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Mindfulness and Acceptance

EXPANDING THE
COGNITIVE-BEHAVIORAL
TRADITION

Mindfulness and Acceptance

Expanding the Cognitive-Behavioral Tradition

Edited by

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—S. C. H. *To my friend and mentor, John D. Cone*

—V. M. F. *To everyone who has taught me so well:
my clients, my students, and my mentors*

—M. M. L. *To Pat Hawk, Zen Master in the Diamond Sangha,
a wonderful friend and mentor*

About the Editors

Steven C. Hayes, PhD, is Nevada Foundation Professor at the Department of Psychology at the University of Nevada. Author of more than 20 books and 325 scientific articles, his career has focused on the analysis of the nature of human language and cognition and the application of this to the understanding and alleviation of human suffering. Dr. Hayes has been President of Division 25 of the American Psychological Association, of the American Association of Applied and Preventive Psychology, and of the Association for Advancement of Behavior Therapy. He was the first Secretary-Treasurer of the American Psychological Society, which he helped form. Dr. Hayes has served on the National Advisory Council on Drug Abuse of the National Institutes of Health.

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Preface

The cognitive-behavioral therapy tradition (defined very broadly to include traditional behavior therapy, cognitive therapy, cognitive-behavioral therapy, clinical behavior analysis, and so on) began in the 1950s and blossomed in the 1960s. In its lifetime, this tradition has been through many changes, yet has maintained its core commitments to science, theory, and good practice. In the last 10 years, a new set of behavior therapies has emerged that emphasizes issues that were traditionally less emphasized or even off limits for behavioral and cognitive therapists, including mindfulness, acceptance, the therapeutic relationship, values, spirituality, meditation, focusing on the present moment, emotional deepening, and similar topics. These have emerged from the most behaviorally oriented wings and the most cognitive wings of the tradition. They differ from what is more common in the behavior therapy tradition not only in their focus but also in their technology, which often seems unexpectedly experiential, involving second-order change strategies, as well as more direct ones. Some involve sophisticated philosophy of science considerations. All are hard to characterize using the traditional distinctions between behavior therapy and other traditions, or those within the behavioral and cognitive tradition.

This is the first volume to try to examine that set of new developments and to ask some basic questions about it. Leading authors, researchers, and clinicians were brought together for a 3-day conference in Reno, Nevada, in the summer of 2002 to discuss all of these issues. They were asked to characterize their approaches clinically, and to consider how the focus of their approaches relates to the broader set of issues embraced by the new behavior therapies. They were asked to articulate their theoretical models, and examine their similarities and differences with other models both inside and outside of behavior therapy. Authors were encouraged to characterize briefly the research in support of their approaches, both outcome and process, and to try to look ahead at the implications of the data for the field. When they returned home, they were asked to react to the kinds of things they heard from other leaders in this set of new approaches.

What results is this volume: a wide-ranging exploration of a field in a phase of rapid development. The data and concepts in these chapters are challenging, exciting, and hopeful. These new developments seem to be broadening behavioral and cognitive therapy, and emboldening therapists to take on some of the most difficult clinical issues and challenges. It is not possible to know where they will lead, but it is clear that we are witnessing a significant expansion of the cognitive-behavioral tradition that is opening up new avenues of exploration for researchers and clinicians alike.

The book is organized such that the first few chapters look at more general technologies and issues, then gradually move toward technologies and issues that become more focused on specific populations. There is no hard and fast line between the two, and there is a great deal of interconnection between these treatments; thus, we did not attempt formal sections.

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Acceptance and Commitment Therapy and the New Behavior Therapies

Beyond their existence in the behavior therapy tradition broadly defined, no single factor unit the methods presented in this volume more than how hard it is to classify them using existing terms within empirical clinical psychology. Many are venturing boldly into areas outside the behavior therapy tradition, such as dialectics, spirituality, relationship, and mindfulness. The methods are unusually flexible, including means that are direct and indirect, didactic and experiential, instructional and metaphorical. Cognitively rationalized approaches are questioning the primacy of changes in cognitive content. Behaviorally rationalized approaches are embracing cognitive topics. What is going on here?

