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INTRODUCTION

This FreeBook is a carefully curated selection of chapters from books published by Guilford Press and Routledge about Cognitive Behavioural Therapy and Acceptance & Commitment Therapy. This FreeBook is ideal for therapists of all levels of experience, including clinical psychologists, psychiatrists, clinical social workers, counselors, and psychiatric nurses.

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CHAPTER 1: OVERVIEW AND HISTORY OF EXPOSURE THERAPY FOR ANXIETY

Exposure Therapy for Anxiety, 2nd Edition helps the clinician gain skills and confidence for implementing exposure successfully and tailoring interventions to each client's needs, regardless of diagnosis. The theoretical and empirical bases of exposure are reviewed and specialized assessment and treatment planning techniques are described. **Overview and History of Exposure Therapy for Anxiety** provides a historical and theoretical framework for using exposure therapy to treat clinical anxiety and fear-based problems.

> *"In order to help people overcome such distressing and disabling anxiety, mental health professionals face the daunting task of selecting an effective treatment strategy from a dizzying array of available options. Some of these strategies are vigorously promoted as "cures" for a wide range of psychological (and medical) problems. Some are touted as short-term or "brief," whereas others ostensibly work over a longer period. Some are designed for individual therapy and others for group settings."*

CHAPTER 2: THE TARGETS OF ACT

Acceptance and Commitment Therapy: 100 Key Points and Techniques offers a comprehensive, yet concise, overview of the central features of the philosophy, theory, and practical application of ACT. In **The Targets of ACT** the purpose of ACT is introduced.

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"Life is not as simple as knowing your values and setting a course. Obstacles inevitably appear on the journey. Where instinctual or automatic learning might suggest these are insurmountable or need to be avoided."

CHAPTER 3: INTRODUCING *EXPERIENCING ACT FROM THE INSIDE OUT*

From leading acceptance and commitment therapy (ACT) practitioners, *Experiencing ACT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists* invites therapists to broaden and strengthen their ACT skills through deep engagement with ACT theory and techniques. **Introducing *Experiencing ACT from the Inside Out*** introduces ACT and self-practice/self-reflection concept.

"ACT is grounded in an appreciation of how we humans are set up for suffering and dissatisfaction by the very nature of human existence and by the dynamic processes embedded in human language and cognition."

CHAPTER 4: CHAIRWORK IN COGNITIVE AND BEHAVIOURAL THERAPIES

Part of the popular 'CBT Distinctive Features' series, *Cognitive Behavioural Chairwork: Distinctive Features* contains a wealth of effective experiential procedures for working with automatic thoughts, emotions, behaviours, core beliefs, ambivalence, strengths, well-being, and cognitive processes such as worry and self-criticism. **Chairwork in Cognitive and Behavioural Therapies** charts the development of chairwork in cognitive therapy and allied psycho- therapeutic approaches.

"Should chairwork become a more routine feature of CBT? Will these techniques undergo the same empirical scrutiny as other experiential techniques such as imagery? Could a 'dialogical' approach to CBT emerge, which centralises self-to-self and self-to-other dialogues through the medium of chairwork? Only time will tell."

CHAPTER 5: INTRODUCTION TO MENTAL IMAGERY AND THE DEVELOPMENT OF MAPP

People with bipolar disorder are particularly vulnerable to anxiety and intrusive mental imagery, which can contribute to mood swings and a heightened risk for relapse. *Imagery-Based Cognitive Therapy for Bipolar Disorder and Mood Instability*

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presents a novel brief treatment that focuses on working with mental images to reduce distress and enhance mood stability. **Introduction to Mental Imagery and the Development of MAPP** looks at why we believe that mental images may play an active role in the maintenance of BD, and why we think that working with these images may improve the effectiveness of psychotherapy.

> *"[M]ental images are sensory events that occur inside someone's mind with-out a corresponding current stimulus in the outside world. They can be "rendered" in a single sense (sight, sound, taste, smell, or somatic sensation) or in more than one sense (e.g., a visual image of one's mother plus the sound of her voice, the smell of her perfume, or the touch of her hand). Mental images can be fleeting, or they may last for longer. They can also be static or moving, clear or blurred."*

CHAPTER 6: IDENTIFYING AND EVALUATING THEORIES OF CAUSE AND CHANGE

Emotional Schema Therapy: Distinctive Features offers a concise overview to what is distinctive about this new approach to helping clients cope with "difficult" emotions. **Identifying and evaluating theories of cause and change** looks at the client's goal in therapy and approaching change.

> *"Emotions can be changed— or if they actually need to be changed. The EST model proposes that the client's theory of emotion not only encompasses the evaluations, interpretations and differentiation of emotions, but also beliefs about which emotions need to be addressed, which emotions one wants to change, how these emotions are described and what the client's theory of causality and change might be."*

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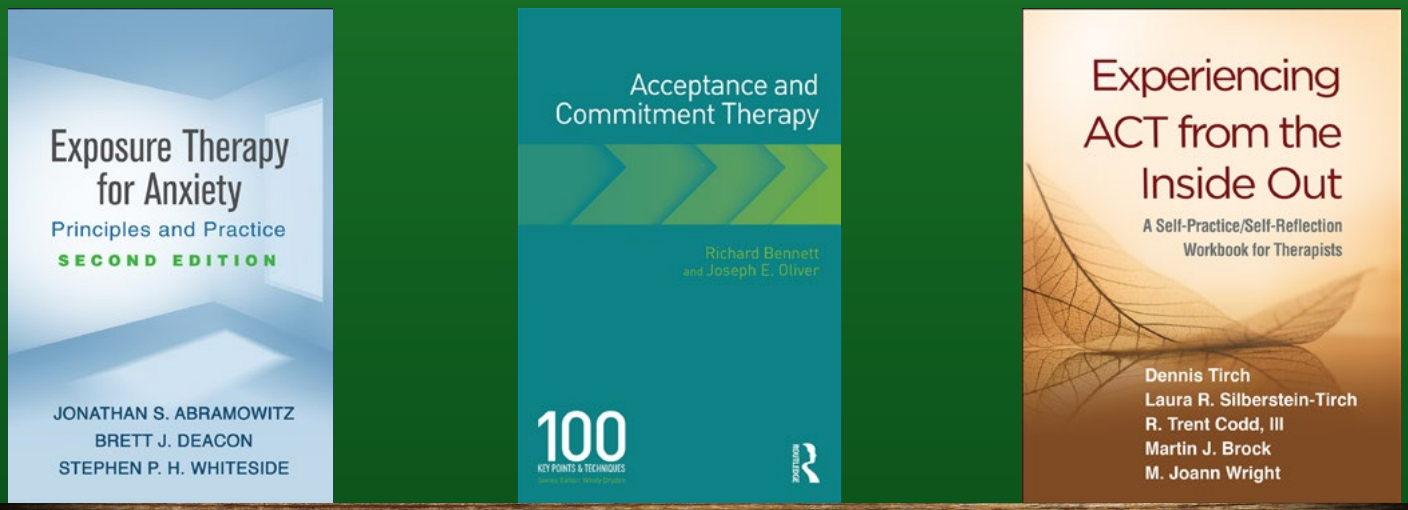

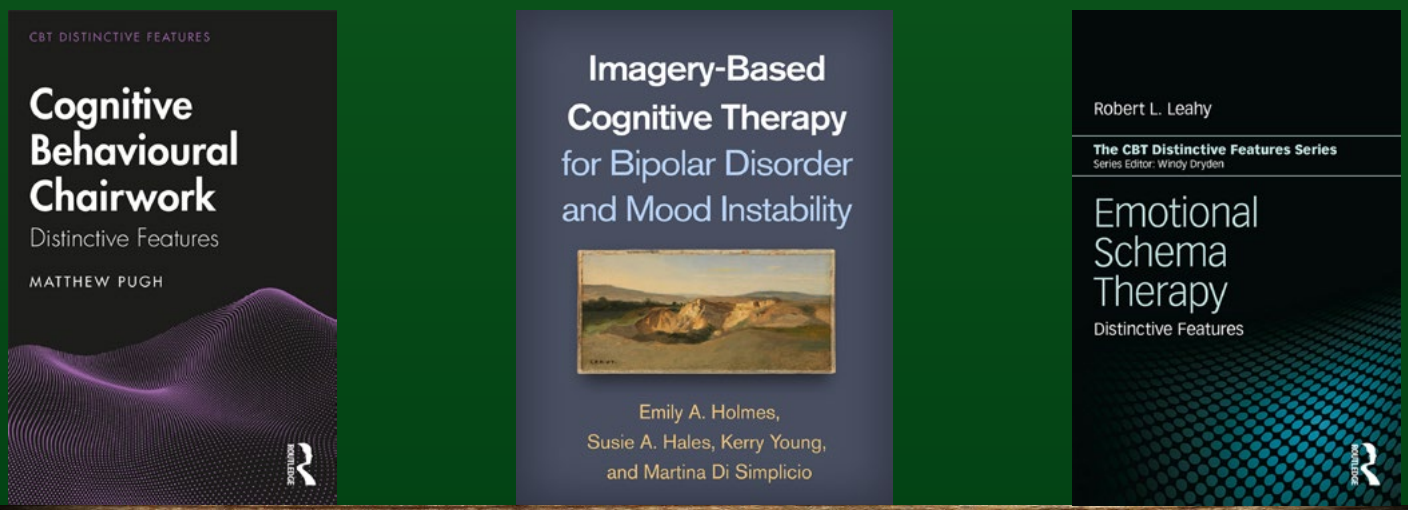

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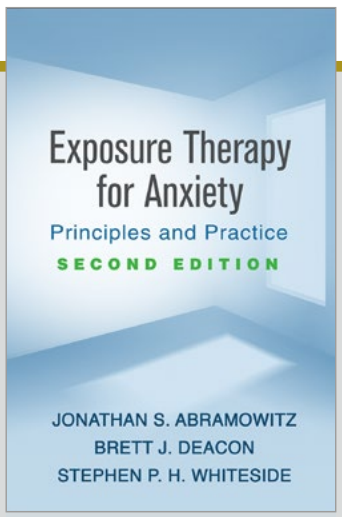
CHAPTER 1

OVERVIEW AND HISTORY OF EXPOSURE AND THERAPY FOR ANXIETY



OVERVIEW AND HISTORY OF EXPOSURE AND THERAPY FOR ANXIETY

Jonathan S. Abramowitz, Brett J. Deacon, and Stephen P. H. Whiteside

Excerpted from *Exposure Therapy for Anxiety, 2nd Edition: Principles and Practice*

The range of human fears is immeasurable. Whereas some people break out in a cold sweat at the thought of riding in an elevator or driving over a bridge, others fear animals (large or small, alive or dead), loss of control, speaking in front of others, or experiencing the sensations of physiological arousal. Still others are afraid of eternal damnation, "immoral" words and "unlucky" numbers, unwanted thoughts about sex or violence, or using public restrooms. There are even those who become immobilized at the sight of a clown, a cemetery, or their own navel.

In order to help people overcome such distressing and disabling anxiety, mental health professionals face the daunting task of selecting an effective treatment strategy from a dizzying array of available options. Some of these strategies are vigorously promoted as "cures" for a wide range of psychological (and medical) problems. Some are touted as short-term or "brief," whereas others ostensibly work over a longer period. Some are designed for individual therapy and others for group settings. Although proponents of most of these interventions claim that they are effective, convincing scientific evidence to support these claims is lacking in the majority of cases.

With so many possibilities, it is inevitable that many interventions that seem plausible are in the end ineffective or even harmful. Indeed, the treatment of anxiety has a long and colorful history dating back well past the fifth century B.C. Dimopoulos, Robinson, and Fountas (2008) recount instructive examples of "treatment" for panic attacks by "trephination," as described by contemporaries of Hippocrates. Essentially, "physicians" of the day—who had little knowledge of human anatomy—bored holes into the sufferer's skull, presumably to coax out from the brain the demons that were thought to cause "insanity." Although we may snicker at this practice now, variations of this approach have endured and are still in use in some parts of the world today. Practitioners used trephination because it "worked," by which we mean that it was occasionally followed by the cessation of panic attacks. However, one can achieve this same *spontaneous remission* of symptoms in about a third of panic sufferers without any intervention at all (Swobota, Amering, Windhaber, & Katschnig, 2001)— which has the added benefit of saving patients a hole in their head! Given the complexity and subtly of clinical fear and anxiety, it is no surprise that so many different treatments have been tried, and that so many have persisted despite a lack of evidence supporting their effectiveness.

This somewhat unruly state of the field demands not only that treatments prove their muster in carefully conducted research trials, but also that we gain knowledge about

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the process by which they produce their outcomes. Accomplishing this task requires demarcating potentially useful and valid principles of therapeutic change. Several candidates common to most, if not all, psychological treatments for clinical fear and anxiety include the therapeutic relationship, the milieu in which the patient is treated, and the patient's (and therapist's) expectations of improvement (Frank, 1989). Yet another common principle of change—that with which we concern ourselves in this book—derives from the observation that alterations in thoughts, feelings, and behavior appear to occur following a strong emotional response to material presented within the context of therapy. Psychoanalytically oriented therapists, for example, confront patients with information about so-called unconscious conflicts and unacceptable wishes through *free association* and the interpretation of dreams (Freud, 1949/1989). Likewise, Gestalt therapists use imagery, role enactment, and group interactions to coax the patient into confronting information that has been avoided (Perls, 1969). In this volume, we focus on a cognitive- behavioral-oriented approach—namely, exposure therapy—that involves a more direct and systematic sort of encounter with feared stimuli.

