Applying Empirically Supported Techniques in Your Practice

Edited by
William T. O'Donohue
Jane E. Fisher

Second Edition

COGNITIVE BEHAVIOR THERAPY

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Jane E. Fisher

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CONTENTS

Preface xiii

Acknowledgments xv

Contributors xvii

1 **Introduction 1**
William O'Donohue and Jane E. Fisher

2 **Psychological Acceptance 4**
James D. Herbert, Evan M. Forman, and Erica L. England

3 **Anger (Negative Impulse) Control 17**
Brad Donohue, Kendra Tracy, and Suzanne Gorney

4 **Assertiveness Skills and the Management of Related Factors 26**
Melanie P. Duckworth

5 **Attribution Change 35**
Rebecca S. Laird and Gerald I. Metalsky

6 **Behavioral Activation for Depression 40**
Christopher R. Martell

7 **Response Chaining 46**
W. Larry Williams and Eric Burkholder

8 **Behavioral Contracting 53**
Ramona Houmanfar, Kristen A. Maglieri, Horacio R. Roman, and Todd A. Ward

9 **Bibliotherapy Utilizing CBT 60**
Negar Nicole Jacobs

10 Breathing Retraining and Diaphragmatic Breathing Techniques 68
Holly Hazlett-Stevens and Michelle G. Craske

11 Classroom Management 75
Steven G. Little and Angeleque Akin-Little

12 Cognitive Defusion 83
Jason B. Luoma and Steven C.Hayes

13 Cognitive Restructuring of the Disputing of Irrational Beliefs 91
Albert Ellis

14 Cognitive Restructuring: Behavioral Tests of Negative Cognitions 96
Keith S. Dobson and Kate E. Hamilton

15 Communication/Problem-Solving Skills Training 101
Pamella H. Oliver and Gayla Margolin

16 Compliance with Medical Regimens 109
Elaine M. Heiby and Maxwell R. Frank

17 Contingency Management Interventions 116
Claudia Drossel, Christina G. Garrison-Diehn, and Jane E. Fisher

18 Daily Behavior Report Cards: Home–School Contingency Management Procedures 123
Mary Lou Kelley and Jennette L. Palcic

19 Dialectics in Cognitive and Behavior Therapy 132
Armida Rubio Fruzzetti and Alan E. Fruzzetti

20 Differential Reinforcement of Low-Rate Behavior 142
Mark Alavosius, Joseph Dagen, and William D. Newsome

21 Differential Reinforcement of Other Behavior and Differential Reinforcement of Alternative Behavior 147
Michele D. Wallace and Adel C. Najdowski

22 Directed Masturbation: a Treatment of Female Orgasmic Disorder 158
Stephanie Both and Ellen Laan

23 Distress Tolerance 167
Michael P. Twohig and Katherine A. Peterson

24 Emotion Regulation 174
Alan E. Fruzzetti, Wendy Crook, Karen M. Erikson, Jung Eun Lee, and John M. Worrall

25 Encopresis: Biobehavioral Treatment 187
Patrick C. Friman, Jennifer Resetar, and Kim DeRuyk

26 Expressive Writing 197
Jenna L.Baddeley and James W. Pennebaker

27 Flooding 202
Lori A. Zoellner, Jonathan S. Abramowitz, Sally A. Moore, and David M. Slagle

28 Experimental Functional Analysis of Problem Behavior 211
James E. Carr, Linda A. LeBlanc, and Jessa R. Love

29 Functional Communication Training to Treat Challenging Behavior 222
V. Mark Durand and Eileen Merges

30 Functional Self-Instruction Training to Promote Generalized Learning 230
Frank R. Rusch and DouglasKostewicz

31 Group Interventions 236
Claudia Drossel

32 Habit Reversal Training 245
Amanda Nicolson Adams, Mark A. Adams, and Raymond G. Miltenberger

33 Harm Reduction 253
Arthur W. Blume and G. Alan Marlatt

34 Putting It on the Street: Homework in Cognitive Behavioral Therapy 260
Patricia Robinson

35 The Prolonged CS Exposure Techniques of Implosive (Flooding) Therapy 272
Donald J. Levis

36 Cognitive Behavioral Treatment of Insomnia 283
Wilfred R. Pigeon and Michael L. Perlis

37 Interoceptive Exposure for Panic Disorder 296
John P. Forsyth, Tiffany Fusé, and Dean T. Acheson

38 Live (In Vivo) Exposure 309
Holly Hazlett-Stevens and Michelle G. Craske

39 Applications of the Matching Law 317
John C. Borrero, Michelle A. Frank, and Nicole L. Hausman

40 Mindfulness Practice 327
Sona Dimidjian and Marsha M. Linehan

41 Moderate Drinking Training for Problem Drinkers 337
Frederick Rotgers

42 Multimodal Behavior Therapy 342
Arnold A. Lazarus

43 Positive Psychology: A Behavioral Conceptualization and Application to Contemporary Behavior Therapy 347
Alyssa H. Kalata and Amy E. Naugle

