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Series Preface

Tony Rousmaniere and Alexandre Vaz

We are pleased to introduce the Essentials of Deliberate Practice series of training books. We are developing this book series to address a specific need that we see in many psychology training programs. The issue can be illustrated by the training experiences of Mary, a hypothetical second-year graduate school trainee. Mary has learned a lot about mental health theory, research, and psychotherapy techniques. Mary is a dedicated student; she has read dozens of textbooks, written excellent papers about psychotherapy, and receives near-perfect scores on her course exams. However, when Mary sits with her clients at her practicum site, she often has trouble performing the therapy skills that she can write and talk about so clearly. Furthermore, Mary has noticed herself getting anxious when her clients express strong reactions, such as getting very emotional, hopeless, or skeptical about therapy. Sometimes this anxiety is strong enough to make Mary freeze at key moments, limiting her ability to help those clients.

During her weekly individual and group supervision, Mary's supervisor gives her advice informed by empirically supported therapies and common factor methods. The supervisor often supplements that advice by leading Mary through role-plays, recommending additional reading, or providing examples from her own work with clients. Mary, a dedicated supervisee who shares tapes of her sessions with her supervisor, is open about her challenges, carefully writes down her supervisor's advice, and reads the suggested readings. However, when Mary sits back down with her clients, she often finds that her new knowledge seems to have flown out of her head, and she is unable to enact her supervisor's advice. Mary finds this problem to be particularly acute with the clients who are emotionally evocative.

Mary's supervisor, who has received formal training in supervision, uses supervisory best practices, including the use of video to review supervisees' work. She would rate Mary's overall competence level as consistent with expectations for a trainee at Mary's developmental level. But even though Mary's overall progress is positive, she experiences some recurring problems in her work. This is true even though the supervisor is confident that she and Mary have identified the changes that Mary should make in her work.

The problem with which Mary and her supervisor are wrestling—the disconnect between her knowledge about psychotherapy and her ability to reliably perform psychotherapy—is the focus of this book series. We started this series because most therapists experience this disconnect, to one degree or another, whether they are beginning trainees or highly experienced clinicians. In truth, we are all Mary.

To address this problem, we are focusing this series on the use of deliberate practice, a method of training specifically designed for improving reliable performance of complex skills in challenging work environments (Rousmaniere, 2016, 2019; Rousmaniere et al., 2017). Deliberate practice entails experiential, repeated training with a particular skill until it becomes automatic. In the context of psychotherapy, this involves two trainees role-playing as a client and a therapist, switching roles every so often, under the guidance of a supervisor. The trainee playing the therapist reacts to client statements, ranging in difficulty from beginner to intermediate to advanced, with improvised responses that reflect fundamental therapeutic skills.

To create these books, we approached leading trainers and researchers of major therapy models with these simple instructions: Identify 10 to 12 essential skills for your therapy model where trainees often experience a disconnect between cognitive knowledge and performance ability—in other words, skills that trainees could write a good paper about but often have challenges performing, especially with challenging clients. We then collaborated with the authors to create deliberate practice exercises specifically designed to improve reliable performance of these skills and overall responsive treatment (Hatcher, 2015; Stiles et al., 1998; Stiles & Horvath, 2017). Finally, we rigorously tested these exercises with trainees and trainers at multiple sites around the world and refined them based on extensive feedback.

Each book in this series focuses on a specific therapy model, but readers will notice that most exercises in these books touch on common factor variables and facilitative interpersonal skills that researchers have identified as having the most impact on client outcome, such as empathy, verbal fluency, emotional expression, persuasiveness, and problem focus (e.g., Anderson et al., 2009; Norcross et al., 2019). Thus, the exercises in every book should help with a broad range of clients. Despite the specific theoretical model(s) from which therapists work, most therapists place a strong emphasis on pantheoretical elements of the therapeutic relationship, many of which have robust empirical support as correlates or mechanisms of client improvement (e.g., Norcross et al., 2019). We also recognize that therapy models have already-established training programs with rich histories, so we present deliberate practice not as a replacement but as an adaptable, transtheoretical training method that can be integrated into these existing programs to improve skill retention and help ensure basic competency.

About This Book

This book in the series is on cognitive behavioral therapy (CBT), an umbrella term for a diverse set of treatments that draw from both basic and applied research on learning, cognition, and emotion (Dobson & Dozois, 2019). Despite the diversity of CBT-oriented approaches, a common maxim is the importance of "learning by doing." A broad and deep familiarity with the theoretical and empirical CBT literature is important, yet this knowledge can never replace direct, hands-on experiences with clients and in the training/supervision process. The importance of experiential learning in the training/supervision process is magnified by the reality that, especially for novice trainees who are just beginning to work with clients, there are relatively few opportunities to practice the wide range of clinical skills that are theoretically at one's disposal. This reality runs counter to key elements of the overall CBT philosophy, which stresses the importance of creating opportunities for exposure and repeated and generalizable practice.

In this book, we adopt deliberate practice methods to support experiential—learn by doing—training opportunities. The described methods and stimuli can facilitate

practicing a range of important CBT skills. In addition, it supports fine-tuning the “how” of intervention delivery, including in a flexible manner across diverse clinical scenarios. Importantly, this book is not intended to replace core coursework and exposure to foundational CBT theory and principles of practice. Rather, this book is intended to augment other common training components.

For example, through coursework or other reading, a trainee might learn that avoidance is a common feature of anxiety disorders, and problem maintenance through negative reinforcement should be a target of treatment. The trainee can understand the concept of negative reinforcement and begin to learn about the types of CBT techniques that are commonly used to address it. This book is about providing opportunities for trainees to practice not only what they would say to an avoidant client, but also how they would say it. In the case of avoidance, the focus is not only on the client's avoidance outside of the therapy context, but also within the therapy context—when the client's avoidance is impacting their ability to make use of CBT. In essence, this book aims to help trainees (at all professional levels) learn how to responsively and fluidly apply foundational “tried-and-true” CBT concepts and strategies, which will add to their overall repertoire of clinical skills and principles. With such an expanded repertoire, therapists can maximize their ability to offer personally compelling treatment rationales and related interventions to each patient, including, in this case, of the CBT variety.

Introduction and Overview of Deliberate Practice and Cognitive Behavioral Therapy

The metaphor of a “toolbox” is often used when describing the techniques available to a psychotherapist. Among the systems of psychotherapy, this metaphor may be most apt for cognitive behavioral therapies (CBTs), as technical factors have been, historically, the primary focus. Indeed, there is an inherent technical eclecticism to CBT. As a clinician, it is reassuring to know that one is working with a relatively large toolbox that holds a diverse set of tools. As a trainee, it is exciting to learn and think about selecting and applying these tools with one's clients.

The learning curve is steep in clinical training. One is rapidly exposed to a wide variety of technical components and principles, largely in the context of assigned readings and discussions. Although transdiagnostic CBT models have emerged in recent decades (Sauer-Zavala et al., 2017), discrete interventions and treatment packages often also remain connected to specific *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) diagnoses. For example, it isn't just learning about exposure; it is learning about exposure for panic disorder, and social anxiety disorder, and obsessive-compulsive disorder, and so on. In other words, trainees are tasked with learning a wide variety of technical components, as well as the decision guidelines for when or when not to apply those components. Rather early in the training process, in most cases, trainees begin sitting across from real clients. In our own graduate training, the expectation was that we would continuously carry a minimum individual psychotherapy caseload of three weekly clients. Outside of a more dedicated clinical assistant position, it was rare for even a more advanced student to carry a weekly caseload of more than five individual clients. Since completing our graduate education, we have observed that this is a relatively common scenario in PhD programs.

