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## I. MAINTENANCE PROCESSES

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   Shannon M. Blakey and Jonathan S. Abramowitz

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Clinicians and researchers in the field of mental health have traditionally operated as if the *Diagnostic and Statistical Manual of Mental Disorders* (fifth ed. [DSM–5]; American Psychiatric Association, 2013) and *International Classification of Diseases* (11th ed. [ICD–11]; World Health Organization, 2018) carve nature at its joints in delineating discrete anxiety and related disorders. This can be seen in the siloed approaches taken by the field’s experts to developing conceptual models and treatment protocols for various DSM- and ICD-defined conditions. An array of empirically supported treatment manuals are available for different disorders, as if each problem requires a distinct intervention program. Yet, the DSM–5 and ICD–11 delineates these disorders superficially—largely on the basis of how anxiety is manifested topographically (e.g., fear of social situations vs. obsessions and compulsions). However, a more careful look at the conceptual models and treatment packages across these conditions reveals a high degree of redundancy in their core underlying psychological processes (e.g., overestimates of threat), active treatment ingredients (e.g., exposure to feared situations/stimuli), and putative mechanisms of change (e.g., changes in cognition). At this more fundamental, functional level, anxiety and related disorders have more commonalities than differences.

Recognizing these issues, we take the perspective that the boundaries around anxiety and related disorders imposed by the DSM–5 and ICD–11 are illusory. Moreover, we argue that the disorder-driven approach in treatment manuals compromises efficiency and efficacy in the treatment of clinical anxiety. Clinicians are traditionally trained to follow separate treatment manuals for each disorder, as if they were distinct, but this is a cumbersome method for acquiring broad competency in providing psychological treatment.
In addition, although manuals serve an important purpose in carefully controlled research studies, they too often emphasize clinical technique and obscure the recognition that the same evidence-based psychological processes and active ingredients in therapy are broadly applicable across anxiety disorders. Manuals are also generally written with an assumption that one size fits all, though most patients with anxiety do not neatly fit diagnostic prototypes and often present with multiple, diverse, and complex manifestations of fear. Providing effective therapy for such individuals necessitates thinking beyond manuals and flexibly applying theoretical principles when implementing treatment.

Our blueprint for this handbook was to put under one cover a more efficient framework for understanding and targeting the processes shown to contribute to clinical anxiety in its various manifestations, irrespective of DSM–5 or ICD–11 diagnosis (often referred to as transdiagnostic processes). Specifically, and diverging from a disorder-based focus, the chapters in this handbook delineate key empirically supported maintenance processes (e.g., threat overestimation) and theorized mechanisms of change (e.g., inhibitory learning) driving treatment efficacy. It is our view that understanding, assessing, and treating clinical anxiety at this functional level allows clinicians to use cognitive and behavioral methods to their maximum capacity. We have asked authors to produce clinically oriented chapters that integrate conceptual and practical content across the handbook’s two parts. The chapters in Part I focus on various processes shown to maintain clinical anxiety, highlighting their conceptual significance, methods of assessment, and implications for treatment. The chapters in Part II focus on candidate mechanisms of change thought to explain how treatment works, describing methods for implementing therapeutic techniques that activate the particular change mechanism.

This handbook represents a progressive, “post-DSM/ICD” approach to understanding and treating clinical anxiety. In our own clinical work—and in training other therapists—we often encounter frustration with the existing diagnostic paradigm and its barriers to the efficient use of empirically supported psychological treatments. It is our hope that this handbook enables clinicians working with patients with anxiety to slip the restrictive bonds of DSM–5 and ICD–11 diagnoses and treatment manuals and operate more flexibly and with a richer understanding of cognitive and behavioral principles and mechanisms of change.

REFERENCES
Introduction to Part I

Why Psychological Maintenance Processes?

Shannon M. Blakey and Jonathan S. Abramowitz

Anxiety, broadly defined, is a natural reaction experienced by all living animals to perceived threat and manifested via cognitive (e.g., racing thoughts), physiological (e.g., autonomic arousal), and behavioral responses (e.g., escape, avoidance). Anxiety is universal and normal, and it is essential for survival. Consider our evolutionary ancestors: If early human beings did not fear and avoid faster and stronger predators, our species would likely have died out long ago. Yet despite this, many individuals experience recurrent episodes of clinical anxiety—excessive or inappropriate anxiety that is disproportionate to the true degree of danger present in a given (or anticipated) situation. If anxiety can be considered a natural and adaptive “alarm reaction” to perceived threat, then clinical anxiety represents a “false alarm.” In standard diagnostic and classification systems, problems with clinical anxiety are often labeled as generalized anxiety disorder, panic disorder, agoraphobia, social anxiety disorder, specific phobia, obsessive-compulsive disorder (OCD), body dysmorphic disorder, posttraumatic stress disorder, and illness anxiety disorder. These anxiety-related disorders constitute the most common class of mental health complaints (Kessler, Chiu, Demler, & Walters, 2005) and are associated with substantial functional impairment and economic burden (e.g., DuPont et al., 1996; Greenberg et al., 1999).

Historically, the treatment and study of clinical anxiety have been dominated by a “disorder focus” (Deacon, 2013). Indeed, clinicians and clinical scientists tend to think in terms of the diagnostic labels described in standard classification manuals, particularly the fifth edition of the American Psychiatric Association’s (2013) Diagnostic and Statistical Manual of Mental Disorders and the 11th edition of the World Health Organization’s (2018) International Classification of Diseases. Researchers tend to be interested in understanding the
epidemiology, etiology, and maintenance of one or more specific disorders, usually with the goal of developing more effective treatments for such disorders. Clinicians are also likely to proceed by conducting diagnostic assessments and then targeting disorders one at a time in treatment (especially because many treatment programs are developed for single, specific disorders).

To be sure, the traditional diagnosis-driven approach has advanced the understanding and treatment of many anxiety disorders as defined in standard classification manuals. However, there is marked similarity in the psychological processes that are involved in the development and maintenance of anxiety across conditions. Research has found stunning overlaps in particular cognitive (e.g., the tendency to overestimate threat) and behavioral (e.g., the use of safety behaviors) phenomena that are observed across anxiety and related disorders. Such processes may exert varying amounts of influence, depending on the manifestation of anxiety, or have different themes across clinical disorders (e.g., selective attention toward feared contaminants in OCD and toward internal sensations in panic disorder), but the fundamental processes and their contribution to the maintenance of clinical anxiety are relatively stable transdiagnostically.

Furthermore, these processes occur on a continuum with normality and do not represent biological “defects” or “malfunctions.” Rather, they are biased forms of thinking, fear-driven ways of behaving, and other individual difference variables and interpersonal processes that are also observed in people who do not meet diagnostic criteria for anxiety disorders. Individuals given a psychiatric diagnosis of an anxiety or related disorder differ from “nonclinical” individuals only in the frequency, intensity, or duration of these processes. There also is a marked similarity in the techniques used in effective psychological treatment for anxiety and related disorders (the topic of Part II of this handbook), which mostly serve to correct the aforementioned psychological maintenance processes.

Overemphasis on psychiatric diagnosis also becomes frustratingly unhelpful for many clinicians. In some cases, an individual with clinically significant anxiety does not actually meet diagnostic criteria for any anxiety-related disorder; in others, someone with a conceptually linked set of fears may receive several anxiety-related diagnoses. In still other cases, the single “correct” diagnosis is difficult to determine. Imagine a woman who describes fears that she has colon cancer and reports that she pays close attention to the perceived signs of such an ailment (e.g., tiredness, abdominal discomfort, changes in the color and consistency of stool), seeks immediate reassurance and medical attention whenever she notices these signs, and experiences panic symptoms when she thinks about colon cancer or believes she has spotted a symptom. Would a clinician be inclined to diagnose her with OCD, illness anxiety disorder, or panic disorder? Alternatively, consider a man who reports crippling anxiety in crowds because such situations elicit hyperventilation, fears of having a “full blown” panic attack, and worries that he will not be able to control himself such that other people will notice him screaming or acting foolishly. Would
a clinician diagnosis him with panic disorder, agoraphobia, or social anxiety disorder? More important—and in line with the aims of this handbook—would different answers to these questions dictate fundamentally different treatment approaches? Should different answers to these questions dictate fundamentally different treatment approaches?

OVERVIEW OF PART I

When these diagnostic dilemmas are considered with the transdiagnostic overlap in psychological processes and their continuum with normality, then the categorical conceptualization of the anxiety-related disorders does not reflect reality. The purpose of Part I of this handbook is to facilitate a shift in perspective away from the traditional disorder-focused approach and toward an understanding of the psychological maintenance processes common across the myriad presentations of anxiety. Research has shown that the anxiety-related disorders share, to a great extent, several key psychological mechanisms that contribute to the development and persistence of clinical anxiety. Most—if not all—presentations of clinical anxiety may be understood in terms of these overlapping phenomena, which also have key assessment and treatment implications.

To this end, the chapters in Part I identify and elucidate 13 empirically supported psychological processes relevant to the maintenance of clinical anxiety. Transdiagnostic cognitive behavior theory recognizes (a) the impossibility of definitively identifying the root cause of a psychological condition, (b) the inability to undo the past (e.g., “unexperience” trauma), and (c) equifinality in the development of psychological conditions (i.e., that multiple experiences—or combinations of experiences—may lead to the same psychological symptoms). Although potential etiological factors are acknowledged, they do not necessarily serve as practical targets for change and are therefore given minimal attention over the course of therapy. That is not to say that the study of etiological variables is not important; such research may inform prevention and early intervention programs. Rather, the cognitive and behavioral factors demonstrated by empirical evidence to be involved in the maintenance of anxiety problems serve as the focus of Part I of this handbook.

Each chapter in Part I follows a general format in which the psychological maintenance process is first defined and described. Next, authors discuss the process’s conceptual implications (i.e., how it contributes to the maintenance of clinical anxiety) and describe methods for assessing the process, including self-report, interview, and observational methods. Finally, authors highlight the clinical implications of the process using case examples to illustrate how a therapist might encounter this process in their clinical work with patients presenting with clinical anxiety.1 We hope that these chapters will move the

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1All clinical case material has been altered to protect patient confidentiality.
reader from a disease-based understanding of clinical anxiety toward viewing these problems as a self-perpetuating cycle in which an exaggerated threat response to a particular set of stimuli is perpetuated by cognitive and behavioral psychological processes.

REFERENCES


Elaine was a corporate accountant who had an intense fear of public speaking. Normally, because of the nature of her work, she was not required to speak in front of groups. Every now and then, however, her supervisor would ask her to provide account updates at department meetings. This involved getting up and speaking about budgets and expenses for 15 minutes in front of a conference room filled with her coworkers. Although Elaine’s presentations were routinely satisfactory and she received only positive feedback after each one, the days leading up to these meetings were always filled with dread. Elaine would anticipate worst case scenarios, such as “I’ll mispronounce a patient’s name,” “I’ll be so anxious that I’ll sweat in front of everyone—I would die from the embarrassment,” and “What if I give inaccurate figures?” Before every presentation, Elaine would convince herself that she would be fired on the spot because of her mistakes and miscues. Then, she told herself, she would never be able to get another accounting job in the city where she lived. As a way of preventing such feared disasters, Elaine rehearsed excessively for her presentations, making sure to pronounce everything correctly and checking her numbers at least five times. She also wore layered clothing and extra makeup to make sure that any signs of anxiety such as blushing or sweating wouldn’t be noticeable.

1All clinical case material has been altered to protect patient confidentiality.

http://dx.doi.org/10.1037/0000150-001

Clinical Handbook of Fear and Anxiety: Maintenance Processes and Treatment Mechanisms, J. S. Abramowitz and S. M. Blakey (Editors)

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A close look at the components of Elaine’s fear reveals that she is overestimating the threat associated with public speaking. Indeed, despite her negative thoughts, she had received only positive feedback about the presentations she gave. Moreover, even if she did make mistakes or appear anxious, this would probably not result in the drastic consequences she feared. To be more specific, Elaine demonstrates two common types of threat overestimations: (a) overestimates of the likelihood (or probability) of feared events and (b) overestimates of the severity (or costs) of feared events.

Likelihood overestimation, also known as “jumping to conclusions,” occurs when negative events are judged as being much more probable than they are in reality. For example, the fear of flying is among the most common phobias (Barlow, 2004; Fredrikson, Annas, Fischer, & Wik, 1996), and many sufferers avoid flying based on the belief that their plane will crash. The probability of a plane crash, however, is exceptionally low. In Elaine’s case, she overestimated the likelihood of making mistakes and others noticing her anxiety even though she routinely performed well and received positive feedback.

Severity overestimation, also termed “catastrophizing,” implies viewing an event as “truly awful,” “unbearable,” or “devastating” (i.e., 101% bad) when, in reality, it is tolerable, even if undesirable, unpleasant, or emotionally or physically painful. Examples of severity overestimations include thinking that a dog bite would be excruciating, a poor grade would mean a lifetime of failure and disappointment, and an emotional trauma would “ruin my life forever.” Elaine’s beliefs that she would “die of embarrassment” and be fired are overestimates of the severity of making mistakes and appearing anxious.

Whereas overestimates of threat are common in the general population regardless of psychological well-being, these thinking errors are most frequently observed among those with clinical anxiety. Moreover, the content of such overestimates are typically specific to the nature and triggers of one’s fear. Although these beliefs might map on to particular diagnostic categories (e.g., disorders described in the Diagnostic and Statistical Manual of Mental Disorders [fifth ed.; DSM–5; American Psychiatric Association, 2013]), as we discuss later in this chapter, they are a transdiagnostic process in that they operate independent of diagnostic status.

**CONCEPTUAL IMPLICATIONS**

In this section, we place the phenomenon of threat overestimation within a conceptual framework and discuss how it presents across different presentations of fear and anxiety.

**Cognitive Model of Emotion**

The concept of threat overestimation is drawn from cognitive and cognitive behavioral models of emotion, which emphasize the role of thinking (e.g.,
beliefs, assumptions) in the production of feelings. In particular, Beck’s (1976) cognitive specificity model stipulates that feelings and emotions are caused not by situations or stimuli per se, but rather (in large part) by how the person ascribes meaning to certain situations or stimuli. Moreover, particular emotional responses are linked with specific interpretations. For example, interpretations concerned with loss lead to depression, whereas the perception that one has deliberately been treated with disrespect leads to anger. In a similar vein, unrealistic (overestimated) perceptions of the degree of threat or danger lead to anxiety (e.g., Amir, Foa, & Coles, 1998; Beck, Emery, & Greenberg, 2005).

Elaine’s case illustrates this point: It is not the presentations that are the problem per se, but rather how she thinks about what will happen in these meetings that leads to her distress. From the cognitive perspective, Elaine’s exaggerated beliefs about (a) what could happen during a presentation and (b) how awful the fallout would be are the core process leading to her fear and anxiety (depicted in Figure 1.1). In this way, overestimates of threat maintain clinical anxiety and fear by directly generating these emotional responses. Accordingly (and as is addressed in several chapters in Part II of this handbook), a critical focus of the treatment of clinical fear and anxiety is challenging and correcting overestimates of threat, as opposed to trying to modify the feared situation or stimulus itself.

It is worth noting that many people overcome irrational fears on their own—their overestimates of threat seem to self-correct. Yet for individuals with clinical anxiety, something appears to prevent such self-correction. Again, consider that Elaine remains fearful of giving work presentations despite receiving positive feedback. She does not seem to notice that her actual performance in the conference room fails to match her beliefs that she is at risk of making mistakes and being fired. Why doesn’t she recognize that she is a more skilled presenter than she thinks? Why doesn’t she realize she is unlikely to lose her job? More generally, why don’t anxious and fearful individuals recognize that they are making mistakes in their thinking and simply correct them?

Role of Safety Behaviors

One reason that threat overestimates persist in the face of even dramatic disconfirmatory evidence is that they lead to safety behaviors—efforts to detect,
escape from, or avoid the feared outcome (as discussed in detail in Chapter 2). Such behaviors may be adaptive when an objective threat is present (e.g., washing one’s hands after touching raw meat while preparing a meal), yet when threat is objectively low, safety behaviors maintain threat overestimates by causing the person to erroneously think that he or she narrowly averted catastrophe (Salkovskis, 1991). Elaine’s practice of excessive rehearsal before her presentations may be considered a safety behavior because the risk and cost of making a mistake are objectively low. Yet when her presentation goes well and she does not get fired, she believes that it was the rehearsal that prevented these negative outcomes, rather than concluding that she is generally adept at giving presentations. Thus, as long as she continues performing safety behaviors, her overestimates of threat remain unchallenged (e.g., Salkovskis, Clark, Hackmann, Wells, & Gelder, 1999).

Role of Information-Processing Biases

As part of the normal human fear (i.e., fight-or-flight) response, individuals automatically filter information in ways that confirm their overestimates of threat. Such a bias serves to protect us from harm when danger is actually present; yet, this way of thinking preserves inaccurate overestimates of the likelihood and severity of threat when the risk of harm is objectively low.

One such information-processing bias is selective attention to threat cues (as discussed in detail in Chapter 12). It is adaptive to be vigilant for sources of harm when danger is perceived—not doing so could be deadly. Accordingly, the perception of threat is naturally accompanied by an automatic shift in attention to the source of danger. As a result, the environment may seem especially dangerous despite an objectively low risk of danger. Using Elaine as an example, she might become highly attentive to anything that could be perceived as a threatening response to her presentation, such as colleagues whispering in the audience, which might be misinterpreted as a sign that someone noticed a mistake.

A similar mechanism engendered by overestimates of threat is confirmation bias. The survival value of assuming that a situation is dangerous is significantly higher than that of assuming safety. Accordingly, when we perceive danger, we automatically seek information to confirm the risks. Yet if the perception of danger is based on erroneous overestimates of threat, this results in the collection and misinterpretation of benign or ambiguous information as danger confirming (while simultaneously discounting danger-disconfirming evidence), which maintains the faulty threat estimates. Elaine, for example, might scan the conference room looking for signs of disapproval (e.g., a supervisor frowning) and may even misinterpret ambiguous feedback (e.g., a colleague’s failure to nod in approval) as confirming her threat overestimates.

Memory bias—the tendency to easily remember information that is consistent with fear-related beliefs—also maintains overestimates of threat (as
covered in detail in Chapter 11). Thus, someone like Elaine might easily remem-
ber and base her predictions on one instance in which she mispronounced a
word while rehearsing two years ago. Together, selective attention, confirma-
tion bias, and memory bias work to increase the probability that fear cues are
noticed, encoded into memory, and subsequently retrieved in related future
situations, thereby maintaining overestimates of threat.

Finally, the experience of anxiety itself in feared situations often gives rise
to the tendency to infer further danger. This phenomenon is often referred to
as emotional reasoning because people mistakenly look to their emotional state
for information about the dangerousness of a given situation (Arntz, Rauner,
& van den Hout, 1995). Returning to Elaine, as she begins to experience
shakiness and “butterflies” in her stomach in the moments before she stands
to give her presentation, her emotional reasoning that she will inevitably
make mistakes and be visibly anxious contributes to the vicious cycle that
maintains her threat overestimates over time.

Origins of Threat Overestimation

One way threat overestimates may develop is through a direct, negative
experience with an object or situation. Following a dog bite, for example, one
may come to expect that dogs are dangerous. Still, many people have traumatic
experiences but never develop overestimates of threat or excessive fear (e.g.,
Ollendick, King, & Muris, 2002). Vicarious conditioning (i.e., modeling), which
refers to learning that occurs through observing others, is another pathway to
the development of threat overestimates. Specifically, we may learn to over-
estimate the likelihood or severity of certain objects or situations simply by
witnessing other people’s experiences or by observing others act in a fearful
manner (Mineka & Zinbarg, 2006). Third, overestimates of threat might be
transmitted by parents, peers, the media, and other sources. For example, the
message that germs are ubiquitous, dangerous, and require diligent cleansing
is often conveyed by well-meaning family members, television commercials
for antibacterial products, and sensationalistic reports in the media.

ASSESSMENT

Overestimates of threat are idiosyncratic to particular situations and the
people who experience them. Many anxious individuals express these types
of beliefs quite readily during the initial interview—in fact, they might be
framed as the presenting problem or reason for seeking help. For example,
“I’ve stopped driving because I’m afraid I’ll cause an accident,” and “my
husband was diagnosed with high blood pressure and I’m afraid he’s going to
die and leave our family in financial ruin.” If such beliefs are not immediately
volunteered, they might be more or less easy to infer from any descriptions
of triggering situations or avoidance behavior. For example, it might be
anticipated that someone who carries hand sanitizer at all times overestimates the threat of contamination. It is, however, important to consider such inferences as hypotheses that can be tested by further interviewing. For example, someone afraid of flying might fear this situation based on overestimates of the likelihood of (a) a crash caused by engine failure, (b) a terrorist hijack, or (c) a panic attack. Therefore, direct and open-ended questions are critical in assessing overestimates of threat.

To this end, during a conceptually driven interview, a clinician might explain the relationship between activating events (triggers), beliefs and interpretations (e.g., overestimates of threat), and emotional and behavioral consequences, soliciting personalized examples of each. Some questions can help to elicit overestimates of threat:

- What goes through your mind when you are in a triggering situation?
- What specifically do you worry about in this situation?
- What leads you to avoid (or perform a safety behavior in) this situation?
- What is the worst thing that could happen in this situation?
- What do you tell yourself would be so bad about the situation?

Within such a clinical interview, the downward arrow technique (Beck, 1976; Beck et al., 2005) is a helpful strategy for identifying specific overestimates of threat (beliefs about probability and cost). This involves identifying an anxiety-provoking situation and asking questions about the anticipated outcomes, including how likely and how awful they would be. The clinician continues to ask the same (or a similar) question until the patient provides a conclusive statement that contains an exaggerated belief about likelihood or severity. Extreme and unconditional statements (i.e., terms such as always, never, and awful) also serve as verbal cues for overestimates of threat.

Because clinical interview data are not always complete, we recommend that psychometrically validated self-report instruments be used as well. These have the advantage of including carefully worded questions that have demonstrated validity and reliability. Moreover, they allow a clinician to compare the patient’s responses to well-established norms. Accordingly, questionnaires are valuable for screening purposes, to corroborate information obtained in a clinical interview, and to bring to light overestimates of threat that might not otherwise be reported during the interview.

Several surveys and self-report measures assess overestimates of threat across various fear domains, many of which are freely available online and in the published literature. Examples are listed in Table 1.1.

**CLINICAL IMPLICATIONS**

As we have discussed, overestimates of threat drive the vicious cycle of anxiety across domains of fear, whether or not they meet criteria for a psychological disorder as defined by the *DSM–5* or the *International Classification*
TABLE 1.1. Self-Report Assessment Measures of Overestimates of Threat Across Different Types of Feared Stimuli

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<td>Blood, injection, and injury</td>
<td></td>
</tr>
<tr>
<td>Dental Anxiety Inventory</td>
<td>Stouthard, Mellenbergh, and Hoogstraten (1993)</td>
</tr>
</tbody>
</table>

of Diseases (10th ed. [ICD–10]; World Health Organization, 1992). Commonly encountered overestimates of the probability and costs of harm for many fear domains are presented in Table 1.2. Next, we discuss in detail the presentation of threat overestimates as they are observed in a number of anxiety- and fear-related contexts.

**Fear of Animals**

Fears of animals are common across the lifespan and are typically classified as specific phobias. Although commonly feared animals—such as dogs, spiders, and snakes—can pose some inherent danger, these risks are generally low. Overestimates of threat in people with animal fears tend to involve concerns about physical harm, such as estimates of the likelihood of suffering pain or physical injury from being bitten or otherwise attacked. For some animal
TABLE 1.2. Common Overestimates of Threat Across Different Types of Feared Stimuli

<table>
<thead>
<tr>
<th>Likelihood overestimates</th>
<th>Severity overestimates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Animals</strong></td>
<td></td>
</tr>
<tr>
<td>The snake will bite me.</td>
<td>I will have to have my arm amputated.</td>
</tr>
<tr>
<td>The bee will sting me.</td>
<td>The pain of a bee sting is unbearable.</td>
</tr>
<tr>
<td><strong>Natural environments and disasters</strong></td>
<td></td>
</tr>
<tr>
<td>I won’t be able to breathe in the elevator.</td>
<td>I will die from suffocation.</td>
</tr>
<tr>
<td>The storm will turn into a tornado as it passes over my home.</td>
<td>The tornado will tear apart my home and I’ll die in the rubble.</td>
</tr>
<tr>
<td><strong>Negative evaluation</strong></td>
<td></td>
</tr>
<tr>
<td>People will think I am boring.</td>
<td>No one will hire me and I will have to go on Social Security.</td>
</tr>
<tr>
<td>Others will notice and be repulsed by my crooked nose.</td>
<td>I will never find someone who will want to marry me.</td>
</tr>
<tr>
<td><strong>Unwanted intrusive thoughts</strong></td>
<td></td>
</tr>
<tr>
<td>Violent thoughts lead to violent actions.</td>
<td>I will smother and kill my husband in his sleep.</td>
</tr>
<tr>
<td>If I can’t remember locking the door, I may have forgotten to.</td>
<td>Burglars will break into my home and kill my family.</td>
</tr>
<tr>
<td><strong>Somatic cues</strong></td>
<td></td>
</tr>
<tr>
<td>I will have a panic attack on the bus.</td>
<td>I’ll go crazy and cause an awful scene.</td>
</tr>
<tr>
<td>If I get dizzy, it probably means I have a brain tumor.</td>
<td>The tumor will be cancerous and fatal.</td>
</tr>
<tr>
<td><strong>Contamination</strong></td>
<td></td>
</tr>
<tr>
<td>If I eat milk on the “best by” date, I will get sick.</td>
<td>Getting sick will ruin my whole week.</td>
</tr>
<tr>
<td>If I use a public toilet, I could contract a disease.</td>
<td>If I use a public toilet, I will get HIV/AIDS and die.</td>
</tr>
<tr>
<td><strong>Traumatic events and posttraumatic sequelae</strong></td>
<td></td>
</tr>
<tr>
<td>If I am alone with a man, he will assault me.</td>
<td>If I am assaulted, I couldn’t have a meaningful future.</td>
</tr>
<tr>
<td>If my son hasn’t texted me, it means his plane crashed.</td>
<td>My son might be dying in a field somewhere.</td>
</tr>
<tr>
<td><strong>Blood, injection, and injury</strong></td>
<td></td>
</tr>
<tr>
<td>If I get an IV put in, I will faint.</td>
<td>If I faint, I’ll fall out of the chair and get a concussion.</td>
</tr>
<tr>
<td>If I play baseball, I’ll end up breaking my arm.</td>
<td>The pain would be unbearable and I’d cause a scene.</td>
</tr>
<tr>
<td><strong>“Not just right experiences”</strong></td>
<td></td>
</tr>
<tr>
<td>If the picture frames are crooked, I’ll have bad luck.</td>
<td>My child’s school will burn down and it will be my fault.</td>
</tr>
<tr>
<td>If I don’t put my left shoe on first, I’ll feel “uneven.”</td>
<td>The discomfort would spiral out of control and never go away.</td>
</tr>
</tbody>
</table>
fears, anxiety stems from overestimates of the severity of an attack, such as choking to death from an allergic reaction to a bee sting. These threat estimates are usually easily articulated by individuals with animal fears.

In other instances, overestimates of severity relate to the emotional and physical reaction experienced when one encounters a feared animal or insect (e.g., disgust, nausea), such as the belief that the unpleasant feelings will persist forever or spiral to unbearable levels. For example, someone afraid of cockroaches may report that roaches are “gross” or “disgusting.” Similarly, overestimates of the dangerousness of anxious arousal and possible panic attacks (i.e., anxiety sensitivity, as discussed in Chapter 4) can play a role in animal phobias (McNally & Steketee, 1985). For instance, a man may believe that being in the same room as a spider will lead to such intense anxiety that it will spiral out of control and lead to a loss of consciousness, perhaps placing him at elevated risk of harm and negative evaluation from others.

In response to their exaggerated estimates of threat, individuals who fear animals may avoid proximity to the feared animal and situations in which they believe they will encounter the animal. This avoidance pattern prevents the person from having opportunities to learn that the risk of harm from such animals (as well as associated emotional reactions) is acceptably low. If a child, for instance, never goes to her friend’s home because there is a dog, she won’t have the opportunity to learn that the dog is much more likely to sniff or lick her than to bite her.

**Fear of Natural Environments and Disasters**

Overestimates of threat, in various forms, also play a role in the fear of certain situations such as standing on a high ledge, driving a car, being in or on water, or being in a crowded or confined place or a storm (i.e., specific phobias of natural environments). Likelihood overestimates often relate to rare (although possible) occurrences, such as a plane crash, elevator accident, drowning, or having one’s home (or life) destroyed by a lightning strike. Severity overestimates often concern beliefs about catastrophes seemingly linked to the feared situation (e.g., “if lightning hits the house, it will cause an explosion and we will all die”).

Clinicians, however, should be aware that individuals with situational fears may also overestimate the dangerousness of experiencing anxiety symptoms in the feared situation. For instance, a man who avoided riding escalators believed that if he became too anxious, he would lose control and wildly push people out of his way in his attempt to escape. People with fears of enclosed places, such as being in a magnetic resonance imaging scanner (as well as other claustrophobic situations), often interpret anxiety-related sensations, such as shortness of breath, as indicating that they are running out of air and suffocating (e.g., Radomsky, Rachman, Thordarson, McIsaac, & Teachman, 2001). Those who fear crowded areas, such as busy shopping centers and
stadiums, overestimate the danger of not being able to “escape” in the event they become anxious or have a panic attack. Other times, severity overestimates focus on the embarrassment of becoming anxious, having a panic attack, or losing one’s composure in public.

The idiosyncratic nature of these beliefs and interpretations highlights the need for a thorough assessment of the cognitive aspects of the fear symptoms. Such overestimates often lead to avoidance, safety cues (e.g., being with a “safe” person), or the use of antianxiety medication (i.e., benzodiazepines), which might decrease anxiety in the short run but prevent the correction of threat overestimates in the long term.

**Fear of Negative Evaluation**

As the example of Elaine illustrates, overestimates of threat contribute a great deal to fears of social and performance situations and are often observed among individuals diagnosed with social anxiety disorder or body dysmorphic disorder. The fundamental overestimates of threat concern the probability and costs of being observed by others, appearing foolish, being criticized, and experiencing embarrassment. People with this presentation of fear thus overestimate the likelihood that others are paying close attention to them and scrutinizing them for minor mistakes, instances of imperfect speech or behavior, or flaws in their appearance. Although interpersonal criticism and rejection is rarely life threatening, socially anxious individuals often overestimate the costs of negative evaluation or ridicule, and perceive it as catastrophic—perhaps on par with serious injury or death. Some might believe it will manifest in the disapproving thoughts and feelings of others, or perhaps in overt ridicule or discrimination.

Overestimates of threat lead to avoidance and other behaviors to reduce the possibility of being noticed, appearing foolish, and being negatively evaluated. These actions maintain the overestimates of threat by preventing the individual from learning that others are generally unconcerned with mistakes and imperfections, and that the anxiety associated with negative evaluation is actually transient and manageable.

**Fear of the Significance or Meaning of Thoughts**

People can also overestimate the threat associated with unwanted thoughts. Obsessions, as defined in the *DSM–5* criteria for obsessive-compulsive disorder (OCD), for example, are characterized by overestimates of the costs of having certain unwanted or senseless thoughts about topics such as sex, violence, blasphemy, and harm. Indeed, research shows that people diagnosed with OCD catastrophically misinterpret their intrusive, unwanted thoughts, images, and doubts as personally significant or as signs of some deeply rooted failing. They might fear punishment from God for thinking “sinful” thoughts or be concerned that they will impulsively act on their sexual or violent
intrusions (Obsessive Compulsive Cognitions Working Group, 2005; e.g., “If I think too much about incest, I will lose control and rape my mother”). Others believe that their intrusive unwanted thoughts mean that deep down they want something awful to happen (e.g., “Thinking about rape means I want to rape someone”).

To prevent the feared consequences of unwanted thoughts (and to reduce the thought itself, along with its associated discomfort), individuals with catastrophic beliefs about thoughts often resort to strategies such as mental rituals (e.g., replacing a “bad” thought with a “good” one), overanalyzing, or seeking reassurance about their thoughts. They might also avoid situations and stimuli that trigger such thoughts, and repeat simple behaviors (e.g., flipping light switches) until the activity can be completed without the unwanted thought. Research, however, demonstrates that negative unwanted thoughts are harm-less normal occurrences (i.e., mental noise; e.g., Rachman & de Silva, 1978; Salkovskis & Harrison, 1984), and thus the sorts of strategies mentioned above block the person from correcting overestimates of threat and learning that it is normal to have even very unpleasant thoughts.

**Fear of Somatic Cues**

Concerns about one’s bodily changes and sensations feature prominently in most anxiety and related disorders. The specific fears associated with somatic cues are principally differentiated by three factors: (a) focus on immediate versus long-term feared health outcomes (e.g., the belief that one either currently has or will eventually acquire a disease), (b) preoccupation with arousal-related (i.e., anxiety-related) versus nonarousal-related sensations, and (c) anticipation of an individual versus interpersonal negative outcome (e.g., the fear that having a panic attack in public will lead to medical catastrophe or social humiliation). Despite the partitioning of psychological disorders in formal diagnostic manuals such as the DSM–5 and ICD–10, individuals who fear somatic cues often present with symptoms that cut across these diagnostic categories, anxious individuals meeting diagnostic criteria for different disorders may endorse identical fears about somatic cues, and many individuals who fear somatic cues may not formally meet diagnostic criteria for any psychological disorder. Therefore, a transdiagnostic approach to conceptualizing the fear of somatic cues is especially advantageous over the disorder-driven approach embodied by diagnostic manuals.

Overestimates of the likelihood of the harm resulting from benign and ubiquitous somatic cues such as anxious arousal (e.g., pounding heart), unexpected sensations (e.g., muscular twitching), or ambiguous bodily cues (e.g., rash) tend to be focused on possible negative physical, mental–cognitive, or social consequences (Taylor, 1999; Taylor et al., 2007). For example, someone with panic disorder may misinterpret a pounding heart as a heart attack, someone with illness anxiety disorder may mistake bloodshot eyes for a symptom of Ebola, and someone with generalized anxiety disorder might
appraise muscle tension as a sign that something awful might happen. Alternatively, someone with OCD might interpret trembling hands to mean that she is about to lose control and act on unwanted impulses to harm, whereas someone with posttraumatic stress disorder may be afraid that difficulties concentrating indicate that he is “going crazy.” Finally, someone with agoraphobia may fear that fainting at the grocery store would cause an “embarrassing scene,” while someone with social anxiety disorder might predict that others would negatively evaluate him for blushing while on a date. Individuals with such beliefs tend to pay close attention to their bodies in order to detect feared somatic cues and prevent anticipated negative consequences (Schmidt, Lerew, & Trakowski, 1997).

Overestimates of the severity of harm related to feared somatic cues can be easily elicited through clinical interview and self-report assessments. Fears about the physical or medical consequences of bodily cues tend to involve immediate threats to one’s life (e.g., heart attack) or serious and potentially fatal long-term illnesses (e.g., lung cancer). People who are preoccupied with the potential cognitive effects of feared somatic cues tend to anticipate complete mental breakdown (e.g., permanent insanity, “losing control and doing something horrible,” having a “psychotic break”). Yet other individuals may be more concerned with being negatively evaluated by others for publicly exhibiting anxiety symptoms or afraid of experiencing intolerable levels of discomfort associated with intense physical arousal.

**Fear of Contamination**

The fear of contamination is most pertinent to illness anxiety disorder and OCD. Individuals with this concern fear stimuli or situations perceived to be contaminated, such as public restrooms, household chemicals, hospitals, or even people who have a serious illness (e.g., HIV/AIDS). Although the prototypical case of contamination fear involves a preoccupation with physical contaminants, some people instead experience mental contamination: feelings of internal dirtiness that arise from thinking about or imagining a subjectively unpleasant, immoral, or disgusting scenario (e.g., imagining committing incest or touching feces; Rachman, 2006). To reduce the physical and emotional feelings of contamination and associated distress, individuals often avoid sources of contamination or “dirty thoughts” and tend to engage in excessive washing, cleaning, thought neutralization, and other “decontamination” efforts.

Like any other condition involving clinical fear or anxiety, the fear of contamination is largely driven by overestimates of the likelihood and severity of contamination. Contracting an illness is the most obvious and common feared outcome of coming into contact with contaminants. Yet one may be concerned with spreading or passing on contamination to others. For example, a woman who worked as a nurse feared that if her hands were contaminated with traces of “fecal matter germs,” she would endanger her entire family by preparing a dinner that they all would eat. Exaggerated beliefs about one’s
own susceptibility to illness often go hand in hand with overestimates of the likelihood of contracting a disease from a contaminant, in that individuals tend to believe that germs are lurking everywhere, they are guaranteed to ingest germs, and the germs will inevitably cause them to contract an awful disease.

A less common class of feared consequences involves taking on the characteristics, typically undesirable ones, of other people through being contaminated with their “germs.” For example, one woman feared that if she touched items belonging to her grandmother who had Alzheimer’s disease, she would develop this disease within a year. Thus, overestimates of the probability of certain feared outcomes may derive from illogical or magical beliefs about the transmission and spread of illness (Rachman, 2004).

Contamination-fearful individuals also tend to overestimate the severity of physical or mental contamination. Although some may even become fearful at the prospect of coming down with the common cold (e.g., “If I had to stay home from work, I would never be able to make up the hours I missed before payday”), most anxious individuals tend to fear contamination because they anticipate more catastrophic outcomes (e.g., contracting a sexually transmitted disease, developing a serious long-term or deadly illness). In some instances, individuals experience disgust rather than fear when they are near sources of contamination; accordingly, severity overestimates may also manifest as predictions that contamination-related disgust will be intolerable or incapacitating (e.g., “I can’t stand feeling contaminated,” “It would be too gross to be covered in germs,” “If I were to be contaminated, I would never feel clean again”).

As mentioned earlier, contamination fears generate urges to engage in unnecessary and excessive cleansing rituals (e.g., hour-long showers) or even avoid potential sources of contamination altogether. Unfortunately, whenever an individual avoids perceived contamination, he or she is deprived of the opportunity to learn firsthand that the feared contaminant does not pose a significant threat and that his or her distress would have decreased naturally over time anyway; consequently, mistaken estimates of threat remain unchallenged.

Fear of Traumatic Events and Posttraumatic Sequelae

Although most people who witness or directly experience traumatic events (e.g., sexual assault, severe motor vehicle accidents) do not suffer long-term psychological consequences, some develop posttraumatic stress disorder symptoms in the wake of such an incident (e.g., Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). That is, whereas “normal” posttraumatic reactions (e.g., nightmares, increased startle) typically dissipate over time as the person processes the event, these symptoms persist and cause clinically significant distress and impairment for trauma survivors who go on to meet diagnostic criteria for posttraumatic stress disorder. Symptoms are often classified along four clusters (intrusion, avoidance, negative alterations in cognition and mood,
and alterations in arousal and reactivity; American Psychiatric Association, 2013), but a common clinical feature of this condition is that survivors tend to hold exaggerated beliefs about the dangerousness of the world, other people, and even themselves (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999). For example, depending on the nature of the traumatic event(s), individuals with posttraumatic stress disorder might endorse beliefs such as “the world is a dangerous place” and “people cannot be trusted.”

Clinicians working with trauma survivors should assess for two common themes related to overestimates of threat. The first concerns the fear of being retraumatized; because many survivors begin to view the world as unpredictable and unsafe after a trauma, they may feel especially vulnerable in situations they associate with their traumatic event (e.g., the neighborhood in which they were held at gunpoint). In effect, this may result in inflated estimates regarding the probability of transportation accidents, physical or sexual assault, or natural disasters. These likelihood overestimates tend to be accompanied by overestimates of the severity of retraumatization. Specifically, trauma survivors may believe that experiencing another traumatic event would be the end of the world (i.e., catastrophic), when in reality many individuals who experience multiple traumatic events are still able to live a meaningful and rewarding life. That is not to say that future traumatic events would not be horrific or frightening; rather, individuals who overestimate the likelihood and severity of retraumatization also tend to underestimate their ability to cope with and recover from trauma.

The second theme concerns catastrophic interpretations of the posttraumatic symptoms themselves as indicating an ongoing threat (e.g., Ehlers & Clark, 2000). For example, trauma survivors may come to believe extreme statements such as “Having uncontrollable nightmares mean I am losing my mind,” “Being constantly ‘on guard’ will cause me to pass out from exhaustion,” and “Being disconnected from others means I’ll never be able to form meaningful relationships again.” Moreover, mistaken beliefs about the likelihood and severity of posttraumatic symptoms often engender urges to avoid trauma-related distress altogether or engage in counterproductive coping efforts (e.g., self-medicate with alcohol or substances). These anxiety-reduction strategies ultimately exacerbate distress related to posttraumatic stress disorder, however, because they perpetuate overestimates of threat associated with the experience of posttraumatic stress symptoms.

The fear of traumatic events may also be clinically relevant to generalized anxiety disorder. Specifically, despite no evidence that a traumatic event will or has occurred, individuals with this disorder report substantial fear or dread that “something terrible” (e.g., a major accident) might happen and that the consequences of such an event would be disastrous (e.g., paralysis, death). Alternatively, people with generalized anxiety disorder may acknowledge that their anxiety and worry is disproportionate to the true probability of a feared event occurring, yet nevertheless believe that the worry surrounding the fear of a traumatic event is intolerable, unyielding, or will “spiral out of control.”
Fear of Blood, Injection, and Injury

Fears related to blood, injection, or injury typically map onto the diagnostic category of specific phobia, although some people with OCD or illness anxiety disorder may also report these fears. Individuals preoccupied with blood, injection, and injury fear a range of stimuli including seeing blood, receiving injections, and undergoing dental and medical procedures. Some individuals are so distressed by blood, injection, and injury that they refuse (or find it extremely difficult) to undergo important medical procedures, become pregnant, or take careers in health care and medicine. The fear of blood, injection, and injury is also unique to clinical anxiety in that individuals may, in fact, faint upon exposure to these fear cues (Öst, 1992).

Overestimates regarding the likelihood and severity of exposure to blood, injection, and injury are heterogeneous and idiosyncratic. For some, these fears are driven by exaggerated beliefs about the probability and intensity of physical pain and its possible consequences (e.g., “The pain will be extreme and intolerable, and it will cause me to lose control and scream like crazy”). Others overestimate the probability of being directly harmed by the stimulus; for example, dying during a medical procedure or being contaminated by blood or needles that results in the acquisition of a serious illness. Many sufferers report prominent and aversive feelings of disgust (rather than fear) upon exposure to stimuli such as blood, wounds, and needles, which they report to be incredibly difficult to tolerate (e.g., “Blood is gross and I can’t stand being near it or having it on me”). For individuals with a history of fainting, blood, injury, and injection cues may be feared because of their ability to cause this reaction. In these cases, although a person’s estimates regarding the likelihood of fainting may be accurate (Öst, 1992), they often overestimate the severity of fainting (e.g., they mistakenly fear that fainting will lead to injury, medical emergency, or intolerable social embarrassment).

Most individuals with fears of blood, injection, and injury avoid these stimuli altogether (e.g., going years without a dental cleaning) to mitigate the perceived likelihood and/or severity of their feared outcome(s). In the long term, however, extreme avoidance not only comes at the price of their health and quality of life but also serves to maintain maladaptive beliefs about (a) the dangerousness of feared stimuli themselves, (b) the extreme emotional reactions they elicit, and (c) their inability to tolerate such reactions.

Fear of “Not Just Right Experiences”

The need to reorder, realign, repeat, or engage in other types of seemingly senseless ordering or arranging behaviors is consistent with one “type” of OCD (although individuals with OCD or high levels of perfectionism who do not meet diagnostic criteria for any psychological disorder might also display these symptoms). Individuals who present with complaints about “not just right experiences” (NJREs) tend to overestimate the negative consequences of feelings of “incompleteness,” “asymmetry,” and the sense that things are
not “just right.” Clinical observations and research studies suggest that the distress associated with asymmetry can result from a fear of NJREs either (a) leading to negative events or (b) initiating an unending sense of incompleteness. Although these two manifestations of NJRE fears may seem similar at the surface level, the underlying overestimates of threat driving clinically significant distress are in fact distinct (e.g., Summerfeldt, 2004, 2008).

In the first form of this problem, the distress associated with NJREs precipitates from magical thinking that links the incompleteness–asymmetry with disastrous events that can only be prevented through ordering and arranging rituals. For example, “If the books are not arranged perfectly on the shelf, I will have bad luck.” Fear-based interpretations that a NJRE portends an external disaster (e.g., accidents), however, is less common than the fear that if allowed to continue, the feelings of incompleteness, imbalance, and imperfection will persist indefinitely. Thus, the second form of NJRE-related distress is driven by dysfunctional beliefs that subjective feelings of incompleteness, imbalance, or incorrectness will increase to intolerable levels and cause some sort of internal harm (e.g., a physical or emotional “breakdown” or other loss of control). In other words, the person believes that he or she cannot cope with the emotional or physical discomfort engendered by NJREs (a phenomenon akin to difficulties tolerating distress, as described in detail in Chapter 6).

Whether NJREs are fueled by overestimates of external (e.g., bad luck) or internal (e.g., overwhelming distress) harm, these concerns are often accompanied by certain corrective actions. The restoration of order through rearranging (and similar behaviors) and the subsequent neutralization of discomfort function to negatively reinforce mistaken beliefs about the likelihood or severity of aversive outcomes related to NJREs, thus leading to the habitual use of ordering and other compulsive behaviors to reduce this sort of discomfort. Unfortunately, the reduction of distress associated with incompleteness (a) prevents the natural extinction of the distress (i.e., habituation) and (b) prevents the individual from learning that his or her estimates of NJRE-related threat are inaccurate.

**CONCLUSION**

The tendency to overestimate threat is among the key transdiagnostic cognitive processes that play a role in the maintenance of clinical anxiety. In this chapter, we defined the phenomenon and discussed its particular role in the persistence of inappropriate fear. We then considered the assessment of threat overestimation before turning to an overview of how this process manifests itself and can be addressed in clinical treatment across the diverse landscape of anxiety-related problems. The overestimation of threat may take a variety of forms, including the tendency to catastrophically miscalculate the probability of negative events, misjudge the presumed severity (or cost) of adverse outcomes, misinterpret the behavior of others as signs of negative evaluation,
and inflate the importance of unwanted thoughts. It also overlaps conceptually with the tendency to catastrophically misinterpret the meaning and consequences of arousal-related body sensations (anxiety sensitivity; see Chapter 4), as well as with catastrophic beliefs about the experience of uncertainty (intolerance of uncertainty; Chapter 3), although research indicates that anxiety sensitivity and intolerance of uncertainty contribute uniquely (beyond threat overestimates) to the development and maintenance of clinical anxiety. As a fundamental cognitive bias in clinical anxiety, a variety of clinical interventions and treatment mechanisms explicitly or implicitly address overestimates of threat, including exposure therapy focused on habituation (Chapter 14) or inhibitory learning (Chapter 15), rational discussion to promote cognitive change (Chapter 16), and interpretation bias modification (Chapter 20), as discussed in Part II of this handbook.

REFERENCES


Multicultural Feminist Therapy
Helping Adolescent Girls of Color to Thrive

Edited by Thema Bryant-Davis

Foreword by Jessica Henderson Daniel
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Who will sing an upbeat Black girl’s song?

We will sing it for ourselves and the world will marvel at how long we hold our notes.

—Thema Bryant-Davis

As a multicultural feminist psychologist and a womanist psychologist, I strive to attend to the marginalized voices in our field and the larger society. Multicultural feminist psychology centers on women of color, whom many psychologists have historically glossed over or painted in muted tones. In addition, psychologists—including feminist and multicultural psychologists—have often sidelined the voices and experiences of girls of color. Minimal work exists on the application of empirical studies for cultivating treatment approaches and strategies that centralize the concerns, strengths, and well-being of adolescent girls of color. Multicultural feminist psychology recognizes the need for the creation of practical

I gratefully acknowledge the assistance of Shavonne J. Moore-Lobban in writing this chapter.

http://dx.doi.org/10.1037/0000140-001
Multicultural Feminist Therapy: Helping Adolescent Girls of Color to Thrive, T. Bryant-Davis (Editor)
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interventions that celebrate and empower girls of color while attending to historical and contemporary manifestations of oppression and injustice.

I am honored and appreciative that one of my mentors in the field, Dr. Jessica Henderson Daniel, requested that I serve as editor of this book, which was one of her initiatives as president of the American Psychological Association (APA). As scholars, practitioners, and educators, Dr. Henderson Daniel and I approached this book project with a shared commitment to multicultural feminist practice and the empowerment of racially and ethnically marginalized youth. This book is primarily for practitioners who serve adolescent girls of color and who are interested in enhancing their awareness, knowledge, and skills and in providing more effective and empowering treatment. The secondary audience for this book is students who have a desire to build a deeper foundation as they prepare to work with diverse populations, including or with a special focus on adolescent girls of color.

