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Clinical approach in users with cognitive behavioral therapy

Abordaje clínico en usuarios con terapia conductual cognitiva

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Abstract

The professional in psychology that develops in applied areas, must resort to the currents of knowledge that are within what we call psychology, all this to enhance the scope of their objectives, which in clinical practice, are called as Therapeutics The purpose of the present work is to develop a review of the clinical approach in users with behavioral-cognitive therapy. It is considered the absence of a body of unified knowledge and is encouraged not to be content with only one contribution, but complement it with others, as if it were to complete a puzzle (metaphorically). It emphasizes the need for knowledge about learning theories, proposals for the formulation of the case and review of studies on empirical support of different therapeutic strategies. It is concluded that both behavioral and cognitive strategies allow us to have not only a series of procedures, but reference frameworks to be able to interpret the specific-circusing events that the professional in psychology is daily.

Keywords: emotional disorders, behavioral-cognitive therapy, clinical psychology.

Resumen

El profesional en psicología que se desenvuelve en ámbitos aplicados, debe de recurrir a las corrientes de conocimientos que se encuentran dentro de aquello a lo que denominamos psicología, todo esto para potenciar el alcance de sus objetivos en la práctica clínica, los cuales son denominados como terapéuticos. El presente trabajo tiene como propósito desarrollar una revisión sobre el abordaje clínico en usuarios con terapia conductual-cognitiva. Se considera la ausencia de un cuerpo de conocimiento unificado y se incentiva a no contentarse con solo un aporte, sino complementarlo con otros, como si se tratara de completar un rompecabezas (metafóricamente). Se enfatiza en la necesidad de conocimiento sobre teorías del aprendizaje, propuestas de formulación del caso y revisión de estudios sobre el apoyo empírico de diferentes estrategias terapéuticas. Se concluye que tanto las estrategias conductuales como cognitivas permiten contar no solo con una serie de procedimientos, sino marcos de referencia para poder interpretar los acontecimientos especifico-circunstanciales que el profesional en psicología se encuentra a diario.

Palabras clave: desordenes emocionales, terapia conductual-cognitiva, psicología clínica.

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INTRODUCCIÓN

In recent years, the so-called mental health problems have once again taken center stage in people's daily lives (WHO, 2021) since the pandemic period has led to interest in the quality of health services, where clinical psychology plays a relevant role (Caycedo et al., 2008). During the period of confinement and the progressive establishment of an apparent post-Covid-19 normality, the urgency of having psychology professionals prepared to face new challenges has been seen, propitiating in their work centers, the development of potentially adjusted responses in their clients, either in face-to-face care or tele-psychotherapy (Acero et al., 2020; Amador-Soriano et al., 2018). Interestingly, the Ministry of Health (MINSA, 2022) reported that in 2021, there were 313,455 cases of depression, i.e., 12% more than reported in the pre-pandemic period, which is why reflection on psychotherapeutic practices is so important.

Clinical psychology becomes more relevant when considering the various negative consequences of the so-called psychological disorders at different levels (e.g., personal, social, economic, etc.). The form of attention has varied since its first implementations, where the so-called behavioral postures have tried to provide a scientific basis for understanding the laws and principles that govern the (psychological) behavior of people. The contribution to the understanding of how experiences generate changes in the performance of subjects in different experimental arrangements has contributed to the analysis and modification of behavior in clinical practice. Research in humans on how verbal interaction can influence behavior at intraclinical and extraclinical levels has favored the use of behavioral approaches to more problems addressed by clinical psychologists.

Psychology as a science still has some way to go, or this can be understood after observing the various debates and proposals for frameworks about what the psychologist is and what he or she works on (Montgomery, 2018; Zilio & Carrara, 2021). There is no such generic psychology from which areas of specialization emerge, but there are different attempts to organize it. Clinical psychology is assumed to be an area of specialization focused on psychological disorders, which can be linked to other areas of work (Uribe et al., 2009; Aguilar & Leal, 1985) such as school-educational, industrial-organizational, social-community, and even other applications such as intervention on the individual behavior of athletes or in companies for the reduction of potentially risky behaviors.

