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INTRODUCTION

The Evolution and Main Components of Cognitive Behavioral Therapy

Amy Wenzel

Cognitive behavioral therapy (CBT for short)—what a term that evokes a distinctive reaction in mental health professionals, in scholars and researchers in medicine and related fields, and in clients who struggle with mental health problems! What began as a simple alternative to the dominant treatments for mental health problems in the second half of the 20th century (i.e., pharmacotherapy, psychoanalysis, person-centered therapy) has evolved into a powerhouse of a theoretical and clinical framework that drives the understanding and treatment of countless emotional, behavioral, and adjustment problems. CBT is arguably the best researched of all the psychotherapeutic approaches that can be delivered to clients in need, and results from empirical studies confirm that CBT is highly efficacious in reducing psychiatric symptoms and problems in functioning and in improving satisfaction in relationships and quality of life (Butler et al., 2006).

There is no succinct definition of CBT. It originated as an active, problem-focused, and time-limited approach to psychotherapy in which interventions had their foundation in the notion that problematic styles of thinking contributed to and exacerbated psychiatric symptoms (Beck, 1967). Perhaps the best way to put it is that cognitive behavioral interventions were designed to be strategic, in that regardless of what they actually involved, their goal was to shift clients' thinking from thinking that is excessively negative, exaggerated, and/or shortsighted to thinking that is accurate, balanced, and wise. In some of the first CBTs that were developed in the 1960s and 1970s (i.e., Aaron T. Beck's cognitive therapy [CT] and Albert Ellis's rational emotive behavior therapy [REBT]), much of the intervention was centered directly on reshaping problematic thinking, either through guided questioning, in the case of CT, or more overt challenging of irrational logic, in the case of REBT.

Although cognitive constructs gained significant attention and continue to hold central importance in explaining psychiatric symptoms, the role of behavioral explanations and interventions for psychiatric symptoms could not be dismissed. Indeed, behavioral psychotherapeutic approaches served as an alternative to psychoanalysis and person-centered psychotherapy in the time preceding the proliferation of cognitive approaches, and they regained traction in the 1980s when combined cognitive and behavioral treatments were developed and optimized for the treatment of anxiety disorders and obsessive-compulsive disorder (OCD; Barlow, 1988; Rachman, 2015; Salkovskis, 1985). It was at this time that the phrase "cognitive behavioral therapy" began to be used by scholars and clinicians (as opposed to "cognitive therapy" or "CT"), emphasizing the relatively equal importance of cognition and behavior in understanding and treating psychopathology. In fact, many regard the early behavioral approaches to treatment based in classical and operant conditioning as a "first wave" of evidence-based psychotherapy, and they view cognitively focused psychotherapeutic approaches as a "second wave" of evidence-based psychotherapy, such that the scientific principles of behaviorism were applied to internal cognitive phenomena.

As many readers likely know, many scholars and clinicians regard the field as currently being immersed in a "third wave" of evidence-based psychotherapy that is characterized by two important features: (a) a focus on function, as opposed to form (e.g., purposes and consequences of thought process instead of modification of thought content); and (b) the inclusion of a focus on acceptance and mindfulness, as opposed to a dominant focus on cognitive and behavioral change and symptom reduction (e.g., Hayes et al., 1999, 2012). It is important to note that some leaders in the field do not necessarily buy into the notion of these three "waves" and them as manifestations of the same underlying principles (Hofmann & Asmundson, 2008). Nevertheless, there is no question that the family of CBTs has been heavily influenced by the proliferation of development in the areas of context, function, acceptance, and mindfulness and that contemporary cognitive behavioral practitioners readily incorporate these constructs into their case formulations and emergent treatment plans (Wenzel, 2017). In fact, I often tell my clients that CBT as it is practiced today in "real-life" settings can be represented as a three-legged barstool, with cognitive change, behavior change, and acceptance being represented by each of the legs. I state (a bit humorously) that CBT should be renamed "CBAT," or "cognitive-behavioral-acceptance-based therapy."

