The Treatment Rationale in Cognitive Behavioral Therapy: Psychological Mechanisms and Clinical Guidelines

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Clinical experience and an accumulating body of research suggest that clients who enthusiastically buy into a cognitive-behavioral treatment (CBT) rationale show more favorable outcomes. But how should a therapist present and discuss a CBT rationale effectively? How does one respond to client concerns and doubts? What are the psychological processes operating when discussing why a client is suffering and what to do about it? We suggest that the treatment rationale is a considerably more subtle and complex process than has previously been assumed. It involves generating expectations, negotiating control and assigning blame, and its function may vary depending on the stage of treatment. We illustrate these points by considering common reactions to a CBT rationale and alternative therapist responses. We conclude that much closer attention should be paid to the treatment rationale in the context of research and clinical practice.

One of the best ways to persuade others is with your ears—by listening to them.

—Dean Rusk

After all, when you come right down to it, how many people speak the same language even when they speak the same language?

—Russel Hoban

THE TREATMENT RATIONALE plays a central role in all cognitive behavioral psychotherapies (e.g., Beck, Rush, Shaw, & Emery, 1979; Craske, Meadows, & Barlow, 1994). Its overarching purpose is to provide clients and therapists with a model of etiology (*Why* is this person having *this* problem?) and treatment (What should we *do* to change it?). Research has documented numerous ways in which acceptance of a treatment rationale is associated with positive treatment outcomes (Addis, Bourne, & Davis, 1999; Addis & Jacobson, 1996, 2000; Braswell, Kendall, Braith, Carey, & Vye, 1985; Burns & Nolen-Hoeksema, 1991, 1992; Edelman & Chambless, 1993; Fennel & Teasdale, 1987; Ilardi & Craighead, 1994; Persons, Burns, & Perloff, 1988).

Despite the relatively large number of studies supporting the importance of the rationale, scant attention has been paid to concrete methods for effectively presenting a rationale. Moreover, with the exception of Jerome Frank's (1971) classic work, little progress has been made in illuminating the psychological processes operating when a therapist and client discuss why a problem exists and what to do about it. Some treatment manuals offer transcripts of therapists orienting clients to treatment, but the client typically has relatively few concerns, and is easily persuaded by a confident therapist. In practice, the process can be relatively straightforward, or it can involve multiple layers of mutual influence unfolding over the course of treatment. Compare, for example, the following three hypothetical therapist-client interactions that might occur just after a therapist presents a CBT rationale.

Example 1

THERAPIST: So you can see how this treatment is based on the idea that changing the way you think about yourself and certain situations can change how you feel.

CLIENT: Yes, I can definitely see that and it makes a lot of sense to me. But I wonder if I'll be able to change the way I think. It seems impossible.

T: Well, it's like learning any new skill. It takes time, but with practice, you'll get much better at it.

C: You mean I'm going to have to work at changing my thoughts.

T: That's right. It's hard work, but in my experience it can really pay off and there is a considerable amount of scientific research to suggest that's the case.

C: That's reassuring.

Example 2

T: So you can see how this treatment is based on the idea that changing the way you think about yourself and certain situations can change how you feel.

C: Uh huh.

T: Good. So that makes sense.

C: Uh huh.

T: Okay. Let's go over your self-monitoring forms and get started on—

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C: I didn't do those. I wanted to but I was so depressed and then I misplaced them.

Example 3

T: So you can see how this treatment is based on the idea that changing the way you think about yourself and certain situations can change how you feel.

C: I read an article that said depression is caused by a chemical imbalance, and my friend is taking Prozac, which seems to be helping him.

T: Drugs are one option for treatment, but this approach has been shown in research to be just as, or more, effective than drugs.

C: Hmm. I guess that's reassuring. I'm willing to try anything at this point.

Example 1 represents the sort of vignette commonly found in treatment manuals. Typically there is little discussion of what to do if a client disagrees with the rationale, or the client's response is unclear. Examples 2 and 3 are closer to the types of reactions therapists see in clinical practice. In Example 2, it might be inferred that the client has a lukewarm response to the rationale as indicated by a weak agreement with the therapist and her inability to complete the homework assignment. However, it's unclear whether this response reflects actual disagreement with the rationale or the strength of the client's current depression. In Example 3, it appears that the client's doubts about CBT versus medication are alleviated by the therapist's reference to empirical research. However, his willingness to "try anything" may reflect an implicit disbelief in the validity of the CBT rationale.