Adolescent girls of color have numerous emotional, cognitive, and social strengths that can be cultivated through healthy community engagement, family practices, internal reflection, and psychotherapy interventions. The needs, goals, relationships, and health of racially and ethnically diverse girls matter. APA has advocated for the protection and preservation of the rights of youth and against many forms of violence and oppression that compromise the development and well-being of children and adolescents. The APA Commission on Violence and Youth (1993) issued a report highlighting the psychological harm of violence against adolescents, the social and cultural factors that impact adolescents of color, and the multisystem-level efforts that are needed for intervening. APA’s Working Group on Child Maltreatment Prevention in Community Health Centers also issued a report of multifaceted approaches to prevent child maltreatment by increasing practices that are geared toward youth’s overall development and well-being (APA, 2009). APA’s Violence Prevention Office (APA, 2010) also developed a national training program, “Effective Providers for Child Victims of Violence,” which aims to increase mental health providers’ clinical skills for working with children and adolescents who are impacted by violence and victimization. Further, psychologists have developed guidelines related to both the therapeutic treatment of racial and ethnic minorities (APA, 1993; Council of National Psychological Associations for the Advancement of Ethnic Minority Interest, 2003; Root, 1985), as well as psychological services for women and girls (APA, 1978, 2007a; Enns, Rice, & Nutt, 2015).

In late 2017, APA’s Board of Professional Affairs sought guidance on an updated working draft of the Guidelines for Psychological Practice With Girls and Women (APA Practice Organization, 2017). According to their call for public and member comments, they intend that the guidelines provide practice recommendations that address considerations such as intersectional
identities, challenges over the life span, strengths of girls and women, and many other areas (APA Practice Organization, 2017). In addition, the National Association of Social Workers has also developed standards for the practice of social work with adolescents, which focus on important issues of adolescent development and clinician cultural competence (Bailey, 2003). There are still, however, few resources that centralize training for the provision of culturally congruent care for adolescent girls of color. *Multicultural Feminist Therapy: Helping Adolescent Girls of Color to Thrive* seeks to fill in this gap using the framework of multicultural feminist therapy.

After Dr. Henderson Daniel requested that I edit this book, I invited multicultural feminist psychologists to shape and contribute to the project. I selected these scholars on the basis of their demonstrated expertise with the particular cultural group and their lived experience of being gender- and race-conscious women of color. Through conference calls, e-mails, in-person meetings, and a peer-reviewed convention symposium, we explored the need for this book and the focus areas we would cover. The project benefits clinicians and trainees by (a) equipping them with an understanding of the sociopolitical history and contemporary context of adolescent girls of color; (b) providing them with a gendered, culturally affirming frame for assessment, diagnosis, rapport development, goal setting, and therapeutic strategy application; and (c) outlining specific intervention approaches through case studies and a multicultural feminist group model.

**NEED FOR THIS RESOURCE**

Cultural and social factors play a role in increased mental health concerns in communities of color (Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009; Williams, Neighbors, & Jackson, 2003). The Office of the Surgeon General (U.S. Department of Health and Human Services, 2001) noted that ethnic and racial minorities are confronted with environments of racism, discrimination, inequality, poverty, and violence, all of which take a toll on their mental health. In their Conference on Children’s Mental Health (U.S. Public Health Service, 2000), they noted a specific concern for issues related to mental health needs of ethnic minority youth. They discussed the higher rates of suicide for Latino youth, higher rates of referrals for conduct problems and juvenile justice interventions (vs. mental health treatment) for African American youth, and overall higher levels of unmet mental health needs for all youth of color.

All populations have a need for mental health services, yet services remain underutilized within communities of color. Communities of color are less likely to seek psychotherapy (Abe-Kim et al., 2007; Harris, Edlund, &
Larson, 2005; Neighbors et al., 2007), and those who do engage in psychotherapy are more likely to terminate prematurely (Fortuna, Alegria, & Gao, 2010; Kearney, Draper, & Barón, 2005). There are well-documented barriers prohibiting some cultural groups from engaging in treatment, such as financial, cultural, familial, and psychological (Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006). Scheppers and colleagues (2006) conducted a literature review to better understand barriers to health services (including mental health services). They analyzed studies from different countries, with sample populations of various ethnic minority groups, and found that barriers exist at three levels: patient, provider, and system. At the patient level, they found barriers in the areas of education, knowledge of health services, socioeconomic status, health insurance, culture, acculturation, language, and values. They stated, “Although the decision to use health services is stated to be an individual choice, we imagine that these choices are mostly framed in the social context through cultural social and family ties; especially for ethnic minorities” (p. 326). Additional barriers for racial and ethnic minorities include distrust of the mental health system (Suite, LaBril, Primm, & Harrison-Ross, 2007), seeking help and support within (vs. outside) the family system (Alvidrez, 1999; Cauce et al., 2002), and concern about mental health stigma (Alvidrez, 1999; Carpenter-Song et al., 2010; Ward, Clark, & Heidrich, 2009). Limited time for therapy due to work and family demands and limited transportation or childcare are additional barriers to consider (U.S. Department of Health and Human Services, 2001). McKay, Lynn, and Bannon (2005) conducted a study to understand the mental health needs of inner-city youth, mostly youth of color, who were referred and accepted to mental health treatment. An alarming result of their findings showed that over one fourth of the youth accepted for services in their study were not seen for their initial appointment and therefore did not receive treatment even when they had significant levels of trauma exposure. McKay and her colleagues provided multiple accounts of adolescent girls who were referred for services with presenting concerns such as trauma symptoms, low self-esteem, and other complex psychological needs but for myriad reasons remained unseen in treatment and without an intentional effort to engage them on the part of the mental health clinic. Although adolescents of color and their families may at times be unaware of the mental health services that are available to them (Ward et al., 2009), they may also believe that services they are aware of do not fit their cultural needs and values. As a result, these families may be reluctant to bring their youth to mental health services (Cauce et al., 2002).

Adolescents of color and their families value wellness and holistic health and may hope that spiritual practices and determination will address mental health issues. Although these positive beliefs and values may serve to buffer
and protect youth of color (APA Commission on Violence and Youth, 1993), they also have the potential for disconnecting youth of color from seeking and participating in treatment. To better address these challenges and provide culturally congruent and effective care, psychologists have to adopt the ethical code outlined by APA (2016), which states that ethical care attends to cultural identity and context. Psychologists should also use resources such as APA's (2017) “Addressing the Mental Health Needs of Racial and Ethnic Minority Youth: A Guide for Practitioners,” which highlights that mental health providers should demonstrate culturally competent practice with youth by showing respect, acceptance, sensitivity, commitment to equity, openness, humility, and flexibility. Additional resources that lay the groundwork for prioritizing the mental health and well-being of adolescent girls of color include the APA Resolution Against Racism (APA, 2001) and the Report of the APA Task Force on the Sexualization of Girls (APA, 2007b).

Although many adolescent girls of color demonstrate intrapersonal and interpersonal strengths, they also face numerous challenges and barriers to their emotional, cognitive, and social development that include (but are not limited to) discrimination, oppression, trauma, and poverty. For example, adolescent girls of color may have developed strength, resilience, and a sense of cultural pride in the wake of being confronted with prejudice and discrimination throughout their lives, but such prejudice and discrimination still have negative implications for important aspects of their growth and development. In a 3-year longitudinal study of correlates of perceived discrimination, Green, Way, and Pahl (2006) found that peer discrimination was associated with increased depression and decreased self-esteem among Black, Latino, and Asian American high school students. Although the exploration of racial identity and cultural pride can be a strength for many adolescents, it can also result in their pain being minimized and overlooked by mental health care providers. As Pahl and Way (2006) found in studying Black and Latino adolescents from low-income families, and as Goodluck and Willeto (2009) summarized from literature looking at Native American families from different tribal groups, the trajectory of ethnic identity exploration, pride, strength, and resilience can be developed in the face of challenging adversity. Lack of awareness of these factors, as well as a dearth of literature on culturally congruent paths to well-being, development, and thriving, can result in mental health professionals being ill-equipped to serve adolescent girls of color. The purpose of this book is to provide mental health care providers with the tools needed to build on the strengths of adolescent girls of color and to cultivate healthy contexts and schemas among this often-underserved population.
STRUCTURE OF THE BOOK: PROVIDING THE ROAD MAP FORWARD

This clinical resource provides thought-provoking considerations to enhance therapeutic services to adolescent girls of color. The contributors to this resource have outlined a number of both unique and overlapping recommendations to inform mental health professionals as they seek to empower adolescent girls of color to thrive. On the basis of contributors’ work, this book’s concluding chapter presents integrative suggestions for individual or group interventions centering on racially and ethnically marginalized adolescent girls. These suggestions are evidence informed and combine cultural modifications and culturally emergent strategies that are born out of the traditions of ethnically diverse girls of color.

Multicultural feminist psychology centralizes both theory and application, as evidenced in quantitative and qualitative research. Womanist, *mujerista*, and multicultural feminist psychologies have a great appreciation for the voices of women of color, and as a result, the chapters include the reflections of both clients and practitioners of color. From meta-analyses to case studies, this project animates the dynamics of therapeutic engagement with adolescent girls of color. Multicultural feminist psychology honors other ways of knowing, and as such, the contributors provide chapters that are rooted in theory, empirical knowledge, clinical experience, and personal wisdom. The book begins with a chapter describing the theory, tenets, and practical application of multicultural feminist psychology with girls of color. The next four chapters of the book focus on the primary racial (American Indian, Black, Asian) and ethnic (Latina) girls within the United States. Each of these four chapters provides information on the sociohistorical context of the racial or ethnic group of focus, then discusses the specific challenges and resources (both internal and external) of the girls of that community, and finally outlines multicultural feminist practice with the focus group. The practice section includes considerations for rapport building, goal setting, diagnosis, strategies, and at least one case study to illuminate the application.¹ The authors conclude by highlighting the contributions that psychologists have made and recognizing the work that remains to be done. The concluding chapter of the book presents an integrative model of multicultural feminist therapy with adolescent girls of color that builds on the knowledge provided in the prior chapters.

¹Client descriptions have been anonymized to protect confidentiality.
WHO ARE ADOLESCENT GIRLS OF COLOR?

For the purposes of this book, adolescent girls can broadly be defined as 13 to 19 years of age. Recognizing the important role of culture in self-definition, however, the contributing authors were free to define the adolescent years in the ways that were meaningful for them. Some cultural groups may perceive adolescence as including the preteen years, and some may consider it to last until the youth has fully launched into independence or their early 20s. When working with adolescent girls, it is important for multicultural feminist psychologists to determine how the girl, her family, her community, and the larger society views her developmentally. The interplay of these varying perspectives will have some influence on the girl’s daily life and well-being. In terms of gender, self-definition for girlhood and culture are important areas for therapists to explore before selecting an intervention. A component of this work is facilitating adolescent girls of color to appreciate their identity in terms of gender and culture. Being respectful of self-definition, the interventions described focus on clients who identify as girls and who are from racially and ethnically marginalized communities. Therapists for gender nonconforming adolescent clients may consider multicultural gender-queer or gender nonconforming affirmative interventions.

The current U.S. census categorizes people racially as White, Black, American Indian, and Asian and ethnically as Latino or non-Latino. The decision to focus this book on Black, American Indian, Asian, and Latina adolescent girls is due to both the U.S. census categories and the availability of research on adolescent girls of the particular race or ethnicity. Instead of having an independent chapter on biracial or multiracial adolescent girls of color, many of the chapter authors address biracial and multiracial adolescent girls within their discourse. Future editions of this book will benefit from including chapters on Alaskan Native, African immigrant, Caribbean immigrant, and Arab American and Middle Eastern adolescent girls.

It is important to note the movement to shift the categorization of Middle Easterners and Arab Americans from White people to people of color. Years ago, members of these groups in the United States advocated for being included within the White racial category; these efforts resulted from their observation that people of color were treated at a secondary level. The term White came with privilege, yet Middle Easterners and Arab Americans—particularly those whose features and/or names are culturally recognizable—have not fully benefited from White privilege but instead have faced stigma and stereotypes as people who are terrorists, dangerous, and un-American. Although we hope that future editions of this book will have the body of literature and possibly the U.S. categorization to have a full chapter about
Middle Eastern and Arab American adolescent girls, for now, we emphasize that culturally congruent counseling with Arab American and Middle Eastern adolescent girls should attend to religion, values, family life, socialization, gender roles, perception and manifestation of mental illness, the challenges of navigating two cultures, the impact of stigma and stereotype, and the importance of honor (Ajrouch, 2004; Ganim, 2001).

Family plays an important role in the development and well-being of Arab American and Middle Eastern American adolescent girls. For Arab American Muslim adolescent girls, quality of maternal relationship mitigates the relationship between stress and behavior (Aroian, Templin, Hough, Ramaswamy, & Katz, 2011). The gender identity of Middle Eastern Muslim girls living in the United States is shaped by identification with their culture, engagement with religious practices, and exposure to foreign cultural values (Abu-Ali & Reisen, 1999). Specifically, those who have been in the United States longer endorse more masculine traits than those who have been here for shorter durations. Those who have higher engagement with their culture and religion endorse more feminine traits and more conservative views of sexuality than those who report less engagement (Abu-Ali, 2004). Multicultural feminist therapists working with Middle Eastern and Arab American adolescent girls should explore the socializing agents in their lives as well as the messages about their identity that they receive, reject, and/or modify. Arab and Middle Eastern American adolescent girls encounter children and youth who hold assumptions about them and their families. Non-Arab American youth endorse the stereotype that Arab Muslim American boys and men are hostile and un-American and the stereotype that Arab Muslim American girls and women are culturally and religiously oppressed (Brown, Ali, Stone, & Jewell, 2017). Along with identifying stressors, multicultural feminist therapists should also attend to and celebrate strengths. In comparison to adolescents in Lebanon, Arab American adolescents endorse a higher self-concept on subscales for physical ability, physical appearance, peer relations, reading, general school performance, and general self-concept; these strengths are consistent with scholarship on the benefits of biculturalism (Alkhateeb, 2010).

CONCLUSION

Envisioned and authored by multicultural feminist psychologists, this groundbreaking book provides a needed resource for mental health professionals working with adolescent girls of color. Some of the highlights
the readers will discover in this text include the therapeutic use of crafts and scents with Native American adolescent girls, religion and music with African American adolescent girls, mindfulness and youth advocacy groups with Asian adolescent girls, and spoken word and activism with Latina adolescents. This resource equips psychologists to better serve adolescent girls of color through cultural humility, a gender-conscious knowledge of their rich and diverse cultural histories and contemporary realities, and practice strategies to heal and empower their clients to thrive.

In addition, throughout this text, readers will note the focus on healing, which is broader than but inclusive of trauma-informed work. Healing-centered engagement is broader than trauma-informed care because it (a) centers on the strengths of clients versus centering on the deficits created by trauma; (b) enthusiastically embraces the holistic, multidimensional identity of clients, including their culture, gender, and spirituality; (c) conceptualizes and addresses trauma as a collective experience and not simply an individual experience; and (d) identifies the appropriate response to family, institutional, and societal violation as not just psychological but political (Ginwright, 2018). Multicultural feminist psychology calls for the healing, celebration, and empowerment of adolescent girls of color so they may fully grow and thrive; therapeutic, healing engagement is one of the vehicles that animates this ongoing journey to wellness, fulfillment, and wholeness.

REFERENCES


Introduction


In a society with pervasive oppression, discrimination, and gendered racism, the wellness and empowerment of adolescent girls of color represent an act of defiance. Multicultural feminist psychologists defy the institutionalized, systemic, and individual efforts to marginalize and silence girls and women of color. This work of healing and justice is the foundation of multicultural feminist psychology. In this chapter, we provide readers with the foundation of multicultural feminist theory and therapies and give attention to gaps in the field that can be addressed using this approach. We describe the context in which multicultural feminist psychology emerged and the defining components of multicultural feminist psychology and its major tenets and then illuminate its application in therapy with girls of color. In the application section, we describe the preparation of the therapist, assessment, diagnosis and presenting problem, rapport building, intervention strategies, trauma-informed multicultural feminist therapy, and therapist self-care.
CONTEXT OF THE EMERGENCE OF MULTICULTURAL FEMINIST PSYCHOLOGY

Feminist therapy and multicultural therapy emerged in response to the ways in which the experiences of entire groups of people (e.g., women, people of color) were being neglected in the psychological development of theory, research, practice, and policy. Enns, Williams, and Fassinger (2013) noted that in the aftermath of the civil rights movement of the 1960s and the second wave of feminism during the same time, feminist psychologists began to voice their critiques of psychology, including alignment with one of Weisstein’s (1968/1993) primary critiques of psychology’s tendency to erase the social context in which behaviors manifest and to overemphasize and pathologize individual traits. The similarities between the psychology of feminist therapy and multicultural therapy became evident at that time. Both psychologies centralize the need for consciousness-raising regarding oppression, agency in the fight for social justice, and empowerment of clients and the larger communities they represent (e.g., women and communities of color; Enns et al., 2013). Both psychologies also noted that clients hold expertise and wisdom about their lives, which should be centralized and celebrated. Interestingly, members of both groups had psychologists who worked to highlight their theories within and outside the American Psychological Association, creating feminist and culturally specific psychological organizations, conferences, and scholarship. From the 1970s to today, these organizations have made advances in institutionalizing attention to and representation of intersectional identities in structure, leadership, membership, mentorship, initiatives, and resources (Enns et al., 2013), which gave way to further the combined efforts as multicultural feminist therapy.

Multicultural feminist therapy emerged in the aftermath of the neglectful treatment of women and girls of color in the feminist and multicultural therapy models. Indeed, feminist psychology theory emerged in the 1960s and 1970s, but it was mostly connected to White feminist psychologists who largely overlooked the needs, ideas, identities, and cultural resources of women and girls of color (Malikiosi-Loizos, 2012). Historically, feminist psychology’s views and theories were shaped by gender, whereas other forms of oppression were often marginalized, if not completely ignored (Reid, 2002). Of note are the culturally diverse early feminist psychologists who consistently advocated for the inclusion and redress of the issues facing women of color. Feminist psychology began to grow, and there was a movement focused on multicultural, liberation, and culture-specific psychologies, which centered on race and ethnicity. These theories brought attention to the oppression of
communities of color in the larger society and the field of psychology as a whole. The theorists challenged notions of pathology and well-being for racial and marginalized communities. Over many years, multicultural psychology theory has encompassed cultural competence, diversity training, cultural humility, multicultural orientation, and liberation, as well as race-specific psychologies such as Black psychology and Latino psychology. However, these empowerment models often routinely erased the impact of gender identity and gender oppression.

As one can see, there were continued gaps in theorists acknowledging multiple and simultaneous oppressions related to gender, race, and ethnicity. As with feminist psychology, liberation and multicultural psychologies had early women contributors who sought to awaken their subfields to the intersectional challenges facing women and girls of color. The work of women of color in feminist psychology and multicultural psychology was present but was not systemically embraced and integrated into the core of the theories until much later. In the meantime, women of color psychologists working as scholars, practitioners, and researchers began naming and centering on the strengths and needs of their cultured and gendered communities; these theories and efforts gave birth to multicultural feminist therapy.

**DEFINING MULTICULTURAL FEMINIST PSYCHOLOGY**

Multicultural feminist psychology, also referenced in the literature as feminist multicultural psychology, centralizes the intersections of oppression, power, and privilege in the lives of self-identified women with an understanding of the quest for social justice as an integral component of wellness (Enns et al., 2013). Multicultural feminist psychology aims to center on the experiences and voices of women of color, highlight intersectionality, and emphasize self-definition and empowerment to combat oppression and manifest holistic wellness (Enns, Sinacore, Ancis, & Phillips, 2004; Hill-Collins, 2000; hooks, 1989). Importantly, multicultural feminist psychologists identify as agents of social change (Palmer, 2004). Although race and socioeconomic status have consistently been explored in multicultural feminist psychology, there has been less attention given overall to sexual orientation, disability, migration status, and age. This book seeks to integrate these neglected areas, with a special focus on age—namely, the experience and identities of adolescent girls of color.

Comas-Díaz (2006) described multicultural feminist therapy (with Latinas) as an integrative approach that seeks to cultivate revolutionary acts of healing, transcendence, and rebirth. Multicultural feminist theory argues that to
achieve these aims, therapy must empower and raise awareness within clients about the ways their social context has affected their perceptions, behaviors, and affective experience. The context may include such factors as migration status, values, family, culture, and so forth. Multicultural feminist theory builds on a foundation of respect for the cultural values of women and girls while prioritizing the presentation of choices of women and girls of color to facilitate growth and agency. Womanist (feminist theology regarding Black women) and mujerista (feminist theology regarding Latina women) psychologies are types of multicultural feminist psychology wherein the core of the theories is not just a form of feminism but goes beyond that to attend to culturally emergent, culturally shaped, and culturally immersed ways of being, knowing, relating, and healing.

Ecological systems theory attends to the context of human development (Barrett & Ballou, 2008; Bronfenbrenner, 1979; Gonzales-Backen, 2013) by exploring individuals’ growth through layers of contextual influences, starting with the immediate surrounding environment (i.e., the microsystem), where children are influenced through personal relationships and interactions within the home, school, and community settings, to the more distal environment (i.e., the chronosystem), where children are more abstrusely influenced by culture and changes in society. Barrett and Ballou (2008) considered these levels through a contextual lens that honors the experience of the clients’ lives. An overarching premise is that growth and development at the individual level occur within the context of relationships and influences from other people, who are either immediately connected to the individual or distally removed within society. In this way, identity development can be seen through multiple aspects, such as identity as individual and identity as relational (Barrett & Ballou, 2008).

Treatment approaches from this perspective include relational-cultural therapy and feminist therapy. Relational-cultural therapy views individuals’ growth (Jordan, 2001) and challenges (Comstock et al., 2008) through relationship and connection to others and within the context of cultural and societal influence. It aligns with the foundational parts of feminist therapy (West, 2005) and focuses on the well-being of women and social change as integral to individual change. For example, the phrase “the personal is political” has been a staple of feminist therapy since Carol Hanisch used it in 1971 as the title of an essay; it continues to signify the need to address personal problems within the context of social and political influences. Both relational-cultural and feminist therapy complement multicultural therapies by encouraging clients to understand the contextual influences of gender-role socializations, marginalization, power, mutuality, and interconnectedness.
Multicultural feminist models of treatment address the cultural context of clients’ lives, with the intention of moving beyond symptom cessation and toward holistic wellness and empowerment (Brown, 2008b; Enns, 2004). Within the framework of multicultural feminist therapy, scholarship has developed on specific approaches, such as womanist psychotherapy and mujerista psychotherapy (for a review, see Bryant-Davis & Comas-Díaz, 2016). These treatment approaches address a number of overarching themes, including but not limited to intersectional identity, family, agency, spirituality, community, coping, resistance, healing, and thriving. These themes are applied to contemporary challenges facing multicultural feminist psychologists, such as covert oppression, unconscious bias, denial of inequity, microaggressions, and the complexity of people simultaneously holding roles of privilege and marginalization (Enns et al., 2013).

**TENETS OF MULTICULTURAL FEMINIST THERAPY**

Key aspects of multicultural feminist psychology are the affirmation of culture, womanhood and girlhood, sociopolitical consciousness, and intersectional awareness. In addition, multicultural feminist therapy centers on an understanding of trauma, oppression, empowerment, healing, and thriving, while attending to connection, spirituality, sexuality, and creativity. Going beyond many feminist theorists who promote acknowledging and resisting multiple forms of oppression, multicultural feminist psychology also centralizes the use of cultural resources and values to shape the therapeutic experience. Healing comes not just from consciousness-raising and empowerment to combat oppression but also in coming home to one’s self as a gendered cultural being, both individually and collectively. Foundationally, multicultural feminist theory asserts that along with addressing the multiple forms of oppression, therapists must attend to holistic identity and functioning. The major tenets of multicultural feminist psychology, which will be summarized next, are egalitarian therapeutic relationship, cultural congruence, intersectional lens, empowerment to combat social justice, community engagement, and growth and resilience (Bryant-Davis & Comas-Díaz, 2016; Carr, Green, & Ponce, 2015; Enns et al., 2013).

The first tenet of multicultural feminist therapy is *egalitarian relationships*. The therapist builds the therapeutic relationship on a foundation of respect, honoring the wisdom that girls carry. Mujerista psychology, a daughter of multicultural feminist therapy, refers to it as reviving the inner knowing, or intuition, of the client (Comas-Díaz, 2016). Womanist psychology, another
daughter of multicultural feminist therapy, would refer to it as Kujua, or remembering that which you already know (Bryant, 1993).

Multicultural feminist therapy rejects notions of colonialism, pity, or rescue and instead embraces notions of cocreating and holding space for the inner and outer healing of girls and women. An egalitarian multicultural feminist therapist offers options; asks questions; self-discloses with appropriate awareness; creates space for the client’s voice, needs, and priorities; and is comfortable with being flexible and attentive to the wisdom of the client.

The second tenet of multicultural feminist therapy is self-definition. Girls are encouraged to define themselves for themselves, as they journey through their cultural identity, racial identity, gender identity, sexual identity, and spiritual or religious identity. Girls are encouraged to explore the meanings, values, and roles they have been directly and indirectly taught and engage in meaning making for themselves. Although the client is encouraged in self-definition, the aim is self-acceptance, affirmation, and celebration of who they are. From this vantage point, girls define what is praiseworthy about the various aspects of themselves as girls of color. Valuing self-definition also means that only persons who self-identify as girls should be addressed as adolescent girls or young women. Adolescents who reject the gender binary or identify as genderqueer or adolescent boys should not have therapists who insist that they embrace girlhood or womanhood. (Clients with fluid or male gender identity may flourish more in a gender queer or adolescent boys group. The therapist does not need to guess. They should honor the wisdom of the client and ask clients how they wish to be identified.) Multicultural feminist therapy creates a path to the client’s affirmation of the various aspects of their identity, resisting the societal messages that negate girlhood, diverse racial and ethnic identities, religious and spiritual traditions, and same gender-loving people. Addressing and celebrating aspects of the self that are often marginalized in treatment, multicultural feminist theory maintains an affirming perspective regarding the sexuality and spirituality of women and girls (Hagen, Arczynski, Morrow, & Hawxhurst, 2011). The final aspect of self-definition addressed in multicultural feminist therapy is that adolescent girls of color recognize that although oppression and trauma have affected them, they are more than what others have done to them. Their identities as adolescent girls of color are much more than a series of violations. Multicultural feminist therapists journey with them as they write the script of who they want to be and how they want to cultivate a life of meaning and purpose.

Adolescent girls of color are tasked with determining pathways to address the potential dichotomy between their ideal selves (the image of who they ought to be) and their actual selves (the authentic and integrated truth of
who they are). These identity markers are influenced by socializing agents in their lives, which carry both positive and negative messages about the adolescent and society as a whole. For example, they may contend with stereotyped images of themselves as hypersexual, exotic, and animalistic, which carry negative messages in society. They may also find strength in messages that affirm more positive, truthful, and nonstereotyped messages about them and the cultural groups to which they belong. These adolescent girls of color knowingly and unknowingly internalize these messages and experience subsequent influences on their identity, development, and social interactions with others, which may be a central part of their therapy process. Multicultural feminist therapists attend to intersectional identity in a proactive way that addresses the full spectrum of adolescents’ identity, including but not limited to gender, age, race, ethnicity, migration status, ability status, socioeconomic status, sexuality, and religion. There is a notion within psychotherapy that clients bring their whole selves into the therapy room and that it is imperative to understand and work with the person as a whole rather than separating them into isolated parts. The underlying tone of this notion is Gestalt, but it is also aligned with multicultural feminist principles focused on the intersection of clients’ identities. By naming, incorporating, and affirming the multiple aspects of the self, multicultural feminist therapists empower adolescent girls of color to accept and affirm themselves.

The third tenet of multicultural feminist therapy is cultural congruence. The task of the therapist is not to force clients to conform to a psychological model that was not created with them in mind but instead to build on the cultural resources that already exist and use them to shape experiences of healing and empowerment. Traditional psychotherapy uses theories and interventions that were primarily developed on the basis of the experience of middle and upper income, educated, White clients. From this vantage point came the notion that if one wanted to create a therapeutic experience one needed a neutral-colored room, without food, 50 minutes, rates over $100 so the client would value the process, and no one present but the individual client and the therapist. Multicultural feminist therapy decolonizes traditional psychotherapy, which also assumes that if people have not gone to therapy in the way just described, they have not worked on themselves. However, people faced difficulty and discovered ways to heal and grow long before psychotherapy was created. In this regard, multicultural feminist therapy recognizes that generations of cultural healing inform us that vibrant colors, scents, food, family, community, expressive arts, spirituality, and retraditionalization (or embracing of one’s legacy of survival) can be therapeutic. Multicultural feminist therapy also recognizes that need for physically and emotionally
accessible spaces. Whether the aim in a given moment is insight, psychoeducation, or skills building, the approach embraces the cultural traditions of the clients.

The fourth tenet is sociopolitical consciousness in the form of intersectional awareness. Adolescent girls experience consciousness-raising in multicultural feminist therapy. They develop critical thinking to identify and analyze the various systems of oppression they encounter. This awareness assists them in resisting internalized oppression, shame, and self-blame for the discrimination, stigma, and bias they experience. It also fosters their ability to relate to other marginalized girls about whom they have adopted negative views as a result of intersectional oppression. This awareness allows girls to look critically at beauty myths in the media, the reporting of history and current events at school, and their feeling about themselves and members of their cultural group.

Identity development is a key component of healthy development for adolescents and includes a number of subthemes, such as racial identity development, gender identity development, sexual identity development, and religious identity development. Adolescence is a time for discovering one’s self and of beginning to debate the existential question “Who am I?” In his seminal book on adolescent development, Erikson (1994) identified the stage of identity versus role confusion, wherein finding a sense of one’s uniqueness and resolving the two polar ends of the stage are essential tasks for adolescent development. This theory places adolescents’ identity development in the context of their egos and epigenetic need to move through psychosocial tasks. However, adolescents are faced not only with understanding who they are as unique individuals but also who they are in the context of their surrounding worlds.

To this extent, Marcia (1966, 1980) furthered Erikson’s (1994) model and posited that adolescents are tasked with engaging in a thoughtful process of reflective commitment that involves understanding their inner needs, abilities, values, beliefs, history, and self-perceptions. Four proposed identity statuses or resolutions resulted: identity diffusion (noncommitment to identity roles and values and without active exploration of related constructs), moratorium (noncommitment to identity roles and values but actively exploring identity constructs), foreclosure (commitment to identity roles and values but without deep exploration of related constructs), and identity achievement (commitment to identity roles and values based on thoughtful exploration of identity constructs). Marcia understood identity in adolescents to be a dynamic process in which elements that constitute identity shift and change over time. Phinney (1989, 1990) understood the same and continued the
work of Erikson (1994) and Marcia by conceptualizing a three-stage process of ethnic identity development. This process included the *unexamined stage*, in which adolescents show a lack of exploration of their identity outside the dominant culture’s characterizations of it; the *moratorium stage*, in which adolescents begin exploration of their identity; and the *achievement stage*, in which adolescents internalize an understanding of their ethnic identity based on meaningful exploration of it.

Importantly, in both Marcia (1966, 1980) and Phinney’s (1989, 1990) theories, adolescence is not seen as the beginning of identity development but rather the first time young people can deconstruct their childhood notions of identity and experiences to resolve a pathway into adulthood. This notion is aligned with Barrett and Ballou (2008), who noted that individual identity changes over time in response to learned experiences within various relationships and environments. Barrett and Ballou discussed the development of a contextual identity through four aspects: identity is that of the individual, identity is relational, identity is based on social units (e.g., race, class, gender), and identity is universal as human. In this model, individuals’ lived experiences shape their internalized sense of self and understanding of who they are in ways about which they are consciously and unconsciously aware.

Adolescent girls of color have quite a task in developing their identity because they have multiple selves to consider, and understanding the intersecting nature of those selves must be attended to. They have to consider who they are as themselves, in connection to others, through the multifaceted and intersecting aspects of their identities and subsequent perceived social roles, and with the spoken and unspoken expectations for those roles. In this way, their lived experiences as ethnic and gender minorities play a critical and early role in their identity development. The development of their identity includes *cultural identity*, which is a complex construct whereby an individual’s self-concept, thoughts, emotions, behaviors, and overall understanding of him- or herself is connected to multiple cultural group identities, such as racial, gender, sexual, and religious identity, to name a few. Cultural identity can be influenced by experiences with members in- and outside the various cultural groups to which one belongs. For adolescent girls of color, their lived experiences as ethnic and gender minorities play a critical and early role in their identity development process. This concept has been explored through research about ethnic (Kiang, Yip, Gonzales-Backen, Witkow, & Fuligni, 2006; Phinney, 1990; Phinney & Ong, 2007; Umaña-Taylor, Yazedjian, & Bamaca-Gomez, 2004) and gender identity (Kroger, 1997; Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013; Tobin et al., 2010). Importantly, strong ethnic and gender role attitudes have been found to be protective against
negative stereotypes messages that adolescents may encounter on a daily basis (Carlson, Uppal, & Prosser, 2000; Martinez & Dukes, 1997).

Through an ecological, phenomenological, and critical race feminist perspective, Clonan-Roy, Jacobs, and Nakkula (2016) developed a model of positive youth development that is specific to adolescents of color. Their model places critical consciousness at the center of developing a reflective awareness of the self, in relation to the social world, that fosters a deeper understanding of the self and leads to great competences in the domains of connection and caring, competence, character, contribution, confidence, resilience, and resistance. They posited that “developing the skills to critically question and analyze power relationships in the social world, and more subtle and interactional forms of gendered and racial/ethnic marginalization, will empower adolescent girls of color to navigate these multiple marginalities” (p. 104).

The fifth tenet of multicultural feminist therapy is empowerment. Some may be concerned that raising the intersectional consciousness of girls could result in them feeling powerless and hopeless. On the contrary, the awareness raising is directly connected to the empowerment. Girls are provided with tools of agency and the freedom to explore the various contexts in which these tools may be used. Honest discussion about potential outcomes of them claiming their voice, as well as attention to the dynamics of when, how, and with whom one chooses to engage, are necessary. Themes such as activism, agency, goal setting, mentorship, and personal and collective response to the problems of injustice also need attention to practical and often urgent responses. Empowerment can take the form of volunteerism, petition creation and signing, letter writing, attending a protest, speaking up about harm that is being done, raising awareness, choosing a career that addresses the issues they are drawn to, using spiritual practices to counter oppression, and showing the radical act of love and celebrating themselves despite the oppression they have experienced.

The sixth tenet of multicultural feminist therapy is community support or interpersonal connection. Appreciating collective notions of identity underscores how we are all related. Often, those facing distress retreat into isolation, when connection could assist in alleviating the pain. Each of the communities of color has held a long tradition of community support. Multicultural feminist therapy encourages clients to build positive relationships, which can include healing and addressing ruptures in the family regarding intergenerational conflict or conflict between siblings. Building positive relationships and addressing ruptures can also extend to other friends and community members. Positive emotional, informational, and instrumental social support has been identified in the literature as a buffer from the consequences of inter-
personal trauma and oppression. Connection can provide a sense of value, support, strength, and guidance. Connection can also take the form of family therapy and group therapy, important modalities for achieving the aims of multicultural feminist therapy, wellness, and empowerment.

The seventh and final tenet of multicultural feminist therapy is growth and thriving. Some scholarship refers to this tenet as recovery oriented or resilient. Multicultural feminist therapy aims to do more than provide distress relief or symptom cessation. The cultivation of healing, wellness, wholeness, and thriving echo many of the principles of community psychology and positive psychology. Multicultural feminist therapists facilitate growth, flourishing, and fulfillment. The presence of joy, purpose, connection, inspiration, and motivation are available and accessible for clients. The cultivation of joy, faith, and hope does not remain dormant while waiting for the elimination of all oppression; instead, it provides fuel for the journey and the fullness of life. Adolescent girls of color learn to nourish themselves; develop and maintain reciprocal, healthy relationships; and create lives of meaning and fulfillment.

APPLICATION OF MULTICULTURAL FEMINIST THERAPY WITH ADOLESCENT GIRLS OF COLOR

Preparation of the Therapist

The provision of multicultural feminist therapy requires attention to (a) ongoing self-examination, (b) sharing power, (c) giving voice, (d) facilitating consciousness-raising, (e) building on strengths, and (f) leaving clients the tools to work toward social change (Goodman et al., 2004). Ethically, mental health care necessitates cultural humility, cultural competence, and an intentional moving away from White ethnocentrism. Cultural humility is a self-reflective, other-oriented, and power-attenuating openness to clients as multicultural beings (Hook, Davis, Owen, Worthington, & Utsey, 2013). The therapist places a high value on clients as the experts on their lives and on therapists as active collaborators. In addition, there are centralized values of respect, openness, egolessness, and consideration of the client’s cultural background. In addition, across studies, cultural humility involves developing mutual partnerships that address power imbalances and openness to new cultural information (Mosher, Hook, Farrell, Watkins, & Davis, 2016).

Cultural humility is a disposition that values the central role of culture and a commitment to lifelong learning that recognizes the expertise of the client on their cultural experience and identity process (Mosher et al., 2016). Cultural competence encompasses self-awareness, including recognition of
one’s multiple identities as a clinician and the related points of privilege, power, and oppression, as well as knowledge about the client’s culture from sources besides the client (Sue, 2001). The therapist takes on the responsibility and benefit of learning about the historical and contemporary challenges and strengths of the client’s cultural group, including the realities of intersectionality. Instead of falling into stereotypes that leave large segments of a community invisible, the therapist attends to the multiple intersecting points of oppression and strength related to gender, race, ethnicity, sexual orientation, age, religion, ability status, and migration status. The reality of living in the United States as an ethnically and/or racially marginalized person is uniquely shaped by additional identity markers of adolescent girls of color. In addition, therapists’ skills are related to cultural competence, including the cultural modification of traditional psychotherapeutic interventions and culturally emergent practice strategies that reflect the client’s cultural heritage. Therapists have to understand and appreciate that the racial identity of the client can vary and will influence their awareness and appreciation of various cultural values and traditions. While assessing the centrality of racial and ethnic identity of clients, therapists must remain conscious of their racial and ethnic identity and the ways their assumptions, identity, and experiences may shape the progression of treatment. Lack of consciousness and humility can result in tendencies toward stereotyping, pitying, idealizing, pathologizing, or dehumanizing. Clinical ruptures will emerge from these tendencies, and therapists have to address and correct these incidents for the healthy development of the relationship and treatment.

There are also practical and systematic steps that mental health professionals should take to prepare the physical space for adolescent girls of color (see Chapter 2, this volume). Practical steps include having art, magazines, and books that represent the cultures of diverse clients. Systematic steps include having a diverse staff (from the leadership to the clinicians to the administrators) at the counseling agency. In addition, community partnerships and outreach reflect a value of community gatekeepers who are more likely to endorse psychotherapy and refer families of color to the agency. These partnerships can include faith leaders or ministers, local public school administrators, and community centers that serve the holistic and/or cultural needs of potential clients. Finally, a center with flexible hours (weekend and/or evening) as well as a sliding scale is more likely to attract and retain families of color.

Building and maintaining rapport with adolescent girls of color and their families is critical for retention and effectiveness (see Chapter 2, this volume). The intake process has to be flexible to accommodate time for establishing
relationships. Beginning the therapeutic relationship with a series of personal questions can result in the erection of emotional and physical walls. Thoughtful use of self-disclosure on the part of the therapist, as well as the integration of culture and arts, can assist in building trust, which is foundational for transformational intervention (see Chapter 5). Along with rapport building, the initial stages of treatment should include an orientation to psychotherapy to address expectations, roles, and stigma related to treatment (see Chapter 4). Attention to issues of confidentiality is highly significant, including disclosure of the conditions under which the therapist will make disclosures of material shared in treatment and to whom—parents, police, and/or child protective services. Although covering confidentiality is a component of all ethical treatment, it is especially relevant for adolescent girls of color who have experienced, witnessed, or been made aware of persons in authority causing harm to families of color, whether intentionally or unintentionally.

**Treatment Focus Areas**

Therapists have to assess and address a number of major mental health themes in multicultural feminist therapy with adolescent girls of color (see Chapter 3). Positive themes to integrate throughout treatment include identity, empowerment, positive gendered racial socialization, strengths, values, sociocultural networks, academic and vocational goals, and spirituality (see Chapter 5). There are also challenges that therapists should not minimize or overlook in psychotherapy; silence on the part of the therapist can keep adolescent girls of color also struggling in silence. The critical themes that have been established in the literature include trauma; depression; suicidality; substance use and dependence; oppression, discrimination, and microaggressions; body image and phenotype (colorism and biases around non-European features); and sexuality (see Chapter 4). Clinicians have to explore the extent to which each of these issues has emerged in the life of the client, their effect, the client’s thoughts and related emotions and behaviors, and the client’s coping and resistance strategies. The client’s strengths, insights, and sociocultural networks can be helpful in the navigation of these difficult waters (see Chapter 3). To address the critical areas, the therapist has to adopt behaviorally specific questions without shaming attitudes or assumptions.

**Assessment**

Multicultural feminist therapists must consider youth through the lens of a social-ecological framework, recognizing systems of bidirectional influence
(see Chapter 3). Ecomaps are an assessment tool used to provide greater clarity of the adolescent’s current stressors and strengths; they are a visual representation of relationships, social support, cultural context, and connections between family and the larger community (Crawford, Grant, & Crews, 2016). Culturagrams are an additional tool to assess and empower ethnically diverse clients by recording immigration, language, health beliefs; celebrated holidays and special events; the impact of crisis events; values regarding family, education, and work; and contact with cultural institutions (Congress, 2004).

Along with these tools, intake interviews, from a multicultural feminist perspective, have to attend to three primary areas. Therapists have to assess cultural values by engaging in exploratory discourse with the adolescent girl and her family members (see Chapter 2). In a cultural values discussion, the multicultural feminist therapist attends to gendered cultural values, such as ideals regarding gender roles and the impact of discrepancies within the client and between the client and her family’s values. In addition, multicultural feminist therapists conduct a full assessment of spirituality and religiosity. This intake includes gathering information about the adolescent’s beliefs, engagement in individual and collective religious and spiritual practices, her introduction to her spiritual and religious orientation, and her conceptualization and encounters with a higher power, ancestors, and other spiritual entities.

The therapist should also explore the adolescent’s positive and negative feelings and experiences as related to her spiritual and/or religious journey. Finally, it is critical to assess the adolescent’s full trauma history, meaning not only assault, abuse, and trafficking but also acts of discrimination, hate crimes, and gendered racism. Asking the question helps to create a safe environment for disclosure and healing.

**Diagnosis and Presenting Problems**

Many families and communities of color socialize girls of color to adopt roles of caretaker, cultural transmitter, and selfless giver. Beauboeuf-Lafontant (2007) described the silencing paradigm that emphasizes feminine goodness, in which girls are socialized to be more attuned and attentive to the needs of others, even to the absence of focus on their own needs and desires. Although these nurturing roles can be assets for girls of color, they can also present in challenging ways that unintentionally lead them to lack self-nurturing and self-care and experience additional stressors. The literature on girls and women of color conceptualizes these roles in various ways, including the stoic sufferer, superwoman syndrome (Woods-Giscombé, 2010), and marianismo (Castillo & Cano, 2007). The stoic sufferer is related to girls of color being
taught to silence their needs and pain, which is reflective of a historical need to be strong in the face of danger, control their emotions in the face of fear, and withstand extreme suffering. The superwoman syndrome (historically, the strong Black woman) can be seen in the latter notions of controlled emotions and unmeasurable strength, where girls of color are taught to deal with adversity by moving forward with their heads held high. Marianismo (historically, the strong but submissive Latina woman) can also be seen in this way, in which girls of color are taught that they should be pure and moral, humble to others’ needs, subordinate and submissive to men, and strong despite pain. In all three cases, girls of color are taught to endure suffering for the sake of others, such as the family, and that there is little place for “weakness” or vulnerability. Because of both the girls’ survival strategy of masking pain, as well as the gendered racial biases of the clinician, mental health professionals may misdiagnose girls of color. Studies have shown the potential for clinician bias toward adolescents of color, who are diagnosed with externalizing disorders (such as disruptive behavior disorders) at rates higher than their White counterparts, even when clinical assessment measures do not indicate a diagnosis based on minimal functional impairment (Nguyen, Huang, Arganza, & Liao, 2007). Adolescent girls of color may be more likely to be seen as resistant to care, devaluing of treatment, angry, irritable, paranoid, prone to violence, delusional, hyperreligious, avoidant, and incapable of insight. Under oppressive conditions, some of these survival responses can be mistaken for pathology. Conversely, responses that highlight mental health concerns can be missed. In fact, many adolescent girls carry untreated trauma and undiagnosed depression, eating disorders, and anxiety (Asnaani, Richey, Dimaite, Hinton, & Hofmann, 2010; Sen, 2004; U.S. Department of Health and Human Services, 2001). Some of the presenting problems that adolescent girls of color may face include the school to prison pipeline, with girls of color being disproportionately penalized and criminalized in school and community settings; the trauma of poverty, which opens the door to numerous violations; unexpressed grief from multiple losses; unhealthy relationships; unhealthy coping strategies; complex trauma, including intergenerational trauma; and challenges with language, acculturation, and pressure to shift selves in various cultural contexts. Wun (2016) conducted qualitative interviews with six high school girls of color who had school discipline records. She noted the girls’ intersecting experiences of gendered violence and poverty, as well as their feelings of helplessness, pain, and anger. Wun suggested that school faculty establish new ways of understanding and responding to adolescent girls of color and that instead of defining and responding to them as problems, faculty should consider their experiences within their communities and
society as a whole, including but not limited to violence, the expression of anger, and the show of resistance. We suggest that multicultural feminist therapists take a similar understanding in working with these adolescent girls of color in therapy.

**Rapport Building**

Research with clients in multicultural feminist therapy discovered that safety and trust are sacred themes in their evaluation of the therapeutic experience (Abousleman, 2010). Multicultural feminist therapists view adolescent girls of color as experts on their lives with knowledge, creativity, strength, and voice to contribute to the therapeutic process (Brown, 2008b; Enns, 2004; Worell & Johnson, 1997). In fact, multicultural feminist therapists recognize the critical nature of adolescent girls of color having space to share their voice and speak their truth from their unique perspectives. As opposed to viewing adolescent girls of color as merely “vulnerable populations” or “at-risk populations,” they are conceptualized as carriers of psychological, vocational, spiritual, and cultural resources and are deserving of care, access, attention, and empowerment. Brown (2008b) further noted that specific symptoms or behaviors that would traditionally lead therapists toward diagnostic labels are reconceptualized in multicultural feminist therapy and understood as evidence of resistance toward experiences of oppression, as well as means to resolve experiences of powerlessness. Understanding a client’s distress should then occur in the context of an egalitarian relationship where the power that is inherent in the therapeutic setting is shared with the client, and the course of treatment is approached with a collaborative effort. In this light, multicultural feminist therapy recognizes that “tolerance” is insufficient and respect is necessary for communication, consideration, planning, and implementation of treatment. Further, multicultural feminist therapists use the therapy setting to be social justice agents of change working with and in support of clients to manifest change in their daily lives and the social-political environment as a whole (Goodman et al., 2004).

Therapists working with adolescent girls of color recognize the appropriate use of self-disclosure as well as the need for cultural humility and self-awareness, which are both required to heal any therapeutic ruptures that may occur. Self-disclosure has long been a part of multicultural feminist therapy because it not only helps with rapport building when done appropriately but it also further shares the power of the relationship and allows for mutuality in the therapy process. However, therapists must engage in humility and self-awareness when disclosing so as not to shift the focus of therapy to themselves or to overidentify with the survivors’ experience.
In this regard, therapists have a fine line to walk. Goodman and her colleagues (2004) stated that even well-intentioned psychologists need to guard against simply imposing their own group’s values on another group in the name of consciousness raising. Moreover, we must be careful that in our attempts to use conscientization, we do not end up denigrating or silencing individuals within a group who may think differently. We must engage people with humility and pluralism, acknowledging that our views arise from our own sociocultural experiences and may not be true for the people with whom we are working. (p. 804)

In addition, rapport building with adolescent girls of color requires appreciating and respecting diverse family structures, which may include extended family members and fictive kin, as well as appreciating and respecting diverse communication styles which may use humor, proverbs, high emphasis on non-verbal messaging, references to cultural associations and constructs, and for some girls, dramatic or expressive communication. Therapists recognize the potential for many different cultural definitions of family, expressions of family roles and expectations, as well as a multitude of cultural dimensions that influence communication, expression, and general styles of families (for a review, see McGoldrick, Giordano, & Garcia-Preto, 2005). Multicultural feminist therapists do not create an environment of interrogation or disconnection but of collaboration and engagement across cultures.

Interventions

Adolescent girls of color come from cultures with active oral traditions. Empowering narrative therapy can be helpful and includes the use of storytelling, spoken word, proverbs, and hip-hop (see Chapter 5). Within these traditions, the girls can name, define, and shape themselves in the present and future. These traditions can create a safe place to shatter the silence around trauma and oppression and hold the duality of the ways they have been mistreated and the ways they still hold agency and power.

Working with adolescent girls of color requires attention to body image, beauty myths, and the traumas that many of them have physically endured (see Chapter 3). Talk therapy may be insufficient for them to reclaim their bodies. Embodied treatment that engages holistic awareness and holistic health may include movement, traditional dance, yoga and/or stretching, postures, gestures, walking, and sports. These activities may be directed or nondirected, central to the intervention of the day or used at the beginning or end of session.

