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Use of Self in Cognitive Behavioral Therapy

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Abstract Cognitive Behavioral Therapy (CBT) has not traditionally utilized "use of self" to describe the clinician's role in counseling but much attention has been given to the importance of the therapeutic relationship and the components necessary and appropriate for a strong working alliance. The CBT approach is discussed within the framework of previously articulated five uses of selves. A case example is presented.

Keywords Use of self · CBT · Cognitive behavior therapy · Therapeutic alliance

Introduction

The clinician's role in a successful therapeutic relationship has been discussed and debated at great length in psychotherapy and social work. In fact, the function of the clinician has evolved over time based on prevailing theories, service delivery settings, financial considerations and other factors. However, it is commonly accepted across modalities that there are aspects of the relationship between the clinician and the client that promote growth and change (Lum 2002; Ganzer 2007).

Use of self is a concept employed to describe the clinician's "self" in the therapeutic relationship. Dewane (2006) proposes five operational uses of self that contribute to the skilled practitioner's ability to effectively blend the professional self in terms of knowledge and technique with the personal self made up of life experiences, beliefs and personality traits. These uses of self include personality, belief system, relational dynamics, anxiety, and self-disclosure. Edwards and Bess (1998) also argue that the carefully developed integration of professional knowledge and skill and the personal self are crucial in the clinician's effective use of self.

While Cognitive Behavior Therapy (CBT) has not traditionally embraced the term "use of self" to describe aspects of the therapeutic relationship, the optimal role of the CBT clinician has been addressed often with great attention paid to the importance of the clinician in the relationship and in the success of treatment (Beck 1995; Hayes et al. 2007). Therefore, "use of self" is utilized here in an attempt to create an understanding of the important relational aspects of CBT. When evaluating or considering CBT, these relational aspects may at times be overlooked with more emphasis and attention placed on the specific interventions used to foster change. Upon closer scrutiny of current CBT theory and practice it is apparent that the clinician's use of self as conceptualized by Dewane, Edwards, Bess and many others is considered an integral part of the approach.

Basics of Cognitive Behavior Therapy

Cognitive Behavior Therapy (CBT) is not one theoretical approach to psychotherapy but encompasses many approaches that share some common theoretical underpinnings. Foremost among these are three fundamental assumptions: cognitions are one of the most important determinants of human emotion and behavior; cognitive

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activity may be monitored and altered; and desired behavioral and emotional changes may be made through changing cognitions (Dobson and Dozois 2001; Ronen 2007). Belief systems influence the meaning one makes out of life experiences and subsequently the reactions that one has in the world.

Belief systems are created through past experiences, environmental factors, biological tendencies and other variables and they are maintained through self-indoctrination (Ellis and Dryden 1987). We have beliefs that are helpful to us and aid us in reaching our goals and beliefs that get in our way and can cause numerous emotional and behavioral challenges. The unhelpful beliefs or thoughts are largely comprised of demands about how we, the world, and others *should* be (Ellis and MacLaren 2005). Since humans tend to be creatures of habit we practice disturbing ourselves over and over again with the unhelpful beliefs or thoughts and become habituated to reacting in dysfunctional or undesirable ways to certain stimuli.

The clinician collaborates with the client to identify, evaluate and respond to dysfunctional thoughts and beliefs while introducing a variety of techniques to aid in changing thinking, mood, and behavior (Beck 1995; Dryden and Ellis 2001). Special attention is paid to the client's identified goals and developing a working plan for achieving them (Hayes et al. 1999). CBT allows that while developing insight about why certain reactions or problems exist may be useful it is not necessary or sufficient for change. We can learn and re-learn ways of thinking, feeling and behaving that are more consistent with how we'd like to be. A CBT approach aims to help clients learn to cope with their life concerns more effectively (Goldfried et al. 2003). Interventions are cognitive, behavioral and emotive in nature and chosen for use with a particular client based on a variety of factors including their past change experiences, preferred learning styles, motivation for change and stated goals (Ellis and MacLaren 2005).

