

COGNITIVE BEHAVIOR THERAPY:

Applying Empirically
Supported Techniques
in Your Practice

Edited by
William O'Donohue
Jane E. Fisher
Steven C. Hayes



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This book is dedicated to our mentors:

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James Geer

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Sister Margaret Ann White, C.S.J.

Michael G. H. Coles

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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 including 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. 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. 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. 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 talked about 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 question lurking here. Something like: "What kind of therapist, with what type of problem, using what kind of cognitive behavior therapy technique, 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 these techniques in O'Donohue (1998); and more of the theories associated with

these techniques in O'Donohue and Krasner (1995).

Finally, we wish to thank all the chapter authors. They uniformly wrote excellent chapters and completed these quickly. We'd also like to thank our editor at John Wiley, Jennifer Simon. She shared our vision for this book, gave us some excellent suggestions for improvement, and has been wonderful to work with. We'd also like to thank Nanci Fowler and Sara Ashby for all their secretarial assistance. She was invaluable. Finally, we'd like to thank our families for their support, especially our children, Katie, Annie, Camille, Charlie, and Essie.

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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. 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 fourteen), 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.

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?

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

Theories can provide answers or at least testable hypotheses for questions regarding more specific problems, such as these: What is the basic nature of this kind of clinical problem? How does this problem develop? What maintains this problem? What are its associated features and why? How is this problem possibly modified?

The third aspect of CBT is its program for knowledge generation. In the main, CBT is experimental and relies on a mixture of group experimental designs (e.g., the randomized controlled trial) and single-subject experimental designs (although in the largest perspective it can be seen to include correlational designs and even case studies). Methodologically, CBT generally embraces constructs such as social validity, clinical significance, follow-up measurements, manualized treatment, adherence and competence checks, the measurement of process variables, independent replications, and real-world effectiveness research. This tool box is complex, but one can discern a few distinct styles—such as that of the applied behavior analyst and that of the cognitive therapist (O'Donohue & Houts, 1985). Other styles can be seen when the nature of the question differs—for example, when the interest is in measurement development and validation or in the questions typically associated with experimental psychopathology.

The fourth aspect of CBT is its approach to measurement. Here a key issue is how to accurately detect and quantify variables of interest. Cognitive behavior therapy is associated with both a distinctive delineation of the domain of interest and distinct methods for measuring this. In general, behavioral assessment can be distinguished from more traditional measurement ap-

proaches by its focus on sampling of behavior rather than looking for signs of more abstract constructs. There are diverse streams of thought within the CBT tradition, however, from the embrace of traditional psychometric standards to the radically functional (e.g., Hayes, Nelson, & Jarrett, 1987). Some of the chapters in this volume deal with assessment techniques either because they are central to therapy or because assessment methods themselves are so reactive that they may be seen, in part, as treatment. However, in the main this book does not focus on the measurement aspect, leaving that task to other fine anthologies (e.g., Haynes & Heiby, in press).

The final aspect of CBT is *technique*—skilled practice. No amount of philosophy or theory will relieve clinicians from this level of analysis. A surgeon may be a biological determinist philosophically and may hold to certain theories of cancer and cancer treatment, but to help patients the surgeon still needs to implement surgical technique in a skilled manner. Similarly, cognitive behavior therapists need to be skilled in the execution of their techniques. In fact, an interesting set of research questions involves the relationship between the degree of skill (e.g., poor, novice, experienced, master) and therapy outcome. For example, if a clinician arranges potential positive reinforcers that are too distal in contingency manager it will be less effective. Similarly, if a clinician conducts systematic desensitization with only a few steps in a fear hierarchy, with weakly trained progressive muscle relaxation skills, and pairings that are few and of very short duration, it is unlikely to be as effective as it could otherwise be.

