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Introduction and the Context of Cognitive-Behavioral Interventions

Cognitive-behavioral therapy is one of a vast array of models of psychotherapy, but it has received considerable attention in recent years because of its strong evidence base and its match to some of the current realities of health care systems around the world. In this chapter, we introduce some of the principles of cognitive-behavioral therapy and discuss both the historical and current context for the development and promotion of this approach. We argue that cognitive-behavioral therapy is an approach to psychotherapy that fits with the current social and cultural demands of the mental health field. Finally, we introduce the general content and approach of the following chapters.

Cognitive-behavioral therapy has broad evidence as a powerful intervention for mental health problems in adults, and interest in this approach to psychotherapy has grown dramatically. A 2015 search of publications in the database PsycINFO using the keywords “Cognitive-behavioral therapy” demonstrated an almost exponential growth of the field in the period from 1980 to 2014 (see Figure 1.1). Many books have been published in the field, from both research and practical perspectives. Cognitive-behavioral treatments have a strong empirical base, and many practitioners around the world are trained with an emphasis on evidence-based health care.

Given the wide support for and training in cognitive-behavioral therapy, why did we write another book for clinicians and trainees on a type of treatment that has been widely described in both the academic and popular press? Consistent with some of our colleagues (Goodheart, Kazdin, & Sternberg, 2006; Layard & Clark, 2014), we believe that the

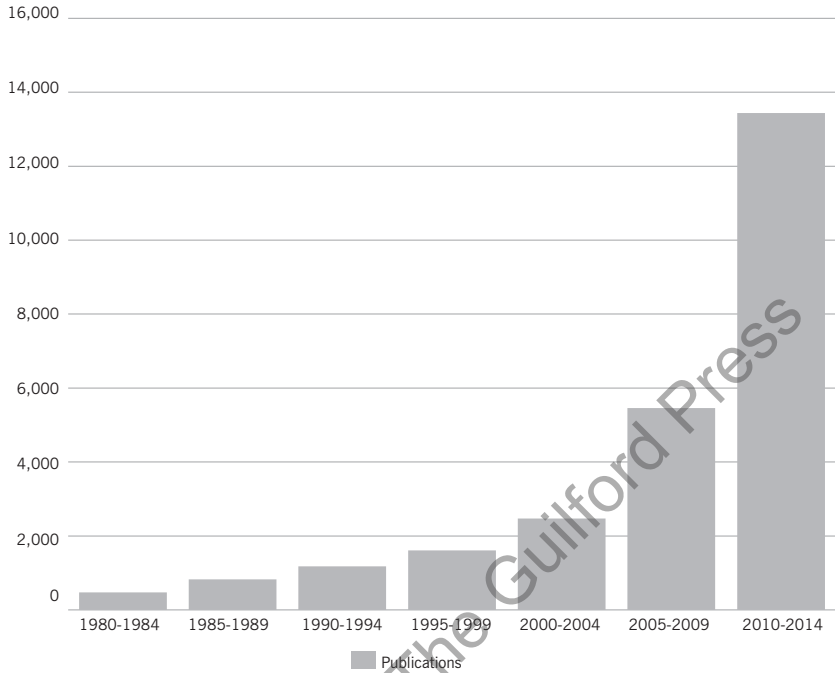


FIGURE 1.1. Increases in cognitive-behavioral therapy publications in the literature.

bridge between science and practice requires more traffic. Many books are written from either a science or a practice base, and few travel in both directions across that bridge. While the cognitive-behavioral model provides an underlying value system that encourages the utilization of current research findings in practice, it is exceedingly difficult for most practitioners to be aware of the research literature in all the areas in which they may provide treatment. As a practitioner in a busy setting, you may wonder how to keep up with the literature. This edition of this volume is our effort to update recent literature, identify changes in practice, and reinforce the bridge being steadily built toward evidence-based practice.

