds, emerge from gene-built physiological systems interacting with historically created social contexts, in relation with the bodies and minds of others created the same way.

This links us to some sense of common humanity; just like other people we are actors in the dramas of life's archetypal motivations; suffering is part of it (Vessantara, 1993). We differ from animals though, in that we have the potential to gain insight into this and begin to choose and cultivate versions of ourselves that are conducive to ours and other people's well-being; we have a range of complex social intelligences to help us (see Gilbert, Chapter 3, this volume). So we move from blaming (because we did not choose the genes that made us nor the contexts that



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shaped us) to taking responsibility for the inner patterns we want to cultivate and the person we want to become (Gilbert, 2009). Similarly, we begin to see others through the same lens, which gives us the courage and insight for forgiveness and letting go of anger that can block compassion (Worthington et al., 2005). We may come to recognise that some of our anger (rage), fear and sadness can be linked to parental figures and can become a focus in therapy (Gilbert, 2010). The emergence of these unprocessed emotions may be one reason why mindfulness by itself can be traumatic for some people without a therapeutic safe haven, containment and guidance. Siddhartha had no insight into the evolutionary dynamics at the heart of life and mind, but clearly his solution is in tune with them. So this psychoeducation process is about increasing not reducing responsibility taking, and this is more likely when we give up a blaming and shaming approach, and rather gain insight into how to cultivate coping with suffering and what is conducive to well-being for us and others.

Clients become able to recognise that we are all particular versions of multiple potentials (phenotypes), the vast majority of which we will never know or live out. As **Table 8.1** describes in point three, if we had been kidnapped as three-day-old babies into violent drug gangs then this current 'version' of ourselves would not exist, and even our genetic expression would be different – we are socially created versions of phenotypes (Conway & Slavich, Chapter 9, this volume). We are also made up of multiple potentials of motives and emotions, each with its own view of the world, talents and priorities (e.g. angry self, anxious self, joyful self, competitive self; Gilbert, 2014; Ornstein, 1986). These patterns arise moment by moment according to how our current physiological states interact with social contexts – for good and bad (see Narvaez, Chapter 10; Zimbardo, 2006). So it is an important realisation that we all have *very tricky brains* for which schools and society ill-prepares us to understand or train. Nothing has necessarily gone wrong for people who suffer or who harm others – rather it can be the mind 'naturally' reacting to the context in which it is operating.

Another stage of the compassion focused therapies is rooted in the understanding of what brings out well-being and the best in us; that is to say, if the natural state of the human condition is not necessarily a happy or healthy one, what can we do to advance that? (Dalai Lama, 1995). In addition to more than 2,500 years of the contemplative and spiritual traditions emphasising compassion for self and others as the path to happiness, wisdom and growth, scientific studies over the last 20 or 30 years have revealed much about human needs and optimal functioning (Singer & Bolz, 2012). As many chapters in this book and others (Seppala & Doty, in press) indicate, there is now considerable evidence that the mammalian reproductive



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strategies, to have small numbers and high investment, 'to care for the kids' and support friends and allies (Gilbert 1989/2016; MacLean, 1985; Mayselless, 2016; Narvaez, Chapter 10, this volume), along with other forms of conspecific caring, had a major impact on the evolution of our ancestral bodies and brains (Dunbar, 2010; Spikins, Chapter 2, this volume). 'Caring' gave rise to physiological systems being highly sensitive to distress signals, with oxytocin (Carter, 2014; Colonnello, Petrocchi & Henrichs, Chapter 6, this volume) and changes in the autonomic system, such as the vagal system, playing major roles (Mascaro & Raison, Chapter 5, this volume; Porges, 2007; Stellar & Keltner, Chapter 7, this volume) in brain development (Vrtička, Favre & Singer, Chapter 8, this volume). In a study conducted by Mascaro, Rilling, Negi, and Raison (2013), in comparison with a control group, Cognitively Based Compassion Training was associated with increased theory of mind, mentalising and motivation. As an indicator of the interconnected importance of the flow of compassion (see Gilbert, Chapter 3, this volume), Hermanto et al. (2016) found that, in a sample of 701 participants, the ability to receive compassion buffered the effects of self-criticism on depression.

FORMS OF COMPASSION FOCUSED INTERVENTIONS

With the rise of an awareness of the power of prosocial, compassionate interactions for well-being, and how their opposite (criticism and neglect) is linked to mental distress, there has been a growth of different approaches to help people cultivate compassion for themselves and others. They differ in various ways, however. For example, CFT distinguishes between therapy and compassionate mind training. Therapy aspects include formulation, the therapeutic relationship and the skills of moment-by-moment therapeutic engagement. Compassionate mind training is the provision of a series of practices to cultivate core qualities of compassion. Many of the newer approaches to cultivating compassion are primarily compassionate mind trainings of various forms, rather than therapies designed to train therapists conceptualise the therapeutic process and be used in therapeutic interactions and contexts with complex mental health problems as CFT was originally developed to do.

