

EMPIRICALLY GROUNDED CLINICAL GUIDANCE PAPER

# Doctoral clinical psychology student commentary on common myths about CBT: lessons learned for competency-based training

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## Abstract

Effective methods for training and education in the dissemination of evidence-based treatments is a priority. This commentary provides doctoral clinical psychology graduate student authors perspectives on common myths about cognitive behavioural therapy (CBT). Three myths were identified and considered: (1) CBT does not value the therapeutic relationship; (2) CBT is overly rigid; and (3) exposure techniques are cruel. Graduate students were engaged in a competency-based course in Cognitive Behavioural Approaches to Psychotherapy at an American Psychological Association (APA)-accredited doctoral clinical psychology program. The origins of common myths identified by graduate students included a lack of in-depth coverage of CBT and brief video segments provided during introductory courses, lived experience with CBT, and pre-determined views of manualized treatment and exposure techniques. Myth-addressing factors discussed by graduate students included holding space at the start of training for a discussion of attitudes about CBT, specific learning activities, and course content described in this commentary. Finally, self-reported changes in graduate students' attitudes and behaviour following the course included a more favourable view of CBT as valuing the therapeutic relationship, as well as implementation of resources provided, and techniques learned and practised at practicum settings. Limitations and lessons learned are discussed through the lens of a model of adult learning that may be applied to future graduate training in evidence-based therapies like CBT.

## Key learning aims

- (1) To understand common myths about cognitive behavioural therapy (CBT) that doctoral students in clinical psychology hold prior to entering a course in CBT.
- (2) To understand the possible origins of these myths, factors that may address their impacts, and changes in attitudes and behaviour among graduate students as a result.
- (3) To examine the lessons learned that can be applied to future training in evidence-based therapies like CBT.

**Keywords:** CBT; clinical psychology; competency; mental health; myths; training and education

## Introduction

Training and education in evidence-based treatments for the next generation of clinicians remains a priority in the field. Becker and Stirman (2011) have argued that we are only in the early stages of understanding best practice in the dissemination and implementation of these treatments. In fact,

many patients still do not receive evidence-based psychotherapies as part of their care (Shafran *et al.*, 2009; Tolin, 2020). Prior research suggests that several factors impact clinicians' uptake of evidence-based approaches. These include a lack of or difficulty accessing training opportunities, failure to address therapist concerns regarding certain treatment approaches (i.e. beliefs or myths held about a treatment), and therapists' concerns surrounding the credibility and use of specific therapy techniques like exposure (Arch *et al.*, 2015; Gunter and Whittal, 2010; Meyer *et al.*, 2020; Shafran *et al.*, 2009; Whiteside *et al.*, 2020). Cognitive behavioural therapy (CBT) is an evidence-based treatment and first-line approach for addressing several presenting concerns, such as mood and anxiety disorders, eating disorders, post-traumatic stress, personality disorders, and alcohol use disorders (Beck, 2021; David *et al.*, 2018; Fairburn, 2008; Foa and McLean, 2016; Ledley *et al.*, 2020; Linehan, 1993; Matusiewicz *et al.*, 2010). Despite such findings, many patients, families and clinicians (including future psychologists in training) may maintain beliefs in commonly held myths regarding the use and efficacy of CBT as a treatment approach and its accompanying techniques (Dobson and Dobson, 2018).

A limited literature has examined the origins of myths held about psychotherapy generally, and more specific to CBT. Norcross (1995) proposed general myths that are pervasive across the field of psychotherapy including that all therapies produce comparable results. Although myths about CBT are often discussed within the grey literature (i.e. work discussed on non-traditionally published platforms such as websites and blog posts), less peer reviewed work has been devoted to this important topic. Of the limited studies that do exist, some common myths about CBT have been identified. These include that CBT is too superficial and unconcerned with underlying dynamics, ignores individual differences in case formulation, lacks the ability to be integrated into other approaches, and is too directive while largely ignoring emotion (Dattilio, 2001; Dobson and Dobson, 2018; Westbrook *et al.*, 2007). Further, Feeny and colleagues (2003) found that myths can also be specific to CBT techniques including exposure. These myths included that exposure techniques are rigid and uncaring to the individual patient's needs, the effectiveness of exposure does not generalize to the real world, and the use of exposure leads to a worsening of symptoms and more treatment drop-out (Feeny *et al.*, 2003). Other modalities of treatment (e.g. family therapy) have also documented myths related to the use of CBT including perceived shortcomings for this treatment in dealing with interpersonal dynamics and emotion, as well as failure to appreciate the role of the therapist in treatment (Dattilio, 2001). Myths about particular treatments are important as Lilienfeld and colleagues (2013) have contended that clinicians' inaccurate beliefs about evidence-based psychotherapies have consequences for therapists' openness to new evidence for the effectiveness of a specific treatment. As a result, identifying, understanding the origins, and then adjusting therapist misconceptions about evidence-based psychotherapies may be an important component of ensuring treatment dissemination among those old and new to the field (Lilienfeld *et al.*, 2013).

