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Series Preface

Some might argue that in the contemporary clinical practice of psychotherapy, evidence-based intervention and effective outcome have overshadowed theory in importance. Maybe. But, as the editors of this series, we don't propose to take up that controversy here. We do know that psychotherapists adopt and practice according to one theory or another because their experience, and decades of good evidence, suggests that having a sound theory of psychotherapy leads to greater therapeutic success. Still, the role of theory in the helping process can be hard to explain. This narrative about solving problems helps convey theory's importance:

> Aesop tells the fable of the sun and wind having a contest to decide who was the most powerful. From above the earth, they spotted a man walking down the street, and the wind said that he bet he could get his coat off. The sun agreed to the contest. The wind blew, and the man held on tightly to his coat. The more the wind blew, the tighter he held. The sun said it was his turn. He put all of his energy into creating warm sunshine, and soon the man took off his coat.

What does a competition between the sun and the wind to remove a man's coat have to do with theories of psychotherapy? We think this deceptively simple story highlights the importance of theory as the precursor to any effective intervention—and hence to a favorable outcome. Without a guiding theory we might treat the symptom without understanding

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the role of the individual. Or we might create power conflicts with our clients and not understand that, at times, indirect means of helping (sunshine) are often as effective—if not more so—than direct ones (wind). In the absence of theory, we might lose track of the treatment rationale and instead get caught up in, for example, social correctness and not wanting to do something that looks too simple.

What exactly *is* theory? The *APA Dictionary of Psychology* defines theory as "a principle or body of interrelated principles that purports to explain or predict a number of interrelated phenomena." In psychotherapy, a theory is a set of principles used to explain human thought and behavior, including what causes people to change. In practice, a theory creates the goals of therapy and specifies how to pursue them. Haley (1997) noted that a theory of psychotherapy ought to be simple enough for the average therapist to understand, but comprehensive enough to account for a wide range of eventualities. Furthermore, a theory guides action toward successful outcomes while generating hope in both the therapist and client that recovery is possible.

Theory is the compass that allows psychotherapists to navigate the vast territory of clinical practice. In the same ways that navigational tools have been modified to adapt to advances in thinking and ever-expanding territories to explore, theories of psychotherapy have changed over time. The different schools of theories are commonly referred to as waves, the first wave being psychodynamic theories (i.e., Adlerian, psychoanalytic), the second wave learning theories (i.e., behavioral, cognitive–behavioral), the third wave humanistic theories (person-centered, gestalt, existential), the fourth wave feminist and multicultural theories, and the fifth wave postmodern and constructivist theories (i.e., narrative, solution-focused). In many ways, these waves represent how psychotherapy has adapted and responded to changes in psychology, society, and epistemology as well as to changes in the nature of psychotherapy itself. Psychotherapy and the theories that guide it are dynamic and responsive. The wide variety of theories is also testament to the different ways in which the same human behavior can be conceptualized (Frew & Spiegler, 2012).

It is with these two concepts in mind—the central importance of theory and the natural evolution of theoretical thinking—that we developed

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the APA Theories of Psychotherapy Series. Both of us are thoroughly fascinated by theory and the range of complex ideas that drive each model. As university faculty members who teach courses on the theories of psychotherapy, we wanted to create learning materials that not only highlight the essence of the major theories for professionals and professionals in training but also clearly bring the reader up to date on the current status of the models. Often in books on theory, the biography of the original theorist overshadows the evolution of the model. In contrast, our intent is to highlight the contemporary uses of the theories as well as their history and context. Further, we wanted each theory to be reflected through the process of working with clients that reflect the full range of human diversity.

As this project began, we faced two immediate decisions: which theories to address and who best to present them. We looked at graduate-level theories of psychotherapy courses to see which theories are being taught, and we explored popular scholarly books, articles, and conferences to determine which theories draw the most interest. We then developed a dream list of authors from among the best minds in contemporary theoretical practice. Each author is one of the leading proponents of that approach as well as a knowledgeable practitioner. We asked each author to review the core constructs of the theory, bring the theory into the modern sphere of clinical practice by looking at it through a context of evidence-based practice, and clearly illustrate how the theory looks in action.