This work is part of our effort to build a stronger bridge between science and practice, one that we hope will be useful in your practice as a clinician. We are in a unique position to provide such a bridge because we bring experience from both of these sides of the discipline of cognitive-behavioral therapy. We hope that information about empirical outcomes and the methods you can use to translate this knowledge into practice will help you in day-to-day work with not only clients but also the sys-

tems within which you practice. Understanding empirical research and using it to bring the art and practice of psychotherapy into the scientific realm are desirable goals for the provision of optimal services to clients.

While evidence-based practice requires a foundational scientific literature, it is also important to underpin the practice of cognitive-behavioral interventions with clinical observations. Our first goal is to bridge science and practice in a bidirectional fashion. Where we can, we present the available scientific evidence regarding the use of cognitive-behavioral therapy for various problems, and in various settings. We also identify gaps in our knowledge from clinical practice. We hope that interested readers and future researchers will pursue these knowledge gaps in the field. As cognitive-behavioral therapy becomes more widely practiced, it is critical that research-based adaptations of the model expand the approach to various cultures around the world, and to the treatment of various problems and populations within our local communities.

A second goal for this volume is to distill the principles of cognitive-behavioral interventions from the literature and to provide practical guidelines for their application in a wide variety of contexts. Many cognitive-behavioral treatment manuals have been written, often for increasingly specific diagnostic categories of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) of the American Psychiatric Association (2013). Typically, these manuals have been developed in a rigorous way and tested on carefully selected clients in specialty clinics. There is a great deal of overlap among cognitive-behavioral treatments for different diagnostic disorders. Yet, in practice, the majority of clients have multiple problems or comorbidities, which may or may not respond fully to the treatments offered in the manuals. What if a client presents with two or more simultaneous disorders; which problem should be addressed first in therapy? What should a clinician do if the client chooses not to work on any of the diagnosable problems? These problems may include subclinical or nondiagnosable problems such as low self-esteem, sleep disturbance, problems of daily adjustment, and interpersonal difficulties. They may also include contextual problems, such as poverty, inadequate access to health care, and family violence. Finally, although diagnosis may offer the clinician an important understanding of a set of symptoms, the client may be more concerned about other aspects of his or her life such as interpersonal relationships or career advancement.

Given these considerations, we offer a broad perspective on cognitive-behavioral therapy that is not tied to diagnosis or even to a particular set of problems. While the provision of a diagnosis may be an administrative requirement, or may even be essential for the client to receive funded services, diagnosis is not necessarily a critical feature of either cognitive-behavioral assessment or case conceptualization. In fact, whereas the use

of diagnostic labeling may be common in some settings, it may not be used to treat clients in other settings, which can also make it difficult to know how to apply manuals. Most practitioners do not work in specialty clinics, and most clients want help with multiple problems.

Cognitive-behavioral treatments have a number of common elements that can be adapted for use with many different problems, and it is useful for clinicians to learn these common elements in their practice and how to adapt them for more challenging situations or clients as needed. Thus, our perspective on the treatment of mental health problems is broad. We hope that it will be helpful to many clinicians to have our current distillation and description of the essential features of cognitive-behavioral treatments for adults. This book is primarily oriented toward the use of cognitive-behavioral therapy with individual adults. Although we appreciate the strong results that some forms of group, couple, or family cognitive-behavioral therapy have attained and recognize that limited resources in some settings conspire against individual therapy, the practice of cognitive-behavioral therapy is largely one of individual treatments.

This volume provides guidelines for cognitive-behavioral practitioners in different settings with “typical clients.” These clients may have problems with anxiety, depression, relationships, or adjustment to change, or simply with living. They may use too many substances and have self-destructive habits or poor lifestyle balance. They may struggle to make decisions about intimate relationships, their careers, or whether or not to have children. They may report being dissatisfied with their jobs or simply unhappy with their lives. They are likely to be worried and to be looking for relief from their concerns. They have probably tried out their own intuitive ideas to solve their problems, and either had limited or no success, so they are likely frightened, anxious, and/or discouraged. These are the types of problems that clients present to their therapists. Cognitive-behavioral interventions can be very helpful for a wide variety of problems. It is important for clinicians to be flexible in their application of treatments to maximize client outcomes and satisfaction. Therefore, another goal of this book is to help clinicians learn to assess and understand their clients’ problems using clinical case formulation, and to make decisions about interventions.