Thus, as of summer 2019 when I am writing this introduction, I define CBT as an active, problem-focused, time-sensitive psychotherapeutic approach that focuses on cognitive change, behavior change, and acceptance as they apply to a host of mental health conditions and adjustment problems. In addition, I highlight several additional features of CBT that many believe are definitional in and of themselves. First, the foundation of the cognitive behavioral understanding and treatment of any one client is the case formulation, or the application of cognitive behavioral theory to understand a client's presenting problem, developmental history, and way of experiencing their current life circum-

stances. In fact, over an intellectually stimulating lunch that took place in 2014, Dr. Beck and I agreed that the case formulation is the "heart" of CBT beyond any specific strategy or technique. Second, CBT is semistructured. Many people mistake this to mean that CBT is rigid or formulaic. As the reader will see throughout this two-volume set, there are many, many ways to conduct CBT, and it cannot be boiled down to a specific formula or step-by-step guidelines. Nevertheless, most cognitive behavioral therapists work with their clients to focus the session on at least a couple of aims that they hope to accomplish, and they strategically work toward achieving those aims rather than talking endlessly without purpose. Finally, cognitive behavioral therapists believe that the most significant change occurs when the therapy's principles are applied outside of session, so clients in CBT are encouraged to complete "homework," or to engage in some sort of practice or application that will allow them to generalize the principles and skills that they are acquiring in session.

DEFINITIONS OF SPECIFIC CBT TERMS

Within the broad CBT framework, there are several constructs that are mentioned in many chapters in this two-volume set. Some of the constructs that are noted most frequently in the chapters are defined below, so it is hoped that this section will serve as a reference point for the reader who is just beginning to become familiar with the nuances of CBT.

Therapeutic Alliance

Cognitive behavioral therapists believe that a strong therapeutic relationship is essential (though not sufficient in and of itself) to a positive outcome in treatment. Interestingly, cognitive behavioral therapists' stance on the therapeutic relationship has long been misunderstood by clinicians who practice from different theoretical orientations. In one of his earliest books, Dr. Beck included a chapter on the therapeutic relationship, and when he lectures, he makes clear that he was heavily influenced by giants like Carl Rogers (Beck et al., 1979). Many cognitive behavioral therapists continue to publish scholarship and research on the role of the therapeutic relationship in CBT, most notably the construct of the *therapeutic alliance.* According to Bordin (1979), the therapeutic alliance is characterized by three constructs: (a) the mutually agreed-upon *goals* of therapy, (b) the *tasks* that take place within the process of therapy in the service of reaching therapeutic goals, and (c) the *bond* between the therapist and client. Research that has examined the contribution of the therapeutic alliance to outcome in CBT typically measures the therapeutic alliance using some version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). Thus, when chapter authors reference research on the therapeutic alliance, unless otherwise specified, the reader can assume that this is the self-reported perception of the client about the goals, tasks, and bonds in therapy.

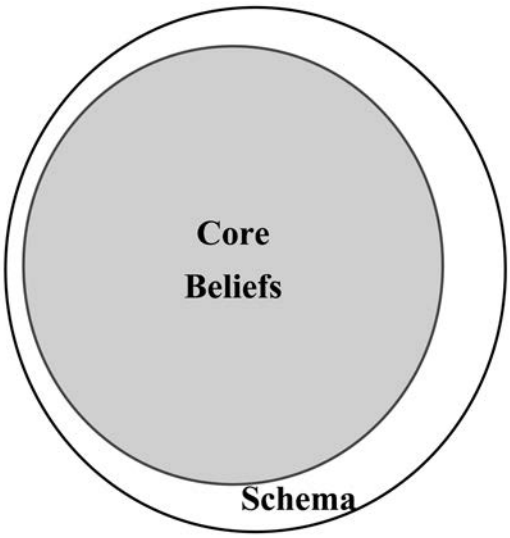
Cognition and Its Modification

A core strategy in the cognitive behavioral treatment of almost all mental health problems is *cognitive restructuring,* or the process by which therapists help their clients identify, evaluate, and, if necessary, modify unhelpful thinking that exacerbates emotional distress. Because of its central importance, this strategy is mentioned in most of the chapters in the handbook set. The type of cognition that is most commonly subjected to cognitive restructuring is the *automatic thought,* named as such because it is a thought that emerges seemingly instantaneously when a person is faced with a challenging or aversive situation. The specific nature of the automatic thoughts that are observed are typically influenced by the contents of a person's underlying *core beliefs,* or fundamental beliefs that people hold about themselves, others, the world, or the future. Core beliefs usually develop through early life circumstances and experiences, although they can be altered (sometimes radically) by notable events that take place during adulthood. The astute reader will note that many chapter authors use the term *schema*, which also encompasses these underlying beliefs that shape the way a person views their life experiences. Although a few chapter authors imply that their use of schema is synonymous with core beliefs, many cognitive behavioral experts view schemas as encompassing core beliefs from a content perspective but as being a bit broader to reflect biases in information processing, or the way in which people filter information. Figure 1 depicts the way in which I view the relation between schemas and core beliefs.

