Basic Principles and Practice of Cognitive Behavioral Therapy

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2.1 Structure of Treatment

As discussed in the previous chapter, cognitive behavioral therapy (CBT) is designed to build a set of skills that increase awareness of thoughts and behaviors and help patients understand how thoughts and behaviors influence emotions. CBT uses a collaborative process in which the therapist and patient work together to problem-solve how to challenge dysfunctional thoughts and behaviors underlying the presenting problem. This is quite different from other types of talk therapy. In CBT, the therapist teaches the appropriate skills to address the clinical problem and then the patient works to apply these skills more generally outside of session.

CBT is structured and time-limited with treatment typically consisting of 8–25 sessions, based on clinical presentation and symptom severity. Sessions typically range from 45 to 60 minutes in length, are generally scheduled every week, and are often tapered (i.e., once every other week, once a month) toward the end of treatment. Although CBT is a structured treatment, the content of each session is certainly not the same, and varies based on diagnosis and case conceptualization. In general, the treatment progresses through the following stages: (1) thorough assessment of symptoms, (2) case conceptualization/formulation, (3) psychoeducation, (4) identification of specific measurable goals, (5) practice and implementation of cognitive and behavioral treatment strategies, and (6) relapse prevention/booster sessions. Each of these stages of treatment will be discussed in further detail in this chapter.

2.2 Early Sessions: Orientation to CBT

At the first session, the therapist should orient the patient to CBT by welcoming him/her and explaining the concept and characteristics of

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CBT. In general, patients feel more comfortable when they know what to expect from therapy and many patients will. Orientation to CBT also involves a discussion of the focused and time-limited nature of the therapy, as well as the rationale (including empirical support) for selecting CBT to treat the patient's presenting problem. It is often helpful to use metaphors or examples that the patient can relate to when starting a new treatment. An example is:

"*CBT is probably quite different than other types of therapy you may have previously tried*; *it is much like taking a class which focuses on how to better cope with your problems. The emphasis is on learning and practicing new skills outside of session*."

At the first session, the therapist should discuss the nature of confidential treatment and any ethical/legal considerations. Also, the therapist can discuss that one of roles of the therapist is to keep sessions on track; so he/she may, at times, need to shift the focus of conversation. Getting the patient's agreement early on will help him/her feel more comfortable if the therapist needs to redirect or interrupt later in the assessment and/or therapy.

After orienting the patient to CBT the therapist should briefly summarize goals for the current session and for the treatment overall. For example, the therapist could say:

"*Today we will talk about the problems you are currently experiencing. Over the course of the treatment, you will learn new ways to respond to the thoughts that are bothering you, along with behavioral skills to help manage your symptoms. This is a collaborative process, so we will work together to set an agenda for each session, and decide on the therapy homework you will be assigned to do between sessions. The homework will allow you to practice new skills outside of the therapy session and to fully maximize the treatment. Over the course of the treatment, I will teach you the skills you need to have so that at the end of treatment, you can become your own therapist.*"

2.3 Early Sessions: Assessment

An initial assessment and diagnostic evaluation is essential for effective treatment planning in CBT. Clinical diagnoses play the primary role in determining how CBT should be adapted for each particular patient. The following information should be gathered and thoroughly assessed:

- Information regarding current triggers, thoughts, and behaviors associated with problem symptoms. Inquiring about specific examples can be helpful in prompting the patient to provide more detailed information about his/her experiences.
- For example, the therapist could ask, "Can you tell me about the last time you experienced those symptoms? What occurred right before these symptoms came on? Where were you? What were you thinking/doing at the time?"
- For patients who engage in avoidance behaviors or other maladaptive behaviors, the therapist should assess the motivation that underlies these behaviors.
- The therapist could say, "What do you think will happen if you do not avoid this situation? What is the worst that you think could happen?"
- Circumstances that may have been related to the onset of the problem/disorder, such as preceding events or stressors (e.g., final exams, medical illnesses, work difficulties).
- A history of the problem/disorder. The therapist could inquire, "How long have you been experiencing these symptoms? When did they first start? How long do the symptoms last? How frequently? Have the symptoms changed over time (e.g., content of thoughts, types of behaviors, intensity of symptoms)?"
- The patient's explanation for the cause of the problem/disorder and the patient's perception of the problem.
- Questions that the therapist could ask include, "What do you think may have caused these problems to start? Was there anything that you believe may have made the problems worse?"
- As many psychological disorders have familial components, it is important to document

the family history of the disorder and other psychiatric problems. The therapist could ask, "Has anyone else in your family experienced psychological difficulties? Do you know if anyone has had the same types of difficulties that you are experiencing now?" As the presence of comorbid conditions can change the treatment trajectory and may even potentially interfere with treatment, co-occurring psychological disorders should be thoroughly assessed and accounted for prior to the start of treatment (e.g., with a structured diagnostic interview).

