CBT

Cognitive Behavior Therapies

A GUIDEBOOK FOR PRACTITIONERS

edited by
Ann Vernon and Kristene A. Doyle

American Counseling Association

Wiley

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AMERICAN COUNSELING ASSOCIATION

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Dedication

We dedicate this work to the key theorists of the cognitive behavior therapies discussed in this book. Each pioneer has had a profound impact on the foundation and evolution of evidence-based counseling approaches. As a result of their innovative work, countless numbers of people of all ages are able to apply the principles to themselves to enhance their emotional well-being.

Table of Contents

Preface vii

About the Editors ix

About the Authors xi

Chapter 1

What Is Cognitive Behavior Therapy? 1

Raymond DiGiuseppe, Rachel Venezia, and Roseanne Gotterbarn

Chapter 2

Behavior Therapy 37

Mark Terjesen, Tara Rooney, Michal Barnea, and Victoria Nicosia

Chapter 3

Cognitive Therapy 75

Silviu A. Matu

Chapter 4

Rational Emotive Behavior Therapy 109

Michael Hickey and Kristene A. Doyle

Chapter 5

Multimodal Therapy 143

Gary B. Kelley

Chapter 6

Acceptance and Commitment Therapy 177

Ioana R. Podina and Daniel David

Case study contributed by *Cristina Mogoaşe*

Chapter 7

Dialectical Behavior Therapy 209

Chris Kelly and Diana M. Robinson

Case study contributed by *Nora Gerardi*

Chapter 8
Mindfulness 247
Anthony Pantaleno and Mark Sisti

Chapter 9
The Case of Marcos From Each
Theoretical Perspective 281

Index 311

Preface

The term *cognitive behavior therapy* (CBT) is familiar to most mental health practitioners throughout the world. As you will read in the first chapter, CBT is a generic term that describes a wide range of approaches, despite the misconception that there is one type of CBT. As O'Kelly (2010) noted, CBT is "like a river" with many tributaries, including classical and operant conditioning and learning theory, among other influences, and the premise that cognitions trigger emotional and behavioral reactions (p. 10). Albert Ellis and Aaron Beck were at the forefront of the cognitive revolution, which has steadily gained momentum and popularity over the years in part because the various CBT approaches have wide applicability and have been shown to be effective with many different types of presenting problems. Furthermore, CBT readily lends itself to a broad array of interventions that are practical in nature and have been proven to effect change.

The authors of these chapters are experts in this field, both as practitioners and as scholars. They provide a comprehensive overview of the following theories: behavior therapy, cognitive therapy, rational emotive behavior therapy, multimodal behavior therapy, acceptance and commitment therapy, dialectical behavior therapy, and mindfulness. They address pertinent information pertaining to the key theorist or theorists associated with the theory as well as give an overview of the basic principles of that theory. In addition, they describe the therapeutic process, with an emphasis on the process of change and specific interventions associated with the theory. Applications and efficacy are also addressed. At the end of each chapter, the authors include a verbatim transcript of an actual counseling session so that you will have a better idea of how the theory works in practice. These transcripts are from a fourth session, with some background about the client and issues addressed in previous sessions. Each author also provides a short critique of why the theory is effective in addressing the problem and what went well or could have been done differently. Clients' names and identifying information for these transcripts have been modified to protect their identities. The final chapter considers the case of Marcos, contributed by Anthony Pantaleno, who coauthors the chapter on mindfulness. After a description of the case, the authors who discussed each respective theory describe how they would conceptualize this case, including the establishment

of the therapeutic alliance, goal setting, the process of change, and interventions to address the targeted issues.

As coeditors and contributing authors, we hope that this book enlightens students and practitioners about the various forms of CBT, dispelling myths and misconceptions. We hope that the emphasis on practical information, further illustrated through the verbatim case examples and the case of Marcos, contributes to a broader understanding of the "what's" and "how to's" of the seven theories addressed in this book.

References

O'Kelly, M. (2010). *CBT in action: A practitioner's toolkit.* Melbourne, Australia: CBT Australia.