Prior research on training in evidence-based therapy approaches for student trainees has revealed factors associated with adopting a new therapy approach. Cook and colleagues (2009) examined factors influencing the applied practice of mental health clinicians including variables associated with adopting new clinical skills. They found that the potential for integration with a therapeutic modality they were already providing and endorsement of an approach by a therapist who was respected were aligned with the uptake of the new approach (Cook *et al.*, 2009). In their study, Bearman and colleagues (2015) found that student views of evidence-based therapies changed during their engagement in an evidence-based practices course provided in a doctoral psychology training program. For example, students' views of evidence-based treatment were more positive following the course with students with bachelor's level education experiencing a larger positive change in attitudes (Bearman *et al.*, 2015). Providing training and education in evidence-based approaches like CBT early on in a graduate training program may facilitate student uptake of the new treatment and later use with patients in the practice setting.

Prior knowledge of and competence in an evidence-based treatment also impacts attitudes toward the treatment. Higa and Chorpita (2008) argued that before an evidence-based therapy is used in everyday practice, the clinicians using the treatment must be both knowledgeable and endorse a positive view of the approach. Nakamura and colleagues (2011) examined clinician knowledge and attitudes toward evidence-based treatments prior to receiving training in the techniques. They found that licensed practitioners with an advanced degree and those in outpatient clinical practice settings had more knowledge and positive views of evidence-based practice (Nakamura *et al.*, 2011). Prior work has also shown that receiving training in an evidence-based treatment like CBT using a case example that outlines the process specific to this treatment increases practitioner's willingness to be trained further in this mode of therapy (Stewart and Chambless, 2007). This points to the need for further discussion of factors influencing graduate students' attitudes about competency-based training in CBT, factors that may address myths about the treatment, and how this training makes its way into the practice setting.

Doctoral students in clinical psychology receive coursework in CBT as part of their formal graduate training. There are available guidelines for training in CBT (Ashbaugh *et al.*, 2021; Canadian Association of Cognitive and Behavioural Therapies, 2019; Klepac *et al.*, 2012) and comprehensive teaching resources made available by the Association of Cognitive and Behavioral Therapies (i.e. sample CBT course syllabi openly available to faculty at <https://www.abct.org/for-professionals/teaching-resources/syllabi/>). To our knowledge and review of the literature, there is limited published work that describes commonly held myths about CBT by doctoral trainees in clinical psychology, and how those myths may develop based on graduate students' first voice commentary. The current article aims to provide trainee/student perspectives regarding the CBT myths commonly held by clinical psychology doctoral students. We also examined the potential origins of these myths and how misconceptions/myths about CBT change following coursework through the lens of a first-person graduate student commentary.

## Methods and procedure

In this commentary, the authors, who are graduate student trainees, explore myths about CBT, as well as their origins in a course on Cognitive Behavioural Approaches to Psychotherapy as a required part of their graduate training. Although all students in the graduate-level course at an APA-accredited doctoral training program were invited to contribute to writing this commentary ( $n = 23$ ), a total of four students were able to participate as co-authors for the article. Myths about CBT were generated during class discussion where the course instructor held space during class for students to talk about common myths they have experienced and the origins of those myths. Specific aspects in training identified by graduate students that helped to address these myths and self-reported changes in their own attitudes and behaviour were generated by the graduate student authors who took part in this commentary following completion of the course. Lessons learned from the commentary aim to better inform the provision of future CBT training and education.

## Cognitive and behavioural therapies course

The Cognitive Behavioural Approaches to Psychotherapy course was provided through an APA-accredited doctoral program in clinical psychology and reviews the impact of CBT on the development of empirically supported treatment approaches. The course is provided to second year students in the fall semester of their doctoral training. Core competencies reviewed in this course include case conceptualization, client engagement and collaboration, and treatment structure. Behavioural competencies under each domain include the history of cognitive and behavioural therapy approaches, cognitive and behavioural theory, evidence-based treatment, the CBT model of treatment, routine outcomes monitoring, cognitive and behavioural approaches

to mood and anxiety disorders, and how to integrate core therapy skills into the effective use of CBT. Other course content includes the CBT session structure, collaborative agenda-setting, how to elicit patient feedback, skills for building a therapeutic alliance, pacing and efficient use of time, guided discovery and Socratic questioning, and how to collaboratively set home action plans. Students also learn about the links between thoughts, feelings, physical sensations and behaviour. Self-monitoring, cognitive distortions, cognitive restructuring techniques, exposure-based approaches, and behavioural experiments are reviewed. Special topics include how to provide CBT with cultural competence and with diverse populations, clinical documentation, continuity of care, patient engagement and barriers to home action completion, and consideration of how to provide CBT within interprofessional teams.

Competency evaluations included two written CBT case formulations for patients that students are seeing at clinical practicum, and 25-minute CBT skills demonstration with a mock patient who has a mood or anxiety disorder. These skills demonstrations are audio recorded with feedback provided using the Cognitive Therapy Rating Scale - Revised (CTS-R; Blackburn *et al.*, 2001). The course was developed based on current best practices in training and education for CBT (Ashbaugh *et al.*, 2021; Klepac *et al.*, 2012). The course instructor is an Assistant Professor, licensed psychologist, and holds formal certification in CBT through the Canadian Association of Cognitive and Behavioral Therapies (CACBT), with over a decade of experience in training, education, clinical consultation and supervision.

