

Cognitive–Behavioral Treatment

Cognitive–Behavioral Therapy/Treatment¹ (CBT) is a problem-focused approach to helping people identify and change the dysfunctional beliefs, thoughts, and patterns of behavior that contribute to their problems. Its underlying principle is that thoughts affect emotions, which then influence behaviors. CBT combines two very effective kinds of psychotherapy: *cognitive therapy* and *behavioral therapy*.

Cognitive therapy concentrates on thoughts, assumptions, and beliefs. With cognitive therapy, people are encouraged to recognize and to change faulty or maladaptive thinking patterns. Cognitive therapy is a way to gain control over inappropriate repetitive thoughts that often feed or trigger various presenting problems (Beck 1995). For instance, in a young person who is having trouble completing a math problem, a repetitive thought may be “I’m stupid, I am not a good student, I can’t do math.” Replacing such negative thoughts with more realistic thoughts, such as “This problem is difficult, I’ll ask for help,” is a well-tested strategy that has been found to help many young people face their academic problems.

Behavioral therapy concentrates on specific actions and environments that either change or maintain behaviors (Skinner 1974; Bandura 1977). For instance, when someone is trying to stop smoking, the individual often is encouraged to change his or her daily habits. Instead of having a cup or coffee upon waking – which may trigger the urge to have a cigarette – the person is encouraged to take a morning walk. Replacing negative behaviors with positive behaviors is a well-known strategy to help change behaviors, particularly when the new behavior is reinforced.

The combination of cognitive therapy and behavioral therapy has proven highly beneficial. For example, in the midst of a panic attack, it may feel impossible to gain control over thoughts and apply cognitive therapy techniques. In this case, a behavioral technique such as deep breathing may be easier to implement, which may help to calm and focus thinking.

¹This is also referred to as Cognitive–Behavior Therapy, which gives the behavioral components of CBT more emphasis. Another known term is Cognitive–Behavioral Treatment. Because of the proven success of CBT, many practitioners and theorists have drawn on its theoretical foundations and have extended them to be useful in many different situations. Such extensions include Rational Emotive Behavioral Therapy (Ellis and Harper 1975), Moral Reconciliation Therapy, and Dialectical Behavior Therapy (Trupin et al. 2002). For purposes of this review, programs are included that are theoretically based on, and use facilitative strategies drawn from, cognitive therapy and behavioral therapy.

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The distinctive features of CBT are as follows:

- It is the most evidence-based form of psychotherapy.
- It is active, problem focused, and goal directed. In contrast to many “talk therapies,” CBT emphasizes the present, concentrating on what the problem is and what steps are needed to alleviate it.
- It is easy to measure. Since the effects of the therapy are concrete (i.e., changing behaviors), the outcomes tend to be quite measurable.
- It provides quick results. If the person is motivated to change, relief can occur rapidly.

The studies reviewed provide consistent empirical evidence that CBT is associated with significant and clinically meaningful positive changes, particularly when therapy is provided by experienced practitioners (Waldron and Kaminer 2004). CBT has been successfully applied across settings (e.g., schools, support groups, prisons, treatment agencies, community-based organizations, churches) and across ages and roles (e.g., students, parents, teachers). It has been shown to be relevant for people with differing abilities and from a diverse range of backgrounds. Studies have found that parents perceive CBT favorably and prefer CBT to pharmacotherapy for treating both externalizing and internalizing disorders (Brown et al. 2007).

The strategies of CBT have been used successfully to forestall the onset, ameliorate the severity, and divert the long-term consequences of problem behaviors among young people. Problem behaviors that have been particularly amenable to change using CBT have been 1) violence and criminality, 2) substance use and abuse, 3) teen pregnancy and risky sexual behaviors, and 4) school failure. Across the range of continuum-of-care, many model programs have successfully incorporated the strategies of CBT to effect positive change.

The future of CBT may involve its integration with other types of approaches. For instance, integration of CBT with motivational interviewing may increase treatment effectiveness among less compliant individuals and populations (Zinbarg et al. 2010). Integrating CBT with strengths-based approaches may similarly yield improved outcomes (Zinbarg et al. 2010). This type of integration may be particularly important for achieving improved outcomes with delinquent youth.

Delinquency, Criminality, and Violence Prevention

The most widely used approaches to treatment in criminal justice today are variations of CBT (Little 2005). Distorted cognition is one of the most notable characteristics of chronic offenders (Beck 1999). Faulty thought processes include self-justificatory thinking, misinterpretation of social cues, deficient moral reasoning, and schemas of dominance and entitlement (Lipsey, Chapman, and Landenberger 2001). Cognitive-behavioral treatments for juvenile offenders are designed to correct dysfunctional thinking and behaviors associated with delinquency, crime, and violence. Moral Reconnection Therapy is one CBT approach that has been implemented successfully in a host of correctional systems, such as residential juvenile facilities and boot camps, and in numerous other venues, such as schools and job training programs (Little 2001).

