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Therapeutic Strategies and Techniques in Early Cognitive-Behavioral Therapy

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Examination of the early phase of therapy is of growing importance. Early improvement in client symptoms and functioning is associated with positive posttreatment outcomes and reduced premature termination, including in cognitive-behavioral-oriented treatments. This article focuses on 3 strategies salient in the early phase of cognitive-behavioral therapy, including the provision of a rationale and goal-oriented framework, cultivating an attitude of collaborative empiricism, and initiating objective client self-monitoring. A description and rationale, relevant supporting research, and case examples are presented for each component. Finally, practical recommendations are offered for therapists and trainees to implement these strategies in their own practice.

Clinical Impact Statement

Question: Which research-supported techniques and strategies are introduced in the first sessions of cognitive-behavioral therapy (CBT) to positively initiate the therapeutic process? ***Findings:*** Establishing a clear treatment rationale and goal-oriented framework, fostering an attitude of collaborative empiricism, and initiating objective self-monitoring are strategies used by the CBT therapist in the first several therapy sessions. ***Meaning:*** Therapists can implement these strategies in the first sessions of CBT to positively initiate the therapeutic process. ***Next Steps:*** Clinicians and researchers should examine the proximal and distal impacts of implementing these CBT strategies early in the therapeutic process.

Keywords: early treatment, cognitive-behavioral therapy, self-monitoring, collaborative empiricism, treatment framework

Early treatment processes, strategies, and techniques are of growing interest and importance to researchers and clinicians. Many critical aspects of treatment are introduced and fostered during the initial sessions of the therapeutic encounter, including factors that are associated with positive outcomes, such as a positive therapeutic alliance (Zilcha-Mano & Errazuriz, 2017) and expectations (Greenberg, Constantino, & Bruce, 2006). In addition, clients who demonstrate improvement in symptoms and functioning during the early treatment phase have significantly better posttreatment outcomes compared with those who improve more gradually throughout treatment, and this pattern holds across different theoretical orientations and clinical populations (Haas, Hill, Lambert, & Morrell, 2002; Melchior et al., 2016; Renaud et al., 1998). However, less is known about specific therapist behaviors and therapeutic techniques that promote positive client experiences and change early in treatment. Consequently, it is important to seek and accumulate knowledge of facilitative early treatment processes and technical factors that integrate theoretical, practice, and empirical perspectives.

The recognized importance of the initial treatment session(s) cuts across different theoretical orientations, including cognitive-behavioral therapy (CBT; Wilson, 1999). However, there are likely differences among treatment models in the strategies and techniques introduced during initial treatment sessions, even if only in degree rather than kind. Many components of CBT are important when initiating the therapeutic encounter, and yet this article will focus on three treatment strategies that may be particularly salient for the CBT therapist in the initial session(s). These strategies include the following: (a) establishing a treatment rationale and goal-oriented framework, (b) developing a therapeutic relationship grounded in collaborative empiricism, and (c) initiating objective self-monitoring of behaviors and experiences. First, we briefly describe our theoretical orientation and the importance of emphasizing the first few sessions of therapy. This is followed by a description of each of the abovementioned three treatment strategies, supporting research, and example clinical exchanges to aid with illustration.

Importance of Early Treatment in CBT

Although the authors are also integrative, they identify primarily as CBT therapists. CBT seeks to improve client functioning by highlighting the connections between an individual's thoughts,

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feelings, and behaviors, particularly surrounding the client's problematic symptoms. The therapist and client critically assess and analyze these components of experience to promote more adaptive behaviors and consequences. The therapist assists the client in identifying less adaptive patterns of behavior and thinking, and in evaluating automatic appraisals and beliefs, to develop new ways of thinking, responding, and coping. The long-term goal is to assist clients in becoming their own therapists and improving their ability to independently assess and understand antecedents, behaviors, thoughts, and consequences, and to implement adaptive skills. A CBT framework is generally directive and structured.

CBT is an effective treatment for numerous disorders (Butler, Chapman, Forman, & Beck, 2006). In addition, improvement in client symptoms and functioning early in treatment is a predictor of positive posttreatment outcomes (Wilson, 1999). In the initial treatment sessions, the CBT therapist establishes a clear treatment rationale and goal-oriented framework; this itself is linked to the establishment of a positive therapeutic relationship that is based on collaborative empiricism. Consistent with the stance of collaborative empiricism, objective self-monitoring of experience is introduced quite early in the treatment process. We illustrate each of these components with excerpts of clinical exchanges from a single case.