CBT is often misunderstood as a set of techniques that are applied indiscriminately based solely on a client's symptoms and diagnosis with little emphasis on the therapeutic relationship or the specific client than in other modalities (Beck 1995). This is largely due perhaps to the fact that CBT is the most manualized psychotherapy. Indeed, as Henry (1998) reminds us, treating symptoms rather than individuals can be a dangerous and ineffective practice. However, because rigorous scientific research requires consistency in the use of interventions in order to enhance the reliability and validity of outcome data, CBT manuals have been created and used for research purposes. The focus in research settings is mostly on the effectiveness of specific interventions for specific problems and the integrity of the research is maintained by virtue of adherence to the treatment manual.

However, the successful and competent practice of CBT in real world settings involves a wide variety of interventions often including the use of the therapist and the therapeutic relationship as catalysts for change. Henry's (1998) contention that manualized techniques are not therapy and that therapy consists of two or more people interacting in emergent and unpredictable ways to foster learning and change is quite accurate. In fact, evidence suggests that CBT clinicians employ relationship skills as much as clinicians from other psychotherapy orientations (Keijsers et al. 2000).

Probably one of the most salient differences between CBT and some other modalities is that while the therapeutic relationship is viewed as important in CBT it is not seen as sufficient to help facilitate or create the change the client is hoping to achieve. The knowledgeable use of appropriate interventions is also a fundamental part of the approach and it is the combination of the relationship and the interventions that ultimately fosters lasting, generalizable change for clients.

Use of Self in Cognitive Behavior Therapy

CBT is an active, collaborative therapy approach guided by goals identified by the client, an ever-evolving formulation of the client, their strengths, and their problems (Beck 1995). In order to facilitate an understanding of the clinician's use of self in CBT it may be useful to review Dewane's (2006) five categories contributing to effective use of self from a CBT perspective.

Use of Personality

As is likely true for most clinicians, CBT practitioners mostly choose this model because it speaks to them. Of course there has been much speculation about why certain approaches may appeal to certain clinicians but that is not the subject of this article. If they are genuine in being compelled towards this approach for intrinsic reasons it follows that they are likely to have an easier time integrating their professional selves with their personal selves because congruence exists between the two.

Unfortunately there are many clinicians who understandably feel forced into espousing CBT or an eclectic approach including CBT as their theoretical model due to managed care or other considerations. Consequently it can be argued that many clinical missteps occur in the name of CBT that are a result of lack of proper training or real faith in the model. While the model is relatively simple from a theoretical perspective the competent application of it to complex human problems within the therapeutic relationship is not.

CBT trainees and clinicians are encouraged to work on their own issues both as an opportunity to genuinely practice the application of cognitive, behavioral and emotive techniques and also to allow them to be better prepared as clinicians to become aware of and handle their thoughts, feelings and behaviors within the therapeutic relationship (Laireiter and Willutzki 2003; Padesky 1996). Practicing techniques on their real problems allows trainees and clinicians to experience them first hand and creates better preparedness for their elegant use with clients. With practice, CBT clinicians develop their own styles for using techniques and interventions that are unique to them and are encouraged to experiment in order to gain an understanding of what feels comfortable and genuine for them.

The appropriate use of humor is encouraged in CBT but driven by the clinician's assessment of the therapy style most suited for the individual (Dryden and Ellis 2001). Making light of an aspect of a client's problem (*but not the client*) can help add perspective and develop the relationship (MacLaren and Freeman 2007).

In general, if a clinician is well-versed and trained in an approach that they fundamentally believe can help their client, they possess self-knowledge and awareness and they are operating within mandated professional boundaries it is much easier to appropriately inject their personality style in their use of self in the therapeutic relationship.

Use of Belief System

As discussed briefly above, CBT clinicians spend a great deal of energy exploring their own beliefs about the world, others and themselves in order to prepare them to be effective change agents (Beck 1995). This self-awareness contributes to an ability to more readily and clearly engage with clients. CBT clinicians then spend a considerable amount of time understanding and helping a client to become aware of and understand his/her belief system. CBT respects the individual's rights to their beliefs.

