CHAPTER 1

Introduction

The work we do as therapists is tough. People come to us and bare their souls, tearfully retelling their most intimate struggles, deepest failures, and greatest fears. We listen not only to tales of sorrow and distress, but sometimes to cries of the most excruciating anguish or unimaginable torment, as in cases of severe trauma. In our faithful commitment to the person, we listen compassionately and try to put ourselves in his or her place in order to better comprehend his or her plight.

What happens in nature is rarely linear (Mandelbrot, 1982), and the same is true for psychopathology. Clients often present an intricate and complicated array of symptoms that wholly and partially align with the criteria for various diagnoses—so we need a framework to tie things together (Hofmann, 2014). We sometimes struggle to make sense of this complexity, even as we attempt to remain true to our roots as cognitive-behavioral therapy (CBT) practitioners. We try our best to facilitate an avenue for clients to develop a sense of patience and compassion for themselves as well as forgiveness for others. We support clients as they acquire specific skills that overlay changes in thinking, feeling, and behaving that may enable them to pursue their hopes and aspirations (Clark & Beck, 1999; DeRubeis et al., 1990; Hofmann, Asmundson, & Beck, 2013; Strunk, DeRubeis, Chiu, & Alvarez, 2007). We try to do this work in a way that builds strengths (Kuyken, Padesky, & Dudley, 2009), is adapted to our clients' unique characteristics and beliefs (Persons, 2012), is respectful of their values and independence, and fosters client ownership over the therapeutic process.

Throughout our professional roles as therapists, we in essence join our clients' personal lives for the brief period of time they are in treatment. For the few hours we spend with them, the ideas and strategies that we help them develop may have a broad impact on their experiences in this world, their relationships with their loved ones, and how they support others through the processes of growth and change.

As therapists, we know that clients' emotions are sometimes fragile. We accept the daunting task of helping them to better understand, identify, and experience their feelings and emotions. Our cognitive case conceptualization helps us to aid them to make sense of the complexity that accompanies their struggles in life and to guide our interventions (Beck, 1995, 2005). Traversing the winding road of cognitions, emotions, and behavior can often prove to be strenuous, as we help identify the meaning that accompanies our client's perceptions and sort out what is what, all the while attempting to maintain our own sense of balance as therapists. These are the essential ingredients of the therapeutic relationship.

When Aaron T. Beck developed his model of cognitive therapy in the 1960s, the world of psychotherapy did not easily embrace any models of psychopathology that varied from the basic tenets of psychoanalysis. Beck took a tremendous risk of being ostracized by his colleagues when he introduced the notion that conscious thought and beliefs had a central role in understanding and successfully treating depression (Beck, 1964), even thoughthis concept had been a foundation of Stoic philosophy and the first "manual for living" introduced by Epictetus long before formal psychological therapies existed (Seddon, 2005). Epictetus included many day-to-day scenarios to illustrate how to maintain a calm and balanced perspective regardless of the situation. He is famous for his dictum "Man is not disturbed by things themselves, but by the interpretation he gives to them." Fortunately, these ideas are still current in many contemporary behavioral and cognitive therapies. The notion that people are not affected by what happens to them as much as by the interpretations and meanings they assign to the outcome is *de rigueur* among modern CBT practitioners. Of course, this idea does not negate the negative reality, or the unfortunate trauma or extreme stress in the course of some people's lives, as the design of CBT was influenced by many great theoreticians and therapeutic modalities. To some extent, CBT can even be considered an integrative form of psychotherapy that depends on both behavioral and cognitive change mechanisms (Alford & Beck, 1988).

Predicated on the seminal scientific work of Beck and colleagues, theorists and researchers around the world began to conduct their own investigations and to adapt Beck's undergirding theory of psychopathology. As a result, we now have many different cognitive models for a wide variety of clinical disorders (Dobson, 2009; Kazantzis, Reinecke, & Freeman,

2010). We also know that many scientific advances have been successfully incorporated into clinical practice. Data from large multinational psychotherapy studies involving a broad range of training backgrounds indicate that most therapists report a practice that has been influenced by Beck's early writing (Orlinsky, Schofield, Schroder, & Kazantzis, 2011). This evolution in psychotherapy is now referred to as cognitive-behavioral therapy (Beck, 2011).