Expressive arts are tools for multicultural feminist therapy that can be used for self-exploration, self-expression, healing, and protest (see Chapter 5).
These therapeutic art forms include drumming, beading, dancing, acting, singing, storytelling, and drawing. The visual expressive arts have also been components of multicultural feminist therapy with adolescents of color. Jewelry making, painting, collage making, pottery, photography, multimedia activities, and filmmaking are interests therapists can use to cultivate healing, protest and resistance, and emotional soothing to give adolescent girls psychological space to process difficult material. Therapists have to be mindful not to overinterpret the artwork, give messages that create a sense of perfectionism and performance, or use materials that are not reflective of the girls’ culture (e.g., magazines for collage making that do not include models of color).

Spiritual practices are also important components of spiritually integrated psychotherapy with adolescent girls of color (see Chapter 3). These practices can include prayer, meditation, smudging (burning leaves or smelling oils associated culturally with cleansing and healing), connecting with ancestors by speaking about them or pouring libations to honor them, and rebuilding trust of their inner wisdom, intuition, or the higher power alive in them (see Chapter 5).

Retraditionalization, decolonization, cultural education, and tapping into cultural resources are all significant aims for holistic health and development for adolescent girls of color (see Chapter 2). Positive racial socialization and knowledge of cultural resources can serve as protective factors for adolescents’ healthy development, academically and socially. Integrating interventions in session and homework assignments that connect girls with their rich heritage can be one pathway to fostering resilience and recovery from stressors and life challenges (see Chapter 2). Adolescent girls of color can receive cultural psychoeducation about the contributions and creativity of their ancestors and elders, as well as contemporary role models. Multicultural feminist therapy aims to reconnect adolescent girls of color with their culture, decolonize their thinking and behavior, and connect them with the cultural wealth of their ancestry.

Critical consciousness-raising is an essential component of empowerment and multicultural feminist therapy (see Chapter 5). Therapists should provide adolescent girls of color with awareness-raising psychoeducation about the realities of intersectionality and oppression in its multiple forms, as well as its effects, healthy coping strategies, and diverse ways to resist (see Chapter 3). Resistance strategies, such as artivism (i.e., the use of art as a medium for activism), can provide girls with lifelong tools to combat oppression and resist internalizing messages that are demeaning, dehumanizing, and marginalizing (see Chapter 5). The intervention does not end with consciousness-raising but empowers girls with knowledge and skills to pursue justice in their lives. At their core, multicultural feminist therapy,
womanist therapy, and *mujerista* therapy are pathways to liberation wherein adolescent girls of color can reclaim their identities and authentically thrive through actualization and activism (see Chapter 5).

Another important aspect of multicultural feminist therapy is spirituality (see Chapter 2). Psychotherapy requires *hope*—the belief that things can get better than they are now and that people can grow beyond what they currently see in themselves. Spiritually integrated psychotherapy engages in reflection and holistic practices, attending to the spiritual, emotional, cognitive, and physical aspects of our identity. In the Latina tradition, adolescent girls are encouraged to reconnect with and honor their intuition, or inner wisdom (see Chapter 5). In the Latina, African American, American Indian, and Asian tradition, spiritual practices may include prayer, meditation, yoga, praise dance, reading inspiring texts, or attending collective services or rituals that reconnect the girls to their spiritual source and community (see Chapter 2). Solution-focused therapy involves exploring with the girls whether there are any spiritual practices they have found nourishing and whether they are considering reactivating those practices. One specific example is the use of cultural proverbs and/or spiritual verses to soothe, encourage, motivate, and inspire adolescent girls of color (see Chapter 5).

Building, enhancing, and maintaining healthy social support are all important for adolescent girls of color (see Chapter 3). The manifestation of this value can take the form of family therapy or group therapy. Discussions about sisterhood or friendship and healthy peer relationships are necessary areas of focus for intervention. Regarding family therapy, it is important to build rapport with the family, whether the entire intervention is family based or the therapist involves the family for the initial sessions and/or the culminating sessions. In meeting with the family, multicultural feminist therapists recognize the importance of acknowledging and demonstrating respect for the family elders and obtaining information from the elders on the family history; assessment of family strengths and struggles is critical, including history of intergenerational trauma and family triumphs (see Chapter 2). In addition, multicultural feminist therapists explore family perceptions regarding gender roles and the transition from girlhood to womanhood. Multicultural feminist, womanist, and *mujerista* therapists recognize the need to empower families to see the strengths and gifts of girls and women, along with the challenges they may face (see Chapter 5). When the family can celebrate their daughter’s present and future, the daughter can more readily celebrate herself. Group interventions should be culturally emergent, such as emancipation circles or cultural modifications of traditional psychotherapy interventions, such as culturally modified trauma-focused cognitive behavior therapy. In family, group, and individual interventions, adolescent girls of color should find the safety
and support to explore their cultural values, including those they may fully adopt, those they may reject, and those they may choose to modify.

Multicultural feminist therapy uses both prevention and intervention models across modalities of individual, family, and group practice. An ecological systems approach is the frame of this intervention, recognizing the multiple layers of interaction that have a bidirectional influence on the lives of adolescent girls of color. There is an appreciation for the culturally modified evidence-based treatments that have been developed and evaluated as well as the interventions that are derived from the cultural heritage of girls of color. Culturally modified evidence-based treatments have been shown to result in significant improvements across a variety of mental health concerns (Griner & Smith, 2006). These treatments should be grounded in a framework that provides an understanding of the unique and complex challenges that survivors face. They should be flexibly geared toward the client’s needs. They should also consider the cultural appropriateness of involving family members and extended networks in the healing process, of course with clear informed consent and a review of confidentiality at the beginning of therapy sessions (Brown, 2008a). These interventions aim to assist in the healthy development of adolescent girls of color through the healing of emotional wounds and empowerment for the transition from surviving to thriving. Empowerment treatment models, such as multicultural feminist therapy, value attainment of joy, purpose, and wholeness as experienced by the client and as observed by the therapists and community members.

**Trauma-Informed Multicultural Feminist Therapy**

Multicultural feminist therapy also acknowledges and addresses the existence and impact of oppression as a potential form of societal and/or intergenerational trauma (Brown, 2008a; Bryant-Davis, 2007; Kirmayer, Gone, & Moses, 2014). The denial or minimization of trauma in the forms of discrimination, stigma, and microaggressions (i.e., intentional or unintentional communications of racial slights or insults; Sue et al., 2007) is a violation of the therapist’s commitment to client-centered, compassionate care. Treating these experiences as unreal or unimportant does not show respect for clients or acknowledge their narratives as influenced by the social context in which their experiences have occurred. Instead, therapists should take an ethnopolitical approach that recognizes and bears witness to (vs. suppressing) the trauma and oppression of clients’ experiences and that uses language to speak to clients’ experiences in ways that promote individual, community, and political change (Comas-Díaz, 2000). In fact, the feminist view that the “personal is political” acknowledges external conditions, such
as oppression, as contributors to internalized trauma. Multicultural feminist therapists screen for these and other experiences of oppression, as well as their impact on the lives of adolescent girls of color.

Treatment goals and interventions are selected collaboratively to address these experiences. Interventions aimed at addressing oppression incorporate positive racial and ethnic identity, affirming humanity, enhancing community support, attending to gendered racism (i.e., interconnected sexism and racism), and developing resistance strategies such as artivism and activism (Bryant-Davis & Comas-Díaz, 2016; Bryant-Davis & Tummala-Narra, 2017). These interventions have long existed in communities of color as a means of surviving the many levels of degradation they have experienced. Working with adolescents of color through interventions that highlight these and other cultural strengths supports them in practices that are normative within their communities and that have historically facilitated healing. For example, the integration of artivism into treatment aligns with cultural traditions of using music, poetry, dance, and other forms of artistry to express pain and anger and transform them into resistance and action.

**Other Forms of Interpersonal Trauma**

Adolescent girls of color, particularly American Indian and African American girls, are at increased risk of a number of forms of interpersonal trauma. For example, there is an increased risk of intimate partner abuse and sexual assault (Morgan & Kena, 2017; Smith et al., 2017), police brutality (Bryant-Davis, Adams, Alejandro, & Gray, 2017; Hansen, 2017), and sex trafficking (Banks & Kyckelhahn, 2011; Farley, 2003; Pierce, 2012). These assaults, which are all rooted in issues of power and control, leave adolescent girls of color and their families further marginalized, silenced, and traumatized by the inequitable injustices they face in society. It is imperative to approach treatment with an understanding of the sociocultural context that impacts the experience of trauma of survivors of color as well as the mental health effects and aftermath (Bryant-Davis, Chung, & Tillman, 2009). Whittier (2016) used a feminist framework to understand the intersectional dimensions that impact sexual abuse in communities of color and specifically against children; she noted that “theorizing sexual violence intersectionally allows us to consider how gender, race, class, and age interact to shape experiences, interpretations, and responses, and points to the need for research guided by this approach” (p. 99). We add that it also points to the need for therapy guided by that approach, such as multicultural feminist therapy.

Multicultural feminist therapy incorporates a full trauma history assessment and relevant trauma-focused interventions to address these violations
with added attention to cultural barriers, disclosure, and cultural strengths, as well as resources for coping and healing, such as spiritual practices and the use of the expressive arts (BigFoot & Dunlap, 2006; Bryant-Davis & Tummala-Narra, 2017; Drake-Burnette, Garrett-Akinsanya, & Bryant-Davis, 2016; Singh, 2009). Multicultural feminist therapists should work with clients to interrupt the powerlessness that comes with enduring abuses, assaults, and exploitations while encouraging clients’ exploration and promotion of self-power and cultural healing. Attention to cultural strengths, resources, and coping can aid in healing and resilience for these youth.

**Therapists’ Self-Care**

Multicultural feminist therapy recognizes the humanity of the therapist. Therapists are not blank slates without needs of their own. Instead, therapists bring their whole selves into the room with intersecting identities, related experiences in the world, potential trauma of their own, and/or potential vicarious trauma from engagement as a trauma therapist. As Brown (2008a) eloquently put it,

> Because [vicarious trauma] is a profound and sometimes hidden experience for trauma psychotherapists, it touches on all aspects of the psychotherapist’s multiple identities and social locations and may aggravate a therapist’s hidden wounds of insidious trauma, betrayal, or cultural experiences of danger. Thus, just as cultural competence is of importance in working with clients so that psychotherapists can hear and know the multiple meanings of their trauma experience in light of their various identities, so such competence is a necessary component of responding to [vicarious trauma] in themselves. (p. 253)

Multicultural feminist therapists provide the best care by actively creating ways to refill their therapeutic well. They engage in self-care through cultural practices; spiritual practices; mutual and reciprocal, healthy relationships; supervision and consultation; appropriate limit and boundary setting; lifelong learning; and engagement in activity, advocacy, or activism for community-level empowerment. They may even do so through self-exploration and seeking therapy from a multicultural feminist therapist who is relationally unknown to them.

**CONCLUSION**

Multicultural psychology and feminist psychology call for attention to and respect for persons who have been systemically underserved, marginalized, and oppressed. The psychological literature has routinely neglected adoles-
cent girls of color, both their needs and their strengths. Adolescent girls of color deserve to be more than an afterthought to developers of practice models. As an act of justice and care, this approach centers on adolescent girls of color, recognizing their gifts, cultural heritage, and praiseworthy girlhood.

Multicultural feminist psychology is holistic, extending beyond mind–body approaches to integrate mind, body, and spirit. From this viewpoint of healing work being sacred, this approach is open to and drawn to the use of expressive arts as well as awareness that manifests in the form of activism. The therapist and the client are not only change agents of the interior self but also potential change agents of family, community, and society. Adolescent girls treated with multicultural feminist therapy are empowered to combat oppression in ways that resonate with them. With the support of internal and cultural resources, they shed the layers of internalized oppression and awaken to their full possibility, which allows them to not only heal but also to thrive. Adolescent girls of color transform when both their wounds and wings are recognized. Multicultural feminist therapists declare to them with spirit, word, and action, “I see you, and I stand with you.”

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As counselors and psychologists, our hope is that therapy is an environment in which clients can come and trust that we will do everything in our power to know them deeply. We want therapy to be a process whereby they can bring the segmented and disjointed parts of their lives to be shared, grieved, and eventually integrated. Healing in the area of cultural identity requires the type of space where a person can find refuge from the all too commonly felt need to segment the self and keep rigid boundaries related to cultural identities. Many therapists do not know how to engage cultural opportunities of this kind.

This problem seems especially evident when it comes to issues of faith or existential worldview. Mental health providers serve a wide variety of individuals and communities, ranging from those with to those without a strong faith in a religious or spiritual community. But many clients consider religion and spirituality to be an important part of their identity (up to 75% of individuals in the United States; Pew Research Center, n.d.). Furthermore, many others have had negative experiences with organized religion or do not attune to this aspect in their daily lives. Despite the importance of religion or spirituality for working with many marginalized groups, many therapists report feeling unprepared to address the spiritual diversity within their clientele. Moreover, some therapists may not know if mindfulness practices are consistent with clients’ ways of being. Therefore, it may be difficult to implement a multicultural vision without addressing this gap.

We considered emerging conversations related to mindfulness as an opportunity to learn more about how to engage people’s spiritual and existential identities. With the mindfulness movement, the mental health profession has become enamored with secularized practices that were originally refined
within a variety of monastic traditions within Buddhism. The popularity of these practices has sparked multicultural conversations about how to make these practices increasingly accessible to the general public while also honoring the cultural and spiritual traditions from which these practices originated.

As therapists, our role is to be able to converse with people about what matters most to them. Many clients may draw on spiritual language to tell us about these matters, and it is our responsibility to prepare ourselves to meet these clients where they are.1 We can assist our clients by learning other ways of being and, more specifically, by not adopting an “all knowing” stance. At the same time, we do not want to burden our clients by expecting them to educate us. Thus, we cultivate a motivation for lifelong learning beyond any one client, or belief system, or way of engaging in therapy. We push ourselves daily, weekly, and yearly to be in a growth mind-set, which is founded in a state of humility. Our clients need us to be able to listen like a trusted confidant—even, and maybe most importantly, when we may not have the cultural background or experiences to make that empathy process simple. Cultural humility is the guiding theoretical framework for our writing. To prepare ourselves for the work of therapy, humility reminds us of our limitations in knowledge more than our strengths or achievements. It can make us more receptive to addressing new and complex situations. It can keep our minds open to new options. These are skills that require refinement for anyone seeking to gain expertise at working in the area of cultural diversity.

Before moving forward, we want to acknowledge and thank several people. First, we thank Sarah Gazaway, the first author’s (D.D.’s) graduate research assistant during the past 2 years. She played a crucial role in helping to keep this project moving forward. She gave feedback on manuscripts, helped reconcile the references, compiled helpful resources, and helped to coordinate the coauthors. This project could not have happened (or happened on time) without her tireless efforts. Second, we thank our mentors, Ev Worthington, Bonnie Moradi, and Karen Kitchener. We are also thankful for our colleagues who provided us with opportunities to dialogue about, as well as concrete examples of, the integration of mindfulness within their work with culturally marginalized groups. In particular, we thank Negar Fani, Carlton Green, Candice Hargons, and Nathan Mascaro.

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1All clinical case material in the chapters is fictionalized.
CONCEPTUAL AND PERSONAL FOUNDATIONS
All of us share in the experience of humanity while facing a changing world that sometimes looks and feels different based on our nationality, gender, race or ethnicity, sexuality, or religion. Technology has made the world smaller and more interconnected. Just think about the past few decades: Innovations in technology (e.g., smartphones, e-mail, social media) have put people in a new and rapidly changing social environment. We face constant exposure to a world of information and images that are only a click away. In a split second, we can interact with someone on the other side of the earth.

These staggering changes continue to accelerate perhaps faster than we are able to adjust to them (e.g., people sleeping with their cell phones and compulsively checking messages throughout the night), and the future developments are likely not even within our current scope of understanding. In this rapidly shifting context, qualities that include flexibility and having an awareness of one’s limitations become increasingly important (Hess & Ludwig, 2017). It is difficult to live well—or help our clients live well—without embracing change to those aspects of life that are frequently changing and yet holding onto those cultural values and beliefs that ground us in our daily lives and within our communities.

This new world seems rich with opportunities and dangers. We have never had more potential for connection with others from different cultures and communities. This increased “connectedness,” though, somehow seems to intensify the potential for loneliness. University students are showing up for

http://dx.doi.org/10.1037/0000156-001
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therapy in droves (Twenge, 2017). In the United States and many other parts of the world, social media perpetuates simmering hostilities between identity groups that can turn violent. Once (at least sometimes) obscured, we now see the ugly side of humanity in plain view—and constantly. We have less room to hide from the reality of life and human suffering. Our technology berates us with images of another school shooting, another killing of an African American person, another campus riot with echoes of racist chants coupled with flaming torches, traumatized students screaming at each other with no unity in sight, another woman subjected to the abuse of power—an endless torrent of human suffering. These dismal reminders of our society are not what define us, but they are part of us—all of us. It is the daily trauma that accentuates the lack of safety and uncertainty in the world, in our country, and in our neighborhoods.

Altogether, the increased potential for connection seems to strain our collective ability to engage cultural differences. In the old world, we might have been able to avoid some of our enemies. Now, social media keeps hostile connections alive. Each time our phone rings, we are trained to reach in our pockets and potentially see someone spewing vitriol. Sadly, many of our professional networks may not fare much better. The more people care about an issue, the more difficult it can be to practice cultural humility.

In our first book on cultural humility (Hook, Davis, Owen, & DeBlare, 2017), we began with an invitation to explore the diversity of humanity and the many cultural stories that make people who they are. To open this book, we invite you to think about your desire for connection with other people. What are the sources of deepest meaning in your life or the people you care for? When have you felt alive, fulfilled, and connected? Who lets you lower your defenses? When have you felt deeply known and loved?

Before you read any further, check in with yourself about how you are doing in the face of all the things changing in your life. Right now—how are you doing? In training to be a psychologist, we learned to keep a professional distance from our clients. But we live in the same world. We are the same kind of humans. We are not too far removed from the same isolation and pain that brings them to our offices fatigued and depleted by their lives. We invite you to consider the parts of your life that make it hard for you to catch your breath, much less flourish.

Some of us are weary of death; we have said goodbye to many loved ones. Some of us are weary of the constant responsibilities of adulthood: tending to kids, bills, and the anxiety caused by our to-do lists. Some of us are weary of our inner self, relentlessly pushing to be better and better. Some of us are weary of the exclusion and discrimination we and our loved one’s experience; we fight a sense of hopelessness that it will ever end. Some of us are weary of conflict—of seeing people undermine others and get their way, even if they are left with broken relationships. What are the sources of persistent suffering that deplete your energy?

Conversely, does reflecting on these areas in life provide perspective, hope, optimism, or joy? Indeed, paradoxically, awareness of suffering can
also reveal sources of strength and hope. What are your sources of strength, hope, peace, love, and compassion? What does it mean to honor your greatest fears without letting them define you? How can you offer your clients compassion in a way that does not undermine their sources of meaning and purpose?

The art and science of mindfulness is the result of a growing interest in contemplative practices within the mental health profession. To answer some of these questions, many psychologists have begun to look beyond Western thinking and ideologies. They have begun to explore a variety of contemplative traditions, particularly Eastern spiritualities and philosophies, which offer an alternative perspective on modern life. Namely, that life is suffering and change.

**WHY DID WE DECIDE TO WRITE THIS BOOK?**

We want to begin by describing some of the organic circumstances that led us to write this book. Several years ago, two of this book’s authors, D. D. and C. D., had a student in our department who introduced us to a group called Octagon (http://www.octagon.life.edu) that was interested in contemplative practices and their implications for larger systems (e.g., education, business, health). Members of the group also had connections with the team at Emory University that developed *compassion-based cognitive therapy*, an approach that integrates theory and practices and is inspired by Tibetan Buddhism (Ozawa-de Silva & Dodson-Lavelle, 2011). While trying to work out the details of how to make contemplative practices available in various settings, Octagon was grappling with practical questions and gaps in the professional literature on mindfulness. So, this community deserves credit for sparking the professional curiosity that led to this book.

The general tone of the group was positive: They viewed the mindfulness movement as an opportunity to make a difference. The group believed that contemplative traditions had something important to offer a variety of systems (e.g., health, education, business) that had seemingly taken on a life of their own. Many of these systems no longer existed to serve people; people existed to serve them or whoever was at the top of the hierarchical scheme. The group believed the interest in mindfulness provided an opportunity to partner in making these systems more humane. The mainstreaming of mindfulness interventions meant that many core systems—often governed by strict social norms related to secularization—had a growing receptiveness to meditation as long as the framing did not violate secularization norms related to proselytizing a religion.

At the same time, the group also raised concerns. First, they were concerned about positivity bias within the mindfulness literature. Through personal communications, they were aware of conversations among professionals about potential barriers or problems with implementing mindfulness interventions,
but these problems seemed muted in the professional literature. Furthermore, many people in this group had undergone extensive meditation training within various Buddhist traditions. They were concerned that practitioners using mindfulness might not be aware of the common problems that arise when people engage long-term meditation practices. For example, starting to meditate can make stress worse before it gets better because people may gain awareness of previously unconscious feelings, especially people with a trauma background (Rapgay & Bystrisky, 2009).

Second, the group was also concerned about cultural diffusion of mindfulness. Members of Octagon had trained within Buddhist traditions. They were also aware of mindfulness-based approaches being used in psychotherapy or other venues. They noticed a growing gap between the two: those groups that joined the so-called mindfulness movement and sought to explore its potential usefulness and those who made explicit arguments about the need to differentiate from Buddhism and draw explicitly on other contemplative traditions within other religions (e.g., Knabb & Frederick, 2017; Knabb & Vazquez, 2018). If not for the shared name, anthropologists in a few hundred years might have little hope of matching what is happening in therapy with the ancient practices from which they were derived.

To give a sampling of potential reasons for cultural diffusion, therapeutic mindfulness (the term we use in this book to refer to mindfulness within psychotherapy) has a different goal. The goal of therapeutic mindfulness is primarily symptom reduction. Within Buddhism, however, mindfulness is part of a much broader spiritual perspective and worldview that seems to promote enlightenment and spiritual awakening. People seek to see the world as it is, with less delusion and distortion, which happens as people attempt to avoid trying to control suffering (Kang & Whittingham, 2010; Rapgay & Bystrisky, 2009).

Therapeutic mindfulness detaches mindfulness from community life; it is an individualistic expression. Within Buddhist traditions, mindfulness is part of a broader culture that provides people with the support and meaning-systems to deal with challenges that arise in meditation. Practicing alone removes a major source of support. Therapeutic mindfulness has the potential to oversimplify a sophisticated spiritual tradition into à la carte activities: People pick and choose parts of various traditions that can fit into segments of a fragmented and overburdened schedule (and life).

Third, the group alluded to cultural difficulties some clients may have with mindfulness. For example, the people who ran meditation groups in the greater Atlanta area noted that many clients dropped out early on. Their sense was that some clients dropped out because meditation wasn’t a good fit with their cultural identities (e.g., religious or spiritual background as well as the intersection of religion or spirituality and other identities, particularly race and ethnicity). They weren’t entirely sure, however, and despite a burgeoning literature on mindfulness, they were not seeing much scientific literature on cultural problems and difficulties.
Taken together, Octagon seemed to have questions that would be of interest to mental health professionals wanting to use mindfulness in their clinical work. We were especially curious how therapists devoted to multicultural values would engage some of these larger systemic challenges, such as adapting mindfulness to different groups while also attending to concerns about cultural appropriation. In short, how could therapists—regardless of commitment to using mindfulness—meet the rising interest in meditation in the general public in an ethical, culturally humble way?

**WHAT IS THE MAIN POINT?**

Our goal in this book is to extend ideas on cultural humility—and the multicultural orientation framework (MCO; Owen, 2013; Owen, Tao, Leach, & Rodolfa, 2011)—to consider these emerging questions about how to contextualize mindfulness to different clients and settings, especially clients from different cultural backgrounds. This contextualization relates to feminist understandings of self-reflexivity and intersubjectivity (van Stapele, 2014). These processes encourage self-reflection, self-analysis, and self-contextualization as a platform for understanding our interpretations of our interpersonal interactions; inherent power differentials are also named in these interactions (e.g., van Stapele, 2014). At the heart of this framework is the virtue of cultural humility.

*Cultural humility* is the virtue language of the MCO framework, and it is infused throughout the other aspects of the model. A variety of scholars converged on the intuition that humility language provides an important complement to the competencies language used to incorporate multicultural values into the training standards of many helping professions (see Foronda, Baptiste, Reinholdt, & Ousman, 2016). Intrapersonally, humility involves having an accurate view of one’s strengths and limitations; interpersonally, it involves an other-oriented stance (as opposed to self-centered) expressed through a lack of interpersonal superiority. Scholars have studied humility in contexts that make it difficult to practice—situations that evoke egoism and defensiveness. Given that belonging to a group comes with commitment- and loyalty-related biases, cultural differences can strain the practice of humility (Davis et al., 2018). Accordingly, Hook, Davis, Owen, Worthington, and Utsey (2013) defined cultural humility as “the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client” (p. 354).

In practical terms, cultural humility involves a way of being more than doing (Hook et al., 2017), openness to the other, inclusiveness, and a willingness to put these values into action—not just in session but across all aspects of life. It also involves refining your ability to listen carefully and compassionately and accept feedback of all kinds without defensiveness. As we have shared the MCO framework more widely, people resonate with the use of
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humility language as a complement to competence language, which can focus people on how they are doing (rather than their cultural way of being in session). Cultural humility encourages a stance of openness and receptiveness that is other oriented rather than self-preoccupied. People seem to get this concept and appreciate the balance that humility language offers.

The most common reactions and questions tend to be practical in nature: What does it look like to express cultural humility? How can I make this more a part of my practice of therapy and lifestyle? Thus, the authors of this book realized that it is important to keep fleshing out what applying the MCO framework looks like in real life. Therefore, as a team of authors, we decided to look for some important places to apply it.

The mindfulness movement in psychology seemed like a timely and challenging area to apply the MCO framework next. It is timely because of massive growth in research and the popularity of mindfulness. As we elaborate in Chapter 2, over the past half-century, the use of meditation in psychology has evolved from being a relatively fringe practice to being one of the more popular approaches in psychotherapy (Norcross, Pfund, & Prochaska, 2013). Where prior attempts to promote meditation were met with cultural resistance (Harrington & Dunne, 2015), mindfulness-based interventions offer a way of presenting meditation that has not only gained entry into, but has been well-received by, several major systems (e.g., health care, education, business). Mindfulness is now a billion-dollar industry, and various segments of society are seeking to compete for a share of the market (Clarke, Black, Stussman, Barnes, & Nahin, 2015). Psychology is a small cog in a much larger industry, and all are situated (in the United States) within a dominant society that perpetuates systems of oppression, discrimination, and racism. As counseling psychologists interested in culture and identity, it is fascinating to entertain the “Why now?” question. It seems likely that a confluence of factors has set the stage for the popularity of the current mindfulness moment (e.g., smartphones, growing self-help industry, positive psychology movement, growing individualism, increasing suspicion of institutions such as religion; C. J. Miller, Elder, & Scavone, 2017).

Mindfulness is a daunting challenge for thinking about the application of the MCO framework because of the nature of emerging cultural critiques. For a time, mindfulness seemed immune from typical lenses multicultural psychology scholars tend to apply to critique therapy approaches. Perhaps people considered mindfulness a fad that would eventually run its course. However, mindfulness now holds a prominent position in a variety of cultural structures and institutions. A striking example is that the U.S. federal government has invested hundreds of millions of dollars in the development and dissemination of mindfulness-based interventions (Hickey, 2010). The investment has paid off, at least in terms of making mindfulness more accessible. Now anyone with an Apple watch or smartphone likely has a mindfulness app installed by default, meaning you actually have to take action to turn off
the app if you decide you don’t want regular reminders to attend to your breathing.

Regardless of the reasons for the initial delay in criticism, the cultural critiques are strong now—and some are scathing (e.g., Hickey, 2010; Monteiro, Compson, & Musten, 2017; Sperry & Stoupas, 2017; Van Dam et al., 2018). We elaborate on these critiques in Chapter 3, but they range from (a) concerns about appropriation to (b) concerns about the need to adapt mindfulness to oppressed and marginalized groups of society to (c) arguments about the need to draw explicitly from the client’s religious tradition to frame contemplative approaches. Our field’s response to these critiques may change mindfulness in surprising ways, but regardless of what the future holds, all signs suggest that mindfulness is here to stay. So, for socially conscious therapists—for those attempting to work out the MCO framework in all aspects of their work and lives—it is time to clarify values and consider important questions. These questions provide an opportunity to apply and test the ideas within the MCO framework.

We are particularly interested in the dynamics that occur between groups and social systems. Mindfulness is a social evolutionary success story. The framing of mindfulness interventions is flexible so that they are able to align with secular norms and accommodate people from a variety of cultural backgrounds. Mindfulness interventions fit in with a growing agenda to offer a more scientific alternative to guiding the good life rather than simply relying on authority structures of religious traditions (Dahlsgaard, Peterson, & Seligman, 2005). The mindfulness movement also follows the pattern of successful positive psychology research programs: Basic research documents benefits to health, mental health, and relationships, and intervention research follows closely behind. We might view mindfulness as one of the most successful fruits of positive psychology. After becoming well-established in several powerful contexts (e.g., hospitals; treatment of depression, personality disorders, bipolar disorders) and exhibiting some treatment success in clinical trials, mindfulness-based approaches have captured the hearts of a generation of therapists (and their clients).

Given the proliferation of mindfulness interventions, we explore in this book the next set of practical questions for therapists committed to a multicultural orientation and who want to work these values out in their potential use of mindfulness in therapy. For example, how should we balance concerns about values regarding avoidance of appropriation with the need to adapt therapies to clients from marginalized groups? How should therapists view their collective influence on people of faith as well as nonbelievers? When, if ever, is it appropriate to intentionally conceal the Buddhist roots of mindfulness for clients who may have a negative reaction to religion and spirituality (C. G. Brown, 2017; Purser, 2015)? Altogether, our focus is especially on addressing a gap in the professional literature on how to contextualize the use of mindfulness to cultural diversity.
WHO IS THE INTENDED AUDIENCE?

Our last book (Hook et al., 2017) focused on a way of thinking about how to integrate multicultural principles into the process of psychotherapy. We offered humility language to complement competence language. On the surface, many of the movements within psychology send a hopeful and positive message about humanity and their potential for growth, but some have pointed out that it may be more difficult than we think to escape cultural narratives regarding the flawed nature of our humanity (Bingaman, 2011).

Psychotherapy is one part of a massive set of industries designed to help people continually work to improve themselves. For many, including therapists in training, an implicit message churns beneath this activity (and reactivity): that we are inherently flawed. Indeed, in our process of training to become therapists, the language of cultural competence implies that someone presumably evaluates skills related to serving clients with marginalized identities. When that person determines a discrepancy between ideal skills and actual practice, they render a judgment. Or even if no such evaluator exists, the implication is that a standard must be achieved, and if that standard is not met, clients suffer because of our failures to succeed. Put simply, competence language antagonizes perfectionistic tendencies, which evoke concerns about performance relative to a standard.

It is important to acknowledge, however, that competence language has served a crucial purpose in the multicultural movement. We wholeheartedly affirm the values and mission of the trailblazers who catalyzed the multicultural movement in psychology and related fields (e.g., D. W. Sue et al., 1998). Moreover, competence language has helped align theory, research, and practice through its goal of infusing multicultural values into training practices. However, as we elaborate in Chapter 4, we developed the MCO framework to apply multicultural values to the context of training therapists about how to engage cultural dynamics in psychotherapy.

From research on expertise and factors that contribute to better therapy outcomes (Tracey, Wampold, Lichtenberg, & Goodyear, 2014), we have some hints about what this process might involve—for example, a commitment to a lifelong pursuit of taking on new challenges, putting ourselves at the crossroads of better feedback, and continually seeking to grow. This challenge is greater when we sit with clients who not only have the pain of life but have this pain amplified by systemic exclusion and marginalization. Many of our clients come to us with little reason to expect responsiveness because they live in family and social systems that are unresponsive to their pain. We agreed with the cacophony of other voices encouraging alternative language related to multiculturalism that would encourage trainees to attend to their moment-to-moment inner world in a way that would, over time, lead to growth in their ability to offer a high-quality presence (e.g., Geller & Greenberg, 2002).

Therefore, the current book picks up the ethos and line of logic of the prior book and extends them to an important opportunity and challenge regarding
how therapists express their multicultural values. The mindfulness movement is an important test for the multicultural community, and we are glad to see more voices engaging these conversations. This book is for therapists who want to work out multicultural values in their use of mindfulness. We hope it will help therapists who want to use mindfulness in their therapy but feel ambivalent because of the debates and cultural critiques (e.g., appropriation of mindfulness practice; ethical quandaries, such as training soldiers with mindfulness; fears that mindfulness may blame the victim or somehow imply that people should accept marginalization). As therapists, we practice our profession within a culture that finds it difficult to stay connected with pain. This book is for therapists who want to cultivate spaces in which people can let their guard down and find healing. Given the intense demand for various forms of escape or numbing, it should come as no surprise that psychologists have begun to listen and draw from spiritual traditions, such as mindfulness, that diagnose this modern malady and offer a potential remedy.

**A CRUCIAL CAVEAT**

At the outset, it is important for us to not overclaim our knowledge and experience. Our expertise is not in mindfulness: We did not develop any of the major approaches, we are not advocates of any particular approach (and we are unable to attempt to recontextualize mindfulness within a Buddhist tradition, as some have called for), and we will not attempt to advocate for any particular therapeutic or Buddhist tradition of mindfulness.

What brings our set of authors together is an intention to explore how cultural identities influence the relationships that develop in therapy and how therapists can show responsiveness to the client’s identities to improve therapy outcomes. We approach our task with the assumption that most therapists using mindfulness are integrating it as a technique within their broader theoretical framework. We also assume attempts to carefully regulate the use of mindfulness will likely fail. For example, a variety of self-help interventions have been developed; the trend is to make mindfulness more accessible and easier to disseminate. So, what training and skills will be required for therapists to engage the growing interest in mindfulness in the broader population?

In addition to a caveat on our professional vantage point, we want to be explicit about the audiences we kept in mind as we wrote the book. We view mindfulness as a practice heavily influenced by Buddhism, which we consider one of the five major religions of the world. We are aware of the notion that many people hold that Buddhism is more of a philosophy than a religion (the perspective makes the most sense when Judeo–Christian religions are viewed as normative); but, for the purposes of this book, we consider it a set of religious traditions. We also hold that many clients are religious or spiritual; many are not Buddhist; and many, when they engage in mindfulness,
experiences changes in their religion or spirituality (for a review, see Stratton, 2015). Therefore, we explicitly focus on spiritual diversity in all of the cases throughout this book.

In light of intersectional theories, we were curious about how religious or spiritual identity might interact with other identities (e.g., race, ethnicity, social class, gender). The mindfulness-based interventions were negotiated within markets that comprised predominately White women who were highly educated and living in urban areas; yet, many of the prominent leaders within the mindfulness movements are White men (Hickey, 2010). We were curious about how a lack of diversity within leaders might have shaped current practices. We tried to develop a way of thinking that could span these various groups and their diverging concerns and interests.

Therefore, we sought to dovetail this commitment to attending to spiritual diversity with a commitment to attending to intersectionality. So, all of the cases in this book consider either a marginalized religious or spiritual identity or Christians who hold at least one or several marginalized identities. For example, we kept in mind American Buddhists, Asian American clients (who may have reactions to the evolution of mindfulness ideas as they interact with an increasingly individualistic culture), African American and Latinx groups that may be theologically conservative about engaging other faith traditions, and marginalized religious or spiritual groups in the United States (e.g., Muslims, Jews, atheists).

A WORD FROM EACH OF THE AUTHORS

We hope one of the advantages of our writing team is that we each hold different identities that allowed us—collectively—to keep a range of perspectives in mind as we were writing and revising this project. In terms of professional expertise, authors D. D. and J. N. H. specialize in positive psychology and the integration of spirituality into counseling. Authors C. D. and J. O. are multiracial and have invested in recent work about the implications of intersectionality theories. To prepare for the book, we conducted interviews with a variety of people who integrate mindfulness into various aspects of their work. These conversation partners were an integral part of our writing team, especially as we developed case studies to illustrate ideas. In the following paragraphs, we each say a little about our interest in mindfulness and how it relates to our professional experience and expertise. We hope this information will give you, as the reader, a better sense of where we are coming from.

Author D. D.

My interest in mindfulness comes out of a general interest in spirituality and its intersection with other identities. Before I even knew I wanted to be a psychologist, I joined my mom in a master’s program that focused on
spiritually sensitive counseling. She had entered the program in preparation for a second career. Soon after, though, she was diagnosed with ovarian cancer. I wanted to spend time with her and thought counseling skills would potentially be helpful for serving within my local church or community. I did a specialization focused on spiritual formation within various Christian traditions. What I learned most during my time there was a more open and curious perspective of other religious and spiritual traditions. Some things are better “caught than taught,” and some of my professors modeled a curiosity and engagement with other faiths that has served me well, not just with religious or spiritual identity but cultural identities in general.

In my doctoral training at Virginia Commonwealth University, I distanced myself from some of these initial interests. Instead, I focused on positive psychology, especially the virtues of humility, forgiveness, and gratitude. For a variety of reasons, I was hesitant (and ambivalent) about being too focused on religion or spirituality. I did not want to get pigeonholed within my clinical training. Also, I was processing ambivalence and grief toward my own religious and spiritual tradition, as well as religion and spirituality in general, after my mom died. Her life seemed cut short by cancer, and as I reflected on her life, I wanted to learn how to avoid passing on the perspectives on gender roles that limited some of her sense of choices earlier in her life—and that were at the heart of some of her identity struggles during her 30s.

At the same time, there is something core to my work as a psychologist (and probably as a human) that relates back to some of those early interests in how religious and spiritual identity can influence people’s development. As a person of faith, I know that my religious and spiritual identity is infused into all of my other identities—for better and worse. In our profession—and society more broadly—we sometimes struggle to talk about religious or spiritual identity. Strong secularization norms help keep the peace—and distance. We have lost some of the skills to relax these norms and cultivate spaces of intimacy with each other about matters of ultimate importance. I am interested in more than just religion and spirituality; I’m interested in how therapists relate themselves to existential questions—to the givens of life—such as facing death, feelings of meaninglessness, responsibility to determine values, and inevitable loneliness (Yalom, 1980). Cultural differences in existential worldviews seem particularly difficult to bridge. These areas are particularly painful and daunting. They have the potential to make us feel very small and powerless. Yet, part of me wants to understand more about how to help people build on their strengths while also learning to address painful aspects of their religious or spiritual or existential identity.

I also need to acknowledge one other person. Terrence Jordan, a doctoral student at the time, introduced me to theorizing on intersectionality in his dissertation work on racial trauma. His dissertation was inspired by societal events that led to the Black Lives Matter movement. His courage to engage that project inspired some of the ideas that eventually motivated this book project. Intersectionality theory gave a language to something I sensed but
didn’t have words for: It delved into the complexity of belonging to different identities and groups and how that affects people’s process of seeking integrity and becoming who they hope to be.

Author C. D.

I have always been a ruminator. I can think about a topic for ages. Sometimes ruminating can be helpful, such as when I think through how to approach a particular problem I’m facing. Other times, I can sit in places of high anxiety and self-critical thoughts. The same energy that helps me to think of a way through to an answer for a complicated challenge can betray me and fuel hours-long or even days-long consideration of an argument I wish I had handled differently. Until graduate school, where I discovered mindfulness meditation, I struggled with how to quiet my more persistent, less helpful, version of rumination.

In my second year as a doctoral student, I had the privilege of being assigned to a supervisor who used mindfulness in her personal and professional life. She was a student of Pema Chödrön and had been participating in Tibetan Buddhist practice. I remember when she recommended Chödrön’s book *When Things Fall Apart: Heart Advice for Difficult Times* and showed me her own very worn copy. Her name was Roberta Seldman, and she passed away in 2018. Roberta was an amazing supervisor in every way I can imagine, but what struck me most about her was her vitality. She was so present! It was something that I could feel. She was not afraid to be in all of her emotions at once and accepting of them. She modeled for me how to sit with authenticity and not ego. I felt seen by her in a whole new way, and it was an awakening for me as a therapist.

I could probably write pages upon pages about all of the things I learned from Roberta, but here I highlight two primary points. First, she started me on a path of self-compassion. She was the first person to point out to me that I had, up to that point, been defining myself by achievements. She reminded me that I had been neglecting or had been actively subduing whole other aspects of myself that actually yearned for expression: my artistic side, my joyful self, my softer self. Second, she created a space that invited vulnerability and pain as part of the full human experience. She helped me to embrace my vulnerabilities along with my strengths. Neither was better or worse; both just were. These lessons put me on a different path as a therapist but also as a person.

In my fourth year of doctoral study, I participated in a mindfulness meditation group in which I learned the basics of mindfulness practice and various meditation practices. This practice deepened and grew the lessons that Roberta had planted within me years earlier. In particular, through the challenges I faced in trying to participate in daily and prolonged practice, I was forced to face my self-critical voice in a different way and the lengths to which my mind would go to distract me from being in the present moment. I also learned
that, for me, self-compassion was going to have to be an intentional activity. Importantly, I discovered that, as much as I considered myself to be compassionate toward others, my abilities in that area were limited by my own self-critical lens. One of the greatest lessons I learned was that you can only be as compassionate to others as you are to yourself; those practices do not occur in isolation. An extension of this awareness was that I became more accepting of my vulnerable feelings and even embraced them (Roberta’s second lesson). To experience them all is to live fully within my present experience.

So, I don’t practice mindfulness these days as much as I would like. Sometimes, my only mindful moment in a given day is when I sit, reflect, and recognize how many thoughts are pulling me away from being present—but I continue to try. It’s a work in progress and one that is more about a way of being than a goal—just like the MCO. For me, this book on integrating mindfulness into therapy practice seemed like such a logical extension of our prior one. Like mindfulness practice itself, cultural humility is so much about compassion, presence, and being okay with the ambiguous. My hope with this book is that in helping therapists and therapists-in-training to integrate mindfulness practice with cultural humility, they are able to grow in both. This one’s for you, Roberta!

**Author J. N. H.**

My interest in mindfulness and mindfulness-based interventions is connected to my interest in acceptance and commitment therapy. When I was beginning my training in graduate school, I was initially drawn to cognitive behavior therapy. I liked the structure of the therapeutic approach, and I also appreciated the focus on making concrete changes. I found cognitive behavior therapy to be quite helpful in the lives of my clients as well as my own life as I tried to work through my own issues and become a more emotionally healthy person.

One of my struggles, both in the lives of my clients and in my own life, was that some things weren’t quite so easy to change. This was especially true about some of my own internal struggles with anxiety both in my personal life and relationships. Even though I “knew” in my head that a thought was unreasonable, for example, I had difficulty getting rid of the unpleasant thoughts and emotions. And I found some areas of my life that I just couldn’t change (e.g., a loved one’s dying, the behavior of a coworker or partner) or “improve.” Some aspects of my life weren’t turning out as I wanted them to, and there wasn’t anything I could do to change them.

These were the places where acceptance and mindfulness were game changers for me. I recognized that even if I couldn’t “get rid of” an anxious thought, I could accept the anxious thought and move forward in my life anyway. For example, I had to do so when I decided to get married. No amount of therapy was going to make my anxiety about marriage completely
disappear. I had to accept feeling a certain amount of anxiety and moving forward anyway. Mindfulness and acceptance helped me do that. Mindfulness helped me to accept the things I could not change so I could live a more peaceful and full life. I’m excited about the possibility about helping therapists integrate mindfulness into their work in a culturally humble way.

**Author J. O.**

Growing up, I was an energetic kid with lots of passions and, at times, without much control of those emotions and passions. Yet, two main influences became more readily influential in my life: my mother and martial arts. Indeed, my interest in mindfulness came when I was exposed to martial art traditions. The class would spend time focusing on aligning the mind–body connection to promote healing and a sense of clarity. I learned how to meditate and ground myself during stressful situations. I learned how to focus on the energy in my body, channel sources of stress and distraction, and how to translate these lessons across my life. Around the same time, I noticed that one of the best role models for mindfulness had been with me all along—my mother. Her sense of calm, peace, and patience was amazing. I didn’t fully realize it as a child, but she frequently practiced mindfulness. It wasn’t until later in life that I fully appreciated her influence.

Throughout my life, I have found a sense of calm and peace when I have been able to use the principles of mindfulness. This sense of perspective also has transformed the ways in which I learn new skills in a therapeutic context. I have found a better sense of my own reactions in sessions and a way to work through complex reactions. In many ways, this approach also has helped me understand my own development as cultural person and professional. I can now sit with the complexity of my own identities as well as how others understand me. Unlike some of colleagues, I did not directly use mindfulness with patients—at least on a consistent basis. Rather, I would channel the spirit into my life as a professional to stay balanced and centered.

Over time, truly reflecting on my core values, feelings, and beliefs has helped inform the MCO framework. The heart of the MCO is a greater connection to others around us and the ability to cherish those interactions for the richness of cultural understanding that they can bring. For me, this book is an extension of the process that led to the MCO: reflecting, slowing down, and being true to one’s self. I hope you enjoy the book and find nuggets of wisdom to inspire your practice.

**OVERVIEW OF THE BOOK**

The book has two major parts. In Part I (Chapters 1–5), we establish the conceptual foundation of the book. In Chapter 2, we illustrate how daunting it would be if cultural competence about mindfulness was primarily about
“knowing enough.” From an MCO perspective, our knowledge helps us in a particular way: It prepares us to approach new situations with a sense of cultural humility so that we don’t make as many costly assumptions.

In Chapter 3, we set up the primary tension of the book. The multicultural critiques of mindfulness come along two fronts: (a) concerns about responsiveness to marginalized groups (especially concerns about various religious or spiritual identities), which calls for contextualization; and (b) concerns about appropriation of Buddhist traditions, which calls for appropriate respect of these traditions and the many cultures that currently represent them in the world.

In Chapter 4, we describe the MCO framework and apply it to the two concerns raised in Chapter 3 and also describe how principles of mindfulness align with the skills required to express the MCO framework in therapy. We have you complete self-assessments that show how the MCO concepts complement the traditional multicultural competencies approach.

In Chapter 5, we draw on theories of expertise as well as work on factors that promote a strong therapy alliance to describe the key aspects of self-awareness related to implementing mindfulness in a culturally humble manner. Given our assumptions about mindfulness as a practice derived from contemplative religious and spiritual cultures, the focus of this chapter is especially on how to develop cultural comfort for religious and spiritual or existential issues.

Part II (Chapters 6–9) focuses on what it looks like in therapy to apply the MCO framework to mindfulness. In Chapter 6, we focus on assessing the client’s religious or spiritual identity and forming a strong relationship. In Chapter 7, we consider how to take this awareness of the client’s intersectional identities to negotiate a plan that may include using mindfulness. Cultural humility calls for an awareness of power (rather than denial or minimization) and a willingness to ally with the clients’ goals and ways of wanting to pursue those goals. In Chapter 8, we consider the cultural context of the individual client. Specifically, we consider how to coordinate care with a religious or spiritual authority figure or community in regard to implementing mindfulness interventions. Many of our clients belong to religious or spiritual traditions, and some communities harbor reservations about the growing cultural interest in therapeutic mindfulness. In Chapter 9, we present a group supervision session. The clients, therapists, and supervisor are based on the interviews we conducted with practitioners who use mindfulness in their therapy practice. It is our hope in this chapter to illustrate challenges presented in the book through real-world applications.

CONCLUSION

Spoiler alert: We do not think the questions we plan to raise are simple or easy to “solve.” Sometimes our work in this book has raised more questions than answers. But we do believe the journey is a worthwhile one—and we are
honored to be part of a community that cares about such issues. Our approach to writing this book was not to try to overly simplify complex and thorny matters. We know we cannot tie a pretty bow on the concerns swirling around the use of mindfulness in our profession. Rather, our goal is to use the MCO framework to encourage therapists to reflect and hold their approach to using mindfulness to greater scrutiny. We want to promote a community that is getting better at “not knowing” and is responding appropriately to its cultural limits.

We believe it matters if psychologists (a) get better at exploring their limitations and biases, (b) engage other groups by building cooperation with the exemplars rather than perpetuating hostility by engaging stereotypes (Volf, 1996), and (c) learn to ask questions that can bridge across disciplines and identities. Where we could, we have tried to draw on direct evidence, but, in many cases, the literature was conspicuously silent, so we tapped our social and professional networks and did the best we could to generate reasonable lines of thought. We present cases rooted in real-life experiences, although all case examples in this book are fictionalized. We have tried to distill the core issues. We hope that what we say in this book will be helpful for your work as a therapist. But even more important than what we say will be what you, as the reader, decide to say and do next. So, let’s begin again.
Secrets and Lies in Psychotherapy

Barry A. Farber
Matt Blanchard
Melanie Love
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INTRODUCTION

From its inception, psychotherapy has always been considered a place where hard truths can and should be disclosed. Clients are exhorted to tell the truth, therapists are trained to deal with inevitable resistances to client truth-telling, and the outcome of the work is often thought to be dependent on the joint efforts of both to make better sense of previously withheld or distorted information. Although over the years clinical and empirical investigations have indicated that psychotherapy clients keep secrets, conceal information, and lie to their therapists, these studies, although heuristically valuable, tended to be small-scale, qualitative efforts. We were interested in designing a large-scale, multimethod research project that would enable us to understand more fully the nature of the secrets and lies of psychotherapy clients. We wanted to know what kinds of information clients tended to conceal or lie about, why they resorted to dishonesty, and what they saw as
the consequences of their various attempts at keeping information away from the prying eyes and ears of their therapist.

