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A Commentary on Cognitive Behavior Therapy: Where We Have Been, Where We Are, and Where We Need to Go From Here

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In this commentary, I use my own career and contributions to cognitive behavior therapy (CBT) as a point of departure and reflect upon where the field was when I obtained my graduate training in the late 60s, how it has changed over the past 50 years, and where it needs to go to remain alive and vibrant in the years ahead. Early on CBT was firmly and almost exclusively grounded in learning theory. Although learning theory remains our foundational core to this day, our primary allegiance these days is to broader evidence-based principles of change and the scientific pursuit of evidence-based interventions. Still, although we have accomplished much, we must do more in the years ahead of us. First we need to become more expansive in our attempts to understand the many and diverse problems we treat and, second, we must become more rigorous in the ways in which we assess and treat these problems. I conclude by indicating that although we are 50 years of age this year, and we have much reason to celebrate, we are really only in the adolescent period of our development. Growth is ahead of us.

In this commentary, using my own career and contributions as a point of departure, I reflect on where the field of cognitive behavior therapy (CBT) was when I obtained my graduate training, how it has changed over the years, and where it needs to go to remain alive and well in the years ahead. My own specializations within CBT are social cognitive theory, developmental psychopathology, and the child and adolescent anxiety disorders. By design, my comments will be limited and reflect my own developmental course and ongoing journey over the years. I do hope my limited comments—along with those of others—will help position ABCT for the next 50 years.

I undertook my graduate training in clinical psychology at Purdue University in 1967. At that time, Purdue was an eclectic training program characterized largely by the humanistic and psychodynamic traditions, which I initially embraced. While there, however, I became fascinated by learning theory and with the emerging field of behavior therapy and, although I did not attend the first annual meeting of the Association for Advancement of Behavior Therapy (AABT, precursor to ABCT) in 1967 (my first year of graduate school), I did attend lectures by Ted Ayllon, Nate Azrin, Al Bandura, Fred Kanfer, B. F. Skinner, Todd Risley, and Tom Stampfl during my graduate school days. Given my more eclectic background and training at that time, I was particularly intrigued by the writings of Tom Stampfl on what he called Implosive Therapy. One of his early papers co-authored with Don Levis and published in the *Journal of Abnormal Psychology* (Stampfl & Levis, 1967) was titled "Essentials of Implosive Therapy: A Learning-Theory-Based Psychodynamic Behavioral Therapy." In that paper and one published the following year in *Behaviour Research and Therapy* titled "Implosive Therapy—A Behavioral Therapy?", Stampfl and Levis carefully described Implosive Therapy and firmly grounded it in Mowrer's (1960) two-factor learning theory; however, Stampfl and Levis (1968) asserted that "dynamically oriented clinicians need not relinquish their fundamental conceptions of the human situation to use it" (p. 497). This approach allowed me to "have my cake and eat it too"! With this treatment approach, I could incorporate some of my psychodynamic training and early leanings into a learning model of intervention. Nirvana was within my naïve grasp! Eagerly, I applied this approach to one of my first clinical cases as a second-year graduate student at Purdue in 1969—the case of an 8-year-old boy who presented with a severe and disabling bodily injury phobia. "Tommy" developed his phobia at 3 and ½ years of age when his sister was born with a blood disease and multiple physical complications that were life-threatening. Tommy, displaced from his former "secure" sleeping arrangement in his parents' bedroom to accommodate his sister, soon developed multiple fears of blood and injury illness himself. His parents speculated that he became afraid of these things not only because

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they thought he could be hurt and would bleed to death as well like his sister but also because he was being displaced and perhaps inadvertently rejected by them. The perfect storm! Of course, from Mowrer's two-factor learning theory, the phobic response represented an avoidance response which served to maintain his heightened level of fear; but, from a psychodynamic perspective, his fear represented repression due to anger regarding his rejection and displacement from his formerly secure position in the family system. Well, the story goes on but suffice it to say that my major professor (noted developmental psychologist Gerry Gruen) and I subsequently published this uncontrolled case study in 1972 in the *Journal of Consulting and Clinical Psychology*—the title of our paper was "Treatment of a Bodily Injury Phobia With Implosive Therapy." It turns out that this was one of the first applications of Implosive Therapy to children and one of my first professional publications.

