1 INTRODUCTION

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Cognitive behavior therapy (CBT) is an approach to human problems that can be viewed from several interrelated perspectives: philosophical, theoretical, methodological, assessment oriented, and technological. This book focuses on the last aspect, so crucial to clinical practice, but situated in the other four, much as any one of a cube's six sides is situated among all of the others.

Philosophically, CBT can be viewed as being associated (or, according to some who put it more strongly, derived) with one or another variety of behaviorism (O'Donohue & Kitchener, 1999). The behaviorisms are generally philosophies of science and philosophies of mind—that is, ways of defining and approaching the understanding of the problems traditionally associated with psychology.

There are at least two broad issues at the philosophical level: (1) What particular form of behaviorism is being embraced (O'Donohue & Kitchener, 1999, have identified at least 14), and (2) what is the nature of the relationship or association between this philosophy and the practice of CBT? Some have argued that behaviorism is irrelevant to behavior therapy—that one can practice behavior therapy and either reject behaviorism or be agnostic with regard to all forms of it. While an individual practitioner can behave in this way, some of the deeper structure that can be generative and guiding is lost. One can drive a car without an understanding of its workings, but one probably can't design a better car or modify an existing car without such an understanding. Similarly, a knowledge of behaviorism allows greater understanding of the choice points implicit in any technology. For example, why not view the client's problem as a neurological difficulty and intervene at this level? Behaviorism often provides possible answers to this kind of general challenge. However, we suggest that in recent decades there has been an unfortunate trend away from a philosophical understanding of behavior therapy to a more technique-oriented understanding.

The second aspect of behavior therapy is its theoretical structure. Here the issues are less philosophical—less about general epistemic issues—and more about substantive assertions regarding more specific problems as well as the principles appealed to in making these assertions. What is panic? What are its causes? What is the role of operant conditioning in children's oppositional behavior? How does one prevent relapse? Should cognitions be modified or accepted?

There are also a wide variety of theories associated with behavior therapy (O'Donohue & Krasner, 1995), including:

- Reciprocal inhibition
- Response deprivation
- Molar regulatory theory
- Two-factor fear theory
- Implosion theory
- Learned alarms
- Bioinformational theory
- Self-control theory
- Developmental theories
- Coercion theory
- Self-efficacy theory
- Attribution theory
- Information processing theory
- Relational frame theory
- Relapse prevention
- Evolutionary theory
- Marxist theory
- Feminist theory
- Dialectical theory
- Acceptance theory
- Functional analytic theory
- Interbehavioral theory

Theories can provide answers or at least testable hypotheses for questions regarding more specific problems, such as these: What is the basic nature of this kind of clinical problem? How does this problem develop? What maintains this problem? What are its associated features and why? How is this problem possibly modified? What makes this technique work? What are contraindications? What are boundary conditions?

The third aspect of CBT is its program for knowledge generation. In the main, CBT is experimental and relies on a mixture of group experimental designs (e.g., the randomized controlled trial) and single-subject experimental designs (although in the largest perspective it can be seen to include correlational designs and even case studies). Methodologically, CBT generally embraces constructs such as social validity, clinical significance, follow-up measurements, manualized treatment, adherence and competence checks, the measurement of process variables, independent replications, and real-world effectiveness research. This toolbox is complex, but one can discern a few distinct styles—such as that of the applied behavior analyst and that of the cognitive therapist (O'Donohue & Houts, 1985). Other styles can be seen when the nature of the question differs—for example, when the interest is in measurement development and validation or in the questions typically associated with experimental psychopathology. CBT is solidly in the stream of ''clinical science'' and as part of this general approach views an experimental approach as key (see Lilienfeld and O'Donohue, 2007, for a fuller exposition of clinical science).

The fourth aspect of CBT is its approach to measurement. Here, a key issue is how to accurately detect and quantify variables of interest. Cognitive behavior therapy is associated with both a distinctive delineation of the domain of interest and distinct methods for measuring this. In general, behavioral assessment can be distinguished from more traditional measurement approaches by its focus on sampling of behavior rather than looking for signs of more abstract constructs. There are diverse streams of thought within the CBT tradition, however, from the embrace of traditional psychometric standards to the radically functional (e.g., Hayes, Nelson, & Jarrett, 1987). Some of the chapters in this volume deal with assessment techniques either because they are central to therapy or because assessment methods themselves are so reactive that they may be seen, in part, as treatment. However, in the main, this book does not focus on the measurement aspect, leaving that task to other fine anthologies (e.g., Haynes & Heiby , in press).