We were interested in these phenomena as part of a long-standing focus of the senior author (BAF) on issues relating to disclosure in the psychotherapeutic process. Beginning in 1992 with a presentation by the senior author and a doctoral student (Desnee Hall) at a conference of the Society of Psychotherapy Research in Berkeley, California, entitled “Disclosure to Therapists: What Is and Is Not Discussed in Therapy,” research teams based in the clinical psychology program at Teachers College, Columbia University, have pursued a series of related questions: In this most confidential therapeutic space, what’s left out of the dialogue, and why? How can we best understand the nature of the dialectic between wanting to be known by one’s therapist and wanting to be seen by oneself and one’s therapist in a favorable light? What factors contribute to how this dialectic is played out? What does the therapist allow the client to know about him- or herself? And how does the tension between honesty and impression management manifest among other psychotherapeutic dyads, including the supervisor and supervisee? The answers, or at least preliminary answers, to these questions have been reported in books and articles and at professional presentations by the senior author and members of his research team over the past 25 years. But until work on this current project began, we had not yet tackled head-on the phenomena of client lies and secrets. We had not, for example, asked clients to report on the specific reasons they concealed or lied about specific topics.

A few other researchers, notably David Rennie, Clara Hill, Bill Stiles, and Anita Kelly, had made some inroads on understanding client concealment and secret-keeping before we undertook our studies. Rennie attributed client withholding to their attitude of “deference” to their therapists. Hill, who has studied multiple aspects of the therapeutic process, published a series of valuable studies with her students and colleagues (most notably, Sarah Knox) investigating such phenomena as client “hidden reactions,” “things left unsaid,” and secrets, finding these related processes to be more common and harder to detect than previously imagined. Stiles delineated the complications in attempting to determine the relationship between client disclosure and treatment outcome. Kelly suggested that withholding certain shameful information from one’s therapist could prove beneficial, serving to maintain the therapist’s positive feelings toward the client. In addition, a group of researchers, including John Archer, Jeffrey Kahn, Erica Shambaugh, and Robert Hessling, have done important work on measuring psychotherapy clients’ tendency to disclose distressing information. Still, for the most part, clients’ lies and secrets have been a neglected aspect of psychotherapy research—a peculiar omission and one perhaps motivated in part by the field’s not wanting to believe that clients lie and keep secrets and that,
therefore, therapists are quite imperfect in their ability to overcome resistance and invoke truth.

It was time, we felt, for a comprehensive examination of this phenomenon, one that would use both quantitative (survey research) and qualitative (in-depth interview) data. And so a research lab overseen by two doctoral students in the clinical psychology program, now the second and third authors of this book (MB and ML), began thinking about ways of collecting data. Several years later and after analyzing the responses of over 1,300 individuals who participated in our studies, we decided to write this book, reporting what we and others have discovered about the nature and importance of psychotherapy clients’ secrets and lies. The narratives contained in this volume are taken directly from the written statements and interviews of research participants and, in a few cases, from clinical case material we have encountered as therapists. Quotations are generally verbatim with only minor alterations for the sake of grammatical correctness, with the exception of several passages of dialogue between client and therapist that have been recreated to the best of our ability. Names and other bits of identifying information are fictionalized to protect the anonymity of our respondents and clients.

We regard this book as a logical sequel to the senior author’s (2006) book, *Self-Disclosure in Psychotherapy*, which drew on both clinical and research perspectives, focusing on the topics that patients tended to discuss in therapy and those they tended to avoid; it also considered the factors, including demographic and cultural variables, that facilitated or impeded disclosure. Furthermore, it addressed disclosure and nondisclosure among other participants in the therapeutic process, including therapists, supervisors, and supervisees. That book did not, however, delve deeply into the related phenomena of secrets and lies. Although instances of nondisclosure, or more commonly, minimal disclosure, are attributable to many of the same factors and result in similar consequences as client lies and secrets, these latter phenomena are also in many important ways distinct in their presentation and clinical implications.

Although our topic is relatively narrow—truth and untruth in the special context of psychotherapy—the scope of this book is quite broad. We begin in Chapter 1 with an overview of this general issue—the ways in which clients are typically deceptive in therapy, the difficulties therapists have in detecting secrets and lies, and the reasons why patient deception matters. The second chapter takes us outside the consulting room and into everyday life, exploring the various attempts made from multiple social science and philosophical traditions to define and categorize the lies, secrets, and deceptions used by the human animal in the eternal struggle for love, status, safety, and self-esteem. The third chapter returns to the world of psychotherapy, reviewing the clinical and empirical literature that tries to answer questions such as,
Why do clients lie? What are the ways in which client deception can be categorized? What topics tend to be concealed, minimized, or lied about? The fourth chapter focuses on factors that affect clients’ tendency to disclose versus keep secrets or lie in therapy, including their perceptions of the benefits and costs of disclosure. This chapter also addresses three other aspects of the disclosure–deceit relationship: What is the process by which clients decide to disclose honestly rather than deceive? What is the relationship between disclosure and various forms of deception? And what are the consequences of keeping secrets and/or telling lies in therapy? Chapter 5 shifts the focus from client to therapist, reviewing the literature on therapist secrets and lies, a fascinating topic in its own right, and one with implications for clients’ tendencies to conceal and deceive.

Chapters 6 through 11 focus extensively on the results of our ongoing studies of client secrets and lies. The first of these chapters reviews our basic findings: the most common lies told, personal and clinical factors affecting their occurrence, and the perceived reasons for and consequences of these lies. The next six of these chapters contain multiple clinical examples and delve into the nature of specific, common client lies and secrets: self-harm and suicidal thoughts, sexual issues, substance abuse, trauma, and clinical progress and feelings about one’s therapist. The concluding chapter of this book deals with the training, research, and clinical implications of client lies and secrets, focused primarily on the question “What’s a therapist to do?”

The primary audience for this book includes practitioners, academics, and students in the mental health fields. We imagine too that many psychotherapy clients, including those who have already terminated therapy and those for whom this extraordinary activity is still ongoing, will find much to identify with in these pages. For these readers, we offer a view of therapy at precisely those critical points where it may be going awry. We sift through client stories seeking the cracks and seams, tensions, and pressures that might bring a treatment down or significantly limit its effectiveness. The simple question “What can’t you tell your therapist?” is our way of examining the core supports of psychotherapy: disclosure, trust, and the therapeutic alliance. We also hope this book will attract curious lay readers, perhaps those considering therapy and/or those who know something about (and are intrigued by) the therapies of friends and family members. But even those with no personal experience with or vicarious knowledge of therapy are likely to have felt some of the pulls toward not-quite-honesty that we discuss in the chapters ahead. For all these potential readers, we offer a judgment-free zone and the shared experiences of others who have struggled to disclose in therapy. Importantly, we believe all patients have a right to their secrets and elisions. We seek only to help with that subset of secrets that patients wish—or mostly wish—they did not have to keep.
Although this book was not influenced by contemporary media scrutiny of truth-telling among politicians and other famous people, its focus nevertheless is remarkably consistent with this cultural moment. Our emphasis on the many ways that truth can be defined and distorted, and the ways that individuals can and do rationalize their decision to avoid honest engagement with others, is certainly consonant with current reports on the statements and actions of prominent figures in our midst. There is, we think, an intriguing aspect to the tendency of many people to lie and conceal information in situations where we do not expect them to do so—including, as this book reveals, the psychotherapeutic setting. Perhaps in contrast to many political figures, what we found was that most psychotherapy clients want to be honest, though they struggle to do so consistently. The details of both sides of this issue are contained in the pages of this book.
There is abundant evidence that in every context of their lives, people lie and keep secrets. They do so from childhood on, beginning with parents and teachers; they do so throughout their lives, with friends, dating partners, spouses, children, potential employers, coworkers, supervisors, and of course, various government agencies, especially the Internal Revenue Service. They sometimes lie when publishing research studies (Markowitz & Hancock, 2014) and writing purportedly nonfiction articles or books (e.g., James Frey, 2003, A Million Little Pieces). They certainly do so when it comes to politics. As The New York Times noted, the truth seemed to be “deeply out of fashion” in the 2016 presidential campaign (Barbaro, 2015, p. 1). “Fake news,” both during and after the election, was prominent enough to warrant a New York Times story with the headline “As Fake News Spreads Lies, More Readers Shrug at Truth” (Tavernise, 2016, p. 1). Who could have predicted that, in the spring of 2017, the cover of Time magazine would read “Is Truth Dead?” These are strange days indeed for public discourse.
In their private discourse, as per Billy Joel (in the epigraph), many individuals find it easier to be consistently kind than consistently truthful. Still, it feels somewhat surprising, even disconcerting, to accept that this occurs in psychotherapy—that even in that sacred space of near-absolute confidentiality, clients lie and keep secrets. Intuitively, or perhaps out of naive hope or expectation, we want this space to be different. We want our clients to trust us enough to tell us their truths, to believe we are trustworthy and safe, and to trust that their most profound, intimate, and shameful disclosures will be honored and respected. And to a great extent, many clients do trust us and disclose a great deal to us, including parts of their lives that are typically viewed as intimate (e.g., sex), private (e.g., money matters), immoral (e.g., cheating on a significant other), illegal (e.g., selling drugs), or especially difficult to acknowledge and talk about (e.g., the experience of being abused).

Nevertheless, in the psychotherapist’s office, as in every other interpersonal situation, the pull for full and honest disclosure is often at odds with the powerful human needs to avoid or minimize shame and to affirm or aggrandize our sense of self. These motives and a host of others, including the wish to avoid hurting others’ feelings, make it nearly inevitable that there will be some degree of secret keeping and lying by most clients in every therapist’s practice. In fact, the emerging data indicate that lies are far more prevalent in the therapeutic process than most therapists realize. Although differing research methodologies and discrepant definitions of terms make it difficult to derive a single, accepted figure for rates of client lying or secret keeping, a definition that included the large and small ways we minimize, exaggerate, omit, deny, twist the facts, or pretend to agree with our therapists would probably state that “client dishonesty is almost universal” (Blanchard & Farber, 2016, p. 2).

In a recent study we conducted—and about which we will have far more to say later in this book—93% of a sample of over 500 clients in therapy acknowledged having lied to their therapist. Moreover, the mean number of topics they reported lying about was 8.4, with minimal differences as a function of client or therapist demographics. Although these numbers are likely inflated given the methodology of this study—people who had lied more to their therapist may have been more motivated to complete a survey on “lying in therapy”—a subsequent study we conducted in which there was no mention of “lying” found that 84% of nearly 800 respondents indicated there was a topic they had either deliberately avoided talking about or been substantially dishonest about in their therapy. That is, even in this second, more neutrally presented study, most clients implicitly acknowledged some form of concealment or deception.
These findings confirm a basic truth noted in other empirical and clinical studies: Although clients often tell the truth, dishonesty also seems to occur frequently and across multiple topics, clinical settings (private practice, clinics, hospitals), and therapeutic orientations. Given the confidentiality accorded to the therapeutic situation, these statistics might appear surprising, but the extremely intimate nature of the therapeutic relationship, including a near-constant focus on the self in the context of face-to-face interaction, may actually increase the frequency of lies and secrets. The therapist’s scrutiny, even gentle and caring scrutiny, can be too much to bear. Much as we all sometimes feel the need to avert the intensity of a seemingly too-prolonged or too-intimate gaze, even from a loved one, our clients cannot always bear our need to know, understand, or care. The vulnerability can feel overwhelming—or, in the words of a song by Dan Hill, “Sometimes when we touch, the honesty’s too much.” As well, the wish to look good, to be seen as competent and reasonably well-adjusted, and to be admired by one’s therapist often makes secret keeping and lying seem like viable options.

The findings of research studies (e.g., Baumann & Hill, 2016; Farber & Hall, 2002; Kelly, 1998; Pope & Tabachnick, 1994; Regan & Hill, 1992) suggest that some, perhaps many, clients adopt a strategy that can be summarized as “I can tell my therapist hard things about a few topics, but I need to maintain a basic level of self-esteem such that I need to minimize, conceal, or distort the truth on other matters. I cannot let my therapist come to think of me as deficient or incompetent in too many areas of life.” These studies point to another common position, one that takes the form “I can reveal a good deal about a hard topic, but there are limits to how far I can go—some real bottom lines as to how vulnerable and shameful I’m willing to feel—and when I get to that point, some aspects of the entire truth about that topic are going to be compromised.”

Thus, therapists often do not get the truth, the whole truth, and nothing but the truth (though hardly anyone does). Sometimes they get no version of it at all, no discussion of a topic of personal importance to the client. And sometimes they get a version of the truth that is sanitized or otherwise truncated in some significant way or perhaps even quite distorted—a truly fictionalized version of the truth. Sometimes they eventually get the whole story, the telling of a previously held secret or the recanting of a previously made-up tale. But sometimes clients leave therapy even after long-term treatment with significant parts of themselves unrevealed to their therapist. Our sense of self—including the way we view our thoughts, feelings, actions, wishes, fantasies, and fears—is often a fragile thing that needs protection from critical self-scrutiny and even seemingly trusted and relied-on others.
CLIENT SECRETS AND LIES: THREE VIGNETTES

Kevin

Kevin, a 28-year-old, White, married (for 2 years), heterosexual man working as a sales clerk, entered therapy for the first time complaining of anxiety related to his marriage and his job. Per the information offered at intake, Kevin had graduated on time from high school and had taken several courses during 1 year attending a junior college. He indicated that he had no history of trauma or drug or alcohol abuse.

Four months into treatment Kevin called to make an “emergency appointment” with his therapist. He had failed a random drug test at work and had been fired from his job. In discussing what occurred, Kevin acknowledged that he had not told the truth about his extensive drug habit (from marijuana to cocaine to assorted pills), fearing that the therapist would view him negatively and attribute all his problems to his drug use. Kevin further acknowledged that his wife had only a “slight” awareness of this problem and that no one else, except the friends with whom he got high, were aware of how much money he spent and how often he got high. During this discussion, the therapist was open to understanding Kevin’s concerns regarding disclosure and accepting of his seemingly genuine apology. She also expressed concern about his ongoing drug use and wondered about his resolve to deal with this issue. During the last part of that session, she and Kevin discussed whether and how they could regain the trust necessary to continue their work together. Kevin did not show up for his next scheduled appointment, did not return repeated phone calls from the therapist, and never returned to therapy.

Catherine

Catherine, a 50-year-old, twice-divorced, currently unmarried White woman with three children in their 20s, who was employed as supply manager in a plumbing company, reentered therapy for the fourth time after a 3-year break from treatment. She first began therapy at the age of 14 at the request of her parents, who were concerned about her poor schoolwork, lack of motivation, and drug and sexual experimentation. She had been in therapy for a total of 16 years—her longest treatment with one therapist was 8 years—with complaints of depression, “not fitting in,” anger and impulsive behavior, and poor relationships with family members, including her mother, her siblings, and her three children. On the basis of her complaints and symptom picture, her new therapist theorized she had been abused as a child, and Catherine acknowledged that this was so—and acknowledged too that although she had admitted to being physically abused to previous therapists, she had never
spoken before about the sexual abuse perpetrated by her father. She had been explicitly asked about this possibility by previous therapists but had consistently denied any such abuse.

**Therapist:** Can you tell me what you were thinking or afraid of when those therapists asked you about that?

**Catherine:** I had told them so much about the physical abuse that had happened to me, gone into great detail, answered all their questions. . . . I felt so low, beaten, awful, terribly guilty, I just couldn’t admit to anything more.

**Therapist:** And when they asked about whether your father had done anything else to you, whether he’d abused you in any other way, you (pause).

**Catherine:** They were okay—they seemed to care—but at those moments I just wanted to retreat and get out of there. I couldn’t stand any more questions, especially about that [the sexual abuse]. So I just said no. Actually, now that I think about it, I said something to one of them—Jennifer, the therapist I worked with the longest—I told her that dad got all the kicks he needed out of beating me.

**Therapist:** I appreciate the fact that you’re letting me know this now, but I also wonder why. Why now tell a therapist about this after all these years of it being a secret?

**Catherine:** I don’t know. It’s just time to let someone know. It’s been on my mind. I was actually going to let my last therapist know, but then she pissed me off about something. I think I was a few minutes late to a session, and she wouldn’t let go of that, and I just said screw it.

**Therapist:** I’m hoping that you can trust me enough to let me know some of the details of what happened, and we can go as slowly as you need to, but for now I’m wondering this: Do you think that keeping this secret got in the way of therapy in some way?

**Catherine:** I don’t know. Maybe. It was a secret, maybe a lie, but I just didn’t feel like I wanted to talk about it. It was too deep, worse even than the physical abuse, though sometimes they happened together, and I just couldn’t imagine dealing with more guilt and shame. It was like the one piece of myself that I didn’t want to share. I guess I felt defiant about it. You can get everything else from me, but I’m not going to talk about that. And I was scared too that talking about that was going to set me off, make me either want to kill someone.
else or myself. He [her dad] died when I was 24, but I still feel I could kill someone when I think of what he did to me . . . but you know what too? Those therapists, particularly Jennifer, helped me anyway. I was really out of control for a lot of years, and I’m better now. Not where I want to be yet, but not quite as out of control.

Therapist: Mm-hmm, I can understand, or at least try to understand why you wouldn’t or couldn’t talk about the sexual abuse, so why now? Why are you willing to do it now?

Catherine: I’m 50 years old. Maybe it’s time to deal with this finally. And maybe if I deal with this, it’ll get those last pieces of anger in me under control. Little things still piss me off, and I still lose it too easily with people . . . and my eldest [daughter] is getting married, and I’d really like that to go well. We’ve already started to argue, and I’m just tired of being angry and arguing with everyone all the time. It still doesn’t take much to set me off.

Therapist: So there’s a sense that talking about the sexual abuse might help with your anger, might help with getting along with people.

Catherine: Look, I know that talking about it is not going to be a miracle thing and make me a patient saint overnight, but I’m tired of it weighing on me. And I know this is crazy, but believe it or not, I actually feel guilty about it, as if some of this was my fault. And I hate thinking that.

Therapist: Does anyone else know about what happened to you? Your mother?

Catherine: Yeah, of course she knew, but she never wanted to talk about it, and when I was a kid and started to ask her about and ask her why she never did anything about it, she said she didn’t want to talk about it, that was the past, and that she had tried to do something like ask him to stop, but then he’d beat her and threaten her. I mostly stopped asking her about it, though sometimes during some of our worse arguments I’d tell her that she was worse than he was, that she was mostly sane and didn’t even protect her own kid.

Therapist: I’m sorry—sounds terrible. I am hoping we can work with this somehow to make it feel less toxic, less your fault, but am wondering too—are there other secrets you’ve kept from your therapists, including me, that may be useful to talk about at some point?
Catherine: Yeah, maybe some things I've done in my marriage, but I don’t want to talk about that now.

Therapist: OK, that’s understandable. I appreciate that you’ve shared what you have. How are you feeling now with this?

Catherine: Shaky. We’ll see what I feel later today or tonight. I’ll let you know next week.

Catherine did return to therapy the following week, and she reported that she had experienced a difficult week with more frequent and vivid memories of her physical and sexual abuse. But she continued to discuss these experiences quite openly and with a great deal of crying and intense anger over the next few months of therapy. Going over what happened to her, including the subsequent effects on her life and her attempts to keep these experiences, especially the sexual abuse, out of consciousness and out of the awareness of others, became for a while the dominant focus of therapy. Catherine stayed in therapy for 3 more years after she first acknowledged the facts of her sexual abuse to her therapist. Both she and her therapist reported significant improvement in multiple areas of her life, especially in her relationships with her children and a new romantic partner.

Stephanie

Stephanie, a White, 45-year-old mother of two teenage girls, married for 18 years, working as a part-time paralegal, came into therapy complaining about her marriage and considering divorce. She had been in therapy briefly as a teen when her parents went through their divorce. She remembered vividly her struggles to come to terms with that—feeling angry, alone, and “abandoned” and “hating the shared custody arrangements.” She did not at present fear being single or alone, but she did have great concerns about how her girls would react to the same situation she had faced as a child.

She and her husband had met in their early 20s and fallen “passionately in love.” They were engaged within a few months of meeting and were married within the year. She described many common interests, including music and traveling, and she considered their first few years together “quite good.” They had several good friends with whom they frequently got together; although they did not have a great deal of money, they had enough to go out to eat occasionally and go on modest vacations. Things changed, Stephanie noted, when they had their first child. Her husband was “all in favor” of having children but “struggled with parenting.” He reacted poorly to the normal frustrations and stresses inherent in parenting a young child, leaving virtually all the parenting—feeding, bathing, preparing for sleep, and so forth—to Stephanie and occasional help from her mother. According to
her, he became a “somewhat better” parent when the girls became older and more independent.

She acknowledged that his work as a middle-school teacher had become far more stressful for him with a transfer several years earlier to a more difficult school, but she nevertheless felt increasingly resentful of the burdens placed on her “with little help from him.” They had frequent verbal spats, although there was no physical violence. He acknowledged his initial difficulties with being a father but felt he had gotten better over the years and was still “trying”; moreover, he accused her of not acknowledging his financial contributions to the household. According to Stephanie, their sex life, once active and mutually enjoyable, had become sporadic and far less enjoyable over the past several years. She acknowledged being “less interested” and attributed this to her fatigue over parenting and her resentment toward her husband.

What she had not told her therapist about—and what she did not think her husband knew about—was the affair she had started a few years after the birth of their second child, an affair that had been ongoing, if intermittent, for the past 10 years. This came to light when the therapist encouraged Stephanie’s husband to attend a joint therapy session. The session started out amicably but devolved quickly into mutual criticism and was punctuated dramatically with her husband’s accusations and apparent knowledge for at least a year of the affair. Stephanie’s initial denials felt unconvincing to both her husband and therapist, and she moved quickly to an angry position of “Yes, but I deserved some happiness and loving and you weren’t giving it to me.”

The therapist referred them to couples counseling, but that ended when they agreed after 2 months to proceed to separation and divorce. The therapist continued to see Stephanie in individual therapy where they worked on three major issues: life for her and her children during this period of separation and expected divorce, the role she played in the dissolution of her marriage (i.e., how she dealt with frustration and disappointment), and questions of trust between the two of them (i.e., Stephanie and her therapist). Regarding this last point, Stephanie initially suggested that she did not share the fact of her affair with the therapist because it was not “relevant” to what they were discussing. She claimed that her resentment toward her husband and their waning emotional and physical intimacy were “real by themselves” and not affected by her affair. Moreover, she felt this to be a “really a private matter” and something she did not want to discuss in therapy. Following the acknowledgment of her affair, Stephanie wavered in her commitment to therapy, missing several sessions. But she did return each time and was able to acknowledge that she was “angry” at her therapist for pushing her to talk about something she did not want to talk about. They worked on this a good deal, with the therapist acknowledging her frustration with Stephanie concealing an important facet of her life and also apologizing for being “clumsy”
in pursuing this issue. Stephanie reluctantly agreed that she had concealed something really important from her therapist and began talking about her difficulty in trusting others to believe her side of any story without distorting or concealing important details.

UNDERSTANDING THESE LIES AND SECRETS

Kevin lied to his therapist about his drug problem, a common topic of client avoidance and deception. He felt that his therapist, who was about 30 years older than he, would take a dim view of his alcohol and drug use and attribute all his problems at work and with his marriage to this one part of his life. Moreover, Kevin believed that he had this part of his life more or less “under control” and did not need help with it. The therapist, for her part, did not investigate fully Kevin's brief comments about “an occasional drink or two” nor about “occasional marijuana use in high school.” She did not want to appear suspicious or otherwise too parental, fearing that doing so could damage the formation or maintenance of an effective working alliance. Of note, too, she had struggled with confronting her children when they were teenagers about their experimentation with drugs and alcohol. To a certain extent, then, the therapist’s issues made it easier for Kevin to avoid telling the truth about his drug use. One could say she colluded with his deceit; from a psychoanalytic perspective, this therapist’s countertransference made it all too easy for Kevin to lie. More generally, this situation reflects the principle that it takes two for a lie to succeed: the liar and the person (sometimes deemed “the dupe”) who tacitly agrees to be lied to.

Although they had a good, open discussion of what happened at work and in the therapy itself, with a seemingly genuine apology on Kevin's part for not telling the truth, that discussion did not include the therapist's acknowledgment of her possible mistakes or even collusion in missing now-obvious clues or failing to ask the right questions. Nor did it include another aspect of therapy that Kevin was not open about: his lingering doubts about his therapist's ability to help him. Partly because he was still too ashamed of his deceit and fearful that his therapist would still be angry at him, partly because he experienced his therapist as not strong enough for him and not able to confront him on issues he preferred to avoid, and partly because he was still ambivalent about wanting or needing to give up these substance-abusing parts of his life, he terminated treatment.

Catherine’s story of concealing sexual abuse had many of the same elements. Like Kevin, she feared acknowledging to her therapist a part of her life story that she felt made her seem too damaged. Like Kevin, she kept this secret from virtually everyone in her life. And like Kevin, her deception was
a combination of secret keeping and lying—in previous therapies, she had explicitly denied any history of being sexually abused. But her most recent therapist was more persistently inquisitive than Kevin’s, and Catherine, having been in therapy multiple times before this experience, may have realized on some level that her lack of candor in regard to her sexual abuse was frustrating her efforts to feel understood and to gain greater relief from her nearly constant states of distress and bouts of self-recrimination. She was ready to acknowledge what had happened to her with her father, though was not yet ready to speak about other parts of her life—things she had done in her marriage (an affair?)—that she had apparently kept secret or lied about. Catherine’s story seems primed for a better ending. She seems committed to continuing her therapy, and we get a sense that she is resolved to be more honest with her therapist about multiple aspects of her life. Furthermore, her new therapist seems to be well-attuned to her style and needs, and they seem to be developing a strong working alliance. Nevertheless, the end of this story has not been written. Catherine’s past behavior, including her impulsivity, anger, and struggles with interpersonal relationships, suggests that despite her current resolve there are likely to be future therapeutic conflicts, resulting in further instances of some form of resistance to treatment, including concealment of salient information.

Stephanie, like Kevin, attempted to compartmentalize her work in therapy—allowing her therapist to know a good deal about the history and current state of her marriage but leaving out a significant part of the story. Whether out of shame (for how she felt about herself for what she was doing) or guilt (for the affair itself), Stephanie did not allow her therapist to know about this part of her life. She convinced herself that she could be helped in her marriage without revealing this, contending that her affair was essentially a meaningless part of the larger story. But to her credit, and to the credit of her therapist as well, she began to work on her problems with trusting others. She was able to see how her patterns of avoidance and lies, both minor and major, were getting in the way of all her significant relationships. What helped too was her therapist’s ability to acknowledge her role in making this topic difficult to address. According to Stephanie,

A turning point was her saying to me something like, “my frustration at you for not telling me the truth wasn’t meant to be a criticism of you, it was about my own frustration about not being to help, about something getting in the way between us.”

Stephanie went on to say,

I knew it was really my problem—I had lied my whole life about lots of things—but she made it easier for me to talk about something that was just so awful and embarrassing. It’s so much easier to blame other people.
LIES AND SECRETS IN PSYCHOTHERAPY
ARE HARD TO DEFINE

These examples—all drawn from interviews with current and former patients with all identifying information altered—are the “easy” illustrations of lying. That is, they depict clear instances of a client either omitting a significant detail of his or her life or, in response to therapist questioning, denying a historical fact or current instance or pattern of behavior. Furthermore, in each case, the client eventually acknowledged his or her lie; in two of these three examples, the client continued to work with treatment. Lying in therapy, however, is typically both harder to define and harder to detect.

It is difficult to define because there are so many varieties of lies, and finding common elements, other than that of general deceit, is surprisingly elusive. As CNN legal analyst Danny Cevallos noted in response to the threat of a prominent public figure to sue one of his many detractors for purportedly lying about an incident of sexual harassment,

And that’s the problem with the term “liar”: what does it actually mean?
Courts recognize that “lying” applies to a broad spectrum of untruths: white lies, partial truths, misinterpretation, deception and just general dishonesty. We all “lie” to some degree at some point—even presidents—maybe even under oath! (Cevallos, 2016, para. 12)

In this regard, too, we are taken with a 2018 New Yorker cartoon by David Sipress in which a person being sworn in for court testimony is asked the following: “Do you swear to tell the truth, the whole truth, and nothing but the truth, even though nobody has any idea what that is anymore?”

On a basic level, one can differentiate between lies of omission (secrets) and commission (lies per se), but in fact, there are multiple means of categorizing lies (see Chapter 2), none of which is entirely satisfactory and none of which reflects the complexity of most interpersonal dynamics, especially that of the therapist–patient situation. Secrets and lies are complicated and sometimes overlapping matters—lies, misguided emphases, or half-truths can, for example, provide cover for secrets.

Furthermore, some lies of omission appear more in the form of secrets and nondisclosure of relatively minor events (e.g., a traffic violation) and some about secrets and nondisclosure of significant facts (e.g., suicidal thoughts or behaviors, feelings about one’s therapist or the progress of therapy). And there are lies of commission that are manifest as exaggeration of details or feelings or behavior (e.g., effusive praise in the absence of genuinely positive feelings, lies that under- or overemphasize one’s role in the success or failure of an event) and lies that take the form of explicit distortion of details (e.g., substituting accounts of verbal abuse for the reality of physical abuse, fabricating personal accomplishments).
Deceit can serve many different personal and social purposes and reflect both benign and malevolent motives. Different kinds of lies—“white lies,” narcissistically induced exaggerations, distortion of significant historical material, and nondisclosure of current feelings between two individuals, among others—have significantly different “feels” to them and are barely containable within a common conceptual framework. White lies, for example, tend not to evoke the interpersonal anger or resentment as these others; by contrast, the awareness that someone close to us is withholding “obvious” negatively tinged feelings (e.g., anger) or being vague or otherwise disingenuous in reporting the details of an event may lead to apprehension and/or considerable annoyance.

More generally, lies are hard to precisely define and identify because, with rare exception (i.e., blatant distortions of agreed-on facts), they exist on a continuum with truth telling. Details are inevitably left out of narratives, memories are faulty, tact and so-called white lies are embedded in the fabric of most cultures and considered necessary and appropriate, and truth is always filtered through personal histories, needs, and cognitive biases. Several individuals, including the late French novelist Andre Gide, have been credited with the astute observation that “the color of truth is gray” (“Gray Is the Color of Truth,” 2017). And, in a similar vein, though over 200 years ago, Jane Austen (1816) wrote in her classic book *Emma*, “Seldom, very seldom, does complete truth belong to any human disclosure; seldom can it happen that something is not a little disguised or a little mistaken” (p. 392).

Truth, though, is not only best seen as existing on a continuum but also as existing “in the eye of the beholder.” Without verifiable information, where can the truth be located but in the differing perceptions of different actors in typically complicated situations? *Rashomon* (Jingo & Kurosawa, 1950), the classic Kurosawa movie, is often used as an example of how idiosyncratically the truth is constituted. The plot involves several characters—a bandit, a wife, a samurai, a woodcutter—presenting their conflicting versions of an incident, the death of a samurai that each professed to witness. As the film critic Roger Ebert noted in his 2002 review,

> Because we see the events in flashbacks, we assume they reflect truth. But all they reflect is a point of view, sometimes lied about. . . . The genius of “Rashomon” is that all the flashbacks are both true and false. True, in the sense that they present an accurate portrait of what each witness thinks happened. False, because as Kurosawa [the director] observes in his autobiography, “Human beings are unable to be honest with themselves about themselves. They cannot talk about themselves without embellishing.” (Ebert, 2002, para. 6)

Like Kurosawa’s witnesses, psychotherapy clients struggle to see things objectively. In therapy, the client is not only one of the witnesses but is also
in fact all of the witnesses—the bandit, the wife, the woodcutter are all parts of self—turning to the therapist for help constructing one workable truth out of his or her fractured perceptions, competing desires, and internal conflicts. But therapists too are bound by their subjectivity and necessarily biased perceptions regardless of whether they have been in their own therapy. Personal therapy may illuminate and lessen the hold of a therapist’s blind spots but cannot eradicate their influence entirely. Empathic lapses in therapy may represent the clinician’s inability to go beyond his or her sense of the truth to sufficiently accept, believe, or synthesize the presented truth(s) of his or her client.

Truth has also become more difficult to define as Western culture has taken on a more postmodern bent. Within this emerging discourse, truth is said to be obscured or confounded by the limitations of language, be “constructed” or “coconstructed” by participants in the dialogue, and shift with context and/or observers (as in Rashomon or, more recently, the movies The Usual Suspects [McDonnell & Singer, 1995] and Gone Girl [Chaffin, Donen, Milchan, Witherspoon, & Fincher, 2014] or books that use the device of an “unreliable narrator,” such as Yann Martel’s [2001] Life of Pi or Julian Barnes’s [2011] The Sense of an Ending). Furthermore, narrative truth may be considered as valid as previously held ideas about objective or documented truth. Thus, memories have been thought of as “true but inaccurate”—true to the belief of the narrator but false in regard to objective or verifiable facts (Barclay, 1986). From this perspective, unless the therapist concludes that the client is intentionally attempting to deceive, the therapist makes use of what the client is saying through the lens of “this is what it felt like to my client” or “this is the truth of his or her experience.” In short, the failures of language and the ever-present effects of power and context add another layer of warping to any effort to locate the truth.

The nature of truth and honest disclosure in contemporary Western culture may be further entangled by the apparent lure and demands of social media. Not only do many people maintain an online presence that may or may not be entirely congruent with their offline presence, but also their online persona may vary across different forms of social media (e.g., Facebook, Instagram, Snapchat). The rise of the selfie, doctored with photo editing apps and filters has allowed individuals to continually shape their identities, to form “curated selves.” This is reminiscent of Winnicott’s (1960) ideas about the false self—the extent to which we conform to the expectations of others in our social environment. We can all choose to show the world certain aspects of ourselves while omitting others; we can even invent or greatly exaggerate aspects of ourselves. These days, it is far more than public relations people who routinely “spin” facts to create impressions. As the English writer, Jeanette Winterson (2016) observed, “The airborne contagion of
advertising and spin, political lying and celebrity froth, makes authentic discourse difficult” (p. 21).

Of course, to a great extent, this has always been the case. As Goffman (1959) so brilliantly documented, we are all constantly preening and presenting ourselves in certain ways to meet social demands and personal needs for affirmation. But technology greatly facilitates this tendency to present a less-than-fully-honest version of ourselves to the world, one that tends to emphasize our uniqueness, importance, and worthiness to be seen, heard, and responded to. It is no wonder that many have suggested that social media serve to promote individuals’ intense pursuit of self-esteem, allowing users to create exaggerated, unreal images of themselves for others to consume. It would hardly be surprising, then, if some of this carried over to the therapist’s office, such that the painful, longstanding, detailed truth of personal experience may be elided, at least in the initial stages of therapy, in favor of other, more superficial truths favored by social media, truths steeped in recent accomplishments and pithy observations.

In considering the nature of truth, it is also important to consider that over time narratives and memories are often altered. Decades of research by psychologist Elizabeth Loftus and colleagues has suggested that eyewitness memories can be distorted simply by asking misleading questions (Loftus & Palmer, 1974)—that, in essence, memory is highly malleable. In a related vein, research into the neural basis of memory has illuminated the process of memory reconsolidation by which memories are vulnerable to distortion and reediting each time they are accessed in the brain (Schiller, Monfils, Raio, Johnson, LeDoux, & Phelps, 2010). Such findings seem to square with everyday life. Chatting with old friends, we find ourselves at odds over the details of time, place, and the people who were there. Images and memories may be lost, regained, or even revitalized under the impetus of “anniversary events” (e.g., the birthday or day of death of a loved one) or even viewing old pictures. As Gregory Cowles (2015), a book reviewer for The New York Times noted, “Even the most honest memoirs are necessarily conditional and incomplete, compromised as soon as they’re pinned wriggling on the page” (p. 21). All this, of course, is not the stuff of lies but rather the changing panorama of truth.

The same can be said for narratives recounted in a therapist’s office. Initial client accounts of important events or people may be fragmented, the details obscured by time or the need to forget that which is too painful to remember. These memories often fill out and become more differentiated over the course of treatment, details slowly restored. Client recollections of early abuse often reflect these influences. Under such circumstances, it often becomes the therapist’s task to help assemble fragmented bits of experience into a more coherent truth. It is also true that these accounts may be distorted,
influenced by client wishes, unconscious or otherwise, to make their lives or those of others grander or starker or more contemptible than they really were. But again, sketchy or inconsistent accounts of lives recounted early in therapy are not necessarily the stuff of secrets and lies; they are often preliminary, best attempts at the truth, though confounded by the usual influences of self-protection.

Furthermore, distinguishing an off-handed, not-meant-to-be-literal comment (“What happened at that party last night was the worst thing that ever happened to me”) from a more significant distortion of the truth may demand a fair amount of clinical acumen. Among other possibilities, an off-handed comment may be a form of small talk, an attempt at humor, or an avoidance of a larger issue or reflect a habitual pattern of exaggerated reporting. Although each of these possibilities suggests an interpersonal strategy that might well be worthy of therapeutic comment, each has its own dynamic, and each suggests a distinct intervention. All attempts at impressing or even distracting one’s therapist do not fall into the category of lies.

And still more nuances surround the nature of truth and lies in psychotherapy, here posed as questions: Does leaving out details of significant events with the vague assumption or expectation that they will be discussed with the therapist at some future point constitute secret keeping or lying? Under what conditions can omitting details be considered a function of the time limitations of a therapeutic hour or treatment rather than an instance of secret keeping? Are clients who prefer to talk about seemingly insignificant aspects of their lives—“people talking but not speaking,” in the smart words of the songwriter Paul Simon—lying or keeping secrets or are they just “testing the waters” or going at their own pace? There are many gradations between deceit and truth and many obstacles in one person’s communicating a thought or feeling accurately to another.

In some cases, particularly with secrets, the client’s personal history and presenting problems are critical determinants of the distinction between nondisclosure and deceit. There is, after all, a true difference between nondisclosure of insignificant events and secret keeping in regard to quite significant events. Note, for example, the difference between a client without an eating disorder omitting any discussion of her meals and the secret keeping of a client with a history of an eating disorder failing to tell her therapist of her apparent relapse into eating-disordered behaviors over the past several weeks. In general, though, apart from egregious and seemingly conscious distortions of material or the withholding of significant information, discriminating between a client lie or secret and a yet-to-be-fully-and-honestly-discussed issue in psychotherapy can be a difficult proposition. Clients sometimes say or otherwise adopt the position of, “I’m getting there, it’s just taking me a while to talk about something this hard.” Or, “It’s still fuzzy; I’m still filling in the..."
blanks.” Or, “I just don’t want to talk about that now.” Or even, “I’m not sure anymore of what did or didn’t happen.”

In short, within the context of a situation such as psychotherapy—one in which there are so many competing forces, especially that between the wish to be known fully and the wish to be judged favorably by oneself and others—it may be difficult, if not impossible, for a therapist to differentiate between narrative and objective truth or even to determine which aspects of the client’s narrative reflect the best of his or her current abilities and which reflect some attempt to conceal or distort even known aspects of the truth in the service of avoiding shame or guilt. Although there is a psychoanalytic tradition dating back to Freud that encourages the therapist to assume the position of final arbiter of truth, few today would take this stance, accepting instead the notion that truth is elusive, iterative, and often coconstructed.

CLIENT SECRETS AND LIES ARE HARD TO DETECT

Client secrets and lies are not only difficult to define, they are also difficult for therapists to detect. In the clinical vignettes presented earlier, the lies eventually came out; that is, the client ultimately acknowledged a difficult truth. In fact, though, research (e.g., Hill, Thompson, Cogar, & Denman, 1993) has shown that most therapists cannot tell when clients are lying or leaving feelings or thoughts unexpressed. Clients, and nonclients too for that matter, are good at being deceitful. Freud (1905/1953) contended that “he that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his fingertips; betrayal oozes out of him at every pore” (pp. 77–78). But contrary to Freud’s assertion, many clients are quite capable of lying and keeping secrets forever—till death—without being found out. (There is an interesting literature on “deathbed confessions”; among the most intriguing of the stories is that of the man who confessed that he had faked the famous Loch Ness Monster.) As the novelist, Javier Marias, noted so wisely in his (2013) book The Infatuations,

Yes, it’s ridiculous, isn’t it, that after all these centuries of practice, after so many incredible advances and inventions, we still have no way of knowing when someone is lying; naturally, this both benefits and prejudices all of us equally, and be our one remaining redoubt of freedom. (p. 246)

Apart from client persistence in keeping up a lie or holding onto a long-held secret, lies may stay intact because most therapists are inclined to believe their clients. Even when their issues do not overlap with their clients’ issues—as in the case of Kevin (discussed earlier)—therapists often
engage in “truth bias.” They want to trust and believe their clients because doing so tends to promote a healthy therapeutic relationship and because most therapists (à la Carl Rogers) want to see the “good” in their clients. And it is not hard to see the good in most clients. Most are courageous in presenting themselves for therapy, are sincere in wanting to be helped, have qualities and competencies we admire, and will make us feel good about our abilities. Thus, as per the lyrics to a popular 1980s song “Eye in the Sky” by The Alan Parsons Project: “The sun in your eyes made some of the lies worth believing.”

Given these considerations, questioning the consistency of a client’s narrative, wondering whether there’s “more” to the story, or gently challenging the credibility of a client’s report (“Really?”) can be courageous actions. When approached with great tact, these interventions can greatly deepen and improve the work. As per the advice to therapists proffered by our colleagues George Goldstein and Jessi Suzuki (2015), “If you see something, say something.” But doing so can also pose dangers. The therapist can be wrong—even if one is sure, one can be wrong—and even if the therapist is right, the timing of this intervention and the exact choice of words and tone had better be near perfect. All individuals need some defenses against the wounds of the world. It is too easy for clients to become even further entrenched or defensive if they feel threatened or insufficiently held.

Therapists who suspect they are encountering clinically significant client concealment or deceit must deal with a host of issues. Some may start with a personal indictment of sorts, wondering why they did not pick up on this behavior earlier in the treatment: “I should have known better,” “I knew something was wrong and didn’t follow up on it.” Some will surely, if unfortunately, silently condemn the client for his or her character flaws while using these instances of lying or concealment as confirmatory evidence of the client’s personality disorder. But all thoughtful therapists will have to consider and discuss the reasons for a client’s secrets or lies. Although many occurrences of omission and distortion can be attributed to the aforementioned needs to avoid shame or project an ideal self, other instances have more to do with legal issues (e.g., admission of a crime), fear of hospitalization (e.g., admitting to suicidal thoughts), a perceived need to not hurt the therapist’s feelings, or culturally mediated mandates about protecting the reputation of family members. And sometimes, though not always, client secrets and lies are a form of “acting out” behavior, a way for the client to express some dissatisfaction with the therapist or therapeutic progress. Understanding the motive for a client’s avoidance of an important truth is almost always a first step in considering therapeutic options, including the option of doing nothing at all, at least at the moment.
THE CLINICAL IMPORTANCE OF CLIENT LIES AND SECRETS

Client honesty has been central to psychotherapy since Freud (1913/1958) set out his “fundamental rule”—that the client should reveal everything that came to mind, as it came to mind, as honestly as possible. Rieff (1959), in his interpretation of Freud’s contributions, contended that it was this “ethic of honesty” and “special capacity for candor” (p. 315) that distinguished psychoanalysis as a healing force. But this demand for total honesty, to say everything that came to mind without censorship, proved impossible for virtually all clients. Why did people struggle so much to speak honestly, especially about those very topics that were most impacting their lives? What was getting in the way of their forthright presentation of thoughts, feelings, fantasies, dreams, and behaviors? Sometimes, Freud understood, it was simply a learned habit. “It is hard,” he wrote, “for the ego to direct its attention to perceptions and ideas which it has up till now made a rule of avoiding” (Freud, 1926, p. 159).

Freud and his followers began to advocate for the proposition that dealing with resistance to the work of psychoanalysis was a prerequisite to actually doing the work. Or rather, dealing with resistance was doing the work. Much later, research confirmed the idea that resistance to treatment—now more broadly defined to include oppositional, angry, avoidant, and devious client behaviors—is inimical to treatment effectiveness (e.g., Beutler, Moleiro, & Talebi, 2002). Fundamentally, though, the inability or refusal of clients to do the work of therapy, including speaking openly about their concerns, history, or current feelings toward significant figures in their lives (including the therapist), compromises the potential of psychotherapy to accomplish established goals.

Simply put, clients’ disclosure of thoughts and feelings constitute the primary source material with which therapists work (Stiles, 1995). Although therapists are also cognizant of nonverbal behavior, much of our attention is directed toward what clients do and do not say. Therapists can and do question, clarify, interpret, and challenge clients’ words—their skill is often reflected in the ways in which clients’ words become more understandable and usable to both parties. But this becomes remarkably more difficult when clients either keep significant secrets or provide material that is substantially untrue. Whereas therapists are unlikely to assume full client disclosure, our sense is that they do assume client honesty. And although there is a fair amount of research on client disclosure—on what is and is not disclosed to therapists and the factors affecting this—there is a surprising paucity of studies on client secret keeping and lies. The study of client dishonesty can highlight problem areas in psychotherapeutic treatment, alerting therapists...
to topics about which they may not have sufficient accurate information to know how to proceed clinically.

One could argue that client lies and secret keeping should be considered normative and expected aspects of all psychotherapies and be dealt with like all other clinical material. That is, lies and secrets and other forms of concealment of the truth could be considered no more or less than other notable aspects of a client's defensive repertoire. From this perspective, therapists would deal with gaps in client narratives, perceived secrets, and other instances of distortions or deceit in ways commensurate with their perceived salience. If this pattern of behavior occurred habitually outside of therapy and interfered significantly with the client's life, including other, nontherapy relationships, it would have to be discussed. If the material left out or distorted was deemed important, if the client's distortion of events consistently interfered with his or her (or the therapist's) understanding of patterns of thoughts or behavior, or if what was missing or distorted seemed to reflect some rupture in the therapeutic relationship, the therapist would have to address these events in an attempt to overcome the resistance and prevent the therapy from growing stale or fading out entirely.

In fact, we believe these scenarios tend to play out as described—that therapists do tailor their interventions to the perceived extent and consequences of their clients' tendencies toward lies and secrets. The problem, as noted earlier, is that recent research indicates that client lies are far more prevalent than most therapists realize. These data, in conjunction with studies indicating that therapists tend to be unaware of the phenomena of client lies and secret keeping, suggest that therapists are in most instances oblivious to the fact that their clients are deceiving them. They may well detect the egregious lies, but many other lies and secrets go undetected—to the likely detriment of therapeutic progress.

We suspect too that a good percentage of premature termination from therapy—a significant problem in the field—is attributable to the fact that what clients need and on some level want to talk about does not fully or honestly get talked about. It is simple to say that it is the client who has the responsibility and agency to talk about whatever he or she wants at whatever level of depth or honesty; typically, in fact, the nondisclosing or explicitly deceitful client blames him- or herself for perceived failures in these realms. But a more complex equation includes the therapist's ability to establish and maintain a sufficiently effective therapeutic relationship for helpful levels of honest client disclosure to occur and for the therapist to have the requisite skills, including awareness of his or her "hot button" issues, to enable the patient to speak about sensitive, shameful, feared topics. If the therapist is perceived to have failed at making it possible for the client to speak honestly—and at least some clients prefer to shift the attribution of their reluctance to speak
the truth to the therapist’s failings or the inadequacies of therapy itself—the risk of early termination of treatment is likely to increase substantially. The client’s belief in the usefulness of therapy may become fatally undermined. Paraphrasing a Billy Joel song ("She's Always a Woman"), she can ruin her faith with her casual lies.

A final reason the study of client lies and secrets is important has to do with evaluating the outcome of psychotherapy. Although we are strong proponents of psychotherapy and one of us (BAF) has spent many years teaching and serving multiple administrative positions in a doctoral program in clinical psychology, we wonder whether process and outcome data based on client evaluations of the treatment are entirely accurate. Client evaluations of treatment outcome correlate only minimally with evaluations provided by therapists and raters (Hill & Lambert, 2004), suggesting that perspective has a great deal to do with determinations of therapeutic effectiveness. Furthermore, our ongoing studies indicate that client lies about their feelings for their therapist and therapy are among the most common forms of deceit in therapy (Blanchard & Farber, 2016), a finding that leads to questions about the validity of previous client self-reports regarding their therapeutic experiences. Whether provided on a one-to-one basis to a specific therapist or on a survey administered anonymously by a team of researchers, evaluations of the effectiveness of psychotherapy may be affected by client tendencies to avoid certain hard truths. Hard truths about the effectiveness of psychotherapy may be especially prone to distortion given clients’ deep investment (both emotionally and financially) in the process.

WHAT ABOUT THERAPIST LIES AND SECRETS?

To this point, we have discussed the phenomena of lies and secrets in psychotherapy as if these are solely in the realm of client behavior. This cannot be the case, and though research is even sparser on the issue of therapist lies and behaviors than it is on the corresponding deceit of clients, the existing literature (as well as common sense) suggests that therapists too are sometimes less than fully truthful. But sorting out what this means reveals complications. Therapists do not inhabit the same roles as clients; that is, therapists are not expected to reveal deeply personal information to their clients (though clients may sometimes push for this kind of material). The roles of therapists and clients are complementary, not reciprocal.