Exposure therapy refers to the process of helping a patient approach and engage with anxiety-provoking stimuli that objectively pose no more than everyday risk without the use of anxiety-reduction "coping" skills. Anxiety-evoking stimuli can be alive (e.g., snakes, clowns), inanimate (e.g., balloons, toilets), situational (e.g., funeral homes, bridges), cognitive (e.g., ideas of committing heinous acts, memories of a traumatic event), or physiological (e.g., racing heart, dizziness). Engagement with the objectively safe (or "low-risk") fear-eliciting stimulus typically precipitates a response ranging from mild apprehension to intense panic, the basis for which is the patient's exaggerated expectation of danger. It is thought that learning of one form or another takes place when a person repeatedly confronts a feared stimulus (e.g., a dog) in the absence of the expected feared consequence (e.g., the dog does not bite). Although debate continues regarding what exactly happens in the mind and brain during therapeutic exposure, a new behavioral repertoire seems to be cultivated and strengthened each time an individual effectively handles a previously feared situation without relying on safety cues or strategies for reducing the anxiety. Before we discuss the implementation of exposure therapy, however, let us explore the concept of anxiety and the history of exposure therapy.

ANXIETY: NORMAL AND ABNORMAL

Although a complete definition of anxiety is outside the scope of the present volume

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(entire books have been written on the subject; e.g., Barlow, 2002), anxiety is, broadly speaking, an organism's response to the *perception* of threat.[1] This implies that actual threat need not be present in order to experience anxiety. The reader will surely recall instances of his or her own intense fear and apprehension that turned out to be baseless. Similarly, it is possible to actually be in danger, yet not become anxious because the threat is not perceived. We have probably all had experiences in which it was only later that we realized how potentially dangerous a particular situation was. Either way, everyone is familiar with the psychological experience of feeling threatened, whether we label it as *anxiety, apprehension, fear, panic, worry, stress,* or something else. Moreover, we are all familiar with the physiological arousal that accompanies this emotion.

NORMAL ANXIETY

At a neurophysiological level, the anxiety (fear) response appears to be implemented in various brain structures, including the visual thalamus, visual cortex, and the amygdala (we note, however, that precisely how anxiety manifests in the brain is not completely understood). The brain stimulates the release of adrenaline from the adrenal glands, which activates the sympathetic nervous system and initiates the body's "fight-or- flight response." This response is the body's built-in way of priming the organism for reacting to a perceived threat by attacking (fighting for one's life) or running (fleeing to safety).

The fight-or-flight response occurs simultaneously on three levels. First, at a physiological level, the body prepares for physical exertion by enriching the blood with oxygen, which is converted to energy for use by the body's muscles. This change involves abrupt and noticeable increases in the intensity of the heart rate and depth of breathing. In addition, feelings of nausea are also common since digestion is not typically involved in fleeing or fighting for ones' life, and thus resources are diverted away from the digestive system to other areas of the body. Second, at a cognitive level, there is an automatic shift in attention toward the perceived threat (and ways to seek safety from it), so that it might seem difficult to concentrate on any extraneous matters. This focus serves as a constant reminder of the potential for harm and allows for early detection of threats and means of

[1] In this book we use the terms *anxiety* and *fear* somewhat interchangeably, although these concepts can be differentiated from one another. Anxiety is a future-oriented mood state associated with preparation for possible upcoming negative events; fear is an alarm response to present or imminent danger (real or perceived; Barlow, 2002).

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escaping them. Finally, at a behavioral level, the individual is compelled to take actions that are geared toward fighting, avoiding, or escaping the feared stimulus, such as by running away, thereby increasing the odds of survival. The fight-or-flight response is critical to the survival of humankind (and most other species in the animal kingdom). Just imagine what would happen if you were crossing a busy street in a large city—cars bearing down on you—and you felt absolutely no stress or anxiety. Most of us can recall a time when spontaneous actions motivated by the fight-or-flight response probably saved our life, or at least helped us avoid serious injury. As more than one author has put it, "in times of danger, anxiety can be a person's best friend" (e.g., Rosqvist, 2005, p. 1).

ABNORMAL ANXIETY

Unfortunately, sometimes the fight-or-flight response is the kind of "friend" that relieves us of the need for enemies. This happens when anxiety occurs in the absence of danger or when it is out of proportion relative to the actual threat. In these situations, such as having to speak in front of others, having your body prepared to run for safety probably won't keep you safe, but may make you sweaty or cause you to stutter due to increased muscle tension. Such excessive anxiety—stemming from the misperception of a safe situation as dangerous—appears to form the basis of most clinical anxiety problems (i.e., anxiety disorders; Barlow, 2002; Beck, Emery, & Greenberg, 1985). In such instances, the fight-or-flight response is triggered unnecessarily and may even worsen the situation by leading to more negative thoughts, such as "Everyone will notice my anxiety and think I'm incompetent." This sort of emotional reasoning bias serves to increase the perception of threat (Arntz, Rauner, & van den Hout, 1995) and maintain physiological responding, thereby creating a vicious cycle in which the perception of threat leads to anxious responding, which leads to more threat perception, and so on.

Another unfortunate consequence of habitually misperceiving objectively safe stimuli as dangerous is the development of strategies for avoiding these fear cues. These strategies may include "passive avoidance," such as a student with social anxiety refraining from raising her hand in class because she fears that her peers will laugh at her if she gives an incorrect answer. Other feared stimuli, including germs and traumatic memories, cannot be completely avoided. In such instances, the anxious individual will often develop strategies that serve as an "escape" from the feelings of anxiety that accompany exposure to these triggers (Barlow, 2002). Such "active avoidance" strategies include compulsive washing and cleaning to prevent illness

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after handling money and remaining close to a "safe person" for protection in a currently safe circumstance reminiscent of a previous traumatic event. By minimizing exposure to stimuli associated with clinical (unrealistic) anxiety, regardless of the form of avoidance, the person never has the opportunity to learn that such stimuli really are objectively safe (i.e., low risk; Clark, 1999). That is, the person cannot correct his or her misperception of the fear trigger, and he or she goes on believing (erroneously) that it is dangerous.

Not only do efforts to escape and avoid perceived threats prevent clinical anxiety from self-correcting over time, they may actually *worsen* the very problems they are intended to alleviate. Accordingly, much of the devastating effects of clinical anxiety result from the extreme lengths to which people go in trying to keep themselves safe by avoiding and escaping from (largely nonthreatening) fear cues. For example, we know of one man with a fear of AIDS who couldn't leave his bedroom for 5 years after someone with HIV had visited his home. A woman drove 45 miles out of her way to work each day to avoid having to cross a certain bridge. Another woman relocated from the West Coast of the United States to Rochester, Minnesota, just so she could be near the Mayo Clinic in case she suffered the extremely unlikely medical emergency she was anticipating. Although medically healthy, this individual restricted herself to traveling no more than a few miles from the clinic, and at all times carried with her various medical devices, self-test kits, and medicines. More detailed information regarding the development and maintenance of abnormal anxiety is presented in Chapter 3.

DSM-5 DIAGNOSES CHARACTERIZED BY ANXIETY

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) assumes a categorical stance and defines *psychiatric disorders* on the basis of observable signs and "symptoms." These diagnoses are intended to inform the clinician about the likely course of the problem and what treatments would be appropriate. The fifth edition of the DSM includes a number of conditions characterized by anxiety, as listed in Table 1.1. Although treatment manuals have been developed and evaluated for most of these conditions, the DSM diagnostic approach has a number of limitations that encumber its use for treatment planning. To begin with, the categorical delineation of the DSM system cannot fully capture the breadth and depth of human emotional experience. As far as anxiety-related disorders are concerned, the various DSM diagnostic labels merely reflect topographical (and largely superficial) differences among problems that have

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essentially the same fundamental psychological mechanism (e.g., Abramowitz & Deacon, 2005). That is, the disorders listed in Table 1.1 can all be conceptualized using the framework outlined above in which relatively safe stimuli are misperceived as dangerous, leading to unnecessary anxiety and what amount to unwarranted avoidance or escape behaviors that perpetuate the problem. Each diagnostic entity, however, has a somewhat unique set of fear cues, ways in which these cues are misperceived, and maladaptive coping responses. Table 1.2 shows these phenomena across the anxiety-related disorders in DSM-5.

TABLE 1.1 • Anxiety-Related Disorders Listed in DSM-5

Anxiety disorders
• Panic disorder with or without agoraphobia
• Specific phobia
• Social anxiety disorder
• Generalized anxiety disorder
• Separation anxiety disorder
• Selective mutism
Obsessive–compulsive-related disorders
• Obsessive–compulsive disorder
Trauma and related disorders
• Posttraumatic stress disorder
• Acute stress disorder
Somatic symptom and related disorders
• Illness anxiety disorder

The DSM also makes an arbitrary distinction regarding the level of severity that constitutes an anxiety (or anxiety-related) disorder (Widiger & Miller, 2008). In this system anxiety disorders are treated like medical diseases, such as cancer, which you either have or (preferably) do not. However, as can be seen from the discussion of normal and abnormal anxiety, fears and worries are more like blood pressure; everyone has it, but having too high (as well as too low) levels can be problematic. A categorically based diagnostic system does not provide treatment recommendations

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for individuals whose symptoms do not fall into a specific category or who have subthreshold symptoms.

TABLE 1.2 • Fear Cues, Misperceptions, and Maladaptive Coping Responses in the Major Anxiety Disorders

DSM disorder	Fear cue(s)	Misperception(s)	Maladaptive coping responses
Obsessive-compulsive disorder	Intrusive thoughts, situational cues	Thoughts are highly significant and equivalent to actions; inflated responsibility for preventing harm	Avoidance, compulsive rituals (e.g., checking, washing, covert neutralizing), reassurance seeking
Specific phobia	Snakes, heights, injections, etc.	Overestimation of the likelihood or severity of danger	Avoidance, use of drugs (alcohol, benzodiazepines), distraction
Social anxiety disorder	Social or performance situations	Other people are highly judgmental;negative evaluation is intolerable	Avoidance, in-situation safety behaviors (e.g., using alcohol at a party)
Panic disorder and agoraphobia	Arousal-related body sensations; situational cues	Misinterpretation of arousal-related body sensations as dangerous (e.g., a racing heart means a heart attack)	Agoraphobic avoidance, in-situation safety behaviors (e.g., going to emergency room), and safety signals (e.g., have safe person nearby, carry cellphone)
Illness anxiety disorder	Unexplained bodily sensations (arousal- or non-arousal-related)	Misappraisal of benign unexplained bodily sensations, perturbations, or changes as indicating a serious medical illness (e.g., cancer)	Seeking information from doctors or over the Internet, checking one's own body (including its vital functions and the properties of its waste products), avoidance of reminders of the feared illness
Posttraumatic stress disorder and acute stress disorder	Intrusive memories of traumatic events	Nowhere is safe,recalling a traumatic memory is intolerable	Avoidance of reminders, distraction, safety signals (e.g., carrying a gun)
Generalized anxiety disorder	Thoughts/images of low-probability negative events	Intolerance of uncertainty; overestimation of the likelihood and severity of negative outcomes	Reassurance seeking, worrying as a form of problem solving
Separation anxiety disorder	Physical separation from parents or other caregivers	Overestimation of the likelihood of threat of harm or permanent separation	Clinging to parents, crying, avoiding situations in which separation is required

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Accordingly, we espouse an alternative approach to diagnosis in which a mental disorder is viewed as a "dyscontrolled organismic impairment in psychological functioning" that falls along a continuum of severity (Widiger & Miller, 2008). In other words, some psychological *mechanism* within the individual, such as how he or she is responding to certain fear cues, is not functioning optimally. This operationalization is compatible with the view that effective psychological therapies don't treat "disorders" as much as they change (or reverse) maladaptive psychological mechanisms that characterize these problems (Abramowitz & Blakey, in press-a). As the reader will find, we approach exposure therapy as targeting key processes underlying the persistence of clinical anxiety rather than a treatment for a specific "disorder" (see Chapter 3).

Although exposure therapy must be modified depending on the particular fear trigger (see the chapters in Part II), this is not the same as using a different *treatment* or *treatment manual* for each different anxiety-related disorder. As we argue in this book, the same basic principles of exposure therapy can be applied to any patient's anxiety problem, regardless of which DSM diagnostic category best describes it. This *transdiagnostic* approach frees the therapist from the arduous task of learning to use a bookshelf full of treatment manuals for all the anxiety-related DSM disorders, and instead emphasizes understanding and treating the common psychological mechanisms that underlie the maintenance of anxiety-related problems in general.