Different compassion approaches include Mindful Self-Compassion (MSC; Neff & Germer, 2013); Compassion Cultivation Training (CCT; Jazaieri et al., 2013); Cognitively Based Compassion Training (CBCT; Pace et al., 2009); Cultivating Emotional Balance (CEB; Kemeny et al., 2012); Compassion and Loving-Kindness Meditations (e.g. CM & LKM; Hoffmann, Grossman, & Hinton, 2011) and Compassion-Focused Therapy (CFT; Gilbert, 2000, 2007, 2014; Kirby, 2016).



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Table 8.2 • Common and specific features of compassion-based trainings and therapy

Common features

- Designed to be secular in approach, utilising Western psychology science and therapies but also informed, to greater or lesser degrees, by contemplative traditions.
- Define what compassion is, with each intervention having a different definition.
- Attention and Mindfulness-based training components.
- Compassion focused visualisations and meditation practices.
- Some form of psychoeducation where rationale provided for intervention.
- Active experiential components.
- Focus on intention or values.
- Homework exercises and regular practice.

Specific features

CFT	MSC	CBCT	CCT	CEB
<ul style="list-style-type: none"> • Compassion definition includes two psychologies, (1) engagement and (2), alleviation and prevention, each with six trainable competencies. • Psychoeducation of evolved 'tricky mind' due to 'old' and 'new' brain interactions. • Evolved function of emotions of threat/protection, drive/ acquisition and soothing/contentment, and the links to (neuro) physiological processes and emotional balance. • The concept of multiple (phenotypic) versions of self arising from gene and social context – focus on cultivating phenotypes for de-shaming, de-personalising and building compassionate intentions. • Breath and posture training creating a friendly tone in one's thinking and thoughts; stimulate vagal tone. • Cultivating compassion for others, open to compassion from others and self-compassion. • Developing compassionate imagery and sense of self using acting techniques of becoming and then 'acting from' constructed self-role. 	<ul style="list-style-type: none"> • Based primarily on Neff's conceptualisation of self-compassion using bipolar constructs of: (1) kindness v. self-judgement; (2) common humanity v. isolation; (3) mindfulness v. over-identifying. • Informed by various approaches including self-experiences of life difficulties, Insight Meditation, CFT and other mindfulness-based interventions such as MSBR. • Inclusion of the self-compassion break exercise, based on self-compassion definition. • Breaks meditations into core, other and informal practices. • Focus on savouring and positive psychology. • Includes letter-writing. • Working with backdraft problems with compassion blocks. 	<ul style="list-style-type: none"> • Based primarily on Buddhist lojong tradition. • Examines compassion as aspirational and active. • Focus on four immeasurables: equanimity, loving-kindness, appreciative joy and compassion. • Teaches active contemplation of loving-kindness, empathy and compassion towards loved ones, strangers, and enemies. • Integrates cognitive interventions 	<ul style="list-style-type: none"> • Based on definition of compassion by Jinpa involving four constructs: cognitive, affective, intentional and motivation. • Begin and end each session with a meditation practice, which includes breath focus meditation. • Inclusion of tong-len. • Primary focus is on meditative practices to cultivate compassion and loving-kindness towards self and others. 	<ul style="list-style-type: none"> • Compassion more focused on others as a prosociality. • Concentration and directive practice meditations. • Recognising emotions. • Understanding emotional patterns. • Recognising emotions in others (face, verbal) as a way to promote empathy • Yoga and movement practices. • Knowledge of functions, sensations, triggers, appraisals and cognitions associated with affective states.

(continued)



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Table 8.2 • Common and specific features of compassion-based trainings and therapy (continued)