A lot of the focus in CBT has been on the content of different disorders, and the techniques or methods that have best efficacy to modify symptoms and presenting problems. Less acknowledged or recognized is Beck's positioning of several specific elements of the *therapeutic relationship* as defining features of how to practice CBT. Beck found that depressed clients could benefit from a relatively short-term therapy of 20 hours or so, rather than the hundreds of hours typically spent in psychoanalysis, as long as they were active participants in the process, and the interventions were skillfully tailored and evaluated within the client's unique situation (Beck, Rush, Shaw, & Emery, 1979; Kazantzis, Beck, Dattilio, Dobson, & Rapee, 2013). Beck also included self-questioning as a key aspect of CBT, modeled for the client through the therapist's use of Socratic questions that help distance, evaluate, and gain alternative views on distressing thoughts (Kazantzis, Fairburn, Padesky, Reinecke, & Teeson, 2014). However, the manner in which the cognitive case conceptualization serves as a framework to adapt counseling skills, collaborative empiricism, and Socratic dialogue has not been comprehensively addressed in previous resources for practice.

This book provides guidance on how to utilize the therapeutic relationship as a change agent in CBT. We believe that understanding how these processes enhance change in the clinical applications of CBT is crucial. Hence, our work clearly shows that the effective use of techniques rests on the fundamental relationship attributes and processes that result in effective CBT. We, the authors, are all practitioners, as well as educators and researchers. We have written this book for you as both students and practitioners, so that you can enrich your work with clients. We consulted with experts in the field, road tested our ideas in workshops around the world, and used the frameworks in research studies. Now, we offer the ideas to you for your use with clients.

Structure of the Book

The first section of this book provides guidance on how to develop CBT-specific relationships. These guidelines make explicit what has been implicit in Beck's theory of psychopathology and system of psychotherapy,

and extend the previous literature on the practice of "Beckian" therapy. We intend to contribute an important resource for practice that builds on those resources that guided our own development and work in CBT. Following this introduction, Chapter 2 defines the therapeutic relationship, which is fleshed out in Chapter 3, where we offer a series of case examples to demonstrate how each of the empirically supported relationship factors (i.e., expressed empathy, expression of positive regard/affirmation, the working alliance, and collection of client feedback) can be adjusted based on the cognitive case conceptualization. This book conveys how you might initially elect to emphasize or deemphasize these elements with different clients.

Chapter 4 offers a definition and guide for the use of collaborative empiricism. Basing our work on established theories and bodies of research, we illustrate how the evaluation of personally relevant information enhances an individual's intrinsic motivation for change, autonomy, self-efficacy, and self-competence (i.e., research stemming from self-determination theory). We note how both the encouragement of active client participation and adoption of the scientific method to evaluate experience are the hallmarks of the therapeutic relationship in CBT.

Chapter 5 outlines the specific application of Socratic dialogue within CBT. Socratic dialogue is a core skill in CBT, and when applied in a discovery-orientated exploration of ideas relevant to the client's concern, it serves as a potent technique to facilitate cognitive change. We clarify how to reach discoveries that are minimally influenced by the therapist but are primarily the result of the client's own insights and ideas.

The second part of the book illustrates how the features of the therapeutic relationship are embedded within the structural features of the CBT session (Chapter 6), interventions during sessions (Chapters 7 and 8), cognitive and behavioral experiments (Chapter 9), between-session (homework) interventions (Chapter 10), and the processes to conclude therapy relationships and engage in relapse prevention (Chapter 11). We divide the therapeutic relationship into its component parts and clarify how these elements interact and overlap, as well as how they are subject to moment-to-moment fluctuations guided by the cognitive case conceptualization. This exposition acknowledges the complexity of the therapeutic encounter in CBT and provides space to consider all the elements that are moving and intersecting at each moment in time.

The third and final part of the book illustrates the relevance of the therapeutic relationship for our ethics and safety practices (Chapter 12), the identification and management of the therapist's own thoughts and emotions during sessions (Chapter 13), and how the same relationship skills can be effectively used in work with couples, families, and groups (Chapter 14), as well as with children and adolescents (Chapter 15). While

we occasionally make reference to previous chapters in the book, the threads in our thinking remain largely sequential, allowing for a linear flow of material.