> Research has documented numerous ways in which acceptance of a treatment rationale is associated with positive treatment outcomes.

These examples illustrate some common ambiguity in clients' responses to a CBT rationale. Subtle and sometimes contradictory responses are overshadowed when a metaphor of "transmission" is applied to the treatment rationale. Within this metaphor, the therapist transmits a body of information (the rationale) to the client and then checks the accuracy of the client's reception (*Do you understand and agree with this rationale?*). What we hope to show in the remainder of this paper is that there are a number of other processes operating, in addition to communicating information, when therapists present and discuss a CBT rationale. Awareness of these additional layers can help therapists facilitate clients' active engagement in CBT.

An Expanded View of the Treatment Rationale

Generating Expectations

When you present a model of treatment to clients, you are telling them how therapy will take place in the future. The process will inevitably lead the client to harbor expectations about treatment, including both hopes and fears. Consider, for example, a client being presented with a cognitive-behavioral rationale for the treatment of social phobia. A description of the diagnosis, the role of cognitive processes in maintaining anxiety, and support for exposure as a key change mechanism might lead to the following, largely private, client reactions:

Wow, what a relief to know this problem has a name; I'm optimistic that this treatment is going to be helpful.

What does she mean by automatic thoughts? I hope I'm smart enough to understand this treatment.

Exposure sounds like I'm going to catch some kind of virus. Wait a minute. You mean I'm going to have to speak in public?! I don't think I'm going to be able to bear that.

These examples illustrate one of the most common fallacies about a treatment rationale. Clients rarely "agree" or "disagree" with a treatment rationale. Instead, they experience a mixture of reactions depending on their personal history, the stage in treatment, and the therapist's style in presenting the rationale. Notice also that if a therapist is concerned only with transmitting the content of the treatment rationale to the client, he or she may easily miss the sorts of hopes and fears generated by the discussion.

Negotiating Control

Jerome Frank said that naming a problem is the first step to gaining control over it (Frank, 1971). This is why it is commonly assumed that one of the functions of a credible treatment rationale is to reassure a client that his or her problem is understandable and can be effectively treated. For example, Fennel and Teasdale (1987) found that clients who were "depressed about being depressed" responded most favorably to a CBT rationale. Similarly, in a review of the role of nonspecific factors in CBT for depression, Ilardi and Craighead (1994) suggested that client remoralization is a result of a clear explanation of a credible treatment rationale. Presumably, a credible treatment rationale increases perceptions that a problem is controllable and fosters hope in the process.

There are other ways in which control is involved in presentation and discussion of a treatment rationale. Simply naming a problem is exerting control over a person's behavior. Experience teaches us that when others name our behavior in different ways, different consequences may follow. Anyone who has questioned a physician's diagnosis of a sore throat or headache knows this from personal experience. "Your headaches are caused by stress" means aspirin, relaxation, or psychotherapy are soon to follow. "I'm not sure what's causing your headaches and I'd like to do a CT scan" means anxiety, fear, and a battle with your HMO are about to follow. The labeling of emotional states such as depression and anxiety can be understood in a similar way. When a parent tells a child, "You're hungry," food will likely follow. "You're being difficult" is typically followed by some negative consequence, and "You're cranky" may generate ambiguous consequences. The process continues in adulthood when significant others, friends, family members, and professionals label our private states ("You look unhappy"; "Wow! You look like you just won a million bucks"; "What you are suffering from is called an anxiety disorder"). In all these instances we are sensitive to consequences associated with different labels for our behavior. Thus, clients will carefully evaluate whether a diagnosis or treatment plan "fits," not only because they are concerned with the therapist's accuracy, but because the potential for subsequent control is psychologically present in any discussion of a treatment rationale.[1]

Assigning Blame

The first author is a novice golfer[2] but has made enough progress to begin wondering why he isn't better than he is. On a recent outing he had the following experience. Having kept his eyes on the ball, his head still, his left arm straight, his knees bent and, impossibly, his mind relaxed, he swung the club and hit an 8-inch chunk of sod a good 60 yards. The ball did not move. At this point, the following conversation ensued:

FIRST AUTHOR [to no one in particular]: Why did I do that?

FRIEND: I think you may have dropped your hands.

FIRST AUTHOR: Yeah.