44 Motivational Interviewing 357
Eric R. Levensky, Brian C. Kersh, Lavina L. Cavasos, and J. Annette Brooks

45 Noncontingent Reinforcement as a Treatment for Problem Behavior 367
Timothy R. Vollmer and Carrie S. W. Borrero

46 Pain Management 375
Robert J. Gatchel and Richard C. Robinson

47 Parent Training 383
Kevin J. Moore and Gerald R. Patterson

48 Self-Efficacy Interventions: Guided Mastery Therapy 390
Walter D. Scott and Daniel Cervone

49 Positive Attention 396
Stephen R. Boggs and Sheila M. Eyberg

50 Problem-Solving Therapy 402
Arthur M. Nezu, Christine Maguth Nezu, and Mary McMurran

51 Punishment 408
David P. Wacker, Jay Harding, Wendy Berg, Linda J. Cooper-Brown, and Anjali Barretto

52 Rapid Smoking 415
Elizabeth V. Gifford and Deacon Shoenberger

53 Relapse Prevention 422
Kirk A. B. Newring, Tamara M. Loverich, Cathi D. Harris, and Jennifer Wheeler

54 Relaxation 434
Kyle E. Ferguson and Rachel E. Sgambati

55 Response Prevention 445
Martin E. Franklin, Deborah A. Ledley and Edna B. Foa

56 Satiation Therapy 452
CrissaDraper

57 Identifying and Modifying Maladaptive Schemas 457
Cory F. Newman

58 Self-Management 466
Lynn P. Rehm and Jennifer H. Adams

59 Safety Training/Violence Prevention Using the SafeCare Parent Training Model 473
Daniel J. Whitaker, Dan Crimmins, Anna Edwards, and John R. Lutzker

60 Self-Monitoring as a Treatment Vehicle 478
Kathryn L. Humphreys, Brian P. Marx, and Jennifer M. Lexington

61 Sensate Focus 486
Lisa Regev and Joel Schmidt

62 Shaping 493
Kyle E. Ferguson and Kim Christiansen

63 Social Skills Training 502
Chris Segrin

64 Squeeze Technique for the Treatment of Premature Ejaculation 510
Claudia Avina

65 Stimulus Control 516
Alan Poling and Scott T. Gaynor

66 Stimulus Preference Assessment 523
Jane E. Fisher, Jeffrey A. Buchanan, and Stacey Cherup-Leslie

67 Stress Inoculation Training 529
Donald Meichenbaum

68 Stress Management Intervention 533
Victoria E. Mercer

69 Systematic Desensitization 542
Lara S. Head and Alan M. Gross

70 Think-Aloud Techniques 550
Gerald C. Davison, Jennifer L. Best, and Marat Zanov

71 Time-Out, Time-In, and Task-Based Grounding 557
Patrick C. Friman

72 Guidelines for Developing and Managing a Token Economy 565
Patrick M. Ghezzi, Ginger R. Wilson, Rachel S. F. Tarbox, and Kenneth R. MacAleese

73 Urge Surfing 571
Andy Lloyd

74 Validation Principles and Strategies 576
Kelly Koerner and Marsha M. Linehan

75 Values Clarification 583
Michael P. Twohig and Jesse M. Crosby

Author Index 589

Subject Index 623

PREFACE

Over the last three decades there has been a significant increase in interest in cognitive behavior therapy. This has occurred for several reasons: 1) Mounting experimental evidence supports the effectiveness of cognitive behavioral therapy for certain psychological problems induding high incidence problems such as depression and the anxiety disorders. The well-known Chambless report, for example, identifies many cognitive behavioral therapies as being empirically supported. In fact, cognitive behavioral techniques comprise most of the list. 2) Cognitive behavior therapy tends to be relatively brief and often can be delivered in groups. Therefore it can be more cost-effective than some alternatives and be seen to offer good value. These qualities have become particularly important in the era of managed care with its emphasis upon cost containment. 3) Cognitive behavior therapy has been applied with varying success to a wide variety of problems (see Fisher and O'Donohue, 2006 for over 70 behavioral health problems in which CBT can be considered an evidence based treatment. Thus, it has considerable scope and utility for the practitioner in general practice or the professional involved in the training of therapists. 4) Cognitive behavior therapy is a relatively straight forward and clearly operationalized approach to psychotherapy. This does not mean that case formulation or implementing these techniques is easy. However, CBT is more learnable that techniques such as psychoanalysis or Gestalt therapy. 5) Cognitive behavioral therapy is a therapy system comprised of many individual techniques, with researchers and practitioners constantly adding to this inventory. A given behavior therapist, because of his or her specialty, may know or use only a small subset of these. A clinician or clinical researcher may want to creatively combine individual techniques to treat some intransigent problem or an unfamiliar or complicated clinical presentation.