This book is intended for mental health professionals at all stages of their careers, who desire to enrich their understanding of the specific relationship elements in CBT. While this book outlines clear frameworks that may appear straightforward on paper, applying these frameworks in practice is typically complex. It is critical to master these elements in order to understand the ways in which CBT offers a rich and flexible system of psychotherapy that embodies the intersection of relationship and technique. As we proceed, we assume you have a foundational understanding of the theory and framework for cognitive case conceptualization (which can be obtained through published clinician's guide books, i.e., Beck, 2005; Dobson & Dobson, 2017). We also assume that most readers of this volume have some knowledge of psychopathology, CBT, and core clinical skills such as cognitive case conceptualization. We recommend that readers consider popular guides for CBT (Barlow, 2014; Beck, 2011; Butler, Fennell, & Hackmann, 2010; Hofmann, 2011) for detailed guidance on how to use the specific interventions of CBT.

Competence Grids

Considerable attention has been given to the concept of what is and is not competent practice in CBT, along with various definitions of "competence" (Newman, 2013; Sburlati, Lyneham, Schniering, & Rapee, 2014). This definitional process can create understandable tension and some anxiety for practicing therapists because we want to be effective in our delivery of CBT. At the same time, as helpers, we want to enjoy the freedom to employ our own style of delivery that includes personality and charm. However, this freedom may at times compromise the integrity and consistency of our work.

Other than the personal meaning assigned to the notion of "competence," the term itself represents an extreme, and less attention has traditionally been accorded to differentiating the gradations of competence. We suggest that overall CBT competence is best conceptualized as a fluid attribute that varies from session to session and from one client interaction to another. An important measure of therapist competence is the Cognitive Therapy Rating Scale (CTRS: Young & Beck, 1980), which embodies this fluidity as it is rated on a session-by-session basis. The CTRS has now been adopted by the Academy of Cognitive Therapy (*www.academyofct.org*) and is utilized as a primary means of providing certification (Kazantzis, Clayton, Farchione, & Dobson, 2017).

The competence grids provided in this book place specific therapist behaviors, or client-therapist interactions, in a pattern of squares to define "higher" and "lower" competence in elements of the therapeutic relationship. These grids are primarily included for illustrative purposes to convey higher or lower competence, but they can also be used as a framework for reviewing a session (i.e., by writing relevant quotations from dialogue or interaction patterns onto the grid, according to where they fit). This type of scaffolding of ideas will be used throughout this book and can provide a useful basis for training, supervision, and self-reflection.

Self-Reflection and Self-Practice

Self-practice activities can enhance learning as well as your development as a CBT practitioner. Hence, we present self-reflection opportunities throughout the book. We invite you, the reader, to reflect on your own experience, to generate questions, and to experiment with new ideas and strategies, so that you may generate your own conclusions and meaning for the services you provide to your clients.

Self-reflection is a process of distancing and reflecting on your own cognitive, emotional, physiological, and behavioral experiences and patterns as a professional (Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015; McGinn, 2015). Self-reflection can be informative as well as provide clarification or help you work through various areas in which you are entrenched with clients (see Beck, 2011). Indeed, self-reflection is not a new idea; actually, it has been part of CBT for some time (e.g., Haarhoff & Kazantzis, 2007). You need to understand yourself, and recognize how your thoughts and emotions are triggered in the processes of therapy. At the same time, self-reflection helps you to realize that understanding is a concept that is constantly evolving and will take a lifetime to complete. One of the great privileges of the therapist role is that we often learn through our client's growth, and we are enriched by their self-exploration, novel perspectives, and insights.

We are all human! Most of us are prone to being excessively emotional and may even be a little irrational at times. Being human, we are sometimes frail and vulnerable. In CBT, we do not aim for our clients to be perfectly logical beings; nor should we aim to be this way ourselves as therapists. In fact, the use of instincts or emotions is not always associated with dysfunction. But extreme or dysfunctional emotionality can encourage us to engage in self-practice, self-reflection, and supervision, or even to change the way we deal with the hand that life has dealt us.