FRIEND: Typically, hitting it fat is caused by dropping your hands or not accelerating on your downswing.

FIRST AUTHOR: Uh huh.

FRIEND: It could also just be that you're too tense.

FIRST AUTHOR: I'm not *&!!#@ tense.

FRIEND: Okay, I'll take your word for it.

FIRST AUTHOR [to himself]: Why is this guy criticizing me? I'm just a beginner. It's not my fault. I'm trying as hard as I can.

This ridiculous but (scout's honor) very real example shows that discourse about the causes of problems inevitably involves talk about who's responsible for them (Antaki, 1994; Fulton, 1998). Although the form of such dialogue may appear to involve a search for "objective causes," causal statements implicitly or explicitly refer to where blame lies. In this case, it was the first author's dropped hands, failure to accelerate, and level of tension. However, if you change First Author to Client, Friend to Therapist, and lousy golf swing to depression, the following dialogue might ensue:

CLIENT: Why do I feel this way?

THERAPIST: We know that when people are depressed they tend to think about things in a very negative way.

CLIENT: Uh huh.

THERAPIST: They also stop engaging in activities that used to give them pleasure and this makes the depression worse.

CLIENT [to herself]: No wonder I'm depressed. Look at all the things I'm doing wrong.

Again, the surface form of the therapist's talk appears to be about an objective search for causes. Yet notice that the causal referent for the depression is always the client's thoughts or behavior. While most therapists have no intention of blaming a client for being depressed or anxious, clients may experience blame, not only because self-blame is characteristic of depression, but because the assignment of blame is an unavoidable aspect of presenting most treatment rationales. In fact, one of the most appealing aspects of a biological treatment rationale (i.e., pharmacotherapy) is that it clearly *removes* blame from the client and assigns it to "chemical imbalances" or something similar. A CBT rationale can be ambiguous with respect to blame. Therapists hopefully don't intend to blame clients for having "dysfunctional beliefs" or "irrational cognitions." Most take the stance that cognitions are learned and the environment thus plays a key etiological role. But our culture assumes a greater degree of autonomy in peoples' thoughts than in their biochemistry. Thus, the notion that "your thinking is at the root of your problem" can function as an ascription of personal blame more easily than the notion of a chemical imbalance.

This last point was well illustrated in a recent interaction with a client suffering from panic disorder. The first

[1] While all clients will be concerned to some extent with the implications of a diagnosis, individual clients will differ in their sensitivity to issues of control in discussing a treatment. At one extreme, some clients may disagree with any model of treatment offered by a therapist simply because disagreeing with others is part of their interpersonal style. Larry Beutler and his colleagues have shown that clients with high degrees of reactance (the tendency always to try and resist influence from others) show better outcomes in self-directed than in cognitive-behavioral therapy (Beutler et al., 1991). Other clients may not be reactant as a personality style, but may still be sensitive to interpersonal issues of control.

[2] The more appropriate technical term is "hacker." However, in the interests of demonstrating the crucial role of language in determining the acceptability of various etiological models, we utilize the less noxious term "novice."

author was attempting to convince the client that experiencing negative automatic thoughts does not indicate a failure in overcoming panic disorder. The client enjoyed softball, so the therapist said, "Look, sometimes you strike out but you keep swinging and over time you get more base hits." The following dialogue ensued:

CLIENT: Look, if I strike out it bums me out but it doesn't get me down the way this does.
THERAPIST: Why?
CLIENT: Because I know there's lots of reasons I could strike out. Maybe I'm having a bad day, maybe the pitches are really good, who knows?
THERAPIST: Right! And if your anxiety thoughts get the best of you some days, who knows why? Maybe you were having a bad day, maybe the thoughts were particularly strong. What I'm suggesting is that your thoughts are just like pitches. They'll come periodically and you do you best to swing at them—but you don't blame yourself too much if you strike out.
CLIENT: That doesn't work.
THERAPIST: Why?
CLIENT: Because the pitches are outside of me and I can't control them. My thoughts are inside me and I should be able to control them.

The idea that we can, in principle, control our thoughts is really at the heart of CBT. It's a useful assumption if it leads a client to succeed in thinking more adaptively. However, as the above example illustrates, it carries with it the implicit ascription of personal responsibility.