- Traumatic experiences, if any, should be identified; however, the therapist should keep in mind that many patients may be reluctant or unwilling to share this information during the initial evaluation period due to the sensitive nature of the experiences.
- Substance use (including tobacco use, alcohol use, caffeine consumption and prescription medication use above and beyond the prescribed dose) may contribute substantially to decreased psychological health. If endorsed, the therapist should document duration and frequency of use, amount used in a single sitting, and level of impairment caused by substance use.
- Psychosocial and functional impairment related to the problem/disorder in work, school, family, and social domains should be assessed. Level of impairment will serve as a marker for progression through treatment (i.e., Is the patient getting better/worse?); therefore, it is important to document specific ways in which the symptoms may cause the patient impairment in these various domains.
- The therapist can ask, "How do your symptoms get in the way of your life? Do they keep you from doing things you want to do? What about your relationships with family and friends?"
- Sleep disturbances can cause or exacerbate existing symptoms. The therapist should assess sleep hygiene and any sleep problems, including difficulty waking up, falling asleep, and waking frequently during the night.
- Assessment of current lifestyle (e.g., daily routines, physical activity family and social life, and employment) will provide information regarding level of impairment, and elucidate whether a patient's lifestyle may be a problematic factor during treatment, or a strength that can be utilized to maximize progress.
- Type, duration, dosage, and effects of current and past medications. Medications, particularly concurrent psychiatric medications, can have a significant impact on the patient's symptoms.
- Assessment of previous psychological treatment and effects allows therapists to get a sense of how the patient may perceive the present therapy and help guide how to tailor the current treatment toward the needs of the patient.
- Questions that the therapist can ask include, "What types of things did you find helpful in your previous therapy?" "What types of things did you feel were not helpful?" "Why did you terminate treatment with your last therapist?"
- Coping strategies that are developed to manage symptoms can differ widely amongst patients, with some adopting healthier strategies (e.g., taking a bath, working out) and others relying on coping behaviors that may exacerbate symptoms (e.g., using substances, avoiding aversive situations).
- The therapist should ask, "What types of things do you do to manage your symptoms when they become overwhelming?" "How do you usually respond when you start to feel that way?"

2.3.1 Symptom Measures

Therapists often find it helpful to use clinician-rated assessments to make informed ratings of symptom-related impairment and distress in comparison to cases they have previously seen. In conjunction with clinician-rated measures, patient self-report measures are frequently administered and can be completed quickly and independently. Additionally, psychiatric patients may sometimes feel more comfortable completing measures independently rather than in response to a clinician's questions. Self-report

measures may help guard against under- or over-reporting of symptoms. Used alongside clinician-rated measures, self-report forms may provide additional information to clarify the clinical picture.

Some commonly used measures include:

- Beck Depression Inventory (BDI-II; [1]) is a 21-item self-report measure that assesses cognitive, behavioral, and somatic symptoms associated with depression. The measure provides a composite score that can be utilized to track the severity of depressive symptoms over time.
- Quick Inventory of Depressive Symptomatology (QIDS; [2]) is a 16-item clinician administered or self-report (QIDS-SR) measure that assesses depression severity using *DSM* criteria for depression.
- Beck Anxiety Inventory (BAI; [3]) is a 21-item self-report questionnaire that measures the presence of clinical anxiety symptoms. Similar to the BDI-II, the BAI has a composite score that can be used in clinical practice to track the progression of anxiety symptoms.
- Post-Traumatic Stress Disorder (PTSD) Symptom Scale-Self Report (PSS-SR; [4]) assesses the presence of a traumatic event and measures the severity of the PTSD symptoms that an individual may experience due to the endorsed trauma.
- Yale-Brown Obsessive–Compulsive Scale (Y-BOCS; [5]) is a semi-structured, clinician-administered interview that assesses the presence of various obsessions and compulsions, as well as the severity of obsessive–compulsive symptoms. A 10-item composite score is provided. The Y-BOCS has been empirically validated and is demonstrated to be sensitive to treatment effects, making the Y-BOCS suitable for clinical practice.
- Schwartz Outcome Scale (SOS-10; [6]) is a brief self-report questionnaire that measures psychological well-being.
- Range of Impaired Functioning Tool (LIFE-RIFT; [7]) is a brief, clinician-administered, semi-structured interview that assesses level of functional impairment due to psychopathology in four domains: work, interpersonal relations, recreation, and global satisfaction.
- MOS 36-Item Short-Form Health Survey (SF-36; [8]) is a measure of quality of life associated with physical health. The following eight domains are assessed: overall health, physical functioning, and limitations due to physical health, emotional well-being associated with physical health, social activity, bodily pain, work, and energy. Each domain provides a score that ranges from 0 to 100 with 0 representing the worst and 100 representing the best quality of life.

