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History of Cognitive-Behavioral Therapy (CBT) in Youth

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Synopsis

CBT represents a combination of behavioral and cognitive theories of human behavior and psychopathology, and a melding of emotional, familial, and peer influences. The numerous intervention strategies that comprise CBT reflect its complex and integrative nature and include such topics as extinction, habituation, modeling, cognitive restructuring, problem-solving, and the development of coping strategies, mastery, and a sense of self-control. CBT targets multiple areas of potential vulnerability (e.g., cognitive, behavioral, affective) with developmentally-guided strategies and traverses multiple intervention pathways. Although CBT is often considered the “first line treatment” for many psychological disorders in youth, additional work is necessary to address treatment non-responders and to facilitate the dissemination of efficacious CBT approaches.

Keywords

Cognitive-behavioral therapy; CBT; cognitive therapy; behavior therapy; children; adolescents; history

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True to its name, cognitive-behavioral therapy (CBT) emerged as a rational amalgam of behavioral and cognitive theories of human behavior, causal and maintaining forces in psychopathology, and targets for intervention [1]. The numerous strategies that comprise CBT reflect its complex and integrative history. Following from early respondent conditioning theories [2], CBT incorporates concepts such as extinction and habituation. CBT went on to integrate modeling and cognitive restructuring strategies from social learning [3] and cognitive theories [4,5]. In addition, Meichenbaum and Goodman's [6] focus on self-talk and D'Zurilla and Goldfried's [7] problem solving are each evident in CBT's general focus on fostering the development of personal coping strategies and mastery of emotional and cognitive processes. Consistent with a tripartite view (cognition, behavior, emotion) of psychopathology [8], CBT targets these multiple areas of vulnerability and employs multiple avenues of intervention.

The present article provides a history of CBT as applied to youth psychopathology. This history can be traced to the 1960's when the value and effectiveness of the prevailing psychodynamic perspective was questioned [9,10] and found to be lacking. Behavior therapy consequently gained prominence but, in the 1960s, these therapies were initially controversial and primarily relegated to the treatment of behavior dysfunction in severely disordered children. It was not until the mid to late 1970's that the gradual expansion of behavioral therapies reached higher functioning clients, integrated the role of cognitive processing, and incorporated a focus on emotions. The transition did not happen at once, and it was spurred by multiple sources. In the end, social cognitive processing, the psychology of self-control, and emotion regulation were melded into behavioral interventions and, eventually, emerged as the multifaceted, widely applicable, extensively practiced, and well-researched CBT of the present day. This article offers a review of (a) the emergence of CBT from child behavioral therapies, (b) the influence of cognitive theories on these early treatments, and (c) the role of multiple perspectives and research evaluations in shaping modern CBT. The current status of CBT for various childhood disorders will be described and future directions for cognitive-behavioral therapy research and dissemination will be offered.

It may be of interest, especially to those with intolerance for grammatical infelicities, to know the history of the hyphen in cognitive-behavioral therapy. With behavior therapy predating cognitive therapy, the label had to be combined. Would it be cognitive behavioral therapy, where "cognitive" is the descriptive adjective for therapies that are "behavioral"? Or would it be cognitive "behavior therapy" or "cognitive behavioral therapies"? With the hyphen (i.e., cognitive-behavioral therapy), therapy was the noun, and "cognitive-behavioral" was the integrated descriptive adjective. In 1979, and in 1981, two of the earliest books on CBT had hyphenated titles [1,11]. It may also be of interest to note that "social," "developmental," and "emotional" are other terms that are aptly part of an extended hyphenated label. Cognitive-behavioral-social-developmental-emotional therapy would be more accurate, but it struggles rather than rolls off the tongue, is rejected by publishing houses that want to capitalize on hot labels (e.g., stick with CBT), and some might even see it as stitched together in a Frankensteinian fashion. Use of the umbrella term, "CBT," prevented the wrestling match that would have no doubt been necessitated by those who would have ordered the adjectives differently.