The experience of blame during discussions about the cause of a problem is also a product of individual learning histories. Consider the following example that should be familiar to couples therapists:

WIFE: I think we would have had more fun if we had rented a car for the week.
HUSBAND: She's blaming *me* for our lousy vacation!

Whether the wife intended to blame her husband for their lousy vacation is less relevant than his experience of being blamed. It may be a function of past experiences with her (e.g., she does in fact blame him), or experiences with close others that are now generalized to the marital relationship. In the same way, whether or not a therapist intends to blame a client for his or her problem when presenting a CBT treatment rationale, the client may experience reproach.

Varying Functions Depending on the Stage of Treatment

Psychotherapy researchers have begun to document the different change processes operating in different stages of treatment (e.g., Howard, Kopta, Krause, & Orlinsky, 1986; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Prochaska & DiClemente, 1992). Howard and his colleagues (1996) suggest that the target of improvement differs according to a three-stage process. Remoralization occurs in the first few sessions of therapy. During this stage, clients begin to feel increased hope that their problems can be worked through and begin to utilize coping resources. The remediation phase of treatment is focused on relieving symptoms, while the rehabilitation phase is focused on changing long-standing maladaptive patterns.

The function of a treatment rationale may differ depending on the stage of treatment. In the remoralization phase, the rationale may combat demoralization by offering hope that things can change (Frank, 1971; Ilardi & Craighead, 1994). During the remediation phase, the rationale cements different interventions into a logical process of symptom reduction. For example, if symptom reduction has occurred quickly (e.g., a client is no longer having panic attacks), the rationale for interoceptive exposure (Craske et al., 1994) can be invoked to show the importance of continuing treatment despite early symptom reduction. Clients' reactions to a CBT rationale also may mean different things depending on the stage of treatment. Disagreements during the remoralization phase may reflect hopelessness, while disagreements during remediation may reflect concerns about particular treatment procedures. There is, of course, no one-to-one correspondence between certain types of reactions and the stage of treatment, yet it does help to consider how a treatment rationale may be operating differently at different points in treatment.

To summarize, the treatment rationale is a key component of all CBT treatments. The transmission metaphor emphasizes transmission and reception of the content of the rationale. This metaphor highlights the importance of therapist and client having a shared understanding of etiology and treatment approach. The metaphor is less adept at highlighting other psychological processes operating in a treatment rationale. A rationale can generate fear and anxiety as well as hope and remoralization. Discussions about what a problem is, why it exists, and what to do about it also invoke issues of interpersonal control and assignment of blame. Finally, the meaning or function of the rationale may vary over time, depending on the stage of treatment. Awareness of these issues leads to some general guidelines for facilitating a helpful dialogue about the treatment rationale.

Presenting a CBT Rationale

For the past 6 years we have been conducting research on various aspects of the CBT treatment rationale. The quantitative results have shown that clients who agree with a CBT rationale show better treatment outcomes and become more engaged in treatment (Addis & Jacobson, 1996, 2000). It also appears that the way people think about the causes of depression prior to treatment is reliably associated with their responses to alternative treatment rationales (Addis & Carpenter, 1999; Addis & Jacobson, 1996). In conducting these studies, we've spent a good deal of time listening to therapist-client discussions of a CBT rationale for treating depression. Our most recent work examines specific therapist and client behaviors that commonly occur in discussing the rationale. Do therapists spend more time persuading clients or exploring clients' questions and concerns? What do therapists do when clients express doubts about the treatment rationale? What are the most common concerns clients have about a CBT rationale? Although we're in the process of analyzing this data quantitatively, we offer here suggestions about presenting and discussing a CBT rationale, and common client concerns or doubts about a CBT approach to treating depression. What follows are clinical impressions. They are not based on empirically established relationships between certain clinical strategies and therapeutic outcomes. Our hope is that some of our impressions might generate additional empirical studies.

Present the Treatment Rationale

Therapists sometimes don't present a treatment rationale. Our impression is that this occurs most often when clients are overwhelmed with distress and feel the need to vent. A certain degree of venting may be necessary to facilitate a therapeutic alliance, particularly early in treatment. However, CBT treatments are structured interventions. Taking the time to present and discuss the treatment rationale is essential, both to start therapy on the right course and to model the type of structure necessary for subsequent sessions. We suggest that when clients need to vent early in treatment, therapists should label this explicitly and incorporate it into the agenda. A therapist might say, "It seems like you really need some time to just talk about what's been happening. I think that's important to do and I'd also like to spend a good portion of the session focusing on the treatment approach. How does that sound? Which would you like to start with?"