Specific features

<i>CFT</i>	<i>MSC</i>	<i>CBCT</i>	<i>CCT</i>	<i>CEB</i>
<ul style="list-style-type: none"> • Developing and using the compassionate mind to address difficulties such as shame, self-criticism and relational conflicts (Figure 8.1). • Developing the 12 competencies of compassion. • Compassion-focused letter- writing and flash card exercises. • Expecting and addressing fears, blocks and resistances to positive and affiliative emotions and the three orientations of compassion. <p>• Therapy approach:</p> <ol style="list-style-type: none"> 1. Individualised and group interventions based on client's presentation and case conceptualisation. 2. Various (clinical and non- clinical) compassionate Mind Training programmes under development including an eight-week intervention, one being piloted. 	<p>• Training program components:</p> <ol style="list-style-type: none"> 1. Introduction and review of self-compassion. 2. Mindfulness training. 3. Application of self-compassion to daily life. 4. Developing a compassionate inner voice. 5. Living in accordance with values. 6. Dealing with difficult emotions. 7. Dealing with challenging interpersonal relationships. 8. Relating to positive aspects of oneself and one's life with appreciation. 9. A mid-program, four- hour retreat often included. 	<p>• Follows eight steps:</p> <ol style="list-style-type: none"> 1. Developing attention and stability of Mind. 2. The nature of mental experience. 3. Developing self-compassion. 4. Developing equanimity for others. 5. Developing appreciation and gratitude for others. 6. Developing affection and empathy. 7. Realising, wishing and aspirational compassion. 8. Realising Active Compassion for Others. 	<p>• Follows six steps:</p> <ol style="list-style-type: none"> 1. Settling and focusing the mind. 2. Loving-kindness and compassion for a loved one. 3a. Compassion for self. 3b. Loving-kindness for oneself. 4. Embracing shared common humanity and developing appreciate of others. 5. Cultivating compassion for others. 6. Active compassion practice (tong-len) and integrated daily compassion cultivation practice. 	<p>• Training program components:</p> <ol style="list-style-type: none"> 1. Concentration training. 2. Mindfulness training. 3. Promotion of empathy and compassion. 4. Yoga and other movement practices. 5. Conceptual discussion including a focus on values, life meaning. 6. Knowledge of functions, sensations, triggers, automatic appraisals and cognitions associated with specific affective states (e.g. anger, fears). 7. Recognising one's own emotions. 8. Understanding one's own emotional patterns. 9. Recognising emotion in others (face, verbal) to promote empathy.
<p>Initial development</p> <ul style="list-style-type: none"> • Complex clinical problems of high shame and self- criticism. Clients being major contributors to development. 	<p>Initial development</p> <ul style="list-style-type: none"> • The general population who struggle with self- criticism. 	<p>Initial development</p> <ul style="list-style-type: none"> • University students and adolescents at risk to develop emotional resilience. 	<p>Initial development</p> <ul style="list-style-type: none"> • The general population to help with emotion regulation and cultivate compassion. 	<p>Initial development</p> <ul style="list-style-type: none"> • The general population to reduce destructive enactment of emotions and enhance prosocial responses.
<p>Source</p> <ul style="list-style-type: none"> • Gilbert, P. (2000, 2010, 2014). 	<p>Source</p> <ul style="list-style-type: none"> • Neff, K., & Germer, C. (2013). 	<p>Source</p> <ul style="list-style-type: none"> • Ozawa-de Silva, B., & Dodson-Lavelle, B. (2011). 	<p>Source</p> <ul style="list-style-type: none"> • Jazaieri, H. et al., (2014). 	<p>Source</p> <ul style="list-style-type: none"> • Kemeny, M. et al., (2012).

Hybrids are also constantly appearing, such as the mindful compassionate living course that combines CFT with more intense mindfulness training (Bartels-Velthuis et al., 2016; van der Brink & Koster, 2012) or the integration of CFT with therapies like Acceptance Commitment Therapy (Tirch, Schoendorfe, & Silberstein, 2015). We cannot review all of them but **Table 8.2** offers a brief description of some of the elements that are similar and different across some of these compassion-based approaches.

To date, there has only been one meta-analysis conducted on compassionbased interventions (Kirby, Tellegen, & Steindl, 2015), which included 23 randomised



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controlled trials (RCTs) over the last 10 years. Results found significant short-term moderate effect sizes for compassion ($d = 0.559$), selfcompassion ($d = 0.691$) and mindfulness ($d = 0.525$). Significant moderate effects were also found for reducing suffering-based outcomes of depression ($d = 0.656$) anxiety ($d = 0.547$), and small to moderate effects for psychological distress ($d = 0.374$). Significant moderate effects were also found for well-being ($d = 0.540$).

While such meta-analyses are important and useful, it is wise to keep in mind that they bring together models from different definitions of compassion, different theoretical underpinnings and different compassion practices (see Kirby, 2016 for a critique of the similarities and differences). To date CFT was developed for, and with, people with severe mental health problems. CFT has been helpful for individuals suffering from a range of difficulties including, but not limited to, psychotic disorders (Braehler et al., 2013), eating disorders (Kelly & Carter, 2015), personality disorders (Lucre & Corten, 2013) and traumatic brain injury (Ashworth, Gracey, & Gilbert, 2011). A recent systematic review of CFT, in a range of clinical settings and with different clinicians, showed good outcomes to support funding for further controlled randomised controlled trials (Leaviss & Uttley 2015). Although CFT was designed for clinical populations, the compassionate mind training practices that have been developed have been found to be helpful for non-clinical populations (McEwan & Gilbert, 2016), including producing changes in compassion and positive emotions, and at improving heart-rate variability (Matos et al., under review). Over time CFT and therapies and interventions will seek to develop the evidence base of the individual *ingredients* of their approach and build better interventions from evidence of specific ingredients or processes (Kirby, 2016).