About the Editors

Ann Vernon, PhD, ScD, LPC, is president of the Albert Ellis Board of Trustees, one of the first diplomates of the Albert Ellis Institute, a member of the International Training Standards and Review Committee of the Albert Ellis Institute, a member of the Board of Consulting Advisors for the *Journal of Rational-Emotive & Cognitive-Behavior Therapy,* and former director of the Midwest Center for rational emotive behavior therapy. In addition, she was selected by the American Psychological Association to do a counseling video demonstration titled *Rational Emotive Behavior Therapy Over Time: Psychotherapy in Six Sessions*. Dr. Vernon is recognized as the leading international expert in applications of rational emotive and cognitive behavior therapy (RE&CBT) with children and adolescents and has written numerous books, chapters, and articles about counseling this population, including *Thinking, Feeling, Behaving: An Emotional Education Curriculum*; *What Works When With Children and Adolescents: A Handbook of Individual Counseling Techniques*; *The Passport Program*; and *More What Works When With Children and Adolescents*. Dr. Vernon is a professor emerita of the University of Northern Iowa, where she served as coordinator of the school and mental health counseling programs for many years. In addition to her university appointment, Dr. Vernon was in private practice for many years, applying RE&CBT with children and adolescents as well as with couples and individuals. She has been a frequent presenter at national conferences and has presented RE&CBT workshops throughout the United States, Canada, Australia, and several countries in Europe and South America. Currently she is a visiting professor at the University of Oradea in Romania, where she teaches courses in school and mental health counseling and continues to do RE&CBT trainings around the world.

Kristene A. Doyle, PhD, ScD, is the director of the Albert Ellis Institute (AEI). Dr. Doyle is also director of clinical services, founding director of the Eating Disorders Treatment and Research Center, and a licensed psychologist at AEI. She is also a founding diplomate in rational emotive and cognitive behavior therapy and serves on the Diplomate Board. In addition to training and supervising AEI's fellows and staff therapists, Dr. Doyle conducts numerous workshops and pro-

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Raymond DiGiuseppe, PhD, received his bachelor's degree from Villanova University (1971) and his doctorate from Hofstra University (1975). He has served as president of the Association for Behavioral and Cognitive Therapies (2006) and the Society for the Advancement of Psychotherapy (2014). He has coauthored six books, including *Understanding Anger Disorders* and *A Practitioner's Guide to Rational Emotive Behavior Therapy*. He has also developed two psychological tests, the Anger Disorders Scale for adults and the Anger Regulation and Expression Scale for youth. He is a professor of psychology at St. John's University and Director of Education at the Albert Ellis Institute in New York. Dr. DiGiuseppe regularly conducts rational emotive and cognitive behavior therapy trainings at the Albert Ellis Institute and its affiliated training centers around the world.

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What Is Cognitive Behavior Therapy?

Raymond DiGiuseppe, Rachel Venezia, and Roseanne Gotterbarn

Cognitive behavior therapy (CBT) represents a form of psychotherapy that solves current problems, disturbed emotions, and dysfunctional behavior by acknowledging the role of human learning as well as the effects of the environment, cognitions, and language in disturbance. It has become the overriding, generic term used to describe a wide range of approaches to counseling and psychotherapy that represent three distinct yet overlapping therapeutic approaches: behavior therapy (BT), cognitive therapies, and mindfulness and acceptance therapies. These approaches are similar but conceptualize the mediation of dysfunctional behavior differently.

CBT originated in BT and remains committed to many of its values and traditions. The main organization that represents the professional and scientific advancement of these therapies was originally known as the Association for the Advancement of Behavior Therapy; in 2004 this group added the term *Cognitive* to its name, thus becoming the Association for Behavioral and Cognitive Therapies.

This chapter provides an overview of CBT and orients you to general concepts that are described more specifically in the chapters of this book. Although there are many varieties of CBT, this book focuses on BT, cognitive therapy (CT), rational emotive behavior therapy (REBT), multimodal therapy (MMT), acceptance and commitment therapy (ACT), dialectical behavior therapy (DBT), and mindfulness. The editors selected these models because they each have good empirical support, are widely accepted, and appear to be growing in popularity.