Most basically, though, there are different principles involved in identifying client secrets than in identifying therapist secrets. Therapists do not, generally speaking, have to reveal personal information to their clients. They are typically strongly advised by supervisors and teachers and ethics boards...
not to do so. But of course, this raises other questions, mostly focused on the need or advisability to withhold clinical information (e.g., feedback, including personal reactions) from clients: Where does the need for tact fit into therapists’ decisions to reveal their feelings about clients or their own struggles with similar problems? Where do therapists’ wishes or needs for authenticity of genuineness fit?

Despite the conceptual murkiness inherent in the concept of therapist deception, Internet blogs of therapists and clients, as well as some emerging research (Jackson & Farber, 2018), seem to suggest that at least some, and perhaps many, therapists lie to their clients at least some of the time. According to these reports, therapists lie about several issues, including what they have remembered about previous sessions, how tired or sleepy or preoccupied they are feeling at the moment (in response to client questioning or commenting on this), their lack of anger or disappointment in regard to a client’s behavior (including lateness and payments for sessions), and perhaps most commonly, their romantic and/or sexual feelings toward their clients (a topic about which most therapists feel inadequately trained to deal with effectively). Although most of the following chapters deal with various types of client lies and secrets, the clinical importance of therapist lies led us to include material on this therapeutic situation as well.

**CONCLUDING COMMENTS**

Evaluations of the effectiveness of therapy aside, the primary reasons to focus on the related issues of client lies and secrets are that (a) they affect the process of psychotherapy; (b) therapists tend not to detect them as they occur; and (c) given their relative neglect in the literature on psychotherapy, therapists are not well trained to respond when they suspect clients are concealing or distorting significant clinical material. Therapists have to know more on those topics about which clients conceal information, the demographic and treatment variables that contribute to this behavior, and the motivations and clinical consequences of this behavior. Therapists should also, of course, be aware of the tools they might use to attenuate the tendency of clients to engage in these behaviors and deal with the consequences when these behaviors occur. Furthermore, therapists have to be aware of their own tendencies to either bend the truth or collude with client avoidance of the truth. Though sometimes such behavior is clinically justifiable, at other times such behavior is more obvious to clients than therapists believe and can lead to significant alliance ruptures and/or termination from treatment.
Mindfulness-Based
Interventions for Trauma
and Its Consequences

David J. Kearney
Tracy L. Simpson
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INTRODUCTION

Our journey teaching, researching, and organizing mindfulness programs did not begin with a focus on trauma or posttraumatic stress disorder (PTSD). Instead, my (David Kearney’s) aim nearly 15 years ago was to offer mindfulness programs with the hope that teaching mindfulness would mitigate the suffering of patients with chronic medical conditions. Although the system in which I practice medicine, a large academic Department of Veterans Affairs (VA) hospital, was adept at providing state-of-the-art testing and an up-to-date array of medications, surgeries, and procedures to treat symptoms and ailments, what seemed needed were more avenues to help people take a more active role in caring for themselves, especially when faced with difficulties that could not be cured or made to go away.

I had been introduced to meditation practice in the 1980s as a medical student, when I sat in on a group led by some ahead-of-their-time therapists who encouraged people with substance use disorders to meditate. I recall at the time being immediately struck by how setting aside a few minutes each day for meditation practice helped me to maintain a sense of centeredness throughout the day, and how the practice felt intuitively healthy and

http://dx.doi.org/10.1037/0000154-001
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important. From that point forward, over many years, I attempted to gradually educate myself about meditation practice in parallel with my efforts to continually deepen my knowledge of the practice of medicine and my specialty of gastroenterology.

Over the course of several years practicing as a physician, as I listened to patients talk of their symptoms, their worries, and their difficulties, I began to wonder why we were not teaching mindfulness. Teaching mindfulness to people with medical problems seemed logical and important, given not just my personal understanding but also knowledge gleaned from the research literature that psychological factors, including daily life stress, fear of symptoms, catastrophizing and beliefs about the meaning of symptoms often worsened conditions such as irritable bowel syndrome and chronic pain. As a clinician I sensed an unmet need for patients, and as a researcher I noted gaps in the scientific literature I could help to fill. With these goals in mind I established a mindfulness program in our hospital and set about coleading, alongside an experienced mindfulness teacher, the initial mindfulness groups for people with medical conditions such as chronic pain and irritable bowel syndrome (IBS).

What I did not expect were the frequent comments by participants about how mindfulness practices seemed to help their symptoms of PTSD. In fact, many patients with PTSD have reported to us that they found the 8-week mindfulness course to be among the most helpful interventions in which they had participated. It is also not uncommon for individuals with PTSD to take the course multiple times so that they can learn more about mindfulness with the support of a group and a teacher. The mindfulness programs at our site gradually expanded to two campuses of a hospital system that serves a population of over 100,000 veterans with a high prevalence of trauma, PTSD, depression, chronic pain and substance misuse. At the time we started offering mindfulness-based stress reduction (MBSR), reports of outcomes for people with PTSD had not yet been published. Given the profound impact of PTSD on individuals across the lifespan, investigating these unexpected reports of benefit for PTSD became a primary focus, and it led to a partnership with Dr. Simpson to further investigate the impact of mindfulness on PTSD.

In many ways my (Tracy Simpson) journey to investigating the potential of mindfulness practice for treating psychological disorders, such as PTSD and their common physical comorbidities, parallels that of Dr. Kearney’s. As a clinical psychology graduate student, I initiated a personal meditation practice in an effort to cope with the pressures and stress associated with graduate training and the attendant weight of responsibility I felt being a
novice therapist to people with significant distress. Formal meditation time became something of an emotional sanctuary that allowed me to ease up on my expectations of myself and to be more patient with others; generally, it was a quality-of-life saver. I did not yet, however, have the tools needed to bring what I was learning on my own into my clinical work and specifically chose to take a postdoctoral position in the late Dr. Alan Marlatt’s lab at the University of Washington to gain exposure to therapeutic applications of mindfulness practices in the addiction realm, my general area of inquiry. From there I transitioned to the Seattle VA and directed the then Women’s PTSD Outpatient Clinic. I had the good fortune to begin working with Dr. Kearney at the Seattle VA on formally evaluating whether courses in mindfulness meditation practices could address the psychological, emotional, and social challenges, including PTSD and chronic stress-related physical conditions, that our veteran patients were bringing into our clinics daily.

Together, our interdisciplinary work has sought to understand how mindfulness-based interventions (MBIs) influence conditions commonly borne by people with trauma. Over the past decade we have facilitated thousands of clinical encounters teaching mindfulness to individuals with a history of trauma and enrolled several hundred individuals with PTSD in quantitative and qualitative research studies. Much of the material in this book is based on sharing this extensive clinical and research experience, along with an effort to summarize and make sense of the broader research literature on this topic. From a clinical perspective, what became clear is that given the multiplicity of clinical challenges faced by many people with a history of trauma, an optimal treatment strategy would not only address symptoms of PTSD and depression but also favorably impact physical health problems that commonly co-occur (e.g., chronic pain; Kearney & Simpson, 2015). What can be considered a common factor for many people with these overlapping conditions are experiences of trauma, which can lead to a host of life challenges.

Most people experience traumatic events over the course of their lives. The majority recover and heal from trauma without specific treatment, but a substantial proportion develop persistent and sometimes disabling symptoms, including PTSD, depression, chronic physical symptoms, or substance misuse. The impact of trauma and PTSD on individuals and society is profound. In addition to distress caused by hallmark clinical symptoms, PTSD disrupts interpersonal relationships; increases the risk of depression, anxiety, and substance use disorders; increases the likelihood of high school and college failure, and teenage childbearing; and reduces the ability to work
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(Davidson, 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Moreover, PTSD frequently results in severe reductions in quality of life (Rapaport, Clary, Fayyad, & Endicott, 2005) and is associated with increased suicidality (Panagioti, Gooding, & Tarrier, 2012); those with PTSD have been shown to be 6 times more likely to attempt suicide as compared with matched controls (Kessler, Borges, & Walters, 1999). Research also indicates that physical health problems occur in excess for people with PTSD, including coronary artery disease, arthritis, asthma, and gastrointestinal symptoms (Boscarino, 1997, 2006). As a result, a high proportion of those with PTSD must simultaneously cope with other psychiatric diagnoses in addition to chronic pain or other symptoms because of medical problems. For people with PTSD, comorbidity is the norm rather than the exception.

To help individuals with PTSD, treatments have been successfully developed, studied, and refined over the past 3 decades. As a result, therapies with proven efficacy, such as cognitive processing therapy (CPT), prolonged exposure therapy (PE), and eye movement desensitization and reprocessing (EMDR), are now available to help treat symptoms of PTSD.

So, why are improved or additional strategies needed, despite significant advances in the field? They are necessary because many individuals continue to experience PTSD symptoms after taking part in evidence-based approaches (Bradley, Greene, Russ, Dutra, & Westen, 2005; Steenkamp, Litz, Hoge, & Marmar, 2015) or they have other symptoms not adequately addressed by existing treatments. As discussed in Chapter 1, the spectrum of clinical manifestations in PTSD is broad, and a one-size-fits-all approach is unlikely to meet the needs of all people (Cloitre, 2015). In addition, the range of available treatments does not necessarily match the range of preferences of people with trauma, which could affect the level of engagement in care, which in turn could influence outcomes (e.g., some people may prefer to start treatment with an approach focused on their trauma, whereas others may prefer a non-trauma-focused approach). The complexity of needs and wide spectrum of symptoms of people with PTSD has spawned efforts to develop new treatment approaches, driven by interest among both clinicians and patients. The purpose of this book is to explicate one category of additional treatment for PTSD that holds the potential to meet some of the challenges faced by individuals with PTSD—interventions based on teaching mindfulness.

In MBIs the emphasis is on changing the relationship to thoughts, emotions, bodily sensations, and associated behaviors. MBIs attempt to enhance the ability to attend to experience with an attitude of nonjudgment, curiosity, openness, acceptance, and kindness (Kabat-Zinn, 2009; Siegel, 2007).
Introduction

By shaping how and where attention is placed, and by providing a framework for understanding the nature of thoughts, emotions, and sensations, increased mindfulness is theorized to foster more adaptive responses to stress and pain (Baer, 2003). In MBIs, group leaders or therapists do not explicitly attempt to provide techniques or guidance to change thoughts, beliefs, or behaviors. Instead, the sessions focus on bringing nonjudgmental attention to present-moment experience with an attitude of curiosity and openness. The core method of bolstering these abilities in most MBIs is through mindfulness meditation practices, such as breathing meditation, body scan meditation, or mindful movement (e.g., walking meditation, Tai Chi, yoga). The meditation practices in MBIs are framed as self-care practices, which participants are encouraged to utilize on a regular basis after finishing the course.

Examples of MBIs based on teaching mindfulness meditation include mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT) as well as many other meditation-based approaches adapted to specific conditions (Bowen et al., 2009; Duncan & Bardacke, 2010; Kristeller, Wolever, & Sheets, 2014). We focus on MBIs that emphasize meditation practices, although we recognize that other interventions with a strong evidence base for conditions other than PTSD, such as acceptance and commitment therapy (ACT) and dialectical behavioral therapy (DBT), teach mindfulness through techniques other than meditation (Hayes, Strosahl, & Wilson, 1999; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). The book is not focused on a specific MBI, such as MBSR; instead, we discuss general principles that we think are applicable to all interventions with a core focus of mindfulness meditation. Our goal is to provide the reader with a working knowledge of how mindfulness can be applied to conditions that commonly occur following trauma, including PTSD, depression, chronic pain, and substance use disorders. We provide a synopsis of the conceptual framework for MBIs for each of these conditions, review the current state of the literature, and offer practical suggestions aimed at helping clinicians to effectively offer MBIs to people with trauma.

For PTSD, the literature on MBIs is still in a nascent state, and the evidence base does not allow us to draw firm conclusions on the efficacy of MBIs for PTSD. However, there is some evidence of benefit for PTSD and other conditions that commonly occur following trauma, and to date there is little evidence to suggest harm. So, why write a book now? One reason is that, despite the need for definitive clinical trials, MBIs are increasingly offered to populations with PTSD. For example, 77% of specialty programs for PTSD in the VA now offer some type of mindfulness training (Libby,
Pilver, & Desai, 2012). Also, the application of MBIs to PTSD by clinicians has been buoyed by the recognition that—at least in theory—mindfulness practice provides gentle, gradual techniques that run counter to deeply ingrained symptoms of chronic PTSD. For example, in mindfulness practice, rather than avoiding distressing situations, a person is encouraged to notice reactivity and regard such experiences with curiosity and openness. Rather than ruminating and attempting to problem-solve difficulties, a person is encouraged to learn how to set those habits aside and “be with” perceived problems. Rather than reacting to distressing stimuli, a person is encouraged to recognize and disengage from habitual patterns. Rather than suppressing unpleasant feelings, a person is encouraged to feel what they feel—even if it is difficult to bear. And rather than being discouraged by shame and guilt, a person is encouraged to acknowledge and allow these experiences with an attitude of kindness and nonjudgment. Whether MBIs can fulfill the above potentialities remains to be seen, as we discuss in the chapters that follow.

Our clinical experience tells us that the upsurge in interest in MBIs for PTSD and trauma is in part driven by the fact that patients with PTSD are often seeking help for multiple challenges, including chronic pain, depression, and substance use disorders, on top of other life difficulties such as poverty, isolation, and fractured family relationships. If, as the evidence suggests, MBIs simultaneously provide some measure of benefit for multiple areas of difficulty (e.g., chronic pain, substance misuse, depression, and possibly PTSD), the MBI can play an important role helping a person with PTSD gain a foothold in their struggle to cope with very challenging circumstances (Holliday et al., 2014; Kearney & Simpson, 2015). In the words of one participant with PTSD who recently completed MBSR:

I don’t feel like I’m circling the gutter now, I feel like I’m getting better and that I have a life ahead of me. So I don’t attribute that all to [the mindfulness teacher], it’s also [my therapist] who does the triggers and coping skills CBT course that’s been incredibly helpful, but I think first and foremost, it’s the combination of all three.

As this quote illustrates, we view MBIs primarily as a complement to other treatments for PTSD. In our experience, many people who have already participated in established PTSD treatments choose to participate in a MBI as a way of working with persistent difficulties, such as a loss of meaning, feelings of disconnection and alienation, or persistent emotional numbing. Others may not feel ready to participate in a trauma-focused PTSD treatment and may choose to participate in an MBI as an initial step toward working with the consequences of trauma. An enhanced ability to tolerate distressing...
feelings and thoughts, with an attitude of openness and kindness, may in theory be of help to them in the future if they engage in therapies specifically focused on alleviating PTSD symptoms.

In our experience, some people come to class desperate to get off their medications or at least minimize the number of medications they take. Some want an alternative to medications because they are concerned about side effects or becoming addicted. Others are interested in mind–body approaches because they understand the link between their stress and pain. Many have never tried meditation before and are open to anything that can help them, whereas others may have pursued integrative medicine approaches in the past and found them beneficial. Most individuals continue to pursue other treatment modalities (e.g., medication management, psychotherapy) while taking part in mindfulness groups and see them as a complement to their other treatments. In addition, some may be looking for help with social isolation and want a group format. Some wish to learn to deal with problems more independently. Others seek insight about their suffering related to PTSD. One participant summarized the reasons for seeking out mindfulness classes:

I think ultimately I was looking to gain some insight and peace on the suffering that I endure from PTSD. I mean, ultimately that was the goal. I've been moderately successful managing pain through meditation on my own so I hoped maybe to get a better tool to do that with. But really the primary reason for going was because PTSD . . . the feeling of remorse, kind of depression, sadness . . . guilt, that's the key word. Guilt. And just kind of a purposeless existence.

Our intention in writing this book is to provide a resource designed both to help clinicians understand the landscape of trauma more fully and to provide practical suggestions to help group leaders effectively teach mindfulness to those who have sustained trauma. In Part I we begin by providing an overview of the landscape of trauma. Each chapter in Part I is designed to provide a working knowledge of clinical conditions that commonly occur following trauma. Chapter 1 focuses on PTSD. It provides an overview of the clinical manifestations of PTSD and discusses how mindfulness is theorized to counter many of the hallmark symptoms of PTSD. A review of the extant literature on the safety of MBIs for PTSD is provided, along with an overview and discussion of outcome studies of MBIs for PTSD. Chapter 2 reviews other posttrauma sequelae: depression, chronic pain, substance use disorders, and functional somatic syndromes. An overview of the clinical manifestations of each condition is provided along with a discussion of the theoretical basis for applying MBIs. The overarching goal of Part I is
to provide readers with a working knowledge of the most common clinical manifestations of trauma and an understanding of how mindfulness can be taught in an effort to benefit these symptoms.

Part II of the book focuses on practical considerations. Chapter 3 provides tips and advice on forming and managing groups, with an emphasis on how best to teach mindfulness to individuals with PTSD, chronic pain, and depression. Suggestions for managing group dynamics are provided. In Chapter 4, specific mindfulness practices are discussed, including the body scan practice, breathing meditation, yoga, and loving-kindness meditation. Suggestions are provided about how to guide each meditation practice, including commentary on tone, content, and use of language when working with populations with PTSD. Advice and suggestions are also provided for teaching individuals with chronic pain. Chapter 5 provides a synopsis of the rationale for understanding key mechanisms involved in maintenance of posttrauma sequelae by MBI teachers and therapists, and it discusses issues surrounding teacher experience and qualifications.

It is our hope that the material presented in this book will lead to a greater understanding of how mindfulness can help mitigate factors that maintain or worsen conditions commonly experienced by trauma survivors, and that this greater understanding will translate into more effective teaching and improved outcomes for patients.
When teaching mindfulness to individuals who have sustained trauma, instructors should understand the map of the territory so that, when needed, they can provide explanations of the rationale for mindfulness along with encouragement and suggestions aimed at helping people learn the material at hand. This chapter provides a brief overview of the epidemiology of trauma exposure and PTSD in the United States, reviews the symptoms PTSD comprises, and describes how PTSD is often associated with significant impairment in multiple domains of health. The multiplicity of clinical presentations associated with PTSD is described along with a brief overview of the current gold standard treatments for PTSD, which are based on cognitive behavior therapy (CBT). The reasons why some individuals may require additional or different types of interventions to address their PTSD symptoms are described, and mindfulness-based interventions (MBIs) are introduced along with discussion of how mindfulness practice can be applied to specific manifestations of PTSD. An overview of the literature base evaluating outcomes of MBIs for PTSD is provided along with a review of what is known about the safety of MBIs for individuals with

http://dx.doi.org/10.1037/0000154-002
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PTSD. We conclude the chapter with a case presentation that illustrates many of the teaching points discussed.

**Epidemiology of Trauma and PTSD**

Most adults experience significant trauma at some point in their lives, yet only a minority develop PTSD. The frequent occurrence of trauma over the lifespan was demonstrated in a large, nationally representative U.S. survey that queried participants about 19 types of trauma (Goldstein et al., 2016). More than two thirds of the respondents reported exposure to at least one potentially traumatic event, and exposure to multiple traumas was common. The most common traumas, in descending order of frequency, were sexual abuse, seeing a dead body, intimate partner violence, and experiencing a serious or life-threatening injury or illness. Other population-based studies have found similar rates of trauma exposure (Breslau et al., 1998; Creamer, Burgess, & McFarlane, 2001; Stein, Walker, Hazen, & Forde, 1997). Across studies there is a consistent finding that women are more likely than men to have experienced rape and sexual molestation, whereas men are more likely to report nonintimate partner violence and exposure to military combat.

It should be emphasized that some distress after a traumatic event is normal. Distress in the face of trauma is considered a normal reaction to abnormal events (Friedman, Resick, & Keane, 2014; Norris, Murphy, Baker, & Perilla, 2003); for most people who experience significant distress following trauma, symptoms abate within a few months. However, a substantial subset of individuals develops PTSD in the wake of trauma exposure. Recent epidemiologic data indicate the lifetime prevalence of PTSD among men and women is 4.1% and 8.9%, respectively, while past-year prevalence is 3.2% and 6.1%, respectively (Goldstein et al., 2016).

The current diagnostic criteria for PTSD in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*; American Psychiatric Association, 2013) include exposure to a traumatic event along with the development of the intrusions of trauma-related memories, avoidance of trauma-related cues, negative alterations in cognitions and mood, and alterations in arousal and reactivity. *DSM–5* defines *trauma* as “actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association, 2013, p. 271). The intrusions symptom cluster comprises five symptoms, at least one of which needs to be present, which are characterized by memories, images, and nightmares related to a trauma and may or
may not be accompanied by strong physiological responses to the memories or to actual, tangible reminders of traumas. The avoidance symptom cluster is made up of two symptoms, at least one of which must be present to meet diagnostic criteria. These symptoms involve avoidance of trauma-related thoughts and feelings and of external trauma reminders, such as places, activities, or situations. The negative alterations in cognitions and mood cluster requires the presence of at least two of seven symptoms that have to do with loss of interest and pleasure in previously enjoyed activities, social estrangement, constricted affect, and persistent negative, typically exaggerated, beliefs about oneself, others, and the world. The final cluster, alterations in arousal and reactivity, is comprised of six symptoms, at least two of which must be present for the PTSD diagnostic criteria to be met. These symptoms tap such issues as anger and irritability, self-destructive or high-risk behaviors, poor sleep and concentration, exaggerated startle reaction, and hypervigilance. Additional diagnostic criteria include that symptoms must have persisted for more than 1 month posttrauma; not be the result of medications, substance use, or other illness; and be associated with significant distress and/or functional impairment (American Psychiatric Association, 2013). In *DSM–5*, PTSD is categorized with traumatic and stressor-related disorders rather than with the anxiety disorders; a shift based, in part, on the recognition that clinical presentations following trauma are heterogeneous and may be quite complex (American Psychiatric Association, 2013; Resick & Miller, 2009). This is illustrated by a study of people with PTSD that found only a minority experienced anxiety as their primary emotion; the remainder reported sadness, disgust, or anger as their primary emotion (Power & Fyvie, 2013). The spectrum of clinical manifestations of PTSD can also include the following subtypes: anxiety, dysphoric/anhedonic, aggressive/substance-abusing, guilt/shame/other and dissociative as well as combinations of these clinical phenotypes (Friedman et al., 2014).

In addition to contending with the symptoms associated with PTSD, people with this condition often experience additional reductions in both mental and physical health. When quality of life is measured for individuals with PTSD, the degree of impairment is often severe, with the largest impact being for mental health and social functioning (Olatunji, Cisler, & Tolin, 2007; Rapaport et al., 2005). Physical health problems also occur in excess for people with PTSD, including coronary artery disease, arthritis, asthma, and gastrointestinal symptoms (Boscarino, 1997, 2006). The overall effect is that many people with PTSD often experience reduced employability, marital instability, failure to meet their educational potential, and
significant impairment in day-to-day functioning (Kessler, 2000). A diagnosis of PTSD is also associated with a significantly increased risk of attempted suicide (Kessler et al., 1999; Panagioti et al., 2012).

It is common for individuals with PTSD to have active symptoms for many years. An older study from the National Comorbidity Survey suggests a median duration of PTSD symptoms of 3 years for those who receive treatment, whereas for those who do not receive treatment, symptoms continue for a median duration of 5 years (Kessler et al., 1995). However, these estimates—which demonstrate years of symptoms related to a traumatic event—do not fully describe the profound burden of PTSD over the lifespan given that many people with PTSD experience multiple traumas (Breslau et al., 1998; Karam et al., 2014). Experiencing additional traumas often leads to additional episodes of PTSD, and each episode can result in years of symptoms. A review of longitudinal studies involving clinical and community groups with PTSD found that people exposed to recurring traumas (e.g., war veterans, first responders, Holocaust survivors) were more likely to have chronic courses than those whose posttrauma circumstances changed significantly (e.g., refugee groups able to resettle in peaceful countries; Steinert, Hofmann, Leichsenring, & Kruse, 2015). When multiple traumas are considered, it is estimated that the typical person with PTSD endures active symptoms for more than 20 years during his or her lifetime (Kessler, 2000).

ESTABLISHED PSYCHOLOGICAL TREATMENTS FOR PTSD

People with PTSD seek help in a variety of ways. The National Comorbidity Survey Replication study estimated that 50% of people with PTSD received some form of treatment in the health care system within the prior 12 months, most commonly through a mental health provider (34%) or a general medical provider (31%; Wang et al., 2005). Additionally, nearly a quarter of people with PTSD report having attended self-help groups at some point in their lives to address mental health concerns other than substance use problems (Simpson, Rise, Browne, Lehavot, & Kaysen, 2019). The relatively low rate of help seeking for PTSD is likely because of multiple factors, including the stigma of mental illness, the expense of treatment, a person’s belief that she or he does not have a significant problem, or the belief that the problem will get better on its own (Kessler, 2000; Wang et al., 2005). Additionally, given that PTSD is characterized by avoidance of trauma reminders, lack of trust in others, and shame and guilt, it is not
surprising that many people avoid treatment. Along these same lines, the nature of PTSD may lead people to feel they are either undeserving of help or beyond help.

Fortunately, a number of psychological therapies for PTSD have been found to be helpful in reducing or alleviating distressing symptoms associated with it. Multiple treatment guidelines exist for PTSD, and they recommend several specific interventions for PTSD, including prolonged exposure (PE), cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), stress-inoculation training (SIT), and present-centered therapy (PCT; Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; “VA/DoD Clinical Practice Guidelines,” 2017). On the basis of numerous high-quality studies that demonstrate the long-term efficacy of PE and CPT, there is general agreement across guidelines endorsing these interventions as first-line treatments for PTSD (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010; Resick, Williams, Suvak, Monson, & Gradus, 2012; “VA/DoD Clinical Practice Guidelines,” 2017). PE is a form of CBT that includes elements of psychoeducation, imaginal exposure, in vivo exposure to fear-producing trauma-related stimuli and processing of trauma memories (van Minnen, Harned, Zoellner, & Mills, 2012). CPT is a CBT designed to provide skills to process maladaptive cognitions and beliefs (Resick et al., 2015; Watts et al., 2013). Both have undergone successful dissemination based on proven efficacy (Hundt, Harik, Thompson, Barrera, & Miles, 2018).

Psychological treatments for PTSD can be broadly categorized as trauma focused or non-trauma-focused. Trauma-focused therapies (e.g., PE, CPT, EMDR) help those with PTSD process trauma-related memories, thoughts, emotions, and beliefs. In contrast, non-trauma-focused therapies do not directly address trauma-related emotions, beliefs, and memories. Rather, most of these interventions (e.g., stress-inoculation training; Meichenbaum, 2007) place emphasis on acquiring skills for stress management and problem-solving in daily life (Frost, Laska, & Wampold, 2014; Meichenbaum, 2017). PCT is another non-trauma-focused therapy that helps individuals with PTSD identify the symptoms that interfere with their quality of life and functionality and then draws ideas for problem solving from the patient with an emphasis on successful past coping (Shea & Schnurr, 2017). Evidence from meta-analyses indicates that non-trauma-focused interventions, including PCT, result in clinically meaningful improvements in PTSD symptoms with medium to large effect sizes (Dorrepaal et al., 2014; Frost et al., 2014; Steenkamp et al., 2015). There is also evidence suggesting that PCT (Frost et al., 2014; Imel, Laska, Jakupcak, & Simpson, 2013) and interpersonal psychotherapy for PTSD (Markowitz et al., 2015) may have lower
dropout rates than trauma-focused treatments. Additionally, a significant subset of patients does not benefit from CBT-oriented PTSD interventions or continue to have significant residual PTSD symptoms (Bradley et al., 2005; Steenkamp et al., 2015), and recognition of this has spurred the search for additional or complementary treatments.

**MBIs FOR PTSD**

In theory, if patients are offered treatments that match the symptoms most bothersome to them and they can do so in a way that matches their preferred starting point (e.g., beginning therapy with a technique that directly works with the trauma vs. a non-trauma-focused approach), increased engagement and improved outcomes might occur (Cloitre, 2015). Patients’ interest in using complementary and alternative medicine (CAM) approaches (now preferably termed complementary and integrative health [CIH]) to help manage their PTSD appears to be increasing over time. Data from 2005 found that 13% utilized CIH, whereas a more recent survey of people with past-year PTSD found that 39% used CIH to address their emotional and mental problems, with 17.5% reporting use of meditation techniques (Kessler et al., 2005; Libby, Pilver, & Desai, 2013). For PTSD, the literature suggests that patient preferences are a key driver in increased engagement in CIH modalities for PTSD because many patients view CIH modalities as more likely to address the whole person rather than just their illness (Kroesen, Baldwin, Brooks, & Bell, 2002). Also, dissatisfaction with conventional care and reliance on prescription medications have been cited as factors motivating patients to seek out holistic, integrative perspectives (Kroesen et al., 2002) such as MBIs.

*Mindfulness* can be defined as “the capacity to maintain awareness of, and openness to, immediate experience—including internal mental states, thoughts, feelings, memories and impinging elements of the external world—without judgment and with acceptance” (Briere, 2015, pp. 14–15). MBIs emphasize changing a person’s *relationship* to thoughts, emotions, and bodily sensations. MBIs teach meditation practices as a core method of bolstering the ability to attend to experience with an attitude of non-judgment, patience, curiosity, trust, nonstriving, acceptance, and letting go (Kabat-Zinn, 2013). In addition to these attitudinal qualities, MBIs teach the ability to sustain, direct, and shift attention (e.g., the ability to intentionally disengage from automatic cycles of thought). MBIs also provide a framework to understand the nature of thoughts, emotions, and bodily
Why Mindfulness-Based Interventions for PTSD?

sensations, which are presented as changing events to be regarded with acceptance and openness. Such a shift in attitudinal and attentional abilities is theorized to foster positive cognitive and behavioral change in response to stress and pain (Baer, 2003). In MBIs, group leaders or therapists do not explicitly attempt to guide participants in the process of changing thoughts, beliefs, or behaviors (beyond the behavioral change of attending class and practicing mindfulness during class and at home).

In MBIs, the primary method of enhancing the ability to attend to experience with mindful attention is through mindfulness meditation practices, such as breathing meditation, body scan meditation, eating meditation, or mindful movement (e.g., yoga, walking meditation, qi gong). The mindfulness meditation practices in MBIs are described to participants as self-care practices, which they are encouraged to continue to use long after finishing the course. Uptake of these practices appears to occur at a high rate; at least 75% report using mindfulness techniques in daily life at follow-up ranging from 6 to 48 months (Baer, 2003; Kabat-Zinn, Lipworth, Burncy, & Sellers, 1986).

MBIs have increasingly been applied in health care on the basis of supportive evidence for a variety of conditions, including chronic pain (Cherkin et al., 2016; Day, 2017; Goldberg et al., 2018; Reiner, Tibi, & Lipsitz, 2013), somatoform disorders (Lakhan & Schofield, 2013), anxiety (Hofmann, Sawyer, Witt, & Oh, 2010), addictions (Bowen et al., 2014; Brewer et al., 2009; Garland & Howard, 2018), and depression (Goldberg et al., 2018; Segal, Williams, & Teasdale, 2013). The research on MBIs in general has grown at an exponential pace, with some studies attempting to address methodological shortcomings that were common in the early literature base, although recent reviews suggest the field still has a way to go to improve the quality of MBI evaluations (Goldberg et al., 2017; Goyal et al., 2014). We include in this chapter a discussion of strengths and limitations of key studies covering the extant evidence base for MBIs for PTSD, which immediately follows an overview of the rationale for applying MBIs to PTSD.

In this book, we focus on MBIs that emphasize meditation practices, although we recognize that other interventions with a strong evidence base for conditions other than PTSD, such as acceptance and commitment therapy (ACT) and dialectical behavioral therapy (DBT), teach mindfulness through techniques other than meditation (Hayes et al., 1999; Lynch et al., 2006). Two of the most prevalent MBIs that are based on teaching mindfulness meditation are mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT). In addition, many other meditation-based approaches have been adapted to the needs of specific
populations. For example, among the many MBIs that have been developed are programs for substance use disorder relapse prevention, childbirth and parenting, and eating disorders (Bowen et al., 2009; Duncan & Bardacke, 2010; Kristeller et al., 2014).

THEORETICAL MODELS OF MINDFULNESS AND RELATIONSHIP TO PTSD

Several conceptual models of mindfulness have been proposed to explain MBI’s effects on distress and psychiatric challenges (Hölzel et al., 2011; Shapiro, Carlson, Astin, & Freedman, 2006; Teasdale & Chaskalson, 2011a, 2011b). Although general models of mindfulness have not been evaluated specifically in the context of PTSD, these models may prove helpful in understanding how mindfulness practice leads to positive change in this setting. One model posits that mindfulness leads to benefit through a shift in perspective termed reperceiving (Shapiro et al., 2006), which is compatible with a number of theorized and demonstrated healthy shifts in cognition described by other investigators, including decentering (Fresco et al., 2007; Safran & Segal, 1990), metacognitive awareness (Teasdale et al., 2002), cognitive defusion (Hayes et al., 1999), and improved attention regulation (Hölzel et al., 2011).

The Shapiro model specifically posits that intention, attention, and attitude are interwoven aspects of mindfulness that lead to the metamechanism of reperceiving (i.e., a shift in perspective). In MBIs, these three interwoven aspects of mindfulness are taught in several ways. In MBIs, intention is often highlighted by asking participants to reflect on their motivation, or personal vision, for taking part in the MBI, along with acknowledgment that this intention can change and evolve over time. Paying attention is taught in MBIs through meditation practices in which a person is asked to observe his or her moment-to-moment internal or external experience. These meditation practices also seek to further develop the ability to sustain attention or shift attention. Finally, a certain attitude or quality of attention is emphasized in MBIs by inviting participants to pay attention without judgment and with kindness, curiosity, and openness. Together, these aspects of mindfulness foster the ability to “step back” such that patients are able to reevaluate themselves, their relations with others, and their relationship with their body, thoughts, and feelings. In Shapiro et al.’s (2006) conceptual model, reperceiving overarches the other direct mechanisms of mindfulness, which include (a) self-regulation; (b) values clarification; (c) cognitive, emotional, and behavioral flexibility; and (d) exposure.
Although this model has not been directly applied and tested in the setting of PTSD, some aspects of this framework are consistent with evidence from the trauma literature that cognitive factors (e.g., fixed posttraumatic beliefs, ruminative coping styles), as well as avoidance, serve to maintain or worsen PTSD symptomatology. For individuals who have long been burdened by symptoms characterized by reactive distress, fixed patterns of avoidance, consistently poor self-appraisal and other appraisals, and loss of meaningful engagement with others and once-valued activities, reperceiving of one’s circumstance may lead to empowerment, positive changes in quality of life, and potentially to symptom reductions.

Theoretical models of mindfulness can also be described from a Buddhist perspective (Grabovac, Lau, & Willett, 2011). In the Buddhist psychological model, experience is formed by a continuous series of sense impressions and mental events, which arise rapidly and pass away. The awareness of a sense object produces a feeling tone, which can be pleasant, unpleasant, or neutral, which causes a person to pursue experiences that are pleasant (termed attachment) and to avoid experiences that are unpleasant (termed aversion or avoidance). Of note, in the Buddhist model, it is not the object of attention that causes attachment or aversion; attachment or aversion arises through one’s responses to the feeling tone of the experience, and the feeling tone of an experience is shaped by many factors, including one’s past experiences. The feelings associated with an initial sense impression produce additional mental events (i.e., thoughts and feelings), which in turn produce additional feelings; this process is termed mental proliferation, which fuels suffering. In the Buddhist psychological model, it is lack of awareness of reactions of attachment and aversion to pleasant, unpleasant, and neutral experiences and associated mental proliferation that maintains the process and leads to suffering (Grabovac et al., 2011).

In Buddhist theory, mindfulness involves observing the three characteristics inherent in experience: impermanence, suffering, and not-self. Such mindful observation in turn leads to insight and understanding, as well as equanimity, defined as a balanced state of mind in which equal interest is taken in pleasant, unpleasant, or neutral states. Insight and equanimity minimize attachment, aversion, or identification with experience and lead to reduced mental proliferation, which includes narrative or ruminative thought processes associated with experience (Grabovac et al., 2011). Concentration, enhanced attention regulation, and ethical conduct also contribute to reductions in mental proliferation. Again, this model has not been empirically tested among individuals with PTSD, but from this perspective, mindfulness may help address PTSD-related distress through reductions in avoidance of unpleasant feeling states and by reducing habitual
reactions and other forms of mental proliferation (e.g., rumination, fixed posttraumatic cognitions, unhelpful narratives) that fuel suffering and increase symptomatology. The result may be not only reduced symptoms but also an expanded sense that one is neither a fixed entity nor alone and cut off from others and the world.

We turn now to an overview of how MBIs may help to address some of the chief symptoms of PTSD and common, often unhelpful, ways of coping with them.

**Avoidance**

Avoidance of trauma-related reminders is a major symptom of PTSD (American Psychiatric Association, 2013). Ehlers and Clark (2000) identified three types of avoidance behaviors: cognitive avoidance (trying not to think of the trauma; occupying mind at all times); emotional avoidance (controlling feelings, numbing emotions; avoiding anything that could cause positive or negative feelings); and behavioral avoidance (taking drugs, avoiding crowded places, avoiding other people; Ehlers & Clark, 2000). Avoidance behaviors also manifest in interpersonal relationships and can lead to a lack of openness and trust in others, resulting in poorer quality relationships in which misunderstanding and miscommunication are likely (Dobie et al., 2004; Gerlock, Grimesey, & Sayre, 2014; Jakupcak et al., 2011). Individuals with PTSD may also limit going places or doing things that they associate with trauma experiences to avoid feeling anxious. Although this may help to prevent distress in the short term, over time this can lead to decreased stress tolerance and an impoverished lifestyle (American Psychiatric Association, 2013).

A central focus of MBIs is cultivating an increased ability to bring mindful attention to present-moment experience, including difficult emotional states, which are prevalent in PTSD. For a trauma survivor, the ability to bring nonevaluative attention to her or his own experience, regardless of whether it is pleasant or unpleasant, as is taught in MBIs, can be considered the opposite of avoidance. An increased ability to access and directly engage psychological pain, whether through mindfulness practice or other therapies, allows distressing material to be processed, which may result in clinical improvement over time (Briere, 2015). In MBIs, participants are taught to become more aware of their patterns of reactivity, to observe these reactions without judgment, and to use mindfulness practices (e.g., breathing meditation) to manage moments of stress, anxiety, and anger. In theory, this may help them to move forward into difficult situations rather than using avoidance strategies to cope with fear or anxiety (Lang et al., 2012).
Evidence from the research literature supports reduced PTSD avoidance symptoms after participation in a MBI, particularly internal avoidance (i.e., emotional numbing; King et al., 2013; Stephenson, Simpson, Martinez, & Kearney, 2016). One study sought to clarify the question of which aspects of mindfulness practice benefit specific symptoms of PTSD by examining the association between changes in specific facets of mindfulness (defined by the Five Facet Mindfulness Questionnaire [FFMQ]) and PTSD symptom clusters over the course of treatment with an MBI (Stephenson et al., 2016). As measured by the FFMQ, mindfulness includes five facets: acting with awareness, observing, describing, nonreactivity, and nonjudgment. The change in each of these facets of the FFMQ was examined in relation to changes in PTSD symptoms (reexperiencing, avoidance, emotional numbing, hyperarousal). The results indicated that increases in acting with awareness (i.e., being aware of one's present-moment experience) and nonreactivity were the two facets of mindfulness most strongly associated with reductions in PTSD clinical symptoms, with the strongest associations for reductions in emotional numbing and hyperarousal.

Mindfulness may also function as a form of exposure that could temper the fear and avoidance that are clinical hallmarks of PTSD. Preliminary evidence for this proposition comes from findings that fear extinction is associated with mindfulness practice but not with instruction to simply relax (Kummar, 2018). When referring to MBIs as a form of exposure therapy, understand that in MBIs (in contradistinction to PE), no attempt is made to specifically reactivate trauma-related memories or content. Instead, in MBIs a person is asked to notice whatever thoughts, emotions, and body sensations arise in the present (including difficult or strong emotions) without a specific attempt to bring trauma-related material to the surface. The practice of stepping back and observing difficult thoughts, emotions, and sensations that arise in the course of mindfulness practice is theorized to gradually lead to “extinction of fear responses and avoidance behaviors previously elicited by these stimuli” (Baer, 2003, p. 129).

**Hyperarousal**

_Hypervigilance_ is a core aspect of the hyperarousal PTSD symptom criterion and is defined as excessive perception of threat-related information in the environment (Dalgleish, Moradi, Taghavi, Neshat-Doost, & Yule, 2001). Individuals with PTSD tend to be hyperaware of and sensitive to potentially threatening cues, with a reduced threshold for threat, such that cues that are nonthreatening are perceived as dangerous (Dalgleish et al., 2001). Threat-related information is more likely to be processed,
maintaining the disorder in a feedback loop, while nonthreatening information is less likely to be processed. Paradoxically, despite being on guard and scanning for threat, people with PTSD are prone to exaggerated startle reactions. Additionally, those with PTSD are apt to respond to others and to situational challenges with irritability and anger, and they often have difficulty concentrating and falling and staying asleep (Boyd, Lanius, & McKinnon, 2018).

Mindfulness is thought to have potential utility in addressing these issues because it teaches individuals to utilize mindfulness practices as a means of adopting a nonreactive stance to distressing aspects of experience. Such nonreactivity is hypothesized to facilitate learning that can lead to extinction of fear responses previously elicited by these stimuli (Shapiro et al., 2006). Intervenotional studies demonstrate that mindfulness interventions reduce physiological arousal and reactivity to stress (Vujanovic, Niles, Pietrefesa, Schmertz, & Potter, 2013). In a before-and-after study of MBSR for veterans, all PTSD symptom clusters decreased significantly over time, but hyperarousal exhibited the largest change (Kearney, McDermott, Malte, Martinez, & Simpson, 2013). Correlational studies also suggest a relationship between mindfulness and hyperarousal (Chopko & Schwartz, 2013; Wahbeh, Lu, & Oken, 2011). As described above, in a study that assessed which facets of mindfulness were associated with reductions in specific symptoms of PTSD, nonreactivity and acting with awareness were associated with reductions in hyperarousal and emotional numbing (Stephenson et al., 2016).

**Posttraumatic Cognitions and Beliefs**

One of the core features of PTSD involves negative changes in thoughts and mood such that following trauma many people develop negative fixed beliefs about self, others, and the world in general that can lead to added suffering. Table 1.1 provides examples of common beliefs and attitudes associated with trauma that can become entrenched in the setting of PTSD.

A fundamental capacity developed by mindfulness practice is the ability to step back from one's thoughts, emotions, and sensations and view them from a new perspective (Shapiro et al., 2006). Thus, mindfulness may help individuals to develop a decentered perspective, in which thoughts are seen as temporary events in the mind and not as reflections of self (Fresco et al., 2007; Safran & Segal, 1990). Regarding thoughts with curiosity and openness holds the potential to reduce distress from and reactivity to thoughts and beliefs that develop after trauma.
TABLE 1.1. Common Beliefs and Attitudes Following a Traumatic Event

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Beliefs and attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fact that the trauma happened to me</td>
<td>“Nowhere is safe.” “I deserved it. I don’t deserve to be happy.” “I can’t trust anyone.” “People who appear to be generous have other motives.”</td>
</tr>
<tr>
<td>Initial posttraumatic stress disorder symptoms that often persist (e.g., irritability, emotional numbing, flashbacks, difficulty concentrating)</td>
<td>“I’m dead inside.” “No one will ever understand me.” “I cannot cope with stress.”</td>
</tr>
<tr>
<td>Other people's reactions after trauma</td>
<td>“They think I am too weak to cope.” “I need to appear strong.” “They think what happened was my fault.” “They just want me to get over it.”</td>
</tr>
<tr>
<td>Other consequences of trauma (physical, social)</td>
<td>“My body is ruined.” “I will never be able to lead a normal life again.” “I am unable to feel close to anyone.” “I cannot love others again.” “I’m unlovable.” “I’m damaged, broken.”</td>
</tr>
</tbody>
</table>


Pervasive feelings of shame and guilt, which often arise in the context of negative posttraumatic cognitions and beliefs, are common among people with PTSD and are theorized to play a key role in the development and maintenance of the disorder (D. A. Lee, Scragg, & Turner, 2001). Shame and guilt can be very limiting because they often affect social identity, attenuate help-seeking, and interfere with emotional processing of traumatic events (D. A. Lee et al., 2001). Feelings of shame can be a focus of rumination (Gilbert & Procter, 2006) and may also lead to a feeling of current threat through an attack on personal integrity (D. A. Lee et al., 2001). Shame can also include feelings of powerlessness, inferiority, unattractiveness, and a desire to hide perceived deficiencies (Gilbert & Procter, 2006). Guilt can occur when a person acted or failed to act in ways that they believe conflicts with their code of conduct (D. A. Lee et al., 2001), which is not an uncommon occurrence during trauma situations (Norman et al., 2018).

Mindfulness practice is hypothesized to re-create or create a safe holding environment (Epstein, 2013) in which difficult emotional experiences (e.g., shame, guilt) can be regarded with acceptance, kindness, and self-compassion, which may prove particularly helpful when kindness and
support are lacking in the environment. There is preliminary evidence that mindfulness practice reduces shame in trauma survivors (Goldsmith et al., 2014). Through mindfulness practice, an increased ability to self-modulate pervasive feelings of shame, guilt, and inferiority may help to restore or establish a sense of connection to the sense of self that has been lost through traumatic experiences or that never developed if trauma happened early in life. This increased comfort with oneself may in turn, allow for reconnection (or connection) with the community as well.

Rumination is a common cognitively based response to trauma, particularly among those with more severe PTSD symptoms (Bennett & Wells, 2010; Ehring, Szeimies, & Schaffrick, 2009). Rumination can be conceived of as a specific way of relating to mental content (Ramel, Goldin, Carmona, & McQuaid, 2004) characterized by a passive and repetitive focus on negative thoughts and emotions. For individuals with PTSD, frequent revisiting of trauma memories, posttraumatic cognitions, beliefs, and feelings can add to distress and the perception of being painfully stuck. Rumination is a key factor in relapse of depression, and for this reason we cover it in additional detail in Chapter 2, this volume. For people with PTSD, there is evidence that rumination is associated with more severe PTSD symptoms (Bennett & Wells, 2010; Ehring et al., 2009; Viana et al., 2017). Although not tested in a population with PTSD, there is some experimental evidence (Williams, 2008) as well as preliminary clinical findings (Chesin et al., 2016) that mindfulness training reduces rumination in other clinical samples. The significance of rumination has also been highlighted by theorists who posit that PTSD may be more accurately characterized by anhedonic mood and anxious rumination than by pathologic fear and externalizing (Resick & Miller, 2009).

In mindfulness practice, when memories of painful past events arise, a person is encouraged to bring mindful attention to the experience, which acknowledges the reality that painful events happened, but without the repetitive patterns of thought that worsen distress. Such cognitive shifts could, in theory, enhance the ability to tolerate the discomfort of reevaluating painful past experiences and lead to changes in perspective toward those experiences, themselves, and others. Learning to disengage from cycles of rumination involves what Kabat-Zinn (2013) described as “letting go” (p. 40), wherein mindfulness practitioners are encouraged to allow experience to be as it is through the process of observing experience from moment to moment. Mindfulness practitioners learn to recognize elaborative, ruminative tendencies and repeatedly let go, or disengage, then
return to the object of meditation (e.g., the breath). Through this process, participants are taught to step out of entrenched patterns of ruminative thinking.

**MBIs AND PTSD: A REVIEW OF THE EVIDENCE**

Three papers published since 2016 provide systematic reviews of the extant randomized clinical trials (RCTs) evaluating MBI interventions for those with current PTSD (Gallegos, Crean, Pigeon, & Heffner, 2017; Hilton et al., 2016; Niles et al., 2018), two of which also include meta-analyses (Gallegos et al., 2017; Hilton et al., 2016). All three papers included a variety of MBI approaches ranging from mantram repetition practices (i.e., to include transcendental meditation [TM]), to yoga, to MBSR. Hilton et al. (Hilton et al., 2016) combined results from eight trials representing a variety of MBI approaches and found an overall standardized mean difference (SMD), which is a measure of effect size and equivalent to Cohen's d, of \(-0.41\) (95% CI \([-0.81, -0.01]\)) indicating a small to medium effect on PTSD symptomatology in favor of MBIs relative to comparison conditions. The authors found that the three MBI types (i.e., mantram repetition, yoga, MBSR) did not differ significantly from one another regarding relative efficacy.