We've identified approximately 70 distinct techniques in CBT, covering both standard behavior therapy and cognitive therapy techniques, and relatively recently developed procedures such as acceptance strategies and mindfulness. This number has to qualify CBT as one of the most variegated therapy systems. This diversity no doubt derives from an interplay of complex factors: (1) the multiple learning theories upon which traditional behavior therapy is based (O'Donohue, 1998); (2) the multielemental nature of each of these theories (e.g., setting events, discrimination training, schedules of reinforcement, generalization processes, fading, etc.); (3) the

influence of other elements of experimental psychology such as experimental cognitive science; (4) the influence of other branches of psychology such as social psychology; (5) the influences of other intellectual domains (dialectics) or other fields of inquiry (mindfulness); (6) the interface of these with a particular kind of clinical problem (e.g., Borderline Personality Disorder); and finally (7) the creativity of the developers. But whatever the source of this tremendous variety, the presence of such a large number of major distinctive techniques leaves no doubt as to the multifactorial nature of contemporary CBT.

We've asked each of the chapter authors to follow a standard format, because we thought these main topics would delineate a bit of the context and all of the essential features needed to competently execute these techniques. We wanted them to describe who might benefit from this technique, contraindications, other factors relevant to making the decision to use or not to use the technique, how the technique might work (i.e., what process or pathway it may be associated with), and some of the evidence for its effectiveness. The major section of the chapter is a step-by-step guide that explains exactly how to implement the technique. Finally, we asked authors to include a brief table outlining the major elements of the technique.

The very number and diversity of CBT techniques place a significant burden on any practi-

tioner of CBT and, even more so, on the student. It is our hope that this volume, by clearly and concisely describing these techniques, will ease this burden. We also hope that precision about techniques can help the field continue to keep its eye on Gordon Paul's (1969) classic question: What techniques, delivered by what type of therapist, for what kind of client, with what kind of clinical problem, in what kind of setting, produces what kind of result, by what kind of process?

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2 ACCEPTANCE

Steven C. Hayes and Julieann Pankey

Psychological acceptance has been variously described as allowing, tolerating, embracing, experiencing, or making contact with a source of stimulation, particularly private experiences, that previously evoked escape, avoidance, or aggression (Cordova, 2001). To some degree, the importance both of therapeutic acceptance of the client and of helping the client accept him- or herself is recognized by all therapy approaches (Linehan, 1994). Acceptance, viewed broadly, is a critical component through which change strategies are engaged and is itself a significant mechanism of change (Greenberg, 1994; Hayes, Jacobson, Follette, & Dougher, 1994; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000). Wide differences exist, however, in conceptual definitions, the techniques employed to elicit acceptance, in the mechanism of change thought to be important (client focused or therapist stance), and in a focus on acceptance as a process and acceptance as an outcome.

Acceptance has a long history in behavioral health areas. Freud (1920) delineated psychopathological processes based on unconscious repression and avoidance of unwanted thoughts and emotions. Rogers (1961) focused on acceptance in terms of the therapist's relationship with the client. Here, acceptance was both a goal for the therapist to undertake in providing an unconditional, consistent, genuine, and noncritical psychotherapeutic context, and a client target for acceptance of self. Rogers posited that a genuine, interested, tolerant therapeutic stance known as

unconditional positive regard was the critical ingredient in the therapeutic process. The therapist sets the context by providing a noncritical place in which the client may recognize and clarify his or her emotions, and the client may then achieve acceptance of self through openness to experience and recognition of his or her "spontaneous self" (Rogers, 1992).

Acceptance has also been part of the tradition of humanistic/existential psychotherapy (Greenberg, 1994). Fritz Perls (1973) discussed acceptance in terms of allowing oneself an awareness of and openness to experiencing emotion genuinely.