Variation in CBT

Despite its popularity, CBT does not represent a monolithic paradigm. Some theorists have used the metaphor of three waves to understand the differences among the forms of CBT. The first wave of CBT started with the behavioral tradition, based on the work of B. F. Skinner and Ivan Pavlov and the clinical areas of applied behavior analysis (Martin & Pear, 2015) and pragmatic behavior therapy (Fishman, Rotgers, & Franks, 1988). Learning principles formed the basis of this initial approach, and interventions included relaxation training, exposure, operant interventions, and the rehearsal of new adaptive responses to problems.

The second wave emerged because of some dissatisfaction with the behavioral model. Behavior therapists recognized that human thoughts and language played a more central role in disturbed behavior than the behavioral model recognized. As the cognitive revolution occurred in BT, the number of approaches increased very quickly. This group of therapies included Albert Ellis's REBT, Aaron Beck's CT, Don Meichenbaum's (1993) self-instructional training, and problem-solving skills training (Nezu, Maguth Nezu, & D'Zurilla, 2013).

The third wave included techniques based on mindfulness and a new approach to language and cognition called *relational frame theory,* which represents a new approach to Skinner's learning theory applied to language. Relational frame theory differs from previous schools of thought insofar as it does not recommend trying to change the content of a belief or thought but instead attempts to break the connections between thoughts and rigid behavior actions. It relies on teaching acceptance of negative thoughts and training flexible behavioral reactions in response to their occurrence.

The metaphor of the three waves might not be the best way to conceptualize these differences in CBT. Waves come in an order, and new waves overtake previous waves, which recede back to the ocean unnoticed. The three waves of CBT did not occur in three different points in time; each has ancient roots in philosophy and psychology. Also, the first two waves have not run out of energy and fallen back into the undertow of science or clinical practice; they still exist and are going strong. A better metaphor would be three branches on an evolutionary bush, such as three groups of apes: gorillas, chimpanzees, and bonobos. Each model has common ancestors in psychology and philosophy and continues to evolve on its own. None of the models has driven the others into extinction.

Even in these three major groups there continues to be diversification and expansion. As early as 1993, Kuehlwein identified 10 schools of CBT. Since that time, more variants of CBT have appeared. Table 1.1 represents an inexhaustive list of types of CBT theories that we uncovered in a recent search.

As noted, this book describes only a few variants of CBT but includes representatives from all three branches or waves. The chapter on BT represents the first branch and includes the basic skills of CBT. The chapters on

Table 1.1
Models of CBT and Their Founders

Form of Counseling	Founder and Reference
Acceptance and commitment therapy	Hayes et al. (2011)
Applied behavior analysis	Martin & Pear (2015)
Behavior therapy	Wolpe (1969)
Cognitive therapy	A. T. Beck (1976)
Cognitive analytic therapy	Ryle (2005)
Constructivist cognitive psychotherapy	Neimeyer (2009)
Dialectical behavior therapy	Linehan (1993)
Fixed role therapy	Kelly (1955)
Functional analytic psychotherapy	Kohlenberg & Tsai (1991)
Meta-cognitive therapy	Wells (2008)
Mindfulness cognitive therapy	Sigel, et al. (2013)
Mindfulness-based interventions	Kabat-Zinn (2013)
Multimodal therapy	A. A. Lazarus (1981)
Parent training	Forgatch & Patterson (2010)
Pragmatic behavior therapy	Fishman et al. (1988)
Problem-solving therapy	Nezu et al. (2013)
Rational emotive behavior therapy	Ellis (1962)
Rumination-focused CBT	Watkins et al. (2007)
Schema-focused cognitive therapy	Young et al. (2003)
Self-instructional training	Meichenbaum (1977)
Trauma-focused CBT (TF-CBT)	Cohen (2006)
Trial-based cognitive therapy	de Oliveira (2016)
Wellness therapy	Fava (2016)

Note. CBT = Cognitive behavior therapy.

REBT (Ellis, 1962), CT (A. T. Beck, 1970, 1976), and MMT (A. A. Lazarus, 1981) represent the second branch. The chapters on ACT (Hayes, Villatte, Levin, & Hildebrandt, 2011), DBT (Linehan, 1993), and mindfulness (Kabat-Zinn, 2013) represent the third branch.