Whether or not a client chooses to change aspects of their belief system is entirely up to them. A CBT clinician can help them evaluate their beliefs in terms of functionality and offer tools to promote change but understands that it is the client's right to make whatever decision he/she deems acceptable. It is important to note that a client's belief in his/her ability to change has shown to be an important variable in subsequent therapeutic gains (Westra et al. 2007).

As Granvold (2007) points out, CBT clinicians are skilled at using the Socratic method to help a client evaluate specific beliefs and arrive at his/her own conclusions about how to proceed without value judgments or preferences communicated by the clinician. And as clinicians our views are informed and impacted by engaging with clients to do this work.

Use of Relational Dynamics

Some necessary components of the therapeutic relationship on the part of the clinician have been articulated as empathy, warmth, acceptance or unconditional positive regard, and genuineness (Beck 1995; Josefowitz and Myran 2005; Rogers 1957). The strength of the therapeutic or working alliance between clinician and client has proven to be a consistent predictor of positive therapeutic outcomes (Baldwin et al. 2007; Hayes et al. 2007). In addition, evidence suggests that the outcome is better the more the clinician and the client agree on the quality of the relationship at the end of therapy (Kramer et al. 2008).

There is no question that effective CBT requires a sound therapeutic alliance (Beck 1995). Evidence shows that CBT clinicians are very involved in the development and maintenance of positive relationships with their clients and that they offer high levels of support, empathy and unconditional positive regard (Keijsers et al. 2000).

Ganzer (2007) notes that from a relational perspective the clinician and client are equals in the therapeutic relationship. This is also true in CBT where the therapist and client are equal participants in the relationship. The client has a great deal of expertise in his/her life and the therapist has additional perspective since he/she exists outside the client's system and is knowledgeable and practiced at offering a variety of possible proven interventions to bring into the relationship based on what the client is trying to accomplish (Hayes et al. 1999). Contrary to the idea that CBT promotes having the clinician maintain an instrumental position as the expert who is putting the client's problems right from a distance (Rowan and Jacobs 2002), clinicians are encouraged to collaborate and work in conjunction with their clients as partners in the change process.

The problem-focused approach of CBT allows clients to tell the clinician what they'd like to change and the clinician subsequently helps the client to the best of their ability. The CBT theory and approach is explained to the client so that the client has an opportunity to ask questions, discuss and ultimately decide if the approach seems like a good fit for him/her. There are no other agendas in the CBT therapeutic relationship. CBT clinicians are not forced to abandon their agendas for treatment because the experienced clinician is curious about the client's experience and flexible in their assessment, consistently re-formulating as they move forward in the therapeutic relationship (Beck 1995). There is emphasis placed on what the client has tried before to change so as not to replicate something that was unsuccessful and to build on anything that has proven useful (Ellis and MacLaren 2005). The goal is to provide

the best support and intervention(s) for this client in this moment given his/her stated goals and assessed problems.

This approach is often experiential and CBT clinicians make use of many techniques in the "here and now" to facilitate understanding, growth and change within the therapeutic relationship. These include in vivo desensitization, role-playing, role reversal, modeling, and teaching (Ellis and MacLaren 2005). In mindfulness-based CBT practice clinicians teach and practice mindfulness alongside their clients for deeper understanding and experience (Segal et al. 2002). CBT offers a safe environment for clients to learn and practice the emotional regulation and social skills they need in order to lead less disrupted and more satisfying lives (Stone 2007). The clinician is able to extend the relational dynamics into the time between sessions through collaboration on between session assignments by which the client is able to practice putting the therapy content into practice in their life.