Something rather obvious about the typical training scenario did not consciously dawn on us until we were faculty members who supervised doctoral students. That is, training based on work performance alone means rarely—and in numerous cases never—using many of the tools in the toolbox, with there being even fewer opportunities to use similar tools with different types of clients. Despite the best intentions

of supervisors and training clinic directors, it can be extremely difficult to assign a variety (in terms of presenting problems and characteristics) of training cases. Even when some diversity of cases exists, there are only so many hours of doing psychotherapy in a given week or month during training. In addition, premature termination rates have been shown to be the highest in university-based training clinics, relative to other community treatment settings (Swift & Greenberg, 2012). Many clients do not stick around, which further limits opportunities to implement strategies that tend to coincide with more advanced stages of a course of CBT.

All of this understandably leaves trainees wondering if they will ever be able to practice implementing many of the tools in the vast toolbox they've been reading about, as well as questioning their competence when they've only been able to implement a given tool on one or two occasions. Many tools gather dust, so to speak, impeding skill development, which requires experience with actual selection and implementation of the tools.

Working with clients is critical; however, in our view, such work performance alone is insufficient to develop a broad and deep set of skills. What is missing are opportunities for behavioral rehearsal with targeted performance assessment and feedback. Use of deliberate practice methods during our training would have facilitated a greater frequency and variety of tool implementation opportunities for us. Deliberate practice methods hold promise for addressing certain gaps in training and professional development through a focus on the rehearsal of discrete skills in any or all of the potentially relevant simulated environments for a psychotherapist (trainee or otherwise). Although it is not a substitute for work performance with real clients, deliberate practice increases one's exposure to the tools in the toolbox. For example, a trainee is not necessarily dependent upon being assigned just the right client to begin developing competence in the evidence-based strategies they have been introduced to in their coursework or in guidebooks and manuals. Similar to other types of parallel processes in psychotherapy, as trainers, supervisors, and clinicians, we are excited about the emergence of deliberate practice in our own training toolboxes.

Overview of the Deliberate Practice Exercises

The main focus of the book is a series of 12 exercises that have been thoroughly tested and modified based on feedback from CBT trainers and trainees. The first 10 exercises each represents an essential CBT skill. The last two exercises are more comprehensive, consisting of annotated CBT transcripts and improvised mock therapy sessions that teach practitioners how to integrate some or all of these skills into more expansive clinical scenarios. Table 1.1 presents the 10 skills that are covered in these exercises.

Throughout all of the exercises, trainees work in pairs under the guidance of a supervisor and role-play as a client and a therapist, switching back and forth between the two roles. Each of the 10 skill-focused exercises consists of multiple client statements grouped by difficulty—beginner, intermediate, and advanced—that calls for that specific skill. Trainees are asked to read through and absorb the description of the skill, its criteria, and some examples of its implementation. The trainee playing the client then reads the statements, which present possible problems and emotional states, or client markers. The trainee playing the therapist then responds in a way that demonstrates the appropriate skill. Trainee therapists will have the option of practicing a response using the one supplied in the exercise or immediately improvising and supplying their own.

After each client statement and therapist response couplet is practiced several times, the trainees will stop to receive feedback from the supervisor. Guided by the

TABLE 1.1. The 10 Cognitive Behavioral Therapy Skills Presented in the Deliberate Practice Exercises

| Beginner Skills | Intermediate Skills | Advanced Skills |
|--|----------------------------|--|
| 1. Explaining the treatment rationale for cognitive behavioral therapy | 5. Working with cognitions | 8. Adherence flexibility |
| 2. Establishing goals | 6. Working with behaviors | 9. Responding to therapeutic alliance ruptures |
| 3. Negotiating a session agenda | 7. Working with emotions | 10. Responding to client resistance |
| 4. Assigning and reviewing between-session activities | | |

supervisor, the trainees will be instructed to try statement–response couplets several times, working their way down the list. In consultation with the supervisor, trainees will go through the exercises, starting with the least challenging and moving through to more advanced levels. The triad (supervisor–client–therapist) will have the opportunity to discuss whether exercises present too much or too little challenge and adjust up or down depending on the assessment. Some exercises provide optional modifications so that trainees role-playing as clients can improvise based on personal experience, rather than using a scripted statement.

Trainees, in consultation with supervisors, can decide which skills they wish to work on and for how long. On the basis of our testing experience, we have found that practice sessions should last about 1 to 1.25 hours to receive maximum benefit. After this, trainees become saturated and need a break.

Ideally, CBT learners will both gain confidence and achieve competence through practicing these exercises. Competence is defined here as the ability to perform a CBT skill in a manner that is flexible and responsive to the client. Skills have been chosen that are considered essential to CBT or that practitioners often find challenging to implement.

The skills identified in this book are not comprehensive in the sense of representing all of the tools in the CBT toolbox. Rather, the book covers many of the important core skills of CBT, some of which will present particular challenges for trainees. Indeed, when selecting the skills, we were guided by our perceptions of essential skills for competent CBT practice and the skills that trainees, particularly novice trainees, have trouble applying with real clients. We also provide a short history of CBT and a brief description of the deliberate practice methodology to explain how we have arrived at the union between them.

The Goals of This Book

The primary goal of this book is to help trainees achieve competence in core CBT skills. Therefore, the expression of that skill or competency may look somewhat different across clients or even within a session with the same client.

The CBT deliberate practice exercises are designed to achieve the following:

1. Help therapists develop the ability to apply CBT skills in a range of clinical situations.
2. Move the CBT skills into procedural memory (Squire, 2004) so that therapists can access them even when they are tired, stressed, overwhelmed, or discouraged.

3. Provide therapists in training with an opportunity to exercise the particular CBT skill using a style and language that is congruent with who they are.
4. Provide the opportunity to use the CBT skills in response to varying client statements and affect. This is designed to build confidence to adopt skills in a broad range of circumstances within different client contexts.
5. Provide therapists in training with many opportunities to “fail” and then correct their “failed” CBT response on the basis of feedback. This helps build confidence and persistence.
6. Help trainees discover their own personal learning style so they can continue their professional development long after their formal training is concluded.

Who Can Benefit From This Book?

This book is designed to be used in multiple contexts, including in graduate-level courses, supervision, postgraduate training, and continuing education programs. It assumes the following:

1. The trainer is knowledgeable about and competent in CBT.
2. The trainer is able to provide good demonstrations of how to use CBT skills across a range of therapeutic situations, via role-play or the many psychotherapy video examples available (see, e.g., J. Beck, 2006; Dobson, 2011; Newman, 2016; Olatunji, 2011; Persons, 2007).
3. The trainer is able to provide feedback to students regarding how to craft or improve their application of CBT skills.
4. Trainees will have accompanying reading, such as books and articles, that explain the theory, research, and rationale of CBT and each particular skill. Recommended reading for each skill is provided in the sample syllabus (Appendix C).

The exercises covered in this book were piloted in 16 trainings sites from across four continents (North America, Europe, Australia, and Asia). Some training sites chose to translate the exercises into their native language to adapt them for use with their trainees. This book is designed for trainers and trainees from different cultural backgrounds worldwide.

This book is also designed for those who are training at all career stages, from beginning trainees, including those who have never worked with real clients, to seasoned therapists. All exercises feature guidance for assessing and adjusting the difficulty to target precisely the needs of each individual learner. The term *trainee* in this book is used broadly, referring to anyone in the field of professional mental health who is endeavoring to acquire CBT psychotherapy skills.

Deliberate Practice in Psychotherapy Training

How does one become an expert in their professional field? What is trainable, and what is simply beyond our reach, due to innate or uncontrollable factors? Questions such as these touch on our fascination with expert performers and their development.

