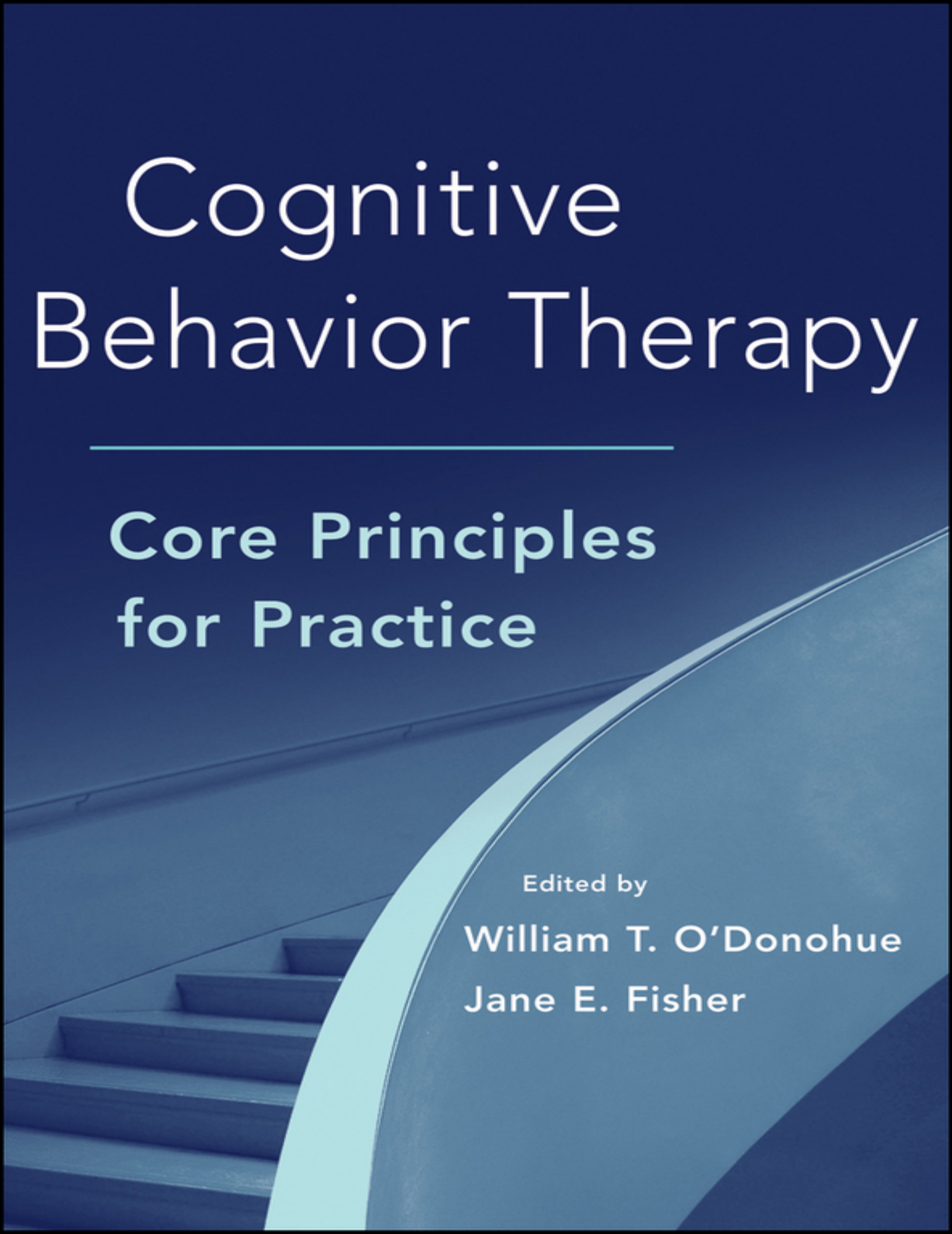
Cognitive Behavior Therapy

Core Principles for Practice



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We would like to dedicate this book to our lovely daughters, Katie and Anna.

