

Introduction

Cognitive behavioral therapy (CBT) is a rich, complex, and evolving model of treatment that has been developed for and applied to a wide range of mental health and physical problems and disorders. From its early days in the 1970s, CBT has grown to become one of the preeminent models of psychotherapy, and it is widely distributed and used around the globe. Specific forms of CBT have been recognized as evidence-based treatments for a vast array of disorders, from organizations as wide ranging as the American Psychiatric Association, the Australian Psychological Association, the British National Institute for Clinical Excellence, and many others in many parts of the world.

This volume was written to elucidate and portray some of the key principles and therapeutic processes that are practiced by effective cognitive behavioral therapists. The organization of this book roughly follows the temporal sequence of a typical CBT application in that we begin with a discussion of the usual ways that we think broadly about the field and

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Cognitive Behavioral Therapy Techniques and Strategies, by A. Wenzel, K. S. Dobson, and P. A. Hays

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then conceptualize the cognitive behavioral approach to psychotherapy. We follow this introduction with a series of chapters that discuss issues related to assessment and conceptualization of clients within CBT, typical early behavioral and problem-solving strategies, interventions that focus on both situation-specific automatic thoughts and underlying beliefs, and the processes used to end successful CBT and reduce the risk of relapse or recurrence of problems. Throughout this volume, we use three anonymized and partly fictionalized cases to provide illustrative examples of the types of in-session interactions that cognitive behavioral therapists and their clients may have, and we offer our insights and suggestions related to these cases. These three cases were chosen carefully because they portray clients with different presenting problems, unique combinations of individual-difference characteristics, and several relationship issues that could be illustrated through the dialogue that was presented.

In this introductory chapter, we provide a context for the later parts of the book, as we present some of the history related to the family of cognitive behavioral therapies. We also discuss the issues associated with foci on both therapy change and therapy process that take place within this treatment model. Finally, we conclude this introduction with a preview the following chapters, so that the reader knows what to expect.

Early CBT

Although CBT continues to evolve, most individuals see the foundation of the approach in one of two domains. For some, CBT grew from its allied field of behavior therapy. By the 1970s, behavior therapy had begun to move beyond an explicit and limited focus on observable behavior to a broader approach that included conceptions related to internal cognitions and emotions. For example, social learning theory (Bandura, 1986) recognized that when children learn a new behavior, they have to observe a model, internalize the actions of that model, and then be able to replicate the observed behavior in themselves. This complex series of acts related to observation, recognition, and planning are all cognitive activities; thus, cognitive processes played a central role in the social learning approach. Research that focused on the process of delay of gratification similarly invoked the idea that children could maintain a cognitive representation of the gratification (i.e., positive reinforcer) that they were going to obtain even as they engaged in the behavior that would eventually lead to the reinforcement. On the basis of these ideas, the field of *cognitive behavior modification* (Mahoney, 1974; Meichenbaum, 1977) began, which set the stage

for *cognitive behavioral therapy*. Applications to issues such as anxiety disorders quickly evolved, and it appeared that cognitive behavior modification and social learning therapy would become movements in their own right.

The other major innovation in the 1970s that led to the development of CBT was more revolutionary than that seen in behavior therapy. Early theorists in what would become the field of CBT, such as Albert Ellis and Aaron T. Beck, were initially trained in psychoanalysis and in that training had an emphasis on early experience, unconscious process, and personality dynamics. Both theorists, however, recognized that many aspects of psychodynamic theory did not appear to contribute to significant change in psychotherapy, and they both articulated a more parsimonious and, some might argue, a more simplistic view of human dynamics in behavior change. For example, both suggested that people's beliefs affected the manner in which they viewed the world and that it was their beliefs and construal of events that was in fact more important in the ultimate response to life's circumstances than the circumstances themselves. Predicated on this assumption, both theorists developed models in which cognitive assessment and cognitive change became the pivotal point for later behavioral adaptation and emotional success. *Rational emotive therapy*, as it was called (Ellis & Whiteley, 1979), and *cognitive therapy* (A. T. Beck, 1970) eventually emerged as well developed psychotherapies that became the focus of training, research, and practice.