Although these models share more similarities than differences, they emphasize different learning, cognitive, and psychological processes as mediating the relationship between environmental stressors and emotional and behavioral disturbances. Furthermore, although they use many different interventions, most of the interventions in each of these models are compatible with the other models. Hofmann, Asmundson, and Beck (2013) described CBT as a theoretically consistent model that focuses on a wide range of clinical problems, each of which might require a different emphasis and intervention. Thus, CBT practitioners might use multiple procedures to accomplish change yet remain theoretically consistent, describing their clients in terms of CBT theoretical constructs that are presented in this book.

Observing a number of professionals delivering CBT sessions might be confusing to the novice because one is likely to see the counselors doing many different things without a consistent pattern. O'Donohue and Fisher (2009) described 74 different CBT interventions. Here is a list of some of the techniques used in CBT:

- Assertiveness training
- Assessing the emotions, thoughts, and behaviors that occurred when the client tried to implement a homework assignment
- Assessing the presence of dysfunctional behaviors or emotions
- Behavioral activation—increasing mastery and pleasuring experiences
- Bibliotherapy
- Challenging the client's irrational beliefs
- Challenging the client's negative automatic thoughts
- Changing the client's underlying schemas
- Decentering
- Defusion
- Diagnostic interviewing
- Distress tolerance
- Exploring the adaptability of the client's belief system
- Exploring the adaptability of the client's emotions and behaviors
- Flooding
- Graduate exposure
- Habit reversal training
- Harm reduction
- Imaginal exposure
- Mindfulness exercises
- Modeling and role-playing new skills
- Negotiating homework
- Offering alternative rational beliefs or schemas to replace the client's irrational beliefs or dysfunctional schemas
- Operant strategies
- Opposite action
- Parent training
- Performing a comprehensive multimodal assessment of behaviors, affect, sensations, imagery, cognitions, interpersonal relationships, drugs, or biological influences
- Performing an ABC analysis of thoughts: activating event, beliefs, and emotional consequences
- Performing an ABC functional analysis of behavior: antecedents, behaviors, and consequences
- Relapse prevention
- Relaxation procedures
- Response chaining
- Response prevention and exposure
- Reviewing homework
- Self-control procedures
- Self-instructional training
- Shaping

- Social problem solving
  - Helping the client generate alternative solutions to problems
  - Helping the client evaluate the consequences and effectiveness of alternative solutions
- Social skills training
- Stimulus control procedures
- Teaching the B → C connection
- Teaching the difference between irrational and rational beliefs
- Token economies
- Validating the client's emotions
- Values and goals clarification

It is important to note that although CBT is eclectic in techniques, it is consistent in its theory. And although many therapists consider themselves eclectic, eclecticism can be a confusing and difficult path to follow. A. A. Lazarus (1967; A. A. Lazarus & Beutler, 1993) pointed out that therapists who practice as theoretically eclectic must inevitably use contradictory ideas, which begs the question of how one chooses or justifies using one theory with one case and a different theoretical approach with another case. However, CBT practitioners can and do use many different interventions while remaining theoretically consistent. A. A. Lazarus (1967) coined the term *technical eclecticism* to describe clinical practice that remains theoretically consistent yet uses a variety of methods that target the theoretical mechanism identified by one's orientation.

Assumptions and Core Principles of CBT

Given all of these variations on CBT, you might wonder what they have in common. In this section, we review the common assumptions, principles, and histories that unite CBT.

For most CBT therapists, the term *behavior* refers to actions of striated muscles as well as to the reaction of the sympathetic nervous system, thoughts, and emotions. Thus, the definition of *behavior* is broad. CBT started with and remains committed to basing its practice on concepts derived from the field of scientific and experimental psychology. CBT-based interventions evolved from basic scientific learning principles. This is reflected in the field of applied behavior analysis (Martin & Pear, 2015) and Joseph Wolpe's systematic desensitization. Also, there remains a strong behavioral tradition using learning theory principles to inform clinical practice (Fishman, 2016). As CBT grew, its practitioners discovered that other factors besides the scientific laws of learning contributed to effective therapies, which influenced practitioners to shift their emphases to developing therapies based on any scientific principles of human behavior (A. A. Lazarus, 1977). Presently learning, cognitive, social, and system principles all influence the practice of CBT.