ETIOLOGY VERSUS MAINTENANCE

The reader will also note that exposure therapy and its conceptual framework for understanding clinical anxiety are focused on the psychological processes that *maintain* the problem, rather than those that might lead to its development or *etiology*. One reason for this is that whereas the maintenance factors in anxiety are well understood based on careful clinical observation and empirical research (e.g., Clark, 1999), we understand much less about the factors that dictate why some people are more vulnerable to developing such problems than are others. Mineka and Zinbarg (2006) have proposed a comprehensive etiological model of anxiety disorders that incorporates early learning experiences, the occurrence and context of stressful events, and genetic or temperamental vulnerability. In other words, the tendency to respond in excessively fearful ways—on physiological, emotional, and behavioral levels—appears to be mediated by both environmental and biological variables.

Psychological treatments, however, cannot "undo" historical events or change genetic and temperamental predispositions. That is, they can't directly address the etiological factors in anxiety problems. In fact, therapists cannot even reliably

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determine the precise ways in which learning experiences and vulnerability factors interact to cause a particular individual's anxiety problem to develop. Yet, treatment can address the *maintenance factors*—that is, those phenomena that interfere with the natural process of overcoming a fear. If we view excessive anxious responding as learned *patterns* of maladaptive thinking and acting, we can help the patient learn healthier patterns to replace maladaptive ones. From this perspective, the following elements are necessary for successful and durable treatment of clinical fear and anxiety: (1) Patients must be presented with information that is incompatible with their maladaptive beliefs about the dangerousness or intolerability of feared stimuli; (2) behaviors that interfere with the acquisition and consolidation of this new information must be eliminated; and (3) this new information must be strengthened in memory and generalized as broadly as possible so that it is recalled in diverse contexts and over time. These elements provide the theoretical basis for the use of exposure therapy to treat most problems involving excessive fear and anxiety (e.g., Craske et al., 2008; Foa, Huppert, & Cahill, 2006). The remainder of this chapter provides a history of the development of this treatment technique.

CONTEMPORARY EXPOSURE THERAPY: AN OVERVIEW

As we detail in the pages of this volume, exposure therapy is both a science and an art. Although there is more than adequate empirical support for its conceptual basis and efficacy (see Chapter 2), implementing exposure still requires careful artistry and therapeutic know-how. No two anxious individuals present with precisely the same fears and avoidance patterns, and therefore no two exposure therapy programs will be exactly the same. This need for a patient-specific, or *idiosyncratic,* approach is one important challenge and a key characteristic of exposure therapy. In Chapter 4, we describe how to conduct a careful assessment that allows the clinician to tailor the treatment to the needs of the patient. The need to persuade anxious individuals to confront their greatest fears also represents a hurdle to successful exposure therapy. In Chapter 5, we present suggestions for conveying a clear and coherent rationale for treatment. What follows next is a general overview of contemporary exposure therapy procedures as commonly implemented. Later, we step back and take a historical perspective.

ASSESSMENT AND TREATMENT PLANNING

In general, exposure therapy begins with a thorough assessment of the patient's problem with anxiety. This "functional (or *behavioral*) assessment" (as we discuss in detail in Chapter 4) focuses on understanding (1) the contexts in which anxiety is

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triggered, (2) the anticipated feared consequences of encountering fear triggers, and (3) the strategies used to seek safety from harm and reduce anxiety by avoiding and escaping from these triggers. The therapist next thoroughly explains the exposure procedures and why they are expected to be helpful. Providing a clear rationale, along with use of helpful metaphors, helps to motivate the patient to see that engaging in exposure is worthwhile, even though it will likely provoke anxiety and distress. As we describe in Chapter 5, an effective rationale includes not only a clear and coherent explanation of the problem in terms that are readily understandable to the patient, but also information about how exposure therapy is commonly experienced, including the provocation of distress and the importance of learning that anxiety is safe and tolerable. The therapist's role as a coach and ally is also described. Information gleaned from the functional assessment is then used to plan the exposure exercises that will be pursued.

The preparatory stage of therapy also introduces the patient to the importance of eliminating subtle and not-so-subtle avoidance and escape (i.e., "coping") strategies that prevent the natural extinction of fear, that is, response prevention. Depending on the nature of the patient's anxiety problem and type of anxiety reduction strategies he or she uses, response prevention may take different forms. For example, individuals with compulsive rituals are taught to abstain from such ritualizing. Those who use benzodiazepine medication or alcohol to cope with anxious feelings are helped to safely reduce the use of these agents. Those who use safety cues such as not leaving home without a "safe person," cellphone, or water bottle are helped to complete exposure exercises without these safety signals.

PRACTICING EXPOSURE

How exposure therapy is carried out depends on the nature of the individual's fear as well as his or her goals for treatment. Although patients might begin by confronting moderately distressing stimuli and gradually working up to more difficult situations (i.e., using a hierarchy), exposure stimuli do not need to be encountered in any particular order. They might be confronted according to the patient's priorities, for example, in terms of how much addressing each item would improve quality of life. Exposure might occur in imagination when the feared stimulus is a thought or memory, such as for someone with intrusive unwanted sexual images or memories of traumatic experiences. Here, mentally visualizing this event (i.e., exposure in imagination, perhaps along with exposure to situational cues) would be the technique of choice. In cases where physiological states, such as anxious arousal itself, are the

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feared stimuli, the preferred method is interoceptive exposure in which the patient purposely elicits such internal stimuli (e.g., by engaging in physical activity or using caffeine). In any case, the aim of a particular exposure is to engage the patient with the fear stimulus in a systematic way and without the use of safety-seeking or anxiety-reducing coping strategies so that the patient can learn that the feared outcome is not as likely or as severe as was predicted *and* that feelings of anxiety are safe and manageable regardless of their intensity or duration.

Each individual exposure exercise concludes when the patient's expectations of the danger and/or intolerability of the stimulus have been contradicted to the fullest possible extent. Learning is focused on whether the expected negative outcome occurred, how manageable it was if it did occur, and the degree to which the patient's distress was tolerable. In some cases, this will require that exposures be prolonged and repeated multiple times and in different settings. When the exposure practice is over, patients are helped to further consolidate the newly gained information by discussing what they learned during the experience. Did their fears come true? Were the feelings of anxiety actually *unbearable*? What surprised them about doing the exposure? Patients are also helped to recognize that regardless of how anxious they felt, and how long those feelings persisted, they were able to get through the experience. As alluded to above, exposure therapy has been rigorously evaluated with thousands of anxious patients, treated by hundreds of therapists in a variety of clinics located around the world. This literature, which we review in Chapter 2, consistently demonstrates the efficacy (success in controlled studies) and effectiveness (success in clinical practice) of therapeutic exposure.

A HISTORY OF EXPOSURE THERAPY

Exposure, as a therapy procedure for reducing clinical fear, has its roots in the behavior therapy movement of the 1950s. The first behavior therapists emerged from multiple schools of psychotherapy, including the then- dominant psychoanalytic view in the United States and the United Kingdom (Krasner, 1971; Krasner & Houts, 1984). Some of the earliest efforts to treat phobias and other anxiety-related problems came from research- oriented psychologists and psychiatrists in South Africa, many of whom eventually made their way to England and the Maudsley Hospital training program directed by Hans Eysenck (Houts, 2005).

As a psychiatrist who was enthusiastic about learning theory and experimental psychology, Joseph Wolpe (1915–1997) turned to his psychologist colleagues to find

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like-minded individuals with whom to discuss clinical problems from a behavioral point of view. Among those he consulted was James G. Taylor (1897–1973) in the Psychology Department of the University of Capetown, South Africa. In the 1950s Taylor had used behavioral therapy procedures for the treatment of anxiety. Unfortunately, he did not publish most of his case studies, and only hints of his work survive in published form. In an interview with Leonard Krasner, Taylor described treating several patients with anxiety using techniques we would today call *situational exposure with response prevention* (Krasner, 1971). For example, in a case of driving phobia, he accompanied the patient on drives designed to elicit anxiety. He also exposed patients with compulsive handwashing behaviors to more and more anxiety-provoking circumstances and blocked their washing behavior. Although Taylor might have been the first behavior therapist to use systematic exposure techniques, more prolific investigators usually receive credit for bringing this form of therapy to the forefront of anxiety treatment.

SYSTEMATIC DESENSITIZATION

One of the first forms of exposure to emerge in the era of behavior therapy was *systematic desensitization (SD)*. Initially described by Salter (1949), but later elaborated by Wolpe (1958), SD involves weakening the association between anxiety and an objectively nondangerous phobic stimulus by pairing the phobic stimulus with a physiological state that is incompatible with anxiety. Procedurally, the patient and therapist first develop a fear hierarchy—a list of the patient's phobic situations and objects, ordered from the least to the most fear-provoking. Next, the therapist helps the patient become relaxed. Then, the anxiety-provoking stimuli are either gradually visualized or actually presented to the patient while he or she is in the relaxed state. Stimuli are confronted in order from the least to the most distressing. If the patient becomes anxious, the feared stimulus may be withdrawn until the patient can once more reestablish a relaxed state.

The goal of SD is for the patient to be completely relaxed while in the presence of his or her phobic stimuli. Wolpe adopted Jacobson's (1938) progressive muscle relaxation technique as the primary anxiety-inhibiting procedure. Once mastered by the patient, Wolpe believed that this technique could be employed at almost any time and in various circumstances both in and outside of the therapist's office. Wolpe also found that the use of imagined, rather than actual, exposure to feared stimuli expanded the range of phobic stimuli that could be addressed by SD. Therefore, although presentation of actual phobic material was occasionally used, SD usually involved

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exposure to thoughts and images of feared situations and stimuli. Wolpe derived his techniques for SD largely from his earlier laboratory research (Wolpe, 1958), and from the work of Mary Cover Jones (1924), which demonstrated that phobic responses (in animals and humans) could be weakened if a response that was the opposite of anxiety (and incompatible with it) occurred in the presence of the phobic stimulus. Wolpe, for example, conditioned cats to become afraid of their cage through the administration of electric shocks to the floor of the cage. He then found that he could weaken this phobic response by giving the cats food at locations progressively closer to the cage. Eating was viewed as a pleasant response antagonistic to phobic anxiety. Wolpe hypothesized that the cats were undergoing a process called *reciprocal inhibition* (i.e., anxiety inhibits feeding and feeding inhibits anxiety), which became the theoretical basis of SD.

A large body of clinical and experimental research amply demonstrates the efficacy and effectiveness of SD, particularly for specific phobias, social anxiety, and agoraphobia. In a classic study of patients with fears of public speaking, Paul (1966) found that SD was more effective than insight-oriented therapy. After only five treatment sessions, 100% of patients receiving SD were improved or much improved, compared to 47% who received insight-oriented treatment. Moreover, the therapists in this study had not been schooled in behavior therapy, suggesting that SD did not require intensive behaviorally oriented training. However, as other behavioral therapies that deemphasized the relaxation part of SD emerged in the 1970s and 1980s, research and clinical interest in SD began to decline (McGlynn, Smitherman, & Gothard, 2002).

FLOODING AND IMPLOSIVE THERAPY

Other precursors to contemporary exposure include flooding and implosive therapy (implosion). *Flooding* refers to a nongraduated approach in which the patient rapidly confronts his or her most feared stimuli, either in imagination or in real life, while minimizing escape from the fear-provoking context (i.e., response prevention). For example, a child with a phobia of large dogs might be placed in a room with such a dog and prevented from leaving until his anxiety subsides. Alternatively, the child might imagine strongly anxiety-eliciting scenes involving a large dog for a prolonged period of time. The assumption is that flooding results in the activation of anxiety, which then subsides over time in the absence of avoidance patterns and results in the extinction of the fear.

Implosive therapy was considered a variation of flooding (Stampfl & Levis, 1967), with the following differences. First, all presentations of fear-evoking situations were done

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in imagination. Second, the imagined scenes were often exaggerated or impossible situations designed to provoke as much anxiety as possible. Third, although derived from learning theory (Stampfl, 1966) and considered a behavioral technique, implosive therapy contained psychodynamic elements. Specifically, the scenes were often based on dynamic sources of anxiety such as hostility toward parental figures, rejection, sex, death wishes, and concepts such as the Oedipus complex. In illustrating implosive therapy for a person with snake phobia, Hogan (1968) described scenes including images of a snake crawling in the patient's lap, biting the patient's fingers off and blood dripping from the fingers, the snake biting the patient's face and pulling the eyes out and eating them, and the snake crawling into the eye socket and nose. Another scene involved falling into a pit filled with thousands of snakes. Assuming the snake is a symbol of male sexuality, a female patient might imagine a large snake sexually violating her and mutilating her sexual organs.

As fear reduction strategies, flooding and implosive therapy derive from the well-established laboratory principle of *extinction,* in which the repetition of the feared stimulus in the absence of the feared consequence and any escape or avoidance behaviors will result in the reduction of the fear. The use of these strategies to successfully treat phobias, posttraumatic stress reactions, and obsessive–compulsive problems proliferated in the 1960s and 1970s. Soon, influential behavior therapists and researchers such as Victor Meyer (1966), Jack Rachman (Rachman, Hodgson, & Marks, 1971; Rachman, Marks, & Hodgson, 1973), and Issac Marks (1973) realized that flooding, implosion, and SD all involved exposure to fear-provoking stimuli and abstinence from fear-reducing escape and avoidance responses. In the 1970s and 1980s, this recognition led to the development and testing of gradual (hierarchy-driven) exposure therapy that is devoid of the relaxation component of SD and the psychodynamic element of implosive therapy.