The final aspect of CBT is *techne*—skilled practice. No amount of philosophy or theory will relieve clinicians from this level of analysis. A surgeon may be a biological determinist philosophically and may hold to certain theories of cancer and cancer treatment, but to help patients the surgeon still needs to implement surgical technique in a skilled manner. Similarly, cognitive behavior therapists need to be skilled in the execution of their techniques. In fact, an interesting set of research questions involves the relationship between the degree of skill (e.g., poor, novice, experienced, master) and therapy outcome. This may also be a function of specific technique (e.g., progressive muscle relaxation may have different relationship with skill level than emotional regulation training). For example, if a clinician arranges potential positive reinforcers that are too distal in contingency manager it will be less effective. Similarly, if a clinician conducts systematic desensitization with only a few steps in a fear hierarchy, with weakly trained progressive muscle relaxation skills, and pairings that are few and of very short duration, it is unlikely to be as effective as it could otherwise be.

We've identified approximately 80 distinct techniques in CBT, covering both standard behavior therapy and cognitive therapy techniques, and relatively recently developed procedures such as acceptance strategies and mindfulness. This number has to qualify CBT as one of the most variegated therapy systems. This diversity no doubt derives from an interplay of complex factors:

- The multiple learning theories upon which traditional behavior therapy is based (O'Donohue, 1998).
- The multielemental nature of each of these theories (e.g., setting events, discrimination

training, schedules of reinforcement, generalization processes, fading, etc.).
- The influence of other elements of experimental psychology such as experimental cognitive science.
- The influence of other branches of psychology such as social psychology.
- The influences of other intellectual domains (dialectics) or other fields of inquiry (mindfulness).
- The interface of these with a particular kind of clinical problem (e.g., borderline personality disorder).
- The creativity and ambitions of the developers.

But whatever the source of this tremendous variety, the presence of such a large number of major distinctive techniques leaves no doubt as to the multifactorial nature of contemporary CBT. It leaves an interesting question regarding how broad competence ought to be across these techniques in order for one to be considered a well-trained cognitive behavior therapist. One of the key variables emerging in the medical literature regarding quality is number of times the physician has implemented the particular technique. One generally finds that hundreds or thousands of times produces outcomes better than those in the dozens. Thus, there can be a bandwith/fidelity trade-off in behavior therapy that can have interesting associations with quality. Those that know more techniques may be less skilled at implementing any particular one.

We've asked each of the chapter authors to follow a standard format, because we thought these main topics would delineate a bit of the context and all of the essential features needed to competently execute these techniques. We wanted them to describe who might benefit from this technique, contraindications, other factors relevant to making the decision to use or not to use the technique, how the technique might work (i.e., what process or pathway it may be associated with), and some of the evidence for its effectiveness. The major section of the chapter is a step-by-step guide that explains exactly how to implement the technique. Finally, we asked authors to include a brief table outlining the major elements of the technique.

The very number and diversity of CBT techniques place a significant burden on any practitioner of CBT and, even more so, on the student. It is our hope that this volume, by clearly and concisely describing these techniques, will ease this burden. We also hope that precision about techniques can help the field continue to keep its eye on Gordon Paul's (1969) classic question: What techniques, delivered by what type of therapist, for what kind of client, with what kind of clinical problem, in what kind of setting, produces what kind of result, by what kind of process?

References

Haynes, S., & Heiby, E. (in press). *The encyclopedia of behavioral assessment*.

Hayes, S. C., Nelson, R. O., & Jarrett, R. (1987). Treatment utility of assessment: A functional approach to evaluating the quality of assessment. *American Psychologist*, *42*, 963–974.

Lilienfeld, S., & O'Donohue, W. (Eds.). (2007). *The great ideas of clinical science*. New York: Routledge.

O'Donohue, W. (Ed.). (1998). *Learning and behavior therapy*. Boston: Allyn and Bacon.

O'Donohue, W., & Houts, A. C. (1985). The two disciplines of behavior therapy. *Psychological Record*, *35*(2), 155–163.

O'Donohue, W., & Kitchener, R. (1999). *Handbook of behaviorism*. San Diego: Academic Press.

O'Donohue, W., & Kramer, L. (Eds.). (1995). *Theories of behavior therapy*. Washington, DC: APA Books.

Paul, G. L. (1969). Behavior modification research: Design and tactics. In C. M. Franks (Ed.), *Behavior therapy: Appraisal and status* (pp. 29–62). New York: McGraw-Hill.