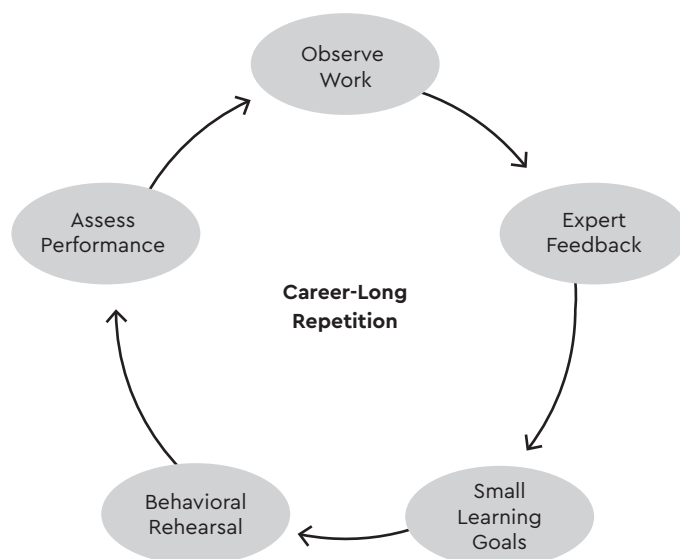
A mixture of awe, admiration, and even confusion surround people such as Mozart, Leonardo da Vinci, or more contemporary top performers such as basketball legend LeBron James and chess virtuoso Garry Kasparov. What accounts for their consistently superior professional results? Evidence suggests that the amount of time and the quality of time spent on a particular type of training are key factors in developing expertise in virtually all domains. "Deliberate practice" is an evidence-based method that can improve performance in an effective and reliable manner.

The concept of deliberate practice has its origins in a classic study by K. Anders Ericsson and colleagues (1993). They found that the amount of time practicing a skill and the quality of the time spent doing so were key factors predicting mastery and acquisition. They identified five key activities in learning and mastering skills: (a) observing one's own work, (b) getting expert feedback, (c) setting small incremental learning goals just beyond the performer's ability, (d) engaging in repetitive behavioral rehearsal of specific skills, and (e) continuously assessing performance. Ericsson and his colleagues termed this process "deliberate practice," a cyclical process that is illustrated in Figure 1.1.

Research has shown that lengthy engagement in deliberate practice is associated with expert performance across a variety of professional fields, such as medicine, sports, music, chess, computer programming, and mathematics (Ericsson et al., 2018). People may associate deliberate practice with the widely known "10,000-hour rule," popularized by Malcolm Gladwell in his 2008 book *Outliers*. Although a useful heuristic, Gladwell's work has perpetuated two misunderstandings. First, that 10,000 is the number of deliberate practice hours that everyone needs to attain expertise, no matter the domain. In fact, there can be considerable variability in how many hours are required (Ericsson & Pool, 2016).

The second misunderstanding is that engagement in 10,000 hours of work performance will invariably lead one to become an expert in that domain. This misunderstanding

FIGURE 1.1. Cycle of Deliberate Practice



Note. Reprinted from *Deliberate Practice in Emotion-Focused Therapy* (p. 7), by R. N. Goldman, A. Vaz, and T. Rousmaniere, 2021, American Psychological Association (<https://doi.org/10.1037/0000227-000>). Copyright 2021 by the American Psychological Association.

holds considerable significance for the field of psychotherapy, where hours of work experience with clients has traditionally been used as a measure of proficiency (Rousmaniere, 2016). But, in fact, we know that amount of experience alone does not predict therapist effectiveness (Goldberg, Babins-Wagner, et al., 2016; Goldberg, Rousmaniere, et al., 2016). It may be that the *quality* of deliberate practice is a key factor.

Psychotherapy scholars, recognizing the value of deliberate practice in other fields, have recently called for this method to be incorporated into training for mental health professionals (e.g., Bailey & Ogles, 2019; Hill et al., 2020; Rousmaniere et al., 2017; Taylor & Neimeyer, 2017; Tracey et al., 2015). There are, though, good reasons to question analogies made between psychotherapy and other professional fields, like sports or music, because by comparison, psychotherapy is so complex and free-form. Sports have clearly defined goals, and classical music follows a written score. In contrast, the goals of psychotherapy shift with the unique presentation of each client at each session. Therapists do not have the luxury of following a score.

Instead, good psychotherapy is more like improvisational jazz (Noa Kageyama, cited in Rousmaniere, 2016). In jazz improvisations, a complex mixture of group collaboration, creativity, and interaction is coconstructed among band members. Like psychotherapy, no two jazz improvisations are identical. However, improvisations are not a random collection of notes. They are grounded in a comprehensive theoretical understanding and technical proficiency that is only developed through continuous deliberate practice. For example, prominent jazz instructor Jerry Coker (1990) listed 18 different skill areas that students must master, each of which has multiple discrete skills, including tone quality, intervals, chord arpeggios, scales, patterns, and licks. In this sense, more creative and artful improvisations are actually a reflection of a previous commitment to repetitive skill practice and acquisition. As legendary jazz musician Miles Davis put it, "You have to play a long time to be able to play like yourself."

The main idea that we would like to stress here is that we want deliberate practice to help therapists using CBT skills to become themselves. The goal is to learn the skills so that you have them on hand when you want them. Practice the skills to make them your own. Incorporate those aspects that feel right for you. Ongoing and effortful deliberate practice should not be an impediment to flexibility and creativity. Ideally, it should enhance it. We recognize and celebrate that psychotherapy is an ever-shifting encounter and by no means want it to become or feel formulaic. Strong CBT therapists mix an eloquent integration of previously acquired skills with properly attuned flexibility. The core CBT responses provided are meant as templates or possibilities rather than "answers." Please interpret and apply them as you see fit, in a way that makes sense to you and, most important, to your individual clients. We encourage flexible and improvisational play.

Simulation-Based Mastery Learning

Deliberate practice uses simulation-based mastery learning (Ericsson, 2004; McGaghie et al., 2014). That is, the stimulus material for training consists of "contrived social situations that mimic problems, events, or conditions that arise in professional encounters" (McGaghie et al., 2014, p. 375). A key component of this approach is that the stimuli being used in training are sufficiently similar to the real-world experiences. This facilitates *state-dependent learning*, in which professionals acquire skills in the same psychological environment where they will have to perform the skills (Fisher & Craik, 1977; Smith, 1979). For example, pilots train with flight simulators that present mechanical failures and dangerous weather conditions, and surgeons practice with surgical simulators that present medical complications. Training in simulations with challenging

stimuli increases professionals' capacity to perform effectively under stress. For the psychotherapy training exercises in this book, the "simulators" are typical client statements that might actually be presented in the course of therapy sessions and call on the use of the particular skill.

Declarative Versus Procedural Knowledge

Declarative knowledge is what a person can understand, write, or speak about. It often refers to factual information that can be consciously recalled through memory and is often acquired relatively quickly. In contrast, procedural learning is implicit in memory, and "usually requires *repetition of an activity*, and associated learning is demonstrated through *improved task performance*" (Koziol & Budding, 2012, p. 2694, emphasis added). *Procedural knowledge* is what a person can perform, especially under stress (Squire, 2004). There can be a wide difference between their declarative and procedural knowledge. For example, an "armchair quarterback" is a person who understands and talks about athletics well but would have trouble performing it at a professional ability. Likewise, most dance, music, or theater critics have a very high ability to write about their subjects but would be flummoxed if asked to perform them.

In CBT training, the gap between declarative and procedural knowledge appears when a trainee or therapist is capable of reciting the textbook rationale for and implementation "nuts and bolts" of exposure, yet the actual implementation begins to fall to pieces when working with a highly anxious or resistant client in the moment. **The sweet spot for deliberate practice is the gap between declarative and procedural knowledge.** In other words, effortful practice should target those skills that the trainee could write a good paper about but would have trouble actually performing with a real client. We start with declarative knowledge, learning skills theoretically and observing others perform them. Once learned, with the help of deliberate practice, we work toward the development of procedural learning, with the aim of therapists having "automatic" access to each of the skills that they can draw on when necessary.