In spite of the absence of a predominant paradigm, this has not impeded the increase of an enormous amount of behavioral technology (O'Neill & Gardner, 1983; Kazdin, 1983), obtaining procedures of analysis of both public (overt) and private (covert) behavior (Cautela & Kearney, 1990; Upper and Cautela. 1983) for its use by psychologists, which has represented a major benefit both in recognition of the discipline and the improvement of the well-being of the users. In this way, robust experimental research has offered greater strength to psychology, where the procedures derived from conditioning (research technique) allowed strategies to be adapted for the modification of behaviors in social contexts.

In its first forms, its application was denominated as behavioral therapy, to which some added mediational elements (variable in O), for the latter, is where combinations such as behavioral-cognitive and cognitive-behavioral would be born, being the difference of the first a) the emphasis on which the understanding of the clinical case was made, b) considering the historical order or c) assuming the cognitive in terms of learning studied by conditioning. Based on the emphasis on the frame of reference used by the professional, they are considered encompassing labels because they embrace a series of contributions, such as reciprocal inhibition therapy (Wolpe, 1977; Eysenck, 1979), operant techniques (Reynolds, 1968), covert conditioning procedures (Upper and Cautela. 1983), techniques derived from social learning (Bandura & Walters, 1974; Kazdin, 2000; Rinn & Markle, 1981) among others. The important thing in any case has been to open the possibility of a scientific theory of behavior that offers answers based on experimental research on the acquisition, maintenance, and possible modification of individual behavior.

The role of experimental research

Psychology, in its beginnings, has been understood as the study of the mind or psyche, and this has led to a series of conceptual problems. Although the first attempts to approach its study have indeed generated different types of contributions, it is

Ivan Pavlov's research that, to a greater extent, would mark a route to obtaining scientific knowledge that finally allowed psychology to have solid data. Watson gathered to speak about behaviorism in 1913, seeking to be recognized as a natural science. Skinner, for his part, was another of the great pillars that contributed to its scientific development, proposing both a philosophical basis (radical behaviorism), basic science (experimental analysis of behavior), and applied science (applied behavioral analysis), from which an enormous amount of knowledge applicable to different problems of socially relevant behaviors was derived. All this occurred while other very important experimental contributions, such as Guthrie, Thorndike, Hull, Eysenck, Tolman, Mowrer, and Staats, to mention just a few (Montgomery, 2002, 2014; Kazdin, 1983). On all these contributions, there would be attempts of unification such as that of Ardila in his experimental synthesis (Alarcón, 1997), while for his part, Anicama (2009; 2010) would speak of a model of scientific theory of behavior to try to solve the three questions of every applied psychologist related to the acquisition, maintenance, and modification of individual behavior.

In this way, psychology and its applications in the clinic have gained much more solidity as they are supported by the different contributions both in experimental research and theoretical formulations of these findings. The so-called stimulus control and contingency management technology (Montgomery, 2002) has been applied to different socially relevant problems, generating satisfactory results. With respect to the interest in the user's language, the consideration of this in behavior therapy has been increasing, assuming it is in terms of learning. Both public (overt) and private (covert) behavior are analyzed and studied under conditioning techniques in laboratory conditions, allowing contributions to the adaptation of strategies in the clinic; this is how procedures such as cognitive restructuring can be assumed in terms of verbal learning (signaling) in session.

The importance of learning theories

The experimental tradition in psychology, in what is called behavioral orientation, has provided a series of findings from which interpretations and theoretical formulations much more robust than those based on common sense have been established. The so-called learning theories allowed an enormous leap towards understanding the personality of each user, now understood as the result of exposure to a series of experiences that have generated (and will continue to propitiate) relatively stable changes in their performance (or tendency to do so) (Kimble, 1969; Ardila, 1979; Froufe, 2011; Pellón et al., 2014). The debate is still open, as the serious question would be whether or not it is necessary to have learning theories (Ribes, 1977) or to handle a scientific behavioral theory model (Anicama, 2009; 2010; Montgomery, 2018; Gonzales, 1971; Alcaraz, 1979; Bandura & Walters, 1974; Domjan, 2010; Alarcón, 1997) to favor the application to clinical users in psychology.