Theoretical Influences

Behavior Therapy

Before there was CBT, there was behavioral therapy – an initially controversial and underestimated approach that ultimately paved the way for empirically-supported treatments

for mental health disorders of youth. For example, the Mowrers' "bell-and-pad" procedure for the treatment of enuresis [12] is an often-cited example of an early behavioral intervention (and it remains a first line treatment for enuresis). Though clinical applications of behavioral strategies did not begin in earnest until the 1960's, the initial work set the stage—by targeting and addressing observable behavior and by measuring outcomes—for later child cognitive-behavioral interventions.

Respondent conditioning explanations of behavior influenced early behavior therapy, particularly for the treatment of anxiety. In respondent conditioning, a conditioned stimulus (CS) closely precedes an unconditioned stimulus (UCS) that elicits an unconditioned response (UCR) of fear. After repeated pairings, the CS alone will elicit the conditioned response (CR) of fear. Internal sensations or cues (e.g., physiological arousal) have also come to be recognized as conditioned stimuli [13]. Although the theory is powerful, it remains a somewhat incomplete explanation of human distress [14]. However, respondent conditioning was historically important in birthing notions of exposure tasks for the treatment of anxiety, now a well-established example, if not hallmark, of modern CBT for child anxiety [15].

Respondent conditioning theories brought the concepts of extinction, habituation, and counterconditioning to the attention of developers of treatments for youth. Initial treatments for child anxiety, for example, followed from these early behavioral perspectives. Extinction of a conditioned fear occurs by way of repeated experience with the conditioned stimulus (e.g., bees) in the absence of the unconditioned stimulus (e.g., bee sting). Habituation naturally occurs, and after long periods in the presence of the feared stimulus without the anticipated negative outcome, the stimulus no longer elicits the same heightened levels of arousal. Wolpe's systematic desensitization, based on counterconditioning [2], advocated for reciprocal inhibition (engaging in an anxiety-antagonistic response, such as relaxation, during exposure trials). Research found that anxiety decreased across exposure trials even in the absence of anxiety inhibitory responses [16] and gradual exposure (often more palatable to clients) may not be necessary for anxiety reduction to occur.

Operant learning theory [17] played a major role in behavioral therapy as well as child CBT. In operant theory, behaviors are facilitated by environmental contingencies that follow their occurrence. Children's behavior may be positively reinforced, even unintentionally or unknowingly, by attention from caregivers in the child's environment. Negative reinforcement may also occur by the removal of demands placed on the child. Children's independent, developmentally-appropriate behavior may even be punished by caregivers. These contingencies play a major role in the shaping of behavior over time. Environments low in predictable and preferred contingencies may lead to decreased self-efficacy and maladjustment.

Early applications of operant theory (e.g., applied behavioral analysis) were geared toward more severe or challenging child clients [18] for whom traditional talk and play therapies were considered inappropriate. Much early behavioral therapy focused on the application of operant contingencies for increasing desired behaviors (e.g., shaping, reinforcement) and reducing undesired behaviors (e.g., reinforcing incompatible behaviors, time-out). These principles have influenced treatments for childhood behavior problems. As discussed by Kazdin [19], early operant conditioning procedures were applied to child-parent interactions. As a result of extensive research, often involving direct observations of parent-child interactions, Patterson [20] determined that inconsistent parenting strategies found in families of disruptive children actually reinforce aggressive and antisocial behavior. Specifically, Patterson observed patterns of coercion between parents and behaviorally-dysregulated children. In his model, a parent responds to a child's disruptive behaviors with

ineffective discipline practices, such as scolding, threatening, and/or physical discipline. The child then “counterattacks,” or increases disruptive, aggressive behavior, and the parent often backs down, thereby reinforcing the child’s disruptive behavior [20–22]. Patterson influenced the field by directing practitioners to help parents be consistent in their contingencies, and to use fewer ineffective punishment strategies [23]. Currently, Parent Management Training Oregon Model [24] (PMTO) is considered a “well-established” treatment for children with disruptive behavior [25].