What is new about acceptance approaches is their manualization, systematic conceptualization, and inclusion in empirically supported therapies. Behavioral and cognitive behavioral researchers and clinicians have been particularly important in this change. From a behavioral point of view, acceptance is a function rather than a form or topography, and it is an action rather than the content of cognition or emotion (Dougher, 1994). Modern research agrees that acceptance applies primarily to the domain of private subjective events and experiences (Greenberg, 1994). For example, Cordova and Kohlenberg (1994) define acceptance as the toleration of the emotions evoked by aversive stimuli. Here, experiential avoidance is orthogonal to acceptance. For example, behaviors that function to limit interpersonal closeness are often avoidance maintained; therefore, tolerance of aversive situations mani-

fested by not engaging behaviors to avoid, escape, or limit interpersonal contact is considered acceptance.

Linehan (1994) posits that acceptance and change highlight the synthesis of polarities in psychotherapy. A key component to Dialectical Behavior Therapy (DBT) (Linehan, 1993a) is the balance of acceptance and change in the treatment of mental disorder. Linehan defines acceptance as an active process of orienting to private experience moment by moment. It is entering reality just as it is at any given moment by noticing and describing without judgment. This sense of engaging acceptance over and over within any given moment is known as *radical acceptance*.

Hayes (1994) has defined psychological acceptance as one of the most important contextual change strategies. Here, acceptance refers to the conscious abandonment of a direct change agenda in the key domains of private events, self, and history, and an openness to experiencing thoughts and emotions as they are, not as they say they are. In this same vein, Dougher (1994) suggests that the key component of acceptance is letting go of one's control agenda and orienting toward valued actions. Defined that way, acceptance is not a goal in and of itself but a method of empowering the achievement of life goals.

EVIDENCE FOR THE IMPACT OF ACCEPTANCE PROCEDURES

Acceptance plays a key role in many empirically supported therapies (Hayes et al., 1994). One such therapy is Integrative Behavioral Couple Therapy (IBCT; Christensen, Jacobson, & Babcock, 1995). This is an acceptance-based treatment for couple discord. A recent comparison study between IBCT and traditional behavioral couple therapy indicated that IBCT resulted in greater increases in marital satisfaction than traditional behavioral therapy (Jacobson et al., 2000).

Psychological acceptance is a vital component of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), a behavior analytically based psychotherapy approach. An ACT model attempts to undermine emotional avoidance and increase the capacity for behavior change. Research from a randomized, controlled

trial of ACT in the workplace (Bond & Bunce, 2000) found that by increasing acceptance, ACT reduced stress and anxiety and increased behavior change in the workplace. Recent data from a randomized controlled trial using ACT to treat chronic, hospitalized seriously mentally ill patients experiencing hallucinations or delusions (Bach & Hayes, in press) found that acceptance of unwanted hallucinations resulted in higher reporting of positive psychotic symptoms. However, these individuals were nearly 4 times more likely to remain out of the hospital than were subjects not taught to accept these symptoms. These data suggest that symptom reporting reflected lower levels of denial and higher levels of psychological acceptance (Hayes, Pankey, Gifford, Batten, & Quinones, 2002).

Dialectical Behavior Therapy (DBT; Linehan, 1994) is an acceptance- and change-based cognitive behavioral treatment for chronically parasuicidal borderline patients. Data from a randomized controlled trial of DBT demonstrated that subjects who received DBT for 1 year had fewer incidences of parasuicide and less medically severe parasuicides, were more likely to stay in individual therapy, and had fewer inpatient psychiatric days (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). A follow-up randomized trial of DBT as compared with treatment as usual in the community at 1 year post-treatment found that during the initial 6 months of the follow-up, DBT subjects had significantly less parasuicidal behavior, less anger, and better self-reported social adjustment. During the final 6 months, DBT subjects had significantly fewer psychiatric inpatient days and better interviewer-rated social adjustment.

Process Evidence

The thought suppression literature provides insight into some of the processes underlying the deleterious effects of avoidance and the positive effects of acceptance (Hayes et al., 2002). Wegner, Schneider, Carter, and White (1987) found that active attempts to suppress targeted thoughts increased the occurrence of these thoughts, suggesting that active attempts to avoid private experience may have an ironic, paradoxical effect in that the attempts themselves increase the like-

likelihood of the thought. Further research (Wenzlaff, Wegner, & Klein, 1991) demonstrated that individuals who try to suppress thoughts experience a reinstatement of the mood state that existed during the initial period of suppression.