The interest in complex behavior is understandable for those who work with people whose performance and variability have forced them to rethink the experimental bases from which the applicative strategies are derived. Summarizing some of the main findings useful for the clinician, we point out the following:

From responsive conditioning, learning is obtained by associating stimuli, where a previously neutral stimulus **EN** becomes considered as a conditional stimulus **EC** after pairing the first one with an unconditional stimulus **EI**; that is, the unconditional response **RI** that only appeared after exposure to the unconditional stimulus **EI**. After repetition n of trials where the EI appears seconds after another neutral stimulus **EN**, the latter would acquire the ability to elicit an **RC** conditional response similar to **RI**. In the case of operant conditioning, the individual organism changes the morphology of its actions on the basis of the responses that are selected by the consequent; we speak of differential reinforcement and contingency relationship, all this in the presence of certain antecedent stimuli that function as a signal of the disposition of the consequent only in case the kind of response previously strengthened is realized, considering terms such as discriminative stimulus **(DS)**, operant response **(OR)** and reinforcing stimulus **(RS)**, where we can only speak of reinforcement after corroborating that a consequent stimulation has had the effect of increasing the probability of occurrence of a given response class.

Another of the contributions that allowed the analysis of social learning has been the imitative-observational conditioning, where an individual observes a model with attention, retains what is observed, and reproduces it later, being motivated

through external reinforcement, vicarious and self-reinforcement. The three mentioned above are the most widespread, but this does not mean that the contributions are only those; some contributions are worth commenting on; the visceral conditioning, also known as internal systems, constituted from the use of biofeedback, a great contribution to altering responses that were believed to be unmodifiable, from the manipulation of the antecedent and consequent stimulation. Finally, it is possible to understand the symbolic responses from cognitive-configurative conditioning, which represents one of the many proposals to understand what is commonly attributed to cognition. This is treated considering Pshonik's findings of isolation of the sensory component in different responses and Brodgen's sensory preconditioning, making possible from inhibition, generalization, discrimination and chaining, a signalization, achieving the formation of the perceptual image, acquisition of verbal repertoire, reaching repertoires of intellectual operations, figurative structures and self-regulation, reaching what is commonly called cognitive assimilation, so that verbal feedback comes to play an important role in the understanding of individual human behavior.

Schemes adapted for the clinician

The data obtained from experimental laboratory research should be adapted to be used for application purposes since what the psychology professional often seeks is not to resolve the question of what the psychological phenomenon is but rather how this knowledge can be used to fulfill his or her work functions. From the analysis and modification of behavior, a series of attempts have arisen to demonstrate the applicability and therapeutic power of these (Ulrich et al., 1979; Yates, 1987; Eysenck, 1979; Galindo et al., 1987; Wolpe, 1977; Ayllon & Azrin, 1974), managing to modify different maladaptive behaviors that were thought to be unmanageable, thus providing a viable alternative to society for the improvement of well-being.

The best-known examples are Wolpe's systematic desensitization procedure, where the therapist is guided through protocols for the elaboration of phobic items, their classification considering subjective anxiety units (SUDS) and inducing the user to a state of relaxation in order to proceed with the symbolic exposure to each identified stimulus. Another example is the protocol developed by Ayllon and Azrin on token economy, so famous and applied in many different cases, originally describing a procedure of identification of potential reinforcers, tokens equivalent to points, and the explanation to the participants of the behaviors to be performed in order to obtain the tokens.

As these classic examples, different protocols are being proposed for clinical work; being necessary to add that the professional in charge must know the logic under which they are applied, that is, the formulations from experimental research, in the first case, reciprocal inhibition and counterconditioning, while, in the second, differential reinforcement. The knowledge of the principles and learning processes that are executed when techniques and strategies are used is the essence of the clinicians, as it allows them to adapt the protocols and make them more flexible when the conditions are not as initially specified.

The behavioral-cognitive therapist's procedure

In the performance of the behavioral-cognitive therapist, it is necessary to order the data obtained in the case study in hypotheses of functional relationships, considering this an E-O-R-C model (Anicama, 2010). Behavioral or cognitive-behavioral therapy does not involve the exclusive application of the knowledge provided by learning theories. However, it contributes from this and other contributions such as psychophysiology, neurosciences, and psychometrics, among others. In this case, the clinical psychologist considers the scientific-experimental method not only to explain the acquisition and maintenance of the problem but also to modify it (Yates, 1970). On a day-to-day basis, professionals do not have all the factors to achieve the necessary control, so the adaptation of procedures will be a recurrently used way out.