COMMON CROSS-THERAPY INTERVENTIONS THAT TARGET PROCESS

There exist over 150 different kinds of psychotherapies that all share a common purpose: to help individuals cope with the varied difficulties of suffering they are experiencing, prevent future ones where possible and come to terms with ones that are not changeable (e.g. one's own death). Many also help patients in their search for personal meaning. Not surprisingly there are many common evidence-based ingredients that are key to CFT, including the therapeutic relationship; psychoeducation (e.g. affective regulatory systems); guided discovery (which can include Socratic dialogues and guided practices); structured formulations and functional analysis (using EFA and identifying safety behaviours); thinking and reasoning strategies (e.g. thought monitoring, reappraisal, mentalising); body-



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focused exercises (e.g. breathing, voice tone, posture); behavioural experiments and exposure; imagery; attention/mindfulness/meditation; letter writing; distinguishing shame-based criticising from compassionate self-correction and homework (Gilbert, 2010). We would like to offer an important note to this in regard to the therapeutic relationship and therapist development. Here, and in Chapter 3, we highlight the Bodhicitta principle and motivation of developing 'self-enlightenment' to help others. This has implications for a therapist's preparedness to understand and work with their own minds (Gale, Schroder & Gilbert, 2015), especially mindfully (Katzow & Safran, 2007). Needing to have insight into one's mind was of course central to early psychodynamic training and is a basis of 'mind awareness'. Certainly, many caution against the idea that therapy is simply learning a mechanical set of techniques (Bennett-Levy & Haarhoff, in press; Bennett-Levy & Thwaites, 2007). The more we understand our own minds in relationship to others (e.g. clients) the less chance we have of simply acting as rescuers, engaging in dissociation or denial, getting caught in complex transference and counter-transference issues, acting out, and justifying or allocating blame to therapeutic ruptures (Gilbert & Leary, 2007). Since CFT was developed as a psychotherapy, embedded in research into affiliative caring motivational systems (social mentalities) these are central issues in building and sustaining a therapeutic relationship (Gilbert, 2007; Gilbert & Leary, 2007).

USING EVOLUTIONARY INSIGHTS TO FASHION THERAPY

A cornerstone of CFT is rooted in the evolution of caring and affiliative motives and behaviours, and in particular attachment, friendship formation and sense of belonging and connectedness. These all contribute to a sense of safeness in the world and provide resources for regulating and integrating our minds (Gilbert, 2014). In his attachment trilogy Bowlby (1969, 1973, 1980) emphasised that there are three core qualities and resources that are fundamental to the infant's growth and development: (1) the ability to be in close physical *proximity* with each other, vigilant to each other's whereabouts/availability; (2) the provision of a *secure base*, which supports the infant's growth, maturation, exploration and development of a separate but connected self-identity and confidence and (3) to provide a *safe haven*, which provides competent soothing for distress. As a secure base, parents facilitate *courage* through encouraging the child to face, at times, difficult or risky things, for example riding a bike or going to school (e.g. using voice tone, touch, and eye contact). Many therapies see these as crucial to therapeutic relationships (Liotti, 2007).



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The self psychologist, Kohut (1977) added the role of parents as approving, admiring others, noting it is important for children to have their own self-worth reflected back, a process he referred to as 'mirroring'. The facial expressions or what he called '*gleam in mother's eye*' stimulates positive emotion about the child's sense of self. In addition, parental mirroring means that as a child achieves small development steps there is a joyful audience. Indeed, for children, successes need to matter to others not just themselves. Imagine growing up, cared for, but with nobody having time or interest or joy in seeing if you do well or not.

Another key function is for the parent to 'hold the child in mind', attentive of the need to recover or rescue. The experiences of 'another coming' when one is lost or distressed provides fundamental learning about the safeness and helpfulness of others. For children who have not received this, when they were distressed and no-one came, the world seemed a dangerous and lonely place. The need to 'feel' there is someone there 'looking over me or out for me' is central to many forms of relating, including religious forms. Archetypal fears of aloneness (which in young primates and mammals would mean probable death via predation or dehydration) can be an archetypal terror and these can sometimes reappear in the therapy. For example, one patient described it as a feeling of separateness and aloneness terror 'as if cast adrift in the dark, silent emptiness of outer space'. Having an evolutionary lens enables the therapist to be aware of the possible terror of disconnection/aloneness.

Once the parent arrives or responds to a distress signal then their capacity to provide soothing and grounding in times of stress or threat becomes central. For example, a parent who returns to a distressed child but is critical of, or irritated with, the child for the distress is not soothing. The capacity to be *available* and *effective* in times of need builds the child's emotion regulation competencies. The *strength* and *wisdom* of the parent provides support for the emerging emotions and motive conflicts of the child's mind.