Let us turn to a little theoretical background on CBT (declarative knowledge) to help contextualize the skills of the book and how they fit into the greater training model.

Cognitive Behavioral Therapy

CBT is an umbrella for treatments that involve behavioral therapy theory and techniques, cognitive therapy theory and techniques, or a combination of these. Behavior therapy developed from basic and applied research on learning theory. Clinical applications followed lab-based experimentation with animals (e.g., Wolpe, 1952). The so-called cognitive revolution followed, with a focus on cognition as the key mediating factor to explain behavior (A. T. Beck, 1976; A. Ellis, 1962; Goldfried & Davison, 1976; Miechenbaum, 1977). Since the introduction of these clinical frameworks, and their often-inherent integration to some degree, considerable research has focused on understanding the etiology and maintenance of mental health problems through the lens of behavioral/learning and cognitive theory (Barlow, 2008).

CBT Theory

Unsurprisingly, cognitive and behavioral (C/B) theories emphasize the importance of associations among cognitions, behaviors, and emotions. Psychopathology is understood

to represent learned schemes (or schemata) that comprise these components and produce less adaptive behaviors and suffering (e.g., depression, anxiety; Barlow, 2008). Most CBT interventions aim to interrupt or modify maladaptive behavioral, cognitive, emotional, and physiological processes or alter the pathological beliefs, emotions, and behaviors that are involved in the maintenance of problem behaviors (Boswell et al., 2011).

Early behavioral theories (e.g., Mowrer, 1939; Watson & Raynor, 1920) posited that psychopathology (understood as less adaptive behaviors) could be explained through classical and operant conditioning principles. Although still connected with learning theory, cognitive theories focused on understanding and elaborating the construct of cognitive schema. Problems, such as major depressive disorder, were explained by negative, rigid cognitive schemata, which prime individuals to interpret experience through a negative, rigid lens. Behavior therapy, therefore, focuses on counterconditioning and manipulating contingencies; cognitive therapy, therefore, focuses on restructuring rigid, dysfunctional interpretations and negative core beliefs (A. T. Beck, 1976). Within the C/B paradigm, theories progressed to create diagnosis-specific models that attempted to explain core symptom clusters through the interaction of particular cognitive, behavioral, and physiological patterns (Barlow, 2008; Clark, 1986).

The empirical tradition of CBT can be observed in the unyielding attempts to test and refine C/B theories. Many such updates include contemporary knowledge of familiar foundational elements and processes, such as extinction (Craske et al., 2008), as well as findings from emotion science (Barlow, 2002; Barlow et al., 2004; Boswell, 2013; Power & Dalgleish, 2008). The empirical status of C/B theories is robust and still actively developing, based on accumulating findings from diverse areas of basic psychology, experimental psychopathology, and applied clinical research.

CBT Process

Although CBT is considered technique-focused, it is important to emphasize the importance of the working alliance in this treatment approach. The importance of developing and maintaining a positive CBT working relationship has been acknowledged explicitly for many decades (A. T. Beck et al., 1979; Foa et al., 1983). Research has also demonstrated that the quality of the working alliance in CBT is quite positive (Fluckiger et al., 2018; Keijsers et al., 2000). Interpersonally, a CBT therapist stance is genuine, empathic, and collaborative (Castonguay et al., 2011). In general, the CBT therapist style is more active and directive, and this makes transparency important; specifically, the CBT therapist provides a clear framework and set of expectations for the focus of the treatment and what will take place within and across sessions. In terms of collaboration, the stance of "collaborative empiricism" is a defining feature, in which the CBT therapist works with the client to develop a scientific attitude toward experience and new learning. Although CBT is less likely to view the quality of the working alliance as a *primary* mechanism of change in therapy, the working alliance is indeed important in CBT and is seen as a critical facilitative factor (Castonguay et al., 2011).

Schemata and fear structures (Foa & Kozak, 1986) are assumed to comprise dynamically interacting information process systems related to behavior, physical sensations, cognitions, and emotions. Any or all of these systems can be a target of treatment, and it is generally assumed that changes in one component of experience will affect changes in others (e.g., behavioral interventions can promote cognitive change;

Goldfried & Davison, 1976). Consistent with its behavioral roots, an understanding of the environment or context in which less adaptive behaviors and experiences occur is critical. The pattern of responses traces the environment and contextualized antecedents, to the mediating cognitions (appraisals and beliefs), and then the behavioral responses. Avoidance behaviors (e.g., fleeing a situation at the onset of panic attack symptoms), presumed to serve a negative reinforcement function, are of particular interest. The process of developing a working model of such patterns is commonly referred to as a functional analysis of behavior. Once the unique pattern has been "diagnosed," most contemporary CBT approaches involve inviting the client to enter or attend to the problematic situation, while evoking and experiencing relevant emotions (e.g., anxiety or fear; to facilitate "hot cognitions" or "emotional processing"; e.g., Barlow et al., 2017), and eliminating avoidance behavior. This more exposure-focused work is often done in conjunction with cognitive appraisal and reappraisal strategies (reevaluating the thoughts that occurred in the situation), as well as brainstorming alternative behaviors (e.g., exposure to feared experience and conversely, avoiding avoidance).

CBT approaches emphasize learning through experience and the therapist works to create opportunities for corrective learning experiences (see Castonguay & Hill, 2012). The nature of the corrective learning might vary as a function of the specific CBT protocol. Behaviorally oriented therapists will emphasize exposure and the elimination of avoidance (behavioral, cognitive, emotional); cognitive therapists will emphasize testing predictions and thoughts with cognitive reappraisal and behavioral experiments to test negative expectancies (e.g., Did the imagined worst-case scenario actually happen?). In practice, there is considerable overlap in terms of what the therapist does and how change is assumed to occur, hence the use of the broader label of CBT. For example, counterconditioning is likely to occur in both exposure and behavioral experiments, as are violations of expectancies (Craske et al., 2008).

Although variability exists among specific CBT protocols, most forms of CBT involve core components, such as psychoeducation, experience monitoring, cognitive reappraisal, exposure, and homework assignments. The type of exposure (e.g., in vivo vs. imaginal) and use of other commonly used strategies, such as behavioral activation, will depend more on the client and the nature of the presenting problem. Returning to the toolbox metaphor, the selection of specific techniques is tailored to the client. Decisions are guided by the working case formulation (functional analysis), with particular attention to the maintaining factors (Fisher & Boswell, 2016). The importance of an individualized case formulation should be emphasized. The use of treatment manuals, which are commonly associated with the CBT tradition, has been critiqued because of the perception that manuals promote a rigidly standardized, one-size-fits-all approach to treatment. Manuals can provide a coherent structure and serve as a useful guide, yet CBT techniques are intended to be applied idiosyncratically to the individual client.

It has become somewhat cliché, but it is very much the case that the CBT approach promotes the client's capacity to be their own therapist. Consequently, it is important for the client to be able to apply the concepts and skills that they have learned within the session (and with the therapist) in their day-to-day lives outside of therapy. In addition, the generalizability of in-session learning is potentially limited if opportunities for application in varied routine contexts does not occur. Practice in real-world environments is essential, and this underscores the importance of between-session activities (i.e., homework). Research has demonstrated a significant positive association between

the use of homework and outcome in CBT (Kazantzis et al., 2016, 2000). As we stated elsewhere (Boswell et al., 2011),

the use of homework in CBT is similar to that of learning a new language. One needs to immerse oneself in the language if one is to be fluent enough to use it in difficult situations. Although the therapy sessions may provide the basics of grammar and vocabulary for the language, only by using it in every opportunity can one truly master it and be able to use it independently even long after treatment. (p. 107)

The CBT paradigm has accumulated significant empirical support over the past 60-plus years. Although varied in emphasis (e.g., behavioral, cognitive, or a combination) and the specific constellation of techniques, the extant evidence supports the use of CBT for a wide spectrum of presenting problems (Nathan & Gorman, 2007). There also remains a constant effort toward evaluating what is working within CBT and how it can be improved. To that end, we conclude this section by providing some additional context for the skills addressed in this book.

