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Cognitive therapy across the lifespan: conceptual horizons

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Important advances have been made in the field of cognitive therapy during the past 30 years, and numerous books have been published describing the application of these models to a range of clinical problems and populations. The ascent of cognitive therapy has been rapid and, in many ways, quite remarkable. It has become an integral part of training in psychiatry and clinical psychology, and has emerged as a dominant paradigm for understanding psychopathology and psychosocial intervention. Even a brief perusal of the contents of contemporary journals attests to the strength and breadth of these approaches.

How did this come about? Cognitive therapy emerged during the late 1950s and early 1960s as the result of the convergence of several historical trends (Mahoney, 1991; Clark and Beck, 1999; Dobson and Dozois, 2001). These included: (1) a growing recognition of the importance of information-processing models in linguistics and experimental cognitive psychology; (2) the publication of studies supporting mediational models of human adaptation, and the emergence of social learning theory as a paradigm for understanding the development of psychopathology; (3) a growing dissatisfaction with traditional drive models of human motivation and the dearth of empirical support for the effectiveness of psychodynamic forms of psychotherapy; and (4) a recognition of limits of classical behavioral models for understanding human development. Cognitive therapy emerged, then, in response to social needs, and as a result of a growing recognition of the limitations of existing models. Its development was supported by the availability of social tools or resources – in this case, experimental methodologies for putting models and treatments based on them to the test, philosophical support for the role of linguistic symbols and cognitive constructs as mediators of human behavior, and a need to develop more effective treatments for specific disorders, such as major depression. It is likely that cognitive therapy, as a paradigm for understanding psychopathology

and psychotherapy, would not have emerged in its present form had these historical trends, social needs, and empirical resources not converged.

Cognitive therapy, then, is a product of its time. Its evolution during the years ahead will be determined by these same factors – the recognition of the limits of extant models, the press of social needs, and the availability of new tools for addressing these shortcomings. A goal of this volume is to examine critically the shortcomings of current cognitive-behavioral models (both conceptually and in clinical practice), and to clarify the limits or bounds of extant theories – what George Kelly (1955) referred to as their "range of convenience." Related goals are to clarify social needs, and to note what emerging tools and resources might be used in addressing them.

Much of the current appeal of cognitive-behavioral therapy (CBT) stems from three factors – its intuitive simplicity, its reliance upon empirical methods for testing the validity of its models and the effectiveness of its treatments, and its clinical utility. These are not unimportant factors. Parsimony, empiricism, and clinical utility are values that have served the field of cognitive therapy well over the past 30 years – they should not be abandoned as models are developed to address a wider range of social concerns.

Cognitive theories of psychopathology and psychotherapy are founded upon a substantial base of experimental research regarding cognitive concomitants of emotional disorders (Dobson and Kendall, 1993; Clark and Beck, 1999). This reliance upon experimental methods for putting theories to the test and for documenting the efficacy of interventions has contributed to an ongoing process of "creative destruction" by which cognitive-behavioral models are made and remade, tested and refined.

The definition of cognitive-behavioral therapy

CBTs are based upon a simple proposition – that thought processes occur, and that they matter. As William James succinctly noted, "the first fact for us . . . is that some form of thinking goes on." This acknowledgment of the central role of cognition in human adaptation, though controversial at the time, was prescient. As research abundantly demonstrates, cognitive processes are implicated in many forms of psychopathology (Dobson and Kendall, 1993), and attempts to modify maladaptive beliefs and attitudes can ameliorate these difficulties. What, however, constitutes a CBT? Is any model that acknowledges the role of cognitive processes in human adaptation a form of cognitive therapy? Are there specific therapeutic strategies and techniques that are shared by alternative forms of CBT? Is cognitive therapy, in essence, defined by its therapeutic strategies and techniques? Are the various forms of CBT that have been developed during recent years similar in practice, and can

they be discriminated from other noncognitive forms of psychotherapy? Is cognitive change necessary and/or sufficient for behavioral and emotional improvement to occur? If it is not, then how does CBT exert its effects? These are questions which must be resolved if we are to understand the nature of cognitive-behavioral psychotherapy.