For all of these reasons, we invite you to use the first self-reflection exercise, below, to reflect on your own thoughts, beliefs, emotions, and behaviors in your professional role as a therapist as you read this book. Some of these exercises may bring to your attention things that you were not previously aware of or did not acknowledge. Rest assured that you are not alone. In our experience, we have witnessed every core belief and schema structure in our CBT supervisees, and we have observed those therapists develop remarkable resilience where at one time they were vulnerable. This process has, in turn, strengthened our work as well as in our supervisees and their belief in the effectiveness of CBT.

SELF-REFLECTION EXERCISE

At this early point in the book, we invite you to consider and reflect on your own values* with regard to being supportive in relationships.

- What values are most prominent within the relationships in your personal life? What excites you? What makes you fearful? What do you hope for?
- How would you like family and friends to portray you 20 years from now—what is the way you want them to describe you?
- Take 5 minutes to consider how those values are expressed in your professional relationships with clients, colleagues, and supervisees/trainees.

*We conceptualize values in this book as just another feature of an individual's belief system that is deeply and strongly held, as well as something that individuals rarely want to change.

We also invite you to write down two helpful assumptions—one of which was shared by Judith Beck in her training offered at the Beck Institute for Cognitive Behavior Therapy and the other of which emerged as a result of our years of providing workshops to colleagues throughout the world:

- "If I am doing something for the first time, then I really should not be any good at it."
- "If I am doing something, and I am confused, anxious, and/or frustrated, then this means I have an opportunity to learn—about therapy, and myself."

There is something special about being an authentic and complete person when you are professionally involved with a client. In fact, like Carl Rogers, the structural family therapist Harry Aponte published a great deal on the topic pertaining to the "person of the therapist," which we discuss later, most extensively in Chapter 14. It might be difficult for a third-party observer to identify and quantify the completeness of this

interaction with present-day research methods, but it is apparent to our clients. Our goal here is to give you the tools to define and understand the components that make up each element of the therapeutic interaction, so that you can more easily place these points in the back of your mind and attend to them when needed. Our work on the therapeutic relationship augments the key elements of CBT by enhancing the assessment and training component of its central processes.

Case Outlines

In this book, we have included rich clinical examples that illustrate the theory and research-based ideas we present. We introduce you to cases showing our work with three different clients with whom the role of the therapeutic relationship was central, not only to engagement but also to facilitating cognitive and important functional changes. In addition to the many brief case examples that are dispersed throughout various chapters, you will also have the opportunity to follow the progress of these clients through this book. We will add to each case and its case formulation as the chapters unfold. The book initially focuses on Cases 1 and 2 to illustrate some of the foundational concepts in the therapeutic relationship. Case 3 is an expanded case because of how it is integrated in later chapters.

Case 1: Johan

Johan was a tall and lean man in his late 20s. His mother referred him to me (N. K.) because of a rather unusual and abrupt conclusion of therapy with his last therapist. Johan's mother explained that the therapist had phoned her to complain about Johan, saying that "He's impossible to treat!" Apart from the obvious ethical violation, it suggested that either the case was too complex for the previous therapist or the therapeutic relationship had ruptured, resulting in its abrupt end. Either way this was very likely an unhelpful resolution for the client. Apart from a description of "intense anxiety" leading to problems at his chosen profession as a mechanic, I had no information about the client preceding the assessment session.

THERAPIST: Would you like to start by telling me the things that bring you here today?

JOHAN: Not really. (*He looks away, seemingly uninterested.*)

Johan was wearing loose, baggy clothing, making it easy to assume that he was at least double his actual weight. I wondered if the extreme disparity between body and appearance was intentional. My assumption was that he had good reason for relating in this less than cooperative way. It had to make sense in the context of his life experience. I waited.

JOHAN: (*After a long pause.*) I don't want to be here.

THERAPIST: [Having just covered the usual informed consent procedures, I felt it was important to check for coercion.] That's a concern for me to hear—is someone pressuring you to be here?

JOHAN: No, I don't want to be here! (*He dips his head toward me and glared as his face reddened.*)

He was clearly underweight, and his veins throbbed on his temples and forehead. He looked and sounded angry. I wondered how much insight he had regarding the ambiguity in his statements. I wondered what function his hostility and uncooperative behavior served. Was this typical of his interactions with other health professionals or people in general? I wondered what beliefs this style of interaction might compensate for and how it had been reinforced.