CBT began with a commitment to conducting research on the efficacy and effectiveness of its interventions. The gold standard for such research

is the randomized clinical trial, but single-subject designs and meta-analytic reviews of interventions and treatments of diagnostic and clinical problems also remain a hallmark of CBT. Adherents to CBT have been responsible for setting the criteria for empirically supported treatments (ESTs). A task force of scientists (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006) set the criteria for the degree and type of scientific support necessary for an intervention to be classified as an EST. Based on reviews of research, two websites identify the interventions that meet these criteria. ESTs for adults are posted and revised online by the Society of Clinical Psychology (Division 12 of the American Psychological Association), and treatments for children and adolescents appear on a website maintained by the Society for Child and Adolescent Clinical Psychology (Division 53 of the American Psychological Association).

In addition to a commitment to research, the original behavior therapists held the following assumptions or values that served as the basis for the field (Fishman, 2016) and are adhered to by the other two branches (DiGiuseppe, David, & Venezia, 2016; Follette & Hazlett-Stevens, 2016). These basic principles included the following:

- All humans learn and maintain normal and abnormal behaviors by the same learning and psychological principles.
- Abnormal behavior can be altered or changed through the scientifically established principles of social learning, including operant learning, classical conditioning, cognitive appraisal, and learning new responses to stressors. These principles are discussed in the other chapters of this book.
- Assessment of clients' problems is a continuous process that informs case formulation, diagnosis, and the monitoring of clinical progress.
- Change methods are clearly identified in a manner that can be replicated by any other professional and objectively evaluated.
- Outcome measures focus on behavior change in the real world and its generalization across multiple situations and time.
- Treatment plans are individually crafted to the particular characteristics of the client after a functional assessment of the problem.
- The client and the counselor jointly decide on the treatment goals and methods.
- The client's goals are described in terms of concrete behaviors and emotions and not by hypothetical or theoretical constructs.
- Practitioners evaluate clients' strengths and try to decrease clients' problems through increasing behaviors that are incompatible with clients' problems.
- Change usually takes place in small steps.
- Flexibility in responses is associated with coping and personal growth, and interventions usually focus on multiple adaptive behaviors.
- The stimuli that precede maladaptive behaviors create connections that need to be changed.

- The consequences of a behavior are a powerful influence on the continuation of the behavior.

CBT practitioners share these assumptions. However, several other theoretical ideas have been added that reflect the contributions of Beck and Ellis via the cognitive revolution in BT. These were clearly identified by Dobson (2010) and DiGiuseppe, Doyle, Dryden, and Backx (2014) as follows:

- Cognitive activity affects behavior.
- Cognitions can be monitored and altered.
- Desired emotional and behavior change can occur through cognitive change.
- The active rehearsal of new incompatible adaptive cognitions to counter maladaptive cognitions affects change. CBT differs from psychodynamic therapy in believing that insight into the relationship between thoughts and emotions or into the irrationality or incorrectness of thoughts is usually not sufficient to bring about desired change.

These last four points represent the most controversial assumptions in the models presented in the following chapters. You are advised to pay close attention to how the models adhere to these assumptions. Some models, such as Ellis's REBT, Beck's CT, and Arnold Lazarus's MMT, adhere to these positions. Steven Hayes's ACT and the mindfulness perspectives see cognitions as stimuli that preceded the disturbed emotions and behaviors. The third-branch therapies of CBT are less concerned with changing the content of clients' thoughts and instead work on breaking the connections between clients' thoughts and behaviors. The goal is to establish new connections between thoughts and a new set of behaviors. BT and DBT change the content of thoughts or the relationship between thoughts and behavior depending on what might work for that client.

The Therapeutic Relationship in CBT

CBT differs from other theoretical orientations in that it does not claim that the therapeutic relationship is a causative factor that helps clients improve. It does not posit that acceptance by the counselor is a curative component of treatment or that an analysis of the client's relationship with the counselor is necessary for change. Because of this lesser emphasis on the therapeutic relationship as a curative factor, many professionals assume that CBT practitioners do not focus on the relationship or work to foster a strong connection between the therapist and client. Nothing can be further from the truth.