2.4 Early Sessions: Case Conceptualization

Case conceptualization is a framework that is used to understand the patient and his/her current symptoms as well as to inform treatment and intervention techniques. It is a set of hypotheses about what variables serve as causes, triggers or maintaining factors for a patient's presenting problems. This description of symptoms provides a means of organizing and understanding how to target interventions to alleviate the problem symptoms. Case conceptualization also serves as a basis to assess patient change/progress. Case conceptualization begins during the first session and is flexibly modified as treatment progresses and more information is gathered. Treatment plans and goals based on the case conceptualization are routinely revisited and changed based on new information and changes in clinical presentation.

The model of cognitive behavioral case conceptualization presented here has multiple origins including the functional analysis literature [9]. Case conceptualization in CBT is based on a constantly evolving formulation of the patient and his/her symptoms. The therapist frequently uses an Antecedents, Behaviors, Consequences (ABC) Model as a formalized model for conducting a functional assessment and examining behaviors in a larger context. This model rests on the assumption that behaviors are largely determined by antecedents (i.e., events that precede) and consequences (i.e., events that follow).

2.4.1 Antecedents

Antecedents, or events that occur before a behavior, can be an affect/emotion, thought, behavior, physical sensation or situation. For example, a patient seeking treatment for a drug abuse problem may identify the desire for relief from uncomfortable physical sensations (withdrawal symptoms) as an antecedent for drug use. To help the patient identify antecedents, the therapist and patient can work to identify conditions that affect the patient's behavior. Questions that the therapist might ask to help identify possible antecedents include:

"*What were you feeling before that happened*?"
"*What physical symptoms did you notice in your body right before you did that*?"
"*What do you usually do when in this situation*?"
"*What thoughts might go through your head before this happens*?"
"*In what situation does this often happen*?"

2.4.2 Behaviors

A behavior in the ABC model is an action the patient engages in. The behavior, in this model, can be something the patient does, feels, or thinks immediately following the antecedent. The behavior becomes problematic as it serves to maintain the ABC model. Some questions that may be helpful in identifying the behavior component of the ABC model are:

"*What did you do in response to that sensation*?"
"*What was the first thought you had when you felt that way*?"
"*Did you do anything to avoid that emotion*?"

2.4.3 Consequences

The consequences can be positive or negative and either increase or decrease the likelihood of something happening again. For example, positive consequences increase the chances that a behavior will be repeated in the future through the experiences of something positive occurring (e.g., receiving praise) or the removal of something aversive (e.g., not having to do chores). Consequences can be of an affective, cognitive, behavioral, somatic or situational nature. Questions the therapist could ask to help identify possible consequences include:

"*What were you feeling after that happened*?"
"*What physical symptoms did you notice in your body right after you did that*?"
"*How do you usually react after you are in this situation*?"
"*How does your family react to your behavior*?"
"*What thoughts might go through your head after this happens*?"

It is important to examine both short- and long-term consequences. Short-term consequences tend to be behavioral reinforcers, while long-term consequences tend to be negative outcomes. In the case of social anxiety, the short-term consequence of avoiding a work situation that provokes anxiety, such as public speaking, is escape from a negative mood/anxiety; the long-term consequence may be trouble at work, job loss, family problems or financial stress. As a therapist, gaining understanding of the positive and negative consequences of a behavior is important in determining how to design the intervention. For example, in the case above, an intervention targeting the anxiety would decrease the need for avoidance of work situations. Here are some examples of questions that may be used to elucidate short-term consequences:

"*Do you receive attention for this behavior in some way*?"
"*What good/bad things happen as a result of this behavior*?"
"*Does this behavior help you avoid something you don't want to do*?"
"*Does this behavior make you feel good/high in any way*?"