Cognitive restructuring uses a process of guided questioning to help clients arrive upon their own conclusions regarding the accuracy and helpfulness of their thinking, called *guided discovery*. The questioning used in guided discovery is called *Socratic questioning*, which has its roots in the teaching style of the Greek philosopher Socrates, who asked questions of his students to elicit critical thinking, rather than simply lecturing to his students and telling them what to think. Although it should be noted that guided discovery is often used by writers to capture the full extent of the cognitive restructuring process—from the identification of unhelpful cognition to the arrival of more balanced thinking—I have also seen guided discovery defined primarily as the process of uncovering previously unacknowledged problematic thinking that is associated with emotional distress. Moreover, guided discovery can also refer to the more general process, both within the process of cognitive restructuring as well as within the process of other BT strategies, in which the therapist asks questions to help the client consolidate the learning that is occurring (e.g., "What did you learn from doing this exercise?" and "How can you apply this knowledge to other circumstances in your life?").

Cognitive restructuring is typically implemented in the spirit of promoting a sense of *collaborative empiricism* between the therapist and client. Collaborative empiricism means that the therapist and client work together as equal members of a team (i.e., collaborative) to examine facts and evidence (i.e., empiricism) to arrive upon the most accurate way of viewing a situation. Collaborative empiricism is a fundamental tenet of CBT. Although it is referenced most often

FIGURE 1. Schemas and Core Beliefs



in the context of cognitive restructuring, as I mentioned is the case with guided discovery, it can be applied more broadly for clients to test the effectiveness of a wide range of strategies as they learn to live their lives in a different, more balanced manner.

Finally, a very specific term that is referenced in many chapters is the *thought record*, or a form in which clients can record their cognitive restructuring work that they do in sessions and in between sessions for "homework." Many versions of thought records exist, including those in which clients simply record thoughts that arise in upsetting situations; thought records in which clients record thoughts that arise in upsetting situations along with the evidence that does and does not support their thinking; and thought records in which clients also construct a new thought that is more accurate, helpful, and balanced as a result of Socratic questioning. Although, traditionally, thought records took the form of sheets of paper on which clients would write using a pen or pencil, over the past several years, many clients have kept "virtual" thought records whereby they record their cognitive restructuring work in electronic computer files or mobile phone applications.

Behavioral Activation

Behavioral activation is a common strategy in the cognitive behavioral treatment of depression. It aims to increase clients' engagement in their lives by encouraging them to do things that give them a sense of joy, pleasure, accomplishment, and/or meaning. It is anticipated that, by more actively engaging in these sorts of activities in their lives, clients will attain a sense of response-contingent positive reinforcement, which has the potential to be just as potent as taking an antidepressant pill. Many cognitive behavioral therapists who implement behavioral activation in their sessions use an *activity log* so that clients can record

the activities in which they are engaging, activities that they are attempting to work into their routines, ratings capturing the benefits that they receive from those activities (e.g., the degree of mastery or pleasure associated with each activity), and an overall depression rating for each day. The idea behind the activity log is that clients will readily see patterns in the "data" that they collect in support of the benefits of behavioral activation and that these benefits will contribute to clients' motivation to adopting the principles of behavioral activation into their everyday lives.

As the reader will see in the chapter on behavioral activation, research shows that it is just as efficacious as a full package of CBT (i.e., a package consisting of behavioral activation, cognitive restructuring of automatic thoughts, and cognitive restructuring of core beliefs; Dimidjian et al., 2006; Jacobson et al., 1996). Although behavioral activation is a strategy that was originally included in Dr. Beck's traditional CT for depression approach (Beck et al., 1979), its current version (Martell et al., 2010) is also viewed by many as a member of the third wave of CBTs because of its current emphasis on recognizing the function that depressive rumination has on behavioral inactivity and on engagement of activities consistent with one's values.