Kendall and Hollon (1979), in defining CBT, proposed that cognitive-behavioral models "attempt to . . . incorporate the cognitive activities of the client in the effort to produce therapeutic change." They are suggesting, as such, that a defining feature of CBT is the explicit focus on promoting cognitive change as a means of bringing about clinical improvement. This is consistent with the view that cognitive processes play a central role in the etiology and treatment of behavioral and emotional disorders. As Dobson (2001) stated, "in order for a treatment to be labeled a cognitive-behavioral therapy, it must be based on the mediational model. A therapist using this model is presumed to make the assumption that cognitive change will mediate or lead to behavioral change. . . . [they] use treatment methods to effect cognitive change in the service of behavioral change"(p. xii).

Dobson and Dozois (2001) proposed that all forms of CBT share three assumptions: (1) that cognitive activity affects behavior; (2) that cognitive contents and processes may be monitored and changed; and (3) that behavioral (and emotional) change may be affected through cognitive change. Other authors have, during recent years, suggested that alternative forms of CBT share additional assumptions as well. Freeman and Reinecke (1995), for example, observed that cognitive-behavioral models implicitly assume that the processing of information is active and adaptive, and that it allows individuals to derive a sense of meaning from their experiences. They noted, as well, that cognitive-behavioral models assume that belief systems are idiosyncratic, and that incoming information is typically assimilated to existing belief systems. Finally, they noted that cognitive-behavioral models assume that clinical disorders can be distinguished on the basis of specific belief (cognitive contents or products) and information-processing strategies (cognitive processes). Additional assumptions of cognitive therapy have been described by Clark and Beck (1999). Whether a model, clinical strategy, or technique may be viewed as a form of CBT depends on whether it is consistent with these assumptions. To the degree that models and techniques diverge from these assumptions, they will be seen as incompatible with cognitive-behavioral theories of psychopathology and change.

CBTs are not, from this perspective, defined by their techniques or by the strategies and technologies of change. Any intervention that brings about cognitive change as a means of facilitating behavioral and emotional change may be considered a form of cognitive therapy. Moreover, any model that explicitly acknowledges the mediating (or moderating) role of cognitive factors in human adaptation may be viewed as a variant of CBT. CBT may be viewed as a family of models, with alternative forms

sharing all, many, or few of the fundamental assumptions of the theory. There is, as such, no bright line or critical feature (save the acknowledgment of the central role of cognitive mediation in human adaptation) that discriminates cognitive-behavioral theories and forms of treatment from those that are not. Models may be more or less similar to the exemplar (the Beck standard model of therapy for depression) depending upon how many of the fundamental assumptions of the model they incorporate. Finally, it is worth acknowledging that cognitive models do not assert that the only pathways to psychopathology involve cognitive vulnerability, or that the only mechanisms of change are cognitive in nature. Rather, they acknowledge that human adaptation and psychopathology are multiply determined. Most psychiatric disorders are multifactorial in origin, and risk factors for them often involve dimensional factors that operate within both the normal and abnormal range. Cognitive models are entirely consistent with contemporary research in developmental psychopathology indicating that environmental, biological, social, personality, and cognitive factors interact in contributing to individual patterns of psychopathology and behavioral maladaptation. Understanding the ways in which these factors interact over time stands as a important challenge for the field.