Case Example

In the remainder of this article, we will draw material from a client who participated in a randomized clinical trial (RCT) that involved manualized CBT for generalized anxiety disorder (GAD; Newman et al., 2011). The client is a 40 year-old Caucasian male with a principal diagnosis of GAD. He reported experiencing significant worry and anxiety as a result of his fast-paced business career, his relationship with his spouse, and stress from raising several children. The RCT protocol was approved by a university internal review board, and informed consent was obtained from the client prior to treatment. Identifying client and therapist information has been masked to maintain confidentiality.

Establishing a Treatment Rationale and Framework

Relative to other orientations, CBT (particularly for anxiety disorders) is structured, directive, and action-oriented (Beck, Rush, Shaw, & Emery, 1979). Although the development of a collaborative spirit is critical, as we will describe in the following text, first sessions are often 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), followed by a check-in of the previous week, including review of any homework exercises and between session activities, followed by discussion of and therapeutic work on the session topic and/or skill, and finally collaboratively setting the homework activities and goals for the subsequent week.

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. Part of this process includes an appeal to the research evidence; for example, the evidence from multiple controlled trials that supports the effectiveness of CBT for GAD (Newman, Llera, Erickson, Przeworski, & Castonguay, 2013). This focus also promotes an efficient use of time and prioritizing of session topics (Dobson & Kazantzis, 2003).

Supporting Research

Although it is difficult to isolate the importance of these specific strategies, it should not be taken for granted that early provision of a treatment rationale, establishing a clear framework, and appeals to research evidence are universal hallmarks of evidence-based CBT protocols for anxiety disorders. Interestingly, some research has shown that "concrete" aspects of CBT, including agenda setting and review of homework, predict symptom reduction in adult patients with depression, whereas other less concrete factors do not (DeRubeis & Feeley, 1990). A recent meta-analyses also highlights the importance of promoting clients' early positive treatment outcome expectancies (Constantino, Vîslă, Coyne, & Boswell, 2018) and perceptions of treatment credibility (Constantino, Coyne, Boswell, Iles, & Vîslă, 2018) for treatment outcome.

Clinical Example

The following exchange occurred during the first therapy session with the client.

Therapist: *This is cognitive-behavioral therapy, and it's broken down into several main components. The first is applied relaxation, which itself is broken down into a few pieces. The first piece is how to identify when you're becoming anxious—identifying markers, or cues, for you. As an example, I want you to close your eyes and scan, and tell me what you notice in your mind, physical sensations, or what is going on around you.* [30 s pass] *What did you notice?*

Client: *Well, I hear a fan going somewhere, and my legs hurt.*

Therapist: *So legs ache, the fans. Great, so that's an example of monitoring. We'll use similar information for indications that you're becoming anxious. Once you detect that you're anxious, we want to teach skills about how to reduce the anxiety; that's where relaxation comes in. The cornerstone of relaxation practice here is progressive muscle relaxation, which I will teach you next time we meet. It's getting your body accustomed to being relaxed. It will teach a competing response to the anxiety, and we will strengthen this competing response. Does that make sense?*

Client: *Yes, it does.*

Therapist: *Great. That is the first piece of this therapy. The next part is the cognitive portion, which we'll spend a lot of time on. That's how you interpret*

things, how you're thinking. People can take the same event, interpret it differently, and then feel differently. The way this is relevant is, we know that the flight-or-fight response gets turned on at the perception of danger or a threat, which could be as minimal as 'I'm going to be late" to "I'm getting a divorce." So we are going to work on your interpretation of events so as not to turn on this fight-or-flight response.

Client: *Yes, I definitely do that. That response is kicked on all the time in overdrive.*

Therapist: *Exactly. One more piece about this therapy is that, I can teach you skills and help tailor practices that will be helpful for you specifically, but what we know from research is that people get better in proportion to how much work they do* [outside of session]. *So, if you take what you learn in here and practice it, things will change much more quickly than if you do not.*

Establishing an Attitude of Collaborative Empiricism

Collaborative empiricism arguably embodies the therapeutic relationship in CBT (Castonguay, Constantino, McAleavey, & Goldfried, 2010). A CBT therapist works to convey and establish this shared attitude/approach early on in the therapeutic encounter. Concretely, the therapist conveys that the therapist and client will work together to reduce symptoms and improve functioning based on shared hypothesis testing, experimentation, and the gathering of empirical evidence (Tee & Kazantzis, 2011). The therapist and client engage in collaborative empiricism early on when identifying coping strategies that are effective (or not) for the client and beginning a functional analysis. The early establishment of collaborative empiricism fosters a scientific mind in the client and allows the client to critically analyze patterns of behaviors and experiences. Consistent with the importance of establishing a rationale and treatment framework, an early appeal to collaborative empiricism provides a structure for how the therapist and client will relate to one another stylistically throughout the treatment.