Important too, for social beings like humans, who are highly socially connected and regulated (Keltner, Kogan, Piff, & Saturn, 2014), is the ability to understand the minds and intentions of others. Intersubjectivity (different to empathy) is a core competency in relating to other minds, creating a sharing of experience and awareness, and it too is a competency that develops through childhood, especially compassionate childhood (Cortina & Liotti, 2010). Recent evidence suggests that our capacities to trust and have an accurate awareness of others is influenced by the early experiences of receiving empathic care (Cortina & Liotti, 2010). So there is a vast range of inputs that caring figures provide to the child that enable them to become a confident, self-regulating,



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interacting social agent, with physiological infrastructures, such as the parasympathetic vagal system, to support them (see Colonnello et al., Chapter 6, this volume; Davidson, 2012; Depue & Morrone-Strupinsky, 2005; Dunbar, 2010; Porges, 2007; Thayer & Lane, 2000). These are the basis of compassionate care and building a compassionate mind.

SADNESS AND GRIEF

Another key attachment question is how a child experiences sadness, loss and grief, and others' responses to them when they do. Crying is one of the most dangerous emotions because one is unable to see, one's breathing is affected and muscles become lower in tone. This could only have evolved in the context of being cared for – otherwise one could be in extreme danger. It is one of the most important emotions linked to a desire for interpersonal (re)connection. The more unsafe we feel, or feel or express that sadness is inappropriate in some way, the less able we may be to feel sadness and grief. In fact, the ability to feel sadness and sorrow is essential to Buddhist models of compassion (Gilbert & Choden, 2013) and has recently been identified as a seriously neglected process for people with mental health problems; indeed some therapies seem to have an avoidance of engaging with painful grief processing (Horwitz & Wakefield, 2007). As noted by Gilbert and Irons (2005), grieving, in the context of a caring other, can have major implications for the reorganisation of inner working models. Gilbert (Chapter 3, this volume) notes too that an inability to grieve for losses in one's own life (e.g. for the loving/protecting parent one wanted and yearned for but never had) can block processes like guilt. CFT therefore facilitates the ability to engage with past losses and work with the associated emotions like anger and fear – but also with sadness and grief – and to see grief not as a vulnerability, weakness or danger but as a very important evolved human process that can have many therapeutic effects.

BUILDING THE COMPASSIONATE MIND IN CFT

CFT seeks to create the conditions in the therapy, *and within the patient*, to provide for the stabilising experiences of the secure base and safe haven, feeling valued (mirroring), with the competencies for empathy and intersubjectivity that enable individuals to understand their own minds and that of others (see [Figure 8.1](#)). As discussed in earlier chapters (e.g. Gilbert, Chapter 3, this volume), compassion stimulates and cultivates care-focused *motivations and intentions*. Therefore, we wish for the client to experience the *compassionate intentionality of the therapist* and to



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some degree elements of the 12 competencies of compassion (Gilbert 2010, Chapter 3, this volume). How these are used clinically are very briefly given in **Table 8.3**.

Ideally then, the client comes to experience the therapist as sensitive, moved by their experience, emotionally/distress tolerant, empathic and non-judgemental with the commitment and wisdom of knowing how to work together.

There are a range of practices that texture CFT to help build the compassionate competencies within the client. These include formulation in the evolutionary model, attention, awareness and mindfulness training; developing a sense of grounding and slowing linked to the balance of the sympathetic and parasympathetic systems partly provided by practices such as how to use the breath to slow the mind and stimulate the vagal system (approximately five breaths per minute); how to create and use friendly postures, facial expressions and inner voice tones to texture one's thoughts rather than hostile self-criticisms; cultivate self and other-focused empathy and mentalising training and build the characteristics of a compassionate self and mind.

CFT compassion practices focus on the *flow of compassion*. There is the compassion we experience *from* others, the compassion we have *for* others and *self*-compassion. As discussed in Chapter 3 of this volume, these are interdependent and build and support each other. Developing experiences of compassion 'coming in' can be through gratitude and appreciation exercises (practising noticing the helpfulness of others) but also through imagery and meditation work. For example, people are guided into how to generate images of compassionate others/minds relating to them with wisdom (that we all just find ourselves here with a tricky brain), strength and complete commitment to them. There is a guided discovery element to this for the client because some recognise they prefer one gender for their image over another; some recognise they struggle even to imagine interacting with a wise, committed caring other, and sometimes they can experience a sense of aloneness, separateness rather than compassion (Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008). Some clients fear that '*if others (even my compassionate image) really knew what goes on in my mind they would not like or care for me*'. Others find even trusting or relating to an inner image to be difficult. Nonetheless, these images are designed to stimulate physiological systems. This is no different, in principle, to imagining a happy memory or lying in bed with erotic fantasies that will create a cascade of hormones from the pituitary and sexual arousal. Equally, fantasising compassion from and for others stimulates affiliative physiological systems including the frontal cortex and with repeated practice is a focus for neuroplasticity (Klimecki et al., 2014).