## Doctoral student commentaries on CBT

### **Myth 1: CBT does not value the therapeutic relationship**

There is a commonly held myth identified by graduate student trainees that CBT does not value the therapeutic relationship. This myth has been documented previously (Dobson and Dobson, 2018; Gilbert and Leahy, 2007; Westbrook *et al.*, 2007), describing the assumption that the therapeutic relationship is not important in the provision of this modality of treatment. The origins of this myth were reported to be based on trainees' prior experiences during their undergraduate and graduate education where they described being exposed to a number of treatment modalities in introductory coursework that did not go into the level of depth required to fully understand CBT. In addition, the combination of didactic class instruction, general discussion, and observation of brief segments of video-recorded psychotherapy sessions were described to likely exacerbate this myth. For example, while viewing brief portions of videos of clinicians providing CBT, the perspective that developed was that the CBT therapist was often tough on the patient and seemingly unconcerned with offending them during the session. The CBT therapist was also viewed as being harsh as evidenced by the therapist repeatedly commenting on the patient's maladaptive thoughts and behaviours. CBT was believed to be pushy and not a good fit for most of the patients trainees would be meeting with in their practicum settings. Another contributing factor to this myth was trainees' self-reported experiences of CBT or that of family and peers. The difference between what was reported to have been experienced in treatment versus what they were now learning about CBT was discussed. For example, experiencing a CBT therapist as cold, not caring, or only concerned with their own agenda for the session were common themes. Negative reports from family and peers about not feeling heard by the CBT provider were also common. These examples from lived experience were reported to have further reinforced the belief that CBT does not value the therapeutic relationship.

Table 1 outlines all the topics and weekly learning activities in the Cognitive Behavioural Approaches to Psychotherapy course. One of the factors that helped to disconfirm the myth that CBT does not value the therapeutic relationship was reported to have occurred in the first class. During the class students were provided with space to discuss their prior attitudes and beliefs about CBT. Interestingly, students described finding comfort in knowing that their fellow

**Table 1.** Cognitive Behavioural Approaches to Psychotherapy course topics and weekly learning activities during the 3-credit hour course

Class	Topics	Learning activities
1	Review course syllabus History of CBT Overview of theory	Assessment and routine outcomes monitoring Class discussion of common myths about CBT CBT session structure *Observe video on CBT session structure and role play
2	Introduction to the CBT model	Socialization to the CBT model of treatment *Role play CBT case formulation *Video practice
3	CBT case formulation continued Cognitive Therapy Rating Scale – Revised (CTS-R)	Psychoeducation and self-monitoring *Observe video, role play CTS-R application and mock skills demo
4	Collaborative goal setting and home actions	Collaborative goal setting and home actions *Role play
5	Cognitive techniques	Socratic questioning and guided discovery *Video, role play Links between thoughts, feelings, physical sensations, and behaviour Cognitive restructuring *Video, role play
6	Behavioural techniques	Breathing retraining and progressive muscle relaxation (PMR) *Video, role play Principles of exposure and hierarchy building *Barlow and Öst snake phobia video Behavioural experiments *Role play
7	Culturally sensitive CBT approaches	Culturally sensitive CBT techniques *Role play
8	Introduction to Dialectical behaviour therapy	Behaviour chain analysis *Role play
9	Introduction to Acceptance and commitment therapy (ACT)	Six core components of ACT *Role play
10	Documentation in CBT Ending the episode of care	Review notes samples Ending episode of care
Final exam	CBT mock patient skills demonstration	

classmates held a similar belief that CBT generally undervalues the therapeutic relationship. Holding space for students to have this discussion early in CBT training and without judgement by the course instructor or peers was reported to be helpful by students. This was also noted to provide a space for beginning to address this myth in the course. For example, recognizing that their own and others lived experience with prior CBT may be more related to the approach of a specific therapist than what the modality includes (e.g. collaboration, interpersonal effectiveness) was viewed as a helpful differentiation.

The next factor identified that helped to contend with this myth was the introduction of the structure of the CBT session (Beck, 2021). Throughout the course, it was gradually recognized that this structure was designed in a way to provide several opportunities for the development and maintenance of a therapeutic alliance. Students noted that this structure may strengthen the therapeutic relationship by making the CBT session predictable and within the patient's control. First, the CBT therapist does a brief check-in with the patient (e.g. 'Did anything come up between this session and last that is important for me to know as your therapist?') and a bridge to content discussed in the prior appointment is provided. Flexibility to meet the patient where they are on a session-to-session basis was noted as surprising to graduate students. Next, the CBT therapist and patient work together to come up with a collaborative agenda for the therapy session (e.g. 'If there were one thing you would like to focus on in

today's session what would that be?'). In fact, students were surprised to learn that therapist's competence with collaboration is something assessed using the CTS-R (Blackburn *et al.*, 2001) and that they would be evaluated in this domain during their mock clinical skills demonstrations. Attending behaviour and active listening were microskills that students learned to enhance collaboration and therapeutic alliance. This dynamic between CBT therapist and patient of collaboration on a session-by-session basis was also viewed to aid in establishing and maintaining rapport, with the focus being patient centered.