Exposure

The counterpart of behavioral activation in the behavioral treatment of anxiety is *exposure*, or the intentional and systematic contact with a feared stimulus or situation (Abramowitz et al., 2011). Many of the chapters on anxiety-related disorders describe exposure as being a central technique in the cognitive behavioral treatment of the condition. There are many types of exposure, including (a) *in vivo exposure*, or contact with a "real-life" feared situation or stimulus; (b) *imaginal exposure*, or the facing of upsetting images, memories, or intrusive thoughts; (c) *virtual reality exposure*, or the use of technology to facilitate simulated contact with a feared situation or stimulus; and (d) *interoceptive exposure*, or participation in an activity that provokes feared bodily sensations associated with the experience of fear and anxiety themselves. When cognitive behavioral therapists facilitate exposure, they usually work with their clients to develop a *fear hierarchy*, or an ordered sequence of feared stimuli and situations ranging from those that are least to most anxiety provoking. The fear hierarchy serves as a guide for the selection of exposures both in and out of session.

As with behavioral activation, research shows that exposure is just as efficacious as a full package of CBT involving exposure and cognitive restructuring (e.g., Foa et al., 2005; Hope et al., 1995). My observation is that clients can do wonderful cognitive restructuring work, but if they continue to avoid feared stimuli and situations, then additional intervention is necessary (and exposure is almost always the necessary intervention). In addition, the field has evolved regarding the ultimate goal of exposure. From the traditional theory based on the work of Foa and Kozak (1986), exposure was hypothesized to work via

habituation, or a reduction in fear, and newer approaches to understanding exposure emphasize fear tolerance and the violation of outcome expectancies (Craske et al., 2008, 2012).

Many cognitive behavioral therapists implement exposure in the form of a *behavioral experiment*, or an instance in which clients "test out" negative predictions and assumptions about what they expect to happen when they face a feared situation. Behavioral experiments facilitate exposure because clients face situations that they dread or of which they are fearful in "real time." At the same time, they, equally, achieve the important aims of cognitive restructuring because they provide "real-life" data to reshape their negative predictions, assumptions, and expectations. Behavioral experiments are perhaps the quintessential example of the notion that cognitive and behavioral change strategies cannot be fully separated from one another, such that change achieved in one area has important implications for change in the other.

ORIENTATION TO THE TWO-VOLUME SET

The reader is about to embark on an ambitious two-volume set that is meant to cover, certainly not exhaustively, the range of contemporary cognitive behavioral scholarship that defines the field today. Volume 1, *Overview and Approaches*, consists of three main sections. Part I provides a contextual background to understand the roots of CBT, its major theoretical and empirical findings, and current issues in the field. In Chapter 1, Robert L. Leahy and Christopher R. Martell, two giants in the field, take on the essential task of summarizing CBT's philosophical and historical roots. Keith Dobson, Amanda Fernandez, and Stefan G. Hofmann contribute, in Chapter 2, an equally essential piece on CBT's theoretical foundations. Chapter 3 turns to the empirical status of CBT outcome, and Claudi Bockting and her impressive collaborators (i.e., Lorenzo Lorenzo-Luaces, Lotte H. J. M. Lemmens, John R. Keefe, and Pim Cuijpers) updated a summary of outcome studies primarily targeting depression, anxiety disorders, OCD, and posttraumatic stress disorder (PTSD). Strategically placed immediately after this outcome chapter, Chapter 4, authored by Janna N. Vrijsen, Rianne A. de Kleine, Eni S. Becker, me, and Jasper A. J. Smits, extends the general notion of outcome and focuses on the mechanisms of change in successful CBT. Peter J. Bieling, Emanuele Blasioli, and Dara G. Friedman-Wheeler provide an excellent critical analysis of case formulation, what I view as the heart of CBT, in Chapter 5. In Chapter 6, on dissemination and implication, Bradley Karlin focuses on the practice of "real-life" CBT in real-life settings with real-life clients—an issue that is essential if we in the field are to ensure that CBT is accessible by people with mental health problems in need. In the final chapter of Part I, Chapter 7, I discuss a topic that is near and dear to my heart—the therapeutic relationship—and consider many ways in which CBT facilitates the therapeutic relationship and ways in which optimal CBT can be conducted with its focus on issues arising in the therapeutic relationship.