There are 24 titles planned for the series. Each title can stand alone or can be put together with a few other titles to create materials for a course in psychotherapy theories. This option allows instructors to create a course featuring the approaches they believe are the most salient today. To support this end, APA Books has also developed a DVD for most of the approaches that demonstrates the theory in practice with a real client. Many of the DVDs show therapy over six sessions. Contact APA Books for a complete list of available DVD programs (http://www.apa.org/pubs/videos).

We are pleased to present this second edition of *Cognitive–Behavioral Therapy.* In this updated version, changes have been made to update citations and provide new discussions on exposure therapy, behavioral activation, cognitive bias modification training, and internet therapy. Michelle G. Craske shows why cognitive–behavioral therapy (CBT) has

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become the most popular model of psychotherapy used in contemporary clinical practice. She highlights a wide range of clinical research that supports the efficacy of CBT with numerous populations and conditions. In addition to the focus on evidence-based practice, Dr. Craske provides case examples to depict how the CBT model works from a process perspective. Because of the widespread adoption of this model by clinicians and training programs alike, *Cognitive–Behavioral Therapy, Second Edition* is an important addition to the Theories of Psychotherapy Series.

—Jon Carlson and Matt Englar-Carlson

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Introduction

The hallmark features of cognitive–behavioral therapy (CBT) are short-term, problem-focused cognitive and behavioral intervention strategies that are derived from the science and theory of learning and cognition. The approach to their implementation and evaluation is guided by principles of empirical science. The behavioral interventions aim to decrease maladaptive behaviors and increase adaptive ones by modifying their antecedents and consequences and by behavioral practices that result in new learning. Examples of behavioral interventions include behavioral activation for depression, problem solving for stress management, behavioral rehearsal for social skills deficits, relaxation training to reduce somatic arousal, and systematic exposure to anxiety-producing situations for anxiety disorders. The cognitive interventions aim to modify maladaptive cognitions, self-statements, or beliefs. The cognitive methods include identification of situational misappraisals and underlying distorted beliefs;

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rational disputation or logical consideration of the evidence to refute such misappraisals and core beliefs; behavioral practices designed to collect further data to disconfirm such misappraisals; and the generation of alternative, more evidence-based appraisals and core beliefs. More recent cognitive strategies extend to mindfulness and defusion approaches that aim to change the function rather than content of negative thinking. Together, these cognitive and behavioral interventions have been shown to be effective for a number of different psychological disorders and conditions, including anxiety disorders, depression, personality disorders, substance-use-related disorders, eating disorders, pain management, couples distress, and aspects of psychosis (see Chapter 5, this volume). Indeed, CBT is widely regarded as having the most substantial evidence base of all psychosocial therapies.

As described in Chapter 2 of this volume, CBT originally derived from the science and theory of classical and instrumental conditioning, or learning theory. Within these theories, emphasis was given to the role of the reinforcing and punishing consequences that guide voluntary behaviors (e.g., positively reinforcing effects of euphoria upon continued drug consumption), as well as responses that become conditional because of associations with innately evocative events (e.g., development of fears of driving following a car accident). Originally, little consideration was given to the role of appraisals or thoughts as determinants of behaviors or emotions, although thoughts could be viewed as "another behavior" and therefore subject to the same rules of reinforcement and conditional responding.

Dissatisfaction with a strictly behavioral set of principles coincided with a rising interest in cognitive principles that was spurred by social learning theory. This led to the content of judgments and underlying belief systems about the self and the world being given credence as determinants of emotion and action. Furthermore, the cognitive movement was fostered by advances within instrumental and classical conditioning theories that recognized cognition as a potential mediator of learning. Thus, *behavioral therapy* became *cognitive–behavioral therapy*, all the while maintaining a science-based approach to the implementation of treatment but now extending from behaviors to judgments and beliefs as targets of intervention. The

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science of cognition and information processing developed separately from the rise of cognitive therapy, and as described throughout this book, the former has raised significant questions regarding the purported mechanisms of the latter. Partly as a consequence of this questioning, recent third-wave developments are reemphasizing behavioral principles and the function of cognition while de-emphasizing the content of cognition.