Many behavioral procedures continue to be used within CBT, even if initially conceptualized within a behavioral perspective. Over time, behavioral therapy began to address the thought processes and cognitive skills that were seen as involved in the implementation and receipt of contingency management and came to be implemented among less severe populations. This shift to higher-functioning youth and to an increased awareness of the role of cognition was an important part of the transition to CBT. It is also worth noting that many behavioral interventions, and cognitive-behavioral interventions, were initiated and researched with children in mind. They were not borrowed adult treatments, or downward extensions of adult treatments applied with children. To its credit, cognitive-behavioral therapies with youth were intentionally developmentally-sensitive and research-informed interventions.

Shift Towards Cognitive-Behavioral Therapy

CBT has been defined as a purposeful combination of the demonstrated efficiencies and methodological rigor of behavioral procedures with the cognitive-mediational processes that influence adjustment [1]. In the 1970’s, internal thought processes (e.g., self-talk [6]) began to be viewed as both targets and mechanisms of change [18], with an emphasis on improving cognitive skills rather than modifying behavior. Two early reports of CBT with children [26,27] were combinations of self-instructional training, with coping modeling and a response cost contingency. As promise was seen in efforts to incorporate children’s developing cognitive abilities into behavior modification to produce therapeutic change [28], cognitive processes became integrated with behavioral interventions. By incorporating cognition, the behavioral model fostered more broad and effective behavior change strategies.

Meyers and Craighead [18] identified several forces that led the shift toward interventions that were cognitive-behavioral in nature. One force, cognitive psychology, was a factor that impacted behavior therapy with children through (a) modeling, (b) self-instruction training, and (c) problem-solving. The cognitive information processing explanation of modeling, or observational learning, holds that even in the absence of respondent or operant contingencies, an individual can learn by viewing another person’s behavior. Although modeling was historically identified with behavior therapy, Bandura’s explanation of modeling effects [29] highlighted attention and retention, which are cognitive processes drawn from an information-processing model of cognitive psychology, as among the major factors that influenced observational learning. Bandura’s account of modeling, which ushered in a cognitive explanation for a portion of behavior therapy, and his discussion of the role of symbolic cognitive processes in behavior change, were springboards for the theoretical advance of CBT [18]. Indeed, various behavior therapy interventions began to be understood from both an information-processing and a more general cognitive viewpoint [30].

Self-instruction training [6] was another avenue through which cognitive psychology impacted behavior therapy. Self-instruction emerged to teach impulsive children how to control their behavior. The program drew from the language-development sector of cognitive developmental psychology, particularly the work of Luria [31] and Vygotsky [32],

who suggested that children learn to control their own behavior by overt and eventually covert speech. Researchers and clinicians continue to draw from the cognitive developmental literature to incorporate cognitive strategies and enhance behavior therapy procedures. For example, the literature on social cognition has contributed to notions of self-talk [33] and social skills training, and to our understanding of mechanisms of behavior change.

Problem solving [7], though once linked with behavioral learning, has a cognitive information-processing flavor. Problem solving within CBT for youth [34] focuses on internal thought processes as one mechanism of change. Several early programs for youth employed problem solving [35–37]. As evidence of its lasting impact, many current empirically-supported programs for youth have a problem-solving focus [38–41]. The emphasis on modifying thought processes as a means for producing both behavioral and cognitive change illustrates the integration of CBT and cognitive developmental psychology.

Interventions that targeted self-control were described as a third force behind CBT for youth [18]. Explanations of self-control procedures were increasingly cognitive in nature [42,43], with influential papers supporting the role of internal factors in self-control. Principles of self-control were being applied to work with children in the mid-1970's, as theoretical advances (e. g., Bandura's self-efficacy [3]) buttressed the relationship between overt and covert events. Studies of self-control and self-efficacy advanced the testing of private cognitive experiences in ways that could be integrated within behavioral paradigms [1].

The emerging successes of cognitive therapy for adult disorders influenced the psychological treatment of children. A core assumption of cognitive therapy is that maladaptive cognitive processes produce psychological disorders, which can be alleviated by modifying these cognitive processes. Ellis' [5] irrational thinking and Beck's [44] cognitive distortions are examples of the key notions, and the key people, who influenced CBT. Specifically, Ellis and Harper [45] proposed that people engage in maladaptive behavior and/or experience negative mood states because they engage in irrational thought processes. Thus, they argued that the focus in therapy is changing maladaptive ways of thinking (given that a person's thoughts lead one to experience negative emotions). Beck [44] similarly maintained that maladaptive cognitions (assumptions and beliefs about oneself and the world) are associated with psychological disturbance. Many research evaluations have supported cognitive therapy with adults [46,47], and clinical work with children has been influenced by, and frequently refers to, the work of Beck and Ellis.