This volume attempts to bring together all of the specific techniques of cognitive behavior therapy. It does this in an ecumenical fashion. Historically, and currently, there are divisions inside behavior therapy that this book attempts to ignore. For example, cognitive and more traditionally behavioral techniques are included. This offended some prospective authors who were clearly warriors in the cognitive-behavioral battle. We wanted to be inclusive, particularly because pragmatically the outcome research favors both sides of this particular battle.

Our major interest in compiling this book was twofold: First we noted the lack of a volume that provides detailed descriptions of the techniques of cognitive behavioral therapy. Many books mentioned these but few described the techniques in detail. The absence of a comprehensive collection of the methods of cognitive-behavior therapy creates a gap in the training of students and in the faithful practice of cognitive behavior therapy. Second, with the increased interest in cognitive behavior therapy, particularly by the payers in managed care, there has been an increasing bastardization of behavior therapy. Some therapists are claiming they are administering some technique (e.g., relapse prevention or contingency management) when they clearly are not. This phenomenon, in our experience, rarely involves intentional deception but instead reflects an ignorance of the complexities of faith-fully implementing these techniques. This book is aimed at reducing this problem.

There is an important question regarding the extent to which a clinician can faithfully implement these techniques without a deeper understanding of behavior therapy. The evidence is not clear and of course the question is actually more complicated. Perhaps a generically skilled therapist with certain kinds of clients and certain kinds of techniques can implement the techniques well. On the other hand, a less skilled therapist dealing with a complicated clinical presentation utilizing a more subtle technique might not do so well. There is certainly a Gordon Paul type ultimate question lurking here. Something like: ''What kind of therapist, with what type of problem, using what kind of cognitive

behavior therapy technique, with what kind of training, can have what kinds of effects. . .'' With the risk of being seen as self-promoting, the reader can learn about the learning and conditioning underpinnings of many of thes techniques in O'Donohue (1998); and more of the theories associated with these techniques in O'Donohue and Krasner (1995). Fisher and O'Donohue (2006) provide a description of particular problems that these techniques can be used with.

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COGNITIVE BEHAVIOR THERAPY

1 INTRODUCTION

William O'Donohue and Jane E. Fisher

Cognitive behavior therapy (CBT) is an approach to human problems that can be viewed from several interrelated perspectives: philosophical, theoretical, methodological, assessment oriented, and technological. This book focuses on the last aspect, so crucial to clinical practice, but situated in the other four, much as any one of a cube's six sides is situated among all of the others.

Philosophically, CBT can be viewed as being associated (or, according to some who put it more strongly, derived) with one or another variety of behaviorism (O'Donohue & Kitchener, 1999). The behaviorisms are generally philosophies of science and philosophies of mind—that is, ways of defining and approaching the understanding of the problems traditionally associated with psychology.

There are at least two broad issues at the philosophical level: (1) What particular form of behaviorism is being embraced (O'Donohue & Kitchener, 1999, have identified at least 14), and (2) what is the nature of the relationship or association between this philosophy and the practice of CBT? Some have argued that behaviorism is irrelevant to behavior therapy—that one can practice behavior therapy and either reject behaviorism or be agnostic with regard to all forms of it. While an individual practitioner can behave in this way, some of the deeper structure that can be generative and guiding is lost. One can drive a car without an understanding of its workings, but one probably can't design a better car or modify an existing car without such an understanding. Similarly, a knowledge of behaviorism allows greater understanding of the choice points implicit in any technology. For example, why not view the client's problem as a neurological difficulty and intervene at this level? Behaviorism often provides possible answers to this kind of general challenge. However, we suggest that in recent decades there has been an unfortunate trend away from a philosophical understanding of behavior therapy to a more technique-oriented understanding.

The second aspect of behavior therapy is its theoretical structure. Here the issues are less philosophical—less about general epistemic issues—and more about substantive assertions regarding more specific problems as well as the principles appealed to in making these assertions. What is panic? What are its causes? What is the role of operant conditioning in children's oppositional behavior? How does one prevent relapse? Should cognitions be modified or accepted?

There are also a wide variety of theories associated with behavior therapy (O'Donohue & Krasner, 1995), including:

- Reciprocal inhibition
- Response deprivation
- Molar regulatory theory
- Two-factor fear theory
- Implosion theory
- Learned alarms
- Bioinformational theory
- Self-control theory
- Developmental theories
- Coercion theory
- Self-efficacy theory
- Attribution theory
- Information processing theory
- Relational frame theory
- Relapse prevention
- Evolutionary theory
- Marxist theory
- Feminist theory
- Dialectical theory
- Acceptance theory
- Functional analytic theory
- Interbehavioral theory