Present It in a Personally Meaningful Way

Clients typically don't speak the same language therapists do. Terms such as "automatic thoughts," "interoceptive exposure," and "reinforcing events" may not make music immediately for clients the way they do for therapists. Incorporating the rationale into an example from the client's own experience is often helpful. At the same time, therapists should clearly define key terms or concepts since they will be referred to repeatedly as treatment progresses. A good rule of thumb is to move through an iterative process of introducing a concept (e.g., automatic thoughts, anticipatory anxiety), asking clients how it might apply to them personally, clarifying the concept, applying it to a personal example, and so on.

Explore Clients' Reactions to the Rationale

We find it useful to assume that clients have meaningful reactions to a treatment rationale, even if they don't express them. Thus, it's essential to explore clients' reactions to any rationale you offer for any aspect of treatment. Ask, "How does that sound?" or, "What do you think about the idea of working on exposing yourself to the things you fear?" If a client says, "Sounds fine," ask, "What sounds fine about it?" "Do you have any concerns?" Table 1 presents a set of questions therapists can use when discussing a client's reactions to a treatment rationale. They're derived partly from our observations of successful therapist-client interactions around the rationale, and partly from our research on explanatory repertoires related to depression (Addis, Fulton, & Iselin, 1998).

Explore Clients' Existing Models and Attributions for the Problem Cause and Change Process

We assume that all clients have at least an implicit idea about why they're having a problem and the most effective way to change it. It is helpful to get the clients' ideas out on the table early in treatment. For example, some clients may be convinced that depression is caused by "a chemical imbalance." Others may assume that treatment is necessarily about exploring how childhood experiences affect our feelings as adults. A safe strategy is for the therapist to assume a stance of respect for alternative theories and treatments, while clearly differentiating

Table 1
Sample Questions to Ask
When Discussing a Treatment Rationale

General Questions for Any Treatment Rationale
1. What are your reactions to what you know about this treatment so far?
2. What parts concerns you?
3. What parts seem positive or hopeful?
4. If you were to explain to a friend or family member how this treatment works, what would you say?
5. What's your understanding of why you're having this problem?
6. What are your ideas about the best way to overcome or cope with it?

Specific Questions About CBT
1. What do you think about the idea that your thoughts play an important role in determining your mood/anxiety/behavior?
2. What do you think about the idea of changing your thoughts and behavior as a way of working on your mood/anxiety?
3. What are some possible downsides to these ideas?
3. What do you think about the idea of having weekly homework related to your problem/situation?

CBT. Respect is key because it may not be clear why a client is attracted to one explanation or another. A focus on early childhood may, for example, relieve a great deal of self-blame and validate the client's inability to change his behavior despite considerable effort. To take a strong stance against this model (e.g., "There's very little scientific support for that approach, whereas this treatment is based on solid research") may unnecessarily sacrifice rapport.

Many clients will assume that the hypothesized cause and treatment of a problem must coincide. Thus, if depression is due to a "chemical imbalance," then pharmacological treatment should be the treatment of choice. Or, if depression is caused by early childhood experiences, then changing current behavior may be viewed as "not dealing with the root problem." CBT therapists know that many interventions (e.g., exercise, breathing retraining, accurate self-talk) can be effective regardless of whether they match a theoretical cause for a particular problem. A therapist has two choices here. One is to try and integrate the client's etiological theory into the CBT rationale. Childhood experiences, for example, can be assumed to have some influence on the development of core beliefs or underlying assumptions. The other option is to educate the client directly about the value of various change strategies and the extreme difficulty in establishing definitive causes for most problems. The second strategy is preferable because it orients clients toward solutions rather than searching for causes. However, if a client insists on matching a treatment to a presumed etiology, then the first strategy is preferable.

> It is a good idea to have clients explain the treatment rationale to you until you are convinced that you are both on the same page about the client's treatment.