Since the early evolution of cognitive behavioral therapies, many other approaches have joined their ranks (K. S. Dobson & Dozois, 2009). It is now recognized that the cognitive behavioral therapies rest on several basic tenets, including the ideas that (a) cognition mediates the relation between activating events or stressors and the reactions to those stressors, (b) cognitions are not unconscious but can be monitored with training and the proper technology, and (c) systematic changes to cognition can lead to planned therapeutic outcomes.

The field of CBT, then, can be said to emerge sometime in the mid-1970s. Two additional phenomena conspired to significantly affect the long-term growth and impact of CBTs in the overall field of psychotherapy. The first was the acceptance by cognitive behavioral clinicians and theorists that clinical research methodologies could be used to evaluate the outcomes of CBT. Beginning in the 1970s, and continuing significantly throughout the next two decades, a large number of open trials, simple comparative studies, and randomized controlled trials were conducted with CBT protocols for a large number of clinical disorders. This work was significantly enhanced by the ability of CBT developers to enunciate the principles and techniques that were incorporated in treatment. Furthermore, the fact that many of the CBT protocols were short

term in nature made them reasonably well suited to being written as treatment manuals.

The second factor that affected CBT's impact in the overall field of psychotherapy, and one that has been somewhat underrecognized, was the evolution of the diagnostic process itself. The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association forms the basis for much clinical research in the field of clinical psychology and psychiatry. The third edition of the *DSM* in 1980 (*DSM-III*; American Psychiatric Association) was a significant departure from its predecessors in that it removed much of the theoretical architecture seen in earlier editions and focused on a descriptive account of psychopathology. This movement to descriptive psychopathology allowed clinicians to develop manuals that could target the specific symptoms and syndromes described in the *DSM*. Thus, it was just as CBT was beginning to develop that this change in psychopathology and diagnosis further enhanced the ability to write specific treatment manuals based on the diagnoses found in the *DSM-III*.

In part because of the preceding two factors, and of course propelled by the positive results from clinical trials that began to emerge, the field of CBT exploded in the latter part of the 1990s and into the early part of the current century. By the early 2000s, meta-analyses were being published that summarized the large numbers of individual trials and that generally documented the significant benefits of CBT for a wide range of both mental health and physical conditions. Although there are certainly limitations to the extent to which one can make this claim, it can be generally claimed that CBT "works" for a wide variety of disorders and that CBT is generally an evidence-based approach to psychotherapy. Thus, when the field began to identify the principles for evidence-based practice (Chambless et al., 1996), it is not surprising that CBT figured predominantly among the therapies that were identified.

Developments Within CBT

As discussed in this section, the field of CBT has grown dramatically since its inception. This growth has taken two primary directions. One of these is related to a more complete understanding of the applicability of the model through the development and evaluation of variants of CBT in a wide range of clinical populations, sometimes as a stand-alone treatment but also integrated with other treatments (e.g., medications), and in diverse settings (e.g., research and clinical settings, with various cultural populations). The second focus has been the effort to understand the mechanisms of change associated with CBT. This focus has

included in-depth studies of the predictors of more and less successful outcomes, therapist behaviors associated with change, and aspects of the therapeutic relationship. Each of these areas is briefly discussed here.

THE FOCUS ON CHANGE

The earliest outcome trials for CBT focused on relatively specific disorders, and research trials at that time often included relatively homogeneous samples of clients and relatively more exclusion criteria than later trials. This focus on internal validity was a natural result of the desire to demonstrate that CBT had strong treatment effects, and it generally was a success in this respect. At the same time, the focus on internal validity in *efficacy* trials led to questions about the generalizability of the results from these trials to actual practice in the clinic. As a result, several researchers began to conduct what are now referred to as *effectiveness* trials to determine whether the results from more restrictive research clinical trials could be replicated in the “real world” (Nathan, Stuart, & Dolan, 2000). Generally speaking, these results were favorable, and so it became the case that treatment manuals were increasingly applied in clinical contexts.