THERAPIST: I acknowledge that it is difficult meeting a stranger, even in a professional role, especially when there is an expectation to share very personal and distressing things.

JOHAN: Yes—you're like a prostitute!

THERAPIST: Excuse me?

JOHAN: The information sheet about your service. It says you have a right to a service free of sexual discrimination and harassment, on the same piece of paper that it outlines the fee schedule. (*Shouting.*) *You're* like a prostitute!

Remaining calm, I noticed my automatic thought, "He's looking for a reaction," and so, in a gentle tone, I responded.

THERAPIST: Well, you're certainly right that it may seem strange to have both things together on the same page, but please allow me to assure you—it is a standard form.

JOHAN: Obviously! (*He sighs.*)

Later in the assessment process, I came to understand that his array of difficulties stemmed from his problems in relating to other people, dating back to important developmental experiences in which he had felt betrayed by those close to him. Aside from his psychometric profile, these distressing family and early-life relationships found expression in his persistent suspicions of other people's motives once he reached adulthood. He was particularly cautious to trust anyone, and his reluctance to confide in others clearly translated into a fearful and dismissive attachment style. Frequently angry during the initial sessions, he persistently saw hidden meaning in ambiguous situations.

In the initial session, he folded the information sheet into a paper airplane and explained, "As a child, I always took pride in making paper airplanes that flew farther than other peoples. You see, the trick is in the way you fold the wings." He then threw the paper airplane across the desk toward the wall next to me. "That one was okay, I guess," he said.

THERAPIST: Johan, you seem to have an awful lot on your mind! I'm hoping that you might get something out of our time today. Would you be able to tell me how you think we can use this session more specifically?

JOHAN: You're getting impatient!

THERAPIST: No, just concerned about making best use of your time in therapy. I'm here to provide a service to you, and I want to be useful to you. Do you expect that I will get impatient, or worse yet, annoyed?

JOHAN: All my other therapists have.

THERAPIST: Oh, I see—that must have been very difficult for you. How did you feel when that happened?

JOHAN: Actually—it hasn't bothered me, I've always laughed at them!

THERAPIST: (*In a curious tone.*) May I ask why?

JOHAN: Because each time it meant I'd won. They got nothing out of me and confirmed to me that they were insincere and selfish people—just like most of the people in the world. They are motivated by money and power. Anyway, most people usually get tired of me.

THERAPIST: Well, let me say that I think your beliefs are important, and your views are very important to our work together. My assumption is that you've had experiences, perhaps even with other people than your previous therapists, which lead you to expect these things from others. Well, I'm here to try to help, and it's not my job to judge or get impatient. Let's try to set some priorities for our session today . . .

We then discussed an agenda.

Case 2: Mary

MARY: Hello? My name is Mary, and I'm phoning today as you were recommended to me by another psychologist because you are an expert in cognitive-behavioral therapy. Do you have time to talk?

Wanting to prevent a lengthy discussion, without having secured written informed consent, I (N. K.) responded:

THERAPIST: Yes, I have a few minutes.

MARY: I should explain that I've seen a lot of psychologists over the years, and while I've made good progress, I still have problems in my relationships—especially with my family at holidays, and with men that I date.

THERAPIST: I see. What's the hardest part about these relationships?

MARY: Stemming from my childhood and the way I've been treated, I have a script running in my head telling me things that I know are not true. My last therapist used acceptance and commitment therapy, and while I gained a lot of understanding of my thoughts, I actually need to change them now!

At this point, I was struck by Mary's articulation of her difficulties, her apparent compatibility with the CBT model through her awareness of a script, and her eagerness to step into what would likely be some of the more challenging therapeutic work. A degree of insight was also clearly apparent.

MARY: But my last therapist kept telling me that I was coping really well, and looked really uncomfortable when I got anxious in sessions. I would think to myself "I most certainly am not coping—that's why I'm in therapy—can't you see that?"