To remain consistent with its epistemological roots, it is only natural for CBT to evolve in response to theoretical, empirical, and practical developments. The development and testing of transdiagnostic CBT approaches is one example. Although most of the core elements of "traditional" CBT protocols are integrated into transdiagnostic approaches, some elements are arguably less traditional and the whole is greater than, or at least somewhat different from, the sum of its parts. For example, mindfulness strategies have been integrated into more recently developed CBT protocols. In some instances, mindfulness theory and practice is more seamlessly integrated into a broadly CBT oriented model, such as with dialectical behavioral therapy (Linehan, 1993). In other instances, mindfulness can be treated as an "add-on" component or module to an otherwise standard CBT protocol. More recently, researchers have developed and tested the integration of motivational interviewing strategies in CBT (Westra et al., 2016). This work has raised awareness of constructs that have historically received less attention in CBT, such as client resistance and change ambivalence, and the therapist's responsive use of client-centered stances and strategies.

In addition, the importance of the working alliance has received more explicit and nuanced attention from CBT researchers and clinicians in recent years. In fact, many of the developments in alliance-rupture repair work and alliance-focused training have taken place within the context of CBT (Eubanks et al., 2018). Finally, Samoilov and Goldfried (2000) argued for the importance of emotion in CBT and suggested that the 2000s would be the decade of emotion for this orientation. In hindsight, this was quite prescient, as CBT has become more explicitly emotion focused in recent decades. A prime example is the Unified Protocol for Treatment of Emotional Disorders (UP; Barlow et al., 2011, 2017). The UP is transdiagnostic, integrates mindfulness, adopts a modular approach to treatment (including a module dedicated to motivation enhancement), and focuses heavily on emotion.

This is not intended to be an exhaustive list or breakdown of contemporary versions or elements of CBT. Rather, these examples are intended to provide context for the remainder of this book. Although this book is very much intended to be, at its core, CBT, "this is not your grandparents' CBT." We have adopted a contemporary CBT "spirit" that is emotion focused and does not shy away from terms like resistance, ambivalence, responsiveness, and the alliance. We view these concepts and elements as ultimately compatible with the CBT paradigm, and we view them as pathways for enhancing its impact.

Deliberate practice methods are particularly well-suited to the CBT paradigm, so developments in this area are exciting. Perhaps more so than any other system of psychotherapy, CBT scholars and practitioners have worked to distill and codify technical skills and associated competence domains. The eclectic nature of this paradigm's technical repertoire also fits a learning approach that prioritizes breaking things down into digestible, meaningful elements (of course, ultimately in a cohesive manner that is consistent with the treatment rationale and plan). The elemental nature of a specific skill falls nicely in line with core features of deliberate practice, such as setting incremental goals that are within one's zone of proximal development and engaging in repetitive behavioral rehearsal. These are common features of any learning process, and CBT clinicians need look no farther than their typical outpatient session to underscore this point. Therapists don't throw the CBT-based kitchen sink at a client during session one, assign remodeling the kitchen as homework, and then move on to refinish the bathroom the next week. Rather, concepts and skills are broken down into digestible units, as repetition promotes and strengthens learning. Moreover, adjustments to intensity and complexity are made for a given client based on careful observation and feedback. The same principles can be applied to therapist training, making it an excellent match for deliberate practice methods.

From a different perspective, one can contrast deliberate practice methods with common training approaches. To be clear, we do not view different approaches to learning CBT as mutually exclusive; rather, we view them as complementary. For example, even with a solid foundation in CBT coursework and application, speaking from personal experience, it can be quite difficult to "learn" CBT from treatment manuals. I (JFB) am admittedly fond of treatment manuals and use them extensively. Most manuals are written first to be applied with actual clients; they are not written first to train therapists, particularly novice therapists (this is not intended to be a critique because our sense is that this statement would not be viewed as controversial by manual developers). However, our experience is that manuals are often used as a core training tool and that the testing and trial-and-error phase of applying the elements of the manual occurs with actual clients. The deliberate practice approach offers a paradigm for taking these same elements and applying them in training simulations that allow for repetition, feedback, and adjustments. Specifically related to this book, there are also opportunities to practice how to respond when things do not go perfectly as planned, which is often the case, outside of "primetime" (see Chapter 3).

Cognitive Behavioral Skills in Deliberate Practice

We have thus far provided a brief introduction to CBT and highlighted how deliberate practice methods are particularly well-suited to the CBT paradigm. In the following sections, we describe the categorization of different CBT skills and outline the skills that will be the focus of the deliberate practice exercises in this book. In addition, we address the importance of basic communication features in CBT, such as emotional expression and nonverbal behavior.

Categorizing CBT Skills

Under the broad label of CBT technical factors, previous work has suggested that skills can be divided into different categories. In cognitive therapy for depression, DeRubeis and Feeley (1990; Feeley et al., 1999), distinguished between *concrete* and *abstract*

cognitive therapy features. Concrete features included, but were not limited to, setting and following an agenda, assigning and reviewing homework, labeling cognitive errors, examining evidence for beliefs, and asking clients to self-monitor and record thoughts. Abstract features included, but were not limited to, addressing the relation between thoughts and feelings, cognitive therapy rationale, exploring underlying assumptions, and negotiating the content of the session. These features were extracted from the Collaborative Study Psychotherapy Rating Scale (CSPRS; Hollon et al., 1988), which was designed to distinguish between sessions of cognitive therapy and alternative psychotherapy models.

Similar assessments of CBT adherence and competence provided additional guidance. Muse and McManus (2013) identified more than 60 measures of CBT fidelity in their comprehensive literature review. By far, the most commonly used measure was the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980). With this measure, there is some precedence for dividing skills categories into (a) general therapy skills (e.g., interpersonal effectiveness/collaboration) and (b) CBT-specific skills (e.g., focusing on key cognitions and behaviors, cognitive conceptualization). Vallis et al. (1986) found support for a general competence factor yet also observed a second factor that seemed more related to session "structure," such as setting an agenda, time and session management, and assigning and reviewing homework assignments.

Ultimately, theory and research have failed to deliver a universally agreed on factor model for the CTRS, yet more recent work indicates that a single, global cognitive therapy competence factor is the best fit for examining cognitive therapy competence at the between-therapist level, which is arguably most relevant for training and certification efforts (Goldberg et al., 2020).

Despite these mixed findings, we used previous competence assessment work to guide our skill selection and categorization, while considering additional factors. For example, although the CTRS has been used extensively in both CT and CBT research, practice, and training, it was initially developed for CT and the items, understandably, more directly align with this specific approach. Most of the existing CBT fidelity measures were developed specifically for CT, BT, or CBT, and focus on a particular diagnosis or a set of diagnoses within the same general class (e.g., anxiety disorders). To enhance generalizability, our goals were to focus on skills that spanned CT, BT, and CBT (both more traditional and contemporary styles), and to adopt a transdiagnostic approach.

Ultimately, we were conceptually inclined toward a distinction among (a) beginner foundational/structural CBT skills, (b) intermediate general problem-focused CBT skills, and (c) advanced flexibility within CBT fidelity-oriented skills (Kendall et al., 2008). With this in mind, we considered (a) explaining the treatment rationale for CBT, (b) establishing treatment goals, (c) negotiating a session agenda, and (d) assigning and reviewing between-session activities (i.e., homework) to be structural skills. These structural skills are nearly universally included in measures of CBT fidelity in controlled trials and training and certification activities.