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Chapter 1

The Core Principles of Cognitive Behavior Therapy

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Cognitive behavior therapy (CBT) is an important therapeutic paradigm as it has been shown repeatedly to be an efficacious and effective intervention for a wide variety of psychological problems (Chambless & Ollendick, 2001). In fact, it might be argued in an important technical sense that it is the only valid therapeutic paradigm—as the honorific *paradigm* is not a synonym for *theory* or *framework.* Rather, in its canonical sense as originated in Kuhn (1996), a paradigm is viewed as emerging from preparadigmatic pursuits when the program solves a problem or problems. Thus, to deserve the descriptor *paradigm,* the approach has to have a demonstrated problem-solving ability. CBT has shown to be effective for a wide variety of psychological problems while other therapeutic theories simply have not (Chambless & Ollendick, 2001; Fisher & O'Donohue, 2006). In this important sense, CBT may be said to be the only or at least the foremost paradigm in psychotherapy.

For example, in the well-known Chambless report, the techniques of cognitive behavior therapy are nearly exclusively those cited as probably supported or definitely supported. Moreover, the range of effectiveness of these CBT techniques is also quite impressive: enuresis, depression, skill building in the developmentally delayed,

and a number of anxiety problems as well as a few dozen other problems (see Fisher & O'Donohue, 2006). It is not a “one problem therapy” as arguably some other interventions are, for example, eye movement desensitization and reprocessing (EMDR) for posttraumatic stress disorder (PTSD). The extension of these core principles has several important practical advantages that are described in more detail further on.

CBT has other significant advantages. It is often quicker (although there are some notable exceptions to this such as the behavior analytic treatment of autism; see Lovass, 1987). CBT often involves a dozen or a few dozen hourly sessions when it is instantiated in individual therapy—which admittedly is still a significant time commitment, but much shorter than traditional psychoanalytic therapy and much shorter than open-ended supportive psychotherapy, which often has no clear terminus. Also, cognitive therapy can be cheaper, as time is the major driver of cost in most therapies. Perversely, in current practice, customers do not tend to have the information that is needed to purchase effectiveness and quality and thus an hour of CBT can cost the same as an hour of rebirthing or sand tray therapy. Managed care has attempted to curb this lack of differentiation in consumer decision making but largely has not been all that successful. However, healthcare reform is oriented toward increasing the value of healthcare purchases and we believe the demonstrated effectiveness will increasingly be a market differentiator (Cummings & O'Donohue, 2011).

Furthermore, cognitive therapy is often conducive to manualization and it can thus be scaled. Some therapies might depend on difficult-to-define constructs that might be unique to the personality of the founder of the therapy school and thus not easily taught and scaled. For example, Fritz Perls's (1973) Gestalt therapy, with its emphasis on

theatrics, confrontation, vague constructs such as authenticity, and in-the-moment interpersonal dynamics might be much less readily taught and disseminated. Scalability is vitally important given the prevalence of the problems psychotherapy attempts to attenuate: The issue is not whether one or a few therapists can master the techniques but whether thousands can.

A significant problem arises, however, with the notion of manualized therapy. It should be understood that the problem attempted to be solved with a treatment manual is fidelity, which is related to generalizability (Haynes, Smith, & Hunsley, 2011). How can the therapy be faithfully executed with other therapists, in other settings, with other clients? With over 600 *Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision* (DSM-IV-TR) (American Psychiatric Association, 2000) diagnoses, is there to be a manual for each of these and thus a competent therapist must master dozens or even hundreds of these treatment manuals? The fidelity problem becomes more complex when one considers either comorbidity or any other second order variable (for example, therapist experience, intelligence, and clinical judgment). The number of permutations clearly becomes unmanageable. Would there be a manual for an individual with major depressive episode that also is suffering from comorbid panic disorder? Would there need to be still another manual for an individual with these two problems who is also Hispanic? When one crosses 600 diagnoses with comorbidity with another set of variables such as the therapist variables mentioned earlier, the combinatory number is staggering and practically unfeasible (for example, 600 × 600 × 8). One sees that one treatment manual for each category of problem as delineated by these kinds of parameters clearly produces an unmanageable number of manuals.