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Table 8.3 • The 12 competencies of compassion in CFT

Engagement	Action
<p>Care for well-being: Is focused on building the desire-intention to begin the process of cultivating compassion and caring motivation. For people who are struggling, fears, blocks and resistances can be related to over-self-monitoring and self-doubt, shame and negative beliefs and early life experiences. Clarify the definition of compassion, including that it is a (building of) courage for a descent into pain/suffering, not an ascent away from it in order to heal or cope with it.</p> <p>Sensitivity: Attentional sensitivity is tuned to noticing the presence of suffering in self and others as it arises. Many psychological therapies offer 'mindful' attention and awareness training in different ways; helping people to become more aware of their emotions, automatic thoughts, (difficulty with) bodily experiences. Sometimes this is direct training (e.g. mindful awareness); sometimes it's therapist-guided, 'bringing to the client's attention key issues as they arise.' 'I notice that when you say "that your body curls up or your faces changes; I notice when we touch on your feelings about X you change the subject/go blank/seem disorientated/become angry etc. ...</p> <p>Sympathy: As attention moves towards suffering for self and others, we become emotionally moved/engaged by what comes into focus and into mind. This can generate emotions like sadness or fear linked to this awareness. These then require distress tolerance and empathic insight.</p> <p>Distress tolerance: Many therapies enable clients to stay with (become tolerant of) distress, and thus to turn towards problems rather than experientially avoid, repress, deny or dissociate. Sometimes this is with specific training and guidance (e.g. graded tasks/exposures, knowledge, mindfulness). It often needs to be contextualised with the use of the secure base and safe haven of the therapeutic relationship.</p> <p>Empathy: In CFT empathy is an umbrella term for a range of mind-reading processes such as emotional attuning/recognising, through to cognitive perspective taking and mentalisation. Understanding both what and why we (and others) are thinking, feeling and behaving. It emphasises the cognitive and emotional understanding, and appreciation of the experience of another and flexibly engaging with their perspective. It also draws upon wisdom and insight, e.g. our tricky human brain. Any sense of common humanity can only come from empathic abilities.</p> <p>Non-judgement: This refers to being open and holding experience in mind rather than condemning and criticising one's experience.</p>	<p>Attention: Recognise how to tune attention and focus to 'what would help you/me at this time to work on this issue' (e.g. creating in mind the pattern of compassionate self, or recalling coping memories or skills).</p> <p>Imagery: Many therapies use forms of imagery to do a range of different things including exposure, stimulating coping rehearsals, through to stimulating physiological systems. Many aspects of imagery in CFT include compassion-focused visualisations and meditations (compassionate self and compassionate-other images) through to imagining compassion focused behaviour rehearsals.</p> <p>Reasoning: Compassion is wisdom-based. Using insights from the evolution model and also a range of cognitive (CBT and ACT) reappraisal practices – but in CFT these are rooted and textured in compassionate intention and motives with appropriate emotions.</p> <p>Behaviour: Considerable evidence shows that changing behaviour is often essential for change. CFT is a very behavioural therapy in many ways. Sometimes this is developing the courage to face threat (e.g. the agoraphobic goes out, the shy person practises assertiveness). Given that some can be fearful of compassion, compassion behavioural rehearsals are important. Fear of compassion and friendly, affiliative emotions can be treated very similarly to the behavioural treatment of any fear. CFT also utilises classical conditioning models.</p> <p>Sensory focusing: This involves using body posture, grounding, soothing rhythm breathing, practising friendly voice tone to one's inner thoughts to create bodily states that are conducive to compassion focusing and changing mental states.</p> <p>Feeling and emotion: Feelings and emotions are often an emergent property of changes in stimulus valence and also behaviour change. Some practices such as loving-kindness and gratitude practices can generate friendly affiliative feelings. For some, though, stimulating these emotions can trigger feared or painful attachment memories and/or a grief process. The feelings and emotions of compassion are also contextdependent. The client's ability to experience caring emotions motives from the therapist can be very important. Affiliative emotions may arise slowly or not at all, e.g. we do not need to feel affiliative in order to forgive.</p>

Note: We draw attention to the fact that these 12 characteristics (6 for engagement and 6 for action) are highly interdependent, and help cultivate the compassionate motives and intentions. For example, the more tolerant of distress we are the more we will be able to pay attention to distress and if we can hold it in mind we can begin to have more guided discovery and empathic insights. These also build courage and help with our reasoning. In CFT, therefore, the therapist is working and using the relationship, and teaching the client how to experience these different characteristics. CFT is an integrative therapy but the key focus is to pull together these characteristics within the context of compassionate motivation, which partly creates a secure base, safe haven and mirroring, and allows integration of beliefs, emotions and memories.