Another issue with respect to the early development of CBT, also related to the use of randomized controlled trials with significant numbers of exclusion criteria in research contexts, was the extent to which trial results generalized to diverse populations. For example, it was noted that some of the early trials had relatively homogeneous cultural groups, and so the extent to which results might apply to other cultural groups was naturally questioned. As a result of this query, several investigators began to develop culturally adapted versions of CBT for specific populations. As one example, an adapted CBT for religiously oriented people with depression was tested and demonstrated significant positive results (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). Ricardo Muñoz and his colleagues also adapted treatments for depression with individuals of Latino heritage and demonstrated that treatment results could be found in this population (Muñoz & Mendelson, 2005). Moreover, as the success of CBT grew, it was perhaps natural that investigators would start to apply these treatments in other countries. Adaptations of CBT now exist for a wide variety of cultural, religious, ethnic, and other groups, and it is generally recognized that an important part of the skillful application of CBT involves a consideration of diversity (Naeem & Kingdon, 2012).

One particular method that has been developed to assist with the transportability and dissemination of CBT to diverse contexts is that of *benchmarking*. Benchmarking takes place when an investigator compares his or her results to those of a standard treatment. Benchmarking can

take place within a given country (Wade, Treat, & Stuart, 1998; Weersing & Weisz, 2002) and across people who vary on diverse characteristics, but it can also be applied across cultures and countries to determine the extent to which the results of various trials have similar or different results (Spilka & Dobson, 2015). There has been a significant effort in recent years to establish a science of dissemination (McHugh & Barlow, 2010) as a practice that respects both the tenets of CBT and its established principles and that also recognizes and adapts to the unique characteristics in which CBT may be applied. These issues of cultural adaptation and diverse application are further discussed in this volume and in other sources.

Not surprisingly, and especially in light of the significant attention shown for CBT in the research literature, clinicians who espoused other theoretical models raised concerns about the movement in the field. They suggested that the short-term nature of CBT, the manualized nature of the treatments, the reliance on *DSM* diagnoses, and other features significantly advantaged CBT in the field of psychotherapy outcome. They also suggested that some of the nonspecific and relationship factors in psychotherapy were being underrecognized because of the manualized nature of CBT. The APA Presidential Task Force on Evidence-Based Practice (2006) served as a reminder that other factors in psychotherapy than the treatment techniques also contribute significantly to clinical outcome (Castonguay & Beutler, 2006). Thus, such factors as the therapeutic alliance, therapist empathy and genuineness, and other features of psychotherapy were given their proper recognition in the field.

Another development in the field of CBT resulted from comparative analyses of the large number of treatment manuals that had been written. By the early part of the current century, it became clear that certain general principles were being used across specific diagnoses, especially in the area of the treatment of anxiety disorders. Some researchers, such as David Barlow and colleagues, suggested that transdiagnostic models of change were possible, and efforts were made to identify transdiagnostic factors in psychotherapy in general, and CBT in particular (Barlow et al., 2011). Indeed, there have been recent studies to examine the efficacy of transdiagnostic treatments, and preliminary data suggest that these treatments are approximately as effective as specific treatment manuals for specific disorders (Farchione et al., 2012).

THE FOCUS ON PROCESS

In addition to the many developments in the outcome literature, a number of clinicians and researchers have also focused on the processes associated with CBT. This work has taken several directions. For example, some researchers have used outcome studies as the framework to study

predictors of outcome or the therapy processes associated with better and worse treatment success. It is relatively easy to assess clients and therapists on a wide variety of dimensions and examine the degree to which these variables predict clinical outcome. In this regard, it is now fairly safe to conclude that client predictors of better outcome in CBT include later onset of the disorder, a less chronic disorder, and lower problem severity at the outset of treatment (Epp & Dobson, 2010). In some respects, however, these general predictors are not surprising, and they also seem to be predictors of outcome for other treatments as well. Thus, in addition to general predictors, there have been some studies that have examined differential client predictors of outcome. Such studies are relatively fewer in number, however, because this type of research requires at least two active treatments in the research study, and they often fail to identify differential predictors.