White (2007) points out that CBT understands transference to be a client's response to the clinician based on generalized beliefs and expectations they have about relationships rather than how the clinician actually behaves towards the client. These interactions are addressed in sessions from a standpoint of unconditional other acceptance (i.e. "I accept you as a person unconditionally but this behavior is cause for concern") and used to help gain further understanding of the challenges faced by the client and how to potentially make changes if that is something the client desires. CBT clinicians, much like those of other modalities, view this as rich grist for the therapeutic mill as it is immediate, accessible and often relevant to the problems being presented in therapy.

Using countertransference to describe the clinician's response to the client based on generalized beliefs and expectations CBT clinicians are advised to continually monitor their feelings and behaviors during therapy sessions to help identify what a client may have said or done to activate any reactions (Goldfried et al. 2003). When CBT clinicians experience reactions to their clients they are encouraged to identify and scrutinize the beliefs creating the negative or positive reactions (Ellis 2001). If change is required clinicians are encouraged to use appropriate techniques and seek supervision as necessary. Clinicians are expected to form alliances with their clients while maintaining therapeutic and ethical boundaries.

Use of Anxiety

CBT trainees and clinicians are encouraged to be appropriately open and honest with their clients if they experience negative reactions or believe that the treatment is at an impasse. If a clinician is experiencing anxiety or any other negative emotion it is a red flag that something is going on for the clinician and/or within the therapeutic relationship that should be addressed since the goal is to help clients as adeptly and quickly as possible to feel and get better (Ellis 2001).

If the client experiences anxiety as a byproduct of the work being done in therapy this is also an important area of focus and it's one of the reasons that CBT clinicians check in so often with clients about their feelings and any changes in feelings (Beck 1995).

For both participants in the relationship, self-evaluation in terms of contributing thoughts is encouraged and a course of action prescribed based on what seems warranted. If the clinician or the client is experiencing emotions that are distracting them from the current therapeutic agenda then those must be addressed in order for the process to continue.

Use of Self-Disclosure

Appropriate self-disclosure in CBT is viewed as an effective tool for facilitating client change and contributing to the therapeutic relationship (Goldfried et al. 2003). Self-disclosure can be used to strengthen the therapeutic alliance, normalize the client's reactions, and provide information to the client about their negative impact on others within the caring therapeutic relationship. It is also a very useful way to model effective coping styles (Dryden 1990).

Self-disclosure is used to promote learning and enhance therapeutic gains and the relationship. It should be relevant to the client and this particular therapeutic process. Of course as is always the case the CBT clinician is tasked with using their best judgment about what is most appropriate with each particular client.

Case Example

CBT is a well-established psychotherapy treatment for panic and panic disorder and has been shown to alleviate panic at a rate of approximately 75%–90% (Sanderson and Bruce 2007). Panic attacks are sudden surges of intense levels of anxiety accompanied by a variety of physiological symptoms. People who have experienced panic attacks can become fearful of subsequent attacks and the possible extreme consequences such as heart attack, stroke, fainting, loss of control, etc.

"Todd" came to therapy because he had been experiencing intense episodes of panic symptoms including shortness of breath, dizziness, rapid heart rate, extreme anxiety, feelings of unreality, and the strong belief that there was something medically wrong with him. He had visited the emergency room and his primary care physician

many times due to these symptoms and they had been unable to find any medical explanation. He had followed all of the recommendations made by the medical professionals including eliminating caffeine and alcohol from his diet but the symptoms persisted. His doctor suggested that he seek professional counseling to explore any psychosomatic possibilities as contributing factors.

Todd was a well-respected, successful professional in the community. He had a strong support network and spent a great deal of his discretionary time and energy volunteering in the community. The symptoms had begun approximately 8 months before with a single episode that was not obviously related to any particular trigger. The panic attacks had increased to about 3 episodes every two weeks and Todd was beginning to worry that they'd only get worse and start impacting his life even more. There had been relatively low day to day impact except for the episodes themselves which lasted about 10 min and that he was cautious about what he agreed to do in case he had an attack. His pre-occupation with it had grown however and he stated that when he wasn't distracted by something else he was thinking about the attacks and his health. His general level of anxiety had increased as well.