Next, students were surprised to learn that near the end of the session the process of setting the home actions remains collaborative and patient centered, with the patient having input into what they will work on between sessions (e.g. 'What do you think would be helpful to work on between this session and the next based on our discussion today?'). This was in contrast to both prior held attitudes and their own or others experiences of CBT therapists as non-collaborative. During the conclusion of each therapy session, the CBT therapist ensures a shared understanding of the content by asking the patient about their take-away or whether anything particular stood out for them that they would like to keep in mind over the next week. Students commented that this part of the structure really challenged the myth that CBT disregards the importance of the therapeutic relationship as it provides the space to allow for knowledge translation of key content for the session a patient would want to keep in mind during the week. Further, the patient is prompted to provide feedback regarding their treatment experience to the therapist (e.g. 'Is there any feedback for me today?'). This provides a safe space for the patient and therapist to check in on how the therapeutic relationship is going and to make sure they are working on the goals the patient set for therapy. It was noted that the instructor's active modelling of the use of the CBT session structure in each class helped to further demonstrate this throughout the course.

Graduate students described a shift in attitude from CBT being viewed as being unconcerned with the therapeutic relationship and even antagonistic to placing value on the collaborative nature of the therapeutic relationship in helping patients meet their treatment goals. It was reported that the concept of collaborative empiricism in CBT helped to further solidify this change in attitude. The inclusion of the CTS-R helped students see that collaboration (i.e. attention, working together with the patient) and interpersonal effectiveness (i.e. empathy, genuineness, and warmth of the therapist directed toward the patient) are important competencies evaluated (Blackburn *et al.*, 2001). In fact, students described starting to use the CBT structure in their practicum settings.

### **Myth 2: CBT is overly rigid**

The origin of the myth that CBT is overly rigid likely stems from a limited knowledge of CBT, as well as pre-existing views about the meaning of manualized treatment. The term manualized treatment can be misleading as it implies that a strict or rigid treatment is effective for a wide array of individual presentations and challenges; such seems paradoxical as it is hard to conceptualize how a firmly manualized treatment can fit the unique characteristics of numerous clients. Aspects of the course that challenged this myth included the introduction to explorative interventions used by the CBT therapist (e.g. Socratic questioning, guided discovery). Experiential learning exercises such as modelling of these skills by the course instructor and class role playing was also helpful for better understanding that the CBT therapist guides clients to arrive at their own conclusions in a manner that is congruent with each of their unique lived experiences. It was also surprising that CBT is flexible within the blueprint of manualized treatment. Despite the previously held assumption that manual-based treatment is rigid, a grey area exists for therapists between treatment adherence and complete autonomy from the treatment program (Kendall *et al.*, 2017). This permitted a bigger picture view of CBT techniques being appreciated when attempting to provide treatment tailored to

multiple disorders with unique presentations, which can be accomplished by using a manualized modality without compromising individualism.

Another helpful aspect of the course for challenging this myth was the course text, *Treatment Plans and Interventions for Depression and Anxiety Disorders* (Leahy *et al.*, 2012). In the text the authors provide helpful blueprints for treatments for mood and anxiety disorders, while balancing discussion on how to also provide an adaptive and client-centered approach with CBT. Course readings also helped illuminate how CBT can be adapted for culture and diversity through specific techniques including inviting conversations of marginalized statuses and adapting cognitive restructuring when marginalized groups negative automatic thoughts have some validity (Graham *et al.*, 2013).

The fact that students were able to address the myth that CBT is too rigid, and instead see the flexibility within the modality was well aligned with the premise of evidence-based practice in psychology as defined by the APA Presidential Task Force on Evidence-Based Practice (2006). Graduate students described a shift in attitude from CBT being viewed as rigid and manualized to more flexible than expected. Students reported that understanding manualized treatment represented a blueprint and not a set of rigid rules to be applied in every case was noted to be helpful. Experiential role playing using different presenting concerns, modelling of techniques by the course instructor, and the course text helped students to see past the manual to how the different elements come together for different patients while appreciating their unique backgrounds. The course text was described to be used outside the class by students for guiding treatment being provided in practicum settings while not being overly rigid.

### **Myth 3: Exposure techniques are cruel**

Similar to Feeny and colleagues (2003), graduate students in this commentary described having the belief that exposure techniques are cruel for patients. Undoubtedly, one of the factors leading to the myth that exposure as a CBT technique is cruel, is that individuals dedicated to the psychological well-being of others enter the field with an inherent desire to ease others' emotional distress. Therefore, novice clinicians in training run the risk of viewing exposure-based CBT techniques as cruel and having the potential to lead to intolerable psychological distress. Similar to the concerns patients may have about these techniques, a common misconception identified by graduate students is that exposure to a feared stimulus will result in a catastrophic increase in anxiety. The myth that exposure therapy is cruel was challenged in the course through the required readings that helped students gain in-depth insight into the behavioural principles that a cognitive behavioural approach to anxiety takes into consideration (Table 2). Students also learned about the role of safety behaviours and avoidance during class discussion and review of the protocols for treating anxiety disorders. Knowing that avoidance denies patients an opportunity to have a corrective experience and recognize their capacity to cope better framed this technique as a necessary element of treatment. One required reading that stood out was the Abramowitz (2013) article where students learned that repeated exposure to a feared stimuli is accompanied by a natural lessening in fear and anxiety responses. Similar to the class discussion, the principles of exposure, especially that exposures are planned, predictable and under the patients' control, also helped to address this myth. In exposure-based approaches the patients get to choose what they work on and it can be broken down into more manageable steps. Safety behaviours may also be helpful for clients at the start of exposure when anxiety is at its highest. As a class we learned about research showing that safety behaviours may in fact help patients to better engage in these exposure techniques (Levy and Radomsky, 2014). Evidently, exposure therapy is not cruel, nor does it cause catastrophic increases in anxiety.