It is necessary to describe the situations where typically appear the kinds of maladaptive responses, considering the consequences of this, to establish then the hypothesis of functional relationships (e.g., to assign the category of a positive reinforcer), both mediating processes and conditioning variables are considered in the organism "O." The former refers to the processes of reception-sensitization of physical agents, figurative representation, symbol transformation, selective drive, organization-actualization of activity, acquisition-preservation of activity

patterns, and the combination of all these in an individual; In contrast, the second would consider the physiological, social, pathological and evolutionary state of the individual, these being the intervening variables in "O," where, as Anicama (2009) refers, behavior is a function of the interaction between the environmental stimulus variables and the organismic variables R = F (E x O). In this case, only those that are functionally relevant both in E-O-R-C are noted.

The clinical psychologist, both in the initial contact and in the different moments of the approach (evaluation, intervention, and follow-up), obtains from the observation and verbal report of the psychology service user's general descriptions (e.g., low self-esteem), which should be specified in such a way that they can be recorded (e.g., verbalizations of the type my friends do not value me). He then classifies the different maladaptive behaviors as excesses, weaknesses, and deficits, also considering the adaptive behaviors that the user continues to perform. From the organization of the information in the functional analysis as a clinical tool, it is understood which of the patient's behaviors should be treated with therapeutic procedures derived from responsive, operant, imitative-observational, visceral, or cognitive-configurative conditioning. In this way, it must assume a position where the user's experiences have been favoring the acquisition of the behavioral repertoires for which he/she comes to the help of the psychotherapist, assuming strategies along the same lines to favor the acquisition of adaptive repertoires.

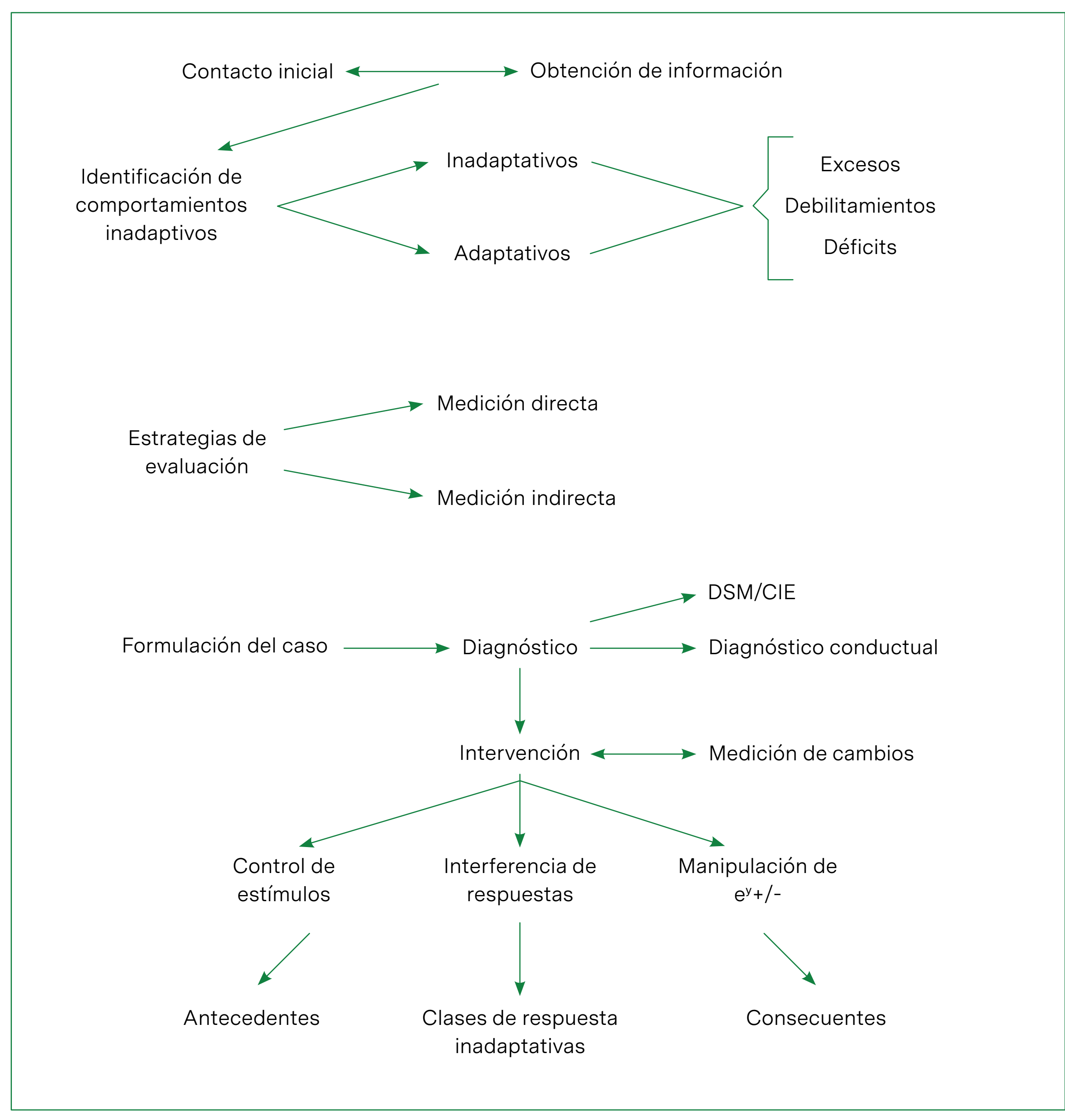
The concept of learning is relevant for these purposes, where, in this line, Domjan (2010) refers to a change in behavioral mechanisms that is lasting and involves both stimuli and specific responses that have been exposed in previous experiences. In this way, the psychologist can precisely design and execute strategies to intentionally expose the client to experiences that generate a therapeutic change, hoping that the types of response emitted are predominantly adaptive (adjusted to social criteria in the medium-long term), for which therapeutic strategies seek to reduce, strengthen and establish certain behaviors. Precisely different reflections (Pérez, 2012; Wolpe, 1977; Montgomery, 2014; Ulrich et al., 1979; Kazdin, 2000) lead to consider that in the psychotherapist's procedure, there is a) a clear intervention modifying the user's daily environment, b) different modalities of exposure inside and outside the office, c) training for better verbal control so that it is the user himself who is instigated to execute potentially more adjusted repertoires and e) training in contingency management to caregivers.