Part II of this set focuses on strategies and techniques that are used across many specific approaches within the family of CBTs. I define a *strategy* as a general intervention approach that is meant to operate according to a specific hypothesized process of change (e.g., cognitive restructuring, behavioral activation) and a *technique* as a specific practice that is implemented to achieve the aim of the strategy (e.g., the thought record). In Chapter 8, Christine Purdon presents a thoughtful description of cognitive restructuring and techniques to achieve that aim. Chapters 9, by Maria M. Santos, Ajeng J. Puspitasari, Gabriela A. Nagy, and Jonathan W. Kanter, and 10, by Lauryn Garner, Emily Steinberg, and Dean McKay, describe the tried-and-true behavioral strategies of behavioral activation and exposure, respectively. In Chapter 11, my colleagues, Deborah H. A. Van Horn and Peter Britton, and I describe the well-established motivational interviewing approach and the way in which it has been used prior to the commencement of CBT to increase readiness for change and during CBT when therapists face ambivalence in their clients. Chapter 12, on the regulation of physiological arousal and emotion, by Holly Hazlett-Stevens and Alan E. Fruzzetti, is an amalgam of two chapters that I had originally proposed for the set: (a) breathing retraining and muscle relaxation and (b) mindfulness and acceptance. The authors presented a compelling argument as to why these strategies should be placed together, and I agreed. Finally, John Ludgate's discussion of relapse-prevention techniques in Chapter 13 is an important reminder for cognitive behavioral therapists to be thoughtful in their strategic approach to ending therapy, consolidating the gains made in therapy, and planning for obstacles that clients might encounter after therapy has ended.

The last section of Volume 1, Part III, focuses on cognitive behavioral psychotherapy packages. The chapters in this section generally follow a format that describes the history of the approach, its main procedures, outcome data, mechanisms of change, applications to diverse populations, and dissemination. At times, chapter authors include clinical examples. In Chapter 14, Amanda Fernandez, Keith Dobson, and Nikolaos Kazantzis describe traditional cognitive therapy established by Aaron T. Beck and his colleagues, and subsequently, Debbie Joffe Ellis discusses her late husband Albert Ellis's REBT in Chapter 15. Arthur M. Nezu and Christine Maguth Nezu summarize emotion-centered problem solving in Chapter 16. Interestingly, I had initially identified this chapter as one on problem solving as a strategy that would be included in Part II; however, the magnitude of the body of literature on problem-solving therapy over the past 30 years suggests that it is an important cognitive behavioral treatment package in its own right. Chapter 17 turns to a consideration of schema therapy by Eva Fassbinder and Arnoud Arntz, complete with two case examples of clients with personality disorders that are followed throughout the chapter to illustrate specific schema therapy techniques. In Chapter 18, Hollie F. Granato, Amy R. Sewart, Meghan Vinograd, and Lynn McFarr describe another cognitive behavioral approach for the treatment of personality disorder and/or chronic conditions: dialectical behavior therapy, a treatment package that balances delivery strategies focused on acceptance and those focused on

behavior change. The subsequent three chapters illustrate other cognitive behavioral treatment packages that incorporate a strong focus on acceptance: (a) Eric B. Lee, Benjamin G. Pierce, Michael P. Twohig, and Michael E. Levin's chapter on acceptance and commitment therapy (Chapter 19); (b) Amanda Ferguson, Lê-Anh Dinh-Williams, and Zindel Segal's chapter on mindfulness-based cognitive therapy (Chapter 20); and (c) Peter L. Fisher's chapter on metacognitive therapy (Chapter 21). Chapter 22, by Raymond G. Miltenberger, Diego Valbuena, and Sindy Sanchez, describes applied behavior analysis (ABA). Although ABA is a field unto itself and was not specifically developed as a member of the CBT family, it is included here because many of its principles are incorporated into treatment packages with a strong behavioral basis to modify problem behavior. Emily E. E. Meissel, Jennie M. Kuckertz, and Nader Amir present a unique treatment in Chapter 23 on cognitive bias modification, which focuses on information-processing biases toward or against pathology-relevant stimuli rather than the contents of cognition itself. Part III ends with two chapters on contemporary manifestations of CBT: Chapter 24, by Todd J. Farchione, Julianne G. Wilner Tirpak, and Olenka S. Olesnycky, focuses on the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders, and Chapter 25, by Nikolaos Kazantzis, Hoang Kim Luong, Hayley M. McDonald, and Stefan G. Hofmann, focuses on the modern practice of CBT.