Efficacy of cognitive-behavioral treatments

Controlled-outcome studies suggest that therapies based upon these assumptions can be efficacious in treating a number of behavioral and emotional problems (Chambless et al., 1996; Nathan and Gorman, 1998; Strunk and DeRubeis, 2001). Cognitive-behavioral models have, over the years, been found to be clinically useful. Cognitive-behavioral treatment guidelines are typically presented in the form of manuals specifying procedures and techniques in a fairly prescriptive manner. There have been, to date, over 325 outcome studies completed examining the effectiveness of CBT (Butler and Beck, 2001). Although studies vary with regard to their methodological rigor, and long-term outcome studies are few, trials completed to date suggest that cognitive-behavioral interventions can be quite effective in treating a number of disorders and conditions. They have consistently been found to be more effective than no treatment in treating mood and anxiety disorders, and have been typically found to be as effective as alternative psychosocial and pharmacological interventions. As a consequence, cognitive therapy has been designated as an "empirically supported" or "well-established" treatment for a number of disorders, including major depression, panic, obsessive-compulsive disorder, and social anxiety (Chambless et al., 1996).

To be sure, the recent development of cognitive-behavioral treatment manuals and a literature on empirically supported forms of treatment has proven controversial (Fensterheim and Raw, 1996; Silverman, 1996; Addis, 1997; Nathan, 1998;

Addis et al., 1999). Concerns have been raised that these approaches are conceptually narrow, that they encourage rigid, formulaic treatment which does not attend to the needs of individual patients, that cognitive-behavioral approaches do not recognize the central importance of the therapeutic relationship as a facilitator of clinical improvement, and that methodologies for demonstrating the efficacy of treatments are biased in favor of problem-focused treatments, such as CBT. Many of these concerns are not entirely without merit. It is worth acknowledging, none the less, that the objectives of work on empirically supported treatments – to develop efficacious interventions, to evaluate the relative effectiveness of alternative treatments for specific clinical problems, and to disseminate information on effective interventions to clinicians in the community – are entirely reasonable. We have an obligation, as clinicians and scholars, to be accountable to our communities by attempting to develop effective treatments, by demonstrating their utility, by acknowledging their limitations, and by training our students accordingly. Although discussions of research into empirically supported psychotherapies have been spirited, a number of larger issues have not been addressed. Treatment manuals are typically developed so that the efficacy of standardized forms of treatment can be examined. What other functions do these manuals serve, and why have they become so prevalent at this point in time? Can these manuals assist us in better understanding the nature of the therapeutic relationship, and the ways in which relationship variables and therapeutic techniques affect treatment outcome? Finally, should treatment manuals be seen as guides for formulating cases and developing strategic treatment plans, or as proscriptive lists of techniques to be introduced in a regimented manner? These are important issues. They are issues that form the core of why treatment manuals have proven controversial.

Treatment manuals, assessment-driven treatment protocols, and best-practice guidelines have proven useful in many areas of medicine, including cardiology and oncology. Despite the increasing availability during recent years of manuals, guidelines, and protocols for empirically supported forms of psychotherapy, it is not at all clear that practitioners actually use them, or if they do, that they follow the manual as intended. Many of these programs, though effective, are not regularly used in everyday practice. Many clinicians do not like structured guidelines or protocols. They are seen as too inflexible and too tied to theories they find unacceptable. Why might this be? As Beutler (2000) observed, clinicians tend to give greater weight to their personal opinions and beliefs than to empirical evidence when making clinical decisions. Beliefs and personal experience are given credence and, when supported by others, are taken as evidence for the validity of their clinical approach. Adopting and effectively implementing something as broad and complex as an empirically supported treatment protocol, as such, can be daunting. It requires support, training, an openness to innovation, and an ability to set aside one's

beliefs and preexisting clinical opinions. As Beutler (2000) succinctly stated, efforts to encourage the use of empirically supported treatments "ignore the unrealistic assumption that practitioners will willingly and easily forsake their own experience and preferences, that they will efficiently learn many different and contradictory methods . . . and that once these skills and techniques have been learned, they will continue, unaffected, indefinitely." Changing clinicians' behavior, as such, can be as complex and challenging as changing that of our patients. Empirically supported treatments, such as CBT, have true potential. The value of empirically supported treatment protocols for psychiatry and clinical psychology, and the ways in which they will influence clinical practices and the culture of psychotherapy, are only now becoming apparent.