Studies of therapist predictors of outcome have been relatively uncommon in the field of CBT. Some studies have examined variables such as therapist gender and age as predictors, but they often fail to find a significant effect. In some respects, the failure of therapists' individual differences to predict outcome is a positive feature of the CBT because the implication could be taken that this type of therapy can be applied by a broad range of clinicians. One therapist variable that has been studied as a predictor and does have a modest association with outcome is therapist competency, but this relation has not been observed in all studies, suggesting either that it is not a robust predictor of outcome, or its measurement is not ideal (Webb, DeRubeis, & Barber, 2010).

Some researchers have examined therapy process factors in the context of clinical trials. For example, with repeated assessment of potential treatment mediators, it is possible to demonstrate whether certain changes precede or follow others in the clinical course. As one notable example of this type of research, DeRubeis and Feeley (1990) examined the association between general and specific treatment methods in CBT for depression across several time points in treatment and demonstrated that early change in depression was predicted by specific treatment methods, which in turn predicted enhanced therapy alliance, which then combined to predict better outcome (see also Feeley, DeRubeis, & Gelfand, 1999). As another example, in a reanalysis of a CBT trial for depression, Tang, DeRubeis, Hollon, Amsterdam, and Shelton (2007) revealed a pattern they termed a *sudden gain*, which consisted of a fairly rapid reduction in symptomatology from one session to the next, followed by relatively stable better functioning. This pattern of change was associated with better long-term outcomes in CBT for depression, relative to more slow and steady change in symptoms.

Another type of process research involves ratings of therapy sessions and the examination of factors that are associated with change. The

compilation of Kazantzis and L'Abate (2007), for example, examined the relation between homework exercise and outcome in psychotherapy generally, and several of the chapters in their volume attest to the importance of homework in CBT in particular. A forthcoming volume (Kazantzis, Dattilio, & Dobson, in press) examines the therapeutic relationship in CBT and draws heavily on process studies of the relationship mechanisms that lead to an enhanced therapeutic alliance and other positive features of the relationship that are associated with better clinical outcome in CBT.

A number of authors have elaborated one of more specific process issues in CBT, examined these issues, and generated implications for clinical practice. Examples of this type of work include the examination of behavioral interventions in CBT (Farmer & Chapman, 2008), the assessment and management of resistance in CBT (Leahy, 2001), and the integration of imagery into CBT (Hackmann, Bennett-Levy, & Holmes, 2011). Other authors have developed models for the management of more general process issues, such as the applications of CBT for challenging problems (J. S. Beck, 2005), strategic decision making in the process of CBT (Wenzel, 2013), and CBT with diverse cultures (Hays & Iwamasa, 2006; Naeem & Kingdon, 2012). Often, this latter type of work draws on clinical cases and illustrations, but it adds considerable depth to the literature and often identifies areas for further theory development and research investigations.

In summary, the field of CBT is now complex and mature. We know much about the conditions for which CBT is effective, its relative efficacy in a number of comparison therapies, the outcomes associated with its clinical practice, a wide variety of predictors of outcome, and the processes associated with sound clinical practice. One of the signal strengths of the CBT movement has been its integration with research studies and the development of a strong foundation of evidence. It is therefore not surprising that CBT is often at the forefront of discussions about evidence-based practice.

The Current Volume

This book has the advantage of the rich and developing field of CBT, as well as the knowledge and experience of three scientist-practitioners who regularly deliver CBT to clients, train clinicians to be competent to practice CBT, and contribute scholarship that advances the field. We are at a phase in the development of the field in which we can make confident statements about a wide variety of principles and methods that generally have benefit across a wide range of populations and problems.

For example, there is now considerable evidence that early success in CBT homework is associated with early change, which in turn relates to improved therapeutic alliance and that all contribute to an ongoing positive association with more successful long-term outcome (Kazantzis, Whittington, & Dattilio, 2010). There is also consistent evidence that a strong therapeutic alliance, regardless of the extent of homework completion, is a significant predictor of positive outcome in CBT (Webb et al., 2011). We also know that the ability to engage in case conceptualization is a predictor of outcome and that consistency in case conceptualization is a skill that can be developed over time (Kuyken, Fothergill, Musa, & Chadwick, 2005). These issues are highlighted here because none of them deals particularly with the techniques of treatment, but rather they all focus on the process of care that is provided. One of the common ideas associated with CBT is that it is exclusively focused on treatment techniques, to the exclusion or diminishment of therapy process, but as the current volume demonstrates, this idea is a myth (D. Dobson & Dobson, 2009).