COGNITIVE-BEHAVIORAL THERAPY

Throughout the 1990s and 2000s, manualized cognitive-behavioral treatments (CBT) to address anxiety disorders proliferated and were tested in numerous randomized controlled trials. Popular empirically supported programs from this tradition include the Coping Cat for anxious youth (Kendall & Hedtke, 2006) and panic control treatment for adults with panic disorder (Craske & Barlow, 2006). These multicomponent manuals typically include exposure along with strategies to manage or reduce anxiety, such as cognitive restructuring, controlled breathing, and relaxation training. In some programs, patients are encouraged to use anxiety

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management strategies as coping skills during exposure tasks, in order to be able to tolerate and benefit from confronting feared stimuli. Although this approach is understandable, given that exposure has the potential to provoke high levels of anxious responding, many therapists emphasize anxiety-reducing coping skills with their anxious patients due to concerns that exposure is dangerous, intolerable, and unethical (Deacon, Farrell, et al., 2013; Whiteside, Deacon, Benito, & Stewart, 2016). As we have discussed, however, anxiety, although uncomfortable, is a universal and safe experience, and more intensive exposure approaches that do not include coping skills are highly effective—perhaps even more so than coping approaches (Ale, McCarthy, Rothschild, & Whiteside, 2015).

PROMOTING FEAR TOLERANCE AND INHIBITORY LEARNING

Anxiety reduction (i.e., habituation) within and between sessions has traditionally been considered a key indicator of therapeutic change (e.g., Foa & Kozak, 1986), and therapists often use a gradual approach to exposure by which patients work their way (i.e., using a fear hierarchy) from lesser to greater anxiety-provoking stimuli (in part) to foster fear habituation. More recently, however, some authors have pointed to limitations of this emphasis on anxiety reduction during exposure. Craske and colleagues (2008; Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014), for example, noted research showing that fear levels during exposure are not consistently reliable or valid indices of long-term fear extinction. Indeed, some patients who seemingly experience habituation in treatment later have a return of their fears, whereas others who do not experience habituation somehow show durable long-term fear extinction. Moreover, authors (e.g., Jacoby & Abramowitz, 2016) have argued that stressing gradual exposure and fear reduction (habituation) shames the experience of anxiety; reinforces the maladaptive belief that fear and other forms of distress are inherently bad, dangerous, or intolerable; and promotes the detrimental idea that exposure therapy is only successful if one is anxiety-free.

Accordingly, a more updated model to account for the effects of exposure focuses on inhibitory learning mechanisms to explain the discrepancies between performance during exposure and postexposure levels of fear. Within the context of exposure therapy, *inhibitory learning* refers to the notion that fear-based cognitions (e.g., thunderstorms are dangerous) are not *removed* during extinction, but rather remain *intact* as new learning about the feared stimulus occurs (e.g., thunderstorms are safe; Bouton, 1993). Put another way, following successful exposure, the feared stimulus is thought to possess two meanings: the original fear-based (excitatory)

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meaning as well as a safety-based (inhibitory) meaning. Thus, even if fear subsides following successful exposure, the original fear-based meaning is retained in memory and may be recovered under certain circumstances, such as a change in context or the passage of time (i.e., spontaneous recovery; Bouton, 2002). From this perspective, the aim of exposure therapy is to help patients develop (1) new nonthreatening cognitions and (2) ways of enhancing the accessibility of these new safety-based cognitions (relative to the older fear-based cognitions) in different contexts and over time.

As we discuss in later chapters, one of the important implications of inhibitory learning is that instead of teaching patients to resist, control, or "fix" their fear or anxiety, exposure is used to promote *fear tolerance,* given that fear and anxiety are universal, inevitable, and safe. This idea is consistent with recent developments in acceptance-based models and treatments for anxiety (e.g., Twohig et al., 2015), as we also discuss in Chapter 22. In the context of inhibitory learning, fear tolerance is accomplished by introducing *desirable difficulties* (Bjork, 1994) into the implementation of exposure therapy, for example, by restricting the use of anxiety coping strategies or by choosing exposure stimuli randomly rather than using a fear hierarchy. Such procedures may be considered "difficulties" because they present added challenges for the patient during exposure and may slow the rate of within- and between-session habituation of fear. On the other hand, they are "desirable" in that they help maximize long-term learning by introducing ubiquitous real-world challenges (e.g., surprise) that have the added benefit of maximizing the retrieval of newly learned information (Bjork, 1994). These desirable difficulties are thought to strengthen fear tolerance (Craske et al., 2008), as patients learn that fear is an opportunity to practice managing distress, as opposed to a sign of relapse or failure.

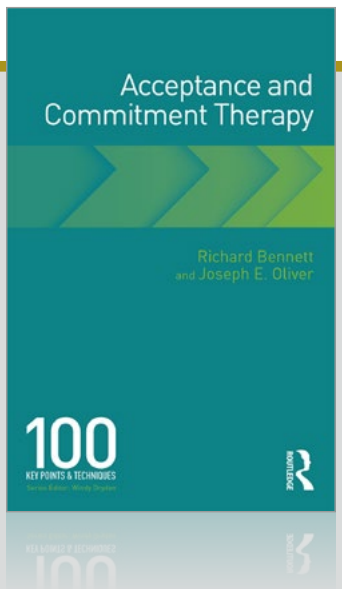
CONCLUSIONS

This chapter provides a historical and theoretical framework for using exposure therapy to treat clinical anxiety and fear-based problems. Although the idea that facing one's fears will lead to a reduction in fear responses has probably been recognized for millennia, it is only within the last century that research has been applied to understand the extent to which it does so and the reasons this approach works. In the next chapter, we review the treatment outcome literature that speaks to the efficacy and effectiveness of this form of therapy.

CHAPTER

2

THE TARGETS OF ACT



THE TARGETS OF ACT

Richard Bennett and Joseph E. Oliver

Excerpted from *Acceptance and Commitment Therapy: 100 Key Points and Techniques*

As an intervention, ACT differs from other therapeutic approaches in that it is not based on a symptom reduction model. Rather, the key targets are increasing value-driven behaviours, whilst at the same time, skilfully managing the internal obstacles that arise in this process. Although symptom reduction is not the focus of ACT, symptoms do often reduce, or begin to be seen in a very different light (this is the difference between feeling better and being *better at feeling*). It is more a matter of emphasis, which from the very beginning of an intervention begins to ask what a meaningful, well-lived life will look like.

Working towards a full, rich, and meaningful life is likely to bring some relief to some of the symptoms clients seek help for, such as disconnection, listlessness, anxiety, or a lack of motivation. Participating in activities and relationships that bring meaning and purpose can be intrinsically rewarding. Of course, living such a life means stepping out of comfort zones, and opening up to difficult emotions or taking risks. You can see the dilemma here for interventions that only focus on symptom reduction, since it becomes difficult to discern which emotions are to be eliminated and which are not. This is why ACT takes a different stance.

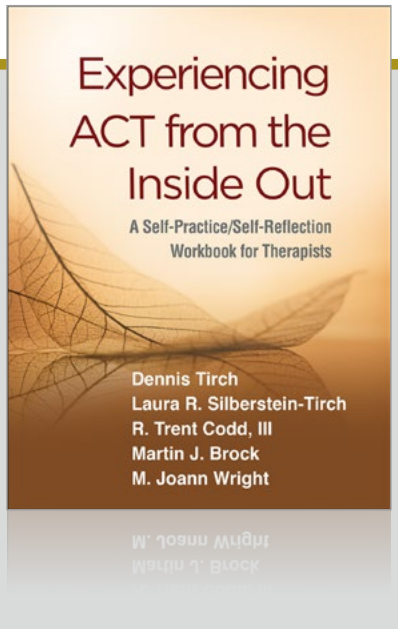
ACT helps clients to explore what is actually important to them in life. In some respects, this becomes an existential therapy, asking the big questions. However, sometimes the answers are not big; sometimes they are quiet, small, and personally relevant, but deeply precious. Just answering such questions is not enough. They need to be actively used as guiding lights in the darkness, suggesting new paths forward. Here, ACT explicitly invites clients to use their values as the guide and take actions in meaningful ways.

Of course, life is not as simple as knowing your values and setting a course. Obstacles inevitably appear on the journey. Where instinctual or automatic learning might suggest these are insurmountable or need to be avoided, ACT offers ways to skilfully respond to these experiences. This means not being blown over by them, but holding on to what is true, like a reed in the wind, with flexibility and without rigidity. Crucially, this means being able to respond to what is *actually in front of us*, not concepts from the past or future that pull for automatic responses. Experiential avoidance and cognitive fusion are ways in which these automatic responses show up, and they become targets for ACT intervention, where they are unhelpful.

CHAPTER

3

INTRODUCING *EXPERIENCING ACT FROM THE INSIDE OUT*



This chapter is excerpted from

Experiencing ACT from the Inside Out:
A Self-Practice/Self-Reflection Workbook for Therapists

By Dennis Tirch, Laura R. Silberstein-Tirch,
R. Trent Codd III, Martin J. Brock, and M. Joann Wright

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Acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999, 2012) is designed from the ground up to bring our best understanding of behavioral science to the problem of human suffering. Through a range of evidence-based techniques ACT emphasizes mindful behavior change and movement toward valued aims as core principles (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Over the last 20 years, a substantial body of research has demonstrated the effectiveness of ACT interventions across a range of human psychological and medical problems (Hooper & Larsson, 2015).During that same time, research has demonstrated that psychotherapists' self-practice and self-reflection (SP/SR) training can have a positive impact on therapist development across every experience level (Bennett-Levy & Lee, 2014; Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015). Accordingly, this book is designed *to apply SP/SR methods to the training of ACT therapists*. Essentially, you can use this workbook as an experiential immersion in the foundational elements of ACT. This means that experienced ACT therapists can work through these exercises and concepts, alone or in a group, to sharpen and deepen their ACT practice. Furthermore, the workbook can serve as an "inside-out" introductory text for beginning ACT therapists.

Not too long ago, the five of us set off on our own ACT SP/SR journey, encountering the methods and processes with which you will be working. It was a transformational experience for each of us. Even though we were all experienced ACT therapists, facing our own problems through ACT SP/SR involved vulnerability and radical honesty. During the time that it took to work through ACT SP/SR and to write this book, we faced some of the most challenging events in our lives. Together we encountered a range of life experiences—traumatic losses and new beginnings, serious illnesses and dramatic recoveries, professional stressors and personal leaps forward—the spectrum of human challenges that Jon Kabat-Zinn (2013) refers to in *Full Catastrophe Living*. During this time, our ACT SP/SR work and our relationships with one another provided us with strength, enhanced perspective, and support.

As a result of our own meaningful experiences practicing ACT from the inside out, we decided that we would use our own problem formulations and observations, rather than use composite characters or fictionalized examples in this book. We are aiming to "walk the walk" here, by introducing you to the reality of our own struggles and our own aspirations. We hope that this creates a context of openness, compassion, and connection as you set off to face similar challenges and opportunities to those we approached.

By engaging in these self-training practices, we hope you will cultivate greater reflective capacity, psychotherapy skills, and a deeper understanding of ACT. Rather

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than this solely being a book about acquiring knowledge, we have worked to provide a systematic series of exercises and reflections that can facilitate growth in both personal and professional areas of life. Our hope is that this will contribute to your well-being and to the growth and wellness of your clients.

We begin by providing an introduction to the essential rationale of ACT and SP/SR. We then provide some basic guidelines for how to approach this book. Chapters 2–4 provide further foundational material for you on your journey through experiencing ACT from the inside out.

THE AIM OF ACT SP/SR: BEING OPEN, CENTERED, AND ENGAGED

ACT is grounded in an appreciation of how we humans are set up for suffering and dissatisfaction by the very nature of human existence and by the dynamic processes embedded in human language and cognition. For example, even under the best of circumstances, much of our day-to-day behavior can seem guided by an "autopilot" mode of action. As we go about our daily tasks, perhaps checking things off our "to-do" list, repeating our habitual patterns of behavior, things might not feel very driven by purpose. If we wish to lose weight, we still might cave in to our urges and eat that second (third?) piece of pizza. Though we desperately long for deeper connections with our friends and family, we still avoid sending that email or planning a weekend together. Sometimes, our behavioral rigidity involves much darker and more painful dimensions. We can't stop ourselves from descending into opiate addiction or finding other escape routes to push away our feelings. We may stay in bed for days due to the weight of our depression, living smaller lives. The momentum of our behavior seems to carry us, unaware, to the next day's actions, like a wave inexorably heading toward the shore. ACT provides us with mindfulness-based interventions that can help us to "wake up" from this autopilot mode of operating. Mindfulness can provide us the space to choose new directions, possibly breaking chains of behavioral rigidity. ACT SP/SR can help us to learn how to feel "centered" in mindful awareness, grounded in this very moment, and ready to take action.