2.4.4 Treatment Plan

It is helpful to keep the treatment plan as simple as possible with reasonable and objective behavioral goals. The treatment plan should be a

"living" document that can be changed based on new data or disconfirmed hypotheses. The therapist might describe the treatment plan to the patient in the following manner:

"*Thus far, we have identified some thoughts and behaviors that are likely contributing to your current difficulties. In particular, your views of yourself and your future are quite negative, and you have started to avoid many work and social situations. At this point it would be helpful to further explore your thoughts and see if we can find a more balanced view of your current difficulties. I would also like to talk with you more about re-engaging in work and social activities in a graduated, structured fashion. What are your thoughts about these goals for therapy*?"

2.5 Early Sessions: Psychoeducation

Psychoeducation is information that the therapist provides to the patient about their presenting problem, the possible causes of the condition, possible maintaining factors and how the CBT treatment for that condition works. It is an important component of CBT and may be associated with symptom reduction on its own [10]. Psychoeducation is often helpful for family and friends of the patient as well. Family involvement in the treatment can serve to enlarge the treatment "team" and family members can help in facilitating the completion of CBT homework assignments.

Psychoeducation can also take the form of assigned readings about a specific problem/disorder. This is also often referred to as bibliotherapy, and is a useful tool for CBT because it allows the patient to read about his/her disorder or CBT between sessions. Bibliotherapy emphasizes the self-management focus of CBT and can accelerate therapeutic progress and maintenance of changes. Reading materials can range from assigning patients to read information on websites, book chapters, or sections of patient manuals.

2.6 Early Sessions: Setting Goals

Setting goals in CBT is a collaborative process in which the therapist and patient identify specific therapeutic outcomes for treatment. The therapist works with the patient to set goals that are observable, measurable and achievable and relate to cognitive or behavioral changes relevant to the patient's presenting problem. Patients often initially describe goals that do not meet many of these criteria (e.g., "I would like to be happy") and the therapist should work with the patient to re-word or specify the goals (e.g., "Improve my mood by increasing amount of time that I exercise each week"). To increase the patient's chance of success, the therapist should try to gauge how reasonable the goals are. For example setting a goal of exercising 60 minutes every day for someone who has not exercised in months would be very difficult. Start with a more achievable goal, such as exercising for 20 minutes twice over the next week, or taking daily 10 minute walks. Also, if the patient is successful he/she will be more likely to remain actively engaged in treatment and continue to work toward his/her goals. Using a graded approach to treatment goals (breaking large goals into smaller pieces that can be worked toward each week) also helps to make goals feel more manageable.

Goals are tied to specific skills that will be addressed later in treatment. When setting goals, the therapist should also try to guide the patient toward goals that involve changing the patient's thoughts and behaviors, rather than changing the thoughts and behaviors of others around them. Treatment goals allow for increased continuity of sessions, help to focus the treatment, and enable the patient and therapist to assess the progress of therapy and identify change objectively. The therapist can think about asking the patient the following questions when guiding the treatment goal setting:

"*How would I be able to tell that your mood/anxiety/etc. was improving*?"

"*What would you be doing differently if you weren't experiencing this symptom right now*?"

"*Is there anything you've stopped doing because of your symptoms that you would like to start doing again*?"
"*How would you like things to be different at the end of this treatment*?"
Examples of goals:
"*I will learn new ways of responding to my negative thoughts*."
"*I want to be able to comfortably ride the subway every day*."
"*I would like to be able to concentrate better while I am at work*."
"*I want to be able to manage stressful situations more effectively*."

2.7 All Sessions: Cognitive and Behavioral Strategies

CBT therapists use data that they gather from each patient to conceptualize the presenting problem and tailor the treatment to the individual patient. Specific cognitive and behavioral strategies will be discussed in other chapters of this book; however, some examples include: cognitive restructuring, exposure, behavioral activation, relaxation techniques, and mindfulness exercises.