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Excerpted from *Compassion*

CFT also uses practices of empathy training and taking actions that are going to *be helpful to others*, for example, taking an empathic interest in other people, mentalising, thinking what one can do that would be helpful and doing it, but also at times assertive training, because compassion is not submissive. Appreciative awareness of the helpfulness of others is also key. Again, the concepts of Bodhicitta are salient here (Gilbert, Chapter 3, this volume)

Core to CFT and the compassionate mind is building the *compassionate self*, imagining stepping into it and thinking and acting for the perspective of 'one's ideal compassionate self', 'imagining ourselves as we would ideally like to compassionately be', with the qualities of wisdom, strength, and commitment (Gilbert, 2010; Gilbert & Choden, 2013). CFT utilises acting training techniques to help people see that we are made up of multiple possibilities or mini-selves. In a conflict situation, for example, we might be regulated by the angry self or inner pattern that thinks and wants to behave in certain ways, or perhaps the anxious self that thinks, feels and behaves in different ways. People can discover that these mini-selves are often in conflict. Angry-self may not like anxious-self, while anxious-self/pattern can be frightened of angry-self/pattern. However, when we notice this we can deliberately stand back and switch to the compassionate self, by slowing the breath, grounding with compassion body postures and remembering our compassion intention and identity that brings wisdom, strength and commitment to any life situation.

The compassionate self can also be used as a focus for working with situations where self-criticism is common. People can learn to recognise self-criticism, its forms and functions, and with functional analysis and guided discovery look at how self-criticism is often hostile, unhelpful and depressing rather than inspiring (Gilbert, 2010). In contrast, compassionate self-encouragement and self-correction, underpinned by compassion motivation, motivates us to try to be at our best in whatever we do and take joy from that. We may feel guilt if we fail but not shame, and hostile self-criticism (Gilbert 2010; see Chapter 3, this volume).

The compassionate self and compassion image act like an internalised, secure base and safe haven with mirroring and mentalising functions (as previously discussed). When we deliberately create these conditions in our mind, and try and function from this inner position, we are in a much better place to be able to work with our threat emotions and integrate them. This process of providing the contexts and conditions for differentiation and integration is central to growth (Siegel, 2016). We can better differentiate our emotions from one another, enabling a better understanding of what



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we are feeling and what is being triggered in us and how one emotion can suppress others. This in turn enables us to integrate and to hold these differing emotions without suppression, avoidance or dissociation, thus integrating them so we can be better at ease with them. The compassionate mind brings insight (from the wisdom of CFT psychoeducation) and can therefore empathise and mentalise the inner emotions – a source for coming to understand ourselves as the evolved and social constructed being we are. This is depicted in **Figure 8.1**.

As these skills and competencies develop people realise others are like this too (we are all made up of multiple potentials of motives and emotions; we are all gene-socially constructed versions of minds; see **Table 8.1**), so we can extend these compassionate insights to others too. There is growing evidence for this way of working (Kirby, 2016; Leaviss & Uttley, 2015) and a recent study of a relatively short compassionate mind training intervention found significant reductions in self-criticism and shame, and major increases in compassion for self and others, and positive affect with improvement in heart-rate variability (Matos et al., under review).