The second volume of the set, *Applications*, opens with Part I, with chapters on applications to clinical populations. Here, chapter authors contribute pieces on the cognitive behavioral treatment of specific mental health problems and other conditions for which clients often seek treatment. The first group of chapters in this section focus, broadly, on the emotional disorders (i.e., depression and anxiety). In Chapter 1, Daniel R. Strunk, Benjamin J. Pfeifer, and Iony D. Ezawa focus on the treatment of depression, describing many specific cognitive behavioral approaches to treating depression and considering the impact of conditions with which depression is often comorbid. Kamila S. White and Vien Cheung describe the cognitive behavioral treatment of anxiety in Chapter 2, providing detailed information about the nature and efficacy of treatment for an array of specific adult and childhood anxiety disorders. Christine Purdon takes on the treatment of OCD in Chapter 3, emphasizing central cognitive behavioral constructs important in understanding this disorder's descriptive psychopathology and corresponding pathways for intervention. In Chapter 4, Anke Ehlers and Jennifer Wild describe principles of the cognitive behavioral treatment of PTSD and emphasize the delivery of their own treatment, cognitive therapy for PTSD.

The remaining chapters in this section focus on CBT for other mental health disorders and conditions that bring clients into treatment. In Chapter 5, Madelyn Ruggieri, Courtney McCuen-Wurst, and Kelly C. Allison provide a thorough description of the treatment and outcomes for the three main eating disorders—bulimia nervosa, binge eating disorder, and anorexia nervosa. Chapter 6, by A. Tom Horvath, turns to the contemporary cognitive behavioral treatment for clients with addiction; Chapter 7, by Cory F. Newman, outlines a

comprehensive cognitive behavioral framework for understanding and treating bipolar disorder; Chapter 8, by Neal Stolar and Rebecca M. Wolfe, provides a detailed examination of CBT for psychosis; and Chapter 9, by Jason G. Ellis, Michael L. Perlis, and Donn Posner, focuses on the innovative and well-disseminated CBT for insomnia (CBT-I). The next three chapters in this section focus on cognitive behavioral approaches for externalizing problems: (a) anger (Chapter 10 by Michael Toohey), (b) suicide attempts (Chapter 11 by Abby Adler, Shari Jager-Hyman, and Gregory K. Brown), and (c) adult attention-deficit/hyperactivity disorder (Chapter 12 by J. Russell Ramsay). The section ends with two chapters on CBT for clients with medical conditions: (a) chronic pain (Chapter 13 by John D. Otis, Alex E. Keller, and Lydia Chevalier) and (b) obesity (Chapter 14 by Jena Shaw Tronieri).

Part II of the set is geared toward consideration of the delivery of CBT in various modalities and settings beyond the traditional outpatient individual psychotherapy format. In Chapter 15, Elizabeth J. Pawluk and Randi E. McCabe describe CBT as delivered in group settings and include important discussion on challenges that can be encountered in group CBT. Frank M. Dattilio and Norman E. Epstein present CBT for couples and families in Chapter 16, providing a rich theoretical and contextual background for the delivery of CBT in this modality. Medical settings are considered in the next two chapters, with Robert A. DiTomasso, Scott Glassman, Christina Berchock Shook, Anna Zacharcenko, and Michelle R. Lent discussing CBT delivered in primary care settings in Chapter 17 and Aaron Brinen discussing CBT delivered in inpatient settings in Chapter 18. Gerhard Andersson and Per Carlbring engage in a fascinating discussion of CBT delivered via the internet in Chapter 19, taking care to comment on the way in which the internet delivery of CBT compares with in-person delivery. In Chapter 20, Jesse H. Wright, Stephen O'Connor, Jessica Reis, and Michael E. Thase provide guidance on the combined delivery of pharmacotherapy and CBT, including rich data on the efficacy of a combined approach for the major mental health disorders. Finally, in Chapter 21, Donna M. Sudak and Robert P. Reiser present a compelling evidence-based approach to supervision in CBT.