2.8 Late Sessions: Relapse Prevention/Booster Sessions

Toward the end of treatment, as the patient is improving and using the tools he/she has learned in CBT, therapy sessions may be spaced out to once every 2 weeks and then once every 3–4 weeks. This allows for the patient to have more time to practice his/her homework between sessions and to take more control of the therapy (as he/she is becoming his/her own therapist). During the weeks when the patient is not meeting with the therapist, it is often helpful for the therapist to assign the patient to schedule a "self-session." The self-session should involve the patient taking time to schedule his/her own agenda, review homework and skills, and set new goals for homework.

Even after treatment ends, it may be helpful to offer patients the opportunity to schedule "booster sessions." Booster sessions help to prevent relapse through early identification of problems and skill use to get the patient back on track if he/she starts to notice his/her symptoms increasing again. Additionally, research supports the use of booster sessions and suggests that CBT interventions with booster sessions are more effective and the effect is more sustainable than CBT interventions without booster sessions [11].

2.9 Structure of Sessions

Individual CBT sessions have a general structure, which clinicians follow, much in the same way as CBT as a treatment has a general structure [12]. During each weekly session, the following is covered: (1) symptom check-in/brief update, (2) bridge from previous session, (3) agenda setting, (4) homework review, (5) cognitive and behavioral strategies from agenda, (6) setting new homework, and (7) summary and feedback [12]. The content of each of these items changes from week to week, based on the patient's clinical presentation and the stage of treatment (e.g., later in treatment less time is spent on introducing new concepts and more time is spent on review and consolidation of concepts). Adhering to this session structure allows CBT to be understandable and time-efficient for both the therapist and patient.

2.9.1 Mood Check/Brief Update

A brief check in at the beginning of the session on the patient's mood and/or physical functioning allows the therapist to gauge how the patient is progressing from week to week. The therapist should ask the patient to provide his/her explanations for any mood improvements or declines that occur. It is important to try to keep this portion of the session brief and structured so that the majority of the session does not become dominated by the events of the previous week rather than teaching new skills.

2.9.2 Bridge from Previous Session

Providing a bridge from the previous session allows the therapist to check in on what the patient understood from the last session and reinforce that all material covered is important to the patient's clinical improvement. Clinicians can also utilize this time to note how previous skills could have been implemented in specific situations the patient may have brought up during his/her update about the prior week. Suggested questions to ask to bridge information from the previous session include:

"*Compared to last week, how is your mood, is it better or worse*?"

"*Did you experience any changes in your physical health over the last week*?"

"*Did you have any thoughts over the last week about what we discussed last session*?"

"*Was there anything we discussed last week that you had questions or concerns about*?"

"*What were the main points that we talked about last week*?"

"*In that situation, which of your skills could you have used to respond differently*?"

2.9.3 Set Agenda

Setting the session's agenda is a collaborative process through which the therapist and patient decide how session time will be used and in what order agenda items will be discussed. Both the patient and therapist can contribute items to be included in the agenda. In the early stages of treatment, the therapist often sets the majority of the agenda items, and toward the end of treatment there is a shift toward the patient setting more of the agenda. A suggested way that the therapist could begin this dialog is:

"*I'd like to begin today's session by setting the agenda—or decide what we are going to work on today. This is how we will start each session so that we can be sure to have enough time to cover the most important items. I have some items I'd like to suggest that we add to the agenda and I will ask you if you have any items to add as well. Does this sound okay to you*?"

By collaboratively setting the agenda, the needs of both the therapist and the patient are met. Agenda items should be in the service of treatment goals. After listing and prioritizing items for the agenda, the therapist can assign a time limit to each issue if needed (e.g., in a situation where later items on the agenda are frequently not being addressed because too much time gets spent on the earlier items). By setting a time limit for each item, chances are increased that all items can be covered in the session. Some example questions that the therapist can ask the patient while creating the session agenda include:

"*What treatment goals would you like to work on today*?"

"*What problems would you like to discuss/prioritize in this session*?"

"*What is causing you the most difficulty right now*?"

"*What do you think we should focus on in the session today*?"

"*What would you like to put on today's agenda*?"