Based mainly on the contributions of Anicama (2010), it is necessary to rely on the stages of the scientific-experimental method in the intervention of the case in clinical practice, as it refers that it constitutes a methodological prescription to study and rehabilitate individual behavior, this would involve that both in the management of the behavioral interview, use of records, use of functional analysis schemes as a clinical tool, among others, should be performed considering the: (a) observation, (b) description, (c) explanation, (d) interpretation, (e) prediction and (f) control, taking them into account at different times as seen in Figure 1.

Assuming an E-O-R-C model, considering the intervening variables, i.e., mediating processes and conditioning variables (relevant to the case), we have models of interview and behavioral clinical history, collecting typical situations where the kinds of maladaptive responses appear, as well as their consequences and data of the consultant, which go from a descriptive analysis to a functional one later for the establishment of the hypotheses with which we will work.

Figure 1

Timing of cognitive behavioral intervention



Note: The moments in the approach are shown, from the initial contact, through the formulation and establishing the intervention through the three strategies: a) response interference, b) stimulus control and c) consequent manipulation.

The use of strategies for the measurement of therapeutic effects is necessary. Martin and Pear (2008) comment that such measurement constitutes a great advantage for the behavior modifier, allowing him to visualize whether or not the strategies are having the desired effect. Assuming the behavior as public (overt) or private (covert) is where recording systems or other forms of measurement should be prioritized, contrasting favorable and unfavorable changes from session to session and between the different phases of the intervention. The challenge that this involves requires not only a review of the literature but also supervised practice, including the use of systems such as checklists on aspects that the psychotherapist himself should have fulfilled in the development of the session. Being a professional in psychology who has the knowledge and the trained ability to be able to generate the necessary spaces and induce the emission of therapeutic responses, strengthening them and linking them to other repertoires of

adaptive behavior, after that, generating the necessary instructions to promote that it is the consultant himself the one who restructures the environment where he/she develops on a daily basis.