Assume the Rationale Isn't Clear Until the Client Can Explain It to You

Both clients and therapists may think that the client understands the treatment rationale, when in fact he or she doesn't. For example, when the first author explained a CBT rationale for treating depression to one client and asked about his understanding of it, the client responded, "Yeah, I've got it, I just have to change my attitude." CBT is, in many ways, about changing attitudes. However, by exploring the client's understanding further (What do *you* mean by attitudes?), the therapist learned that a former spouse often accused the client of "having a bad attitude." Thus, the CBT rationale, though logical to the client, also carried with it excess baggage of criticism and blame. By emphasizing that changing attitudes is hard work, and failure to do so is not due to a lack of will, the therapist was able to get the client more on board with the CBT rationale than would have been possible without exploring the client's idiosyncratic reactions. As a rule of thumb, it is a good idea to have clients explain the treatment rationale to you until you are convinced that you are both on the same page about the client's treatment. This may take time as a client's understanding of the treatment approach evolves over several sessions.

Assume Clients' Reactions to the Rationale Will Change

Much of CBT is based on the assumption that people have stable beliefs about themselves and their world. While this premise may have considerable clinical utility, its status as a psychological fact is questionable. In our research on reactions to a CBT rationale, we ask people each week, "Does the treatment you are receiving match your ideas about what helps people in psychotherapy?" We have found that answers to this question can change dramatically from week to week. Because of this, and because CBT is a multifaceted intervention, it is essential to check in regularly with clients regarding their reactions to the treatment. This is especially true when moving from one phase of treatment to another (e.g., from behavioral activation to cognitive interventions for depression, or from cognitive interventions to exposure in the treatment of anxiety).

Validate the Client's Reactions to the Rationale

Marsha Linehan (1993) defines validation as follows: "The essence of validation is this: The therapist communicates to the patient that her responses make sense and are understandable within her *current* life context or situation" (p. 222, italics in original). Although Linehan is known for developing a CBT for borderline personality disorder, validation is essential for all CBT treatments. Rather than disputing a client's concerns about a CBT rationale and risk having them become defensive, the therapist should seek to understand exactly what those concerns are and how they are sensible given the client's current situation. Imagine the following client response to the therapist's presentation of a CBT rationale for depression:

CLIENT: I'm sure that this treatment is effective for some people, but I really doubt it's going to work for me. I've tried everything.

Now consider the following three possible therapist reactions.

T1: What makes you different than other people?
T2: Well, the research shows that this treatment is highly effective. Your doubt is probably part of the depression, which makes everything seem hopeless.
T3: You're having trouble believing this treatment could be helpful. That's understandable. Why should you think anything would be helpful when you haven't tried this treatment, and nothing you've tried previously has worked? I think that if I was in your situation I would have the same concerns.

Only the third response validates the client's concern. The first response may be directed toward an important clinical issue (i.e., the client may see herself as different than others, and this may be contributing to her depression), but it does not facilitate the current therapeutic goal of getting the client on board with the treatment rationale. The second response may be reassuring to some clients, but not to others. Responses 1 and 2 might be helpful if the therapist first validated the client's reactions to the treatment rationale. Validating does not mean agreeing with the client's assessment that the treatment won't work. It means seeing the client's perspective and concerns as sensible. Validation is also more than a detached intellectual process; it means *really* being able to understand the validity of the client's perspective.

Be Up Front About the Importance of the Treatment Rationale

With the exception of highly reactant clients, it can't hurt to overemphasize the importance of the treatment rationale. We suggest being very clear with clients about the importance of agreeing with the therapist regarding the treatment rationale. The therapist as a "coach" or "trainer" is a useful metaphor in CBT. It emphasizes that the therapist and client must agree on the appropriate strategy for tackling a problem, and that the client will be doing the majority of the work, with the therapist serving as an expert guide.

Trust the Data, Don't Argue Too Much, and Adopt a Wait-and-See Attitude

Some clients will never fully accept the CBT rationale. Clients struggling with anxiety disorders, for example, may be willing to try CBT but have much greater faith in medication early in treatment. In such cases, the therapist must believe the research data demonstrating the efficacy of the treatment and, at the same time, be willing to accept a client's doubts. Accepting them doesn't mean ignoring them. It should be clear by now that exploring a client's concerns about the treatment rationale is essential. However, if they've been explored and the client is still less than 100% on board, it is best to adopt a wait-and-see (rather than an agree-to-disagree) attitude. The general stance should be something like, "I believe this treatment works because I've seen it work, and I think it can be helpful for you. However, I can see that you're not sure at this point, so why don't we give it a try and see how it goes. I'll be checking in with you regularly to see how it's going." An ambivalent or doubtful client does not necessarily mean a treatment failure. In our research, we often see people working through a number of different models of etiology and treatment, rather than sticking to a single explanatory framework (Fulton, 1998). An ambivalent or doubtful client may experience a successful outcome without ever fully buying into the CBT rationale. Other clients may, over time, become more convinced as they experience positive outcomes over the course of therapy.