The bounds of cognitive-behavioral theory

Although CBTs were developed as models of psychopathology and psychotherapy, need they be limited to these domains? What, for example, is the relationship of CBT to rational, postrationalist, and poststructuralist models currently used in such diverse fields as economics, political science, literature, history, and cultural anthropology? These are important questions in so far as they direct our attention to identifying the defining features of cognitive-behavioral theories and therapies, and to identifying the limits of our models. They direct our attention, as well, to issues, questions, and problems that are just beyond this boundary.

CBT has traditionally relied on quantitative research methods to put its models to the test and to examine the efficacy of treatments based on them. There is now a strong movement in psychology advocating the value of qualitative research methodologies and questioning the legitimacy of concepts such as objectivism, validity, empiricism, and scientific neutrality. This postrationalist tradition traces its lineage not to the view of psychology and psychiatry as sciences (based on the German experimental laboratory ideal and Lockean or Democritan models), but to the French ideal of *la clinique* in which all interventions had to be demonstrated as effective with individual patients, at the bedside, before they could be accepted as scientifically validated, and to Kantian or Platonic models. Postrationalist models are often associated with postmodern schools of thought, and are most clearly apparent in cognitive-constructivist theories of psychopathology and psychotherapy. How the field of cognitive therapy will evolve as postrationalist understandings are applied to an essentially rationalist model is not yet clear.

Cognitive formulations based upon the assumptions of cognitive therapy – that cognitive activity (broadly conceived) affects behavior, that cognitive contents and processes may be monitored and changed, and that change may be effected through cognitive processes – may usefully be applied to a range of issues and concerns

outside clinical psychology, psychiatry, and social work. Cognitive and perceptual processes, many of which appear, at first glance, to be irrational or maladaptive, appear, for example, to play a role in economic and political decision-making. These observed limits on human rationality have profound philosophical and social implications (Gigerenzer and Selten, 2001; Searle, 2001) and are worthy of exploration from a cognitive-behavioral perspective. In a similar manner, shared beliefs, attitudes, expectations, goals, attributions, and values (many of which may be tacit or unstated) may serve as a foundation for cultural identity. This view is consistent with a strong cognitive research tradition in social psychology that looks at culture from a cognitive perspective. Culture may be understood from a cognitive perspective as a set of shared tacit beliefs, attitudes, expectancies, and values that characterize a group, along with cultural "products" derived from these beliefs. These would include the art, music, architecture, and social or political institutions developed by the group. Culture, as a set of stable, shared beliefs, will have an influence on social patterns and adaptation. There may, as such, be links between culture, cognition, and mental health. It would not be implausible to hypothesize that cognitive processes may influence cultural assimilation and the ways in which groups with differing tacit beliefs interact.

Goals of this book

Although CBTs enjoy wide acceptance and are supported by an impressive body of empirical evidence, there are a number of unresolved concerns and issues. One goal in developing this book has been to provide a broad and critical examination of the field of cognitive therapy and the historical context in which the model evolved. Few articles or chapters have attempted systematically to identify weaknesses of the models and obstacles to developing more effective cognitive approaches for understanding and treating clinical disorders (Segal, 1988; Haaga et al., 1991; Segal and Dobson, 1992; Robins and Hayes, 1993; Clark and Steer, 1996). It is unclear, for example, that cognitive factors associated with various forms of emotional distress are specific to the disorder in question, or that they serve as vulnerability factors for the development of the condition. Moreover, it is also not clear whether relationships exist between changes in proposed mechanisms and clinical improvement. The ways in which social, biological, environmental, and cognitive factors interact over time in contributing to vulnerability for psychopathology are not well understood (Rutter, 1996; Ingram and Price, 2001), and the role of emotion in CBT is deserving of additional study (Lazarus, 1991; Safran and Greenberg, 1991; Samoilov and Goldfried, 2000). Cognitive processes are often viewed as static – the depressed individual, for example, may be viewed as possessing a relatively stable set of maladaptive beliefs, attitudes, attributions, and cognitive biases which will be