2.9.4 Homework Review

Homework review should take place during every session. The review serves two main purposes: (1) it reinforces the importance of practicing the skills learned in session outside of the therapy appointment and (2) it allows the therapist to assess skill acquisition and retention from the previous session. In general, patients who complete homework between sessions show significantly greater symptom improvements than those who do not [13]. If it becomes clear during the homework review that elements of the cognitive behavioral techniques learned in the previous session were misunderstood or forgotten, it is then a good idea to use additional session time to review the skill. If a patient does not complete his/her homework, it should be directly addressed in the session. Setting up and encouraging a "win-win" scenario can be a helpful approach to homework compliance. For example, using metaphors such as likening therapy to "taking a class" or "learning a musical instrument" are often helpful. The more time spent out of session

practicing the skills, the "better grade you'll get" or "more quickly you'll be able to play." Additionally, barriers to homework compliance (e.g., difficulty organizing time, external stressors, and avoidance) should be frequently monitored and addressed quickly. Some helpful questions to ask during homework review are:

"*What did you attempt/complete for homework since the last session*?"

"*How did the assignment go*?"

"*What did you learn from doing this homework assignment*?"

"*How many times and for how long did you practice your homework*?"

"*What do you think got in the way of completing your homework assignments this week*?"

2.9.5 Cognitive and Behavioral Strategies/Work on Agenda

The therapist should discuss each agenda item, starting with the most important (as decided by the patient and therapist previously). During the early treatment sessions, this portion of the session is often more didactic in nature with the therapist doing the majority of the talking. If time runs short, the therapist can discuss with the patient that items that were not addressed this week will be put on the agenda for the following week. It is the therapist's responsibility to keep the treatment discussion on track and focused; the therapist should guide the patient back to the problem being discussed when he/she drifts to other topics. If the patient persists on a tangent or topic not on the agenda, it can be helpful to ask the patient if he/she would like to add this topic to the agenda for the following week. In some cases it may be necessary to educate/review with the patient the nature of CBT and what kinds of issues are relevant for the agenda and how to spend session time optimally.

2.9.6 Setting New Homework

As previously mentioned, homework is an important part of CBT and contributes to positive treatment outcomes [13]. CBT therapists typically meet with individual patients once per week for 45–60 minutes, which amounts to less than 1 % of a patient's waking hours in a week. In order to influence the remaining 99 % of the patient's time and to practice what is learned in session, homework becomes an integral part of the therapy. Homework is assigned at every session and involves practice of the cognitive and behavioral strategies used in the treatment session that week. At the beginning of treatment, it is often helpful to start with educational reading. Self-monitoring homework, such as completing logs to document mood, anxiety or activity levels is also very useful as it can be used to guide the case conceptualization and treatment approach.

Much like the treatment sessions, homework often requires patients to experience some discomfort or anxiety, such as in exposure homework assignments. Additional assignments might include cognitive restructuring. These assignments aid patient skill acquisition, treatment compliance, and symptom reduction by integrating treatment concepts into the patient's daily life. Homework is important for between-session work and making progress toward patient goals.

2.9.7 Summary and Feedback

Summarizing the main points of the session and eliciting feedback from the patient at the end of the session contributes to the collaborative nature of CBT. At the end of the session, the therapist should summarize the main points of the session. As treatment progresses he/she patients to complete the session summaries themselves (further emphasizing the role of the patient in eventually becoming his/her/his own therapist). Encouraging the patient to provide feedback strengthens the therapeutic relationship and reminds the patient of the active role he/she/he plays in the treatment itself. This can also be a time for the therapist to provide feedback about progress he/she noticed and encourage and motivate patients to continue working toward their goals. Suggested questions

to ask patients during the summary/feedback portion of the session include:

"*What were your impressions of today's session*?"

"*Did we neglect to discuss anything that you think is important*?"

"*Was there anything about today's session that you did not understand*?"

"*Was there anything that we discussed today that bothered you*?"

2.10 Summary

CBT is a goal-oriented and time-limited therapy that encourages patients to change their thinking as well as their behavior. To achieve the goals of therapy, a thorough evaluation is necessary at the start of treatment to identify both problem areas and aspects of the patient's life that might be contributing to or exacerbating the symptoms. While patients are taught specific skill sets to manage their symptoms, the treatment is flexible in nature where goals of therapy may change with ongoing assessment and certain skills may be emphasized depending on the needs of the patient. The process is always collaborative, with the therapist working with the patient to agree on treatment goals and therapy homework assignments. As the skills learned in CBT are meant to be utilized regularly, homework assignments are an integral part of the therapeutic process and allow patients to practice CBT skills in their everyday lives. Although the therapy is time-limited, booster sessions are recommended after the end of treatment to help patients maintain their gains by giving them a means to review the CBT skills with their therapist.

Additional Resources

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