The Gallegos et al. (2017) meta-analysis separated the mindfulness MBIs, which were based primarily on MBSR, from both the yoga and the other meditation-based MBIs, which were based primarily on mantram repetition (Gallegos et al., 2017). Across the nine mindfulness MBI RCTs for PTSD that were included, the effect size was \(-0.34\) (\(p < .001\), 95% CI \([-0.49, -0.18]\)), again indicating a small to medium effect for mindfulness MBIs. To contextualize the results of their meta-analysis, Gallegos et al. (2017) provided information from a prominent meta-analysis (Bisson et al., 2013) on the effect sizes associated with individually delivered trauma-focused and nontrauma CBT interventions for PTSD, both of which were large (Cohen’s ds of \(-1.62\) and \(-1.22\), respectively). The authors also noted that the effect size associated with MBIs is comparable with that found for medication management, which is recommended as a second-line treatment for PTSD (U.S. Department of Veterans Affairs, 2017). They concluded that all three types of MBIs likely provide some benefit, increase patient choice, and because they are typically group based, may be a cost-effective complement to CBT interventions for PTSD.
The systematic reviews accompanying both meta-analyses as well as the Niles et al. (2018) systematic review echo the findings from the meta-analyses. Further, all three papers caution that there is marked heterogeneity across studies in terms of outcomes and that, overall, the quality of the extant RCTs evaluating MBIs is weak. Methodological problems that were highlighted include generally small sample sizes, failure to use intent-to-treat analytic models, short follow-up assessment windows, lack of active comparators, and failure to state an a priori power calculation (see Hilton et al., 2016, for details regarding study quality). Niles et al. (2018) specifically cautioned that because many of the extant MBI studies for those with PTSD involved small samples, there is concern that negative trials may not be published, resulting in the “file drawer effect.” This concern is amplified by the fact that all three reviews appear to have used standard search strategies that likely would not have yielded “gray literature” (e.g., unpublished dissertations, conference presentations, funded grants that did not result in publications), though Gallegos et al. did include results from a study that was not published at the time that has since been published (L. L. Davis et al., 2018).

**Commentary on Key Trials of MBSR for PTSD**

Two RCTs that evaluated MBSR for PTSD (L. L. Davis et al., 2018; Polusny et al., 2015) merit particular attention; both are relatively large, and both compared MBSR with an active intervention, PCT, which as noted earlier is considered an empirically supported alternative for treating PTSD. The use of PCT as an active, credible comparator is an important design strength of both studies because it at least partly controls for changes that may be due to positive expectancy, relationship with the group leader, and other nonspecific elements (Palpacuer et al., 2017; Wampold & Imel, 2015). Key features of both studies, including findings and methodological strengths and weaknesses, may be found in Table 1.2.

The Polusny et al. (2015) study randomized 116 combat veterans to receive group-based standard format MBSR or standard format PCT. Although the first MBSR session included supplemental education about PTSD and an explanation of the treatment rationale, the remainder of the course was delivered without modification of the meditation practices, which included the standard duration for body scan meditation, sitting meditation, and mindful yoga. An experienced MBSR instructor led the MBSR groups, and daily homework was assigned in the form of guided meditations. Experienced group leaders led the PCT groups. Fidelity of both interventions was
### TABLE 1.2. Key Features of L. L. Davis et al. (2018) and Polusny et al. (2015) Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>MBSR</th>
<th>PCT</th>
<th>Assessments</th>
<th>Outcomes</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>L. L. Davis et al.,</td>
<td>214 veterans with PTSD</td>
<td>1.5 hours weekly for 8 weeks plus 6-hour retreat</td>
<td>1.5 hours weekly for 8 weeks plus lunch gathering</td>
<td>Posttreatment 2-month</td>
<td>PTSD symptom severity</td>
<td>MBSR: 5 unrelated serious adverse events</td>
</tr>
<tr>
<td>2018</td>
<td>191 included in analyses (attended at least one session)</td>
<td></td>
<td></td>
<td></td>
<td>Depression, mindfulness, attendance</td>
<td>PCT: 2 unrelated serious adverse events</td>
</tr>
</tbody>
</table>

**Findings**

**PTSD Outcomes:** The groups were not found to differ on PTSD severity as measured by the CAPS (primary outcome) at either time point, but PCL results showed a significant difference favoring MBSR at immediate posttest. Both groups saw clinically significant responses (i.e., ↓30% point drop on CAPS; MBSR: 45.2%; PCT: 37.7%, *ns*) and remission rates (i.e., ↓45 on CAPS; MBSR: 30.7%; PCT: 27.3%, *ns*).

**Depression:** No between-groups differences on the PHQ-9, and little change from baseline to posttreatment or 2-month follow-up.

**Mindfulness:** No between-groups differences on Five-Factor Mindfulness Questionnaire scores; both reported small increase in mindfulness from baseline to 2-month follow-up.

**Attendance:** No between-groups differences on overall number of sessions attended, but 31.2% of MBSR participants completed 7+ sessions vs. 58.9% of PCT participants (the difference was not tested by the authors).

**Strengths and Limitations**

**Strengths:** Large sample size; comparability of time/attention across conditions; fidelity of treatment delivery evaluated; Type I error control for secondary analyses; assessors blind to treatment assignment; use of gold standard PTSD assessment; randomization done electronically; groups were comparable at baseline; provided a priori power analysis; provided information on safety.

**Limitations:** Modified intent-to-treat analyses that may be sensitive to treatment assignment; alteration of standard MBSR; short follow-up duration.

*(table continues)*
TABLE 1.2. (continued).

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>MBSR</th>
<th>PCT</th>
<th>Assessments</th>
<th>Outcomes</th>
<th>Safety</th>
</tr>
</thead>
</table>
| Polusny et al., 2015 | 116 veterans with PTSD | 2.5 hours weekly for 8 weeks plus 6.5-hour retreat | 9 weekly 1.5-hour sessions | Posttreatment 2-month | PTSD symptom severity  
Depression, quality of life, mindfulness, attendance | 1 PCT participant attempted suicide |

**Findings**

**PTSD Outcomes:** Both groups improved on PTSD severity as measured by the PCL (primary outcome) from baseline to 2-month follow-up; the MBSR group showed significantly greater improvement than the PCT group over time. The same pattern of results was found on the CAPS (secondary outcome). The groups did not differ on loss of diagnosis at either time point (immediate posttest: MBSR 42.3%; PCT: 43.9%; 2-month follow-up: MBSR: 53.3%; PCT 47.3%). Significantly more participants in MBSR had a clinically meaningful decrease in PCL score (10+ reduction) at 2-month follow-up than those in PCT (48.9% vs. 28.1%, respectively).

**Depression:** No between-groups differences on the PHQ-9, and little change from baseline to posttreatment or 2-month follow-up.

**Quality of Life:** MBSR participants reported significantly greater improvements on the WHO Quality of Life-Brief measure than PCT participants at 2-month follow-up.

**Mindfulness:** MBSR participants reported significantly greater improvement on the Five-Factor Mindfulness Questionnaire than the PCT participants at 2-month follow-up.

**Attendance:** Treatment completion (attending 7+ sessions) was significantly lower in the MBSR group (77.6%) than the PCT group (93.1%).

**Strengths and Limitations**

**Strengths:** Large sample size; standard format for both interventions; fidelity of treatment delivery evaluated; intent-to-treat analyses; assessors blind to treatment assignment; randomization done electronically; a priori power calculations included.

**Limitations:** Interventions differed markedly on time and attention; randomization failed to yield comparable groups; short follow-up duration; Type I error was not controlled.

*Note.* PTSD = posttraumatic stress disorder; MBSR = mindfulness-based stress reduction; PCT = patient-centered therapy; PCL = PTSD Checklist; CAPS = Clinician-Administered PTSD Scale; PHQ-9 = 9-item Patient Health Questionnaire; WHO = World Health Organization. Data from L. L. Davis et al. (2018) and Polusny et al. (2015).
assessed over the course of the study and found to be satisfactory. Of note, although the study included PCT as an active comparator, the total length of time spent in sessions was twice as long for MBSR, raising concern that the increased provider contact in the MBSR arm may have influenced outcomes (see the critique by D. J. Lee & Hoge, 2017, and the reply by the original authors, Erbes, Thuras, Lim, & Polusny, 2017).

The results showed that though there were no significant between-groups differences at immediate posttest, those randomized to MBSR had greater improvement in PTSD symptoms on both the self-report PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993) and the gold standard Clinician-Administered PTSD Scale (CAPS; Weathers, Keane, & Davidson, 2001). Additionally, significantly more of those participating in MBSR (49%) had improvement in symptoms in the range considered clinically meaningful as compared to PCT (28%) at 2 months, though there was no difference in the likelihood of losing one’s PTSD diagnosis. There were no between group differences on depression at either time point, but the MBSR group reported improvements in both quality of life and mindfulness that were significantly stronger than the PCT group at the 2-month assessment. Both interventions were well tolerated with low treatment attrition rates, though those assigned to MBSR were significantly less likely to complete seven or more sessions than those in the PCT group (77.6% vs. 93.1%, respectively), and one participant in the PCT group attempted suicide (which was determined not to be related to involvement in the study).

L. L. Davis et al. (2018) randomized 214 veterans to either group-based MBSR or PCT, and the 191 who attended at least one treatment session were included in the analyses (modified intent-to-treat analyses). In light of concerns about differential time and attention across conditions, L. L. Davis et al. modified MBSR to be eight weekly 1.5-hour sessions (with a 6-hour weekend retreat) and added a lunch gathering to the eight 1.5-hour weekly PCT sessions to partially account for the MBSR retreat time. Both the MBSR and PCT groups showed clinically significant improvement at 2 months (i.e., ≥ 30% point drop on CAPS; MBSR: 45.2%; PCT: 37.7%) as well as moderately strong remission rates (i.e., ≤ 45 on CAPS; MBSR: 30.7%; PCT: 27.3%), but there were no between-groups differences on PTSD severity as measured by the CAPS at either immediate posttest or the longer follow-up. The MBSR group did show greater improvement than the PCT group at immediate posttest on the self-report PCL. There were no between-groups differences on depression or mindfulness and neither index showed much within subject change over time. The authors did not find that the two groups differed on the number of treatment sessions
attended, but calculations done with detailed information provided on session attendance suggest that the rate of treatment completion (using the same 7+ session indicator as Polusny et al., 2015) was greater for those assigned to PCT (58.9%) than for those assigned to MBSR (31.2%).

The findings from both studies suggest that MBSR, whether delivered in its standard format or an abbreviated one, yields improvement in PTSD that is at least as strong as that associated with PCT (an empirically supported treatment for PTSD). Neither study, however, tested a noninferiority hypothesis, so we do not yet know whether there are or are not meaningful differences between these two interventions. Considering both studies’ important methodological strengths, the findings suggest that MBSR may be a useful alternative or complementary intervention for PTSD. With regard to these studies’ strengths, both studies are far larger than the other published RCTs testing MBSR, though the Polusny et al. (2015) study was somewhat underpowered based on their a priori power calculations. Additionally, both included a valid clinician-rated assessment of PTSD, assessors were blind to study condition, and treatment fidelity was systematically evaluated and found to be good. The two studies do, however, share a critical design limitation in that the longest follow-up assessment was 2 months posttreatment, limiting our ability to gauge endurance of treatment gains over a longer time period, whether one or the other treatment does a better job of maintaining gains, and whether there might be “snowball effects” associated with either treatment such that with more time, people exposed to MBSR and/or PCT may improve even more.

It is also noteworthy that the two studies opted to handle the issue of disparate treatment time differently. The earlier Polusny et al. (2015) study delivered MBSR in its standard format (26 hours total) and PCT in its standard format (12 hours), thereby approximating how each are typically delivered in practice but sacrificing the ability to determine whether any advantage of MBSR might have been due to the greater exposure to the teacher and fellow group members. L. L. Davis et al. (2018) addressed the time and attention issue by truncating MBSR sessions to 1.5 hours and adding a nonstandard lunch gathering to the PCT intervention. Thus, while greater methodological control was asserted, it is not possible to know whether the general lack of between-groups differences found in this study was perhaps because of having curtailed the in-session meditation practice time provided in standard MBSR courses. Both studies recruited military veterans exclusively, and there are currently no well-powered RCTs evaluating MBSR for PTSD among civilians.

Other, smaller scale studies that have evaluated abbreviated versions of MBSR have found comparably modest between-groups differences. For
Why Mindfulness-Based Interventions for PTSD?

example, Niles et al. (2012) compared an 8-week MBI (two sessions in person followed by six telehealth sessions, based on MBSR) with similar length psychoeducation sessions for PTSD among combat veterans. Although they found greater reductions in PTSD symptoms for MBI than for psychoeducation at immediate posttest, improvement in PTSD symptoms in the MBI arm waned at follow-up. Another trial randomly assigned veterans with PTSD to four 1.5-hour mindfulness training sessions adapted from MBSR that were delivered in primary care or to usual care (Possemato et al., 2016). No differences between brief mindfulness training and usual care were found, but for those who completed the experimental intervention there were significantly larger decreases in PTSD severity and depression (Possemato et al., 2016).

Evaluation of Other MBIs for PTSD

MBCT is an 8-week MBI originally derived from MBSR for prevention of depressive relapse (Segal et al., 2013), and there is preliminary information on an adapted version for PTSD. In a nonrandomized trial comparing PTSD symptom reduction following MBCT to outcomes following other non-trauma-focused groups for combat veterans with chronic PTSD (N = 37), MBCT participants had greater reductions in PTSD symptom scores (King et al., 2013). The greatest reductions in symptoms were seen for avoidance/numbing symptoms, and reductions in posttraumatic cognitions were also observed.

The studies previously described report on outcomes of interventions based on teaching mindfulness without a specific focus on trauma-related exposure. Given the robust evidence base for PE (Jeffreys et al., 2014; Kehle-Forbes, Meis, Spoont, & Polusny, 2016; Tuerk et al., 2011), King et al. (2016) developed an intervention that combines elements of trauma-focused exposure therapy with mindfulness training. The clinical rationale for the combined intervention, called mindfulness-based exposure therapy (MBET), is to teach patients mindfulness as a method of improving emotional regulation and stress tolerance, which in turn is predicted to help them engage in trauma-focused exposure therapy (King et al., 2016). MBET consists of 16 weekly 2-hour sessions that include daily mindfulness training based on MBCT, in vivo exposure from PE, PTSD psychoeducation, and self-compassion exercises. Preliminary findings from 23 combat veterans show reduced PTSD symptoms in both MBET and PCT, which were not significantly different. However, the investigators report on before-and-after functional MRI (fMRI) neuroimaging data regarding resting-state functional connectivity in the default mode network (DMN) and salience network (SN). Patients
treated with MBET were found to have significantly increased DMN resting-state functional connectivity with brain regions associated with executive control; this change was not observed in the active control group (King et al., 2016). The change in functional connectivity is consistent with an increased ability to shift attention from one type of self-referential state (e.g., rumination) to another, such as experiencing sensation and interoception (e.g., attention to the breath; King et al., 2016). Overall, the study provides a possible mechanism for the beneficial impact of mindfulness interventions on emotional regulation.

**COMMENTARY ON THE SAFETY OF MBIS FOR PTSD**

On the basis of available evidence from clinical trials, MBIs for PTSD appear safe and generally well tolerated. Several clinical trials of MBIs for PTSD have reported no serious adverse effects of MBIs related to the MBI (Bremner et al., 2017; Cole et al., 2015; L. L. Davis et al., 2018; Goldsmith et al., 2014; Kearney, McDermott, Malte, Martinez, & Simpson, 2012, 2013; Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010; Niles et al., 2012; Polusny et al., 2015; Possemato et al., 2016). Given that PTSD symptoms fluctuate over time in the absence of specific interventions, it can be expected that individual patients in clinical trials will sometimes experience worsening of symptoms. For example, in an RCT comparing MBSR with treatment as usual (N = 47), Kearney et al. (2013) found that one patient in each arm of the study had an inpatient psychiatric admission related to worsening PTSD symptoms during the study period, and in a larger RCT (N = 116) comparing MBSR with PCT, there was one serious adverse event, as noted above (a suicide attempt), which occurred in the PCT arm (Polusny et al., 2015). In the larger L. L. Davis et al. (2018) study (N = 214), which also compared MBSR with PCT, among patients who attended at least one session, there were three participants randomized to MBSR hospitalized with suicidal ideation, whereas in the PCT arm one was hospitalized for suicidal ideation; all adverse events were deemed unrelated to the study procedures (L. L. Davis et al., 2018). The extant literature does not suggest that PTSD symptom exacerbation occurs as a person progresses through a mindfulness class series. For example, the Polusny et al. (2015) and L. L. Davis et al. RCTs, which measured PTSD symptoms at Weeks 3 and 6 after beginning an 8-week MBSR series, did not show a rise in average PTSD symptom score during the course of treatment.
Another piece of evidence suggesting that participation in an MBI is not problematic for individuals with severe PTSD symptoms is a study that assessed the impact of baseline PTSD severity on clinical outcomes after MBSR, which found that those with the most severe baseline PTSD had greater improvement in PTSD symptoms compared with those with less severe PTSD (Felleman, Stewart, Simpson, Heppner, & Kearney, 2016). The perceived clinical safety and benefit of MBIs for individuals with PTSD is also indicated by the widespread use of MBIs for PTSD treatment in the Department of Veterans Affairs; Libby et al. (2012) found that some type of mindfulness training is offered by 77% of specialty programs for PTSD.

Qualitative research can be useful as an additional method to assess safety and to learn of potentially unmeasured side effects from the perspective of the participant. In a qualitative study of barriers and facilitators to participation in MBSR in a veteran population with a high prevalence of trauma, PTSD symptoms were not described as a barrier to practicing mindfulness, although some individuals had an aversion to participation in groups (Martinez et al., 2015). In a subsequent qualitative analysis of 15 veterans with PTSD who participated in MBSR, no participants described exacerbation of PTSD related to mindfulness practice or reported that the practices were too difficult because of PTSD (Schure, Simpson, Martinez, Sayre, & Kearney, 2018). Themes identified by veterans with PTSD who participated in MBSR included dealing with the past, staying in the present, acceptance of adversity, breathing through stress, relaxation, and openness to self and others (Schure et al., 2018). Two additional studies that employed qualitative research methods, each involving nine individuals with PTSD who participated in MBSR, reported satisfaction with the intervention, although some participants found it difficult (Cole et al., 2015; Müller-Engelmann, Wünsch, Volk, & Steil, 2017).

The comments here are not to suggest that individual participants may not sometimes experience anxiety or distress while practicing meditation; there have been occasional reports of anxiety or distress during meditation practices for people with a history of trauma in the literature. For example, King et al. (2013) reported that two of 20 people undergoing MBCT experienced anxiety during mindfulness exercises that contributed to dropout, with an overall dropout rate of 25%, which is similar to or lower than dropout rates for other interventions for PTSD. Other anecdotal cases of distress, anxiety, and possible clinical deterioration associated with meditation have been published (Treleaven, 2018; Van Dam et al., 2018). However, anecdotal reports cannot be used to draw conclusions about the frequency of side
effects, which must be determined through prospective monitoring in clinical trials or other large-scale monitoring procedures.

When a person experiences distress or troubling emotional content during a mindfulness exercise in a therapeutic milieu, it is important to remember that it does not necessarily represent an adverse event. In the treatment of PTSD, activation of trauma-related memories or fear is considered beneficial because it leads to habituation and symptom reduction over time (Foa & Kozak, 1986). When individuals with trauma experience distressing memories, emotions, images, and thoughts, participation in the mindfulness class is framed as a valuable opportunity to learn new ways of working with these experiences. Individuals with PTSD most likely experience similar forms of distress outside of the class setting, and working with unpleasant memories, thoughts, and emotions in class, aided by a skilled mindfulness instructor and supportive group, can be considered an opportunity to learn new habits of responding. We suggest providing meditation instructions that include wording that seeks a balance between wise effort and safety; participants are encouraged to trust their intrinsic wisdom and sometimes pause, stop meditation practice, or pull back in their effort if it feels wise, and to do so without judgment. These considerations are discussed in more detail in Chapter 4. Overall, our impression, based on the extant clinical literature described in this chapter and clinical experience, is that the level of trauma-related distress experienced in MBIs is clinically acceptable and does not lead to excessive dropout, symptom exacerbation, or suicidality.

In our experience, based on thousands of clinical encounters teaching MBSR to veterans with PTSD over an approximately 10-year period, in the rare instances when a person reported trauma-related memories or distress associated with the mindfulness practices, it was possible to suggest subtle modifications or alternate practices, which allowed the person to continue and successfully complete the course. We have not had veterans with PTSD report flashbacks or other forms of dissociation during MBSR practices, which is consistent with reports of safety in clinical trials reported above. In clinical practice, we routinely frame the discussion of whether to participate in an intervention in terms of the potential risk versus the potential benefit for an individual patient. In the case of PTSD, harm has not been shown in prospective clinical trials as a result of participating in an MBI, and there is some evidence of modest benefit, as reported in the meta-analyses above. Our overall impression is that the practices are generally well tolerated by individuals with trauma, and that people with PTSD are often strongly motivated to practice mindfulness meditation despite finding the process to be difficult at times.
SUMMARY

Trauma exposure is the norm, and although most people do not go on to develop PTSD, a substantial proportion do, and their symptoms may become chronic, particularly in the face of additional trauma exposures. There are several empirically supported CBT-based interventions available to treat PTSD, and the extant literature suggests that MBIs may serve as alternatives or complements to these treatments in that they are safe, well-tolerated, and appear to result in as much symptom reduction as PCT, a non-trauma-focused CBT intervention. However, more rigorous trial designs (e.g., noninferiority trials) with larger samples and longer follow-up are needed. In addition, thoughtful consideration of treatment time/attention issues and inclusion of more varied study samples are necessary to evaluate the true promise of MBIs for treating PTSD.

In Chapter 2, we provide an overview of other common sequelae associated with trauma exposure—depression, chronic pain syndromes, and substance use disorders—and discuss the rationale for applying MBIs in these clinical settings. The extant MBI treatment outcome base for each type of condition is also summarized, along with the strengths and limitations of these literatures.
Emotion-Focused Family Therapy

A Transdiagnostic Model for Caregiver-Focused Interventions

ADELE LAFRANCE, KATHERINE A. HENDERSON, AND SHARI MAYMAN
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A 30-year-old man moves into his parents’ basement after losing his job and separating from his wife. He is suffering from serious depression, rarely leaving his room and refusing to engage socially with anyone. His parents, who oscillate between worry, helplessness, and frustration, contact you for support. You urge them to encourage their son to seek help, and you suggest they set limits, if necessary, but you are left with a nagging feeling that this family needs more. Although you feel deeply for this family, you too feel helpless. Now imagine that you receive this same phone call, but you have at your disposal a set of tools tailor-made for this scenario. You inform the parents that, despite their son’s reluctance to connect and access supports, there is much that can be done and you can help them to support their son using interventions from emotion-focused family therapy (EFFT).  

1Emotion-focused family therapy is not to be confused with the similarly titled emotionally focused family therapy. Although they share similar roots, to our knowledge, the latter is a more traditional approach to family therapy, whereas emotion-focused family therapy is primarily focused on equipping caregivers with advanced skills to support their loved one struggling with a behavioral or mental health issues. Techniques from both models can work well together and we encourage readers to benefit from the models’ strengths in supporting families.

http://dx.doi.org/10.1037/0000166-001
Emotion-Focused Family Therapy: A Transdiagnostic Model for Caregiver-Focused Interventions, by A. Lafrance, K. A. Henderson, and S. Mayman
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EFFT is an innovative transdiagnostic approach to the treatment of mental health issues across the lifespan that involves caregivers for their healing power. EFFT is a flexible approach that can be used to treat many behavior or emotion-based disorders, and specific interventions can be adapted for use in other treatment approaches. Unlike other family therapies that are more systemic in nature, the goal of EFFT is to support parents, partners, and other carers to increase their role in promoting the health and wellness of their loved ones. To do so, EFFT clinicians teach a set of skills to caregivers that allow them to provide emotional and practical support to individuals of all ages and with a wide variety of challenges. In addition, EFFT practitioners attend to and transform the unprocessed or maladaptive emotions that can impede treatment progress, whether their own or those of caregivers, using a variety of techniques for improved outcomes. The EFFT model was designed to be flexible in its implementation with single families, carers only, dyads, and multicarer groups. In fact, one of the key strengths of the EFFT approach is that clinicians can guide caregivers to provide home-based support, even when their loved one refuses or is unable to access service. The tools and techniques of EFFT can also be integrated within other treatment modalities and at various levels of care to empower families and clinicians alike.

CORE PRINCIPLES

EFFT is built on a foundation of core principles that guide clinicians and therapists in their work. The first and perhaps most important guiding light is the belief that it is most therapeutically worthwhile for caregivers to implement behavioral and emotional interventions with their loved one. As such, EFFT privileges the caregiver’s role as an active agent of healing, regardless of their loved one’s age or motivation for change, and even when caregivers present with difficult behaviors or emotional challenges of their own. Second is the emphasis on the role that emotion processing plays in the onset and maintenance of mental health difficulties, given that it is a factor that may be more easily targeted in the service of symptom reduction. It is expected that in supporting their loved ones in these ways, caregivers will require “advanced caregiver skills”—skills not previously acquired or that are not required for “typical” caregiving. As such, a third principle relates to a focus on skill development and experiential practice. EFFT is also guided by the principle of “no blame,” meaning that caregivers are not to blame for the development of mental health challenges in their loved ones; they are instead conceptualized within a broader framework of historical and societal
influence, intergenerational trauma, and the expression of individual differences. Clinicians also commit to collaborating with caregivers in a manner that is transparent, in particular when it comes to clinical decisions. For example, the clinician does not determine whether the caregiver is capable of engaging in a particular intervention. Rather, they discuss together the risks and benefits of doing so, boosting caregiver empowerment and reducing the likelihood that the clinician will impede treatment progress on the basis of their own unspoken fears or assumptions. The final guiding principle of EFFT lies in the concept of the one-degree effect, in that even small shifts in caregiver attitudes and behaviors can lead to meaningful change in their loved one over time. This principle is meant to encourage EFFT clinicians to brainstorm ways to include caregivers who initially present as “incapable” or who may have previously been excluded from treatment due to limited resources or capacities.

**DEFINITION OF KEY TERMS**

Throughout this manual, the individual delivering EFFT is referred to as the *clinician* unless the technique being described is psychotherapeutic in nature and therefore reserved to those authorized to practice psychotherapy. In these cases, the term *therapist* is used. In the context of the model, we also use the terms *loved ones* and *caregivers*. The term *loved one* is defined as an individual who is affected by a behavioral or mental health issue, including a diagnosed mental disorder. A *caregiver* (also referred to as *carer* throughout this text) is an adult who cares about the welfare of the identified individual and who, in the context of their relationship, engages in caregiving to various degrees. Within this framework, caregivers can refer to parents or guardians, stepparents, grandparents, or other extended family members. A caregiver can also be a spouse, partner, or friend. Depending on the nature of the relationship, the caregiver’s involvement may differ in its intensity, and additional factors may be considered. For example, in parent–child dyads, there is a strong attachment within a hierarchical relationship, making it such that there is an expectation they will care for their child, and more so than other family members or important others. The extent to which they actively provide caregiving may change over time as a function of their child’s increased need or independence, their living situation, their relationship status, and the severity of their issues, but not simply because of their age. With respect to romantic partnerships, although there is an expectation of caring for one another, there is also an expectation of reciprocity, which requires consideration to maintain the health of the union.
When family members, significant others, or close friends are available on a limited basis or altogether unavailable, personal support and group home staff or nursing home attendants can also be recruited as caregivers, but this within the parameters of their employment.

**PURPOSE OF THE MANUAL**

This book serves as a clinical manual for the delivery of EFFT in the treatment of behavioral and mental health issues. It is intended to provide a comprehensive introduction to the model for those who are new to EFFT and a deepened understanding of its theory and application for those already familiar with the stance and its interventions. Throughout the book, we provide theory, research evidence, treatment protocols, and clinical examples of the application of EFFT across the lifespan in the context of different caregiving relationships, and across diagnoses. We also provide an in-depth description of its application in the context of eating disorders as an example of the therapeutic process that clinicians can apply to other disorders.

**INTENDED AUDIENCE**

It is our hope that this clinical manual will appeal to a wide range of health care professionals. Clinicians and students in the fields of psychology, social work, psychotherapy, and family counseling, including divinity counseling, will find this manual useful whether they adopt EFFT as a primary approach or as an adjunct to other approaches. We also hope to inspire our colleagues rooted in other therapeutic modalities to explore the amalgamation of theory, principles, and techniques of EFFT within their current work. In fact, we believe that whether someone is trained in cognitive and/or behavioral techniques, process experiential modalities, or structural family therapy, this book will build on existing clinician strengths and add significantly to one’s skill set in working with caregivers of individuals struggling with mental health issues. We also believe that clinicians working with children, adolescents, or adults can benefit from this manual to supplement individual interventions. We have found that doing so can offer hope to individuals and families who are suffering, especially when standard approaches have not yielded expected outcomes. Others who may benefit from this text include

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2Client information in the case examples has been disguised to protect confidentiality.
those in community public health and nursing, allied health (e.g., dietitians, physiotherapists, occupational therapists) education (e.g., teachers, professors, guidance counselors), and child and youth work. The skills in this book can help to navigate difficult conversations, improve treatment engagement and cooperation, and guide caregivers to support their loved one’s health and wellness in various contexts.

**CHAPTER OUTLINE**

The five modules in EFFT include (a) emotion coaching, (b) behavior coaching, (c) therapeutic apologies, (d) caregiver blocks, and (e) clinician blocks. In the first three modules, caregivers are equipped with tools to support their loved one to process overt and underlying emotions fueling problematic behaviors, interrupt symptoms and increase health-focused behaviors, and heal relational injuries to strengthen the power of their efforts. The remaining modules are clinician-led and involve techniques to address the emotional states fueling therapy-interfering attitudes and behaviors in caregivers and clinicians that arise throughout treatment.

Chapter 1, “Emotion-Focused Family Therapy Explained,” provides an in-depth exploration of the development and application of EFFT, including an elaboration of core principles and modalities of treatment delivery.

Chapter 2, “Emotion Coaching,” introduces theory and research supporting the focus on emotions and emotion processing, followed by a practical introduction to the model of emotion coaching. Commonly encountered challenges faced by caregivers and the clinicians who support them are also presented.

Chapter 3, “Behavior Coaching,” provides a framework for empowering and supporting caregivers to lead behavioral interventions in the home setting. Clinical scenarios and sample scripts are provided.

Chapter 4, “Therapeutic Apologies,” introduces the module on this topic and guides the reader through the theory, principles, and intervention techniques to relieve self-blame and strengthen family relationships—and therefore the impact of caregiver supportive efforts. The ingredients of a skilled therapeutic apology are also highlighted through clinical vignettes.

Chapter 5, “Working Through Caregiver Blocks,” introduces the reader to the model’s conceptualization of problematic caregiver attitudes and behaviors as stemming from unprocessed or maladaptive emotion. Building on this theoretical foundation, the chapter then describes various tools and techniques for clinicians to use in supporting caregivers to work through such blocks.
Chapter 6, “Working Through Clinician Blocks,” extends the theory of blocks to clinicians and treatment teams. The reader is guided to engage in self-reflection or guided supervision activities to work through emotional reactions that can affect treatment decisions and therapeutic outcomes.

Chapter 7, “Emotion-Focused Family Therapy for Eating Disorders,” provides a detailed example of the model’s application in the context of a specific mental disorder. This chapter provides examples of the ways in which each of the modules in EFFT can be integrated in the treatment of eating disorders with clinical examples and vignettes. Although this chapter reviews symptoms and strategies that are specific to eating disorders, such as meal support to promote normalized eating, the underlying principles of EFFT are emphasized throughout the chapter, illustrating a general process that can be adapted to other behavior and emotion-based disorders.

Chapter 8, “Frequently Asked Questions and Future Directions,” reviews the answers to questions that are most frequently asked during EFFT trainings and supervision. We also introduce extensions of the model for those individuals who struggle with an eating disorder and a comorbid substance use disorder, as well as emotion-focused applications in school settings and in health care more broadly.

The reader will note that each chapter begins with a quote from a caregiver and ends with a testimonial from a clinician. We share their enthusiasm and gratitude with readers to provide inspiration to integrate these teachings into practice, even if they reflect a shift in practice corresponding to a single degree. The epilogue includes personal reflections from the authors about the impact of EFFT on their personal and professional lives, followed by appendices that include supplemental materials to support the implementation of skills outlined throughout the book, including caregiver handouts and other therapeutic tools.3

**NEXT STEPS**

This manual is meant to serve as an introduction to the model and a guide for implementation. In fact, we encourage readers to integrate these tools and techniques into their work with clients knowing that they can rely on their existing clinical or psychotherapeutic skills should they encounter challenges with implementation. That being said, the interventions presented

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3The handouts in the appendices are also available online at this book’s companion website so that clinicians can download and distribute them to their clients (http://pubs.apa.org/books/supp/lafrance/).
do require a minimum level of training when a clinician is working with a mental health disorder, especially given that competence is an essential element of ethical practice, as stated in Section 2: Competence of the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association [APA], 2017a). We also strongly recommend obtaining supervision to ensure implementation adherence. Those interested in deepening their knowledge of EFFT are encouraged to view the this book’s companion video where the first author (AL) demonstrates the use of caregiver block chair work in a live demonstration, followed by a discussion of the theoretical underpinnings of the approach more generally.\footnote{This book’s companion video is available online (https://www.apa.org/pubs/videos/4310012).} Readers may also be interested in attending one of the many online and in-person trainings recognized by the International Institute for Emotion-Focused Family Therapy. These core and advanced trainings are offered by highly skilled facilitators who provide standardized training opportunities to interested educators, clinicians, and therapists worldwide. Certified facilitators commit to ongoing personal and professional development, as well as the embodiment of EFFT principles in their personal and professional lives. Certification pathways are available for clinicians (e.g., nurses, dietitians) and therapists (e.g., psychologists, psychotherapists, social workers) committed to the practice of EFFT and involve minimum training and supervision requirements. For more information on training opportunities and certification requirements, visit the International Institute for Emotion-Focused Family Therapy’s website (https://efftinternational.org).

Finally, although outside of this book’s scope, clinicians must consider cultural factors that influence familial structures and behaviors in the implementation of EFFT. Although the model has been shown to be applicable worldwide (including in Europe, Central and South America, and Asia), systematic research is required to clarify the nuances in its application across cultures. Until then, we direct readers to APA’s (2017b) recently updated Multicultural Guidelines for guidance and inspiration.
This approach changed my outlook and mind-set and gave me the tools I needed to support my child, and with confidence.

—Caregiver

Codeveloped by psychologists Adele Lafrance and Joanne Dolhanty, the essence of emotion-focused family therapy (EFFT) is to empower caregivers to take on an active role in the healing of their loved one’s mental health issues. The recruitment of caregivers extends beyond childhood and adolescence to the full lifespan, and the foci of interventions are both behaviorally based and emotion focused. Specifically, the EFFT clinician is tasked with supporting caregivers to support their loved one with the interruption of symptoms and the increase of health-focused behaviors, the processing of overt and underlying emotions fueling problematic behaviors and symptoms, and the repair of relational injuries to strengthen the power of their efforts. Throughout treatment, the EFFT clinician also seeks to transform emotion blocks in caregivers who struggle to support their loved one. Such
emotion blocks are also identified and processed in clinicians as they implement these interventions.

This focus on the engagement of caregivers as an extension of the treatment team can represent a departure from conventional methods, particularly when clients are adults. However, given the dearth of services available to those struggling—whether due to psychological or financial barriers—the model offers the possibility of filling important gaps in the mental health care system. More important, given that outcomes are improved for all involved in treatment efforts, EFFT offers the possibility of healing that extends far beyond the identified client.

THE SIX PILLARS OF EFFT

The pillars of EFFT were elaborated to clarify the therapeutic stance of the model for families, clinicians, and policymakers, enabling them to make an informed decision about engagement. They serve as guideposts in the integration of EFFT theory and interventions within one’s practice, and, when grounded in the spirit of the model, clinicians can navigate tricky scenarios with increased confidence. Over time and with more experience, EFFT clinicians can also bring creativity and flexibility to their application of the techniques, knowing that these reference points maintain their alignment with the core therapeutic values.

Caregiver Empowerment and Involvement

The first and perhaps most important pillar of EFFT relates to the recruitment of caregivers as active agents of healing. Caregivers represent an often-untapped resource for enhancing change in individuals who struggle with mental health issues. As we often state to caregivers in the initial stages of therapy, caregivers know their loved ones best and love them the most; therefore, we can harness the power of their bond for healing. Caregiver efforts are also thought to be more neurologically powerful than those of a stranger, including a trained clinician, and even when those efforts are imperfect or of lesser intensity (Bartels & Zeki, 2004; Cassidy & Shaver, 2002; Hughes & Baylin, 2012; Siegel, 2010). There are other practical reasons for the involvement of carers. First, those who struggle with behavioral or mental health issues often live at home, with a spouse or partner, or are dependent on their families in some way. Therefore, it is sensible to equip these individuals with evidence-based skills for use in day-to-day interactions. When caregivers can offer support in the real-world settings where
their loved one is most likely to struggle, outcomes also improve (Gordon, Arbuthnot, Gustafson, & McGreen, 1988; Henggeler et al., 1999). Finally, some caregivers report tremendous frustration with mental health systems that are underresourced and therefore ill-equipped to meet their loved one’s needs. They often find themselves on the outskirts of treatment when they could be utilized to fill in these systemic gaps. Providing caregivers with an active role in the service of their loved one’s healing also decreases their feelings of powerlessness and paralysis, which can lead to burnout, relationship strain, and problematic behavior patterns (Sepulveda, Lopez, Todd, Whitaker, & Treasure, 2008). Finally, it is sometimes the case that individuals who seek out their own therapy for significant mental health issues terminate service when their pain begins to surface. This leaves the clinician without avenues to reengage the client, especially if they are considered high risk. If caregivers are involved in some way, even peripherally, they can continue to receive services on behalf of their loved one as surrogate healer.

There are some cases in which the recruitment of a caregiver may prove challenging. Some carers initially refuse to be involved or insist on individual therapy for their loved one. Clinicians may also determine that caregiver involvement is inappropriate or potentially harmful, or they do not feel equipped to work with the parents or caregivers of their clients. In these instances, EFFT provides a framework for working through such impasses to facilitate or increase the involvement of caregivers in a manner that is developmentally sensitive. In fact, one of the core beliefs in EFFT is that regardless of their age, people want to be supported by their carers, and carers want to support their loved ones in healing. Filtered through the EFFT lens, resistance to carer involvement in treatment (on the part of the caregiver, the loved one, or the clinician) is believed to be rooted in fears about the potential negative outcomes related to such involvement or fueled by other unprocessed emotional states (e.g., hurt, resentment) that can be targeted and transformed.

**Focus on Emotion Processing**

Within the EFFT perspective, it is theorized that problematic emotion processing plays a key role in the onset and maintenance of behavioral problems and mental health issues (e.g., depression, anxiety). Emotional avoidance (i.e., suppressing or ignoring emotions) is also considered a maladaptive coping strategy that drives a variety of symptoms. Although numerous factors (e.g., genetics, culture, trauma) can contribute to the development of a mental health disorder, the ways in which individuals and their families attend to and process emotions can actually be targeted and transformed.
Thus, the EFFT clinician supports carers to support their loved one with emotion processing. By doing so, loved ones will be more likely to turn to their caregiver in times of overwhelm, rather than to symptoms or problematic behaviors, to cope. Over time, this support will also lead to the internalization of the loved one’s capacity to manage emotions in healthier ways.

**Focus on Skill Development**

While a respect for the capacity of carers to activate their own internal resources to support their loved one is inherent in the EFFT approach, so too is the provision of skill training. These skills are referred to as *advanced caregiving skills* because they are not required under typical circumstances and their absence does not trigger the development of mental health issues. One parent captured the spirit perfectly when she realized that “not using these skills didn’t get us here, but using them can get us out.” When teaching these skills, repeated experiential practice is essential for caregivers to develop the capacity to override default modes of responding to their loved one, and instead draw on their newly acquired skills when needed.

**Foundation of No Blame**

EFFT is an approach that takes a firm and explicit stance of “no blame.” In part philosophical and in part spiritual, this stance is supported by various lines of research relating to myriad factors that contribute to mental health issues (and the complex relationships among them; Uher, 2014; Uher & Zwicker, 2017) as well as the evidence for the generational echo of trauma (Dias & Ressler, 2014; Schickedanz, Halfon, Sastry, & Chung, 2018). In fact, one of the primary foci of intervention is to support caregivers to release their narratives of self-blame. It is our experience that caregivers often blame themselves, whether overtly or covertly, when their loved one struggles with mental illness. Their self-blame can lead to the experience of deep pain, potentially problematic interactional cycles, and an overall sense that “I can’t be the solution if I caused the problem.” As such, when caregivers share with us their shortcomings or the “mistakes” they’ve made, however serious, the EFFT clinician guides them to widen their lens of interpretation to understand at a much deeper level that they did their best with the internal and external resources to which they had access. With this wider lens, the notion of blame becomes irrelevant, and its effect on caregivers is diminished. When the EFFT clinician takes time to explore and actively work through caregivers’ self-blame with structured interventions, he or she
also supports them in rewriting the narrative of the family’s life in a way that is more compassionate.

Collaboration and Transparency

Within EFFT, the relationship between the clinician and the caregiver is collaborative and transparent. Caregivers are the experts on their loved one and the one most available to effect change, while the clinician is the expert on mental health issues. Clinicians do not make decisions about the appropriateness of caregiver involvement nor do they establish the treatment goals without caregiver input. The clinician uses a genuine and transparent approach in sessions, providing the caregiver with the same information as any other member of the treatment team. When the clinician is concerned about the caregiver’s capacity to engage in a task, the clinician brings these concerns to session for discussion. For example, should a therapist worry about a caregiver’s capacity to engage in caregiver block chair work, she would be honest in communicating her concerns and work with the caregiver to determine whether it is in fact an appropriate intervention, and if so, whether the timing is right. This level of transparency boosts rapport and enhances caregiver empowerment. Perhaps equal in importance is the effect that this transparent approach has on the clinician. This way of being with clients serves to protect clinicians from their own fears or clinician blocks, including making incorrect assumptions about a caregiver’s capacity to engage in specific ways.

The One-Degree Effect

The final pillar of EFFT lies in the concept of the one-degree effect. Consider the following: If a plane flew from Toronto to Chicago and its navigation was off by a single degree, it would travel 92 feet off course for every mile flown—a slightly different trajectory with a vastly different outcome. For this reason, when clinicians ask us how best to determine a caregiver’s capacity to engage in EFFT, the simple answer is: “We don’t.” Clinicians aim to engage carers as much as possible. In situations where a caregiver is underresourced or severely limited (e.g., in hospital, incarcerated, or struggling with severe mental health issues) and members of the treatment team feel discouraged or hopeless about their capacity for involvement, the goal is to work toward a change in the caregiver’s interactional style that corresponds to a single degree. Clinicians do so knowing that it can be the beginning of a significant shift over time, even though they may not see the results during the
course of treatment. We have personally observed tremendously positive outcomes of the one-degree effect, even when carers presented initially as resistant, in denial, critical, dismissive, hopeless or suffering from physical or mental illness or a personality disorder. This uncovering of caregiver capacity is a central task within EFFT and one that can only be achieved when the clinician holds a deep belief in caregivers’ abilities to contribute to their loved one’s recovery, even in seemingly minor ways. In fact, we take seriously the notion that a little can go a long way. The guiding principles of EFFT, listed in Exhibit 1.1, embody the heart of the approach and are considered the clinical “guiding lights,” especially when clinicians recognize the emergence of their own blocks.

**EFFT MODULES**

There are five modules in EFFT. Three of these involve the empowerment of caregivers to actively support their loved one via emotion coaching, behavior coaching, and the initiation of therapeutic apologies, if relevant. Skills and strategies related to each of these modules are taught to caregivers for implementation in family sessions, dyad sessions, or outside of the office. The remaining modules, those of identifying and working through caregiver and clinician blocks, are clinician-led and involve tools and techniques to address therapy-interfering attitudes or behaviors in carers and clinicians that are expected to emerge throughout treatment.

**EXHIBIT 1.1. Guiding Principles of Emotion-Focused Family Therapy**

Loved ones yearn for the support of their caregivers, even when they try to convince the clinician or therapist otherwise.

Caregivers are motivated to support their loved ones to heal, even when they try to convince us otherwise.

Carers struggling with mental health issues themselves do not require extensive psychotherapy to engage in EFFT in meaningful ways.

Even when severely underresourced, caregivers can make small yet significant contributions to their loved one’s mental health.

With targeted support, carers can move through emotion blocks that may be keeping them paralyzed or stuck in unhelpful patterns of relating to their loved ones.

Caregivers need to be empowered and provided with skills and opportunities for experiential practice to support the realization of their potential.

Clinicians are not immune to the influence of emotion blocks. They can work through these blocks to help the family get on track with wellness, even in dire circumstances.
Emotion Coaching

Carers are equipped with advanced skills to support their loved one with emotions. In doing so, they aid in the transformation of the loved one’s inner world, addressing problematic patterns of emotion processing that fuel mental health issues. To lay the foundation for the emotion-coaching framework, the EFFT clinician teaches caregivers about the nature of emotion, as well as its role in the onset and maintenance of mental health issues. Caregivers then learn the steps of emotion coaching, derived from the theory of emotion processing in emotion-focused therapy (EFT; Greenberg, 2015, 2017) and influenced by Gottman (Gottman, Katz, & Hooven, 1996). The emotion-coaching module includes a comprehensive five-step model of emotion coaching and a brief two-step model. The two-step model was developed in response to caregivers who required a simplified approach that could be effective in the face of emotions, thoughts, urges, and behaviors, although both versions can be used to enhance the implementation of other EFFT interventions as well as to strengthen relationships.

Behavior Coaching

Mental health issues often involve behavioral symptoms. Caregivers are encouraged to support the interruption of these symptoms as well as the development of health-focused behaviors. The ways in which caregivers can support their loved one in doing so will vary according to their symptom profile. For instance, caregivers with a loved one suffering from an eating disorder will be taught strategies for meal support as well as tools to interrupt related behaviors such as purging and compulsive exercising (refer to Chapter 7 for more information). A caregiver with a loved one suffering from anxiety will be coached to codevelop a fear hierarchy followed by the facilitation of graduated exposures in real-world settings. Regardless of the symptoms targeted, caregivers are encouraged to combine the skills of this module with the strategies of emotion coaching to maximize effectiveness.

Therapeutic Apology

Inspired by the facilitation of forgiveness in EFT for couples (Greenberg, Warwar, & Malcolm, 2010; Meneses & Greenberg, 2011, 2014), the therapeutic apology intervention is a psychotherapeutic technique that involves the delivery of a specifically constructed apology to support the resolution of old pain and strengthen the caregiver–loved one relationship, given that it is the vehicle for the behavioral and emotional interventions. This intervention can also lead
to relationship reconciliation or releasing the loved one, caregiver, or both from maladaptive self-blame. This is a powerful mechanism for strengthening family bonds, and many caregivers find it helpful across a broad range of circumstances; it is perhaps the most potent of the EFFT interventions.

**Caregiver and Clinician Blocks**

Within the context of family-based treatment, it is expected that unprocessed or maladaptive emotion will negatively affect carers as they make attempts to understand and support their loved one. For example, when the caregiver presents as unmotivated, unwilling, or uncaring, EFFT theory posits that these clinical presentations are merely symptoms of an emotion “block” in need of processing. Within this fourth module, the most common emotion blocks include fear, shame, hopelessness, helplessness, and resentment. The clinician is encouraged to use various tools and techniques to support the caregiver in working through the emotion block driving the problematic attitudes or behaviors. Strategies to work through these blocks include increasing awareness of common blocks and their emotional drivers as well as engaging in experiential exercises (i.e., role-play, two-chair dialogues) to transform them.

**Clinician Blocks**

Emotion blocks can also occur in clinicians and teams as they support caregivers and their loved ones. As such, the model includes a fifth and final module related to the resolution of such blocks. Similar to caregiver emotion blocks, EFFT clinicians identify and work through their own emotional reactions that arise as they provide treatment through self-guided, peer- or hierarchical “emotion-focused” supervision. For example, we’ve observed that clinicians can be less likely to engage carers who present with high expressed emotion, who engage in overt criticism of the loved one, or who display symptoms of a mental health issue or personality disorder, particularly when the client is an adult. Although there may be valid concerns about involving certain caregivers in treatment, attending to the emotions evoked in such cases can open new avenues for clinicians to work with them in some manner and, in some cases, guided by the principle of the one-degree effect.

**Integrating EFFT Modules in Other Treatment Settings**

Clinicians can use most of the tools and techniques within each of the modules to support clients and their families at various levels of care. Those
involved in care may include medical professionals, psychologists, social workers, nurses, dietitians, educators, and others who interact with individuals, parents, and families in the service of physical and mental health. The exceptions include the psychotherapeutic strategies involved in therapeutic apologies and caregiver block chair work, which are reserved for those with specific training and credentials for the delivery of psychotherapy.

**EFFT IN PRACTICE**

Guided by the principles underlying EFFT and supported by the tools and techniques, clinicians can work with families in various ways. The most common methods of delivery include variations of caregiver-focused, family-based and dyadic applications, multicaregiver workshops, and the integration of tools and techniques within other evidence-based treatment modalities.