Finally, context matters. The problems that people develop are within the contexts of their lives and the social systems with which they interact. We also practice within certain contexts or systems, and these factors make a significant difference in how we treat our clients. If funding models for health care are limited, then treatment is likely to be brief, even for people with severe problems. If the health care system reduces or eliminates hospital beds, then outpatient community-based care will become

the standard for treatment. If our system does not support cognitive-behavioral interventions, we will be less likely to deliver them. Similarly, the time and the culture within which we practice no doubt affect society's approach to therapy. It is no coincidence that cognitive-behavioral therapy originated in Western cultures, and in particular, in those with a positive orientation toward science, a belief in logical positivism, and a general conviction that science can solve most of humankind's problems. Just as it is important to understand how our clients' learning history led to the development of their current strengths and problems, it is also important to have a perspective on the historical and cultural context of therapy itself. Various histories of cognitive-behavioral therapy exist (e.g., Dobson & Dozois, 2010), so the interested reader is encouraged to pursue this historical perspective. We now provide a brief review of the principles of cognitive-behavioral therapy, then consider some of the social and cultural factors that influenced its development and continue to influence our practices.

PRINCIPLES OF COGNITIVE-BEHAVIORAL THERAPY

Therapists often wonder about the relationships among various treatment approaches including “cognitive-behavioral therapy,” “cognitive therapy,” “problem-solving therapy,” “rational-emotive (behavior) therapy,” “interpersonal cognitive therapy,” “dialectical behavior therapy,” “acceptance and commitment therapy,” “schema therapy,” and the variety of other titles that have become associated with this broad approach to treatment. By way of a brief overview, and consistent with Dobson and Dozois (2010), we see the following three basic propositions, or principles, that cut across all of the treatments in the cognitive-behavioral therapy movement:

1. *The access hypothesis* states that the content and process of our thinking are knowable, or can be accessed. Thoughts are not “unconscious” or “preconscious,” or somehow unavailable to awareness. Rather, cognitive-behavioral approaches endorse the idea that, with appropriate training and attention, people can become aware of their own thinking.

2. *The mediation hypothesis* states that our thoughts mediate our emotional and behavioral responses to the various situations in which we find ourselves. The cognitive-behavioral model does not endorse the idea that people simply have an emotional response to an event or situation, or simply act without any cognitive processes, but rather, the model holds that the way that we construe or think about the event is pivotal to

the way we feel. Similarly, it is our cognitions or thoughts that strongly influence our behavioral patterns in various life situations. For example, we feel anxious only when we view a situation as threatening. When we have a “threat cognition,” we are also likely to attempt to escape the situation or to avoid it in the future, if possible. These thoughts, as well as the corresponding emotional responses and behavioral reactions, may all become routine and “automatic” over time. Even in cases where emotional and behavioral responses seem to be reflexive, though, cognitive-behavioral theorists argue that there is cognitive mediation between the event and the person’s typical responses in that situation.

3. *The change hypothesis*, which is a corollary of the two previous ideas, states that because cognitions are knowable and mediate our responses to different situations, we can intentionally modify the way we respond to events around us. We can become more functional and more adaptive as we come to understand our emotional and behavioral reactions and learn to deploy cognitive strategies systematically in service of our life goals.