Beyond the routine and inflexible patterns of our actions, our thoughts themselves can also give us a lot of trouble. A great deal of our time can be spent in struggles with emotional pain and negative thoughts. We listen to our inner critic recite the litany of our failures as we distractedly go about our business. We worry about all of the things that could go wrong, imagining potential financial disasters, relationship breakups, or problems within our families. When these imaginary disasters and scolding

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inner voices show up, we feel them as though they were all too real. Images of failure and tragedy can set our hearts racing. Ironically, the more we try to suppress this kind of thinking, the worse it tends to get, and our efforts to avoid these thoughts only lead us to more intense spirals of feeling threatened and inadequate (Hooper, Saunders, & McHugh, 2010). But it doesn't have to be this way. We don't have to live robotically, and our minds don't need to feel like minefields. ACT involves methods for seeing thoughts and mental events clearly, as what they are and *not what they say they are* (Hayes et al., 1999). By training ourselves to know the difference between real-world situations and the demands of our minds, we may become better able to face the actual challenges and opportunities of life (Deacon, 2011). ACT SP/SR involves training in how to remain "open" to mental events, and how to thereby free ourselves from their excessive influence.

From a foundation of mindful awareness, noticing and accepting the flow of mental events that constantly pulls at our attention, ACT invites us to become the author of valued directions in our lives (Dahl, Plumb, Stewart, & Lundgren, 2009). When we have woken up to the moment, shaken off the cobwebs of mental projections, and set a course for valued living, we may be able to dedicate ourselves to living with greater purpose and meaning. What is it like when we feel that our lives are focused on what matters most? How do we feel when we know that our struggles are a part of moving toward a life that is worth working for, worth suffering for?

Beneath our patterns of automatic responding and our battles within ourselves we can envision some qualities of "doing" or "being" that we wish to bring into the world more fully. We wish to know meaning. We wish to stand for something. If we allow ourselves to quiet the mind and slow the body, turning in kindness to what matters most in this lifetime, we can envision living with purpose and vitality. For example, we might want to be more caring parents. At times, we might hope to become a better partner, or a more responsive friend. Some of us might feel driven to create great art. Establishing financial security might serve as a "true north" compass point for many of us. For those on a more contemplative or spiritual path, daily actions might be guided by the pursuit of personal awakening. Some of us might work to approach our relationships as the Bible tells us Jesus Christ would, aiming to extend love even to those who would seek to harm us. Perhaps we earnestly hope to develop more discipline in our approach to exercise. The range of values that we might carry with us and aspire to realize is as diverse as we are. Whatever your freely chosen values may be, ACT SP/SR involves methods to train ourselves to be "engaged" in our lives, with a commitment to becoming the version of ourselves we most wish to be.

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The qualities of being open, centered, and engaged are not just clever ideas in ACT SP/SR. These three "pillars" of our ACT SP/SR practice reflect evidence-based processes and procedures that we can use with our clients in experiential psychotherapy (Hayes et al., 2012). They also represent core processes that we can activate in our personal and professional development, which is one of the goals of the program we share with you in this book. Taken together, being open, centered, and engaged is described as "psychological flexibility." Research has established that cultivating psychological flexibility is key to overcoming a range of psychological problems and to establishing greater well-being (Powers, Zum Vorde Sive Vörding, & Emmelkamp, 2009; Ruiz, 2010). Developing greater psychological flexibility through ACT SP/SR is at the heart of our journey together.

WHAT IS ACT SP/SR?

Consistent with the ACT model, this book focuses on how therapists can breathe life into the pursuit of their valued aims with greater flexibility, compassion, and courage through a systematic and evidence-based SP/SR approach. ACT SP/SR is a structured, experiential training method that involves using ACT techniques on ourselves through self-practice (SP) and of reflecting on that experience through written self-reflection (SR). Through ACT SP/SR, we apply our psychotherapy approach to our own challenges in our personal and professional lives. Of course, any ACT training will involve time focusing on ourselves. Indeed, a great deal of foundational ACT workshop-based training involves experiencing ACT processes in ourselves. ACT SP/SR invites us to devote some time and attention to specifically and methodically deepening our ACT practice by using ACT techniques on ourselves.

Through ACT SP/SR we become our own therapist, sometimes in the company of trusted and caring colleagues who are sharing this journey. In order to structure and organize the inner work undertaken with this workbook, *we are asking you to choose a specific problem or domain of action to focus on during your work in this ACT SP/ SR program*. This can be a problem in your professional or personal life, or perhaps an issue that spans both of these aspects of your world. After engaging in each period of ACT SP, you will take time to engage in SR about your work and lived experience. These reflections appear to be more meaningful and impactful if they are written down, rather than just articulated out loud or even spoken "in our heads" (Bennett-Levy & Lee, 2014; Bennett-Levy, Lee, Travers, Pohlman, & Hamernik, 2003). These reflections involve many levels of application, doing, and being. For example, after practicing radical acceptance techniques around a distressing emotion, we might

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reflect upon the meaning of our experience for ourselves, for our work with clients, or even what implications our insights might have for ACT theory and practice.

ACT SP/SR work can be done as an individual practice. Indeed, readers of this book will likely more often be practicing on their own, working through these techniques as a part of their ongoing education and inner work. Importantly, SP/SR work can also take place in a group. Much of the research on SP/SR work took place in a group context (Bennett-Levy, McManus, Westling, & Fennell, 2009)—we formed just such a group as we developed this approach. In this context, we weren't serving as a support group or therapy group or providing therapy to one another—rather, we were working on ourselves in the context of a supportive and trusted community of friends. The research tells us that SP/SR participants have often reported a "deeper sense of knowing the therapy" (Bennett-Levy et al., 2015; Thwaites et al., 2015). We also shared this observation during a meaningful period of work. Candidly, this work lifted us up during some difficult times, and it helped us know our work and ourselves better while learning ACT from the inside out.

WHY ACT SP/SR?

In a sense, the SP/SR method and the development of ACT are both extensions of a seismic change in the zeitgeist of the cognitive-behavioral tradition, sometimes described as a "third wave" (Hayes, 2004). This shift of emphasis away from mechanistic models and toward methods that embraced experiential and reflective practice began near the end of the 20th century and has continued into the first decades of the 21st century (Tirch, Silberstein, & Kolts, 2015). While early cognitive-behavioral therapy (CBT) training did not involve much explicit emphasis on the exploration of the therapist's own process, SP/ SR method developer James Bennett-Levy (personal communication, August 13, 2018) has noted that a significant trend toward appreciation of interpersonal process and self-exploration emerged within CBT in the mid-1990s, contributing to the development of the SP/SR approach. SP/SR was designed as a training strategy to enhance the development of therapists' skills through practicing therapy techniques on themselves and engaging in SR from both a personal and professional perspective (Bennett-Levy et al., 2001).

The SP/SR approach became a part of a growing body of research within traditional CBT that emphasized and examined self-experience and SR. During roughly this time period, ACT and the contextual movement within the behavioral sciences also flourished and spread rapidly. With an emphasis on mindfulness, acceptance, and

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compassion, ACT naturally emphasized self-exploration, though using a different series of techniques. Accordingly, you are likely to find that integrating an SP/SR approach into ACT can be a much smoother transition than you might expect.

The growing body of SP/SR research demonstrates that this form of training allows us to develop greater attunement in the interpersonal dimension of the psychotherapy relationship (Gale & Schröder, 2014; Thwaites et al., 2015). Therapists who have completed SP/SR training have reported growth in important dimensions of the therapy relationship, including empathic understanding, therapeutic presence, and compassion (Gale & Schröder, 2014; Spendelow & Butler, 2016; Thwaites et al., 2015). These SP/ SR research findings have been found across countries, groups, and levels of experience (Bennett-Levy, 2019). Additionally, psychotherapists have reported greater self-confidence and confidence in their therapy approach after training in SP/ SR (Gale & Schröder, 2014). This has involved therapists reporting an enhancement of both their conceptual skills and technical skills after taking part in SP/SR training.

Pakenham (2015) has repeatedly explored the value of self-care and ACT SP, with a particular emphasis on dealing with the impact of stress during graduate training. While this research does not follow a manualized SP/SR protocol, it has pioneered the use of the ACT model for personal practice. Based on a review of the literature, Pakenham and Stafford-Brown (2012) note that high levels of stress and potential burnout among clinicians have not been adequately addressed by current training models. Their group has put forward a call to arms for the field, suggesting the implementation of mindfulness- and acceptance-based methods consistent with our ACT SP/SR approach (Stafford-Brown & Pakenham, 2012). Using a "self-as-laboratory" approach, Pakenham and his colleagues examined the impact of ACT training and SP in several studies involving clinical psychology trainees. Their research reported that participants had significant improvements in mindfulness, specific therapist skills, increased psychological flexibility, and decreased personal distress. Thus far, research in the ACT work has mirrored the findings of research using SP/SR among CBT practitioners and suggests the value of learning ACT from the inside out, in the way we elaborate in this workbook.

ORIENTATION TO *EXPERIENCING ACT FROM THE INSIDE OUT*

This book is divided into two parts. The first main section includes the foundational chapters that explain our approach and help you prepare to engage in the practical work that follows throughout our ACT SP/SR

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method. We suggest that everyone using this book should read Chapters 1–3. Chapters 1 and 2 provide the theoretical orientation and conceptual foundation for ACT SP/SR. Some of you who are more familiar with the underlying philosophy of science, theory of cognition, and therapy method involved in ACT might find these two earlier chapters to be a review. *Nonetheless, we invite you to return to this material with fresh eyes and a " beginner's mind" as much as you can as you begin your ACT SP/SR journey*. If you can, put yourself in the place of your client or an early career therapist and begin to engage with this material from a fresh perspective.

One of the central concerns in the ACT community involves approaching ACT as a model of applied contextual behavioral science rather than as a toolbox of psychotherapy techniques. ACT was never intended to be adopted merely as a therapy protocol, but was designed and developed as a scalable model for cultivating well-being grounded in evidence-based processes and principles. Understanding the underlying philosophy and conceptual model that supports ACT is *the key* to using ACT techniques effectively. For this reason, we highly suggest working with the material in the introductory chapters and responding to the reflective questions that are included. The best ACT therapists we know use their mastery of basic behavioral principles to improvise and develop new interventions that are sensitive to real-time contingencies that they encounter with their clients. Our hope is that your review and engagement with this material will help you hone these skills through your SP/SR journey.

Chapter 3 provides guidelines and suggestions for any person participating in an ACT SP/SR group. This chapter will help you consider practical considerations, such as whether it will be best to practice on your own or with a group. The chapter offers suggestions about how you might identify and understand the problem you are choosing to work on as you use this ACT SP/SR workbook. Additionally, the chapter provides further information about how to best approach SR and how to bridge among our personal practice, reflection, and application.

Chapter 3 also prepares you to use the practice-based components of the book that are organized as "modules." The modules each reflect the processes that interact to bring forth and enhance psychological flexibility. Furthermore, the modules build on the psychological flexibility model to

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help us bring greater mindfulness and self-compassion into our work with ourselves as psychotherapeutic instruments. While it might seem easy, and even tempting, to breeze through the modules by giving them a quick read, and maybe taking a technique or two out for a "test drive," you will clearly get the most out of this ACT SP/SR program by deeply engaging with the material and the practices provided. We suggest taking at least 2–3 hours for each module, and possibly more time if some of the experiential exercises expand to become a part of a daily personal practice. Furthermore, several of the modules directly ask you to devote time to daily practice over the course of a week or more and to reflect upon the sum of that work in your SR questions or group discussions.

Chapter 4 is designed to help those of you who wish to facilitate ACT SP/SR groups. As such, much of this chapter might be less relevant for the solo practitioner or group member. Consider this an "optional" chapter, unless you are thinking about bringing together a group as a facilitator. If you are planning to organize and facilitate a group, the chapter walks you through the steps needed to get a group together and helps you anticipate some of the ups and downs you might run into as the group proceeds.

The second part of the book walks you through a series of modules that provide experiential SP exercises and a series of SR questions. These practices are organized around the psychological flexibility model and they provide an opportunity for you to cultivate specific capacities. Training the mind in psychological flexibility has broad empirical support throughout several scalable levels of intervention (Hooper & Larsson, 2015; Powers et al., 2009; Ruiz, 2010). Our aim is to provide you with an opportunity to use ACT SP/SR to develop evidence-supported processes leading to personal transformation. As a result, most of this workbook does not follow the format of a technical manual or narrative journey. The second section of this book is a "hands-on" guide for your own ACT SP/SR journey.