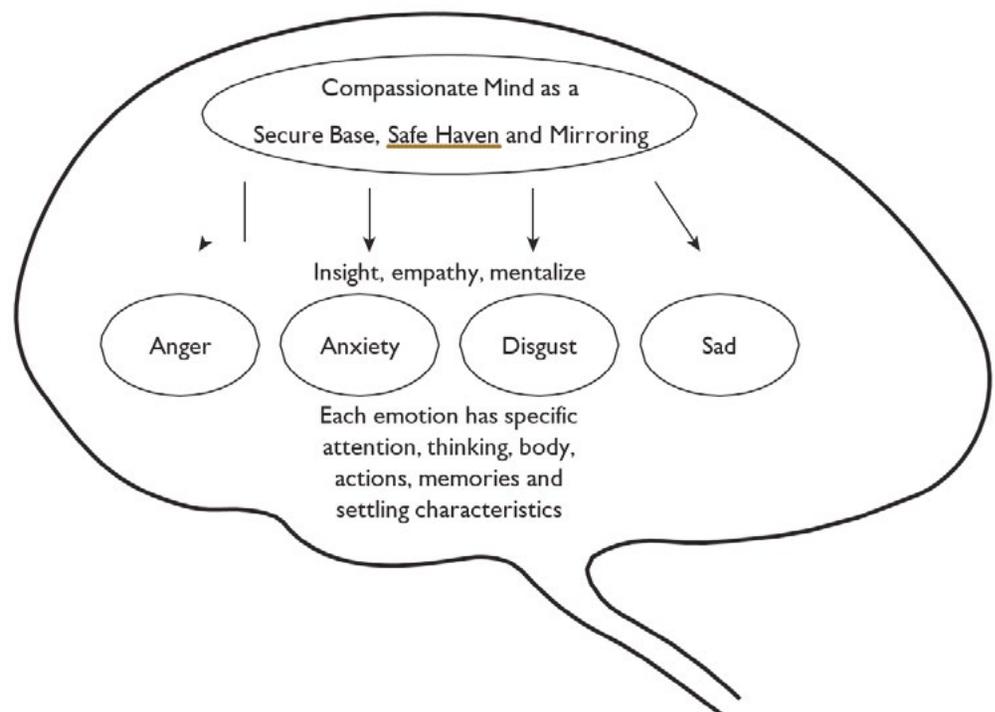


Figure 8.1 • Representation of the integrated and therapeutic effects of building the compassionate mind. © Paul Gilbert.



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FEARS OF COMPASSION

One of the most important therapeutic CFT challenges can be because people experience *fears* of compassion (e.g. wanting to be compassionate but feeling they don't deserve it or are frightened of the feelings it ignites – especially the fear of sadness and grief), feeling blocked (e.g. struggling to find time to practise or remember) and resistance (seeing compassion as weak and undesirable, known collectively as fears, blocks and resistances (FBRs) (see Gilbert & Mascaro, in press, for a review). Highly self-critical people can even respond to compassion with physiological indicators of threat as measured with fMRI (Longe et al., 2010), heart-rate variability (Rockliff et al., 2008) and salivary alpha amylase (Duarte et al., 2015). Gilbert, McEwan, Matos, & Ravis (2010) developed measures to explore metacognition of fears of compassion *to others*, fears of *receiving* compassion from others and *self-compassion*. Not surprisingly these are linked to mental health problems, fears of happiness in general and problems in emotions processing (Gilbert et al., 2013). Importantly, however, compassion training can reduce the fears of compassion (Jazaieri et al., 2013; Lawrence & Lee, 2014; Matos et al., under review). Importantly, not all resistances to compassion are based on fears. Indeed there are many complex factors that produce compassion resistance (Gilbert & Mascaro, in press)

Some of the emotional difficulties that arise when engaging with compassion motives and emotions can sometimes be explained in classical conditioning terms. For example, images and fantasies of a holiday will trigger positive affect for most people. But if one has experienced a recent holiday where one was robbed or injured then holiday stimuli could activate (classically conditioned) trauma memory and be unpleasant. If the people one has looked to for caring have been hostile and abusive then, when we stimulate the attachment system, what are released are trauma memories not affection ones. Hence, these can be the first experiences of individuals when they begin compassion work – the return of abuse-type feelings. So therapist and client work to 'detoxify' the attachment-linked trauma memories that are creating the fears and blocks to compassion, and enable a sense of social connectedness to emerge (Gilbert, 2010). Also not uncommonly, in people who have experienced emotional neglect, as they begin to open the affiliative and attachment systems, they can experience a sense of loneliness with a yearning and grief for the connectedness and love they wanted but did not get. Partly because crying is the most vulnerable state we can experience, and also because it requires a sense of connectedness, it is one of the most feared emotions by some people. This is why in CFT therapists need to be able to work with attachment trauma of various kinds



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and profound grief (Gilbert & Irons, 2005). Healing these process, especially fears of compassion, have their own therapeutic sequence (Lawrence & Lee, 2014).

CONCLUSION

The human brain evolved in a piecemeal fashion, subject to many constraints from what had evolved previously, and with many trade-offs. As such it is full of conflicting motives and emotions in pursuit of survival and reproductive strategies. These have recently been equipped with a whole range of newly evolved, socially intelligent competencies (Gilbert, Chapter 3, this volume). While these give rise to modern cultures of science and art, and the pursuit of knowledge and meaning, they also underpin many mental health problems, not to mention difficulties with violence and tribalism.

One problem with current psychotherapy is that it can see mental health problems as 'errors and disorders' that can be categorised according to DSM or ICD. Obviously there are genetic polymorphisms and structural processes that do give rise to mental health vulnerabilities. However, it is clear that many mental health problems, not to mention domestic and tribal violence that are undesirable (and harmful to others), are variations in phenotypes, adaptations and reactions to life histories and social contexts.

This is what makes compassion such a powerful process to focus on in therapy for social change in general, and the integration of mind(s) (Siegel, 2016). As we recognise the tragedy of the human condition, with our tricky, poorly integrated minds, and lives of threat, loss, decay and death, we can look to common processes on how to cope together. The evolution of caring and then human socially intelligent competencies fundamentally changes how minds work, are soothed and find purpose and meaning. The core focus of the compassion focused therapies therefore is less trying to remove or correct something than trying to develop and cultivate the best of us – conducive to the flourishing and well-being in all.