In addition to these principles, the cognitive-behavioral movement also endorses a general philosophical perspective termed the *realist assumption* (Dobson & Dozois, 2010; Held, 1995). Although there are variations on this perspective within the cognitive-behavioral therapy movement, the general idea of the realist assumption is that a “real world,” or an objective reality, exists independently of our awareness of it. Thus, people can come to know the world more accurately and operate within its principles. Generally speaking, the realist assumption argues that a more accurate appraisal of the world, and a closer adaptation to its demands, are indicators of good mental health. Conversely, we may misperceive the situation around us and, as a result, might act out of concert with the social environment. As a result, we are likely to experience negative emotional and interpersonal consequences. Of course, we can’t know our world perfectly, and our cultural, social, and personal history will influence our belief systems and habitual ways of thinking about ourselves and the world. As a result, we are all to some extent “out of step” with our environments, but even so the cognitive-behavioral model holds that an individual who distorts the world around him- or herself, or fails to see situations for what they are, is likely to have more problems than someone else who is more realistic.

In addition to the *accuracy* of situation-specific thoughts, the cognitive-behavioral model considers the *usefulness* of different thoughts. We recognize that patterns of thinking, including general ideas, assumptions, core beliefs, and schemas (see Chapter 10 for definitions of these terms),

are derived over time from our experiences with the social environment. These core beliefs also affect how we view the world and choose to interact with it. Furthermore, because these cognitive patterns potentially limit the types of situations into which we put ourselves, or the possible range of activities in which we can imagine ourselves engaged, they predispose us to certain ways of thinking that may become self-fulfilling. Thus, once core beliefs become established, they not only affect our memories of past experiences but also influence our future development and range of activities. In this sense, people literally “create” as well as react to their own reality.

CURRENT CONTEXT: WHERE ARE WE NOW?

The development of evidence-based medicine and, in particular, evidence-based psychotherapy has been helpful to cognitive-behavioral therapy (Goodheart et al., 2006; Layard & Clark, 2014). In the 1990s, there was a movement toward the identification of empirically supported treatments (Chambless & Ollendick, 2001). Mental health disciplines within North America have also endorsed the need for training and practice in empirically supported therapies. For example, the psychiatric residency standards of the American Psychiatric Association, as well as the accreditation standards of the American and Canadian Psychological Associations for the training of clinical and counseling psychologists, require that trainees must at least be exposed to empirically supported treatments.

Empirically supported treatments and evidence-based practice do not typically emerge in a mature and final state. As recently described (Dozois et al., 2014; see Figure 1.2), there is often an evolution of theory and preliminary ideas about the utility of a specific approach to a given clinical problem, followed by case studies and open trials of a preliminary treatment model. Predicated on early success, more formal research trials often are completed, which are then ideally replicated by independent investigators to build a body of evidence, both in research settings and clinical settings more broadly. Finally, as the field matures and sufficient numbers of high-quality studies are completed, meta-analyses and syntheses of the literature can provide summative judgments about the overall clinical value of a given treatment, including its strengths and limitations, success relative to other treatments, and (ideally) direct cost and cost offset analyses. Throughout this process, there will ideally be a productive dialogue and bidirectional influence from research to practice, and from practice back to the research endeavor.