Supporting Research

The "spirit" of collaborative empiricism may be unique to CBT; yet it broadly maps onto Bordin's (1979) transtheoretical model of the working alliance. The importance of the working alliance for treatment outcome is clearly established in CBT. Not surprisingly, it is more difficult to empirically assess a "spirit." Nevertheless, two components—collaboration and empiricism—have been considered separately in CBT process studies (Tee & Kazantzis, 2011). Ratings of therapist–client collaboration during an intake or first therapy session have been linked to lower rates of premature termination (Tryon & Winograd, 2002). Furthermore, client-rated experience of goal consensus early in treatment (i.e., Session 2) is a predictor of subsequent symptom reduction (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). In addition, some research has demonstrated that the Working Alliance Inventory (Horvath & Greenberg, 1986) subscales that arguably map more closely onto the notion of collaborative empiricism may be more important for CBT outcome. Webb et al. (2011) found that early agreement on tasks and goals was significantly related to symptom change in depressed clients, whereas the bond was not significantly associated with outcome. Furthermore, Bennett-Levy (2003) found that behavioral experiments were more powerful in changing beliefs than thought records, which participants expressed was partly due to the experimental aspect of the task. Researchers are developing and testing a measure to assess collaborative empiricism more directly.

Clinical Example

The following exchange occurred during Session 3 while discussing anxiety related to the client's job.

Therapist: *The idea is that whenever anybody experiences anxiety, they are predicting that a bad thing is going to happen to them in the relatively immediate future. So, what is bad about this? Let's think together about what might be the threat.*

Client: *I think the overall threat is that I'm going to lose my job. That's the ultimate threat. I guess the closer threat is that my boss is going to sense that I'm not working hard. Which I'm not because in business, you can work as much as you want. The work never ends. There is always more work to do.*

Therapist: *OK, so one thought is that the boss will think I'm not working hard enough. Ultimately, the fear at the end is that I will lose my job. We can work at either end or in the middle, but let's work together to pick a target. So, let's take the thought that the boss will think I'm not working hard enough. . . . Let's consider the evidence, pros and cons. What's the evidence that the boss thinks that?*

Client: *There's really no evidence. There's never been a comment or any indication.*

Therapist: *OK, so let's ask the question, what's the evidence of any other outcome? Do you have evidence that the boss thinks in any other way about the work that you do? Negative or positive. So, is there even evidence to the contrary?*

Early Introduction of Objective Monitoring

The CBT model is grounded in empiricism, and the near-immediate objective monitoring of experience is a hallmark treatment strategy. This can include teaching the client to observe and record the timing, frequency, and sequence of antecedents, behaviors, symptoms, emotions, thoughts, and consequences. There are several ways in which the therapist can ask clients to engage in self-monitoring. In CBT, one common example is for patients to complete a daily activity diary, which is collaboratively reviewed and discussed during each session. When focused primarily on problematic symptoms, this monitoring is more or less interchangeable with what is broadly referred to as routine outcome

monitoring (Lambert, 2010). Self-monitoring early in treatment encourages early client involvement in treatment and enhanced self-awareness. In addition, it helps the therapist understand the nature and severity of patient problems and informs the course and goals of treatment. The collected information is also used to draw connections between client behaviors, thoughts, and emotions throughout the therapy process (Cohen, Edmunds, Brodman, Benjamin, & Kendall, 2013).

Supporting Research

The research support for client self-monitoring is robust. Client self-monitoring appears to have a reactive effect, meaning that the frequency of an observed behavior changes simply as a result of the self-monitoring task (Korotitsch & Nelson-Gray, 1999). This effect is seen across many problematic behaviors and symptoms, including suicidal ideation (Clum & Curtin, 1993) and alcohol consumption (Sobell & Sobell, 1973), and provides benefit for subsequent behavior change (Korotitsch & Nelson-Gray, 1999). For example, a recent study found that individuals with attention deficit hyperactivity disorder (ADHD) who were asked to self-monitor the ADHD symptoms showed significant improvement in symptoms, academic behavior, and grade point average compared with a group that did not include self-monitoring tasks (Scheithauer & Kelley, 2017).