Client Concerns Following Presentation of the Treatment Rationale

Recently we've also begun to look more closely at instances in which clients express any concern or doubt about a behavioral activation rationale for treating depression. These reactions are important because they occur early in treatment and can potentially set the stage for subsequent interactions around specific techniques or interventions. As one angle, we discuss below the most common concerns or doubts clients express about an activation rationale.[5] We also provide some preliminary impressions about different ways to respond to each concern.

Do Clients Express Concerns About the Treatment Rationale?

We found that, *when prompted for reactions*, 58% of clients verbally expressed disagreement with or doubts about the rationale. It is safe to assume that other clients had doubts but were unwilling or unable to share them. In fact, the majority of those clients who did express doubts were prompted several times before they verbalized their disagreements. Expressing disagreement with the treatment rationale (and thus implicitly with the therapist) may be a difficult process for some clients, and some therapists may not present themselves in a way that makes it acceptable for clients to express their doubts. Again, it is crucial to elicit clients' reactions to the treatment rationale in an inviting and nonthreatening manner.

Treating the Symptom and Not the "Real" Problem

Some clients view the idea of changing behaviors as a superficial focus on symptoms without correcting the "real underlying" problem itself. Like taking aspirin for

[5] Whether these concerns are the same ones that would emerge for a more cognitive rationale is an empirical question. It is unlikely that clients are more doubtful overall in their reactions to a behavioral or cognitive rationale. Addis and Jacobson (1996, 2000) did not find any differences between CBT and behavioral activation in overall reactions to the rationale (positive or negative).

the treatment of a headache caused by a brain tumor, changing behavior is seen as temporary and incomplete. Clients in our sample said things such as "This [treatment] won't change the real cause of the depression," "This deals with the symptoms and not the real problem," and "Keeping busy is just a distraction from my real problem." Furthermore, some clients worry that if they participate in an activation-oriented therapy, they will further delay treatment of the actual problem. For example, one client in our sample stated that she feared engaging in this treatment because if she did the homework and other tasks she would "never get to the real problem." While other disagreements surrounding this theme showed up (e.g., preferences for physiological or societal explanations), the idea that changing behavior is superficial was one of the most common client concerns, expressed by nearly 20% of clients who verbalized some disagreement or doubt.

> It is essential for clinicians to foster clear and repeated bidirectional communication about the treatment rationale. If we could leave readers with one idea it would be to ask, and ask repeatedly, about clients' reactions to a treatment rationale.

There are several options for responding to this concern. First, it is always a good idea to find out more about the concern. What are the anticipated consequences of engaging in a treatment that doesn't get at the "real" problem? Does the client think that revealing the "true" cause of depression is the only way to effectively treat it? From a cognitive perspective, one might ask what evidence the client has that there is an underlying problem that must be dealt with before behavior can be changed. Often the only evidence available is the intensity and duration of the clients' suffering, and the widely available cultural assumption that "emotional" problems are caused by deep-rooted feelings, beliefs, and self-images. Second, therapists can (and should) always refer to the research on the effectiveness of behavior change as a treatment for depression (Jacobson et al., 1996; Lewinsohn, Antonuccio, Steinmetz Breckenridge, & Teri, 1984). Third, references to research should be tempered by a wait-and-see attitude (e.g., "My experience is that this treatment can be quite helpful, although I understand that you have some concerns that it doesn't deal with the real problem. Why don't we try this approach and see where it takes us?"). Finally, therapists should get very clear on what the real problem is from the client's perspective. Often, apparently nonbehavioral problems can be framed with little effort into a behavior-change–oriented treatment (see Goldfried & Davison, 1994). One common example is a client who disagrees with the idea of changing current behavior because past painful experiences are seen as causing the depression. The therapist can ask, "In what ways have those experiences affected how you behave today?"

Oversimplification

Understandably, clinicians try to present treatment rationales as clearly as possible. Unfortunately, what we perceive as parsimonious, and even elegant, may appear to a client as simplistic. In our sample, several clients reacted to the treatment rationale with statements such as "There must be more to this" and "This theory is oversimplified." Some clients express doubt that anything that appears this simple can be effective.