The source of this misperception goes back to a debate between Rogers (1950, 1957) and Ellis (1948/2000, 1959, 1962). Rogers (1957), in his client-centered therapy approach, proposed that unconditional acceptance

by the therapist was a necessary and sufficient condition for human therapeutic change, a position he held for some time. By *necessary,* Rogers meant that change could not take place without unconditional acceptance; by *sufficient,* Rogers meant that unconditional acceptance alone was all that was required for change. Ellis (1948/2000, 1959, 1962) responded by suggesting that unconditional acceptance was neither necessary nor sufficient for human change. It was not necessary because many people changed without it, often through engaging in bibliotherapy, attending lectures, modeling friends, or numerous other experiences. Ellis contended that unconditional acceptance could not be sufficient because many clients experienced unconditional acceptance from their psychotherapists and still failed to change. It is notable that Ellis (1962) concluded that although he thought that unconditional acceptance by therapists was neither necessary nor sufficient for therapeutic change, it was still important. Without attaining a close relationship, the client would most likely not listen to the therapist and fail to benefit from other therapeutic methods.

Jacques Barber (personal communication, August 20, 2015), a psychodynamic clinician, made an interesting observation about the role of the therapeutic relationship in CBT. He noted that the founders of CBT, theorists such as Aaron Beck, Albert Ellis, George Spivack, Marvin Goldfried, and Walter Mischel, were originally trained in the psychodynamic tradition. They learned how to establish and use the therapeutic relationship. However, they went on to develop new theories and did not write about this aspect of their work in the first generation of textbooks on CBT. The second generation of CBT therapists, people such as Arthur Freeman, Marsh Linehan, and Raymond DiGiuseppe, were trained by the first generation of CBT theorists, who modeled how to form good therapeutic relationships, but still did not lecture or write about the therapeutic relationship. The first and second generations focused on emphasizing how their theories differed from client-centered and psychodynamic approaches. The third generation of CBT practitioners might have failed to learn about forming good therapeutic relationships, as it was not part of the curriculum. This has now changed. Those who write about and demonstrate all forms of CBT explicitly teach the importance of developing a strong therapeutic relationship (DiGiuseppe et al., 2016; Fishman, 2016; Follette & Hazlett-Stevens, 2016). Although CBT believes in the notion of establishing a good relationship, many CBT theorists take the position that a good relationship is necessary but not sufficient for change (J. Beck, 2011; Brady, 1980; DiGiuseppe et al., 2014; Persons, 2008).

Closely tied to the establishment of a good therapeutic relationship is the concept of unconditional self-acceptance, which has become a central tenet of all forms of CBT. Although the importance of unconditionally accepting the client is crucial, it would be quite hypocritical to believe that clients have to accept themselves and others and yet the therapist is not expected to model and display the same acceptance. Thus, it is important

that not only clients but also therapists acknowledge the existence of their own faults, negative thoughts, and uncomfortable emotions without condemning themselves.

The active and directive nature of CBT also leads some to believe that CBT does not place importance on the therapeutic relationship. Modern research on the therapeutic relationship refers to the importance of the relationships as the therapeutic alliance. This concept is a multidimensional construct and includes (a) agreement on the goals of therapy, (b) agreement on the tasks of therapy, and (c) an emotional bond between the client and therapist. Research dating back more than 40 years has demonstrated that behavior therapists establish as strong or stronger therapeutic relationships with their clients compared to psychodynamic therapists (Sloan, Staples, Cristol, & Whipple, 1975). However, the myth about the lack of attention paid to the development of the therapeutic alliance has persisted. Using a measure based on Carl Rogers's model of the therapeutic relationship, DiGiuseppe, Leaf, and Linscott (1993) countered this claim. They found that clients receiving REBT/CBT had scores on therapeutic relationship scales that were equal to or greater than those reported by clients in all studies conducted using that instrument.

Factors Affecting the Therapeutic Relationship

It is common for a therapeutic alliance to rupture in CBT when clients are reluctant to engage in identifying or challenging their beliefs. Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) found that attempts to resolve the rupture by persuading clients of the validity of the cognitive rationale were *negatively* correlated with outcome. These interventions worsened the alliance and thus potentially interfered with client change. In contrast, successful strategies to repair the relationship included (a) inviting the client to explore the potential rupture; (b) offering an empathic response by expressing concern about the client's emotional reaction toward the therapist or therapy; and (c) disarming interventions, such as exploring and validating some aspects of the client's perception of the therapist's contribution to the rupture. After discussing the rupture in the alliance, therapists can continue applying CBT techniques.