For the therapist, client self-monitoring provides objective information that is helpful for building a strong case conceptualization and treatment plan (Persons, 2008). This is likely because clients form connections between thoughts, behaviors, and feelings that were not seen previously. In addition, a core feature of most homework assignments in CBT, particularly early in treatment, involves closely monitoring one's experience. The use of homework is associated with positive outcomes in CBT (Kazantzis, Deane, & Ronan, 2000), and treatment arms in research protocols that include homework assignments have demonstrated better outcomes compared with therapies that did not assign homework (Kazantzis, Whittington, & Dattilio, 2010). In addition, routine outcome monitoring has been associated with reduced rates of psychotherapy deterioration and dropout (Shimokawa, Lambert, & Smart, 2010).

Clinical Example

The following exchanges occurred across the first two therapy sessions.

Therapist: *One of the first things that would be useful to do is to monitor your moment to moment experience in a different way than you've done before. And that is the technique I'd most like to talk about today. It's called symptom monitoring. We want to notice feelings of anxiety as they are happening so we can intervene early. If you catch it when it's just starting, it's easier to have an impact before it has a life of its own. . . . I'm going to ask you to do this throughout the day.*

[Next session, reviewing the daily activity diary]

Therapist: *What was your experience filling this out?*

Client: *It was good. It made me stop and realize what sorts of things were really bothering me.*

Therapist: *OK, great. It looks like your anxiety levels are up and down. . . . So, an hour and a half before work is over it seems like the anxiety had grown more intense for you, and then before bedtime, some nights it's come down considerably, and some nights it's gone up. . . . Does that seem to fit your sense of the pattern of what your anxiety looks like?*

Client: *Yes, I think so, But this past weekend was a bit odd because I was getting sick, so it'll be useful to keep tracking.*

Practical Recommendations

We chose to highlight a few early CBT strategies, and yet it is important to note that there are many other techniques and strategies that CBT therapists can emphasize and utilize early in therapy to engage the client and begin the therapeutic process on a positive note. We end this article by providing some recommendations for successfully implementing and evaluating the provision of a rationale and goal-oriented framework, an attitude of collaborative empiricism, and client self-monitoring early in CBT treatment.

First, particularly for beginning therapists, we suggest rehearsing and role playing providing a rationale and setting up the CBT frame. Of course, working formulations will be unique to the individual client; yet, the basic rationale and framework will remain relatively consistent across cases and relatively broad at this early stage. In the spirit of collaboration, it is critical to check in with the client to assess their degree of understanding and any concerns regarding the rationale and framework. If the proximal goals are to promote perceptions of treatment credibility and positive outcome expectancies, these can be assessed both verbally in session and with established self-report measures, such as the Credibility and Expectancy Questionnaire (Devilly & Borkovec, 2000). The therapist might even map out the rationale, framework, and agenda on a white board in the therapy room (Dobson & Dobson, 2013).

To foster a working relationship grounded in collaborative empiricism, it is important for the therapist to engage the client in a collaborative way during the initial sessions. A therapist can model this attitude by displaying a genuine curiosity regarding the client's experience and encouraging the client to reflect on their experience in a nonjudgmental way. Although CBT therapists often assume the "expert role," it is important to communicate that one does not know all of the answers. Conversely, it may be more relevant to consider strategies that are *inconsistent* with collaborative empiricism and attempt to refrain from such actions. For example, providing too much advice, psychoeducation and failing to provide space for the client to contribute to the process are inconsistent with a collaborative approach. Such behaviors may foster a sense of dependency on the therapist and undermine self-efficacy in a manner that inhibits long-term, independent growth. In addition to checking in with the client about their experience of working collaboratively (or not), the therapist can invite the client to complete self-report measures, such as the

Working Alliance Inventory, to assess the level of agreement on therapy goals and tasks.

The implementation of objective self-monitoring is facilitated and maximized by providing a clear rationale for the usefulness of the monitoring process and consideration of the obtained information. Consistent with homework more broadly, the usefulness of monitoring is severely undermined if the therapist ignores this information in session (e.g., fails to check in about how it went or budget time to review the information). Clinicians can also practice self-monitoring behaviors with the client in the initial session. For example, the therapist can assist the client in completing a daily activity diary for the day prior or ask the client to note and describe their physical or cognitive symptoms during any moment in the session. Reviewing self-monitoring tasks at the beginning of early sessions and providing encouragement and positive feedback to the client is a useful way to ensure the client continues self-monitoring.

Finally, it is useful to recognize the relationships among these three components in the early phase of CBT treatment. For example, setting up and maintaining a consistent, agreed-upon framework is likely to support objective monitoring. Consistent objective monitoring and consistently budgeting time for review in session will provide opportunities for and reinforce collaborative empiricism (Dobson & Dobson, 2013).

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