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Mindfulness and Acceptance

EXPANDING THE COGNITIVE-BEHAVIORAL TRADITION

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Expanding the Cognitive-Behavioral Tradition

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To my friend and mentor, John D. Cone

—S. C. H.

To everyone who has taught me so well:
my clients, my students, and my mentors

—V. M. F.

To Pat Hawk, Zen Master in the Diamond Sangha,
a wonderful friend and mentor

—M. M. L.

About the Editors

Steven C. Hayes, PhD, is Nevada Foundation Professor at the Department of Psychology at th University of Nevada. Author of more than 20 books and 325 scientific articles, his career has focuse on the analysis of the nature of human language and cognition and the application of this to th understanding and alleviation of human suffering. Dr. Hayes has been President of Division 25 of th American Psychological Association, of the American Association of Applied and Preventiv 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 th National Advisory Council on Drug Abuse of the National Institutes of Health.

Victoria M. Follette, PhD, is Professor of Psychology and Chair of the Department of Psycholog at the University of Nevada. She heads the Trauma Research Institute of Nevada, using a contextu behavioral approach to understanding the sequelae of trauma. Dr. Follette's areas of interest includ taking science into applied treatment and mindfulness- and acceptance-based approaches to treatmen

Marsha M. Linehan, PhD, is Professor of Psychology and Adjunct Professor of Psychiatry an Behavioral Sciences at the University of Washington and Director of the Behavioral Research an Therapy Clinics, a consortium of research projects developing new treatments and evaluating the efficacy for persons with severe mental disorders and multiple diagnoses. Dr. Linehan's primar research is in the application of behavioral models to suicidal behaviors, drug abuse, and borderlin personality disorder. She was president of the Association for Advancement of Behavior Therapy an is currently a Fellow of the American Psychological Association and the America Psychopathological Association, as well as a Diplomate of the American Board of Behavior Psychology. Dr. Linehan has written two treatment manuals, *Cognitive-Behavioral Treatment o Borderline Personality Disorder* (1993, The Guilford Press) and *Skills Training Manual for Treatin Borderline Personality Disorder* (1993, The Guilford Press), and has published extensively scientific journals. She also serves on a number of editorial boards.

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Preface

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

This is the first volume to try to examine that set of new developments and to ask some bas questions about it. Leading authors, researchers, and clinicians were brought together for a 3-da conference in Reno, Nevada, in the summer of 2002 to discuss all of these issues. They were asked characterize their approaches clinically, and to consider how the focus of their approaches relates the broader set of issues embraced by the new behavior therapies. They were asked to articulate the theoretical models, and examine their similarities and differences with other models both inside an outside of behavior therapy. Authors were encouraged to characterize briefly the research in suppo 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 hea 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 developmen The data and concepts in these chapters are challenging, exciting, and hopeful. These ne developments seem to be broadening behavioral and cognitive therapy, and emboldening therapists take on some of the most difficult clinical issues and challenges. It is not possible to know where th will lead, but it is clear that we are witnessing a significant expansion of the cognitive-behavior 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 issue then gradually move toward technologies and issues that become more focused on specif populations. There is no hard and fast line between the two, and there is a great deal of interconnectio between these treatments; thus, we did not attempt formal sections.

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STEVEN C. HAY
VICTORIA M. FOLLET

Contents

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 tern within empirical clinical psychology. Many are venturing boldly into areas outside the behavi therapy tradition, such as dialectics, spirituality, relationship, and mindfulness. The methods a unusually flexible, including means that are direct and indirect, didactic and experiential, instruction and metaphorical. Cognitively rationalized approaches are questioning the primacy of changes cognitive content. Behaviorally rationalized approaches are embracing cognitive topics. What is goi on here?

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

FIRST- AND SECOND-GENERATION BEHAVIOR THERAPY

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 well-specified and rigorously tested applied technologies based on scientifically well-establishe basic principles (Franks & Wilson, 1974). It rejected existing clinical theories and technologies th 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 tha could be occasioned by the simplest of phobias or other clinical disorders (e.g., Freud, 1909/1955). A a form of instructive ridicule, behavior therapists trained simple actions by direct shaping in th chronically mentally ill, and then watched with amusement as psychoanalytic colleagues concocte bizarre symbolic interpretations of behaviors that had known and simple histories (e.g., Ayllon Haughton, & Hughes, 1965). The alternative presented by behavior therapy was direct, humbl rational, and empirical. Abandoning an interest in hypothesized unconscious fears and desire behavior therapists focused instead on direct symptom relief. The psychoanalytic worry that th would result only in superficial behavioral gains (e.g., Bookbinder, 1962; Schraml & Selg, 1966) wa criticized (e.g., Yates, 1958), puzzled over (Bandura, 1969, pp. 48–49), and shown empirically to b largely unfounded (Nurnberger & Hingtgen, 1973).

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

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

Some of the leaders of these new approaches sought to overthrow behavior therapy, as was reflecte 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 mo flexible than that. What made a relatively smooth transition to the second generation of behavi therapy possible was the first-order change focus of the cognitive movement: “Cognitive therapy