The final section, Part III, focuses on applications to diverse populations that are typically encountered in treatment. The first three chapters in this section focus on CBT across the lifespan, with R. Trent Codd III and Nathan Roth describing CBT as applied to children and adolescents with externalizing disorders in Chapter 22; Amber Calloway, Nicole Fleischer, and Torrey A. Creed describing CBT as applied to children and adolescents with internalizing disorders in Chapter 23; and Kenneth Laidlaw describing CBT as applied to older adults in Chapter 24. In Chapter 25, Maegan M. Paxton Willing, Larissa L. Tate, and David S. Riggs discuss mental health conditions most often encountered in military populations and ways in which CBT can be adapted to veterans and military servicemembers. Next, in Chapter 26, Trevor A. Hart, Julia R. G. Vernon, and Tae L. Hart consider guidelines for the cognitive behavioral treatment of gay, lesbian, bisexual, and transgender individuals. Gayle Y. Iwamasa presents a compelling framework for adaptations of CBT for cultural and ethnic minorities, along with results from available empirical research with specific

cultural groups, in Chapter 27. Finally, Chapter 28 by Moses Appel and David H. Rosmarin, ends the two-volume set with a fascinating consideration of CBT as applied to individuals of various religious groups.

Two additional notes about this set are warranted. First, the astute reader will notice that some chapters refer to consumers of services as "patients," whereas other chapters refer to consumers of services as "clients." Indeed, the use of terminology for this purpose has sparked quite a bit of debate (e.g., Joseph, 2013). There is no absolute "correct" way to remedy this issue, so I allowed chapter authors to use their preferred terminology. I saw that a number of chapter authors used "client," another large chunk of chapter authors used "patient," and still other chapter authors alternated between "client" and "patient" (which prompted me to ask them to choose one or the other and use it consistently throughout, as it activated my own obsessive-compulsive tendencies). Regardless of the terminology used, cognitive behavioral therapists hold the utmost respect for each of their clients (patients), and they truly view themselves as being in a collaborative partnership with their clients (patients) in which all parties bring valuable knowledge to the working alliance.

In addition, the astute reader might also notice that many of the chapters (other than the chapters in Part IV, which were targeted toward specific mental health conditions) focus on depression and anxiety much more than other mental health disorders. This is not for want of my trying diligently to encourage authors to comment on the full range of pathology beyond depression and anxiety, including bipolar disorder, psychosis, eating disorders, substance use disorders, and personality disorders. However, the continued focus primarily on depression and anxiety led me to see that this emphasis reflects the state of the literature—that empirical research on cognitive behavioral theory is much more sophisticated, to date, in its application to depression and anxiety than other mental health disorders. I elaborate upon this much more in the conclusion, where I propose tangible directions for future research that will advance the field.

LOOKING AHEAD

The editorial staff at APA Books and I recognize that there are many CBT handbooks on the market. Why is another handbook warranted, and what makes this one unique? When I read comprehensive reviews on an important aspect of CBT for my own scholarly work, my reaction is that multiple chapters on the same topic, even if there is overlap, help reinforce central information and provide unique perspectives and supporting evidence to fill in the overall picture. Moreover, the field is always evolving, so there are references to empirical research in the chapters in this set that would not have been made available to authors of chapters in even recent handbooks.

However, most importantly, I strove to include a balance of traditional and innovative topics. Although this handbook includes many chapters on subjects that are included in other CBT handbooks, there are a number of fairly unique

chapters in this handbook. I take great pride in the emphasis on the therapeutic relationship in the chapter that I drafted for the handbook, as well as its consideration in other chapters. Increasingly, the field is turning its attention to dissemination and implementation of CBT, so Karlin's chapter on this topic is timely in its summarization in the literature and work that remains to be completed. In addition to chapters on fairly "traditional" CBT approaches (e.g., CT, REBT, exposure), I also included chapters on more recent developments in CBT, such as metacognitive therapy (MCT; Fisher), cognitive bias modification (CBM; Meiseel, Kuckertz, & Amir), the United Protocol for the Transdiagnostic Treatment of Emotional Disorders (Farchione, Wilner Tirpak, & Olesnycky), and insights into the delivery of CBT from a modern, or contemporary, perspective (Kazantzis, Luong, McDonald, & Hofmann). In the realm of special populations and issues, CBT for veterans and military servicemembers (Paxton Willing, Tate, & Riggs) and religious individuals (Appel & Rosmarin) has become a popular focus for blog posts and podcasts of late. Even when authors took on fairly traditional topics, they were strongly encouraged to adopt an innovative approach to their presentation by including the latest, cutting-edge research and considering mechanisms of change, applications to special populations, dissemination, and case illustrations on client engagement or the resolution of tricky clinical issues.