Cognitive-behavioral therapy has been used in the treatment of a

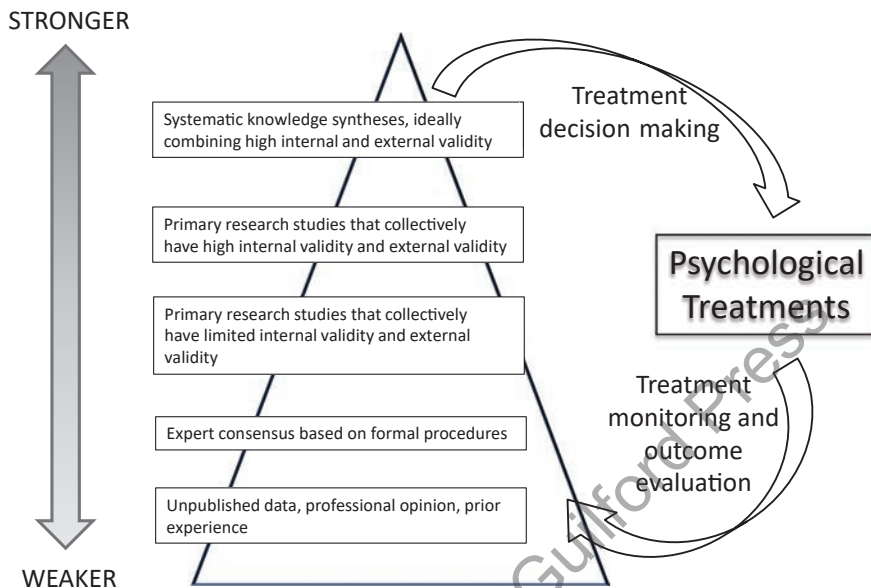


FIGURE 1.2. The hierarchy of evidence in psychotherapy. From Dozois et al. (2014). Copyright 2014 by the Canadian Psychological Association. Reprinted by permission.

wide variety of disorders and problems. It has been broadly disseminated through treatment manuals and books to members of the mental health community, and increasing knowledge about this approach is disseminated to the public through the media and websites (e.g., *www.academyofct.org*). The public is increasingly knowledgeable about evidence-based treatments and often requests psychotherapy in general (McHugh, Whitton, Peckham, Wedge, & Otto, 2013) and cognitive-behavioral therapy in particular as its preferred approach to treatment (Layard & Clark, 2014). As clinicians who value research, we must be cautious to ensure that the popularity of cognitive-behavioral therapy does not surpass the evidence for its efficacy (see Chapter 13). Cognitive-behavioral therapy is certainly more in demand in Western society than the number of available providers and services. Indeed, there is an acute shortage of qualified cognitive-behavioral therapists in many countries relative to demand and the therapy's potential value to society.

To take the example of depression, the 2012 National Survey on Drug Use and Health conducted in the United States by the Substance Abuse and Mental Health Services Administration (2012) found that the annual rate of depression was 6.9% for adults. The population of the

United States was approximately 319 million people in 2014, so if we assume a depression rate of 6.9%, this translates into approximately 22 million cases of clinical depression. Clinical trials of cognitive-behavioral therapy for depression often use a 20-session treatment protocol. If all of these cases of depression were treated using this protocol, approximately 440 million treatment sessions would have been required! And this estimate is for depression alone; the annual rate of all treatable mental disorders is obviously a much larger number. Any cursory review of the number of available providers and programs makes it clear that this quantity of cognitive-behavioral therapy sessions is simply not available.

The shortfall in the availability of cognitive-behavioral therapy relative to the demand for it has led different health care systems to attempt varied solutions. Some health care systems, such as the National Health Service in England, have recommended a “stepped approach,” whereby minimal interventions are used for mild problems (D. M. Clark et al., 2009). These interventions can include bibliotherapy, psychoeducation, and cognitive-behavioral self-help groups. One of the purposes of these new approaches is to extend available resources. Most clinicians in busy practices are looking for treatment “extenders,” such as self-help groups or community programs. There is a burgeoning industry of telehealth, Web-based, and smartphone-based technologies to make cognitive-behavioral therapy available in rural and remote settings, and for those clients who would simply not access more standard forms of psychological services (Andersson, 2010; Green & Iverson, 2009; Hadjistavropoulos et al., 2011).

Given the dramatic imbalance between demand and supply of cognitive-behavioral services, what is happening? The demand for evidence-based therapy has prompted mental health training programs to incorporate more of these treatments into their curricula. It is likely that more service providers will be available to deliver evidence-based practice over the long term. In the shorter term, we also note the development of a large market for postdegree continuous learning certificate programs, continuing education activities, the publication of treatment manuals, and other diverse forms of education for existing practitioners. Many practitioners take advantage of these activities.