Given what was learned in class, perhaps the same is true of therapists providing exposure as part of CBT. That is, therapists' own distress about seeing patients in distress impacts the use of

**Table 2.** Required readings for the Cognitive Behavioural Approaches to Psychotherapy course

Course textbooks
American Psychological Association (2020). <i>Publication Manual of the American Psychological Association</i> (7th edn). Beck, J. S. (2020). <i>Cognitive Therapy: Basics and Beyond</i> (3rd edn). Guilford Press. ISBN: 9781462544196.
Leahy, R. L., Holland, S. J. F., & McGinn, L. K. (2012). <i>Treatment Plans and Interventions for Depression and Anxiety Disorders</i> (2nd edn). Guilford Press.
Ledley, D. R., Marx, B. P., & Heimberg, R. G. (2020). <i>Making Cognitive-Behavioral Therapy Work: Clinical Process for New Practitioners</i> (3rd edn). Guilford Press.
Journal articles
Abramowitz, J. (2013). The practice of exposure therapy: relevance of cognitive-behavioral theory and extinction theory. <i>Behavior Therapy</i> , 44, 548–558. <a href="https://doi.org/10.1016/j.beth.2013.03.003">https://doi.org/10.1016/j.beth.2013.03.003</a>
Barlow, D. H. (2010). Negative effects from psychological treatments: a perspective. <i>American Psychologist</i> , 65, 13. <a href="https://doi.org/10.1037/a0015643">https://doi.org/10.1037/a0015643</a>
Barlow, D. H., Harris, B. A., Eustis, E. H., & Farchione, T. J. (2020). The unified protocol for transdiagnostic treatment of emotional disorders. <i>World Psychiatry</i> , 19, 245. <a href="https://doi.org/10.1002/wps.20748">https://doi.org/10.1002/wps.20748</a>
Blackburn, I.-M., James, I. A., Milne, D. L., Baker, C., Standart, S., Garland, A., & Reichelt, K. (2001). The Revised Cognitive Therapy Scale (CTS-R): psychometric properties. <i>Behavioral and Cognitive Psychotherapy</i> , 29, 431–446. Retrieved from: <a href="https://ebbp.org/resources/CTS-R.pdf">https://ebbp.org/resources/CTS-R.pdf</a>
Clark, D. M. (1999). Anxiety disorders: why they persist and how to treat them. <i>Behavior Research &amp; Therapy</i> , 37, S5. <a href="https://doi.org/10.1016/s0005-7967(99)00048-0">https://doi.org/10.1016/s0005-7967(99)00048-0</a>
Cuijpers, P., Karyotaki, E., Ciharova, C., Miguel, C., Noma, H., Stikkelbroek, Y., Weiz, J. R., & Furukawa, T. A. (2021). The effects of psychological treatments of depression in children and adolescents on response, reliable change, and deterioration: a systematic review and meta-analysis. <i>European Child &amp; Adolescent Psychiatry</i> . <a href="https://doi.org/10.1007/s00787-021-01884-6">https://doi.org/10.1007/s00787-021-01884-6</a>
Dalgleish, T., Black, M., Johnston, D., & Bevan, A. (2020). Transdiagnostic approaches to mental health problems: current status and future directions. <i>Journal of Consulting &amp; Clinical Psychology</i> , 88, 179–195. <a href="https://doi.org/10.1037/ccp0000482">https://doi.org/10.1037/ccp0000482</a>
Ehlers, A., & Clark, D. M. (2000). A cognitive model of post-traumatic stress disorder. <i>Behavior Research &amp; Therapy</i> , 38, 319–345. <a href="https://doi.org/10.1016/s0005-7967(99)00123-0">https://doi.org/10.1016/s0005-7967(99)00123-0</a>
Foa, E. B., & McLean, C. P. (2016). The efficacy of exposure therapy for anxiety-related disorders and its underlying mechanisms: the case of OCD and PTSD. <i>Annual Review of Clinical Psychology</i> , 12, 1–28. <a href="https://doi.org/10.1146/annurev-clinpsy-021815-093533">https://doi.org/10.1146/annurev-clinpsy-021815-093533</a>
Hinton, D. E. & Jalal, B. (2013). Parameters for creating culturally sensitive CBT: implementing CBT in global settings. <i>Cognitive and Behavioral Practice</i> , 21, 139–141. <a href="https://doi.org/10.1016/j.cbpra.2014.01.009">https://doi.org/10.1016/j.cbpra.2014.01.009</a>
Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: model, processes and outcomes. <i>Behaviour Research &amp; Therapy</i> , 44, 1–25. <a href="https://doi.org/10.1016/j.brat.2005.06.006">https://doi.org/10.1016/j.brat.2005.06.006</a>
Huisman, P., & Kangas, M. (2018). Evidence-based practices in cognitive behavior therapy (CBT) case formulation: what do practitioners believe is important, and what do they do? <i>Behaviour Change</i> , 35, 1–21. <a href="https://doi.org/10.1017/bec.2018.5">https://doi.org/10.1017/bec.2018.5</a>
Murphy, R., Calugi, S., Cooper, Z., & Dalle Grave, R. (2020). Challenges and opportunities for enhanced cognitive behavior therapy (CBT-E) in light of COVID-19. <i>the Cognitive Behaviour Therapist</i> , 13, 1–31. <a href="https://doi.org/10.1017/S1754470X20000161">https://doi.org/10.1017/S1754470X20000161</a>
Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. <i>the Cognitive Behaviour Therapist</i> , 12, 1–17. <a href="https://doi.org/10.1017/S1754470X19000060">https://doi.org/10.1017/S1754470X19000060</a>
Pachinkis, J. E., Soulliard, Z. A., Morris, F., & van Dyk, I. S. (2022). A model for adapting evidence-based interventions to be LGBTQ-affirmative: putting minority stress principles and case conceptualization into clinical research and practice. <i>Cognitive and Behavioral Practice</i> . <a href="https://doi.org/10.1016/j.cbpra.2021.11.005">https://doi.org/10.1016/j.cbpra.2021.11.005</a>
Riva, G., Malighetti, C., & Serino, S. (2021). Virtual reality in the treatment of eating disorders. <i>Clinical Psychology &amp; Psychotherapy</i> , 28, 477–488. <a href="https://doi.org/10.2196/jmir.7898">https://doi.org/10.2196/jmir.7898</a>
Veale, D. (2008). Behavioural activation for depression. <i>Advances in Psychiatric Treatment</i> , 14, 29–36. <a href="https://doi.org/10.1192/apt.bp.107.004051">https://doi.org/10.1192/apt.bp.107.004051</a>
Zickgraf, H. F., Chambless, D. L., McCarthy, K. S., Gallop, R., Sharpless, B. A., Milrod, B. L., & Barber, J. P. (2016). Interpersonal factors are associated with lower therapist adherence in cognitive-behavioural therapy for panic disorder. <i>Clinical Psychology &amp; Psychotherapy</i> , 23, 272–284. <a href="https://doi.org/10.1002/cpp.1955">https://doi.org/10.1002/cpp.1955</a>



