

# The Problem with Trauma Focused Cognitive-Behavioral Therapy

There is an unfortunate trend in the mental health field today. Mental health professionals (and those supervising them) are seeking training in very specific areas of mental health rather than learning a system that can be applied to any problem / concern.

That unfortunate trend is also evident in the cognitive-behavioral therapy field. Our organization has seen quite an increase in requests for training in "Trauma Focused Cognitive-Behavioral Therapy". The purpose of this article is not to denigrate TFCBT. In fact, we are not questioning its value or effectiveness. Rather, the point is to inform the reader of what we consider to be a better approach to helping people across the board.

When mental health professionals learn approaches to CBT, like Rational Living Therapy ( <http://www.cbtonlinetraining.com> ) or Maxie Maultsby's Rational Behavior Therapy (RBT), they learn a systematic approach that is both very practical and very philosophical. When trainees in those approaches learn the theory, philosophy, and systematic approach, they realize that indeed they are able to help clients to apply it to any concern or problem.

Imagine a pharmacy student studying "anti-hypertensive medication-specific pharmacy" without having knowledge of the basics of pharmacy. That would result in a very limited understanding of medications as well as greatly limit the student's future career.

Precious training funds are limited today. When deciding how to train staff, we recommend that staff be trained in a general, systematic approach that indeed can be applied to any problem / concern, rather than having the receive a "trauma specific" training or a "depression specific" training. So whether it is Rational Living Therapy (RLT),

or Rational Behavior Therapy (RBT), or Rational Emotive Behavior Therapy (REBT), or Cognitive Therapy (CT), we strongly recommend that trainees have a solid foundation in one of those approaches and then focus on applying the selected approach to specialty areas.

The following is an article that I wrote in 2009 that explains the main reasons why “cognitive-behavioral therapy” sometimes is not as effective as we would like it to be.

**When Cognitive-Behavioral Therapy is Less Effective:  
The Five Most Common Reasons**

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Psychotherapy outcome research over the years has established that cognitive-behavioral psychotherapies, when utilized properly, are effective at helping people to achieve their emotional and behavioral goals.

However, this fact does not always translate into success for the individual therapist. My experience with supervising many therapists throughout the United States has revealed to me the following five most common reasons they sometimes are not as successful with implementing CBT as they would like to be.

1. The Therapist Has No Coherent System

Many therapists believe that the practice of cognitive-behavioral therapy consists simply of reaching into their toolbox and pulling out the technique that *seems* most appropriate at the time. They do not have a systematic approach to CBT that serves as a therapeutic road map for them.

When the therapist utilizes a systematic approach to CBT, there is a point to each session that is consistent with the system, and each session builds on the client’s previous learning. For example, with both Maultsby’s Rational Behavior Therapy and my Rational Living

Therapy (<http://www.rational-living-therapy.org>), the next step after teaching the client the ABCs of Emotions is to teach the client the Rational Questions. The Rational Questions help the client to determine whether his or her thinking is rational, but there is no point to teaching the client those questions if the therapist first has not established that our thoughts cause our feelings and behaviors. The client will wonder, "Why are we talking about my thoughts? I want to talk about my situation!"

## 2. The Therapist Has Not Established Accurate Empathy

The term *accurate empathy* refers to developing an accurate understanding of what the client is explaining to the therapist, and then sharing that understanding with the client. When the therapist has established accurate empathy, the client comes to the conclusion, "My therapist understands me."

One mistake many therapists make is that they begin disputing thoughts before they have established in the client's mind that accurate empathy has been established. Therefore, when the therapist offers a more rational way of thinking that is contrary to the client's, the client immediately thinks, "My therapist doesn't understand me. If he did, he wouldn't be saying this."

## 3. The Therapist Does Not Recognize the Client's Irrational Thoughts

Usually, therapists are raised in the same society as their clients. Therefore, it is not surprising when a therapist has some of the same irrational beliefs their clients hold. When this is the case, it is difficult for the therapist to diagnose a client's thoughts as being irrational.

For example, most cognitive-behavioral therapies encourage people to replace the words "awful, terrible, and horrible" with "unfortunate". However, sometimes therapists will ask me, "That's fine, but what if a person's situation really is terrible?"

## 4. The Therapist Does Not Help the Client Develop a New Rational Replacement Thought

Therapists often say to me, "I told the client that her thought was irrational, but that didn't change her behavior."

The human brain does not like a vacuum. If the therapist does not help the client develop a new rational replacement thought, the client will revert back to the only explanation he or she has had for their situation. It is analogous to a client who lives in Washington, DC, wanting to drive to Maine, but is driving toward Florida. The therapist tells the client, "The way to get to Maine is not to drive to Florida." What the therapist failed to mention is how to travel to Maine.

#### 5. Therapist Practices CBT Superficially

Some cognitive-behavioral therapists practice CBT very superficially. They focus on thoughts rather than underlying assumptions. For example, a person walks past a group of people and they begin laughing. Most people's thought about the situation would be, "They are laughing at me." Good therapy sounds something like this, "There is no evidence that they were laughing at you, and there are other possible explanations. They might have been laughing at a joke as you were walking by. Therefore, there is no point in thinking they were laughing at you." True therapy, though, would address the underlying assumption, "it is terrible when people laugh at me." When the underlying assumption is corrected, the person will not be nearly as concerned with whether he or she is being ridiculed.

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