Among the hypotheses generated during this conversation was that this client had been subjected to distressing experiences and that these experiences had forged her pervasive negative beliefs and schema about others and the world. The comment regarding the previous therapist, the reference to having seen a lot of psychologists, and her view of the previous therapist looking really uncomfortable were flags. I reminded myself that it is not uncommon for clients who present with persistent relational difficulties to find it difficult to form stable relationships with professionals. I resisted making other predictions.

MARY: That's a long answer. The short answer is that I feel uncontrollably anxious in these relationships—and, ironically, I am very calm and I am effective in my career. Do you think you can help me?

At this point I took the opportunity to clarify some broad distinctions between acceptance and commitment therapy (ACT) and CBT, and suggested that an initial assessment session would be an appropriate starting point. The client was willing to consider an initial session.

As our discussion was wrapping up, I noted that we had covered a lot of ground. It was a productive exchange, so I had some appreciation for Mary's interpersonal skills in occupational functioning spheres. Something in her communication made me wonder, though, to what extent I was being shown a constructed presentation of herself that veiled an emotional fragility and possible dependency.

THERAPIST: Many people have learned to function very well in some life contexts, yet feel quite vulnerable and experience marked challenges in other contexts. I get what you are saying.

MARY: That's good. Now, I want to get the most out of this as possible; is there anything I can bring to our first session to help?

This request took me by surprise, as clients rarely ask to do work before their first therapy session. It was possible that Mary wanted to appear likable or was striving for my approval, and was feeling anxious that I did not immediately agree to ongoing therapy at the outset of the conversation. I chose to take it on face value, express genuine appreciation for the offer, and encourage her interest in between-session work.

THERAPIST: Well, that's not something I'm often asked, but it's a great idea. Would it be too much to ask you to keep a note of the situations that trigger anxiety for you?

MARY: I can see how that would inform our work and save time—Okay, I'll do that.

THERAPIST: Thank you. Just do what you can. If it becomes too upsetting or distressing, then just bring what you have done. It would also help to know what emotions go with the triggering situations—would you be able to keep track of those reactions, too?

MARY: Sure thing, I keep a diary anyway. I'm looking forward to our session already.

Case 3: Juliet

Juliet was a 47-year-old wife and mother who suffered from weekly panic attacks. She had previously seen another therapist for several months in a city several hours away. The therapist referred her to me (F. M. D.) because Juliet complained about the long drive after attending treatment, and I was closer to her hometown. Juliet was also under the care of a local psychiatrist who had prescribed antidepressant medications.

Juliet had been married to Jack for 17 years, and they had two teenage children. Her chief complaint was that three years prior to the start of treatment, she began experiencing generalized anxiety that eventually culminated in panic attacks. She recalled that she thought she was having a heart attack during the first major panic attack, and so she drove to the emergency department of a nearby hospital for an immediate cardiac assessment. She went to the emergency room six more times owing to similar episodes before it was suggested that she should seek mental health treatment. Subsequently, Juliet became overly focused on her health, and the panic attacks continued.

During the initial assessment, Juliet informed me that her mother had always "babied" her, even through her adult years. She also stated that her husband showed little compassion for either her anxiety problems or her health issues. She also spoke of her poor relationships with her father and how he had criticized her all of her life.

After the intake interview, the goals and strategies of treatment were discussed with Juliet. She was provided with several options, which included a combination of medication and a variety of cognitive-behavioral interventions. She elected to begin CBT.

It was during the third session that Juliet began to explain that she felt very anxious because she believed herself to be a failure. When questioned about whether she tended to be a little hard on herself at times, she exploded and lashed out.

THERAPIST: Juliet, you stated a moment ago that because you often feel anxious, you feel like a failure. Can you tell me more about that?

JULIET: I don't know. I just feel like I can't do anything right. I have had this for so long. I just feel that I am a loser.

THERAPIST: That seems a little harsh! Don t you feel that you are being a bit hard on yourself at times?

JULIET: Oh yeah, right! So you're saying that it's my fault—well, fuck you!

At this moment Juliet's demeanor turned cold and vicious, almost as though someone had flicked a switch. This reaction was startling. Juliet

proceeded to denigrate me, complain that I was insensitive, and say that maybe she could not work with me. This reaction came totally out of the blue and began to raise some questions in my mind as to whether this set of reactions could be suggestive of a personality disorder. It was at this point that a shift in the therapeutic relationship occurred. It was important that I attempt to clarify Juliet's diagnosis so that I could readjust the treatment intervention.