Another positive development has been the growth of services that offer or at least include cognitive-behavioral therapy. Cognitive-behavioral therapy clinics now exist in a variety of settings, ranging from private practice to outpatient clinics, tertiary and specialty care clinics, and community-based programs. In particular, health maintenance organizations (HMOs) in the United States have incorporated cognitive-behavioral therapy programs as part of their range of services. This is no doubt predicated in part on shorter-term treatments and consequent lower costs relative to alternative treatments. It is also a result of the increased success of these

approaches relative to other, typically longer-term approaches. Reduced time to recovery promotes improved overall functioning on the part of the client, and reduced costs translate into lower overall health care costs.

Notwithstanding the previously mentioned positive features of the emphasis on cognitive-behavioral therapy, there are a number of difficulties and challenges. Many practitioners want to obtain more training and supervision, and to be able to declare competence as a cognitive-behavioral therapist. When can clinicians state that they have expertise in cognitive-behavioral therapy? In the absence of a “gold standard” to train therapists in this approach, there is likely a great deal of variability in the quality of cognitive-behavioral therapy, and what is being described as “cognitive-behavioral therapy” will have different meaning in different settings. For example, we know that clinicians often use cognitive-behavioral techniques in the context of another type of treatment, or use a hybrid approach. Practitioners may add cognitive-behavioral therapy methods to other approaches and use techniques in an “eclectic” practice, but without an overall cognitive-behavioral case formulation. A fairly common misconception is that because cognitive-behavioral therapy is “technique” driven, it is relatively easy to learn and apply in practice. Some therapists may believe that their clinical experience gives them license to pick and choose elements of cognitive-behavioral therapy manuals without consideration for the overall treatment program. As we argue later in this book, our general position is that if there is an evidence-based, manualized treatment for a particular problem and a client presents with that problem, then the clinician should adhere closely to the manual and place less emphasis on his or her clinical judgment, unless there is strong reason to do otherwise. We generally reject the utility of selecting some cognitive-behavioral methods or techniques in the absence of an overall cognitive-behavioral approach to treatment.

Another downside of the public demand for cognitive-behavioral therapy is that clinicians are tempted to use it to treat problems for which there is little or no evidence of its success. This temptation is natural because clinicians generally try to mitigate the distress of their clients, and other effective treatments may not exist. Unfortunately, if a treatment fails in an area in which it has not been developed or validated, the poor outcome might be taken as evidence that the treatment model itself is at fault. The overzealous application of the principles of cognitive-behavioral therapy in problem areas in which it is less likely to work represents a challenge because the reputation of the approach will suffer in the long run.

It is important to recall that the evidence base for many of the cognitive-behavioral therapies was first gathered in research clinics. Such clinics provide an excellent first test of the clinical efficacy of treatments,

but they often employ strict inclusion and exclusion criteria for participants. Typically, the evaluators closely supervise the therapists, and there are often extra services located within the research context. In contrast, clients with multiple problems often present to a clinical practice, where the possibility of screening for inclusion and exclusion criteria is unlikely. These clients are generally more difficult to treat than clients seen in research clinics. Given these differences in clientele, it should not be surprising to learn that outcomes in clinical settings are often not as strong as those in the first research trials. Thus, although cognitive-behavioral therapy may well have strong clinical utility, the context of the mental health clinic may delimit those benefits in comparison to the trials that led to the development of the treatments in the first place. Put otherwise, there needs to be a distinct and concerted effort given to the science and practice of dissemination of cognitive-behavioral therapy (see McHugh & Barlow, 2010, 2012) to maximize the chances that treatment outcomes will be similar to those from clinical research settings.

These points bring us back to our reasons for writing this book. We have attempted to provide an overview of effective treatments, and to help you to understand ways to approach and treat mental health problems using the principles of cognitive-behavioral treatments in practical and evidence-based ways.