Following graduation from Purdue in 1971, my appetite for psychodynamic theory and practice not yet satiated, I obtained a postdoctoral fellowship at the Devereux Foundation Institute for Clinical Training and Research in suburban Philadelphia. At that time, Devereux was one of the leading child and adolescent psychodynamic training sites in America. There I was exposed to psychodynamic thinkers including Gunther Abraham and Austin Deslauriers—active theorists, outstanding clinicians, and prolific writers. I even had the opportunity to read psychological evaluations of some of the youth in residence at Devereux written by Anna Freud herself! I also had the good fortune of meeting my now long-time friend, Al Finch, Jr., who had been trained in more behavioral interventions at the University of Georgia and the University of Alabama. I recall many a time sitting down with Al and trying to understand and develop treatment plans for the self-injurious and self-stimulatory behaviors of severely impaired, nonverbal autistic children from a psychodynamic perspective. Eventually, we abandoned this approach and set up a token economy on one of the residential units on which we were assigned, and we saw some dramatic changes—thanks to the pioneering work of Ted Ayllon, Nate Azrin, and others. Some years thereafter, I read a paper by Al Bandura titled "The Psychology of Chance Encounters and Life Paths" published in the *American Psychologist* (1982). Bandura, in this seminal paper, noted that chance encounters play a prominent role in shaping our lives. He further noted that in a chance encounter—although the separate chains of events have their own causal determinants—their intersection occurs fortuitously rather than through a deliberate plan: "Some fortuitous encounters touch only lightly, others have more lasting effects, and still others branch people into new trajectories of life" (p. 747). He was right! I had experienced several such fortuitous encounters in my early career, and I continue to do so to this day.

Behavior Therapy Then and Now

Although behavior therapy had its roots in the early learning theory of Pavlov, Skinner, Mowrer, Watson, and others as well as the early clinical works (in alphabetical order) of Ayllon, Azrin, Barlow, Franks, Lazarus, Marks, Rachman, Salter, Wilson, Wolpe, and many others, behavior therapy really did not hit its stride as a clinical intervention until the mid-1960s, and it has continued to flourish over the past 50 years. Early on, in my opinion, behavior therapy emphasized four things: (a) learning models of symptom development and modification, (b) the direct treatment of those symptoms/behaviors, (c) the evidence base of the efficacy of these treatments, and (d) the rejection of traditional psychodynamic and other non-learning-based approaches (much to my early chagrin). To wit, the work of Stampfl and Levis was never fully welcomed into the behavior therapy armamentarium—partially at least due to its psychodynamic allegiance—even though Dollard and Miller (1950) had thoughtfully translated psychodynamic concepts into laboratory and learning-based principles and procedures many years earlier. Behavior therapy embraced the work of individuals who espoused clear experimental, learning-based orientations—whether based in classical, operant, vicarious, or information processing origins. Such demarcations were evident in Marv Goldfried and Jerry Davison's (1976) seminal *Clinical Behavior Therapy*, and our own book modeled after this one, *Clinical Behavior Therapy With Children* (Ollendick & Cerny, 1981). Both of these books, written for clinicians, carefully tracked the learning basis of the various treatments and the evidence base for their use, and both books went to great lengths to differentiate these approaches from more traditional, psychodynamic ones. These books, and others, also began to incorporate cognitive procedures that were not based solely in learning theory. Acknowledging the "cognitive revolution" in the work of Tim Beck, Don Meichenbaum, Mike Mahoney, and several others, the complexion of behavior therapy began to change; still, there was adherence to the notions that behavior and now cognition should be directly assessed and treated and that other therapies like the humanistic and psychodynamic ones should be excluded. In recognition of these developments, much discussion ensued over a 10- to 15-year period about changing the name of our organization from the Association for Advancement of Behavior Therapy to the Association for Behavioral and *Cognitive* Therapies (ABCT)—a movement that was finally accepted by our membership in 2005, a mere 10 years ago.