Clients' motivation is another factor that can affect the therapeutic alliance. Specifically, people seeking counseling have differing attitudes toward change. The stages of change model (Norcross, Krebs, & Prochaska, 2011) identifies attitudes toward change along a continuum from not thinking one needs to change (the precontemplative stage) to thinking one is ready to take concrete action (the action stage). CBT is most useful when clients have reached this action stage of change because by nature CBT represents a set of action stage interventions. Unlike psychodynamic psychotherapy, CBT is not a treatment designed for exploration. Some CBT techniques such as behavioral activation or reinforcement sampling could be used to increase clients' motivation for change and move them to the

action stage. However, given CBT's predilection to action, asking clients to actively change their thoughts, feelings, and behaviors could cause a rupture or break in the therapeutic alliance if they have not reached the action stage and are ambivalent about change. Therefore, it is important to first assess clients' attitude motivation to change to prevent the possibility of a rupture in the alliance. Therefore, it is important to first assess clients' attitude motivation to change to prevent the possibility. If clients have not reached the action stage of change, CBT practitioners can first use motivational enhancement intervention until the clients are motivated to change (Miller & Rollnick, 2012).

Transference and countertransference can also impact the therapeutic alliance. *Transference* refers to clients acting toward therapists as they do with significant others in their lives, such as their parents. *Countertransference* refers to therapists' feelings and thoughts about clients that relate to their own personal issues and interfere with therapy. These concepts have been central aspects of psychodynamic therapy. Although CBT therapists do not believe that an analysis of transference is a necessary mechanism of change in psychotherapy, they regularly attend to transference and countertransference issues. Countertransference issues come up regularly in CBT supervision sessions (DiGiuseppe et al., 2014), even though empirical literature exploring the nature of countertransference in CBT does not appear to exist. Ellis (2001) noted that countertransference is almost inevitable and can have both beneficial and destructive effects. He described how CBT practitioners could make good use of countertransference. Several CBT theorists (DiGiuseppe et al., 2014; Leahy, 2012) have speculated that countertransference can arise more often in active, directive psychotherapies, such as CBT. For example, when a client presents an emotionally charged issue, a therapist using a less active approach would perhaps avoid dealing with the issue. However, when following CBT protocol, counselors confront or restructure the upsetting thought, belief, or schema even though they might find this upsetting.

The Status of CBT in Counseling and Psychotherapy

The origins of BT date back to the 1950s with the development of Wolpe's (1958) book *Psychotherapy by Reciprocal Inhibition* and the founding of the University of London's Maudsley Hospital under Hans Eysenck. The first use of the term *CBT* occurred at the First Conference on Cognitive Behavior Therapy in 1976, hosted and funded by the Albert Ellis Institute (Hollon & DiGiuseppe, 2011). Presently CBT has become a major force in counseling and psychotherapy. CBT has many specialty journals dedicated to theory, practice, and research; articles on CBT appear in the most prestigious journals in counseling, clinical and counseling psychology, and psychiatry. Andersson and colleagues (2005) noted that CBT is acknowledged as an effective intervention for almost all psychiatric conditions and numerous somatic conditions and that it is difficult to find a psychological prob-

lem for which the efficacy of CBT has not been tested. For many conditions, CBT has become the treatment of choice. The commitment to research has fostered this legacy of CBT as a successful form of psychotherapy.

CBT has evolved into a major and the most popular theoretical orientation to psychotherapy among practitioners and faculty members. A Delphi poll of counseling and psychotherapy experts rated CBT as the most likely form of psychotherapy to increase in popularity by 2022 after eclectic/integrative approaches, which emerged as most likely to increase in popularity (Norcross, Pfund, & Prochaska, 2013). When writing this chapter, we conducted a PsycINFO literature search for the term *CBT* in the abstract. We uncovered 8,562 citations, which is evidence that CBT has attained a predominant position in the field of academic counseling as well as in the psychotherapy literature. This research emphasis garnered the support of CBT in the academic community, particularly among academic scholars who seek university positions and then train new generations of mental health professionals.