The current volume demonstrates broad principles related to CBT that an effective cognitive behavioral therapist must learn and flexibly practice with his or her varied clients. The first chapter in the book highlights the importance of case conceptualization and the model that is used to understand problems from a cognitive behavioral perspective. In this chapter, we discuss the process of psychological assessment, including the diagnostic interview, case review, and formal psychometric evaluation but also the way in which all of the assembled information combines to provide an overall evaluation of the client in the form of a cognitive case conceptualization. This case conceptualization is in many respects the heart of CBT because it is the case conceptualization that drives the choice of techniques that the therapist will deploy, and even aspects of the manner in which the therapist relates to the client (Kuyken, Padesky, & Dudley, 2008; Persons, 2008).

An important feature of CBT is that it is relatively efficient and focused. Novice cognitive behavioral therapists learn how to use their time well through a variety of structuring methods, as described in Chapter 2. For example, there is a typical beginning phase within a CBT session in which the therapist gathers brief assessment information about the client's experience in the past week or since the last appointment, any current problems or concerns, the ongoing issues that are relevant from previous sessions of therapy, and any particular methods that the therapist wants to introduce into the current session. All of this information feeds into an agenda, or list of topics that the therapist and client will address during the ensuing session. These topics are then engaged in one by one, and ideally as each topic is concluded, there is some idea about homework or practical exercises that will take the ideas expressed in

therapy back into the client's day-to-day life to provide a practical application of the therapy discussion. Finally, the last part of a CBT session includes a review of the session, a review of the exercises that the client has agreed to do, and feedback about the session. This relatively structured format is something that can be learned relatively easily by novice therapists but that, in practice, is a complex set of skills to use seamlessly and with good social skill. Therefore, we spend some time talking about the flexible use of session structure in CBT to portray the nuanced and dynamic way that session structure is applied in practice.

Following our discussion of session structure, we also consider some of the major behavioral strategies that are used in the context of CBT. As noted previously, there is almost always an emphasis on the development of "real-life" applications of the therapy work, and behavioral strategies are a natural extension of therapy dialogue. That said, the nature of behavioral techniques is highly variable and needs to be tied to the case conceptualization. Although certain behavioral exercises are typical in various disorders (e.g., exposure to a feared social situation in social anxiety disorder, behavioral scheduling for individuals with depression or avoidance), the exact nature of those exercises relies on the cognitive behavioral therapist's sympathetic, collaborative, and complete understanding of the client's clinical presentation.

Although a common perception of CBT is that it implies that clients' problems are "all in the head," nothing can be further from the truth. Cognitive behavioral therapists recognize that their clients face real-world problems and that problem solving must be an important part of helping clients. Because of this understanding, cognitive behavioral therapists will typically assess the life problems each client faces, evaluate his or her past efforts to cope with these problems, assess his or her skills at problem identification and solution, and possibly engage in training new problem-solving skills so that they can be effectively applied in the client's life. These skills are described in Chapter 3. In many instances, clients only come from therapy when they have exhausted their current ability to deal with problems and need the help of a professional. As such, it is only natural that cognitive behavioral therapists will assist clients with this problem-solving focus. Often, working on concrete problems also involves the development of behavioral skills, the practice of these skills in therapy, and the translation of skills developed in the therapy context to the real world, so homework and practice are common features of problem solution.

In addition to problem-solving strategies, cognitive behavioral therapists recognize that some of the distress that clients experience is a result of particular patterns of thinking, and in some cases the underlying beliefs that clients hold about themselves, their world, or individuals in their lives. As such, a significant portion of typical CBT cases includes

the assessment of clients' thinking, in terms of both the particular situations that they face and their general ways of approaching their lives. Two chapters in the current volume focus on cognitive interventions. The first of these, Chapter 4, examines the particular ways in which a client's situation-specific thoughts can be either distorted or simply unhelpful. Techniques to address distorted thinking focus on the evaluation of evidence that supports or does not support particular thoughts and the development of more accurate ways for clients to view their life circumstances. In contrast, cognitive interventions can also focus on unhelpful thinking, regardless of its evidence base. Techniques that can be used in this regard include encouraging clients to be more compassionate or caring toward themselves, imagining what a friend might say, or simply evaluating how helpful it is to be focused on a negative thought in a given situation. Examples of how these interventions can be applied with a variety of case studies are elucidated so that the reader can appreciate the strategy from both a theoretical and a practical perspective.