Meta-analyses of programs designed for criminal offenders have shown cognitive-behavioral programs to be highly effective in reducing recidivism rates (Little 2005; Lipsey, Chapman, and Landenberger 2001; Pearson et al. 2002; Wilson, Bouffard, and MacKenzie 2005; Walker et al. 2004). A meta-analysis by Landenberger and Lipsey (2005) looked at whether certain components of CBT programs used with adult and juvenile offenders were associated with greater recidivism effect sizes. They concluded that programs with better implementation quality and fidelity, along with higher-risk

offender populations, were associated with greater effect sizes. Programs incorporating anger control and interpersonal problem-solving components enhanced effectiveness, while those incorporating victim impact and behavior modification components diminished effectiveness. Programs were equally effective for adult and juvenile populations. Programs with the most effective CBT implementation and components corresponded to a decrease in recidivism of 50 percent, compared with a control condition. Examples of successful programs that draw on CBT are Operation New Hope and SAFE-T.

Many of the model programs that target young people who are at risk for delinquency often involve the family in applying the strategies of CBT. Some model programs that have proven successful in this area include Functional Family Therapy, Multisystemic Therapy, and the Michigan State Diversion Project. Multiple context approaches such as these that encourage CBT implementation in the home and in the school have demonstrated their effectiveness at positively changing the life course of some of these young people (Brosnan and Carr 2000). A good example of a multicontext program is FAST Track. Techniques used to promote change include modeling, reframing and reattribution, and behavioral training.

Substance Use and Abuse

Particularly for young people, the initial draw to smoking cigarettes, drinking alcohol, or doing drugs is the perception that everyone experiments or uses (Prokhorov et al. 1993). The primary prevention strategy used by many model programs is to alter these faulty beliefs and attitudes about the universality of alcohol, tobacco, and other drug use, and to teach young people the behaviors needed to refuse if, or when, presented with the opportunity (Botvin, Botvin, and Ruchlin 1998). Evidence suggests that resistance skills are essential protective factors for the reduction of substance use in adolescence (Dusenbury and Falco 1995). For some successful program examples, see LifeSkills® Training and the Midwestern Prevention Project.

Other cognitive-behavioral based programs that target substance use and related problems view use as a learned behavior that is initiated and maintained in the context of environmental factors (Waldron and Kaminer 2004). Programs built on this premise concentrate on helping young people anticipate and avoid high-risk situations as a means to facilitate abstinence. Techniques used to facilitate change include identifying the circumstances surrounding use, learning strategies to manage urges and cravings, and remembering to engage in positive behaviors (Kaminer 2004).

For more advanced use and abuse issues, successful programs such as Adolescent Portable Therapy have involved the family in the treatment. There are quite a few model programs that concentrate on the family in general and on parenting in particular. These well-evaluated, science-based programs often incorporate CBT in their facilitative strategies (Ferrer-Wreder et al. 2003; Taylor and Biglan 1998) (see Program Types Parent Training and Family Therapy for more details).

Teen Pregnancy and Risky Sexual Behavior

Programs designed to significantly reduce harm related to adolescent sexual behavior have also found that using CBT strategies contribute to the overall effectiveness. These programs are designed to forestall the initiation of sexual activity or address the health needs of adolescents who are currently sexually active. The emphasis of these latter programs is on reducing a range of behaviors that include unprotected intercourse, sexually transmitted diseases, and unintended pregnancy. Practical and Cultural Education (PACE) Center for Girls is one model program that includes sexual health in its curriculum. The program concentrates on helping at-risk adolescent girls make positive lifestyle choices. Many of these students had been the victims of physical, emotional, or sexual abuse, and a portion of them had prior pregnancies. The curriculum, which encourages girls to have healthy

attitudes and make positive choices regarding their health, has shown to decrease subsequent pregnancies (Harrington 2001). For another promising program that uses CBT-based strategies to strengthen girls' protective knowledge, attitudes, and behaviors about the origins and modes of transmitting HIV/AIDS, see Urban Women Against Substance Abuse.

School Failure

There are numerous programs designed to promote academic competence in children and teens by using strategies based on the foundations of CBT (McLaughlin and Vacha 1992; Wilson, Lipsey, and Derzon 2003; Wood and O'Malley 1996). Often one of the strongest pathways to school failure is self-defeating, attributional biases (Ferrer-Wreder et al. 2003). These biases are negative, self-blaming thoughts about poor performance that are based on a history of failure and skill deficits. These attributions can influence students to behave in ways that reinforce these negative thoughts and increase their chances of actual failure (Nurmi 1993).

Research provides support for the relations between these negative achievement strategies, a range of youth problem behaviors, and adult adjustment difficulties (Calabrese and Adams 1990; Costa, Jessor, and Turbin 1999; Durlak 1997; Eronen and Nurmi 1999; Schulenberg, Maggs, and Hurrelmann 1997). Many academic achievement programs directly target these negative thoughts and reinforce positive behavior by using CBT strategies delivered by teachers, mentors, tutors, peers, and school staff. Some of the strategies to be found most effective are those that draw on the behavioral strategies posited by Skinner's Operant Conditioning Theory (e.g., positive reinforcement of positive behaviors and having well-defined rules and consequences) and Bandura's Social Learning Theory (e.g., providing opportunities for positive peer role-modeling).

These have been applied at many different levels: at the individual level (e.g., one-on-one mentoring programs, such as Across Ages), the classroom level (e.g., classroom management programs, such as The Incredible Years), the school level (e.g., schoolwide programs, such as the School Transitional Environment Program), and within the community (programs such as Movimiento Ascendencia).

School-based behavior management strategies often fall into four categories: structured playground activities; behavioral consultation; behavioral monitoring and reinforcement of attendance, academic progress, and school behavior; and special educational placements for disruptive, disturbed, and learning-disabled students.

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