Moreover, one still needs to understand the core of the treatment manual. A treatment manual for PTSD may contain many particular requirements and subgoals, but some of these are much more critical than others. All requirements in a manual are not of equivalent importance. For example, in a therapy manual for PTSD clearly instantiating exposure principles is important, and how the therapist goes over homework in session two, less important (Zalta & Foa, this volume, Chapter 4). This kind of consideration suggests that understanding the core principles of behavior therapy can be useful in faithfully and effectively delivering evidence-based treatment.

In addition, manuals cannot anticipate the idiosyncratic nature of many actual clinical cases. An understanding of the core principles embodied in the manual can be helpful to successfully adapting a manual to an idiosyncratic situation. For example, the range of trauma can be unique; for example, viewing one's brother dying from a untreated rattlesnake bite would be an occurrence that could be part of therapy but is not of a frequency that will ever be described in any detail in a treatment manual for PTSD. However, when one understands the core principle of exposure one is more likely to be able to effectively adapt a CBT PTSD treatment to this case.

Thus, one advantage of thinking in terms of principles is that it allows a more parsimonious but at the same time a deeper understanding of the mechanisms of change underlying treatment. This is of importance because although there are currently 600 individual diagnoses in the DSM-IV-TR (American Psychiatric Association, 2000) the trend across additions of the DSM is for new additions to include many additional diagnoses. Our field would be very complex indeed if each diagnosis had its own treatment manual with unique change principles underlying each diagnoses. Instead and quite fortunately it appears to be the

case that a set of core principles underlies effective cognitive behavior therapy. For example, exposure therapy and modifying beliefs seems to be key to a variety of anxiety disorders (see Zalta & Foa, this volume, Chapter 4). Skills acquisition and contingency management seems to be the keys underlying treatments for the developmentally disabled and autism spectrum disorders (see chapters by Twohig & Dehlin, this volume, Chapter 3; Rummel et al., this volume, Chapter 2). Thus, understanding some central core principles can povide a more coherent and parsimonious way of understanding the treatment of a broader range of individual disorders.

Second, these core principles allow a deeper understanding of change processes. Treatment manuals tend, by their nature, to have a fair amount of detail. Each detail specifying some therapeutic requirement does not have equal weight in producing beneficial outcomes. Understanding the principles that are being instantiated in the therapy manual can help the clinician to better understand the key components of treatment. Also, if the therapy needs modifications to meet the individual needs of the patient (for example, the patient needs more compressed treatment because they don't have time for the full 18 sessions that the manual specifies) an understanding of the core principles underlying the manual can help the clinician to accomplish these modifications in a faithful and effective manner.

A corollary of this is that manuals should be explicit on what principles they are attempting to instantiate. These ought to state something along the lines of “in the next two sessions two principles are being implemented: (1) identifying and modifying irrational beliefs and (2) apply behavioral activation principles so as to increase the patient's contact with positive events.” This will allow the

clinician a better understanding of the underlying importance of some of the goals of the therapy manual.

This can also mean that more process research is needed to better understand the actual mechanisms of change in therapies that have been identified as effective. The Chambless report mentioned earlier sometimes does this but mostly fails to. This is partly due to a notable particularity of trends in CBT research. In the early years, especially in the behavior analytic tradition, process variables were identified and directly manipulated to see their impact on outcome variables (O'Donohue & Houts, 1985). Titles of papers were more along the lines of “The effect of contingency management on increasing homework.” The principle—contingency management in the outcome research—was clearly specified. Increasingly, therapeutic packages or therapies with general titles are tested and it is unclear what the active ingredients of change are. Thus, if the title is something along the lines of “The effect of ACT on depression”; or “DBT reduces parasuicidal behavior,” it is much less clear in these multicomponent packages what principle or principles are being employed. Clearly we need more process research and dismantling research to better identify key elements of change. Otherwise, the relative importance of the components of a manual are not clear.