A meta-analysis of coping strategies (Suls & Fletcher, 1985) found that avoidance strategies (denial, distraction, repression and suppression) were more adaptive in the short-run; but that nonavoidant strategies (attention, noticing, and focusing) had more positive long-term outcomes. Avoidance is omnipresent by nature in all its overt and covert iterations. Contrasted with the beneficial health outcomes related to reductions in emotional avoidance (McCurry, 1991), it seems clear that acceptance in some form may be widely beneficial across the continuum of more benign forms of psychological unrest to more overt psychopathology (see Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, for a review).

THOSE WHO BENEFIT AND CONTRAINDICATIONS

Acceptance is particularly helpful with clients facing problems that are not amenable to the instrumental change strategies (Cordova, 2001), such as a difficult childhood history, automatic thoughts, or conditioned emotions. In some areas (e.g., acceptance of the continuity of consciousness or of self) acceptance is the only healthy alternative available.

Acceptance procedures are contraindicated, however, when they are applied to external situations or behaviors that can and should be controlled. For example, a pedophile might be encouraged to accept the presence of urges to molest children, but should not be encouraged to accept molesting behaviors; an abused spouse might be encouraged to accept angry reactions or feelings of shame, but should not be encouraged to accept abusive behavior or an abusive environment; a trichotillomanic might be encouraged to accept thoughts about pulling hair or the urge to do so, but should not be encouraged to accept hair pulling; a person with self-loathing thoughts would be encouraged to accept these thoughts as an ongoing process (e.g., “now I am having the thought that I am bad”) but would not be en-

TABLE 2.1 Steps in the Use of Acceptance Methods

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1. Detect and challenge experiential avoidance.
 2. Encourage aware, flexible, open exposure to previously avoided events.
 3. Encourage the development of new response functions in the presence of previously avoided events.
 4. Use defusion techniques when exposure to private verbal events leads to verbal entanglement.
-

couraged to accept their literal content (e.g., “and in fact I am bad”). The evidence is not yet clear on this distinction in some areas, however. For example, it is not known if it is better to accept thoughts as thoughts (see Chapter 13 on cognitive defusion) or to dispute their content.

ACCEPTANCE TECHNOLOGY

Acceptance is not a specific technique per se, in relation to other techniques or treatment technologies, but rather a stance or posture from which to conduct therapy and from which a client can conduct life. It is a context.

The techniques that foster this context (see Table 2.1) are

1. Detecting and challenging experiential avoidance
2. Encouraging aware, flexible, open exposure to previously avoided events
3. Encouraging the development of new response functions in the presence of previously avoided events, and
4. Using defusion techniques when exposure to private verbal events leads to verbal entanglement.

Detecting and Challenging Experiential Avoidance

It is not possible to foster acceptance unless the logical alternative is challenged and reduced. Clients arrive in therapy convinced that they need to reduce or eliminate various private events (e.g., fear, sadness, self-doubt, etc.) in order to live a powerful and vital life. This stance is usually simply assumed—it is more a metacognition than a cognition. If this control-focused stance is not challenged, the client will view acceptance as

a new, more sophisticated way to manipulate or control negative private experience (e.g., “if I stop trying to control my fear, it will go away”). There is little evidence that this is useful, and in functional terms it represents nothing new.

A wide variety of techniques can be helpful in challenging an ingrained control- and avoidance-focused agenda. Previous internally focused change efforts can be explored in depth, and the client can be asked if each was an ultimate, final, and fully satisfactory solution. The answer is always “no,” or else the client would not still be seeking services. When a full set of control-focused efforts are developed, the therapist can point out the obvious: The client’s own experience suggests that internally focused change efforts have provided no ultimate, final, and fully satisfactory solution. A client might be asked, “Which are you going to believe: your mind or your experience?”