this technique in the practice setting. Some work has shown that therapists' negative beliefs about exposure (e.g. how strenuous it is for the provider) are associated with lack of dissemination of this technique (Pittig *et al.*, 2019). Student attitudes after the course were that exposure therapy is not cruel, nor does it cause catastrophic increases in anxiety; rather, exposure techniques are planned, predictable and under the patient's control. Having a more in-depth comprehension of the theoretical underpinnings of CBT for anxiety and the mechanisms that make exposure therapy effective helped to address this myth (see Abramowitz, 2013). Practice gained through in class experiential role plays was helpful. Graduate students also described that viewing and discussing as a class the Barlow and Öst treatment of a snake phobia video (<https://www.youtube.com/watch?v=zKTpecooiec>), where it is evident just how much of the patients own distress is normal to illicit in session and that anxiety goes up and then eventually comes back down, was beneficial (Öst, 1987).

Lastly, the final exam for the course was a mock CBT skills demonstration where students select a presenting problem for the course instructor or teaching assistant (e.g. a senior level graduate student who has completed the course) to role play and then apply a CBT technique (e.g. cognitive restructuring, reviewing the principles of exposure, and building a graduated exposure hierarchy). The course instructor provided active modelling and experiential role playing of all CBT techniques during in class role plays with follow-up discussion. Students are audiotaped and feedback is provided using ratings from the CTS-R (Blackburn *et al.*, 2001). These activities provided a better appreciation for how exposure is competently delivered. Consistent with prior work, the instructor's adherence to treatment principles may have been related to whether a trainee or supervisee adhered to those same principles (Schoenwald *et al.*, 2009). In addition to shifts in graduate trainee attitudes about exposure as a CBT technique, they also noted its use outside of the class setting increased, as well as their interest to seek further training in exposure techniques. Based on this student commentary, this is consistent with past work showing that when instructors model and role play techniques for trainees there is more practice use in the subsequent therapy sessions than when only supervision involving discussion is provided (Bearman *et al.*, 2013). Therefore, it is important course instructors have a do-as-I-do rather than a do-as-I-say teaching approach consistent with models of adult learning (Kolb, 1984).

### Lessons learned

The current article provides a first voice discussion of myths held by doctoral students in clinical psychology prior to completing training in CBT. Consistent with prior knowledge of common myths held about CBT (Dobson and Dobson, 2018; Feeny *et al.*, 2003; Meyer *et al.*, 2020; Westbrook *et al.*, 2007), graduate students endorsed beliefs that CBT does not value the therapeutic relationship, is an overly rigid form of treatment, and that exposure therapy is cruel for patients. The student perspective yielded noteworthy insights into the origins of these myths. Limited prior knowledge of the theory behind CBT, prior learning activities in introductory coursework (e.g. didactic lectures going into limited depth on CBT, short video segments of therapy, etc.), and lived experience with the treatment were described. Graduate students also commented that pre-determined beliefs about the meaning of manualized treatment and the perceived incongruence between exposure techniques causing patients distress and the goal of therapy to alleviate patient suffering also reinforced these myths.