Therapy Is Not an Art

An implication of the identification of key principles underlying effective behavior change techniques is that therapy is not essentially an art. This is good news, because there are very few good artists and a lot of hacks. However, when something is a technical enterprise—such as civil engineering—there can be a high degree of general competence across practitioners. Therapy is at least in large

part a technical enterprise that involves the skillful application of the active ingredients of change. It is thus partly a technology. Certainly this is not to say that therapy is mechanistic or algorithmic. However, a key question each therapist can ask herself in each session is: “What principles of change am I implementing in the treatment design?” If the answer is none, the therapist is likely to be wasting the client's valuable time and money.

It is certainly the case that these principles can be somewhat artfully instantiated. It is important to note, however, that these principles also provide constraints. It is not acceptable art to do sand tray therapy, or rebirthing, or psychoanalysis, or supportive psychotherapy, as there are no identified causal mechanisms that can bring about change—particularly when compared to the alternatives discussed in this book. That is, if one is doing, say, nondirective therapy with someone who has panic attacks, then this can be legitimately criticized through this observation, “Exposure therapy and cognitive restructuring have been shown to be effective for this problem. The techniques you are implementing have not been. Why are you harming your patient by failing to provide them with a therapy based on principles that have empirical support?” This implies there are right answers in therapy; it is not a free-form art, though, but rather at least partly a technical problem, that is, what regularities have been shown to bring about the ends sought and how do I as therapist instantiate these regularities in this case? These principles need to play a large role in case formulation and treatment planning.

We believe that the principles outlined in this book bring accountability to therapist behavior and treatment planning. Therapists cannot simply implement a therapy that has caught their fancy but rather must design and implement therapies that are based on principles that have been supported as effective. This also implies that those that only

rely on nonspecifics when designing or implementing therapy are doing so with the proverbial one hand tied behind their backs. Nonspecifics are clearly important. We believe, however, that the reviews such as the Chambless report entail the following conclusion: “It is important to deliver empirically supported therapy in a warm, empathic manner. Delivering only warmth and empathy, however, is insufficient and constitutes malpractice.”

Thus, to some extent, therapeutic eclectism ought to be dead. However, regrettably, in our field there are too few burials. This was a favored label of many therapists for self-identification for decades. Therapists seemed to describe themselves as eclectic because it connoted open-mindedness, versatility, a breadth of knowledge, and a wide skill set. (This may be more revealing of therapist narcissism than simply a label of therapeutic alliance.) Adding therapeutic techniques that have no known efficacy, however, is subtractive and diluting. The same can be said for those infatuated with therapeutic integration (Norcross & Goldfried, 2005; also see O'Donohue & McKelvie, 1993). *Integration* as a word has a lot of positive connotations but a surgeon who combines voodoo into established scientific surgery techniques is not being integrative in any positive sense but rather unethical and is committing malpractice. Antiseptics are to be used in surgery; throwing powder from a rhinoceros's penis is not. Therapeutic eclectism can only be justified by adding other empirically supportive techniques (say, for example, interpersonal techniques to CBT techniques in the treatment of depression, since interpersonal therapy has also been shown to be effective) (Klerman & Weissman, 1993). The possibilities for such empirically supported eclecticism are very limited, however, because of the lack of evidence of the efficacy of the techniques from other therapy theories.

The Varieties of Instantiations of These Principles

Another advantage of explicating the core principles of effective therapy is that this can contribute to the exploration of alternative ways these can be instantiated. Individual and group therapy are viable modalities but cannot meet the need for services. Individual psychotherapy is currently expensive, is of relative long duration (a dozen hours or more) and presents serious problems of accessibility. (The rural and the poor can have grave difficulties getting access to individual therapy.)