Specific commonsense metaphors can be used to show that sometimes deliberate change efforts are doomed to failure. Acceptance and Commitment Therapy (Hayes et al., 1999) uses the following metaphor as one of several designed to make this point:

The situation here is something like those “Chinese handcuffs” we played with as kids. Have you ever seen them? It is a tube of woven straw about as big as your index finger. You push both index fingers in, one into each end, and as you pull them back out the straw catches and tightens. The harder you pull, the smaller the tube gets and the stronger it holds your finger. You’d have to pull your fingers out of their sockets to get them out by pulling them out once they’ve been caught. Maybe this situation is something like that. Maybe these tubes are like life itself. Maybe there is no healthy way to deliberately get out of certain aspects of your life, like your history, your memories, or your automatic feelings and any attempt to do so just restricts the room you have to move. With this little tube, the only way to get some room is to push your fingers in, which makes the tube bigger. Maybe this situation is like that. Pushing in may be hard at first to do because everything your mind tells you to do casts the issue in terms of “in and out” not “tight and loose.” But your experience is telling you that if what you are struggling with is cast in terms of “in and out,” then

life will be tight. And your life has gotten tighter and tighter, has it not? Isn’t that really part of why you came to see me? Well, maybe we need to come at this situation from a whole different angle than what your mind tells you to do with your painful experiences.

A variety of similar metaphors can be used to make the same point (e.g., struggling with anxiety is like struggling in quicksand; trying to push away experiences is like trying to push away flypaper; etc).

Encouraging Aware, Flexible, Open Exposure to Previously Avoided Events

Acceptance is not merely passive—it involves directly contacting the previously avoided functions or events. For example, acceptance of anxiety involves detecting its presence and deliberately exploring how it feels to be anxious. The methods of interoceptive exposure can be thought of in this way, as can many methods drawn from Gestalt and more experiential traditions.

An example of an acceptance technique of this kind is the “tin can monster” exercise used in ACT. The idea is that many experiences are difficult to experience because they are multifaceted. Like a huge monster made up of many less threatening pieces (e.g., bubble gum, bailing wire, and tin cans) it might be easier to deal with the pieces rather than the entire monster all at once. The client is asked to close his or her eyes and get into contact with a private experience he or she is trying to avoid or escape (e.g., anxiety). The client is then directed to notice, one at a time, specific bodily sensations that are occasioned by this overall experience. As each sensation is identified, the client is encouraged to see where the sensation begins and ends, what it feels like, and whether it is possible to feel that one sensation without avoidance. After several sensations are examined, the same approach is used with other response dimensions, such as emotions, urges to act, memories, and thoughts. Within each domain individual experiences are identified, examined, deliberately produced, and ultimately no longer avoided.

Marlatt and Gordon (1985) have presented a metaphor for this stage of acceptance from their

work on addiction: “urge surfing.” Cravings ebb and flow throughout our lives. At the peak of the wave (crest), individuals are most vulnerable to giving in to an urge because they fear that it will only get worse. The urge surfing metaphor is employed to help clients understand that individuals can become skilled at experiencing the rising and passing of urges without allowing themselves to be thrown off balance.

Encouraging the Development of New Response Functions in the Presence of Previously Avoided Events

Acceptance allows the response functions of previously avoided events to be more varied. Etymologically, *acceptance* means “to take in.” Taking in what a situation affords is not merely a matter of feeling, sensing, or thinking what one has always felt, sensed, or thought. It also means developing *new* functions. Acceptance procedures can thus include any technique that multiplies and variegates the functions of previously avoided events. For example, suppose a panic disordered person is taken to a mall. Deliberately and with awareness, the therapist and client might spend time guessing the careers of the people walking by, or find the ugliest storefront in the mall, or see how long it takes to walk from one end of the mall to the other, or see how long they can balance on one foot, or together agree to do something silly (e.g., if the person is worried that panic will lead to social humiliation, the client and therapist might go into a women’s clothing store and order a hamburger). The nature of the new functions that are established is not as important as the process of expanding a constricted repertoire.