Several factors could account for the ascendance of CBT. First, advocates of CBT emerged from BT that strongly valued research. Using randomized clinical trials to test treatments has always been a hallmark of CBT because this type of research has strongly influenced the conversation about the effectiveness of counseling and therapy among academics, practitioners, the public, and governments. The major professional organization for CBT, the Association for Behavioral and Cognitive Therapies, continually provides resources to disseminate knowledge and practice of CBT interventions to all mental health professionals (DiGiuseppe, 2007). The dissemination of CBT has been extended to include training of primary health care providers such as nurses and physicians (Mathieson et al., 2013). Second, CBT theorists stated their hypothetical construct in definitions that promoted the measurement, testing, and falsification of their theories. The hypothetical constructs identified by CBT theories were more easily turned into self-report measures than the constructs of psychodynamic theories. Automatic thoughts, underlying schemas, irrational beliefs, cognitive flexibility, defusion, and social problem-solving skills all spawned self-report measures that assess clients' thinking and test the models of CBT, helping counselors and therapists assess what to target in therapy and how to assess change in these constructs over the course of treatment.

Third, all types of CBT prescribed relatively brief and structured treatments that easily fit into the cost-effective, managed care, and evidence-based zeitgeist of the past several decades. Fourth, the structured nature of CBT theories and the clearly identifiable skills then makes them easy to teach; many treatment manuals are available to guide the training of practitioners and graduate students. CBT interventions are simple enough that live or video demonstrations of sessions can illustrate the techniques to practitioners.

Fifth, CBT has achieved an integration of psychodynamic psychotherapy's focus on the internal experience, early BT's focus on observable behavior, and the focus of client-centered therapies on forming therapeutic relationships. Focusing on clients' present and conscious thoughts, emo-

tions, and behaviors allows counselors to access internal experiences and thoughts about past harmful events while at the same time maintaining the goals of assessing and changing something observable. The focus on both stream-of-consciousness thoughts and tacit, underlying beliefs and schemas provides insights into the deeper aspects of clients' personalities. Attaining a good working alliance with clients allows them to experience a healthy relationship with a helping professional. This integrative aspect of CBT allows practitioners to focus on the best aspects of the psychodynamic, humanistic, and behavioral methods.

Sixth, strong personalities have historically dominated the field of counseling and psychotherapy. Charismatic personalities developed most variants of CBT. Each of them were inspirational speakers and teachers, innovative theorists, compassionate therapists, leaders of professional organizations, and recipients of prestigious awards.

In 2009 Cook, Biyanova, and Coyne surveyed more than 2,400 North American psychotherapists and counselors and asked them to identify the most prominent figures in the field of psychotherapy and counseling. Although Carl Rogers continued to hold the position as the most prominent theorist, the next two of the top 10 represented CBT, with Aaron Beck second and Albert Ellis third. We predict that if that study were replicated now and data collection extended beyond North America, more CBT scholars would be added among the top 10 most influential theorists.

CBT has strongly influenced the professional education of mental health professionals. CBT is the predominant psychotherapy theoretical orientation for faculty teaching in clinical psychology doctoral programs (Levy & Anderson, 2013). The dominance of CBT has not been as extreme among the faculty of counseling psychology doctoral programs. However, most (43%) of the faculty in this field identify with CBT, whereas only 28% identify with the humanistic orientation, 21% identify as systemic theorists, and only 19% report an allegiance to the psychodynamic paradigm (Norcross, Evans, & Ellis, 2010). In the past decade, CBT has also made substantial inroads into psychiatric residency programs because of medicine's commitment to empirically based practice in general and to the larger research literature supporting CBT. However, psychodynamic training remains the most popular orientation in psychiatry (Sudak & Goldberg, 2012). No such data exist for faculty in mental health counseling or social work programs, although given the increased popularity of CBT, it is likely that there is growth in these programs as well.

The History of CBT

When CBT emerged, psychoanalytic therapy dominated the field and Rogerian client-centered therapy was a close second. As noted previously, the first generation of CBT therapists based their work on the learning theories of Pavlov and John Watson (Martin & Pear, 2015). They believed that humans learned maladaptive behavior and emotional reactions from learning