My hope is that, after finishing the desired chapters, readers can see the significant theoretical and empirical foundation on which the family of CBTs and its strategies and techniques rest, as well as the promise for its optimization, dissemination, and implementation in the future. CBT has transformed the lives of countless individuals, yet many individuals who suffer from mental health disorders continue not to have access to CBT. This two-volume set represents the latest attempt to highlight the rigor, power, and promise of CBT's application in an ever-changing world.

REFERENCES

Abramowitz, J. S., Deacon, B. J., & Whiteside, S. P. H. (2011). *Exposure therapy for anxiety: Principles and practice*. Guilford Press.

Barlow, D. H. (1988). *Anxiety and its disorders*. Guilford Press.

Beck, A. T. (1967). *Depression: Clinical, experimental and theoretical aspects*. Harper and Row.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. Guilford Press.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, & Practice*, *16*(3), 252–260. https://doi.org/10.1037/h0085885

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, *26*(1), 17–31. https://doi.org/10.1016/j.cpr.2005.07.003

Craske, M. G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy*, *46*(1), 5–27. https://doi.org/10.1016/j.brat.2007.10.003

Craske, M. G., Liao, B., Brown, L., & Vervliet, B. (2012). Role of inhibition in exposure therapy. *Journal of Experimental Psychopathology*, *3*(3), 322–345. https://doi.org/10.5127/jep.026511

Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmaling, K. B., Kohlenberg, R. J., Addis, M. E., Gallop, R., McGlinchey, J. B., Markley, D. K., Gollan, J. K., Atkins, D. C., Dunner, D. L., & Jacobson, N. S. (2006). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *Journal of Consulting and Clinical Psychology*, *74*(4), 658–670. https://doi.org/10.1037/0022-006X.74.4.658

Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A., Riggs, D. S., Feeny, N. C., & Yadin, E. (2005). Randomized trial of prolonged exposure for PTSD with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology*, *73*(5), 953–964. https://doi.org/10.1037/0022-006X.73.5.953

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, *99*(1), 20–35. https://doi.org/10.1037/0033-2909.99.1.20

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. Guilford Press.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). Guilford Press.

Hofmann, S. G., & Asmundson, G. J. G. (2008). Acceptance and mindfulness-based therapy: New wave or old hat? *Clinical Psychology Review*, *28*(1), 1–16. https://doi.org/10.1016/j.cpr.2007.09.003

Hope, D. A., Heimberg, R. G., & Bruch, M. A. (1995). Dismantling cognitive-behavioral group therapy for social phobia. *Behaviour Research and Therapy*, *33*(6), 637–650. https://doi.org/10.1016/0005-7967(95)00013-N

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Consulting Psychology*, *36*(2), 223–233. https://doi.org/bzjxtr

Jacobson, N. S., Dobson, K. S., Truax, P. A., Addis, M. E., Koerner, K., Gollan, J. K., Gortner, E., & Prince, S. E. (1996). A component analysis of cognitive-behavioral treatment for depression. *Journal of Consulting and Clinical Psychology*, *64*(2), 295–304. https://doi.org/10.1037/0022-006X.64.2.295

Joseph, S. (2013, August 4). Patients or clients? What word should psychologists use to describe the people they help? *Psychology Today*. https://www.psychologytoday.com/us/blog/what-doesnt-kill-us/201308/patients-or-clients

Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2010). *Behavioral activation for depression: A clinician's guide*. Guilford Press.

Rachman, S. (2015). The evolution of behaviour therapy and cognitive behaviour therapy. *Behaviour Research and Therapy*, *64*, 1–8. https://doi.org/10.1016/j.brat.2014.10.006

Salkovskis, P. M. (1985). Obsessional-compulsive problems: A cognitive-behavioural analysis. *Behaviour Research and Therapy*, *23*(5), 571–583. https://doi.org/bt7qmf

Wenzel, A. (2017). *Innovations in cognitive behavioral therapy: Strategic interventions for creative practice*. Routledge. https://doi.org/10.4324/9781315771021