Todd was not sure that a talking therapy approach would change his symptoms but he was willing to experiment with the possibility and be open to what happened. He agreed with the general idea that we tend to create some of our own upset through what we focus on in our thinking and reported being interested in exploring how his thinking might be contributing to the problem. He indicated that there was a familial tendency towards anxiety but that to his knowledge no one had suffered from panic disorder or panic attacks. He had never experienced panic before these episodes. His goal was to "get a handle on this" and ultimately alleviate the symptoms.

During the initial meeting it became clear to the clinician that Todd volunteered at an organization that the clinician not only did not support but had serious concerns about on political and social levels. The clinician experienced a negative reaction to this information and realized that some preconceived ideas and judgment existed about the type of person who would align himself with this organization. In addition, as they lived in a small community there was concern that since the clinician volunteered at an opposing organization it might become an issue in the therapy. This caused the clinician to consider whether or not the case should be referred to another clinician but in reviewing the thoughts associated with the reaction and seeking supervision from a peer the clinician decided that it would be possible to change the initial judgment by working on the unhelpful thinking that had been associated with it and practicing unconditional other acceptance. The clinician decided to address this with Todd in the event that he had experienced any rupture in the alliance and because there was a strong possibility that he would discover the clinician's affiliation with the other organization and there was concern that he might have a negative experience of this if it were to happen. The clinician explained the concern and they discussed whether or not it would be an issue for treatment. Todd thanked the clinician for being so forthcoming and concerned and reported that he did not believe it would have a negative impact on treatment. They agreed to check in about it again if it seemed necessary to either of them. This proved to be effective and the relationship was able to proceed.

The clinician first helped Todd explore what he thought of himself and how he felt about experiencing the panic. CBT posits that clients often have feelings and thoughts about their primary feelings and thoughts which should preferably be identified and addressed early on so as to allow the primary issues to be more accessible (Ellis and MacLaren 2005). In this case Todd identified that along with thinking he was "foolish" he felt embarrassed for having these symptoms for no discernible reason. He also feared he would have them forever and that there was something "seriously damaged" about him that he was having the experiences at all. Embarrassment, shame and guilt all alert the CBT clinician to explore the possibility that there is some self-downing contributing to the problem.

The clinician engaged Todd in a discussion about his embarrassment:

Clinician: "Can you describe the last time you felt embarrassed by the panic?"
Todd: "OK. I was talking with a friend yesterday about the weekend and he asked me what I had done. I knew perfectly well I'd been in the emergency room for several hours after a panic attack but I knew I couldn't tell him that so I said something lame and made an excuse to get off the phone. I was really embarrassed."
Clinician: "Can you recall what went through your head before you felt the embarrassment?"
Todd: "I remembered being in the ER and then thought that I couldn't tell him that."
Clinician: "Because?"
Todd: "Because he'd think I was insane."
Clinician: "And what if he did think that?"
Todd: "Well, at this point I'd probably have to agree on some level since the doctors can't find anything wrong with me and think it's all in my head."
Clinician: "And why did you go to the ER?"
Todd: "Because I thought I was having a heart attack and it seemed like the safest place to be."
Clinician: "And what did the doctor say?"
Todd: "That it wasn't a heart attack and that all my vital signs were perfectly fine once my heart rate slowed back down to normal."