the focus of treatment. More recent clinical and theoretical formulations, however, have focused upon understanding the individual in context. An emphasis is placed on understanding the individual's social environment and the ways in which this intersects with cognitive factors in maintaining and exacerbating his or her distress (Joiner, 2000). Familial influences on adaptation and the ways in which culture and history influence individuals' understanding of themselves, their relationships with others, and their mood represent new arenas for development in CBT. This research will be of both theoretical and practical importance as it may inform the development of cognitive-behavioral primary and secondary prevention programs (Jaycox et al., 1994; Clarke et al., 1995; Hannan et al., 2000).

An explicit goal in developing this volume, then, has been to review the current status of cognitive-behavioral models for understanding and treating clinical problems, to identify weaknesses in the theoretical and empirical literatures surrounding these approaches, and to suggest strategies for resolving these obstacles. We have asked our authors to identify emerging themes and issues in the literature. Although empirical papers and reviews regularly conclude with a call for additional research, these needs are rarely specified. Our authors have been encouraged to recommend specific areas in need of exploration and to suggest novel approaches for addressing intransigent clinical and conceptual issues. We asked each of our contributors to address several specific questions. These included: (1) What are the primary unresolved issues or questions confronting the field? (2) What are the most important trends as you review the recent development of the field? (3) What specific areas, issues or problems are most in need of investigation? and (4) What strategies might be employed to address these issues?

CBT is a rapidly evolving field. Although many writers cite the original Cognitive Therapy of Depression treatment manual (Beck et al., 1979) as a touchstone for understanding cognitive-behavioral interventions, the model and therapy have evolved dramatically since that time in both scope and sophistication. With this in mind, our contributors were encouraged to emphasize research focusing upon more recent models and interventions.

Many principles and techniques of CBT, once considered revolutionary, have now been assimilated into other forms of therapy. Maintaining a trusting collaborative therapeutic relationship, educating patients about their difficulties and providing a rationale for treatment, developing a shared vocabulary for understanding their concerns, therapeutic activity, maintaining a structured and problem-focused therapeutic stance, developing coping skills, providing feedback and support, facilitating the development of feelings of hope and personal efficacy, and conducting a developmental examination of the origins of maladaptive beliefs and interpersonal styles are widely accepted clinical strategies. As Rehm (1995) cogently observed, many forms of effective psychotherapy share these characteristics. Like dynamic

concepts of unconscious motivation and person-centered notions of therapeutic rapport before them, cognitive-behavioral procedures are being accepted as an integral part of contemporary clinical practice. As we have seen, however, there are many unanswered questions, and a range of issues which have simply not been addressed.

If there is a difficulty in contemporary scholarship it is not that we think too broadly, but too narrowly. Specialization and hyperspecialization are valuable both for developing academic careers and for refining our conceptual models. They do so, however, in a tedious, incremental manner. Clinical scholars tend, as a group, to crawl along the frontiers of knowledge on all fours, magnifying glass in hand. We rarely lift our heads to see the wide vistas before us. Our subject matter – human development, adaptation, emotion, the making of meaning, and the amelioration of human suffering – is important, engaging, and noble. Too often, however, our discussions are reduced to debates regarding conceptual minutia, the psychometrics of specific instruments, and details of research methodology. To be sure, these are important issues. They are not, in the final analysis, the *most* important ones. They rarely yield paradigmatic shifts or rapid gains in understanding. Our goal, in this book, was to encourage our contributors to lift our eyes to the broad vistas before us. What are the strengths and limitations of our models? What are the strengths and limitations of our clinical approaches? How can we understand our field from historical and cultural perspectives? What are the most important opportunities for interdisciplinary scholarship? Where, looking toward the horizon, should we be heading?

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