In practice, individual clinicians vary in the degree to which they embrace behavioral, as compared with cognitive, principles and interventions. Some clinicians remain more behaviorally focused and treat cognitions within a behavioral framework, such as behavioral activation therapies for depression, in which cognitions are viewed as potential sources of avoidance that maintain depressive rumination. Other clinicians take an integrative approach, combining behavioral principles and interventions with cognitive principles and methods designed to modify the content of cognition. Still others are more cognitively focused and view the content of cognition as the driving factor behind all behaviors and emotions and as the primary focus of all therapeutic effort. The latter approach generally is referred to as *cognitive therapy.* However, cognitive therapists still rely on behavioral methodologies to obtain evidence for disconfirmation or disputation of maladaptive cognitions. Hence, it is hard, if not impossible, to distinguish between cognitive therapy and CBT. Even within strictly behavioral therapies based on instrumental learning theory, thoughts can be regarded as antecedents to behaviors. Hence, if a set of verbal statements is an antecedent that elicits maladaptive behavior, then treatment aims to replace those statements with "alternative antecedent statements" that elicit more adaptive behavior. Clearly, such behavioral strategies overlap with cognitive strategies.

Thus, whereas more behaviorally versus more cognitively oriented clinicians rely on somewhat different principles for treatment formulation and understanding therapeutic change, they may use the same procedures for intervention.

Conversely, both behavioral theory and cognitive theory principles can be evoked to explain therapeutic change within the same intervention strategy. As an example, behavioral theory attributes the effects of

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repeated exposure to feared situations to extinction of conditional fear responses; in accordance with cognitive theory, the same method of exposure serves to gather information that disconfirms mistaken judgments about danger.

Despite these variations in emphasis on behavioral and cognitive principles and methodologies, the CBT approach is unified by its empirical foundation, its reliance on the theory and science of behavior and cognition, and its problem-focused orientation. Whatever the emphasis given to behavioral or cognitive principles, the CBT therapist aims to replace maladaptive behaviors, emotions, and cognitions with more adaptive ones. Also, the CBT therapist accomplishes that aim within the context of ongoing evaluation of the effectiveness of intervention strategies and their modification, when necessary, to achieve optimal effects.

CBT is used widely by clinicians. For example, of 591 American Psychological Association (APA) members who were randomly surveyed, 45.4% regarded themselves as CBT in theoretical orientation (Stewart & Chambless, 2007). This rate exceeded the rates for all other theoretical orientations, including psychodynamic (21.9%), eclectic (19.8%), humanistic/experiential (4.4%), family systems (3.9%), and other (4.6%). That being said, a number of clinicians who regard themselves as delivering CBT may not deliver the key elements of CBT (Stobie, Taylor, Quigley, Ewing, & Salkovskis, 2007; Waller, Stringer, & Meyer, 2012). These deficiencies may be due to inadequate training in CBT. Programs in psychiatry, psychology, and social work across the United States were surveyed to establish the adequacy of training in empirically based psychotherapies, the latter being comprised mostly of CBT (Weissman et al., 2006). Only 17.8% of training programs provided both didactic and clinical supervision training in empirically based treatments. It is interesting to note that the highest rates of adequate training were in psychiatry, possibly because of the inclusion of CBT in accreditation criteria for psychiatry residency programs. Such requirements do not exist for psychology or social work programs. Lack of CBT competency, even among self-described CBT clinicians, may be additionally attributed to the overemphasis on training in CBT procedures at the cost of training in CBT principles. This imbalance may stem in part from

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the manualization of CBT interventions for various problems. Whereas manualization is a positive feature that facilitates empirical evaluation of CBT and enhances CBT dissemination, it may have inadvertently encouraged too much focus on procedure over principle. A good understanding of the principles underlying CBT, an exposition of which is a primary goal of this book, is necessary for optimal tailoring of CBT procedures to each presenting problem.

Nevertheless, even in the hands of less experienced therapists, CBT is a highly effective approach, in addition to being noted for having the best evidence base of all psychotherapeutic treatments. As such, CBT is entirely consistent with the evidence-based practice movement being encouraged by APA (2005; APA Presidential Task Force on Evidence-Based Practice, 2006). Evidence-based practice principles encourage clinicians to combine their clinical expertise with available research evidence for treatment planning. To facilitate the dissemination of evidence-based principles, APA Division 12, Society of Clinical Psychology, has a continually updated website that contains information about treatments that work for particular problems and their supporting evidence. The majority of empirically supported treatments are cognitive therapies; behavioral therapies; and cognitive and behavioral therapies, jointly termed CBT herein. In addition, APA is undertaking the development of a series of *Practice Guidelines* that are derived from empirical evidence (Hollon et al., 2014).