### Factors addressing myths about CBT

There were several factors in the CBT training identified by graduate students that helped to address the myths about CBT. First, holding space early in training for students to discuss their attitudes about evidence-based treatments like CBT and hear other students' beliefs was considered helpful. Group process in these discussions permitted students to provide each

other with corrective feedback around some of the commonly held myths. Specific learning activities outlined in Table 1 were also noted to assist. Learning the structure of the CBT session and review of CTS-R and its emphasis on competency in collaboration and interpersonal effectiveness were noted to be beneficial. Students described that it was helpful to have the course instructor model the lectures using the CBT session format, as well as demonstrate other techniques and competencies during course instruction. In class experiential role playing, the course readings and required text, and the final exam where students had to demonstrate a CBT technique and be recorded for feedback using the CTS-R were also noted. Students identified that having a more in-depth understanding of the principles and behavioural underpinnings of exposure assisted them in grasping the rationale for the use of this technique. Ultimately, this was reported to enable graduate students to shift perspectives to view exposure as collaborative, planned, predictable, and under the patient's control. Indeed, prior work shows that even highly trained and well-meaning clinicians may stray from evidence-based treatment and especially exposure-based approaches (Waller and Turner, 2016). Having the CBT skills demonstration portion of the course audio taped with feedback from the course instructor provided real time exposure to trainee's own anxieties and a teachable moment for how exposure-based techniques work. Perhaps in the spirit of Levy and Radomsky's (2014) findings course instructors in CBT may think skillfully about how to discuss and address some of the safety behaviours of graduate student trainees (e.g. avoiding eye contact during class discussions, checking emails in class, acting distracted when asked to volunteer for in class role plays, and overpreparing for skills practice). This may serve to help students better engage in all aspects of CBT training.

It has been argued that many of the criticisms of CBT's lack of consideration for the importance of the therapeutic relationship are exaggerated (Gilbert and Leahy, 2007). Graduate student commentaries noted a shift in this perspective during training similar to that noted by Okamoto *et al.* (2019) who described the inherent value CBT places on this relationship. In fact, graduate student commentary in this paper was consistent with Leahy's (2008) concern that emphasis on the need for training in treatments like CBT may risk that the importance of the therapeutic alliance is dwarfed by an over-emphasis on techniques. In their systematic review Luong and colleagues (2020) found that CBT values group cohesion, treatment expectations, and collaboration. They also noted that these variables are linked with improved outcomes for patients. Graduate students' discussions were consistent with prior work showing that failure to address therapist concerns regarding certain treatment approaches and about the use of specific therapy techniques like exposure are important factors for facilitating the uptake of evidence-based treatments (Gunter and Whittal, 2010; Meyer *et al.*, 2020; Shafran *et al.*, 2009).

### Changes in attitudes and behaviour

Prior work has argued that the dissemination of evidence-based treatments may be promoted through courses and workshops, in particular trainings that first target graduate students (Cook *et al.*, 2009). Graduate student perspectives and self-reported changes in their attitudes and behaviour during the course described in this commentary would suggest the same. In fact, course instructors likely play an important role in any efforts to improve student familiarity and confidence with evidence-based treatments like CBT. Kuckertz and colleagues (2020) found that patients take responsibility for knowing options for psychotherapy and may be split between whether it is more important to receive a treatment that is evidence-based versus one that comes recommended by another provider. Prior exposure to a type of therapy like CBT is associated with a greater likelihood of patients recommending it to others (Kuckertz *et al.*, 2020). Interestingly, the same could also be said of graduate student trainees whereby exposure to CBT training may be associated with a greater likelihood of it being recommended to other graduate student trainees. However, future work is needed to evaluate this.

A change in attitude about CBT not valuing the therapeutic relationship and being overly rigid was described in this commentary. Learning activities in the course helped to shift students to appreciate the role of clinical judgement in psychotherapy overall, recognizing that, like other theoretical orientations, CBT can be flexible and adapted for individual patient needs. This was in line with the findings of Bearman and colleagues (2015) that graduate course training can result in more positive views of CBT. Training may focus on teaching students the fundamental competencies of Socratic questioning and guided discovery within the structure of the CBT, and how such protocols and worksheets are intended to be integrated into the broader CBT case formulation (Beck, 2021). This is consistent with Kendall and colleagues' (2017) description of providing evidence-based treatments like CBT using 'flexibility within fidelity' (p. 23). In order to facilitate the use of new evidence-based approaches, training should focus on ways that clinicians can easily integrate the new skills into a clinicians' pre-existing therapy toolbox (Cook *et al.*, 2009).

In this commentary, graduate students reported the positive transfer of the CBT techniques learned in the course into the practice setting. They also endorsed active use of resources from the course (e.g. course text, worksheets, etc.), as well as positive experiences with feedback from their patients and supervisors. This feedback may have helped to positively reinforce alternative attitudes about this evidence-based therapy among graduate student trainees. Further, this may support Higa and Chorpita's (2008) proposition that before an evidence-based therapy is used in a practice setting the clinicians using the treatment need to endorse a positive view of the approach. Providing training in evidence-based approaches like CBT early on in a graduate training program may facilitate more positive views, improve student uptake, and help promote the use of CBT techniques in the practice setting.