In turn, we considered (a) working with cognitions, (b) working with behaviors, and (c) working with emotions to be general problem-focused CBT skills. You will likely notice that these skills are framed around the *focus* of the therapist rather than a specific technique. For the purposes of this book, these skill labels are intentionally broader than specific skills, such as exposure, Socratic dialogue, relaxation training, or mindfulness. It is notable that within the deliberate practice approach, even these specific skills are likely too broad. For example, "doing an exposure" is a rather complex intervention. It

includes, among other features, providing a rationale, establishing a hierarchy, delineating expectancies, repeated implementation of stimuli, monitoring, and debriefing. We describe each of these skill exercises (working with cognitions, working with behaviors, and working with emotions) in more detail later. We note here, however, that the diversity of circumstances to implement more specific skills (e.g., guided discovery) is represented in the diversity of client stimuli in each of the exercises in this book. That is, rather than create a separate exercise for exposure therapy, many of the stimuli in the working with behaviors exercise call for an exposure-oriented response, in addition to other types of behaviorally oriented responses (e.g., stimulus control, activity scheduling).

Our tongue-in-cheek description of the third category of skills in this book, flexibility within fidelity (all considered to be advanced skills), is what to do when CBT starts going off the rails. More specifically, the skills within this category focus on CBT implementation in the face of impasses and implementation roadblocks and include (a) implementing adherence flexibility, (b) responding to therapeutic alliance ruptures, and (c) responding to client resistance. The ultimate focus of these skills is to help trainees learn how to maintain a consistent, collaborative CBT framework with clients in the face of difficulties, while exercising flexibility and tailored responsiveness that meets the clients where they are in the session or a given treatment.

The CBT Skills Presented in Exercises 1 Through 10

This section briefly describes the skills presented in the deliberate practice exercises and highlights any important takeaways for each skill that will be helpful for trainers and trainees to keep in mind. The skills are grouped by difficulty (beginner, intermediate, and advanced), and their order matches the order of the exercises in Part II.

Beginner Skills

Exercise 1: Explaining the Treatment Rationale for Cognitive Behavioral Therapy. Explaining the rationale for CBT is an essential skill that helps get therapy off on the right foot (King & Boswell, 2019). In our experience, after some basic coursework in CBT theory and application, trainees are able to give a nice textbook explanation of the CBT model and rationale. It is quite another thing to provide a convincing treatment rationale when interacting with an actual client. Importantly, the skill of providing a rationale is not limited to the first session with a client; therapists should be sensitive to rationale throughout therapy, in order to help facilitate a collaborative therapeutic relationship and evolving treatment plan (Coyne et al., 2019).

Although the development of a collaborative spirit is critical, early sessions are a bit more didactic. This includes a description of the broad CBT model and an initial working formulation from this perspective, which leads to a preliminary description and discussion of the treatment tasks and goals. The focus on treatment tasks includes the basic structure of the treatment session(s)—what the client and therapist's time together will look like—for example, setting up the expectation that sessions will begin by setting an agenda (in collaboration with the client). Establishing a rationale and goal-oriented framework in the first session(s) capitalizes on the importance of perceived treatment credibility, as well as the facilitation of task and positive treatment outcome expectancies.

Therapists can use this skill unprompted or in response to client inquiries about how CBT works, what methods CBT therapists use, and what will happen in the sessions. Like

much of CBT, explaining a treatment rationale is not a singular event; rather, it should be used as needed, perhaps especially when a client expresses confusion about, or doubt in, elements of the CBT model. Provision of a treatment rationale, establishing a clear framework, and appeals to research evidence are universal hallmarks of evidence-based CBT protocols. Findings from meta-analyses also highlight the importance of promoting clients' early positive treatment outcome expectancies (Constantino et al., 2018a) and perceptions of treatment credibility (Constantino et al., 2018b) for treatment outcome.

Exercise 2: Establishing Goals. CBT is a goal-oriented approach. Establishing shared treatment goals and tasks early in treatment not only facilitates a positive working alliance and congruent expectancies (both of which can facilitate good outcomes), but also provides a personalized treatment roadmap. It is difficult to navigate the journey when one does not know the destination. Such navigation to long-term goals is aided by establishing short- and middle-term goals. In addition, some research has shown that early participant agreement on goals and tasks is particularly important for CBT outcome (Webb et al., 2011).

Although therapists should use this skill at the outset of CBT, similar to providing a rationale, attending to and negotiating goals and tasks is not a singular or solely early treatment event. Even if not explicitly addressed in a given session, goals and tasks are invariably in the background. Moreover, they might require close attention as treatment unfolds, such as when a client masters a skill and prefers to refocus on something else, or when progress has stalled or failed to develop. In addition, goal-setting is not a skill that the therapist unidirectionally "delivers"; rather, it is typically (and most usefully) a collaborative exercise. A big part of the skill is to negotiate with the client personalized CBT goals that they value, as well as a corresponding framework (personalized rationale) and goal-consistent tasks.

Exercise 3: Negotiating a Session Agenda. Negotiating a session agenda is an essential skill that helps get the session off on the right foot, clarifies expectations for the appointment, and fosters continued collaboration on specific goals and tasks. In addition, some research has shown that techniques, such as agenda setting, are uniquely associated with symptom reduction in CBT (DeRubeis & Feeley, 1990).

Therapists should use this skill at the beginning of most CBT sessions. However, like much of CBT, setting a session agenda is not a singular event; rather, it is foundational to overall session and time management and requires attention at various points in a session. Moreover, it is typically (and most usefully) a collaborative exercise. The client's input on the agenda should be directly solicited. A big part of the skill is to negotiate with the client personalized CBT agendas that they value and includes goals that they are at least to some degree motivated to work toward in the moment. When agenda negotiations seem to be moving in a direction that is inconsistent with the established treatment framework and plan, therapists may need to rely on some of the more advanced skills covered in this book (see Exercises 8–10).

Exercise 4: Assigning and Reviewing Between-Session Activities. Between-session practice and activity (i.e., homework) is a core feature of CBT. Homework's importance has been researched relatively thoroughly and shown to be a significant predictor of outcome in CBT (Kazantzis et al., 2000, 2016). Between-session activities facilitate the corrective learning process—both in and outside of CBT sessions. Furthermore, work outside of the sessions assists with generalization and helping the client to become their own therapist. Although completing homework can certainly be challenging for clients, there is a general expectation that some form of homework be incorporated

across most sessions. Thus, when socializing clients to CBT, setting this expectation and discussing any questions or concerns that the client has is important. In particular, therapists should emphasize how homework can help generalize the skills learned in, and the experiences of, therapy to daily life outside of the therapy appointment.

Given its ubiquity, we view assigning and reviewing homework as a beginner or "basic" skill. When following a typical session agenda, time is budgeted at the end of each session to collaboratively identify between-session activities, such as experience monitoring, behavioral experiments, exposures, or relevant readings. In turn, time is budgeted at the beginning of the subsequent session to review the previous session's assigned homework. It is also important to tailor assignments to the individual client.

Intermediate Skills

Exercise 5: Working With Cognitions. As established, CBT involves a mix of C/B strategies. Even in more strictly behavioral treatment approaches, such as behavioral activation, cognitions remain important. Guided discovery is an essential process of cognitive work in which the therapist assists the clients in finding their own understandings of, and solutions to, personal concerns. To facilitate this process, CBT clinicians often use the cognitive method of Socratic questioning.

In our experience, it can be easier to first describe guided discovery (and Socratic questioning) by what it is not (or, at least, not intended to be). Guided discovery is not, for example, telling clients that their thinking is wrong or convincing them to change their beliefs. It is also not a series of "why" questions that imply a current problem or irrationality in thoughts, emotions, or behaviors. Rather, in the spirit of collaborative empiricism, guided discovery involves helping clients gather relevant information, examine it in different ways (without judgment from the therapist), and develop a personalized plan for what to do with it. In other words, the goal of working with cognitions is not to simply tell clients to think differently or point out flaws; rather, it is to teach clients a process for evaluating their own experience and determining subsequent actions based on this self-reflection. Consistent with more contemporary CBT perspectives on working with cognitions (e.g., Barlow et al., 2017), we view facilitating the client's cognitive flexibility as a central aim of working with cognitions.