Through the strategies of a) response interference, b) stimulus control, and c) manipulation of the consequences, training is carried out in those repertoires that are potentially beneficial for the client, as in the case of assertive training, social skills, self-control, identification and execution of pleasant activities. Thus, this can be applied to couple problems, obsessions, compulsions, aggression and violence, specific phobias, stuttering, developmental delay, dyslexia, and behavioral medicine, to mention just a few examples (Anicama, 1993, 1989; Wolpe, 1977; Ramirez, 1975; Yates, 1987; Galindo et al., 1987; Perez & Bernardo, 1993).

The search for empirically supported psychotherapy

In recent decades, it has been seen that the therapeutic procedures that have gained the most ground are those that have made good marketing of their empirical support, i.e., popularizing the beneficial therapeutic effects of a procedure in comparison to other treatments and the waiting list (Vera, 2004). Evidence-based therapy EBT, as it has been called, has represented an improvement with respect to the defense of the psychologist's participation in the enhancement of the well-being of individuals; as Labrador (2008) reflected, several decades ago, it was expected that people (non-psychologists) had no idea of what a clinical psychologist does, nor of the potential it has to improve their quality of life, but this has changed significantly, precisely as a consequence of the empirical support that different procedures have been gaining.

The need for evidence-based psychotherapy (EBT) is supported by the negative consequences of psychological/psychiatric disorders, as well as their link to medical problems. Although EBTs are shown to be very beneficial, they are not necessarily available to all psychology service users (Cook et al., 2017) and should be valued more highly. These professionals must review specialized literature on the empirical support that different protocols and procedures have precisely to be able to provide the user with the most supported service possible. In this way, not only is the personal opinion of the psychotherapist considered, but data on the efficacy, efficiency, and effectiveness of the PR procedures applied should support this.

The evidence does not only come from randomized controlled clinical trials but should be with different methodologies, such as the contribution of case studies (Rousseau & Gunia, 2016). Consider also not only symptom reduction but complementing it with improvement of quality of life. Another challenge is to overcome criticisms due to misunderstandings, such as those where the EBTs are accused of only instructive to be applied without readaptation, which would be wrong since the APA (2006) itself would have considered that it is necessary to add both the judgment and experience of the professional in its application.

With regard to the clinical approach in users with cognitive-behavioral therapy, when the term behavioral is found first, the predominance of such contributions that the professional will consider in his clinical intervention is made explicit, both for the choice and readaptation of the strategies to the particularities that the user shows at that moment. In view of the need to be more congruent as far as possible and seek the highest quality in psychotherapy to users of the psychology service, empirical support would not only be found by the effects reported in comparing treatment groups and waiting lists but also proposals arise to analyze the therapeutic interaction itself, understanding it under the basic principles of learning to verbal behavior issued in consultation, both by the user and the psychotherapist, seeking a single line in the understanding of learning processes in its general approach.

CONCLUSIONS

Cognitive-behavioral therapy gathers different contributions from both behavioral and cognitive orientations, with a predominance of the former. In spite of the different attempts to propose a single line for the understanding and establishment of strategies for the application in clinical practice, there are still contributions that are only partially compatible. The line used has considered procedures of behavior therapy and behavior modification, trying to integrate

them and assuming verbal interaction as a key element of change. The importance of using the tool of functional analysis of individual behavior in the formulation of the case is reviewed, complemented with the behavioral diagnosis (behavioral excesses, weaknesses, and deficits), considering the strategy to evaluate the changes achieved, carried out as a way to monitor the therapeutic progress achieved (or its absence). It is understood that the strategies derived from the behavioral orientations have been covered more and more in the analysis of behavior modification. These aspects at the beginning did not, both in the clinical area and in others, increase the study of the verbal interaction between consultant-psychotherapist. The link between experimental research, learning theories, adaptation of schemes for the approach of the case in the clinic, and the search for empirical support of intervention strategies should be preserved. After the functional conceptualization of behaviors operationalized and described in the antecedent, response, and consequent sequences (considering the relevant ones in "O"), we proceed with a) response interference, b) stimulus control, and c) manipulation of the consequents.

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The author declares under oath that he has no conflict of interest in the preparation of this article.

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