Using Defusion Techniques When Exposure to Private Verbal Events Leads to Verbal Entanglement

Acceptance of thoughts is a difficult process, because what is being accepted is not their content but the process of thinking that content. Defusion techniques (see Chapter 13) are very helpful in allowing acceptance of private events.

Mindfulness techniques (see Chapter 35, this volume), such as those used in DBT (Linehan, 1993a, 1993b), involve all four of these steps. Mind-

fulness has to do with the quality of awareness that one brings to activities and requires for its practice acceptance of the moment (Linehan, 1994). These skills are taught to individuals in an effort to help them focus on one task or activity at a time, engaging in it with alertness, awareness, and wakefulness. Dialectical Behavior Therapy also offers skills training in *distress tolerance*, which promotes tolerating distress rather than acting from a place to ameliorate the pain. These skills include distraction, self-soothing, improving the moment, and learning pros and cons, which focuses on the pros of tolerating versus the cons of not tolerating. These skills are the mechanism by which one can *radically accept*, or enter reality as it is in the moment, accepting of total allowance now.

CONCLUSION

It is a paradox that acceptance is one of the more powerful forms of clinical change, because it involves a change in the purpose of change efforts themselves. There is a growing evidence base that acceptance skills are central to psychological well-being and can increase the impact of psychotherapy with a broad variety of clients.

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3 ANGER (NEGATIVE IMPULSE) MANAGEMENT

Brad Donohue and Nicole Cavenagh

Anger is an internal affective experience that varies in its intensity and chronicity (Deffenbacher, 1996). It may be experienced as a negative impulsive reaction to a specific stimulus in the environment (e.g., aggression in response to being kicked; swearing consequent to being struck in the thumb with a hammer; urges to use drugs in response to an argument) or may persist over time and across situations. Problem-solving skill deficits, maladaptive withdrawal, child and spousal abuse, and increased risk for health problems such as essential hypertension and cardiovascular disease are all examples of problems often strongly influenced by ineffective management of anger (see, e.g., Deffenbacher, Demm, & Brandon, 1986; Gentry, Chesney, Gary, Hall, & Harburg, 1982; Krantz, Contrada, Hill, & Friedler, 1988; Novaco, 1979).

To assist in the remediation of anger and other negative impulsive behaviors, several cognitive behavior methods have been developed, including thought stopping, relaxation training, problem solving, and self-reward for performance of non-anger-associated behaviors. We will briefly delineate each of these methods, including their theoretical rationale and empirical support. We will conclude by describing an urge control intervention that combines these methods in the effective management of negative impulses that are associated with behavioral misconduct and impulsive urges to use illicit drugs.

RESPONSIVE POPULATIONS AND CONTRAINDICATIONS

The state of the literature in anger management does not allow clear guidance for specific populations who might or might not benefit. Anger and aggression can sometimes be a side effect of various biological processes, however, so these factors should be considered before focusing entirely on psychological approaches.

THOUGHT STOPPING

Thought stopping is a method that may be utilized to interrupt undesirable or unproductive thoughts that often lead to anger. The method is particularly effective when the level of arousal is relatively weak (i.e., first recognition of the stimulus eliciting anger). As exemplified by Wolpe (1990), the procedure begins with the patient closing his or her eyes and verbalizing a thought that has been associated with negative arousal or anger. The therapist consequently shouts, "stop!" and then points out to the patient that the thought has actually stopped. After practicing the termination of similar thoughts in separate trials, the patient is encouraged to practice the termination of thoughts subvocally. Other phrases or visual images (e.g., "cut it out," image of red stop sign) may be used instead of "stop!" to mentally dis-