**Caregiver-Led EFFT**

Caregiver-led EFFT is one of the more common approaches to implementing the model. Within this method of delivery, the therapeutic work occurs primarily with a caregiver or cocaregivers. These sessions can occur weekly over the course of several months as in traditional models, or they can occur in the context of an intensive piece of work. An intensive piece of work involves a focus on one or two identified goals to increase caregivers’ capacity to support their loved one in specific ways. This short-term application usually consists of three to six sessions of 2 hours, every 2 to 3 weeks, to ensure opportunities for integration and practice of learned skills. Before participation, parents and caregivers are invited to review online EFFT resources as a primer. Once engaged in the treatment, the clinician and caregivers establish a set of goals to guide the integration of the modules. For example, the parents of an anxious child who is unable to sleep in her own bed may choose to focus on the integration of emotion-coaching skills to support behavioral exposure exercises. Should one of the caregivers hesitate to follow through on the agreed-on interventions (e.g., fearing the intervention will cause the child too much distress), the emotional states fueling this resistance are processed to resume working on the targeted behavior. Therapeutic apologies are integrated as necessary—whether to strengthen the relationship, to increase the power of the caregiver’s efforts, or to release the caregiver or the loved one of self-blame. Table 1.1 outlines an example of a short-term framework developed to support the parents of
<table>
<thead>
<tr>
<th>Number of sessions</th>
<th>Concepts to cover</th>
<th>Resources to provide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>Validate parents’ experience seeking treatment.</td>
<td>Super-feeler handout</td>
</tr>
<tr>
<td></td>
<td>Collaborate on the identification of clear goals for the piece of work.</td>
<td>Caregiver Traps Scale</td>
</tr>
<tr>
<td></td>
<td>Introduce contributing factors to behavioral and mental health issues, including their loved one’s status as a super-feeler, if relevant.</td>
<td>Relationship Dimensions Scale</td>
</tr>
<tr>
<td></td>
<td>Reframe their loved one’s symptoms as maladaptive coping strategies to manage stress and emotional pain.</td>
<td>Animal Metaphors Handout</td>
</tr>
<tr>
<td></td>
<td>Introduce the New Maudsley method’s animal metaphors; provide psychoeducation and identify polarizations, if relevant.</td>
<td>Tree Metaphor Handout</td>
</tr>
<tr>
<td></td>
<td>Introduce the caregiver block framework, including the paper-and-pencil tools to facilitate the identification of potential blocks.</td>
<td>Website link: <a href="http://www.emotionfocusedfamilytherapy.org">http://www.emotionfocusedfamilytherapy.org</a></td>
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<tr>
<td></td>
<td>Introduce the skills of emotion coaching (brief version) with in-session opportunities for targeted practice relating to goals.</td>
<td></td>
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<tr>
<td></td>
<td>Set behavioral and emotion coaching goals related to presenting problem.</td>
<td></td>
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<tr>
<td></td>
<td>Encourage carers to share with their loved one what they learned in the session, excluding specifics relating to caregiver blocks.</td>
<td></td>
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<tr>
<td></td>
<td>Invite coparents to support one another with emotion coaching when faced with challenges, if relevant.</td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>Review parents’ attempts at meeting behavioral and emotion coaching goals in the home setting.</td>
<td>Relationship Repair worksheet (if relevant)</td>
</tr>
<tr>
<td></td>
<td>Highlight successes and challenges, including the manifestation of caregiver blocks.</td>
<td></td>
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<tr>
<td></td>
<td>Engage in caregiver block chair work related to identified blocks in the implementation of home-based interventions.</td>
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<tr>
<td></td>
<td>Introduce and practice a therapeutic apology, if appropriate.</td>
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</tr>
<tr>
<td></td>
<td>Set behavioral and emotion coaching goals related to presenting problem.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Set therapeutic apology goals, if relevant.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prepare for the end of the piece of work.</td>
<td></td>
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</tbody>
</table>
TABLE 1.1. (Continued)

<table>
<thead>
<tr>
<th>Number of sessions</th>
<th>Concepts to cover</th>
<th>Resources to provide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>Review behavior, emotion coaching, and therapeutic apology goals.</td>
<td>Website link for caregiver videos and resources: <a href="http://www.mentalhealthfoundations.ca/resources">http://www.mentalhealthfoundations.ca/resources</a></td>
</tr>
<tr>
<td></td>
<td>Process caregiver blocks using emotion coaching and chair work, if necessary.</td>
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<tr>
<td></td>
<td>Review the guiding principles of EFFT.</td>
<td></td>
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<tr>
<td></td>
<td>Set short and long-term behavioral and emotion-coaching goals related to the presenting problem.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Set short and long-term goals for a therapeutic apology, if relevant.</td>
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<tr>
<td></td>
<td>Bring closure to the piece of work and plan for next steps.</td>
<td></td>
</tr>
<tr>
<td>Next steps</td>
<td>Depending on the severity of the situation, next steps may include regular boosters</td>
<td>Website link for online parenting series: <a href="http://www.mentalhealthfoundations.ca/parent-coaching">http://www.mentalhealthfoundations.ca/parent-coaching</a></td>
</tr>
<tr>
<td></td>
<td>to support the work, or carers may be encouraged to take a treatment break to practice their skills.</td>
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</tr>
<tr>
<td></td>
<td>Treatment breaks are typically 2 to 3 months in duration. Parents are also encouraged to refer to online EFFT resources between sessions.</td>
<td></td>
</tr>
<tr>
<td>Considerations for separated and blended families</td>
<td>When working with parents who are separated, you may discuss the benefits of meeting in the same session or in separate sessions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>We also recommend the involvement of stepparents and extended family members significantly involved in caregiving.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>It is important to acknowledge some of the challenging dynamics that can arise with separated and/or blended families, including the ways in which they can reinforce problematic caregiving styles.</td>
<td></td>
</tr>
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</table>
Family-based EFFT

The EFFT clinician can also work with parents and their children, spouses, or caregivers and their loved ones in the same session, introducing the modules of the model, developing home-based treatment plans and facilitating emotional or relational work in vivo. For example, the clinician may support the development of behavioral protocols, assist carers to engage with their loved one using the skills of emotion or facilitate a therapeutic apology, if relevant. The clinician may also support the caregivers to meet their loved ones’ needs for security or identity development (Greenberg & Goldman, 2008). In high-conflict scenarios, it may be helpful for the clinician to support the identification of negative cycles of interaction between the caregiver and their loved one or between coparents (Greenberg & Johnson, 1988; Johnson, 2004). Doing so increases awareness of vicious cycles, deescalates conflict, and develops new narratives for the family.

Throughout treatment, when caregiver blocks emerge, the EFFT clinician attends to family members affected by the block and supports the caregiver to move through the stuck point with psychoeducation, emotion coaching, or a combination of these. Should the carer remain blocked, the EFFT clinician may choose to meet with the caregiver on his or her own for a few sessions, as an adjunct to the family work. The clinician may also identify dyads within the family most in need of attention and structure a targeted piece of work to address potentially problematic dynamics.

Two-Day EFFT Caregiver Workshop

Based on the principles of EFFT, a structured, manualized intervention was developed first for parents of individuals with eating disorders and then extended for delivery among carers of loved ones with a variety of presenting problems. The initial format involved a weekly multicarergiver group format with eight to 10 participants to address the needs of a regional outpatient eating disorder program. Although caregiver feedback was positive and research findings demonstrated encouraging outcomes (Kosmerly et al., 2013), many parents and caregivers struggled to attend each of the eight sessions. In response to this observation, a 1-day intervention was developed and piloted with three groups of 15 to 20 caregivers in treatment or on a wait list. Throughout the day, material from each of the EFFT modules was
presented, with techniques practiced in the context of role-plays. As a result of caregiver feedback, the intervention was expanded and delivered over the course of 2 days to offer participants more opportunities to work with the different modules, and in particular those relating to emotion coaching and caregiver blocks. Over time, the main goals of the intervention were to educate and support caregivers in mastering the skills involved in emotion coaching, behavior coaching, and working through emotion blocks to effective support, with opportunities for skills practice (Lafrance Robinson, Dolhanty, Stillar, Henderson, & Mayman, 2016). Parents and caregivers also streamed in by video from up to three additional rural sites, where clinicians were present to support the uptake of the intervention. Lafrance, Henderson, and Mayman then manualized the 2-day caregiver workshop to study caregiver outcomes across eating disorder programs in Canada (Strahan et al., 2017). From there, it was adapted for use more broadly, and it is now regarded as a transdiagnostic intervention for emotion-based disorders.

Currently, the 2-day workshop is administered by two certified facilitators and delivered to carers in a workshop setting. The group-based setting allows for vicarious learning and mutual support as participants work through various experiential activities related to each of the modules together. Some caregivers engage in the workshop as an adjunct to treatment, whereas others derive benefit as a primary treatment, including repeat attendance or additional one-to-one sessions to refine their skills. Today, many certified facilitators are providing this intervention throughout the world in community-based settings for prevention and early intervention, as a wait-list intervention in outpatient mental health, or as a part of the treatment curriculum in higher levels of care. Organizations have also adopted this intervention to replace the traditional “family and friends” support groups in line with a shift in affording caregivers a more active role in their loved one’s health and wellness. The 2-day EFFT caregiver workshop continues to evolve based on parent and caregiver feedback and multiple research projects are in progress.

**Adjunctive to Other Treatment Models**

EFFT is perhaps best known for its integration within other well-established treatment models. Many clinicians and therapists who attend EFFT trainings are already rooted in a therapy modality with which they feel well aligned. In these instances, it is not practical, nor is it necessary, for experienced clinicians to abandon what they have learned. Rather, EFFT was developed for integration within other modalities to harness the strengths of each approach. The following are examples of the integration of EFFT modules within established treatments.
Supplementing Interventions With Individual Clients
Modules of EFFT can supplement individually focused interventions to increase the structured involvement of carers. When individually focused interventions are primary, parents and caregivers can be recruited separately to learn skills consistent with the treatment approach to support their loved one’s efforts in the home setting. For instance, cognitive behavior therapists may teach parents and caregivers to lead activities to address their loved one’s cognitive distortions, facilitate interoceptive exposures, and support the practice of progressive muscle relaxation. They may also integrate the skills of emotion coaching to address resistance and increase the positive impact of their supportive efforts.

Processing Caregiver Blocks in Family-Based Therapies
Caregiver block interventions can increase the potency of family-based therapies for those who do not respond to standard care. Regardless of the family therapy orientation, the Relationship Dimensions Scale described in Chapter 5, this volume, can be used with each of the family members. Doing so can illuminate new paths for healing by identifying relational vulnerabilities and polarizations within systems and subsystems. Caregiver block chair work (see Chapter 5) can also be integrated within adjunctive sessions of family therapy when carers become stuck in patterns of criticism, hopelessness, or problematic patterns of engagement. Currently, a working group is exploring the integration of emotion coaching and caregiver block chair work within family-based treatment for eating disorders. These modules would be introduced to parents and caregivers whose loved one has not gained sufficient weight within the first few weeks of treatment, a critical target that can predict treatment outcome.

Processing Clinician Blocks in All Forms of Treatment
The clinician blocks module can provide a framework for working through clinician or team blocks, regardless of therapeutic modality or treatment setting. Perhaps the most straightforward to integrate within clinical settings, the Clinician Traps Scale, described in Chapter 6, can be used to quickly identify potentially problematic reactions to individual clients, couples, or families. Likewise, the clinician block chair work can be used to explore and move through problematic attitudes or behaviors or assist in decision-making processes to increase clinical objectivity. For example, an adult inpatient psychiatry team uses this framework during monthly team meetings, during which a clinician who is reacting negatively to one of the patients will volunteer to engage in experiential chair work facilitated by a colleague. Team
members observe the process, benefiting from the vicarious processing of their own potential blocks. They then engage in a practice of debriefing, allowing the experience to inform care practices. Doing so also creates a culture on the unit where clinician blocks are regarded as normal and where their processing allows for improved team dynamics by revealing shared vulnerabilities.

There are numerous other examples of the integration of EFFT principles, tools, and techniques within existing treatments. The current state of mental health interventions reflects a need for new and innovative treatments, and we believe that working together across various modalities can lead to promising developments. As such, we hope to inspire readers to explore the amalgamation of theory, principles, and techniques from cognitive behavior, emotion-focused, somatic, experiential, and other approaches.

### The Role of Individual Therapy in EFFT

EFFT was developed for use primarily with families, dyads, and parents and caregivers. As such, EFFT therapists tend to prioritize caregiver involvement over the delivery of classic individual therapies, if at all possible, especially when the affected individual is a child or an adolescent. However, this work does not need to be at the exclusion of individual treatment plans that are often helpful and necessary. As such, it is our belief that when EFFT clinicians are guided by the therapeutic principles, and hold on to the deep belief in the healing power of families, they can skillfully navigate the provision of service to individuals and their caregivers, as necessary. For example, adjunctive individual work is likely appropriate if the client's symptoms are deeply entrenched, as are their caregiver's emotion blocks. The therapist then serves to support both the individual and his or her carer(s), in separate sessions, building an emotional bridge between them. It is also appropriate with clients with more long-standing or challenging issues who require more intensive support.

When EFFT therapists engage clients in individual psychotherapy as a primary or adjunctive mode of treatment, they hold in mind certain considerations to maximize benefit. First, when clients develop a therapeutic alliance with an individual therapist, without careful management, it can become a competing emotional attachment, leading to a distancing from parents, caregivers, or relationship partners. Therefore, when working with clients individually, EFFT therapists are careful to preserve healthy attachment with caregivers to avoid this problematic shift and promote the strengthening of these bonds as part of the therapeutic goals. Second, in an
effort to validate their client’s suffering, some well-intentioned therapists can place too much emphasis on the shortcoming of their client’s significant relationships without cultivating in them a belief that they are loved and that their carers are doing their best. The risk increases when clinicians have strained or estranged relationships with significant others themselves because this unfinished business can cloud their judgment and limit their belief in others. In these instances, EFFT therapists ensure they engage in regular experiential supervision to mitigate this potential, knowing that for the deepest healing to occur, clients must feel validated in their pain and have the capacity to hold anger, hurt, and love toward their loved ones.

**EFFT RESEARCH**

Research on EFFT was first conducted in the context of eating disorder treatment across the lifespan. Qualitative outcomes of an 8-week parent group of transitional age adults with an eating disorder revealed that participation in the intervention led to decreases in caregiver shame and guilt and increases in self-confidence, motivation, and hope (Kosmerly et al., 2013). Participants reported improved family functioning in general and specific to the relationship with their loved one. They also felt the module on emotion coaching was the “missing piece” in family-based treatment. Finally, parents involved in the study were more aware of their emotion blocks and had a better understanding of the nature of the illness, including the ways in which symptoms and their underlying emotions could be addressed in the home setting (Kosmerly et al., 2013).

Quantitative research on the application of EFFT for eating disorders within a 2-day workshop setting also revealed positive outcomes for caregivers (Davidson, Stillar, Hirschfeld, Jago, & Lafrance Robinson, 2014; Hirschfeld, Stillar, Davidson, Jago, & Lafrance Robinson, 2014; Lafrance Robinson, Dolhanty, Stillar, Henderson, & Mayman, 2016). A pilot study of a 2-day EFFT intervention for parents of adolescent and adult children (mean age of 18 years) with ED led to healthier attitudes with respect to their children’s emotions and their role as emotion coach. Parents also reported increased parental self-efficacy, a reduction in the fears associated with their involvement in treatment, and a decrease in self-blame. With respect to their active role in their loved one’s recovery, parents reported greater intentions to implement strategies that were consistent with the targeted treatment domains. Levels of satisfaction with the intervention were also high (Lafrance Robinson et al., 2016).
Process research has been conducted to explore the theoretical underpinnings of EFFT. Relationships were explored between common emotion blocks and caregiver outcomes among a sample of 137 carers (parents, step-parents, relatives, and partners) of a loved one diagnosed with an eating disorder. Specifically, results revealed that caregiver fear and self-blame were predictive of lower levels of caregiver self-efficacy and increased engagement in accommodating and enabling behaviors (Stillar et al., 2016). An EFFT process model was then tested in the context of a 2-day EFFT intervention for parents of loved ones with an eating disorder across various treatment sites. The results showed that the intervention was effective in decreasing parental fear and self-blame, which subsequently led to an increase in parental self-efficacy and an increase in positive intentions to engage in treatment-enhancing behaviors (Strahan et al., 2017). These results underscore the importance of transforming parental fear and low self-efficacy to support carers to become positive and active agents of healing in their loved one’s treatment.

The application of EFFT has also been researched in the context of parenting and mental health. A Norwegian study of EFFT (Bøyum & Stige, 2017) revealed that 2 to 4 months after a 2-day parenting workshop, parents who were interviewed reported feeling more secure in their parenting role and more confident in their abilities. They also reported an increase in their understanding of their child, increased focus on emotions in relationships, and improved communication. Parents shared that despite how challenging the work, they continued to make efforts to implement their new skills with positive results.

Most recently, a large-scale study examined the long-term outcomes of a 2-day EFFT caregiver intervention for general mental health (Foroughe et al., 2018). Parents of children, adolescents, and young adults were the target of the interventions, and their children suffered from a variety of issues, including neurodevelopmental disorders, anxiety disorders, mood disorders, disruptive disorders, feeding and eating disorders, substance-related disorders, and other emotional, social, or relationship difficulties warranting clinical attention. One hundred and twenty-nine parents completed the intervention and provided data a week before intervention, postintervention, and at 4-month follow-up. Among other outcomes, participant parents experienced reductions in fears and increased self-efficacy regarding their role in their child’s recovery, and their children experienced reductions in symptoms that were sustained over time.

A number of additional research projects are also in progress. These include a qualitative and quantitative follow-up of caregiver and client
outcomes following EFFT interventions, as well as the qualitative study of clinician perceptions of clinician blocks. Task analysis research is also underway to examine the processes through which therapeutic change occurs via the caregiver block chair work intervention. Preliminary data suggest that outcomes are best when therapists can support parents to connect with their deepest fears related to their involvement, in tandem with the pure love they hold for their child.

**CLINICIAN’S CORNER**

In the past year, we’ve introduced the EFFT 2-day caregiver workshop within our mental health and addictions services in a large pediatric hospital. Currently, we run the workshops as part of a research pilot, evaluating its effectiveness. Preliminary findings are significant, and parent feedback has been exceptional. Three themes that we hear consistently from caregivers after a workshop are that the work is incredibly difficult but definitely worth it, that they wish they had this opportunity sooner in their lives, and that all parents should have access to this knowledge and these skills. As an EFFT therapist, supervisor, and trainer, I practice EFFT with individual families and lead the workshop, and my preference is definitely in leading the workshop. There is something extremely powerful about the model’s application in a group setting. In the very first moments of the workshop, there are often significant expressions of vulnerability, including tears, which I attribute to the power of the experiential components of the therapy. Not unlike other group therapy settings, we’ve also observed the positive impact on caregivers when they hear others share similar struggles, including feelings of guilt, shame, and feelings of isolation, which are often targeted over the 2 days. Facilitating the workshop does require advanced EFFT skills on behalf of facilitators, given the care required to support caregivers who share their greatest vulnerabilities or work through blocks in front of others. That said, as a clinician, it is an incredibly rewarding process to witness, and we always reflect to caregivers what a gift and honor it is to have supported them through these challenging 2 days. It is especially rewarding to witness transformation in families who have been engaged in service for many years, with limited results. In fact, most caregivers in our program report beginning the workshop feeling stuck, hopeless, and frustrated, then moving to a place of increased self-efficacy and hopefulness, reporting new shifts in themselves and their loved ones.

—Psychologist and supervisor
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Some might argue that in the contemporary clinical practice of psychotherapy, evidence-based intervention and effective outcome have overshadowed theory in importance. Maybe. But, as the editors of this series, we don’t propose to take up that controversy here. We do know that psychotherapists adopt and practice according to one theory or another because their experience, and decades of good evidence, suggests that having a sound theory of psychotherapy leads to greater therapeutic success. Still, the role of theory in the helping process can be hard to explain. This narrative about solving problems helps convey the importance of theory:

Aesop tells the fable of the sun and wind having a contest to decide who was the most powerful. From above the earth, they spotted a man walking down the street, and the wind said that he bet he could get his coat off. The sun agreed to the contest. The wind blew, and the man held on tightly to his coat. The more the wind blew, the tighter he held. The sun said it was his turn. He put all of his energy into creating warm sunshine, and soon the man took off his coat.

What does a competition between the sun and the wind to remove a man’s coat have to do with theories of psychotherapy? We think this deceptively simple story highlights the importance of theory as the precursor to any effective intervention—and hence to a favorable outcome. Without a guiding theory, we might treat the symptom without understanding the role of the individual. Or we might create power conflicts
with our clients and not understand that, at times, indirect means of helping (sunshine) are often as effective—if not more so—than direct ones (wind). In the absence of theory, we might lose track of the treatment rationale and instead get caught up in, for example, social correctness and not wanting to do something that looks too simple.

What exactly is theory? The APA Dictionary of Psychology defines theory as “a principle or body of interrelated principles that purports to explain or predict a number of interrelated phenomena” (2nd ed., VandenBos, 2015, p. 1081). In psychotherapy, a theory is a set of principles used to explain human thought and behavior, including what causes people to change. In practice, a theory creates the goals of therapy and specifies how to pursue them. Haley (1997) noted that a theory of psychotherapy ought to be simple enough for the average therapist to understand but comprehensive enough to account for a wide range of eventualities. Furthermore, a theory guides action toward successful outcomes while generating hope in both the therapist and client that recovery is possible.

Theory is the compass that allows psychotherapists to navigate the vast territory of clinical practice. In the same ways that navigational tools have been modified to adapt to advances in thinking and ever-expanding territories to explore, theories of psychotherapy have changed over time. The different schools of theories are commonly referred to as waves, the first wave being psychodynamic theories (i.e., Adlerian, psychoanalytic); the second wave, learning theories (i.e., behavioral, cognitive–behavioral); the third wave, humanistic theories (person-centered, gestalt, existential); the fourth wave, feminist and multicultural theories; and the fifth wave, postmodern and constructivist theories (i.e., narrative, solution-focused). In many ways, these waves represent how psychotherapy has adapted and responded to changes in psychology, society, and epistemology as well as to changes in the nature of psychotherapy itself. The wide variety of theories is also testament to the different ways in which the same human behavior can be conceptualized depending on the view one espouses (Frew & Spiegler, 2012).

It is with these two concepts in mind—the central importance of theory and the natural evolution of theoretical thinking—that we developed the American Psychological Association (APA) Theories of Psychotherapy
Series. Both of us are thoroughly fascinated by theory and the range of complex ideas that drive each model. As university faculty members teaching courses on the theories of psychotherapy, we wanted to create learning materials that not only highlighted the essence of the major theories for professionals and professionals-in-training but also updated readers on the current status of the models. Often in books on theory, the biography of the original theorist overshadows the evolution of the model. In contrast, our intent is to highlight the contemporary uses of the theories as well as their history and context. Further, we wanted each theory to be reflected through the process of working with clients that reflect the full range of human diversity.

As this project began, we faced two immediate decisions: which theories to address and who best to present them. We looked at graduate-level theories of psychotherapy courses to see which theories are being taught, and we explored popular scholarly books, articles, and conferences to determine which theories draw the most interest. We then developed a dream list of authors from among the best minds in contemporary theoretical practice. Each author in the series is one of the leading proponents of that approach as well as a knowledgeable practitioner. We asked each author to review the core constructs of the theory, bring the theory into the modern sphere of clinical practice by looking at it through a context of evidence-based practice, and clearly illustrate how the theory looks in action.

There are 24 titles planned for the series, and many titles are now in their second edition. Each title in the series can stand alone or be grouped together with other titles to create materials for a course in psychotherapy theories. This option allows instructors to create a course featuring the approaches they believe are the most salient today. APA Books has also developed a DVD for each of the approaches that demonstrates the theory in practice with a real client. Many of the DVDs show therapy over six sessions with the same client. For a complete list of available DVD programs, visit the APA website (http://www.apa.org/pubs/videos). Most programs are also available in streaming video format.

Narrative therapy is unlike most traditional approaches to psychotherapy. As a bit of the new kid on the block, narrative therapy is a truly
collaborative approach to helping in which the therapist and client re-author the client’s problem story. Grounded in poststructural, feminist, queer, postcolonial, and postmodern anthropological theories, the narrative approach occupies theoretical space in opposition to the historical top-down approach of psychology in which dominant notions of mental health are used to explain the experiences of clients. With social justice and social change increasingly becoming part of mainstream psychological practice, narrative therapy offers an innovative and inclusive model for honoring the lived experience of clients. Stephen Madigan presents this poststructural approach clearly, with a memorable personal and narrative style. Dr. Madigan had originally titled the first edition of this book *Who Has the Storytelling Rights to the Story Being Told?*—which accurately depicted the stance of the therapist in this important approach. The narrative therapist believes there is no one objective truth, but rather multiple “truths” that provide other possible interpretations for client problems (and solutions). The narrative therapist is also acutely aware that problems are created in social, cultural, and political contexts (including the actual practice of psychotherapy) that often serve to obstruct and marginalize the very lives of those whom therapists purport to treat. This second edition of *Narrative Therapy* presents an evolution of the approach. Even though less than a decade separates the two editions, this new edition presents a substantial amount of new information highlighting the rapid growth of narrative therapy across the world. We have no doubt that the reader will thoroughly enjoy this important addition to the series.

—Jon Carlson and Matt Englar-Carlson
Welcome! You are about to embark on a reading of the second edition of Narrative Therapy. I am deeply thankful for your interest and the opportunity the American Psychological Association (APA) has afforded me to write this new edition. The prospect of the second edition arose because the organization generously supported and marketed the first edition, and subsequently it sold remarkably well. My intention for this new edition is to introduce the most important new developments in narrative therapy practice since the first edition was published in 2011.

Discerning what new narrative therapy work to include and what to leave out entailed making difficult choices. How this was reconciled was to include (a) international narrative therapists whose published work since 2011 (in journals and their own books) had the most significant influence on new narrative practice and theory, and (b) narrative therapists whose practice ideas I had the pleasure to study, examine, interrogate, and experience in their taped therapy sessions, unaltered therapy transcripts, and workshops.

Interwoven throughout the book is a reworking of theory. Chapter 3 introduces several newfangled theoretical ideas recently shaping narrative therapy practice. Topics discussed include narrative values, companion stories, intersectionality, gender, queer theory, narrative habitus, narrative wreckage, neoliberalism, critiquing internal state suffering/trauma
narratives, and DSM technology, as well as the concept of how difference precedes identity.

Several practice ideas from the first edition were revised and introduced alongside the most significant new developments in narrative therapy practice. In Chapter 4, ideas on therapeutic practice have been revised, and Chapter 6 explores a wide range of original new work, including (a) fresh practice developments in deconstructing mainstream psychology’s ideas on grief, loss, trauma, and death; (b) innovative ways to understand, question, and engage with children, youth, and families; and (c) the influence queer-informed narrative therapy has had on furthering Michel Foucault’s ideas on identity formation, normativity, power/knowledge, and so on, within narrative therapy’s practice experience when working with children, youth, and families.

There are many more innovative ideas discussed in this second edition. For example, the first edition had almost no discussion regarding the intricate particularities and practices associated with couple therapy. This edition includes a lengthy section in Chapter 6 on the latest elaborations surrounding my new narrative therapy-informed relational interviewing (RI) work with conflicted couple relationships. A concentrated discussion of RI work is presented, including (a) a close-up four-session guide to the RI method, (b) a critique of modern day couple therapy, (c) therapeutic letters written to the couple relationship, (d) ways to involve the couple relationship’s community of concern, (e) transcripts of session questions, and (f) a step-by-step outline of this new style of working with relationships. The section on couple therapy also includes a brief discussion of French poststructural theorist Gilles Deleuze, whose ideas are gaining the attention of more and more narrative therapists.

This new edition emphasizes a myriad of new teaching ideas to outline the Vancouver School for Narrative Therapy’s (VSNT) fierce commitment to transparency learning and supervision. Since the first edition was published, the faculty spent several years studying the question “How might the learners of narrative therapy best learn narrative therapy?” I have rigorously pursued this puzzle by asking all manner of student trainees, practicing therapists, colleagues, and professors, as well as our associate international presenters, one primary question:
“In order to improve a learner’s ability to learn narrative therapy, what did the relationship between students and teachers of narrative therapy need most (or, at the very least, need more of)?”

The majority who answered the query pointed toward one clear answer: The practices involved in narrative therapy training must mirror the genuine relational practice experience of what goes on in the narrative therapy room. Of course!

With this knowledge clearly in hand, the VSNT faculty set out to completely restructure the very foundations of our narrative therapy workshops, conferences, trainings, and supervision. Chapter 6 demonstrates how, over time, specific transparency learning and supervision practice shifts have emerged in narrative therapy and continue to grow forward.

Transparency learning steered the VSNT faculty to fully demonstrate and articulate the daily chaos, the not knowing, and slip-ups therapists make in therapy. An “antiperfection” teaching stance was taken to demonstrate what happens in everyday therapy rooms. To further a more genuine experience of therapy, the faculty (and now our conference presenters) have agreed to perform our therapy work live in front of the learner and only use unchanged and unaltered session transcripts to study and interrogate our session questions.

With our imperfect narrative therapy sessions on full display, learners are invited to feel these transparent domains of humility as an uncomfortable reality to be expected. However, they now know that this is a reality experienced by every practicing therapist. The only way out from under the therapy room’s discombobulating discomfort was to tape their work; meticulously study their own and other therapists’ transcripts; approach a clear understanding of poststructural theory; and practice, practice, and practice.

The new edition makes every attempt to explain the practice of close-up transparency learning and supervision, and the ethics and responsibilities involved for the supervisor, client, learner, and supervisee. The book also builds a case for a stronger commitment from trainers, professors, and supervisors to publicly show, interrogate, and critique their own unaltered therapy session work/tapes/transcripts before they invite the supervisee and learner to do the same.
On a cautionary note, the second edition makes an honest attempt to underscore how difficult the practice of narrative therapy can be. But fear not. There is hope. Narrative therapy is not rocket science, but becoming comfortable with narrative work requires a deep commitment to thinking and practicing differently.

Most of you who read the first edition of *Narrative Therapy* know the story of how I began my “actual” therapeutic journey after completing a mishmash BA in social work, philosophy, and environmental studies at the University of Waterloo (located 60 miles from where I grew up in Toronto, Canada) and the 8-month travel adventure abroad in the middle of this degree. And how after graduating I really didn’t know what I would do next.

I had an open invitation to work with my Irish relatives in the film industry in Europe and was also considering traveling abroad again. While contemplating the next adventure, I happened upon an advertisement in Canada’s national newspaper about a large hiring of young persons from across the country to work in a brand new youth treatment facility in Calgary, Alberta. I didn’t know much about Calgary other than when I hitchhiked out to Banff, Alberta, with high school friends at age 16. From this experience, I remembered loving the mountains we hiked, so I applied. Before I knew what hit me, I found myself packing up my old car and moving 1,700 miles west. Upon arriving, I somehow landed a job as a group therapist (running transference interpretation groups, no less) under the guidance of two young and hip psychoanalysts.

The new work situation was fabulous. The new recruits were all around my age; the pay was abnormally high; my group therapy work was videotaped and supervised each day; and there was plenty of time off to play hockey, travel, hike, and ski. But what turned out to be a really great and unexpected experience was meeting the wildly inspired Canadian psychiatrist, Dr. Karl Tomm (1984a, 1984b, 1986, 1987a, 1987b, 1988). Tomm was the director of (and continues to run) the world-renowned Calgary Family Therapy Centre through the University of Calgary. During the early days, Tomm hosted these astonishing free “lunch bag” seminars, where he spoke about his work and discussed Humberto Maturana,
Gregory Bateson, and Milan Family Therapy. I had no idea what he was talking about, but carried on.

Over time Tomm helped many of us develop a solid ideological/theoretical/therapeutic foundation as well as a rather unusual (and particularly voracious) appetite for family therapy ideas from this era. Personally, I just couldn’t seem to get enough of therapy’s compelling storylines of hard times and human relationships. The readings pulled me in and never let me go, even though the study of therapy was a bit of a departure from the wildness of my working class neighborhood, my guiltless run-ins with the law, a hippie sense of adventure, a strong commitment to left-wing politics, and a prior all-star hockey career filled with extreme competitiveness, machismo, stitches, and broken bones. Happily, I found a way to make peace between these worlds.

During that time, Tomm showed us how a therapist could stand in the hard therapeutic and political places within the field of psychotherapy. His three articles on interventive interviewing helped to kick-start my discovery and love of therapeutic questions.

1 It was through Karl Tomm’s influence that (prior to obtaining my PhD) I went on to devour the work of the Mental Research Institute (Jay Haley, Paul Watzlawick, John Weakland, etc.), Milton Erickson, R. D. Laing, Irving Goffman, and the Milan team of Boscolo, Cechin, Palazoli, and Prata. I knocked back other “favorites,” by the feminist women of New York City’s Ackerman Institute: Virginia Goldner, Olga Silverstein, Peggy Papp, and Peggy Penn. There was also Sal Minuchin, Lynn Hoffman, Murray Bowen, Harry Goolishian, Carl Whitaker, and Virginia Satir. I then crossed over a life-changing threshold toward the second-order cybernetic writings of Paul Dell, Heinz Von Forester, and Bradford Keeney (and it was Keeney’s book The Aesthetics of Change, 1983, that helped me fall in love with the relational ideas of Gregory Bateson). I found myself mesmerized by the therapeutic feminist/social justice writings of the “Fifth Province” Irish Team of Imelda McCarthy and Nollaig Byrne (who became mentoring friends), and feminist hero Rachel Hare-Mustin (who wrote the first published feminist article in family therapy literature). In doctoral school also, I became completely engrossed in the writings of the French/Algerian psychiatrist Franz Fanon, postcolonial author Edward Said, along with the social constructionist camp spearheaded by Ken and Mary Gergen, Rom Hare, Michael Billig, John Shotter, Erica Berman, and Ian Parker.

2 However, when I look back, I realize the example my Irish immigrant parents (Frank and Theresa Madigan) set by working in Toronto, Canada (without pay) alongside the poor and the dispossessed throughout their entire lives. I grew up witnessing them visit the same seniors’ home every Monday evening for 35 years, set up a summer camp for disadvantaged youth, work tirelessly in what were then called soup kitchens, make regular neighborhood visits to persons who found themselves struggling in poverty, and offer up many other generative acts of kindness.


4 Karl Tomm introduced me (and the rest of North America) to the complex relational ideas of Chilean biologists Humberto Maturana and Francesco Varela. I must have read their articles a dozen times over while painstakingly making detailed notes and trying desperately to make sense of all that I was reading. I even put together reading groups to help with any new or emerging therapy theory and practice ideas. Karl Tomm was instrumental in helping me get hooked on therapy.
I remember reading everything I could get my hands on. I wasn’t at all certain what many of these new therapy authors and theorists were talking about, but my instincts told me that it was pretty cool stuff, and more importantly, the material seemed miles ahead of what I’d learned in my undergraduate psychology and social work classes. When reflecting upon these halcyon days of reading and knowledge acquisition, I realize I spent most of the mid-1980s and early 1990s in a constant state of startled confusion and untamed excitement. However, nothing prepared me for just how baffling my therapy journey would become in the aftermath of my first meeting with the pioneer of narrative therapy, legendary Australian therapist Michael White.

My personal expedition into narrative therapy began in the fall of 1986 when I attended White’s family therapy presentation in Calgary (this was his first “official” workshop in North America). He was presenting his therapeutic approach with families through the relational ideas of MRI director and cultural anthropologist Gregory Bateson (whom I was a huge fan of by then), and Karl Tomm stood beside him presenting his therapeutic ideas through the Chilean biologist Humberto Maturana.

During the first coffee break, White walked across a crowded reception room and introduced himself to me (probably because I looked most like the participant who didn’t belong!). We ended up laughing a lot and jumped into the deep end of the Gregory Bateson pool. He kindly invited me to have lunch and then inquired if I’d like to join him in the upstairs clinic to watch him interview a 10-year-old boy who was struggling with encopresis. I was by far the youngest person in the workshop (and probably the only person wearing ripped jeans, motorcycle boots, and a Neil Young T-shirt), so being invited to watch live narrative therapy practice for the first time was a little overwhelming and fundamentally irresistible.

That first evening I sat behind a one-way mirror and watched White in therapy. I sat alongside Karl Tomm and four senior family therapists.

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5 At the time of the 1986 workshop, Michael White had not yet named this method of therapy narrative—this name came along in 1990, when he titled the seminal book *Narrative Means to Therapeutic Ends* (White & Epston, 1990).

6 To view clips of Michael White and Karl Tomm’s 1986 workshops, please go to https://tctv.live/
What I witnessed blew my mind. Despite all my reading and early practice, I had nothing to compare White’s practice with. For example, within the first few minutes of the interview, he and the youngster had renamed the problem of encopresis as “sneaky poo” (White observed that therapeutic progress was enhanced when the therapist and person were able to talk about the problem in a more relational and contextualized way). Not privatizing the problem of encopresis inside the boy’s body afforded a therapeutic space to “language” the problem as relationally distinct and separate from the child (the child’s identity was not directly tied to the problem nor totalized as problematic). White called this relational repositioning of the problem externalizing the problem.7

To relationally externalize a problem, the therapist draws on post-structural ideas regarding the constituted formation of the self to relationally situate the problem and person in a correlated discursive context as a way to therapeutically externalize internalized problem discourse (Madigan, 1996).8 For example, by using externalizing language, White coconstructed the label sneaky poo (in reference to the encopresis) with the boy and his mother and personified it as a relational subject external to the child (more explanation of this to follow).

At the time of this interview, I didn’t fully comprehend the theoretical complexity and therapeutic rigor involved with White’s adamant refusal to privatize problems inside clients’ bodies. I wasn’t at all knowledgeable about externalizing problems in relational ways, and I am fairly certain that (other than Tomm), no one else sitting behind the one-way mirror that evening (nor anywhere across North America) did either. However,

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7 Externalizing is a concept that was first introduced to the field of family therapy in the early 1980s by Michael White. Initially developed from his work with children, relational externalizing has to some extent always been associated with good humor and playfulness (as well as thoughtful and careful practice). There are many ways of understanding a relational externalizing position, but perhaps it is best summed up in the phrase “the person is not the problem, the problem is the problem.” To relationally externalize a problem is not a suggestion to establish an off-the-rack description of a problem. Externalizing the problem brings forth possible redescriptions and the chance for clients to reposition themselves with the problem. Externalizing is by no means a requirement of narrative therapy and represents one option within a range of narrative practices.

8 For some theorists of the constituted self, norms, interests, sexual identity, and so on, are brittle constructs amenable to virtually unlimited manipulation and rapid change. As Michel Foucault (1980) argued, the constituted self is both wholly determined and decentered.
even without a full understanding of what I was watching, I found White’s therapeutic style of interviewing and relationally externalizing problems highly engaging.

I eventually came to understand that learning the craft of narrative therapy interviewing is at times exasperating, because the structure and theory supporting our narrative practice language are not based on what is generally taught in schools of psychology, social work, and psychiatry. Narrative therapy is neither essentialist, structural, psychodynamic, systemic, humanist, nor based on individualizing principles of the self. Nor does narrative theory advocate the use of developmental models, theories of the individualized self, the use of psychological testing, or the employment of texts such as the *Diagnostic and Statistical Manual of Mental Disorders*, which is not used as a basis of information or explanation in narrative therapy. Nor does the practice readily turn to pharmaceuticals as a first solution.9

I left Calgary and entered an MSW program at the University of British Columbia in Vancouver, Canada. It was there that my young and developing therapist/student identity took the first steps to learn the poststructural ideas on which narrative therapy was based (and its underlying respectful critique of social work, psychology, and psychiatry). For the most part, I engaged in this complicated reading and learning on my own.

By 1990, narrative therapy had hooked me all the way through by radically changing my thoughts on the culture of therapy and what life as a social justice–minded, anti-individualist therapist could be. By this time, I’d jumped into a doctorate degree in marriage and family therapy in South Florida. My dissertation involved the politic of narrative therapy questions and poststructuralism (and I completed this while at the same time training, touring, and playing in international tournaments with Canada’s National Ultimate Frisbee team). By this time I’d made a resolute decision to dedicate myself to practicing narrative therapy full time. This meant hurrying up my dissertation and quitting the Canadian team—a

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9Narrative therapy does, however, view the use of pharmaceuticals as necessary for persons at certain times but does not support the widespread overuse of drugs as a primary mode of treatment.
blown anterior cruciate ligament to my right knee at the USA Nationals tournament and a narrative, poststructural-friendly faculty and department chair Dr. Ron Chenail at Nova Southeastern University helped expedite the decision.

Initially, I tried to read and keep up with everything my mentor White was reading, but this proved to be quite unsuccessful given that he was reading and studying across so many different social science disciplines. Nevertheless, I sustained my learning curve on a steady diet of exciting new authors\textsuperscript{10}—very few of whom graced the pages of mainstream psychiatry, psychology, family therapy, or social work journals.

A dramatic turning point in my learning came when (for several months in 1991 and again in 1992) I was invited to live and work with Michael and Cheryl White in Adelaide, South Australia. This was the beginning of a real-life therapeutic apprenticeship. It was during these intense “home stay” work visits that I had the luxury and privilege of fully immersing myself in the intimate particularities of Michael’s everyday narrative therapy practice and Cheryl’s feminist and social justice ideas.

The apprenticeship visits also established my relationship with Alan Jenkins (in Adelaide) and introduced me to his narrative therapy work on gender violence, abuse, and trauma\textsuperscript{11} (Jenkins, 1990, 2009). I also struck up an enduring friendship with Vanessa Swan and Ian Law, who lived in Adelaide and were White’s first narrative therapy teaching assistants.\textsuperscript{12}

During this apprenticeship, I was also invited to live and work alongside Taimalie Kiwi Tamasese, Charles Waldegrave, and the Just Therapy Team in Wellington, New Zealand (Waldegrave, 1990); Alan Rosen in

\textsuperscript{10} A few of these writers included Barbara Myerhof, Victor Turner, and Clifford Geertz from cultural anthropology; I learned poststructuralism through Roland Barthes, Pierre Bourdieu, Gilles Deleuze, Jacques Derrida, Michel Foucault, and Julia Kristeva. Gayatri Spivak, bell hooks, Stuart Hall, and Edward Said were the beginning of the postcolonial writers, and I continued to follow a course of readings by Bakhtin, J. Bruner, Gergen, Sampson, Parker, and Shotter. Then came the writings of Judith Butler, Jack Halberstam, Julie Tilsen, and David Nylund, on queer theory and identity and so on. I feel quite strongly that without a fellowship with these scholarly writers and areas of thought, narrative therapy practice could only ever be quite limited.

\textsuperscript{11} To watch Alan Jenkins workshops and keynotes, go to https://tctv.live/

\textsuperscript{12} In 1996, Ian and Vanessa moved to Vancouver to work and teach alongside us at the Vancouver School for Narrative Therapy and Yaletown Family Therapy. Our coauthored book, PRAXIS: Situating Discourse, Feminism and Politics in Narrative Therapies (Madigan & Law, 1998), emerged from this time of working together. As of 2018, Ian is the CEO of Relationships Australia.
Sydney, Australia; and David Epston in Auckland, New Zealand, in 1991. These were heady times indeed.

To say that I took this narrative therapy apprenticeship seriously would be an understatement. For example, when observing therapy sessions with Michael (I would participate in six or seven sessions each day), I wrote down each and every therapeutic question he asked. In the evenings after work, I would ask him dozens of questions about all the narrative questions he had asked during that day—to understand what I suppose might be called a *genealogy* of each question.\(^\text{13}\) I would ask him what the questions’ “family of origin” was; what category of narrative questions they belonged to; the intent behind their use, purpose and direction; why questions collapsed temporality (past, present, future); why a certain grammar of expression was used; what theory and author a particular question belonged to; what the direction and conscious purpose of the question was; what the ideology and politics were that influenced the question; what other questions he could have asked but did not ask; and so on. Whew! He was so patient.

Each day, we saw persons struggling with a range of issues, including anorexia, night fears, violence, trauma, stealing, voices, bedwetting, and abuse. And each new session brought about new sets of questions, followed by my questions about his questions. It felt like an ethnographic narrative therapy learning lab in which no question went unanswered and no question was free from reflexive scrutiny. It was exhausting work, but with his assistance, I slowly managed to get the hang of it. And inevitably, just when I thought I was finding my way in narrative therapy interviewing, Michael would introduce a new concept and/or author that I had to go out and investigate.

I’d taken to poring over and studying his raw unaltered session transcripts (that he’d generously send to me) line by line. And it was within this practice of studying unaltered transcripts (a practice I still use to this day!) that I began to more easily recognize and match specific structures,

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\(^{13}\) Michel Foucault’s concept of *genealogy* is the history of the position of the subject that traces the development of people and society (and in this case, narrative therapy questions) through history (Foucault, 1994; Prado, 1995).
rhythms, patterns, poetics, and “know-hows” within my own and Michael’s interviews. I noted his particular ways of positioning the temporal experience of questions, and I began to theoretically understand and phrase specific sets of words, ideas, and questions together. For a young therapist, there wasn’t any better feeling in the world than sensing a growing confidence in the face of any problem that walked through the clinic door!

When I returned to my doctoral program, I catalogued these narrative questions further and dictated each question into a tape recorder, included a bibliography for each one, and drove around South Beach Miami listening to them. Ha!

After completing my doctoral degree and returning to Vancouver, Canada, I took the advice Cheryl and Michael offered me about my future and resisted all recruitment offers to work within various institutions or universities—for at least 5 years. I opened the Vancouver School for Narrative Therapy (through Yaletown Family Therapy) in March 1992. When I look back, this was a risky and hopelessly optimistic decision.

This new edition touches on the many beautiful, unconventional, and creative ideas my friend and teacher Michael White brought to the world of therapy and our narrative community. Tragically, on April 4, 2008, Michael died of sudden heart failure during a narrative therapy workshop in California (see Madigan, 2008). He was only 59 years old. Michael’s unconventional thinking and poetic practice creativity play a large part in my daily therapy sessions, and in the daily therapy sessions of thousands and thousands of other practicing narrative therapists around the world. I miss him—a lot.

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14 For a brilliant description of the use of the temporal dimension in narrative therapy questions, see my 1995 interview with Michael White and David Epston on https://tctv.live/

15 For example, 10 days after I had moved into my empty office, I received a call from the local “Hollywood North” film industry wanting to meet me at my new office to discuss a therapy contract (in 2 days’ time). This would entail becoming the primary therapist to their 1,600 unionized film workers. The possibility was thrilling (a first post-PhD contract!). But as I looked around the office space, I realized all I had was a phone, the futon I was sleeping on, and my freshly minted PhD. I also realized that I had less than $1,000 in my bank account. So I called up a few friends, rented a truck, and loaded up their desks, artwork, rugs, chairs, tables, and anything else to make my Yaletown Family Therapy and the Vancouver School for Narrative Therapy office look like a “real” therapy office. Fortunately, the meeting went well. I received the contract, and an hour later we were reloading the truck and returning the furniture to its rightful owners.
Whatever sense we have of how things stand with someone else’s inner life, we gain it through their expressions, not through some magical intrusion into their consciousness. It’s all a matter of scratching surfaces.

—Clifford Geertz (Works and Lives: The Anthropologist as Author)

This book intends to unravel the mysteries of narrative therapy theory and practice by escorting the reader on a casual intellectual stroll through narrative therapy’s personal, theoretical, and practice history. Australian therapist Michael White began his novel therapeutic work in the late 1970s in Adelaide, but he did not coin the term narrative therapy until 1990, when he published the seminal book Narrative Means to Therapeutic Ends (White & Epston, 1990). By the early 1990s, narrative therapy ideas had a relatively small but passionate following throughout North

1 Michael invited Canadian cum New Zealand therapist David Epston to coauthor the book.
America and Europe. In 2019, narrative therapy is the primary therapeutic practice used by thousands upon thousands of therapists worldwide.

Renowned American cultural anthropologist Clifford Geertz (1983) wrote

The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world’s cultures. (p. 229)

Geertz (1973, 1983, 1988) described a view of human identity that is considered relational, contextual, communal, discursive, and anti-individualist. Narrative therapy holds a similar point of view. At the heart of narrative therapy is an unswerving commitment to a relational/contextual/anti-individualist therapeutic understanding of persons, problems, and relationships. This relational/contextual/anti-individualist practice was founded on a therapy designed to counter the prevailing dominant psychological ideas regarding the skin-bound individual self.

Narrative therapy contends that to properly study a “self,” a reader must understand how it is related to their concept of the self (Madigan, 2004, 2007, 2011; Madigan & Nylund, 2018a). A narrative therapy point of view brings forth a multisited and multistoried idea of the subject. Narrative therapy’s approach to the self stretches out beyond

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2 During a conversation in Vancouver, Michael White stated that perhaps more than any other idea, he had organized narrative’s therapeutic work through an anti-individualist theory and practice.
3 This discursive self-perception plays a critical role in one’s interpretation of meaning. Whereas different poststructural thinkers’ views on the self vary, the self under study is said to be constituted by discourse(s) (Foucault, 1979).
4 For example, in a poststructural approach to textual analysis, it is the reader of a text who replaces the author as the primary subject of inquiry. This displacement is often referred to as the destabilizing or decentering of the author (in our case, think of the therapist), although it has its greatest effect on the text itself (Derrida, 1991).
5 In an unpublished interview, Michael White respectfully responds to a question regarding the limits of systems thinking by suggesting that, when considering systems thinking, one might consider a close-up review of the effects of modernist notions of the self; structuralism; science; individualizing problems; ethnocentric/eurocentric ideas of race, gender, sexual preference; family values; Parsonian ideas and so on.
the more popular and generalized accounts of who persons are (e.g., dominant and individualized categories of personhood) and of who the person is stated or labeled to be by the expert of psychological knowledge (Madigan, 1997).

I received a call from a staff person at a local psychiatric ward asking if I would consider counseling Tom. Tom was described to me as “suicidal and chronically depressed,” a person on whom the hospital had “tried everything possible.” The “everything” they had tried included 40 electroconvulsive therapy (ECT) sessions, six varieties of selective serotonin reuptake inhibitors and antipsychotic medication, and group and individual cognitive behavior therapy, all within the same 12-month period.