SOCIAL AND CULTURAL FACTORS IN COGNITIVE-BEHAVIORAL THERAPY

The development of any psychological treatment does not take place in a vacuum but is inextricably linked to societal beliefs and practices at the time of its inception. Cognitive-behavioral therapy has developed within the context of a number of different societal and cultural trends. As cognitive-behavioral therapists, it is important to understand the context of what we do because this understanding provides a backdrop to our practices, placing our approach to the identification and treatment of problems within the social and cultural context in which we all live. A brief consideration of these factors can help us appreciate the limits of cognitive-behavioral therapy and know when to vary the standard practices to meet the needs of particular clients. Just as psychodynamic therapy grew out of the social and economic climate of late-19th- and early-20th-century values, cognitive-behavioral therapy is primarily a product of Western values in our time.

While valuing family and social connection, Western societies place an emphasis on individualism, independence, personal choice, and the ability to determine and have control over the future. Many individuals in Western cultures believe that they can control many, if not most,

aspects of their lives. Theoretically, this perception of personal control can lead people to take more responsibility for their physical and mental health. Conversely, with this sense that they *should* have control, individuals who feel helpless, or lack resources and therefore experience reduced choices, can experience negative affect and anxiety.

Distressed people are likely to become more easily isolated in a society that places more emphasis on individualism. Family, work, and community social groups may assume less responsibility for looking after these individuals' needs. Consequently, people may be more likely to feel isolated and lack a sense of community. Rather than look to social supports for help in fulfilling these needs, people may seek therapy, especially if it might help them learn needed skills to meet their own emotional and social needs. The originators and practitioners of cognitive-behavioral therapy continue to value setting goals, making choices, and taking action and control where these options are realistic. These aspects of cognitive-behavioral therapy make it an ideal approach for the type of society within which it was developed.

We also live in a world where technology has led to a veritable explosion of information available to the average person. One of the by-products of the enormous change in the availability of information has been a certain "demystification" of psychotherapy. Technologically savvy clients can scan international journals and university libraries around the world for current, reputable evidence about treatments. Clients frequently have information about self-diagnosed problems and request specific types of help, although the Internet also contains a lot of well-intentioned misinformation. It is not uncommon for clients to have done preliminary research and reading, and to come to an outpatient mental health service requesting cognitive-behavioral therapy by name.

With an increase in the accessibility of information comes greater openness toward people with mental health problems and decreased stigma. Many organizations, such as the National Alliance on Mental Illness, the Canadian Mental Health Association, and the New Zealand Ministry of Health have sponsored public awareness campaigns, and the results of mental health literacy surveys have been surprising. For example, in Alberta, Canada, approximately 85% of people randomly surveyed by telephone in 2006 were able to accurately identify a depressed person in a standardized scenario (Wang, 2007). Although stigma still exists, the same survey showed a 10% increase in awareness about depression in Australia over a decade (Wang, 2007).

In addition to increased public awareness, it is becoming more socially acceptable to seek treatment for mental health problems. Psychotherapy satisfaction surveys have been completed in popular and widely read magazines. It has become more acceptable for the average person

to seek out psychotherapy services, and many more public figures have come forward to talk openly about their psychological disorders. Elton John, Brooke Shields, Jane Pauley, Catherine Zeta-Jones, and J. K. Rowling are just a few of these courageous individuals. When inspired by public figures to seek treatment, people commonly request practical and effective therapies such as cognitive-behavioral treatments.

People often receive the message that they are “consumers” of health care, and that they need to purchase a good “product.” Popular magazine articles provide their readers with sets of questions to ask of their health care providers. Therapists receive demands from potential and actual clients with specific service requests, including cognitive-behavioral therapy. Consumers of mental health services have also become strong lobbyists for themselves and their families. The advocacy groups that have developed help to hold the health care “industry” accountable for its practices. In general, the consumer movement has been helpful to empirically supported and short-term treatments, and to treatments that take an active collaborative and egalitarian stance with clients. Transparency in therapy is also desirable for most consumers, especially if the goals, rationale, methods, potential outcomes, and likely costs of the approach can be clearly described. These characteristics are typical of cognitive-behavioral therapy.