In addition, because a mix of cognitive and behaviorally oriented strategies is common in most treatments, it is important for trainees and trainers to keep the context of the deliberate practice exercise in mind. Depending on the nature of the individual treatment, as well as the preferences and expectations of the client and therapist, the same client statement could conceivably be met with a cognitive-, behavior-, or emotion-focused therapist response—all remaining under the broad CBT umbrella. It is not, therefore, "wrong" for a trainee to focus instinctively on behavior when working on the cognitive skill exercise. However, we strongly encourage trainees and trainers to work within the skill of interest; that is, even if one's general preference or instinct is to focus on behaviors, it is important to prioritize a focus on cognitions when practicing the working with cognitions stimuli. The recognition that practicing such a narrow focus is more difficult for some trainees is important information; perhaps they are developing their style as a more behaviorally focused CBT therapist. That is great! Concomitantly, this means that these trainees need to build up their cognitive "muscle" in the interest of becoming a more well-rounded CBT therapist.

Exercise 6: Working With Behaviors. Even in more strictly cognitive treatment approaches, explicitly working with behaviors remains important (e.g., conduct of behavioral experiments). Behavioral work relies on principles of classical and operant

conditioning, which translate to a relatively eclectic toolbox of strategies. Behavioral interventions can focus on antecedents, the behavioral repertoire itself (including skill deficits), contingencies, and consequences, depending on the nature of the presenting problem. Behavioral strategies can include exposure, stimulus control, activity scheduling, contingency management, and behavioral skill training, among others.

Selection of the appropriate behavioral target and intervention can vary greatly among clients, even within ostensibly similar presenting problem domains, thus requiring an idiographic approach. Given the need for an idiographic approach and the diversity of skills and strategies that can be placed under the behavioral umbrella, we are unable to address them all in this book. Rather, we focus on working with (or targeting) behaviors more broadly, as well as the application of learning principles to facilitate change processes more broadly.

Once again, it is important for trainees and trainers to keep the context of the specific deliberate practice exercise in mind. Depending on the nature of the individual treatment, as well as the preferences and expectations of the client and therapist, the same client statement could conceivably be met with a cognitive-, behavior-, or emotion-focused therapist response—all remaining under the broad CBT umbrella. It is not, therefore, “wrong” for a trainee to focus instinctively on cognition when working on the behavior skill exercise. However, we strongly encourage trainees and trainers to work within the skill of interest; that is, even if one’s general preference or instinct is to focus on cognitions, it is important to prioritize a focus on behaviors when practicing the working with behaviors stimuli. The recognition that practicing such a narrow focus is more difficult for some trainees is important information; perhaps they are developing their style as a more cognitively focused CBT therapist. That is great! Concomitantly, this means that these trainees need to build up their behavior “muscle” in the interest of becoming a more well-rounded CBT therapist.

Exercise 7: Working With Emotions. A therapist’s ability to evoke, tolerate, and work effectively with client emotions are critically important in CBT. Moreover, “working with” implies helping the client to tolerate their emotions and emotion-related distress, such as in the case of exposure. Exposure is a potent, yet often intense intervention, both for the client and therapist. In addition, beyond exposure-based interventions, contemporary CBT models attend explicitly to emotions in varied ways, often with a goal of reducing emotion-related avoidance (Barlow et al., 2017; Boswell, 2013). It may be more intuitive to think about this skill as focusing on helping clients work on their emotional experience and processing, yet the emotions serve both inter- and intrapersonal functions, and research demonstrates that both client and therapist emotional expression are associated with treatment outcome (Peluso & Freund, 2018).

As such, the decision to implement exposure or to work with emotions and address emotion avoidance in other ways is predicated on the therapist’s skill of tolerating the inherent discomfort often affiliated with such foci. Difficulty with this skill can translate to the therapist maladaptively avoiding the use of this potentially potent intervention and/or reinforcing client avoidance and, thereby, maintaining the problem(s). Thus, practicing this skill can help therapists circumvent this fairly typical, understandable, and inadvertent negative reinforcement process.

Advanced Skills

Exercise 8: Adherence Flexibility. Although extant evidence fails to demonstrate a consistent, linear relationship between adherence and treatment outcome, there is both direct and indirect evidence for the importance of maintaining a coherent treatment frame-

work (Boswell et al., 2010). Furthermore, among the wide variety of CBT techniques included in evidence-based treatments, the evidence supporting the importance of any specific technique is mixed (Cuijpers et al., 2019). There is some evidence that adherence aligns with the story of Goldilocks (McCarthy et al., 2016). The extreme ends of the adherence continuum appear to be problematic—that is, rigid adherence or haphazard eclecticism (or the absence of working from a coherent framework). The “just right” findings underscore the importance of flexibility within fidelity (Kendall et al., 2008). When considering flexible practice, others have made the distinction between fidelity-consistent and fidelity-inconsistent modifications to a specific treatment protocol. When following a CBT manual, for example, a therapist might adopt a technique that is not specifically included in the designed protocol, yet the adopted technique is still consistent with the broader CBT model (fidelity-consistent modification). Conversely, fidelity-inconsistent modifications represent the adoption of techniques that are inconsistent with the broader CBT model. Setting aside arguments that, on closer inspection, some techniques that initially appear to be unique to a particular model may not be (Castonguay, 2011), in this skill, we focus on what we would consider fidelity-consistent modification or flexibility. That is, responding in a flexible manner to the needs and circumstances of the individual client, while remaining anchored in the broad CBT model.

Exercise 9: Responding to Therapeutic Alliance Ruptures. Therapist flexibility and the ongoing tailoring of CBT to the specific client and context represents evidence-based practice in its most complex and fullest form. Complementing the skill of CBT fidelity-consistent modification and flexibility, there is also growing evidence that CBT is more effective when therapists fully, although temporarily, “depart” from standard CBT skills in the face of certain in-session process markers or moments (see Constantino et al., in press). Depending on the marker, the therapist can use specific and evidence-informed CBT fidelity-inconsistent strategies until the salient (and often hindering) process has been addressed; such resolution would then precipitate a return to standard CBT. In this skill, we focus on the responsive use of *humanistic and interpersonal* skills to address alliance ruptures that may emerge in the client–therapist relationship during a course of CBT.

A quality therapeutic alliance is commonly and pantheoretically defined as comprising three interrelated components: (a) client and therapist agreement on treatment goals; (b) client and therapist agreement on the tasks that will be used to achieve those goals; and (c) a dyadic bond that the client and therapist experience as secure, warm, and friendly. Such relational qualities can wax and wane during therapy, especially considering the natural strains of therapeutic work or other dyadic misattunements that might rupture (in one participant, the other, or both) a sense of coordinated collaboration or close connection. When such ruptures occur, they can relate to maladaptive treatment processes and outcomes (Eubanks et al., 2018). Importantly, though, they can also represent potential change opportunities that, if handled skillfully, can be therapeutic. That is, rupture repair can be a therapy change mechanism that operates instead of, or alongside, the putative mechanisms of the treatment being delivered. In this case, rather than persist with CBT in the face of rupture markers, which might involve trying to convince the client of CBT’s merits, research supports a contextual shift from CBT to a more humanistic and interpersonal stance and strategy.