The theories of Beck and Ellis, and the emerging empirical support for their clinical procedures, contributed to growing acceptance that cognitive attitudes, beliefs, expectancies, and attributions are critical for producing, understanding, and modifying the behavior of individuals with psychopathology [1]. Given the increasing number of studies supporting therapeutic benefit for cognitive therapy, an increasing focus was placed on assessing and understanding cognition [11] despite traditional difficulties with isolating and measuring such phenomena. The position that cognition is subject to the laws of learning [48,49] led to attempts to apply functional analytic assessment and contingency-based interventions to the modification of cognition. Although controversy existed regarding this approach, such efforts nonetheless provided an avenue for behaviorists to enter the cognitive arena. Some of the early cognitive therapy with adults relied on persuasion and reason, though later efforts underscored the benefit of prospective hypothesis testing and behavioral tasks (i.e., homework, behavioral activation). The results of rigorous methodological research evaluations spurred further interest [50,51].

The integration of the strategies of cognitive and behavioral therapy thrived due to the desirability and viability of this combination to produce clinically meaningful outcomes. Indeed, without the favorable research evaluations, the approach would not have gained interest from practitioners nor maintained itself among researchers. Simply put, the use of contingencies to facilitate a child's engagement in exercises that produce cognitive change was both data-supported and clinically appealing.

Expanding CBT

Though its initial impetus was the wedding and integrating of cognitive (e.g., thoughts influence behavior and emotion) and behavioral (e.g., research evaluation, contingencies) traditions, CBT rapidly evolved and emerged as a treatment informed by a wider set of models. CBT grew and materialized to address salient disorders in youth, as well as developmental vulnerabilities toward psychopathology. Just as the role of cognition has, in its pioneering fashion, come to be incorporated into behavioral therapy, so too have forces related to social environments, genetic vulnerabilities, therapeutic processes, and familial and peer relationships.

As an illustration of expanding models, consider Clark and Watson's [52] tripartite model as an explanation for the extensive overlap of the otherwise-seen-as-separate disorders, anxiety and depression. The tripartite model describes how anxiety and depression share a common component, negative affect, which accounts for symptom overlap. Negative affect is the sense of high objective distress and includes a variety of affective states such as being angry, afraid, sad, worried, and guilty. The model suggests that negative affect is a shared dispositional vulnerability for emotional psychopathology, specifically anxiety and depression. By contrast, low positive affect is a factor specific to depression and autonomic arousal is a factor specific to anxiety [52]. CBT for addressing emotional disorders, in sync with the tripartite model [53], also targets overlapping features. However, Barlow suggested that anxiety is different from autonomic arousal. He proposed that negative affect is a pure manifestation of the emotion of anxiety, while autonomic arousal is a manifestation of the emotion of fear [54]. Despite small differences, autonomic arousal, high levels of general distress and negative affect, and low positive affect are seen as important predisposing traits of emotional psychopathology [54]. Targeting and treating these salient factors across disorders is a strategic approach that has been accepted within CBT.

Barlow described a triple-vulnerability model of emotional disorders: (1) a general genetic vulnerability, (2) a general psychological vulnerability characterized by a diminished sense of control, and (3) a specific psychological vulnerability resulting from early learned experiences [8]. This diathesis-stress model is consistent with how children may develop a sense of diminished control through experiences with both their own highly reactive arousal system or high negative affectivity and with uncontrollable life events [13]. Once a diminished sense of control is developed, a child is more likely to perceive other events as uncontrollable, even those for which the child could potentially manage. For example, overcontrolling, unresponsive, and unpredictable family environments can foster a sense of uncontrollability and an external locus of control, a major psychological vulnerability [13,55,56]. A specific psychological vulnerability can arise from early socialization experiences with the family or peers, and can contribute to experiencing psychopathology in particular areas. In accordance with this vulnerability model, CBT approaches for youth incorporate parent training with an increased focus on contextual issues and the development of children's mastery over their own environment.