Chapter 5 then considers beliefs that can undergird negative thinking patterns and habits. Strategies to identify unhelpful underlying beliefs are discussed, and a variety of intervention methods are further described and illustrated with case studies. Cognitive behavioral therapists generally believe that it is the identification and modification of negative underlying beliefs that results in the most complete reduction of problems for the client's current problems and helps to reduce the likelihood of problems in the future. As such, most cognitive behavioral therapists will spend several sessions working at the level of underlying beliefs to try to obtain these therapeutic benefits.

Chapter 6 discusses the ways in which a cognitive behavioral therapist will attempt to complete the therapy process. CBT is generally an educational process, and as such, it is expected that the client will develop a series of skills, insights, and strategies that he or she can apply in the future if problems recur. To consolidate this level of understanding, it is typical that the therapist will encourage clients to reflect on the therapy process toward the end of treatment, to write down the major conceptions and strategies that they have learned over the course of therapy, and to plan for possible future stressors or challenging situations. Ideally, clients will leave with a relapse prevention plan that will help them cope with difficult situations that may occur in the future. That said, cognitive behavioral therapists recognize that not all difficulties can be anticipated, that skills may erode over time, and that sometimes it is simply a good idea to engage in a "tune-up" of skills that were previously learned. As such, cognitive behavioral therapists generally do not think about terminating the therapeutic relationship so much as closing a particular chapter, with the recognition that it may be necessary to open the next chapter if the client would benefit from future treatment.

Throughout this book, we attempt to highlight that CBT is a contextually driven and flexible treatment model. Although the essence of CBT theory should be respected across all cases, the particular skills and techniques that are practiced must make sense in the context of clients' lives and their particular struggles. CBT can be formally adapted to specific cultures (Naeem & Kingdon, 2012), but every case is recognized as unique. As such, we have incorporated a chapter (Chapter 7) on culturally responsive CBT that highlights the many diverse ways in which clients present and the wide range of diversity considerations in which an effective cognitive behavioral therapist must engage (Hays & Iwamasa, 2006). This chapter highlights the ADDRESSING formulation for the consideration of diversity characteristics (Hays, 2016), through which we encourage all readers to consider when they work with their clientele.

In contrast to the early days of CBT, the contemporary practice of CBT is complex and diverse. There now exist a large number of treatment manuals for many specific disorders, volumes that deal with non-diagnostic and transdiagnostic issues in the context of CBT, as well as a large number of books that deal with nonspecific treatment factors in psychotherapy such as homework, the therapeutic alliance, and other issues that cut across all models of psychotherapy. The field continues to evolve through the consideration and incorporation of treatment methods from other theoretical models, including mindfulness- and compassion-based interventions (Cayoun, 2011), acceptance-oriented methods (Hayes, Strosahl, & Wilson, 2011), and emotion-based models and therapy strategies (Leahy, 2015). This significant growth of the field adds to the clinical sophistication through which cognitive behavioral therapists can approach their clients but, at the same time, can create some conceptual confusion, and certainly some technical difficulty for the novice cognitive behavioral therapist.

We have distilled some of the essential treatment methods seen in CBT in this volume. We have also used hypothetical cases to illustrate some of the major methods that are discussed and to make the theoretical discussion as "real" as possible. This volume was developed as a companion to a DVD series that has also been published by the American Psychological Association. If the reader is interested, we strongly recommend that the various chapters encompassed in this book should be read alongside the viewing and discussion of the corresponding DVD for each chapter. Through the consideration of both this written work and that DVD series, we believe that the interested therapist will get the most benefit and come away with the richest possible understanding of the various ideas and methods described in this volume.