To responsively apply such strategies first requires noticing markers of alliance rupture, which (when originating with the client) can be generally classified into two types. The first, *withdrawal markers*, represent the pursuit of relatedness at the expense of one’s

need for self-definition or assertion (i.e., being reluctant to confront because of fear of losing the relationship). The second, *confrontation markers*, represent the expression of self-definition at the expense of relatedness. Whatever the type, the marker represents an important message about the state of the relationship and treatment that a clinician would be wise to explore via the interpersonal strategy of metacommunication or bringing immediate awareness to bear on the relational process as it unfolds (Muran & Eubanks, 2020). Such temporary and contextual departure from CBT can be facilitative, both on its own as a corrective interpersonal experience and by restoring the working relationship to the point of returning to the CBT plan.

Exercise 10: Responding to Client Resistance. As noted, therapist flexibility and the ongoing tailoring of CBT to the specific client and context represents evidence-based practice in its complex, fullest form, including deviating from CBT when clinically indicated. For this departure skill, we focus on the responsive use of *client-centered* skills to address client *resistance* that may emerge during a course of CBT (Leahy, 2003).

Namely, research supports a contextual shift from CBT to motivational interviewing (MI) strategies and "spirit" when a client demonstrates resistance to the direction of the treatment or provider (e.g., Westra et al., 2016). Resistance, a regularly occurring clinical process, can stem from a few common precipitants. For example, it may reflect a client's diminishing belief in the personally relevant logic or efficacy of CBT, despite being motivated to reduce symptoms and improve functioning. Alternatively, resistance may be the manifestation of a client's understandable ambivalence about change and moving away from what is familiar (even if it is maladaptive). Such resistances can take different direct forms (e.g., homework noncompliance, explicitly disagreeing with the treatment rationale, criticizing the therapist) or indirect forms (e.g., missing sessions; in-session withdrawing, interrupting, or sidetracking), but the general experience is palpable client opposition to the current session agenda or general direction of treatment. Importantly, though, resistance is usually a valid client message that the treatment is misaligned with their ideas about improvement, that they are ambivalent about changing, that the therapeutic relationship is misattuned, or a combination of these. Whatever the reason, persisting with the current plan is unlikely to help, whereas engaging more client-centered, MI principles, precisely in this context, can be facilitative (see Westra, 2012; Westra & Constantino, 2019).

A Note About Vocal Tone, Facial Expression, and Body Posture

Among the overarching aims of CBT deliberate practice, the hope is that learners will develop the ability to apply skills in a range of clinical situations and use this as an opportunity to exercise the skills using a style and language that is congruent with who they are. Just as we encourage those who are role-playing as the client to adjust the difficulty of the stimuli (e.g., their tone and the quality and intensity of affect), we also encourage therapists to adjust and experiment with their vocal tone, facial expressions, and body postures, as appropriate. Of course, basic principles should be generally followed, such as engaging in nonverbal behaviors that communicate active listening and engagement. However, even factors such as maintaining consistent eye contact may need to be adjusted, depending on the characteristics of the individual client. Relatedly, on multiple occasions, supervisees have asked about whether it is best to try to match the client's vocal tone and affect or to maintain a neutral tone and posture, regardless of the circumstances. The admittedly frustrating answer is it depends. As noted, research demonstrates that therapist emotional expression is associated with treatment outcome (Peluso & Freund, 2018). However, this is an overall effect, and the

association between emotional expression and outcome at the individual client-therapist dyad level is complex. Therefore, we encourage learners to be mindful of their emotional expressions and nonverbal behaviors while engaging in the deliberate practice exercises.

The Role of Deliberate Practice in CBT Training

In this chapter and before each exercise in this book, we provide a brief introduction to the skill(s) that includes some attention to theory, research, and generally accepted application principles. However, neither this book nor the deliberate practice method in general is intended to be sufficient for obtaining competence in CBT on its own. Although we envision this book as being useful for CBT training and professional development at all levels, our working model has been a method that can be integrated into a one- or two-semester practicum or other application-oriented courses (see the sample syllabus in Appendix C). With this in mind, trainees should have prior and/or parallel exposure to CBT theory and application in dedicated coursework and readings. In line with what we said earlier in this chapter, this loosely reflects the distinction between declarative and procedural knowledge. The CBT deliberate practice methods outlined in this book are not intended to be a primary source of declarative knowledge. In addition, they are not intended to replace or stand in for work performance or work with actual clients or training cases and case-based supervision (e.g., with review of actual session audio or video).

Deliberate practice methods should play a complementary role in CBT training, in the service of augmenting core readings and work performance with real clients. For example, deliberate practice methods could provide the first opportunity for a trainee to translate their textbook definition of CBT learned in a seminar to the provision of a treatment rationale with an actual client. The simulated environment mimics the clinical interaction, while providing opportunities for behavioral rehearsal and feedback. Later in this chapter, and throughout this book, we recommend resources that provide more information about CBT principles, skills, and training.

Overview of the Book's Structure

This book is organized into three parts. Part I contains this chapter and Chapter 2, which provide basic instructions on how to perform these exercises. We found through testing that providing too many instructions up-front overwhelmed trainers and trainees, and they ended up skipping past them as a result. Therefore, we kept these instructions as brief and simple as possible to focus on only the most essential information that trainers and trainees will need to get started with the exercises. Further guidelines for getting the most about deliberate practice are provided in Chapter 3, and additional instructions for monitoring and adjusting the difficulty of the exercises are provided in Appendix A. **Do not skip the instructions in Chapter 2, and be sure to read the additional guidelines and instructions in Chapter 3 and Appendix A once you are comfortable with the basic instructions.**

Part II contains the 10 skill-focused exercises, which are ordered based on their difficulty: beginner, intermediate, and advanced (see Table 1.1). They each contain a brief overview of the exercise, example client-therapist interactions to help guide trainees,

step-by-step instructions for conducting that exercise, and a list of criteria for mastering the relevant skill. The client statements and sample therapist responses are then presented, also organized by difficulty (beginner, intermediate, and advanced). The statements and responses are presented separately so that the trainee playing the therapist has more freedom to improvise responses without being influenced by the sample responses, which should only be turned to if the trainee has difficulty improvising their own responses. The last two exercises in Part II provide opportunities to practice the 10 skills within simulated psychotherapy sessions. Exercise 11 (Annotated Cognitive Behavioral Therapy Practice Session Transcripts) provides sample psychotherapy session transcripts in which the CBT skills are used and clearly labeled, thereby demonstrating how they might flow together in an actual therapy session. CBT trainees are invited to run through the sample transcript with one playing the therapist and the other playing the client to get a feel for how a session might unfold. Exercise 12 (Mock Cognitive Behavioral Therapy Sessions) provides suggestions for undertaking actual mock sessions, as well as client profiles ordered by difficulty (beginner, intermediate, and advanced) that trainees can use for improvised role-plays.

Part III contains Chapter 3, which provides additional guidance for trainers and trainees. While Chapter 2 is more procedural, Chapter 3 covers big-picture issues. It highlights six key points for getting the most out of deliberate practice and describes the importance of appropriate responsiveness, attending to trainee well-being and respecting their privacy, and trainer self-evaluation, among other topics.

Three appendixes conclude this book. Appendix A provides instructions for monitoring and adjusting the difficulty of each exercise as needed. It provides a Deliberate Practice Reaction Form for the trainee playing the therapist to complete to indicate whether the exercise is too easy or too difficult. Appendix B includes an optional deliberate practice diary form, which provides a format for trainees to explore and record their experiences while engaging in deliberate practice between focused training sessions with a supervisor. Appendix C presents a sample syllabus demonstrating how the 12 deliberate practice exercises and other support material can be integrated into a wider CBT training course. Instructors may choose to modify the syllabus or pick elements of it to integrate into their own courses.

For supplemental materials related to this book, see Clinician and Practitioner Resources at <https://www.apa.org/pubs/books/deliberate-practice-cognitive-behavioral-therapy>, which features the three appendixes from this book.