Current Status and Future Directions

Disorder specific applications of CBT for children and adolescents have enjoyed widespread application. A search of key terms “cognitive behavioral therapy” and “children” on *PsycInfo*, an online database of psychological literature, revealed 1192 articles, 1156 of which were published since 1990. Increased interest in and research on CBT has firmly established its presence in the field of clinical child and adolescent psychology and psychiatry. The initial book on CBT with children and adolescents [57] is now in its fourth edition [58], with numerous chapters describing CBT procedures for specific disorders.

True to its ties with the empirical methods of behavior therapy, CBT with children and adolescents continues to be guided by empirical research. Studies of the nature of specific disorders inform treatment procedures, and evaluations of treatments applied to real cases inform dissemination and practice. To date, an impressive series of empirical research reports support the use of CBT for the treatment and prevention of various psychological disorders in youth. The American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures [59] established criteria for use in determining whether treatments can be considered empirically-supported (see also Chambless & Hollon’s criteria [60]). Based on the criteria, treatments can be categorized as either “well established,” “probably efficacious,” “possibly efficacious,” or “experimental.” CBT has emerged as the treatment with the most empirical support for numerous internalizing disorders in youth [61–64]. Specific modalities of CBT have been categorized as “well established,” such as child-only groups and child groups plus a parent component for youth with depressive disorders [62]. A specific CBT protocol for youth exposed to traumatic events, Trauma-Focused CBT [65], is also considered “well-established” [64]. Many other CBT protocols have been categorized as “probably efficacious” [64] for the treatment of internalizing disorders, including the Coping Cat Program [66] for anxiety and phobic disorders, school-based group CBT [67] for exposure to traumatic events [63], and individual exposure-based CBT [68,69] for obsessive-compulsive disorder [61]. Although less support has been found for the use of CBT for externalizing disorders in youth, group CBT is considered a “well established” treatment for adolescent substance abuse [70] and some CBT protocols, such as Anger Control Training [71] and Rational-Emotive Mental Health Program [72], are considered “probably efficacious” for the treatment of disruptive behaviors in youth [73]. Overall, CBT is often considered the “first line of defense” in the treatment of psychological disorders in youth.

Although additional work is necessary to strengthen the efficacy of CBT for youth, researchers have called for a shift toward examining the mediators, moderators, and predictors of treatment outcome [74–76]. This call implores researchers to go beyond evaluating the degree to which treatment works and to move toward examining why and for whom it works [77]. Future research has many worthy candidates of investigations. Potential mediating variables worthy of exploration include the individual components of treatment protocols, therapeutic process variables such as therapeutic alliance and child involvement, and within-client change processes [78]. Future work is also necessary to delineate whether certain pretreatment characteristics, comorbid conditions, and treatment formats moderate or predict outcome. Given the ever-increasing use of technology in society, a particular area ripe for research includes the use of computer technology in CBT protocols [79,80].

A pressing concern and an area requiring empirical support is how best to disseminate CBT to community practice [81]. The growing empirical support of the efficacy of CBT does not guarantee its use. “Bridging the gap” between research evidence and clinical practice is an endeavor requiring effort from all parties involved, including researchers, practitioners, policymakers, and mental health consumers [82]. It can be argued that the pursuit of

dissemination constitutes the next chapter in the history of CBT. Engagement in this endeavor will likely lead to global improvements in the mental health care of youth.

Summary

CBT represents an integration of behavioral, cognitive, and other (e.g., developmental, social) theories of human behavior and psychopathology. The numerous strategies that comprise CBT reflect its complex and integrative history and include conditioning, modeling, cognitive restructuring, problem solving, and the development of personal coping strategies, mastery, and a sense of self-control. CBT targets multiple areas of potential vulnerability (e.g., cognitive, behavioral or affective) and provides avenues of intervention. CBT is often considered the treatment of choice for mental health disorders in youth. Additional work is needed to understand the mediators, moderators, and predictors of treatment outcome, and to pursue the dissemination of efficacious CBT approaches.

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