We wish you well on this shared path of personal and professional growth. As we become available to our own mindfulness, compassion, and wisdom, we are better able to share these resources with those who suffer. A path like this requires self-direction, discipline, and dedication. We wish all of these for you, as well as an openness to the help available through our communities of clinicians and fellow travelers. We are all in this together, and the prevention

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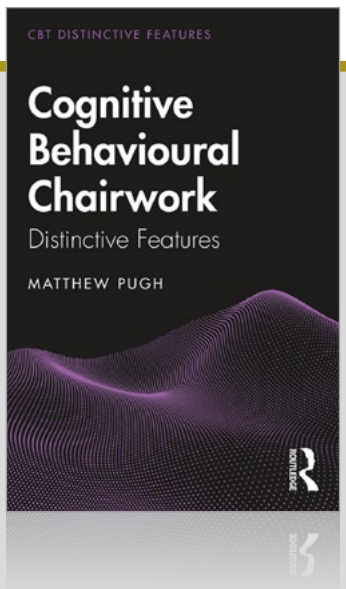
and alleviation of human suffering is a cause worth dedicating ourselves to with an open heart and determined commitment.

Note: The contextual behavioral science (CBS) community appreciates that gender involves behaviors that can be viewed as a performative spectrum, and that the arbitrary application of binary gender constructs can be limiting and even stigmatizing to many. As a result, we have chosen to use the singular "they" pronoun wherever possible throughout this text. This flexibility in our working with the fluid rules of grammar and style, in response to context, is consistent with the psychological flexibility model and our aims in CBS. We hope this will work for all our readers, and thank you for coming along for the ride.

CHAPTER 4

CHAIRWORK IN COGNITIVE AND BEHAVIOURAL THERAPIES



CHAIRWORK IN COGNITIVE AND BEHAVIOURAL THERAPIES

Matthew Pugh

Excerpted from *Cognitive Behavioural Chairwork: Distinctive Features*

Despite its rich history of applications, many CBT therapists are unfamiliar with chairwork. To contextualise the inclusion of these techniques in clinicians' technical repertoires, this chapter charts the development of chairwork in cognitive therapy and allied psycho-therapeutic approaches.

BEHAVIOUR THERAPY

Behavioural therapy (BT) emerged in the 1950s with the intention of modifying maladaptive behaviour. One of the first behavioural interventions widely applied by clinicians, assertiveness skills training sought to alleviate clients' social and emotional inhibitions by encouraging a "return to excitation" (Salter, 1949, p. 39). These ideas were extended by Wolpe (1958) who theorised that assertiveness generated therapeutic effects through the "reciprocal inhibition of anxiety" (p. 115). To help clients develop their assertiveness skills, Wolpe regularly employed in-session 'psychodramas'. This precedent would prompt widespread use of behavioural rehearsal in BT (Lazarus, 1963) – a term behaviourists seem to have favoured more than psychodrama. Informed by theories of social learning (Bandura, 1969), these experiential methods were later broadened to include modelling, coaching, 'contrasted' role-plays, and 'exaggerated' behaviour rehearsal (McFall & Twentyman, 1973; McNeilage & Adams, 1979).

RATIONAL EMOTIVE BEHAVIOUR THERAPY

Often considered a forerunner to CBT, Albert Ellis's 'rational therapy' (now rational emotive behaviour therapy [REBT]) proposed that psychological disturbance originated from underlying irrational beliefs. Developing a rational perspective on one's problems, Ellis argued, could alleviate distress and encourage behaviour change (Ellis, 1962). Whilst disputing irrational beliefs often proved effective, Ellis observed that some remained resistant to change. In these circumstances, he recommended that 'forceful' chairwork techniques be used to bring irrational beliefs into sharper focus and ensure their disputation was memorable (Ellis, 2004). Interestingly, it was the adoption of these evocative interventions that partly inspired Ellis to rename his approach 'rational-emotive therapy' (Ellis, 2001). Several influential chairwork techniques have since emerged from REBT including role-reversal and rational-emotive dialogues (Dryden, 1995).

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COGNITIVE THERAPY

Beck's cognitive model, which aimed to generate symptomatic relief through cognitive modification, represented a radical departure from BT (Clark, 1995). Over time, Beck's cognitive therapy (CT) was gradually adopted by many behaviourists, leading to an assimilation of first-wave BT and second-wave CT ('cognitive behavioural therapy') (Hayes, 2004). Whilst cognitive interventions where centralised in CT, Beck (1991) believed these "by no means [defined] the limits of cognitive therapy" (p. 195). Assuming that other techniques remained compatible with its underlying principles, technical eclecticism was welcomed in CT. Experiential interventions such as chairwork, which exposed the client to transformational experiences, were regarded as a particularly effective means to accelerate cognitive modification (Beck, 1976). Second only to behavioural interventions, gestalt and psychodrama techniques appeared to be the chief integrations in early CT (Beck, Emery, & Greenberg, 1985; Beck, Rush, Shaw, & Emery, 1979). Indeed, Beck has since acknowledged that his use of "enactive, emotive strategies was influenced, no doubt, by psychodrama and gestalt therapy" (Beck, 1991, p. 196).

Cognitive treatments for complex presentations were elaborated throughout the 1990s (e.g. Beck et al., 1990; Young, 1990). These longer-term therapies advocated the use of active and evocative schema-level interventions in difficult-to-treat disorders, including chairwork. Emerging theories of cognition and affect also provided sophisticated rationales for the inclusion of these techniques, including a need to work with 'hot' cognitive material, the limits of analytic interventions when applied to primitive schematic structures, and the importance of emotional arousal in enabling cognitive modification (Arntz & Weertman, 1999; Safran & Greenberg, 1982; Teasdale & Barnard, 1993). Consequently, chairwork was often recommended when 'traditional' cognitive interventions proved ineffective (Beck, 1995).

THE EMERGENCE OF ALLIED APPROACHES

The 1990s also saw a new generation of allied psychotherapies emerge (previously referred to as a 'third-wave' of cognitive therapy; Hayes, 2004). These included acceptance and commitment therapy (ACT), compassion focused therapy (CFT), and dialectical behaviour therapy (DBT). Whilst markedly different in many aspects, these approaches shared certain principles in common including the therapeutic role of acceptance, non-judgemental awareness, and metacognitive processes (Gilbert, 2010; Hayes, Strosahl, & Wilson, 2012; Linehan, 2015). Also defining of this new

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generation of therapies was growing appreciation for the role of 'self-multiplicity'. Whilst CBT had previously referred to the existence of multiple 'mindsets' and 'modes' of information processing (Beck, 1996; Teasdale, 1997), working directly with parts of the self had rarely been a focus for treatment. In contrast, third-wave approaches embraced this multifaceted and dynamic model of selfhood (see Chapter 6). To help disentangle, concretise, and stimulate interactions between self-parts, many third-wave approaches incorporated chairwork as core therapeutic intervention. In doing so, dialogical models of cognitive-affective change, involving self-parts engaging in meaningful exchanges with other self-parts, were recognised in CBT.

'INTEGRATIVE' COGNITIVE THERAPY

Descriptions of how CT could be combined with experiential psychotherapies emerged shortly after its development (Arnkoff, 1981; Edwards, 1989). These 'integrative' approaches were justified on several grounds including shared principles of change (e.g. discovery through experience), implementation strategies (e.g. collaborative working), and, more recently, the hypothesis that affect-focused techniques such as chairwork could enhance CBT by encouraging more productive emotional processing (Newman et al., 2011). Supporting these assertions, research indicates that CBT combined with gestalt and emotion-focused chair technique is capable of generating promising results (see Chapter 15).

PROCESS-BASED CBT AND CORE COMPETENCIES

Modern CBT appears to be moving away from protocol-driven interventions and towards the application of evidence-based procedures for core psychological processes (Hofmann & Hayes, 2018). Similarly, CBT therapists are expected to utilise generic and disorder-specific 'core competencies' to ensure treatments are evidence based and theoretically informed (Roth & Pilling, 2007). Whilst chairwork has received some recognition within process-based and competency-focused frameworks (e.g. Arntz, 2018), opportunities to train in these techniques remains limited. In addition, many processes associated with cognitive behavioural chairwork (e.g. self-multiplicity, personification, and embodiment) are yet to be recognised by these approaches.

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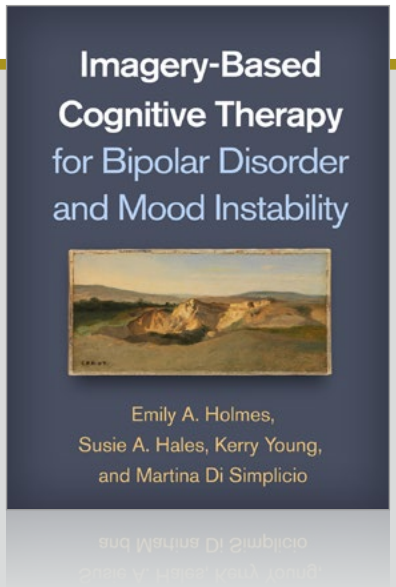
THE FUTURE OF CHAIRWORK IN CBT

Integrating experiential methods into CBT represents an important direction for its continued development. Consistent with this endorsement, cognitive therapies which utilise chairwork as a primary method of intervention have emerged in the last decade (de Oliveira, 2015; Hayward, Overton, Dorey, & Denney, 2009). These developments raise important questions. Should chairwork become a more routine feature of CBT? Will these techniques undergo the same empirical scrutiny as other experiential techniques such as imagery? Could a 'dialogical' approach to CBT emerge, which centralises self-to-self and self-to-other dialogues through the medium of chairwork? Only time will tell.

CHAPTER

5

INTRODUCTION TO MENTAL IMAGERY AND THE DEVELOPMENT OF MAPP



INTRODUCTION TO MENTAL IMAGERY AND THE DEVELOPMENT OF MAPP

Emily A. Holmes, Susie A. Hales, Kerry Young, and Martina Di Simplicio

Excerpted from *Imagery-Based Cognitive Therapy for Bipolar Disorder and Mood Instability*

In Chapter 1, we have described the main features of and contemporary treatments for BD. We have also proposed an imagery-based approach to treating BD, called MAPP. In this chapter, we explain why we believe that mental images may play an active role in the maintenance of BD, and why we think that working with these images may improve the effectiveness of psychotherapy. Then we describe the development and implementation of MAPP. We begin with a discussion of mental imagery and how it functions.

WHAT IS MENTAL IMAGERY?

Mental images form a significant part of how we think about the world and react to events around us. Kosslyn, Ganis, and Thompson (2001) have provided a useful definition:

> Mental imagery occurs when perceptual information is accessed from memory, giving rise to the experience of "seeing with the mind's eye," "hearing with the mind's ear" and so on. By contrast, perception occurs when information is directly registered from the senses. Mental images need not result simply in the recall of previously perceived objects or events; they can also be created by combining and modifying stored perceptual information in novel ways.

In other words, mental images are sensory events that occur inside someone's mind without a corresponding current stimulus in the outside world. They can be "rendered" in a single sense (sight, sound, taste, smell, or somatic sensation) or in more than one sense (e.g., a visual image of one's mother plus the sound of her voice, the smell of her perfume, or the touch of her hand). Mental images can be fleeting, or they may last for longer. They can also be static or moving, clear or blurred. They can be drawn from memories or may reflect novel or even impossible combinations of elements. Just as verbal thoughts can be, mental images can be retrieved deliberately or involuntarily, cued by an internal or external stimulus. Mental images can have positive, neutral, or negative content. Most of us may become aware of mental images and the extent to which they are present in our lives only when we start to pay attention to them.

HOW DOES MENTAL IMAGERY FIT IN WITH CBT?

From his first published works, Aaron T. Beck emphasized the importance of mental images in understanding psychological distress (Beck, 1970; Beck & Emery with

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Greenberg, 1985). He argued that images, memories, dreams, and nightmares often hold important information about people's appraisals of themselves, the world, and others. Rachman (1980, 2001) developed these ideas further in his work on "emotional processing." He argued that intrusive negative images and memories are often markers of a lack of emotional processing, and that a reduction in these phenomena should be expected after successful psychological interventions. Peter Lang (1977) pioneered the use of imagery techniques, seeing emotional mental images as simulations of reality. (For a review in tribute to Lang's work for the 50th anniversary of the Association for Behavioral and Cognitive Therapies, see Ji, Burnett Heyes, MacLeod, & Holmes, 2016.)

Awareness of the importance of mental imagery in CBT has increased in recent years. From clinical research, we discover that across many disorders, clients' intense emotional reactions or states are accompanied by vivid mental images. Mental imagery is well established as being a central component of posttraumatic stress disorder (PTSD) and intrusive memories of trauma (e.g., Ehlers & Clark, 2000), and has also been discovered in specific phobias (Pratt, Cooper, & Hackmann, 2004), obsessive–compulsive disorder (OCD) (de Silva, 1986), social anxiety disorder/social phobia (Wells & Clark, 1997), depression (Brewin, Watson, McCarthy, Hyman, & Dayson, 1998), bulimia nervosa (Somerville, Cooper, & Hackmann, 2007), health anxiety (Muse, McManus, Hackmann, & Williams, 2010), body dysmorphic disorder (BDD) (Osman, Cooper, Hackmann, & Veale, 2004), substance misuse (Kavanagh, Andrade, & May, 2005), schizophrenia (Morrison et al., 2002), and BD (Holmes, Geddes, et al., 2008). Readers wanting more information about the presence of mental imagery across disorders are referred to the opening chapters of the Oxford Guide to Imagery in Cognitive Therapy (Hackmann, Bennett-Levy, & Holmes, 2011; Holmes & Mathews, 2010). While it is clear that emotional mental images are a crucial part of many psychological disorders, interventions that target mental images are not as widely known as those targeting verbal thoughts. In this chapter, we introduce the most commonly used techniques for working with mental imagery. Then, in the rest of the book, we describe in practical, step-by-step detail how we have applied many of these techniques with people suffering from BD.