When many new approaches emerge that are difficult to classify, it is possibly a sign that the field itself is reorganizing. This has happened before in behavior therapy. It seems to be happening again (Hayes, in press).

Behavior therapy (referring to the entire range of behavioral and cognitive therapies, from clinic behavior analysis to cognitive therapy) emerged as an approach committed to the development of well-specified and rigorously tested applied technologies based on scientifically well-established basic principles (Franks & Wilson, 1974). It rejected existing clinical theories and technologies that were poorly specified, vaguely argued, and little researched. Behavior therapists criticized (e.g., Bandura, 1969, pp. 11–13; Wolpe & Rachman, 1960) the amazing flights of psychoanalytic fancy that could be occasioned by the simplest of phobias or other clinical disorders (e.g., Freud, 1909/1955). As a form of instructive ridicule, behavior therapists trained simple actions by direct shaping in the chronically mentally ill, and then watched with amusement as psychoanalytic colleagues concocted bizarre symbolic interpretations of behaviors that had known and simple histories (e.g., Ayllon, Houghton, & Hughes, 1965). The alternative presented by behavior therapy was direct, humble, rational, and empirical. Abandoning an interest in hypothesized unconscious fears and desires, behavior therapists focused instead on direct symptom relief. The psychoanalytic worry that this would result only in superficial behavioral gains (e.g., Bookbinder, 1962; Schraml & Selg, 1966) was criticized (e.g., Yates, 1958), puzzled over (Bandura, 1969, pp. 48–49), and shown empirically to be largely unfounded (Nurnberger & Hingtgen, 1973).

The rejection of existing clinical concepts and methods had several collateral effects, beyond the inclusion of science and well-established basic principles. It became unfashionable in behavior therapy to dabble in clinical issues that were too subtle, complex, or broad in scope. Clinical targets generally involved “first-order” change. If an anxious child was not going to school, going to school or anxiety about going to school was the target, not unconscious interests or conflicts. The approach was not only first order but also often direct. Perhaps because the products of science are sets of verbal rules, the clinical approaches themselves tended to be presented to clients in relatively straightforward or didactic ways. If social skills were poor, attempts were made to specify verbally the various components of “good social skills” and then train them directly, often including such methods as instructions and feedback.

This first generation of behavior therapy changed dramatically with the advent of cognitive methods. Both stimulus–response associationism and behavior analysis had failed to provide an adequate account of human language and cognition, and early behavior therapists soon learned that they needed to deal with thoughts and feelings in a more direct and central way. The cognitive therapy movement (e.g., Beck, Rush, Shaw, & Emery, 1979; Mahoney, 1974; Meichenbaum, 1977) attempted to do so. The objections of early founders that cognition had been dealt with all along (e.g., Wolpe, 1980) were largely ignored, because it was the centrality of cognition and the ability to deal with it in a natural way that was more at issue. In the absence of adequate basic accounts, early cognitive behavioral therapies approached cognition in a direct and clinically relevant way. In this work “cognition” generally referred to the commonsense categories of thoughts, ideas, beliefs, and suppositions. Through the use of questionnaires and clinical interviews focused on such target areas, clinicians learned to identify cognitive errors in particular patient populations, and direct means were developed to correct these problems.

Some of the leaders of these new approaches sought to overthrow behavior therapy, as was reflected in Beck’s well-known challenge: “Can a fledgling psychotherapy challenge the giants in the field—psychoanalysis and behavior therapy?” (1976, p. 333), but the behavior therapy tradition proved more flexible than that. What made a relatively smooth transition to the second generation of behavior therapy possible was the first-order change focus of the cognitive movement: “Cognitive therapy

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