Again, the first step here is to find out more about the concern. What does "simple" mean? What are the anticipated consequences of engaging in a simple treatment? The concern may be a variation on not getting at the real problem. A simple treatment may also mean, "If it were this simple I would/should have figured it out long ago. The fact that I'm still depressed either means that it's not that simple, or that I'm really screwed up." Second, it should be explained that while the treatment rationale appears simple, the treatment itself certainly is not easy. The treatment requires considerable effort and the willingness to make difficult changes. We all know that *changing behavior is not easy.* It takes considerable practice and often good coaching.

Self-Doubts About Competency

Obviously, it would not be a good idea to emphasize the difficulty of the treatment to a client who appears overwhelmed. Many clients enter therapy demoralized and with low levels of perceived self-efficacy. While some may become remoralized as a result of merely entering therapy and hearing a credible treatment rationale, others remain skeptical about their ability to complete therapeutic tasks. Several clients in our sample made statements such as "This makes sense intellectually, but I can't do these things when I'm depressed," "My life is too screwed up to even begin something like this," or "There is no way that I'll ever be able to fill these logs out."

Responses to these types of concerns depend upon the function of the client's response. If a client is simply reporting a lack of self-confidence, the therapist can reassure the client that change is possible, though it takes practice and will be accomplished in manageable steps. The concern may also be functioning as avoidance. "My life is too screwed up to even begin something like this" may mean, "Don't expect me to change very much" or "I'm uncomfortable knowing you [the therapist] have expectations that I'm going to complete forms, practice homework assignments, etc." The first step, as always, is to find out more about the concern. What makes you think you'll never be able to practice pleasurable activities? What are you concerned would happen if you had difficulty practicing? Some therapists may utilize these questions as cognitive challenges—searching for the evidence supporting an expectation of failure. Alternatively, the questions can be viewed as simple information gathering. It is impossible to get a client with doubts to buy into a treatment rationale without thoroughly understanding what those doubts are. As the quote at the beginning of the article suggested, it is often easier to persuade by careful listening than by premature debate.

Summary and Conclusion

We began this article by suggesting that the treatment rationale is an essential component of all CBT interventions. We also suggested that our current understanding of the function of rationales is incomplete. In addition to fostering remoralization, a treatment rationale generates short- and long-term hopes and fears. It is thus essential for clinicians to foster clear and repeated bidirectional communication about the treatment rationale. If we could leave readers with one idea it would be to ask, and ask repeatedly, about clients' reactions to a treatment rationale.

A treatment rationale also sets in motion processes of interpersonal control and blame. Control and blame are not necessarily therapist agendas; rather, they are unavoidable components of our histories with respect to talk about causes and solutions to problems. When people talk about why a problem occurs and what to do about it, they are establishing a context where interpersonal influence is likely to occur, if only in the naming of a problem. They are also designating the locus of responsibility for the problem. Because these processes are unavoidable, it would be a mistake for a therapist to ignore them. Rather, clinicians must be aware of power issues when discussing a treatment rationale or corresponding intervention, and take steps to foster as high a degree of collaboration as possible within the structure of relatively directive interventions. We must also remember that clients' responses to a CBT rationale are not fixed beliefs; they are contextually situated reactions. They may vary as a function of the stage of treatment, the therapist's skill in presenting the rationale, or individual past experiences contributing to the perceived meaning of a notion, such as "your thoughts control your mood."

Why have we devoted an entire article to something as specific as the treatment rationale in CBT? It would probably not be too much of a stretch to say that the questions *Why am I feeling this way?* and *What should I do about it?* are psychologically present at most, if not all, points in treatment. Yet we are convinced that, with a few exceptions, the power of the rationale has been underestimated by CBT theorists and researchers. Perhaps its designation as a "nonspecific" factor has relegated it to that category of variables that must be controlled in order to rule out placebo effects and demonstrate the efficacy of specific techniques. But are there other ways to look at the treatment rationale? For example, rather than viewing it as a nonspecific factor whose mechanisms of change are well-understood (i.e., increasing hope), perhaps it is a pervasive technique surrounding all other interventions. Perhaps its change mechanisms are not well-understood. Such a perspective opens up the possibility for treatment development and research with the goal of maximizing meaningful client involvement in CBT.

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