### Limitations

Although this work adds to our understanding of the origins of myths associated with CBT held by graduate students in clinical psychology, counteracting factors, and important lessons learned for future CBT training, it is not without limitations. First, the sample for the first voice commentary was relatively small. Although we had invited participation from all graduate students in the course ( $n = 23$ ), engagement in writing the commentary was noted to be declined due to other graduate degree requirements requiring their time and attention. Perhaps this is worth further consideration in how evidence-based therapies like CBT are situated within graduate training programs and emphasis placed on their importance relative to other courses and degree requirements. Future work would benefit from sampling a larger pool of graduate students in clinical psychology, and perhaps other mental health disciplines, to gather their reports of myths about CBT and factors that help to address these misconceptions. Next, this was a first-person commentary involving the graduate student authors and course instructor. This work could be replicated in future research using an experimental design where the participants are blinded to the purpose. Information could also be gathered pre- and post-training in CBT in order to further evaluate the findings of this commentary. While this has been done previously examining doctoral students' views of evidence-based therapies generally (Bearman *et al.*, 2015), the origins of these views and factors that may address these attitudes toward CBT warrant further evaluation.

When considering more effective means of teaching and disseminating evidence-based treatments like CBT, one may also consider the importance of models of adult learning (Kolb, 1984). In this commentary it was noted that specific stages in Kolb's Learning Cycle (1984) may have helped to facilitate changes in graduate students' attitudes and behaviour. The experiential learning cycle consists of four stages including: (1) active experimentation (e.g. graduate students practising what they have learned during in-class role play or the mock skills demonstrations); (2) concrete experience (e.g. graduate student behaviour change towards using CBT techniques in the practice setting under supervision); (3) reflective observation (e.g. having sessions videotaped for viewing and discussion in supervision at a later time or

holding space in class for self-reflective discussions as a group); and (4) abstract conceptualization (e.g. where the knowledge translation takes place for student learning from direct experience in clinical practicums) (Kolb, 1984). In this Cognitive Behavioural Approaches to Psychotherapy course, active experimentation was used through in-class role playing of specific CBT techniques with feedback from the course instructor, and students were concurrently enrolled in practicum outside of the course providing an opportunity for the positive transference of CBT skills into the practice setting (i.e. concrete experience). Reflective observation was provided through the use of audio recording skills practices with feedback provided using the CTS-R and time held at the end of each class for a discussion of what students would take away from class to both parallel the CBT session structure and provide space for self-reflection and abstract conceptualization. Course instructors in CBT may benefit from further consideration of the components of adult learning as part of their efforts to teach and disseminate evidence-based treatments like CBT. For example, adults want input into their learning, need to know how the material is relevant, and use their own life experience to facilitate their learning (Cook-Sather, 2011). Holding space for discussion of their experiences with CBT and providing opportunities for active skills practice and discussion of how to use techniques in the practice setting may be advantageous. Course instructors in CBT would also benefit from consideration of pedagogical transparency, modelling of techniques by the trainer, and discussions of factors increasing positive transference of what is being taught in the course and how it makes its way into the practice setting (Cook-Sather, 2011).

## Conclusion

This first voice graduate student commentary on myths about CBT, origins of these attitudes, factors helpful for addressing misconceptions, and changes in attitude and behaviour after training represents an important window into the process of uptake of evidence-based treatments like CBT among graduate students in clinical psychology. CBT training would likely benefit from increased time dedicated to processing students' pre-existing attitudes, providing a safe milieu for experiential practice and process, and learning activities for myth-busting that align with adult learning. Consequently, establishing a foundational understanding and appreciation of evidence-based treatment during the onset of training is important as it may help to shift students and trainees from being convicted to questioning when it comes to pre-existing myths about CBT. This is in line with Tolin's (2020) hopes that 'rather than stifling psychologists' creativity, the establishment of a list of Empirically Supported Treatments is hoped to increase practitioners' use of scientific results and methods in their work, influence psychology training programs toward EPB, and result in more effective treatment for those we serve' (p. 4). Thus, the way we approach training the next generation of therapists matters.

### Key practice points

- (1) There continues to be a number of commonly held myths about CBT that may impact both uptake by professionals receiving training, as well as dissemination of evidence-based care.
- (2) Doctoral student commentaries revealed myths including CBT not valuing the therapeutic relationship, being overly rigid, and that exposure as a technique is cruel.
- (3) Origins of these myths included lack of in-depth training, past experience with CBT, and pre-determined views of manualized treatment, and beliefs that exposure techniques cause more anxiety where therapists are meant to alleviate it.
- (4) The learning activities addressing these myths and subsequent change in attitudes and behaviour reported by trainees have important lessons for how we approach the CBT training of doctoral clinical psychology students and other mental health professionals moving forward.
- (5) Adult learning models and approaches may be used by course instructors to enhance graduate students' engagement in training and the positive transference of techniques into the practice setting.

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