At this juncture in the session, I adopted a less direct posture and allowed Juliet to emotionally vent. I also used this time to reflect on what had just occurred and began to reformulate my case conceptualization, particularly with respect to her core belief regarding criticism and her sense of self-worth. It is during such tenuous times that a therapist must walk on eggshells, avoiding making any statements or overtures that might inflame the client or facilitate an abrupt termination of treatment. Because of her heightened sensitivity, a much different approach would eventually have to be used to confront Juliet about her problems.

Juliet left this third session very angry, stating that she wasn't sure she would return since she didn't feel she could trust me. I offered her every leeway to reassure her that the choice was hers and that I would be supportive of whatever she decided. I also suggested that Juliet think about the session and call me before she scheduled another appointment. It was crucial that I not say anything she might construe as abandonment.

THERAPIST: Juliet, I'm afraid that we are out of time for today. I know that you are upset right now and are not sure that you want to return.

JULIET: Well, you're certainly perceptive about that—no shit!

THERAPIST: Just take some time to think about this a little more. I will respect anything that you decide to do. I'm certainly willing to meet you again and at least explore your feelings further—but of course, that's certainly your call. How about if you call me in a few days and let me know how you feel about the situation?

JULIET: Whatever—I'm out of here!

Juliet eventually rescheduled. At the fourth visit, I attempted to discuss her thoughts and feelings about the previous visit. I was no doubt on shaky ground with her since this was obviously a tenuous process for her. My automatic thought was that I had clearly struck a nerve during the previous session and that this certainly would not be my last glimpse of a raw

part of Juliet's emotions. It became evident to me that one of Juliet's schemas involved a damaged sense of self-worth, which eventuated in hypersensitivity to any hint of criticism and the possibility of future explosions.

Based on this formulation, it seemed likely that although a major early focus of therapy would be related to Juliet's anxiety, it would also be important at some point to focus on her tumultuous relationship with her parents and the core beliefs she had developed over time, as they appeared to exert an influence on current relationships.

From this point, developing a solid therapeutic relationship with Juliet became the initial treatment objective, before any future interventions were attempted. Bonding in relationships was difficult for Juliet because of her fear of abandonment. Teaching Juliet self-soothing techniques and coping strategies became important, as was developing a method of monitoring her spontaneous cognitions. In particular, several techniques borrowed from dialectical behavior therapy (DBT) helped Juliet to regulate and express her emotions more appropriately and constructively. In DBT, clients learn how to disengage from distressing thoughts and feelings in the service of emotion regulation and distress management (Linehan, 1993).

As treatment progressed, the development of trust in therapy became paramount, especially as this trust could serve as a model for change in her life. In essence, Juliet's relationship with me became a fertile ground for trying novel responses and processing her emotions regarding fears of abandonment as well as confusion about resentments. It was particularly difficult for Juliet to move away from the rigid and often dichotomous thought content she had developed about relationships because this was how she came to view the world—all or nothing!

I was eventually able to encourage Juliet to think a little differently and move away from the rigidity of her dichotomous thinking. I went on to gently remind her that I didn't immediately withdraw during our third session, when she became very upset with me, but that instead I tolerated her emotional outburst and came back to her. This was clearly a part of role modeling in the therapeutic relationship and one of the crucial initial steps that would help her develop some tolerance for emotional distress. Part of the case conceptualization with Juliet's condition was that she had limited tolerance for gray areas in life, and her primary response to such threats was to avoid potentially painful situations. Hence, I began to use the therapeutic relationship to help her build tolerance for distress and to change her perspective in a manner that she could use to deal with various situations in her life more effectively.

We sincerely hope you find use in these ideas for your practice, and that some of the ideas within this book will assist you to obtain even more fulfillment from your work as one who supports others. We learned a great deal from our journey in producing this work—so we are grateful for the learning and the opportunity to share these ideas with you. It is quite simply our privilege and our pleasure to offer this resource.

Thank you for joining us on this journey.

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