A related issue is cost containment in health care. Health care costs in most developed countries have escalated dramatically within the past few decades for a number of reasons, including advances in technology and an aging population. Cost containment provides a justification for the use of short-term, practical treatments. Because of the combination of increased requests for mental health services and increased openness, as discussed earlier, combined with the limited availability of treatment, there have been pressures for short-term treatments, “caps” on services, or limits on the access to services. Health authorities, hospital governing boards, HMOs, and insurance companies regularly monitor economically related parameters such as length of hospital stay, number of treatment sessions, client satisfaction, and health care outcomes. Most health care systems must be accountable to the *bottom line*, which is almost always conceptualized as the direct cost of providing services. More sophisticated health care systems also consider the cost-offset of providing one or another program and compare the outcomes of various services (e.g., outpatient care vs. hospitalization; medications vs. psychotherapy). All of these factors make cognitive-behavioral therapy desirable because it is relatively inexpensive to provide, demonstrates measurable and observable positive outcomes, tends to lead to lower relapse rates, and often can reduce the need for more expensive and invasive treatment alternatives.

The emphasis on economic factors has influenced research and development, as well as direct service delivery. In broad terms, research dollars flow from either public or private interests. Increasingly, the availability of public research and development funds has been limited, and increasingly the focus of these sources of funding is on the solution of public problems, social issues, or perceived health care system needs. With a relative decrease in public funds for research, lobby groups, foundations, and private research agencies have increased their influence in the research enterprise. In general, the research and development funding groups' focus on short-term, evidence-based interventions has been conducive to further research and the development of cognitive-behavioral theories and therapies.

The final general factor that has spurred the development of cognitive-behavioral therapy is our faster-paced society, with the attendant perception of limited time and a commensurate emphasis on efficiency and effectiveness. This time pressure has led to a focus on practical and short-term solutions to problems. Many people report increased stress in their lives and feel pressed for time. Most families in North America have two income earners, leading to a "time crunch" relative to self-care and other types of personal activities. There is an increased demand for quick, commonsensical, practical, accessible, and reasonably affordable care. These attributes are all found in cognitive-behavioral therapy.

IN SUMMARY

The evidence base for cognitive-behavioral therapy has risen dramatically over the past 20 years, and increasing numbers of people are aware of cognitive-behavioral therapy and what it can offer to them. Agencies that fund these therapies, such as public health care systems, private insurance companies, HMOs, and foundations, are increasingly aware of, and committed to, positive and measurable treatment outcomes. If two types of therapy have roughly equivalent outcomes, but one is quicker and less costly, most people are likely to choose the more rapid and cheaper option.

Why should the average clinician care about these factors? It is important to understand these contextual factors and the system pressures that provide the context for your work. The knowledge base regarding cognitive-behavioral therapies and the demand for services far outstrip their availability as a health service. The challenge for the next generation of researchers, mental health planners, and clinicians will be to learn how to disseminate effective mental health treatments to the largest number of people possible. One conclusion from this discussion

is that cognitive-behavioral therapy has become a very suitable type of psychological treatment for this time in our history. Cognitive-behavioral therapy can be viewed as “a therapy whose time is now.”

The following chapters provide practical suggestions for applications within your practice, based on the best and most recent research evidence. We discuss the common elements of all types of psychotherapy, and cognitive-behavioral therapy in particular. We provide guidelines for the assessment of clients and case formulation, as well as the major behavioral, cognitive, and schema-focused interventions. Ending treatment can be difficult for many practitioners, and we provide discussions on this step, including relapse prevention. Many challenges can and do occur in practice, and we provide suggestions for ways to manage some of these issues.

Even as we promote the practice of cognitive-behavioral therapy, it is crucial that we continue to question its components. We also need to be open to other effective approaches as they become available. Just because a cognitive-behavioral treatment has been shown in clinical research trials to be effective compared to a waiting-list control group or a medication treatment does not necessarily mean that the same treatment will be effective in your practice. As therapists, we must retain not only our humanity (McWilliams, 2005), but also our humility and curiosity regarding the various elements of cognitive-behavioral therapy.