Clinician: "So if you were to tell your friend that you had some concerning physical symptoms that caused you to decide to go to the ER but it turned out everything was physically OK he'd think you're insane?"
Todd: "No, not that part. He'd probably just be concerned about me if I told him that. He'd think I was insane because there's nothing wrong with me."
Clinician: "And only insane people think there might be something wrong with them when doctors can't find anything?"
Todd: "Well, no. I'm sure there are pretty reasonable people who think there might be something wrong with them but then it turns out they're OK."
Clinician: "And that makes them….?"
Todd: "Lucky." (laughs)
Clinician: "I'd like to go back to something you just said. You said there's nothing wrong with you but it seems like the symptoms you've described are pretty real when they're happening."
Todd: "They're definitely real. They freak me out. I meant that the doctors don't have a medical reason for why this is happening."
Clinician: "Oh, OK. So are you saying that when someone has uncomfortable experiences that doctors can't explain with a medical diagnosis that means they're insane?"
Todd: "Um, no, not necessarily. Sometimes there's just other stuff going on or sometimes they just haven't found the problem."
Clinician: "So let's go back to your friend. If he were to tell you that he was having some physical symptoms but the doctors couldn't find anything medically wrong with him and, in fact, they had encouraged him to speak with a therapist, what would you think?"
Todd: "Poor guy."
Clinician: "Anything else?"
Todd: "I'd probably just try to tell him that things would be OK."
Clinician: "So it sounds like you'd really feel for the guy and you'd try to support him?"
Todd: "Yeah. In fact, I had a friend who was having a hard time sleeping and didn't have much energy or appetite and he was really afraid that he had cancer or something. The doctors couldn't find anything wrong with him and told him to see a shrink. He did and it turned out he had some depression problems."
Clinician: "And what did you think of him for having a problem with depression?"
Todd: "I was sorry for him and hoped he'd be able to get some help and get better soon."
Clinician: "Did you think he must be insane?"
Todd: "No, not at all. Lots of people have problems. I was just glad that he was taking care of it."
Clinician: "Did you ever think or tell him that he should probably feel bad or be embarrassed for having symptoms that his medical doctor couldn't diagnose and were all in his head?"
Todd: "Of course not."
Clinician: "How come?"
Todd: "Because he didn't know what was wrong with him and it made sense to go to the doctor because that's usually where people go when they don't feel well. He was trying to get help and just because it turned out there wasn't anything physically wrong with him is no reason to feel bad. It's frustrating but it's no reason to be embarrassed. He didn't do anything wrong."
Clinician: "And you really believe that?"
Todd: "Definitely. It's hard to get help sometimes. Especially therapy help. I told him I respected him for taking care of himself."
Clinician: "So I guess I'm wondering why the same logic doesn't apply to you?"
Todd: "What do you mean?"
Clinician: "I mean, you seem to genuinely and strongly respect your friend for getting the help he needed even when it turned out the problem was at least partially psychological but when you talk about what's going on with you I hear you getting down on yourself. What do you think?"
Todd: 'Well, I haven't really thought about it like that. I guess I just wish I wasn't having to deal with this and I feel silly that it's happening."
Clinician: "And what would you tell this friend you mentioned if he said the same thing to you?"
Todd: "I'd tell him that he was being too hard on himself."
Clinician: "Hmm."
Todd: "OK. I get it. I'm being too hard on myself."

Todd was able to show himself through the clinician's use of Socratic questioning that the embarrassment was a product of holding himself to a higher and unreasonable standard than he held other people. While he believed it was acceptable for others to be fallible and have problems he was not allowing it in himself. He was also able to address his catastrophizing about the future and see that he was confusing fact and fiction. He had the real fact of the panic experiences and then the fiction that they would continue forever which he was experiencing as fact and was causing a great deal of upset. The clinician was able to normalize his experiences by giving information about common panic attack symptoms and model unconditional acceptance of Todd with this problem. Todd came to understand that if he could accept himself with this problem and stop catastrophizing about the future he would not only feel better but have a stronger chance of reducing the

symptoms. He developed some coping statements to support these new ideas and agreed to practice them between sessions. His general anxiety level decreased.

In subsequent meetings Todd was able to identify additional thoughts and behaviors that were contributing to his symptoms. For example, every time he thought he was experiencing a symptom he rushed to a computer and typed the symptom into an online diagnostic program which would then list all of the possible conditions for which the symptom could manifest itself. Upon a quick review of the list he would determine that he had the most fatal of the diagnoses and his experience of the symptoms would intensify. When discussing this habit it became obvious that Todd was using the online "evidence" to reinforce the belief that his symptoms were life-threatening. In evaluating this practice Todd came to see that beyond the initial symptom, which he reported was at a low level of intensity or discomfort, he was creating evidence to support the belief that he was dying and then experiencing appropriate reactions to learning of one's imminent death. When he decided to stop the practice of checking his symptoms against diagnoses he was able to satisfy the urge to act by looking up the weather somewhere pleasant and tolerate the mild symptom until it went away which it generally did very quickly.