COMMONLY USED TECHNIQUES FOR WORKING WITH MENTAL IMAGES

In order to help us organize our thoughts about imagery techniques, Holmes, Arntz, and Smucker (2007) suggest distinguishing between techniques that involve *directly* working with an image (generally either evoking or manipulating an image) and

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those that involve working *indirectly* with the image (e.g., metacognitive approaches). Furthermore, they suggest that these direct and indirect techniques can also be viewed in terms of whether they involve reducing negative imagery or promoting positive imagery (see Figure 5.1).

Figure 5.1 • An illustration of the distinction between direct and indirect techniques, as well as between working to reduce negative images and working to promote positive images. Based on Holmes, Arntz, and Smucker (2007).

	Targeting NEGATIVE imagery	**Enhancing POSITIVE imagery**
Imagery-content focused **Direct techniques**	Imaginal Exposure	Scripting compassion-focused imagery
	Imagery rescripting of intrusive (image-based) memories	Building positive future-self images
	Imagery rescripting of fantasy images	
Image-property-focused **Indirect techniques**	Mindfulness-based cognitive therapy	
	Metacognitive image-based interventions	Imagery-based positive interpretation training
	Visuospatial imagery-competing tasks	

DIRECT TECHNIQUES

The direct techniques, as just mentioned, enable a therapist and client to focus on working with the images themselves. Here, we describe the key direct techniques commonly used in treatment.

Imaginal Exposure

Imaginal exposure involves deliberately evoking a troublesome image. Typically, the client is asked to bring to mind the image and recount in detail what he or she can see, hear, taste, smell, feel, and think, as follows:

> "I am going to ask you what you can see, hear, smell, taste, and feel in the image... all of the details. Also, about what happens in the image and when. This is because I want to be able to understand it well enough to see it myself, inside my own head.

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> When was the last time that you had that image? Now close your eyes and take yourself back to that moment: What were you doing? Where were you? Now can you get the image back in your head? Is it there? Now can you describe it to me in the first person and the present tense—for example, 'I can see *X* and I can hear *Y*'?"

Imaginal exposure can provide useful information for assessing intrusive images, and it has been a fundamental part of treatment for anxiety disorders since the beginnings of CBT (e.g., Foa & Rothbaum, 1998; Shapiro, 2001; Stampfl & Levis, 1967; Wolpe, 1958).

There is much debate about the mechanism(s) of change during imaginal exposure when it is used as a treatment for anxiety disorders. However, most clinicians and researchers would agree that during imaginal exposure, clients are able to reflect upon and possibly reappraise their negative mental images. Clients also learn that they can cope with holding those images in mind.

Restructuring Fantasy Images

Many people experience exaggerated or distorted mental images of anxiety-provoking situations, often called "fantasy images." For instance, clients who fear dogs may realize that whenever they see a dog, they experience a vivid image of it jumping up and biting them. Having identified and elaborated this fantasy image, a therapist could discuss with such a client how realistic it is, and help the client think about how to restructure/change the image. Alternatively, as in all areas of CBT, "behavioral experiments" can be used to test predictions contained in fantasy images. For example, clients who experience vivid mental images of themselves looking anxious in meetings at work may avoid meetings altogether or may become extremely anxious when one begins. The therapist can help such a client explore the image and then devise a behavioral experiment to test whether what the client sees in the image is true. This experiment might involve the client's videoing him- or herself in a meeting or asking others, "How do I look in meetings?" This information could then be used to correct or restructure the client's fantasy image.

Rescripting Image-Based Intrusive Memories

If imaginal exposure alone does not promote spontaneous reappraisal of negative images, then "rescripting" can be brought in to help the process along. Verbal rescripting involves introducing new verbal information into imaginal exposure. For

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example, in PTSD, the client may be asked to relive the traumatic event (e.g., a car crash) and then introduce updated verbal information at points of peak emotion (saying, "I survived," at the point in the account of the crash where the client had thought he or she was going to die) (Ehlers & Clark, 2000; Grey, Young, & Holmes, 2002). With imaginal rescripting, the updated information takes the form of an image rather than words (e.g., for the same car crash, an image of the client alive and well today).

Rescripting a troubling or negative image using another image is often employed when a verbal update/rescripting does not produce a strong enough change in affect. It can also be crucial when a change in somatic sensations is needed. For example, Jung and Steil (2013) describe a powerful three-session intervention for adult survivors of childhood abuse who presented with persistent feelings of contamination alongside PTSD. The clients were encouraged to research using the internet/medical texts whether it was still possible for their bodies to contain the body fluids of their abusers. They all discovered that the cells in question had "turned over" hundreds or thousands of times since the abuse. Next, they were encouraged to generate and practice an image that represented this information about the renewal of their cells. Finally, they were asked to "bring on" the old feelings of contamination and then swap in the new, "clean" images.

Imaginal rescripting can also be useful to change what happens in an intrusive memory. For example, a therapist can help a client rescript memories of childhood abuse by getting the client to introduce (in imagination) adults to protect and comfort the child who has been abused, or to prevent the abuse (e.g., Arntz, Sofi, & van Breukelen, 2013; Layden, Newman, Freeman, & Byers Morse, 1993; Smucker, Dancu, Foa, & Niederee, 1995; Weertman & Arntz, 2007). Indeed, in the field of PTSD, exposure plus some form of verbal or imaginal rescripting tends to have some superior effects to exposure alone (e.g., Arntz, Tiesema, & Kindt, 2007; Ehlers et al., 2003).

Recent research has also shown the potential of extending rescripting of negative intrusive images to other disorders, such as depression (Wheatley et al., 2007) and social phobia (Wild, Hackmann, & Clark, 2007, 2008). Similarly, as already mentioned, using evidence gained during *in vivo* exposure, clients can successfully rescript fantasy/distorted images (e.g., of giant, aggressive snakes in snake phobias; Hunt & Fenton, 2007). A recent meta- analysis concluded that imagery rescripting is a promising intervention for a range of psychological complaints related to aversive memories, "with large effects obtained in a small number of sessions" (Morina, Lancee, & Arntz, 2017).

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In Chapter 9, we explain rescripting techniques in detail.

Building Positive Imagery

In recent years, CBT therapists have sought to promote more positive, balanced imagery rather than focusing only on changing negative images. Evidence from neuroscience, sports psychology, and cognitive science points to the strong impact of positive images on emotions (e.g., Decety & Grèzes, 2006; Holmes, Mathews, Dalgleish, & Mackintosh, 2006; Holmes, Mathews, Mackintosh, & Dalgleish, 2008) and to the benefits of using imagery in goal setting and skills development (Cumming & Ramsey, 2008; Jones & Stuth, 1997; Renner et al., 2019).

Positive image generation can help in a number of quite different scenarios:

1. Rehearsing anxiety-provoking situations to increase confidence—for example, in the treatment of social phobia (Wild et al., 2007, 2008).
2. Rehearsing undertaking homework tasks to increase compliance in CBT (Beck, 2005)—for example, in depression when positive future is imagery lacking (Holmes, Lang, Moulds, & Steele, 2008).
3. "Fleshing out" goals for the future, to increase compliance with taking steps toward the goals—for example, in study skills research (Greitemeyer & Wurz, 2006; MacLeod, Coates, & Hetherton, 2008; Renner et al., 2019).
4. Compassionate Mind Training (Gilbert, 2009; Gilbert & Irons, 2005; Lee, 2005), which involves (among other things) generating an image to help a self-attacking client experience feelings of compassion and care. It can involve constructing a "perfect nurturer" (Lee, 2005) in imagination, which can be used regularly to guide the client toward self-compassion.
5. Constructing new, more helpful mental representations of oneself—for example, in Competitive Memory Training (COMET; Korrelboom, de Jong, Huijbrechts, & Daansen, 2009; Korrelboom, Marissen, & van Assendelft, 2011; Korrelboom, Van der Gaag, Hendriks, Huijbrechts, & Berretty, 2008; Korrelboom, van der Weele, Gjaltema, & Hoogstraten, 2009), which involves (among other techniques) using imagery, posture, and music to strengthen and make more vivid personal memories containing positive representations of oneself. These are then practiced regularly to increase the likelihood of their being accessed in preference to more negative memories.
6. Being used as a stand-alone technique to promote positive or safe feelings.

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Chapter 7 contains information to clarify the neuroscience behind the apparent power of mental imagery in changing emotions. Chapter 10 has more details about how to generate and use positive imagery.

INDIRECT TECHNIQUES

The indirect techniques, as mentioned earlier, do not involve direct manipulation of the content of mental images. Rather, they involve understanding and working with the properties of these images. Here, we describe the key indirect techniques commonly used in treatment.

Metacognitive Techniques

Metacognitive techniques are a group of strategies aimed at lessening an image's impact on a client by changing how he or she relates to it. These techniques reinforce that the image is "just an image," not a physical reality, and that the client does not have to pay attention to the image and should direct attention elsewhere. In most cases, there is no real engagement with the content of the image. Metacognitive techniques fall into two main categories:

4. "Switching techniques," in which the client switches the focus of attention from internal images to the outside world—for example, focusing on the sight/texture/sound of objects in the outside.
5. "Image property techniques," in which the client changes the image in a way that reinforces its unreality—for example, imagining popping the image like a balloon, shrinking, changing its color or making it look comical.

Chapter 8 contains more information about using metacognitive techniques to work with mental imagery.

Imagery-Competing Tasks

One novel approach to treating or managing troublesome images is to disrupt or interfere with them using competing visuospatial tasks—tasks that have a significant visual and/or spatial component, such as playing a visual computer game or playing football. Competing tasks are often used when a client is troubled by a high volume of different images and needs an immediate coping strategy to help reduce the negative impact of images.

The use of competing visuospatial tasks to manage troublesome mental images has its roots in cognitive psychological research (e.g., Engelhard, van den Hout, Janssen,

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& van der Beek, 2010; Holmes, James, Coode-Bate, & Deeprose, 2009; Iyadurai et al., 2018; James et al., 2015; Kavanagh, Freese, Andrade, & May, 2001). In essence, these studies have found that if a client undertakes a concurrent visuospatial task while thinking about a troublesome visual image, both the vividness and emotionality of the image can be diminished. Researchers hypothesize that this effect occurs because the image and the visuospatial task compete for the limited visual processing space within the client's mind.

Chapter 11 gives details of how to use competing visuospatial tasks to manage troublesome images.

Positive Interpretation Training

The relatively new field of computerized "cognitive bias modification" (CBM; Koster, Fox, & MacLeod, 2009; MacLeod, Koster, & Fox, 2009) takes as its starting point the assumption that some psychological difficulties (e.g., depression) are associated with cognitive processing biases (e.g., "glass half empty" thinking). CBM paradigms involve using computers to train participants repeatedly to resolve ambiguous scenarios in a positive way, with the aim of reversing the bias. Researchers have found that the effect of CBM can be greater if participants imagine the positive outcomes rather than simply processing them verbally (Holmes et al., 2006). So far, there is only limited evidence that imagery-focused positive training can improve anhedonia (but not all depressive symptoms) in people with clinical depression (Blackwell & Holmes, 2010; Blackwell et al., 2015); however, further research is needed.

THE DEVELOPMENT OF MAPP

As discussed at the start of this chapter, mental imagery is a feature of human cognition. Just as traditional forms of CBT work by targeting clients' verbal thoughts, so too can treatment gain traction by targeting people's mental imagery. One key feature of mental imagery is that it has a powerful impact on emotion—something of particular relevance to BD. Moreover, a focus on mental imagery opens up the possibility that we can try out a range of new intervention techniques, such as rescripting imagery or creating adaptive positive imagery.

BD is a recurrent, severe, complex mental disorder, as discussed in Chapter 1, and it is generally treated with medication. But as also mentioned in that chapter, not all clients respond to current drug therapies; 50–60% of people with BD relapse within

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1 year of recovery from an episode (Kessing et al., 2004). In addition, individuals with BD tend to experience residual anxiety and depressive symptoms throughout their lives, even between episodes of depression, mania, or hypomania (Judd et al., 2002). In view of that track record, and of the damaging effects the disorder has on clients and those close to them, new types of interventions tailored to the needs (and strengths) of this group are long overdue.