There has recently been important moves to instantiate core principles in delivery modalities that are less costly, quicker, and more accessible. This is an important and promising set of developments that again point to the importance of understanding these core principles. For example, the bibliotherapy movement has seen the production of a number of self-help books that contain these principles and that have themselves been subjected to randomly controlled trials showing their efficacy. David Burns's (1999) *Feeling Good* is arguably an instantiation of cognitive restructuring for individuals suffering from clinical or subclinical major depression. It has shown to have efficacy in a number of clinical trials (Scogin, Hamblin, & Beutler, 1987). Other books instantiate exposure principles (Foa & Wilson, 2001), contingency management (Patterson, 1977), or even a package of principles such as those found in relapse prevention approaches (Sbraga-Penix & O'Donohue, 2004). This is a very promising development.

Also, ehealth has also grown tremendously in the past couple of decades. This is a further important development that has the potential to allow core principles to be delivered at low cost over the web to millions of consumers (O'Donohue & Draper, 2010). Innovators have attempted to

instantiate these core principles in therapy modules delivered in an automated manner on the web. The Australian site ecouch (http://ecouch.anu.edu.au) has used behavioral activation and cognitive restructuring in a free site for those with problems with depression. They have also developed web-based programs that have used exposure principles for anxiety disorders. Stoppulling.com uses contingency management principles to address trichotilimania. Lorig, Ritter, Laurent, and Plant (2006) has developed web-based programs that use cognitive restructuring, particularly self-efficacy to help improve treatment compliance in a variety of chronic illnesses such as diabetes. These attempts to provide low cost, effective, and widely disseminable instantiations of the core principles of CBT are important developments, as they have tremendous potential to provide high quality interventions to an enormous number of people for a wide variety of problems (O'Donohue & Draper, 2010).

We welcome these developments. We hope that more innovation will occur along these lines, as there is much to be gained, especially in helping to make progress on some of the facets of the healthcare crisis. To best design and develop other effective modalities to help individuals either prevent behavioral health problems or resolve them, however, we must first understand the key principles that must be embodied in any such modality. In an important sense, bibliotherapy and ehealth are based on the commitment that it is the change principle that is important to instantiate, not the nonspecifics of the therapeutic relationship. This is controversial to those who have different theoretical commitments.

The Structure of CBT: Where Do Principles Fit In?

Behavior therapy is an increasingly complex approach to the treatment of human problems. In the 1950s, it began with a few simple principles: From Skinner, behavior therapists learned how to use contingency management, and from Wolpe, relaxation and exposure in his systematic desensitization. In the last 50 years, behavior therapy has ballooned to nearly a 100 separate techniques. It is daunting for the student or practitioner to understand and implement each of them (O'Donohue & Fisher, 2009).

We believe, however, that it is important to note that contemporary CBT is not a one- or two-principle therapy. It is based on a number of principles (we have enumerated 13 major principles in this book). These principles are themselves fairly unique—exposure is quite different from the use of positive psychology. To be competent at CBT, one has a large but definable task—understand and be able to implement these principles. It is also important to note that these principles are sometimes interrelated in an interesting web. Contingency management (Rummel et al., this volume, Chapter 2) is highly related to skill building (Twohig & Dehlin, this volume, Chapter 3), which is also related to behavioral activation (Kanter & Puspitasari, this volume, Chapter 9). Important theoretical work can be done in explicating the interrelationships between these principles.

We can thus see that, overall, the intellectual edifice of CBT is also complex. It can be said to have broad philosophical aspects, often involving views of the philosophy of science. Radical behaviorism, for example, makes statements about how a science of behavior ought to be conducted (see O'Donohue & Ferguson, 2001 for an explication of this). Going down from abstract to concrete, the next step in CBT's intellectual edifice might be the theories of CBT (see O'Donohue & Krasner, 1995). Theories such as alarm theory (Carter & Barlow, 1995) or reciprocal inhibition (Wolpe, 1969) or even feminist theories that