Through collaboration with his clinician Todd became a very astute consumer of his thinking and was able to identify helpful and unhelpful patterns, some of which dated back to his childhood. He pushed himself to take appropriate risks and create opportunities to step out of his comfort zone to prove that he could and gained a greater sense of self-efficacy. He was able to apply what he had learned to other situations in his life to effectively manage his reactions. During therapy there were times when the clinician offered hypotheses which did not ring true for Todd and the clinician continued to re-formulate based on this feedback. CBT clinicians routinely offer up hypotheses about the nature of client problems through questioning and with experience they are often accurate but have to remain open to the possibility that they are not to maintain the integrity of the therapeutic relationship. Flexibility is one of the crucial elements of truly elegant therapy. Ultimately he was able to reduce and alleviate the panic symptoms in approximately three months through attending weekly counseling and the application of a variety of techniques in session and between sessions.

It should be noted that there was another important component to this treatment which was several discussions in therapy about what he valued and where his energy was being spent. Todd was very successful professionally and enjoyed volunteering but had become less excited about his work and longed for something more creative. He did not present any unhelpful thinking, feeling or behaving associated with this issue and it was not directly related to the problem of panic but because he had introduced it into the therapeutic relationship it was respected as an important element and much attention was given to exploring this issue. The clinician self-disclosed having grappled with a similar situation and Todd reported being reassured by the information. He ultimately decided to make some changes to free up time for creative pursuits.

Some of Todd's desired creative pursuits had to do with the organization mentioned previously with which he was affiliated and the clinician was challenged by continuing to disagree on a personal level with the organization's goals and still support Todd's goal of putting more of his energy towards this organization. This required consistent self-monitoring and careful attention to respecting Todd's right to believe whatever he chose to believe. Together, the clinician and Todd created a committed, working relationship that allowed for positive change despite their differences. The clinician was able to develop a better understanding and greater acceptance of a group with whom there had previously been negative thoughts and feelings.

While all therapies certainly do not work for all clients there are many clinicians who claim to practice CBT but have no or very little formal training and attempt to utilize techniques without fully understanding when, why or how to implement them. There is an inherent disconnect when this happens that easily and understandably alienates clients. In fact, anecdotal experience indicates that the majority of clinicians who claim to be CBT focused practitioners have not received any formal training that involved actual, hands on experience with supervision and have gained the majority of their information from books, workbooks and half or one day seminars that only begin to scratch the surface of effective CBT, or other, practice.

Conclusion

Cognitive Behavioral Therapy recognizes the importance of the therapeutic relationship and the therapist's use of self in successful therapy. A skilled CBT clinician is able to formulate problems, offer techniques and create interventions in cognitive behavioral terms while interacting with clients in a warm, genuine way.

As a final note on CBT manuals it is important to note that since CBT has proven to have a high success rate with many problems manuals have been used outside of the research world with varying levels of success to augment or replace more expensive and time-consuming formal training in CBT. Unfortunately, there is an assumption that the clinician will have the skills and knowledge to adapt

the material to the individual client which is generally not the case for clinicians who don't have appropriate training or supervision (Huppert and Abramowitz 2003). The flexible application of CBT manualized treatment catered to specific individuals can be effective (Levitt et al. 2007) but does require a relational aspect for the clinician to be able to use the manual discriminately.

Whatever the modality, it stands to reason that truly experienced therapists tend to have a much higher percentage of clients who improve and a small number that get worse or stay the same and that training and practice in the performance of specific skills tends to increase treatment efficacy (Beutler 1997). Experience and training allow the therapist to integrate their professional and personal selves in a way that allows them to full engage in the therapeutic process and relationship.

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