One potential development might be to examine the (at times) problematic mental imagery that we know exists in BD and to use imagery-focused CBT techniques to help stabilize mood (see the BAP guidelines; Goodwin et al., 2016). Again, we know that mood instability (moving between positive and negative mood) persists in BD, even when an individual is not experiencing full-blown mania or depression. Mental imagery can act as an "emotional amplifier" of mood states—anxiety, depression, and mania (Holmes, Geddes, et al., 2008)—and thus can exacerbate mood swings. People with BD can have vivid, distressing emotional imagery (e.g., of committing suicide; Hales et al., 2011) or imagery associated with manic mood states (e.g., of winning awards/buying expensive cars; Ivins et al., 2014). Furthermore, in Chapter 1, we have discussed the finding that people who score high on measures of bipolar character traits are more susceptible to developing negative intrusive imagery after a stressor (Malik et al., 2014). Therefore, finding ways to help clients reduce/ignore problematic imagery and/or to enhance adaptive imagery should contribute to improving mood stability in BD. Moreover, the potential benefits of working with imagery should also be relevant across any psychological difficulties (such as those discussed in Chapter 1) in which mental imagery affects emotion, not just BD.

With these ideas driving our efforts, we developed MAPP as a clinical psychology service for BD, within the psychiatrist-led Mood Disorders Clinic in Oxford, United Kingdom (Hales et al., 2018). The development of the approach has been an interdisciplinary endeavor, including input from clinical psychology, psychiatry, experimental psychology, neuroscience, and math. Psychological treatment innovation informed by mental health science is a team effort.

In MAPP, we provide extended psychological assessments and individual structured psychological treatments (described in detail in Part III) for clients with BD, based upon principles of CBT and professional standards of care. The treatment spans 10 sessions. After assessment, a clinician and client agree on a treatment target (e.g., social anxiety, trauma) that has an impact on the client's mood stability. In essence, the approach:

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1. Targets problematic imagery associated with BD in general, and bipolar anxiety in particular (if present).
2. Uses imagery-based CBT techniques, such as those used for anxiety disorders (e.g., social anxiety disorder/social phobia).

The anxiety associated with BD is emphasized in part because of the high levels of comorbidity (up to 90%; Freeman et al., 2002; Merikangas et al., 2007). Moreover, as mentioned in Chapter 1, we know that the presence of anxiety in BD is a major contributor to poor functioning and a worse prognosis (Otto et al., 2006; Kroon et al., 2013), as well as to an increased suicide risk (Simon et al., 2007). However, as also discussed in Chapter 1, the medications traditionally used to manage anxiety can lead to a "manic switch" in people with BD (Baldessarini et al., 2013; Pacchiarotti et al., 2013). Therefore, addressing anxiety symptoms in psychological treatment may be critical to attaining full recovery in BD.

TESTING MAPP

Treatment innovation for BD has been hampered by a lack of techniques to target a hallmark symptom: ongoing mood instability. Because of this, in developing MAPP we routinely monitored clients' mood symptoms via a daily and weekly self-report mood system. In this system (the True Colours system; for further information, see https://oxfordhealth.truecolours.nhs.uk/www/en and Miklowitz et al., 2012), clients sent in their mood ratings via short message service (i.e., text messaging) or email. Our key clinical outcome in testing MAPP was improvement in mood stability—namely, the symptom profile of mood scores before and after the psychological intervention. For example, repeated daily mood measurement (e.g., of depression) over a short time frame (1 month) provided data from which we created individual bipolar mood instability profiles/graphs. (In fact, using these profiles, clients can see and review their own progress over the course of treatment.) We also measured client satisfaction.

We tested the MAPP approach in a case series of 14 clients with BD (Holmes, Bonsall, et al., 2016). The results showed that weekly mood monitoring and treatment target data improved for the whole sample combined. In addition, mathematical time series analyses of the daily mood data, kept for 28 days pre- and posttreatment, demonstrated improvements in mood stability for 11 of the 14 clients (Holmes, Bonsall, et al., 2016). In addition, MAPP clients were highly satisfied with the intervention.

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These findings offered preliminary support for this new imagery-focused treatment approach. Importantly, we found that daily measurement offers a description of individual mood instability in a clinically meaningful way, with clients finding it useful and encouraging to see graphs charting the progress they are making. Further research is warranted, and we hope that this book facilitates that endeavour.

CONCLUDING COMMENTS

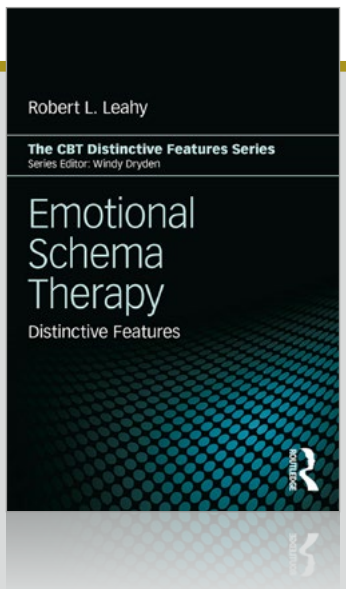
BD can be a chronic and disabling mental illness, and we urgently need innovation in treatment approaches for it (whether these are pharmacological or psychological). MAPP shows promise as a treatment technique for improving mood stability in BD in a small number of sessions. The rest of this book details the general frame for implementing MAPP, and the assessment and treatment methods used in MAPP, in a clinician-friendly manualized format. As we emphasize throughout, while the original focus of MAPP was on working with mental imagery in BD, the techniques will be of use to clinicians working with a variety of psychological difficulties characterized by vivid mental images.

For further reading on mental imagery, we recommend the following: Pearson, Naselaris, Holmes, and Kosslyn (2015), for good coverage of the scientific background to mental imagery; Hackmann et al. (2011), for detailed descriptions of how to design and implement behavioral experiments; Holmes, Blackwell, Burnett Heyes, Renner, and Raes (2016), for a review of the role of mental imagery in depression; and Holmes, Geddes, Colom, and Goodwin (2008), for a review of imagery as an emotional amplifier in BD.

CHAPTER

6

IDENTIFYING AND EVALUATING THEORIES OF CAUSE AND CHANGE



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Robert L. Leahy

Excerpted from *Emotional Schema Therapy: Distinctive Features*

It is a truism that clients come to therapy often with the goal of changing the way that they feel. And, of course, the clinician has her own beliefs or theories about how emotions can be changed—or if they actually need to be changed. The EST model proposes that the client's theory of emotion not only encompasses the evaluations, interpretations and differentiation of emotions, but also beliefs about which emotions need to be addressed, which emotions one wants to change, how these emotions are described and what the client's theory of causality and change might be.

DESCRIBING EMOTION

The first level of evaluation is how emotions and experiences are *described*. Are emotions described in over-generalized or vague terms—for example, "feeling upset" or "it was a difficult time"? Or are emotions described in more specific terms—for example, "I felt somewhat jealous" and described in terms of eliciting circumstances, "When my partner seemed to be flirting with her"? It is instructive to note that mindfulness-based cognitive therapy was first developed as a form of training in paying attention because clients with a history of recurrent depression often had "over-generalized thinking" (Segal et al., 2002). Mindfulness was a technique to help clients focus on an immediate experience, rather than to generalize to more abstract thinking, and to observe this experience in a non-judgmental way without attempts to immediately control the experience. If clients lack specific vocabulary for an emotion—and simply talk about "being upset" or "uncomfortable"—then it becomes more difficult to differentiate emotions, link these emotions to specific situational or cognitive triggers and develop strategies for emotion regulation. For example, a vague description— "I felt upset"— ignores the wide range of emotions and thoughts that might accompany this very general and vague feeling. In contrast, the individual who identifies her anger— "My boss ignored the hard work I did and criticized a small detail"—gives specific information as to the feeling, the trigger and—possibly—a pattern of anger related to feeling ignored, marginalized and dismissed. One way that the clinician can emphasize specificity is to ask, "If I were to take a picture or video of the situation that got you upset, what would we see in this picture or video?" Specific details—when, with whom, what was happening and what was the sequence of events—allows the client and clinician to evaluate the interaction between the client's specific vulnerabilities and cognitions, and specific triggering events. Thus, the first level of analysis is the degree to which specific emotions are described, their intensity noted and the situations and cognitions that precede or accompany these emotions are elucidated.

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THE CLIENT'S GOAL IN THERAPY

Related to over-generalized descriptions of emotions is the use of over-generalized and vague descriptions about the goal of therapy. For example, is there over-generalized thinking in describing goals, e.g. "to change my life", vs. more specific goals, such as "to change the way I respond to my partner when I get upset" or "to change this specific behaviour"? Feeling overwhelmed or helpless in the face of an emotion can often be linked to these over-generalized and vague descriptions of emotions and goals. The EST therapist can assist the client in narrowing down the specific emotions, specific contexts of these emotions and specific goals for change. Inquiry includes the following questions: "What specific emotion do you feel most concerned about?", "What situations are most likely to give rise to this emotion? Please describe in detail one of these situations", or "What would be your goal about these emotions and behaviours? Are you trying to eliminate them entirely or is there some middle ground that you could find acceptable?" The client who has the goal of eliminating all negative emotions—rather than to reduce their intensity, frequency and impact—will find herself frustrated and discouraged.

FIXED VS. GROWTH EMOTIONS

Related to the descriptions and goals for change the clinician can explore the client's use of "fixed" vs. "growth" views of emotions. For example, Dweck (2006) has proposed that people vary in their belief about abilities—some believing that their *abilities* are fixed and others believing that their abilities can change—that is, that they have the capacity for growth. Clients often have beliefs about their emotions—or those of others—that they are fixed, that they cannot change. In addition emotions are often equated with the self—for example, "I am an anxious person", or, "He is a jealous person". These "trait" attributions add to the sense that emotions are fixed, unchangeable and that the individual is reduced to their emotion—rather than viewing each person as capable of a wide range of emotions that vary according to the context and the individual's specific cognitions at the moment.

THE CLIENT'S THEORY OF CHANGE

What is the patient's theory of how to change their emotion? Does the client believe that changing emotion requires focusing on the past, "I need to understand how I got this way", and, "what my parents did to me". Is there a focus on biological determinism, "it's genetic", or on "brain chemistry"? Does the client believe

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that some external event or someone else has to change? These theories of change may interfere with the goals of therapy. The therapist can help the client examine the consequences of these beliefs and how they may interfere with more flexible responses.

Theories of causality of emotion can be divided into distal vs. more immediate causes. For example, distal causes can include childhood experiences, genetics or past traumatic events or experiences. Causes that are more current—and in some cases viewed as more enduring—can include biological imbalance (brain chemistry), personality (borderline personality) or cognitive style (pessimistic). In contrast to these more general and, in some cases, more distant "causes", the client may view their emotion as being caused by the immediate situation ("My partner was critical of me"), recent experience ("I lost my job"), thoughts in the situation ("I thought he didn't respect me") or even the emotion itself as a cause ("I was anxious, that's why I was upset"). Each of these causal attributions has implications not only for theories of cause of emotion but theories about what needs to change. The client may be asking herself, "Do I need to change my brain chemistry by taking medication?" or, "Do I need to change my personality?" or, "Do I need to change the way I think and behave?" It appears reasonable to assume that the more distant the cause of an emotion—genetics, early experience, past trauma—the less amenable the emotion will be to change.

Descriptions of emotion and theories of causality are linked to beliefs about how one can change an emotion in one's current experience. For example, some clients may adapt their parents' negative view of emotion and conclude that the best way to cope is to ignore the emotion—or, if possible—to avoid situations that give rise to the emotion. Others may have over-generalized views of "changing my life". Still others may believe that reviewing the past, "figuring out how I got this way", or uncovering distant and "repressed" memories will provide relief. Others may take a passive approach and hope to rely on medications to reverse the current negative and painful experiences. And, others may argue that they cannot change until someone else has changed— "The only way I can feel better is if my wife changes her behaviour". Each of these theories of change has implications for how the client will respond to any CBT-oriented therapy—including EST.

Some clients even argue that they should not have to change anything, that they are entitled to feel the way that they feel, but— at the same time—they may complain about their emotions and ruminate about them. For example, a man indicated that

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he was upset that his wife did not validate him when he was upset and he claimed he had a right to feel angry and hurt, but at the same time he claimed that he felt stuck on these feelings and he continued to ruminate about them. Others may adhere to a catharsis model of change— "I need to get all my emotions out—I need to express them." Clients who focus excessively on expression and catharsis often find that they get hijacked by their negative emotions and, when interacting with their supportive friends, may alienate the very support that they seek. For example, a woman complained that her husband seldom showed an interest in her feelings. As a result she would complain to him, often going to great lengths to express any negative feeling that she had. His response was that he felt overwhelmed and her continued expression and unloading of her emotions drove him further away. Each of them had problematic beliefs about emotion—hers were, "I need to express all the feelings I have", and "I need him to understand all of my feelings". His belief was that she was out of control and that if he validated her she would just continue on. We will explore problematic beliefs about validation in a later chapter.

Some clients have adaptive beliefs about change. For example, the belief that "I can modify my emotions by seeking support" has some validity in that a supportive relationship is helpful in moderating emotion. This is especially true if friends and family are validating of the client's emotions. However, as the behavioural interpersonal model suggests, continued expression of negativity accompanied by rejection of support can alienate others, thereby leading to the isolation, rejection and lack of support that contributes to depression (Joiner, 2000). Other adaptive strategies of change, which we will discuss, include thinking of things differently, accepting what can be accepted, problem-solving, changing one's goals, directing compassion toward oneself, behavioural activation and improving communication with significant others.