The hospital staff person explained that the therapy staff had “all but given up” on Tom—a 66-year-old, White, middle-class, able-bodied, married, heterosexual man. They said Tom had been living “off and on” as an “unsuccessful patient” within their hospital institution for just over a year. And although he had been administered a variety of psychiatric technologies of normalization, “nothing had worked.”

Throughout the 12 months of hospital contact, Tom participated in the hospital’s ongoing systematic creation, classification, and control of anomalies in his social body. From my discussions with the hospital staff (who had worked alongside Tom throughout the year), Tom’s “chronic” body had been attributed and situated within particular sets of psychological meaning (i.e., a severely depressed person). This helped lead me to imagine that Tom’s body had fit categorically within the memorized moments of psychological history—read through the archives of certain expert others—and then transformed into professional documents regarding who, in fact, Tom was.

When I first met Tom, he weighed in with (and was described through) a 6-pound paper hospital case file. From the outside, Tom was unanimously described as having a chronic major depressive disorder. This suggested the “documented Tom” (or the “Tom of the file”) was viewed by the staff within the confines of an essentialist, interior (modern) self. Our phone conversations, as well as the hospital’s interpretations of
Tom, translated through the case files, helped me locate the context of the staff’s expertise of knowledge about Tom.

Respectfully, the obvious contradiction in my contact with the hospital was realizing that the hospital had condemned Tom to a life of chronic identity death (chronic meaning he could not be helped; Madigan, 1999); while at the same time, the hospital desired him to “recover” through their psychiatric technology. Unfortunately, Tom was judged to be unfit since he could not please the hospital team (primarily because their specific psychological practices had not assisted him). And as the hospital staff’s description might suggest, Tom became both cultural object and intellectual product of the institution (Brinkmann, 2016; Madigan, 1996; Strong, 2014).

Within the model of scientific medicine and understanding the psychiatric ward used to situate Tom, the body of the subject (in this case the body of Tom) was viewed as the passive tablet on which (his) disorders were inscribed (written onto). In other words, the hospital staff’s knowledge was used to write pathologies onto and about Tom’s body. Deciphering the proper inscription to fit with Tom’s body was a matter of determining a cause of the disorder and required an interpretation of the symptoms fitting within their prevailing diagnostic texts.

The process of Tom being inscribed into the Diagnostic and Statistical Manual of Mental Disorder (DSM) text required a trained (i.e., highly specialized) professional who had been afforded the opportunity and privilege to unlock the secrets of Tom’s disordered body. This specialized knowledge, mediated through specific sets of

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6 Michael White (1995a) wrote “since the pathologizing discourses are cloaked in impressive language that establishes claims to an objective reality, these discourses make it possible for mental health professionals to avoid facing the real effects of, or the consequences of, these ways of speaking about and acting towards those people who consult them. If our work has to do with subjecting persons to the ‘truth’, then this renders invisible to us the consequences of how we speak to people about their lives, and of how we structure out interactions with them; this mantle of ‘truth’ makes it possible for us to avoid reflecting on the implications of our constructions and of our therapeutic interactions in regard to the shaping of people’s lives” (p. 115).

7 With over 400 possible ways to be considered abnormal (Breggin, 1994; Caplan, 1995), plotting a person’s entire life story within the text of the DSM is not that uncommon or difficult (for some) to achieve.

8 Canadian psychologist Tom Strong (2014) suggested that for what he termed brief therapists, the DSM, and the evidence-based practices often administratively coupled with any diagnosis, present a conversational challenge. At worst, conversations with clients can be overtaken when this discourse of symptoms (and what should be done to treat them) is prescribed in ways that preclude the pragmatic ways in which brief therapists practice.
agreed-upon power relations and those subsequent levels of professional status afforded (to us professionals), allowed a hospital professional to bring this forward as a meaningful (and taken for granted) description of Tom.

Our professional story-naming rights are negotiated and distributed through the professional institution and its archives (Foucault, 1972). This naming procedure dictates the control of who gets to say what about who is normal and who is not, and what will be done as a consequence and with what authority (Madigan, 1997). Central to the narrative therapy critique of the modernist psychological platform (which includes a critique of DSM technology) is the analysis of who should not be afforded legitimate speaking rights because they have not acquired the proper rational inquiry brought on as a result of systematic thought and orderly investigation (Madigan, 2008).

Tom, for our purposes, is now known as the person without knowledge (Madigan, 2003). The psychologized/individualized view held that he was operating without a context (thereby viewed as living in a relationally disembodied context), but classified within gender, race, age, ability, sexual orientation, and “dysfunction.” Judging from my contact with the hospital staff, Tom could only acquire legitimized speaking rights through a specified institutional matrix that distributes and negotiates (in this case psychological/psychiatric) knowledge, power, and his storytelling rights.

After my contact with the hospital professionals, I saw Tom in therapy for eight sessions over the course of 3 months. He left the hospital ward after the fifth session during Week 7 and never returned. His speech continued to be a little bit slurred due to the ECT sessions, but overall he and his family members reported his comeback had been quite successful. Our conversations concentrated on relationally separating Tom from the hospital’s totalized chronic identity description of major chronic depression and, helping him to re-member aspects and abilities of his life that

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*One of the many differences narrative therapy has with the DSM–5 is that the manual has no consistent requirement that the everyday behavior used as diagnostic criteria actually be the result of mental disorder and not the result of other life experiences (Crowe, 2000).*
lived outside the parameters of the problem’s identity conclusions that had helped him remember to forget.

During our eight sessions of narrative therapy, there were no other-worldly charms or scientific medicines used in helping Tom take his life back from depression. Quite simply (as I reported back to the hospital staff), Tom had stated he had experienced a lot of relational appreciation, compassion, and listening during our talks, along with the support of his partner and local support of therapeutic letters from his community of concern. He also stated he liked the way we stepped “outside the box” to get a better understanding of his relationship with the problem by reviewing aspects, qualities, values, memories, and stories of his life that could not be explained through the problems and the hospital’s definition of him.

Tom (under the supervision of a medical doctor) committed to begin getting off the psychiatric medications prescribed to him by Week 12 of our therapy. He also began volunteering at an AIDS hospice, gardening a few vegetable plots, and having “a lot of fun” with his grandchildren. Tom also became an anti-depression consultant to the Vancouver School for Narrative Therapy’s narrative therapy training program.

For the first-time reader, entering into the theoretical ideas raised in this book (and their application to therapy) can sometimes be a difficult and a somewhat daunting task. Fear not. This is a common experience for most persons and there is really no way around it. The book makes every attempt to rescue the reader from as much discomfort as possible by deciphering the intellectual precision and code of the post-structural theory/narrative therapy relationship—by placing the rigor of theory alongside the imagination of common everyday narrative therapy practice examples.

Throughout the book’s theoretical discussion, I demonstrate that unlike the formal systems of psychological analysis, narrative therapy does not seek to establish global accounts of life and universal categories of human nature by constructing naturalized and essentialist notions of the self (Madigan, 1992, 1996, 2008; Madigan & Nylund, 2018a, 2018b). Narrative therapy finds no cause or reason to diagnose and/or label a person’s lived experience.
Narrative therapy perceives that all formal diagnostic analysis produces flat monologic\textsuperscript{10} descriptions of psychological life that attempt to render events predictable (J. S. Bruner, 1986; Parker, 2008; Sampson, 1993; Strong, 2014). White found that psychology’s more formalized description of personhood championed the norm through generalizations regarding who people actually were, whereas narrative metaphors were based in a dialogic encounter rendering the unexpected invisible and unique, so as not to be misled by the general (M. White, personal communication, 1992\textsuperscript{11}).

The second edition continues to explore several key poststructural concepts that provide a foundation for narrative therapy practice. These concern the relationship between power and knowledge, intersectionality, structural inequalities, the textual identity of the dialogic relational person, the social location of the multisited person, the influence prevailing cultural discourse has on the shaping of how we view persons, values, and problems, and questions the origin and location of problems.

By way of numerous case examples, the book demonstrates how poststructural theory finds a congruent fit within a practice of narrative therapy. The book explores a few key questions pertinent to the construction of narrative therapy practice regarding (a) who determines what gets to be said in therapy (e.g., about persons and problems, and how this intersects with other institutions like medicine, the judiciary, psychiatric wards, school systems, families, media) regarding a person’s identity and problems, (b) who gets to say what about people and problems in therapy, and (c) under what professional and cultural influences.

Finally, a primary question I attempt to raise in the book is based on a rather simple question: \textit{Who has the storytelling rights to the story being told?}

\textsuperscript{10} Conventional psychological thinking supports the idea of a self-contained individual who is fundamentally monologic: “a hermetic and self-sufficient whole, one whose elements constitute a closed system presuming nothing beyond themselves, no other utterances” (Bakhtin, 1981, p. 273).

\textsuperscript{11} Throughout the book, I refer to particular personal conversations I have had with people who influenced my work. These dialogues were part of an ever-growing fabric of up-close conversational learnings and are not necessarily found in books or articles. To experience an extensive sample of these public dialogues on a wide range of topics, visit https://tctv.live/
Integrative Couple and Family Therapies

Treatment Models for Complex Clinical Issues

Edited by Patricia Pitta and Corinne C. Datchi
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Introduction

*How Do Integrative Therapies Help Couples and Families?*

Patricia Pitta, Corinne C. Datchi, and Jerry Gold

In times of adversity, couples and families face many stressors and challenges. In clinical practice, therapists work with clients who often describe feelings of loss, confusion, disconnection, pain, fear, shame, guilt, and heightened anxiety in response to stressful events. They talk about their failed attempts at resolving the problems of everyday life and enter treatment stuck in transactional patterns that contribute rather than solve their distress. Their interactions produce high levels of expressed emotion in the family—negativity, criticism, and worrying—that support the development and maintenance of individual psychopathology, including severe mental illness (e.g., bipolar disorder; Hooley, Miklowitz, & Beach, 2006).

How can practitioners help couples and families master the challenges of the lifecycle in hard times? What clinical strategies are most effective to address clients’ mental health needs and enhance their functioning? What intervention programs make it possible to successfully treat couples and families in their broader social, political, and cultural contexts? The complexity and variety of problems in clinical practice require a therapeutic approach that allows for responsiveness and flexibility as well as rigor and sophistication.

This edited volume shows how expert clinicians answer these questions using integrative treatment models to help couples and families find solutions to complex challenges: Infidelity, infertility, divorce and remarriage, military deployment, incest, racism, undocumented immigration, gender inequity, new technologies of communication, and incarceration are contextual stressors and

http://dx.doi.org/10.1037/0000151-001

*Integrative Couple and Family Therapies: Treatment Models for Complex Clinical Issues,*
P. Pitta and C. C. Datchi (Editors)
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clinical issues that fall outside established domains of mental health research (e.g., the National Institutes of Health [NIH] framework for investigating mental disorders; NIH, n.d.). However, they affect interpersonal processes that are closely linked to individual functioning, namely family structure, roles, transactions, and cohesiveness (Cliquet, 2003; Minuchin, 1974). The challenges addressed in this book were selected for their contemporary salience, nationally and internationally, as evidenced by drug crime and immigration policies in the United States and abroad, American and European military intervention in the middle East, and the worldwide #MeToo movement that supports community action against sexual violence.

**DIVERSITY AND COMPLEXITY OF COUPLE AND FAMILY LIFE**

In the past 50 years, there have been significant changes in the structure and living arrangement of families in the United States. Marriage rates have declined, and the number of cohabiting partners and divorce cases has increased. The nuclear family of the 1960s is no longer the prevalent model of family life (Pew Research Center, 2015; Walsh, 2012). In 2014, 46% of children lived with two parents in a first marriage (Pew Research Center, 2015), and in 2017, 20% lived with a single mother (Pew Research Center, 2018a). In 2016, 50% of U.S. adults were married compared with 72% in the 1960s, 18 million adults live in a cohabiting relationship (Pew Research Center, 2018b), and the divorce rate was 2.4% for partners age 25 to 39 and 2.1% for partners age 40 to 59 (Pew Research Center, 2017b).

Divorce, marriage, and cohabitation have contributed to the growing diversity and complexity of family life; they also account for the fluidity of U.S. families, with more adults and children transitioning from a two-parent household in which both parents are in their first marriage to a single-parent, cohabiting, and/or remarried households. Amidst complexity and change, family members may struggle to form new relationships with each other; as a result, they may experience a lack of connection and belonging, and feel lost and anxious. Multigenerational stepfamilies illustrate the relational challenges that come with divorce and remarriage, in particular difficulties with family roles and loyalty (see Chapter 10, this volume).

Other contributing factors to complex clinical issues originate in the social and political context of family life (e.g., changes in norms; technological progress; policies about illicit drugs, undocumented immigration, marriage). On average, today’s young adults defer getting married until their late 20s (29.5 years for men and 27.4 years for women; Pew Research Center, 2018a). This represents a change in coupling behaviors: In 2012, 20% of adults age 25 and older remained single compared with 10% in the 1960s (Pew Research Center, 2014). Forming a couple at a later age creates new challenges (e.g., fertility). According to the Centers for Disease Control and Prevention (2017), about 12% of women had difficulties conceiving a child or carrying a pregnancy to term between 2011 and 2015,
and approximately 17% of couples struggled with infertility (Ali, Ebraheem, & Mohamed, 2013). New assisted reproductive technologies offer a solution; however, their success is not guaranteed. Frustration, sadness, and despair are some of the feelings that define couples’ experience of infertility and treatment. Some may also describe this experience as a traumatic journey that takes a toll on their relationship satisfaction and mental health (see Chapter 1, this volume).

How individuals connect, form, and maintain relationships is changing as well. The digital world has much to do with this change. Technological innovation provides solutions to medical problems, but also new ways of communicating and bonding with one another. In particular, the Internet and social media have become a pervasive aspect of our lives, with 69% of U.S. adults using at least one social media site in 2018 (Pew Research Center, 2018d). According to the Pew Research Center (2018c, 2018d), up to 74% of individuals age 18 and older are daily users of social media, and millennials (age 18–35), gen-Xers (age 36–53), and baby boomers (age 54–72) are rapidly closing the gap in their adoption of new technologies. Today 57% of baby boomers use social media, 67% own a smart phone, and 52% own a tablet computer (Pew Research Center, 2018c).

Although the Internet and social media help bridge physical and social distance, they also present new challenges for individuals, couples, and families: They have become a place where we escape to cope with individual and relational distress. Rules and rituals for relating to one another in the digital world are still unclear (Tong, Hancock, & Slatcher, 2016). Some people struggle to put down their smartphones and unplug from the Internet and social media, and the boundary between work and family life has become more diffuse (see Chapter 5, this volume). In sum, new technologies have brought people closer to one another while simultaneously creating new forms of disconnection.

Changing gender norms shape individuals’ experience in society; they also influence the dynamics and structure of families and the power each family member has in relation to each other (Knudson-Martin, 2012). Despite efforts to promote gender equality, gender disparities and discrimination persist: In the workplace, 20% of women reported experiences of sexual harassment in 2017 and 42% stated they were subjected to gender bias and ill-treatment (Pew Research Center, 2017c). In the family, gender disparities affect relational processes like decision making and the allocation of roles and responsibilities (Knudson-Martin, 2012; Lyonette & Crompton, 2015). Finances are a domain of family life where partners’ interactions may reproduce gender inequality (see Chapter 4, this volume). Likewise, family violence, including child sexual abuse, is linked to power differentials in gender relationships that affect family functioning (see Chapter 2). These inequities are a major source of stress, exhaustion, anxiety, and resentment in couple and family relationships; they interfere with partners’ and family members’ ability to balance individual and relational needs (Pitta, 2014).
Changing norms also contribute to positives such as the growing visibility and acceptance of same-sex couples, socially and legally. The percentage of same-sex unions has doubled since the 2015 ruling of the U.S. Supreme Court on same-sex couples’ constitutional right to marry (Pew Research Center, 2017a). Same-sex marriage now offers gay and lesbian couples a legal pathway for creating a family through adoption or in vitro fertilization. It also legitimizes the attachment bonds of gay and lesbian couples and creates opportunities for healing from the social shame and rejection they experienced during their formative years (see Chapter 9, this volume).

U.S. immigration policies and the criminalization of undocumented immigrants are environmental factors that have had a deleterious effect on individuals and families seeking refuge from war and gang violence in their home country. Immigration is a journey that often involves family disruption and exposure to traumatic events: When individuals leave parents, children, or siblings behind and travel thousands of miles to the United States, they encounter many forms of violence, physical and sexual, from smugglers and/or border patrol agents (Ochoa O’Leary, 2017). At the U.S. border, they may be arrested, detained, deported, and/or placed with relatives who are U.S. citizens. This may be the first time they meet U.S. family members, and the trauma related to immigration and detention complicates the formation of family bonds (see Chapter 8, this volume).

The “tough-on-crime” policies of the war on drugs are yet another contextual factor that has had an important bearing on U.S. families, particularly Black and Latinx communities. The war on drugs officially began during the Nixon administration and expanded dramatically during the 1980s and 1990s with the criminalization of drug use and the incarceration in unprecedented numbers of nonviolent drug offenders (Drug Policy Alliance, n.d.). In 2016, there were over 1.5 million drug arrests, 80% of which were for drug possession; Blacks and Latinx incarcerated for drug offenses represented 80% and 60% of the federal prison population (Drug Policy Alliance, 2018). Harsh drug policies have had collateral consequences for couples and families with loved ones behind bars, including new financial burdens and the separation of children from their parents (Datchi, Barretti, & Thompson, 2016; see also Chapter 7, this volume).

War and childhood sexual abuse are traumatic events that are “extremely upsetting, and at least temporarily overwhelm the individual’s internal resources, and produce lasting psychological symptoms” (Briere & Scott, 2015, p. 10). When loved ones are deployed to combat zones in foreign countries, military families experience the stress of separation and the fear of loss (Riggs & Riggs, 2011). Over time, when deployments are prolonged or repeated, they may become estranged from one another and struggle to rebuild family cohesion after the military member returns home. Trauma-related disorders, such as posttraumatic stress disorder (PTSD), exacerbate their difficulties with family reunification (see Chapter 6, this volume). They are associated with impaired relationship functioning, emotional withdrawal, and physical and psychological aggression (Pukay-Martin, Torbit, Landy, Macdonald, & Monson,
High levels of negative emotions and low levels of support in family relationships contribute to the development and maintenance of trauma-related symptoms and interfere with recovery.

It is estimated that 25% to 35% of women and 10% to 20% of men have experienced childhood sexual abuse in the United States (Briere & Scott, 2015). Child abuse is a traumatic event that produces significant distress for the individual and the family, more so in cases where the perpetrator is a family member. When the abuse is uncovered, the family system is pressured to change to provide for the children’s physical and psychological needs. In cases of childhood incest, systemic change is a complex relational process that involves resolving feelings of anger, guilt, and grief and undoing loyalty binds and cross-generational coalitions (see Chapter 2, this volume).

The term trauma has also been used to describe the impact of broader societal processes such as racism and other forms of oppression (Holmes, Facemire, & DaFonseca, 2016). The scientific literature has documented the overt (e.g., hate crime) and covert (e.g., microaggressions) expressions of prejudice and discrimination and their traumatic impact on individuals and their relationships (Holmes et al., 2016). When oppression is internalized (i.e., when individuals adopt negative cultural messages about their social identities), individuals are at risk for psychological distress (e.g., low self-esteem, depression, suicidal ideation, substance abuse, disordered eating; Holmes et al., 2016). Internalized oppression may contribute to hostility and violence between family members (Falicov, 2014); it has also been linked to low relationship satisfaction and low rates of marriage among Black couples (Besharov & West, 1998; Kelly & Boyd-Franklin, 2009; see also Chapter 11, this volume).

Extramarital sex is a form of betrayal that may produce psychological distress similar to PTSD (Gordon, Baucom, & Snyder, 2008). The injured partner may report high levels of rage, shame, depression, and powerlessness; may experience a sense of abandonment; and may express shock, numbness, and intrusive thoughts about the affair. They may also engage in denial or avoid their significant other in response to what they perceive as a traumatic interpersonal event. Infidelity is a strategy partners may use to deal with unhappiness and disconnection (Perel, 2017) that can be understood as the outcome of poor self-differentiation in couple relationships (see Chapter 3, this volume).

Current knowledge about divorce, trauma, violence, addiction and social inequities shows the complexity of the clinical problems that couples and families present in psychotherapy. It is critical that practitioners be informed about these contemporary issues and their impact on individual and relational functioning and also adopt a treatment approach that makes it possible to conceptualize the multi-faceted challenges of couple and family life. Couple and family therapy integration is a strategy available to clinicians to increase treatment responsiveness through considerations of clients’ unique clinical needs, characteristics, and preferences as well as empirical knowledge about what works with whom and under what circumstances.
Psychotherapy integration involves the combination of separate psychotherapy theories and techniques into unified treatment models that can meet the ever-changing needs of clients. It calls for the reconsideration of practitioners' identification with a single theory and highlights the limitations of individual systems of psychotherapy (Stricker & Gold, 2006). Psychotherapy integration is founded on the following presuppositions: first, that “no single approach to psychotherapy can deal with all of human functioning” (Goldfried, Pachankis, & Bell, 2005, p. 34) and second, that it is possible to combine the strengths of different theories into a broader and more effective approach to treatment.

Specific approaches to psychotherapy integration have been grouped together within a typology of modes, a term referring to the ways in which theories and techniques are combined to form new integrative systems. These modes have been named technical eclecticism, the common factors approach, theoretical integration, and assimilative integration. Various systems within the discipline of psychotherapy integration can be identified as an example of one of these modes, although the boundaries between them sometimes may be unclear (Gold & Stricker, 2012).

Technical eclecticism refers to a type or level of integration that focuses almost exclusively on using techniques from various systems of psychotherapy while retaining a single theory as its conceptual basis. An integrative approach is identified as belonging to this mode when that approach promotes the use of clinical strategies and interventions that originate in two or more established therapies. Technically eclectic models tend to rely heavily on comprehensive approaches to the individualized assessment of patients, which in turn lead to very specific treatment plans that allow for the selection of techniques from most or any forms of psychotherapy. The role of theory is downplayed in these models, which usually are based on a single theory or are in fact atheoretical. Once the assessment of the client is completed, interventions are chosen on the basis of the best match of particular techniques to the needs of the client, as guided by the empirical literature and clinical experience.

The second mode of psychotherapy integration is known as the common factors approach. Integrative systems that fall under this approach are based on the assumption that it is possible to compile a list of effective ingredients that cut across many, if not most therapies. It is the therapist’s clinical task to determine which of the several common factors may meet the patient’s clinical needs and produce the desired changes. The next step is to select techniques or interventions that have been demonstrated to activate those change factors within the context of therapy. The recent scientific literature has confirmed the critical role of common factors in the effectiveness of treatment (Messer & Wampold, 2002). Overlapping lists of the most important common factors have been presented as guides to more effective treatment. They include the therapeutic alliance; catharsis; exposure, the corrective emotional experience, learning, and practice of new behavior; hope and positive expectations of change; therapists’
ability to instill hope and to reinforce positive expectations; and a therapeutic rationale (Grenavage & Norcross, 1990; Weinberger, 1993).

Theoretical integration refers to the mode of integration that is most conceptually driven and theoretically complex and sophisticated. Theoretically integrative approaches are constructed through the process of combining concepts from two or more distinct and often seemingly incompatible theories into a novel, integrative model with an expanded understanding of psychopathology and new mechanisms of change. Frequently, these theoretically integrated theories assume that environmental, motivational, cognitive, and affective variables exist in mutually influential spheres, affecting each other in reciprocal ways. The linear perspective of cause, effect, and change that is typical of most traditional therapies is replaced by nonlinear or circular understanding of the causes of behavior and psychological change. The first and still most influential model of this type of theoretical integration is Wachtel's (1977) cyclical psychodynamic theory.

Assimilative integration, the fourth mode of psychotherapy integration, might best be understood as falling somewhere between technical eclecticism and theoretical integration. Messer (1992), who coined this term, pointed out that all actions are defined and contained by the historical, physical, and interpersonal contexts in which they occur. Therapeutic interventions are highly complex interpersonal actions defined by the larger context of psychotherapy, and as a result the impact and meaning of a therapeutic technique changes when it is used in a context other than the one where it was developed. If a method such as relaxation training is used within the context of psychodynamic therapy, its meaning to and effects on the client are different than when it is used within the context of a standard behavioral treatment.

Psychotherapy integration is a movement that recognizes the importance of evidence-based practice (Boswell, 2017; Goldfried et al., 2005); its aim is to enhance the effectiveness of treatment and to promote data-driven strategies for identifying which activities are most successful with whom, for what type of problems, and under what circumstances. Psychotherapy integration provides an avenue for reducing the gap between science and practice, at the level of the clinician and the patient, through the integration of theoretical and empirical knowledge about therapeutic change mechanisms including common factors and model-specific techniques.

A Brief History of Psychotherapy Integration

The first integrative efforts in psychotherapy can be found in the writings of Freud (1914), who, early in the history of psychoanalysis, recommended an open and experimental approach to clinical practice. Freud's call for innovation had little traction on subsequent generations of clinicians except for French, Kubie, and Rosenzweig. French (1933) and Kubie (1934) studied the then current work in classical conditioning and described the advantages for using Pavlov's theories and methods within a psychoanalytic framework. Rosenzweig (1936) wrote about the common, underlying, and unifying change
factors that could be found in most, if not all, versions of psychotherapy. Rosenzweig argued that the systematic use of specific change factors, such as exposure or instilling hope, could lead to individually tailored therapies that would be far more effective than a “one size fits all” approach. Rosenzweig’s goal of addressing each patient’s unique needs and matching those needs with specific techniques and change processes eventually became a central tenet and goal of modern psychotherapy integration.

In the 1940s and 1950s, several proposals for integrative therapies appeared in print, yet were met with little enthusiasm. Shoben (1949) was concerned with integrating psychoanalytic theories and methods with the more sophisticated, cognitively mediated approaches to learning advanced by researchers like Hull (1952) and with models of operant conditioning. During the 1960s, the approach of searching for therapeutic common factors initially introduced by Rosenzweig (1936) was reexamined by Frank. In 1961, Frank published *Persuasion and Healing*, a book that demonstrated how psychotherapy-like interventions exist across cultures and historical periods and how these interventions share certain common change factors. This book created interest in identifying common change factors in existing psychotherapies and became an explicit foundation for further integrative efforts.

As behavior therapy (Goldfried & Davison, 1976) moved out of the lab into real-world practice settings, several psychodynamic therapists seized on these empirically tested methods and incorporated them into their clinical work. Writers like Marmor (1971) and Feather and Rhoads (1972) described the integrative use of techniques like desensitization to reduce unconscious conflict by gradually exposing patients to their warded-off fears and fantasies. Paul (1978) proposed an integrative model on the basis of the synthesis of client-centered therapy and psychoanalysis; and Lazarus (1976), concerned about the lagging effectiveness of his standard behavioral techniques, developed multimodal therapy, a version of cognitive behavior therapy.

Many students of the history of psychotherapy integration consider the publication of the book *Psychoanalysis and Behavior Therapy: Toward an Integration* (Wachtel, 1977) to be the watershed moment in the development and legitimization of the discipline. Wachtel produced the first complete integrative theory and associated integrative psychotherapy, both of which exerted considerable, lasting influence and served as models for future work.

During the 1980s and 1990s, work in psychotherapy integration proliferated at a rapid rate, and this approach entered the mainstream in a powerful way. The Society for the Exploration of Psychotherapy Integration was founded in the early 1980s, and its official publication, the *Journal of Psychotherapy Integration* made its debut in 1991. Currently, psychotherapy integration has been accepted as a central model of psychotherapy, and almost all compendia of psychotherapy approaches include a chapter or more on integration (see Lebow, 2008; Messer & Gurman, 2013).

The impact of the psychotherapy integration movement also is apparent in the numbers of articles that have appeared describing psychotherapy integration as a viable approach in many countries around the world. Norcross (2005)
surveyed the scientific literature on therapists’ theoretical orientations and found that less than 20% of clinicians identified with a single school or orientation. In the United States, approximately 30% defined their approach as integrative, and the rates of practitioners who identified as integrative therapists ranged from a low of 7% among psychologists in Australia, to about 33% in Ireland and New Zealand, to a high of 42% among counselors in Great Britain (Norcross, 2005). Stricker and Gold (2011) found that psychotherapy integration was a well-established approach in countries such as Sweden, Japan, Germany, Switzerland, Argentina, and Chile. In Portugal, 25% or more of therapists reported they adhered to an integrative orientation (Vasco, 2008). In Spain, Coscollá and colleagues (2006) found an increase in the number of clinicians who identified as integrative, from 37% to 46%.

**Couple and Family Therapy Integration**

Couple and family therapy (CFT) was originally an integrative field of clinical practice influenced in its development by diverse theoretical frameworks such as experiential, humanistic, and behavior therapy; general systems theory; cybernetics; and psychoanalysis (Carr, 2016). However, the history of CFT, like individual psychotherapy, shows it was not immune from fragmentation into competing theories and interventions (Lebow, 2014). The 1970s and 1980s witnessed the growth of separate CFT schools with charismatic leaders like Minuchin and distinct training institutes. In the 1990s, proponents of family therapy integration together with family therapy research began to pave the road for rapprochement: CFT science established the role of common factors in treatment outcomes (Friedlander, Heatherington, & Escudero, 2016), and new CFT programs emerged that integrated concepts and interventions from diverse approaches to CFT, including empirically supported treatment models.

Many evidence-based intervention programs in the field of CFT are integrative approaches: emotionally focused couple therapy (Johnson, 2004, 2008), functional family therapy (FFT; Alexander, Waldron, Robbins, & Neeb, 2013; Sexton, 2011), and integrative behavior couple therapy (IBCT; Jacobson & Christensen, 1996). Emotionally focused couple therapy is a model that integrates attachment and bonding theory (experiential therapy and structural family therapy) to help couples and families learn to attach in a more secure way to promote individual and relational health. FFT is an integrative and empirically validated family therapy model for adolescents age 11 to 18 with externalizing behavior problems. Treatment is a phasic and relational process that activates common as well as model-specific mechanisms of change to increase the family’s capacity to solve problems and to buffer against individual and contextual risk factors. IBCT is an empirically supported model that integrates strategies for increasing mutual acceptance into the theoretical framework of traditional behavioral couple therapy (Jacobson & Christensen, 1996). IBCT can be traced back to the early days of behavior therapy research with couples (Stuart, 1969; Weiss, Hops, & Patterson, 1973), to the concepts of mutual reinforcement and reciprocity (Azrin & Nunn, 1973), and to Jacobson and Margolin’s (1979) social
learning model of couple therapy that helped partners build effective communication and conflict resolution skills with the goal of disrupting problematic interactions and promoting healthy patterns of relating.

The first book on integrative CFT edited by Mikesell, Lusterman, and McDaniel (1995) described the various systemic orientations of CFT practitioners and the practice of integrative family therapy across the life cycle with a variety of clinical issues. It was accompanied by a casebook that offered an ecosystemic framework for family therapy integration (McDaniel, Lusterman, & Philpot, 2001). In the ecosystemic approach, the family is seen as a system that has strengths and whose well-being and functioning are influenced by other systems (e.g., workplace, community) and their interactions. The emphasis is on collaboration and the creation of respectful partnerships where power is distributed fairly, thus allowing the goals, needs, and wants of the clients to surpass those of the therapist (McDaniel, Hepworth, & Doherty, 1992). Lastly, the therapist is a coach whose role is to equip the client with new perceptions, tools, and ways to change.

In the 1980s and 1990s, Pinsof (1983, 1995) developed an integrative and problem-centered approach to treatment that offered a systematic method for the selection of interventions from various family and individual psychotherapies. This approach focused on three contexts (family–community, couple, and individual) and six metaframeworks (behavioral, biobehavioral, experiential, family of origin, psychodynamic, and self-psychology) to assess how problems are created and maintained in the client’s system. The therapist then identifies constraints that prevent the resolution of presenting problems. Since the 1990s, Pinsof and his colleagues (2017; see also Chapter 11, this volume) have built on the original framework of the problem-centered approach and created a theoretically integrative model that includes the following components: collaboration between the therapist and the client; psychoeducation; empirically supported solution sequences; common sense; therapist’s experience, intuition, and feelings with a deep attention given to the client’s contexts; and common factors (Sprenkle, Davis, & Lebow, 2009).

In 2014, Lebow described the shared theoretical and empirical base of separate CFT approaches and highlighted the common factors, strategies, and techniques that cut across CFT models and constitute generic domains of CFT practice. He distinguished two categories of common factors: The first category, classic common factors, represents therapeutic processes essential to individual and systemic therapies like the therapeutic alliance, therapist characteristics, collaborative goal setting, hope, motivation for change, and feedback about clients’ progress in treatment. The second category comprises common factors unique to CFT. These involve developing and sustaining a relational understanding of the problem and a multisystemic focus; mixing individual, couple, and family sessions; managing session interactions; and promoting positive family communication processes through the use of reframing and solution-oriented, strength-based language.

Lebow (2014) identified four frameworks for CFT integration: the first framework relates to metatheories of CFT practice like integrative systemic
therapy (IST; for detailed information, see Chapter 11, this volume). The second framework corresponds to specific integrative CFT models that assemble common factors with elements of two to three CFT theories like Gurman’s (2008) integrative couple therapy, a treatment approach that focuses on intrapersonal and interpersonal difficulties in couple relationships from a combined behavioral, psychodynamic, and family systems perspective. The third framework is assimilative integration, one of the four modes of psychotherapy integration described earlier. Assimilative family therapy (AFT; Pitta, 2014) is an example of assimilative integration in CFT. This model was developed by Pitta in the 1990s and integrates psychodynamic, cognitive behavior, and communications concepts and interventions into the home theory of Bowen family systems therapy (for detailed information, see Chapter 1, this volume). AFT can also serve as a generic framework for assimilative integration in CFT (see Chapter 8). The fourth framework proposed by Lebow (2014) refers to a group of integrative and idiosyncratic CFT approaches developed by individual practitioners over the course of their career. These individualized approaches typically emerge from the lifelong assemblage of diverse methods and strategies that seasoned clinicians find most effective and suitable for their own practice. Lebow formulated a set of guidelines for the creation of individualized, integrative CFT models. These guidelines call for less emphasis on specific techniques and more attention to the therapeutic relationship and the role of therapists’ personal characteristics. They also emphasize common factors, systems theory, clear and coherent principles and procedures for service delivery, and multiple domains of assessment and interventions—intrapersonal, relational, and contextual. Lastly and importantly, Lebow recommended that integrative CFT approaches be evaluated in light of possible negative interactions between theoretically diverse concepts and interventions.

**THIS BOOK**

*Integrative Couple and Family Therapies: Treatment Models for Complex Clinical Issues* demonstrates the variety of individualized and well-established integrative approaches to CFT in real-world practice settings. It brings together expert clinicians who use a combination of theories and techniques to resolve complex clinical issues and address the unique concerns of diverse clinical populations. This book is intended for a broad audience of practitioners, including psychologists, social workers, marriage and family therapists, and counselors who work with couples and families and who wish to enhance the effectiveness of their approach through CFT integration.

The book chapters are organized into two sections that represent common foci in psychological research and practice: integrative CFT with complex clinical problems (Chapters 1–5) and integrative CFT with diverse clinical populations (Chapters 6–11). Since the 1980s, the field of CFT has witnessed the development and enhancement of intervention programs as well as therapy models and treatments designed to address specific clinical problems and/or populations.
The many integrative theories and models presented in this book enables a practitioner to conceptualize and treat the many complex issues throughout the life cycle in our modern society. This organization highlights the relevance of integrative CFT to the treatment of specific clinical problems and populations.

Each chapter begins with a patient vignette that illustrates a set of developmental and clinical challenges followed by a summary of the research about the issues at hand, the description of the integrative approach, and how it is used to develop a case formulation and a treatment plan that are sensitive and responsive to human differences. (To protect clients’ anonymity, the authors used pseudonyms and changed identifying information.) Multicultural issues are an integral part of effective therapies regardless of the theoretical orientation; however, discussion of how diversity factors like race and gender shape interpersonal dynamics in integrative CFT is beyond the scope of this book. Likewise, our view is that common factors are essential ingredients of all CFT models; for this reason, each chapter describes the role of common factors in the integrative CFT approach and the mechanisms that activate these factors.

Each chapter explains how theoretically diverse concepts and techniques were combined to create a coherent and systematic model of practice with clear guiding principles, key concepts, and mechanisms of change, using one or more framework for psychotherapy integration. Although some approaches fall nicely into one mode of integration, like AFT and IST, others are best situated at the border between technical eclecticism, assimilative integration, theoretical integration, and/or the common factors approach. Most chapters describe expert clinicians’ work with couples. This reflects today’s landscape of CFT practice in the United States where practitioners are more likely to treat couples than families for material reasons like difficulty scheduling sessions with multiple family members (Lebow, 2014).

In Chapter 1, Pitta highlights the key principles and interventions of AFT, an integrative model grounded in the home theory of Bowen’s (1978) family systems therapy that integrates concepts and interventions from psychodynamic, cognitive behavior, communications, and other systemic theories. Chapter 1 shows how to use AFT to understand a couple’s experience of infertility, to help them manage the stress of medical treatment, to resolve difficult emotions about their inability to conceive a child, and to explore alternatives to pregnancy.

In Chapter 2, Fraenkel presents a mode of integration that he defines as multiperspectival and theoretically eclectic, because it brings together, in a systematic fashion, concepts and techniques from different theoretical orientations: structural family therapy, intergenerational family systems, narrative therapy, and feminist family therapy. Treatment consists of using selected concepts and techniques to create conditions necessary for positive outcomes in cases of childhood sexual abuse. These conditions include the creation of a safe environment, a collaborative therapeutic relationship, a focus on cognitive schemas and emotions as well as here-and-now interactions, and a conceptualization of childhood sexual abuse that considers gender and power disparities.

In Chapter 3, Regas describes how to understand and treat infidelity with an assimilative model called mindful differentiation couple therapy that integrates
concepts and techniques of acceptance and commitment therapy into Bowen’s (1978) family systems theory of self-differentiation. The goal of this assimilative model is to foster couples’ self-differentiation using mindfulness techniques designed to promote emotional regulation, reduce anxiety, and balance the partners’ needs for autonomy and connectedness in their intimate relationship. The assumption is that greater self-differentiation is a necessary condition of intimacy.

In Chapter 4, Patterson and Datchi examine financial conflict in couple relationships in relation to gender and power. They also discuss how to reduce interpersonal distress that stems from concerns about money and sharing, with a well-established, integrative model called cognitive behavior couple therapy (CBCT). This therapy offers a systemic understanding of the reciprocal influence between behaviors, cognitions, and emotions in the context of couple relationships and their broader environment and is supported by abundant research on the outcomes and processes of cognitive and behavioral therapies. In particular, the basic principles of CBCT help conceptualize couple dynamics in relation to gender socialization; they provide a valuable framework for assessing partners’ beliefs about money and for understanding their interactions around financial matters. Recent developments of the CBCT model have made space for emotionally focused therapy techniques and dialectical behavior therapy interventions to achieve the goals of treatment.

In Chapter 5, Nielsen highlights the benefits and challenges that new technologies have introduced into couples’ everyday life. He shows how to address these challenges through a theoretically integrative approach to couple therapy called couple therapy 4.0, which combines psychodynamic concepts drawn from depth psychology and psychoanalysis, structural family therapy, and Gottman’s research on successful marriages with psychoeducation, systemic, and behavioral interventions. Nielsen discusses how couple therapy 4.0 can help to understand and treat a middle-age couple with presenting concerns centering on the use of online pornography and sex-themed chatrooms. He also describes how the therapist uses social media to reduce the partners’ social isolation.

In Chapter 6, Katz discusses the unique concerns of military couples post-deployment, and describes the clinical application of an assimilative couple therapy model called holographic reprocessing couple therapy with veterans who have experienced military stress and trauma. This therapy integrates various family therapy techniques (e.g., family genogram, circular questioning) into the framework of holographic reprocessing therapy to help military couples resolve trauma-related symptoms and develop new communication and behavior patterns.

In Chapter 7, Datchi discusses the importance of maintaining couple and family relationships during incarceration and proposes an assimilative model on the basis of FFT to address the unique needs of justice-involved adults and their loved ones or significant others. Specifically, she shows the clinical application of the assimilative FFT model with a married African American couple behind bars. This assimilative model integrates concepts and techniques from Gottman’s research, IBCT, and behavioral couple therapy for substance use into
the home theory and clinical protocol of FFT to assess, conceptualize, and treat the specific relational dynamics that influence the couple’s resilience and risk of further contact with law enforcement. The goals of treatment are to support the partners in their efforts to maintain their bond, to strengthen the protective factors in their relationship, and to increase the likelihood that the husband will successfully return home.

In Chapter 8, Cervantes examines the stress and trauma of undocumented immigration from Latin America to the United States, and their impact on the well-being of unaccompanied Latinx youth. He discusses the need for culturally responsive treatment approaches that take into consideration the spiritual values of Latinx communities and describes an integrative model of family therapy called SALUD, which combines concepts and techniques of structural family therapy and narrative therapy with empirical knowledge about Latinx families. A clinical example is provided to illustrate how SALUD helps resolve the effects of trauma associated with the hazards of illegal immigration.

In Chapter 9, Greenan describes resiliency-focused family therapy, an assimilative model based on the home theory of structural family therapy that incorporates mindfulness practice, effective communication skills, and concepts and techniques of accelerated experiential dynamic psychotherapy. This model is designed to address the reenactment of past attachment trauma in couple and family relationships, to improve emotional regulation and communication, and to develop interactional patterns that enhance relationship satisfaction. Greenan illustrates the implementation of resiliency-focused therapy with a gay couple who experience difficulties with intimacy, a product of their gender socialization.

In Chapter 10, Browning and van Eeden-Moorefield present stepfamily therapy, a model that uses strategic family therapy as a home theory and that integrates concepts and techniques of structural family therapy and Bowen family systems therapy. The authors argue that traditional systemic therapies are ill-fitted for clinical practice with stepfamilies because they do not take into consideration the fluidity and diversity of living arrangements that follow divorce and remarriage. This chapter describes how stepfamily therapy responds to the relational needs of a stepfamily struggling to form new bonds across three generations.

In Chapter 11, Jérémie-Brink and Chambers discuss the clinical application of IST with an African American couple. IST was developed from the integration of two approaches: integrative problem-centered therapy designed by Pinsof and metaframeworks created by Breunlin and his colleagues (Lebow, 2016). IST can be defined as a metatheoretical and empirically informed model of family therapy integration. It provides a set of guidelines and a blueprint that allow for the integration of strategies from different treatment models (Russell, Pinsof, Breunlin, & Lebow, 2016). Jérémie-Brink and Chambers demonstrate that IST is particularly well suited for clinical practice with African American couples, given its emphasis on resilience and contextual factors.
CONCLUSION

The APA Presidential Task Force on Evidence-Based Practice (2006) defined evidence-based practice in psychology as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 273). This book provides examples of what evidence-based practice looks like in real-world clinical settings with the aim of giving readers examples they can use to design their own integrative approach to clinical work with couples and families.

It is our hope that, by illuminating the wide range of integrative practices in CFT, this volume will help professionals begin to identify which practices are the best fit for the complex clinical problems they encounter in the therapy room. We also hope that by pairing summaries of empirical knowledge relevant to the treatment of diverse couples and families alongside our CFT experts’ description of how their interventions work, this book will help readers provide the best services they possibly can to improve their clients’ individual, relational, and social functioning.

REFERENCES


Introduction


INTEGRATIVE COUPLE AND FAMILY THERAPY WITH COMPLEX CLINICAL PROBLEMS
Sandra and Bob have been married for the past 6 years and have been struggling with infertility for the past 4 years. They are both 34 years old and Caucasian. Sandra is of Italian and Irish descent and Bob is of Italian and German descent. They are both college educated and work in managerial positions. Their joint income of over $225,000 per year places them in the upper middle class. They began couple therapy because they were unsure whether to continue in vitro fertilization (IVF) attempts, use a surrogate, adopt, or give up on becoming parents.

The couple was “battle fatigued” as a result of experiencing an emotional rollercoaster over the past several years. Their days were filled with hope, despair, disappointment, hopelessness, and grief as a result of four failed rounds of IVF treatment. Sandra felt her body was a medical experiment, and she was carrying the burden as well as the blame and shame for why the couple could not conceive a child. She was diagnosed with endometriosis, which made it difficult to become pregnant. Sandra felt that she suffered from two chronic illnesses: endometriosis and infertility. She questioned her womanhood and felt there was something wrong with her that affected her self-esteem. The multiple losses experienced through failed IVF procedures were too much for Sandra to bear. She described her fertility life as a “nightmare” that left her feeling traumatized, unable to try more attempts, and questioning her purpose in life. Sandra described looking at herself differently and isolating herself because her infertility had taken on a life of its own. She felt she had become more obsessed with thoughts about her infertility with each failed IVF attempt.
Sandra reported that she could not be with her family members; although they were supportive, she felt they did not understand. They would say, “Things will work out when the time is right,” which would infuriate Sandra because she felt those statements had no meaning. She even found it impossible to go to baby showers or family events organized around children. Sandra felt she could not rationalize why other people could have children so easily when it was such a struggle for her. To make matters more difficult, most of their couple friends were having their second child.

Bob was also filled with utter sadness but was more concerned about his wife than his own well-being. According to the couple, at the time they began therapy, their optimism was at the lowest levels they had ever experienced. The couple’s level of resilience at this point was also very compromised. Bob described himself as the “fixer” and Sandra as the “emotional one,” which made him afraid for her mental stability. They felt they suffered from posttraumatic stress disorder (PTSD) after an extensive journey in which they relived a cycle of hope at becoming pregnant and then grief and despair when they did not. Oscillating between constant hope and disappointment for the past 4 years had left this couple feeling depressed and anxious and questioning the meaning of their lives in terms of becoming parents. Couples like Sandra and Bob who struggle with infertility suffer from anxiety, depression that can result in marital problems, and feelings of low self-worth, which can taint their view of life. With repeated failures of the fertility treatments, PTSD symptomatology and risks are increasing in this population (Corley-Newman, 2017; Maercker, Neimeyer, & Simiola, 2017). This couple’s journey and struggles with infertility can be conceptualized in terms of experiencing trauma and complicated grief and loss.

In addition to PTSD symptomatology, the couple was overwhelmed with the monetary investment in fertility treatments. They had put off buying a house because they were unable to make a down payment after their money was spent on IVF treatments. Sandra had continued to work but was having difficulty maintaining her responsibilities; her boss was giving her time to recover from the disappointments and medical procedures. Bob was doing all that he could to keep his job intact while dealing with the weight of his own sadness, worrying about Sandra, and reassuring family members who were hurt by her distancing. On top of this emotional work, Bob primarily arranged the logistics of their medical treatments and managed the financial decisions needed to offset the couple’s losses. This was a great deal of pressure for Bob to assume, but he compartmentalized his feelings and struggled with underlying depression and anger about what was going to happen to his wife’s long-term adjustment and their relationship.

The couple are Roman Catholics and put their faith in God but felt lost within a “sea of disappointment and despair.” They had embryos left from a previous round of IVF and questioned what would be “morally correct” if they chose not to proceed with further embryo transfers. The couple struggled to face these issues within their efforts to become parents. They were experiencing emotional, medical, social, financial, ethical, and spiritual crises all at once.
INFERTILITY

The issues Sandra and Bob faced are not uncommon, and recognizing that there are others facing similar difficulties can help couples and individuals feel more supported. The widely recognized definition of infertility is the inability for a couple to conceive a pregnancy after 12 months of having regular sexual relations without contraception (Corley-Newman, 2017; Zegers-Hochschild et al., 2009). There is also primary infertility versus secondary infertility, in which the former is distinguished by never having a biological child and the latter by having at least one previous conception (Keskin et al., 2011). About 15% of couples experience infertility issues (Ali, Ebraheem, & Mohamed, 2013; Thoma et al., 2013; World Health Organization, 2015). Between 2011 and 2013 in the United States, approximately 7.4 million women reported using some form of fertility services in their lifetime (Centers for Disease Control and Prevention, 2015). Infertility rates have dropped from 8.5% in 1982 to 6.0% in 2010 for women between the ages of 15 and 44. Women are attempting to become pregnant at older ages (25–44), and as a result of advanced technology, these older women are able to give birth (Chandra, Copen, & Stephen, 2014).

STRESS AND TRAUMA OF INFERTILITY

It has been suggested that infertility causes emotional, physical, social, spiritual, and economic crises within couples (Wenzel, 2014). Most people assume that they can become pregnant (Greil, 1991; McQuillan, Greil, White, & Jacob, 2003), and the idea of becoming a parent is so much a part of their identities, it makes infertility even more stressful (Corley-Newman, 2017). When couples face infertility, they experience high levels of distress. As they proceed with medical regimens like artificial reproductive techniques (ART), their identities can come into question and begin to falter (Burton, 1998; Lin, Li, & Chen, 2017; Turner & Lloyd, 1995). It is thought some women find it difficult to separate motherhood from their feminine identities, which can affect their self-worth and how they think of themselves in relation to others (Jessup, 2005; Morshed-Behbahani, Mossalanejad, Shahsavari, & Dastpak, 2012). Scheper-Hughes (1985) indicated that motherhood becomes the most significant part of a woman’s identity. The concept of “couple love” romanticized by Hollywood is paralleled by the state of motherhood. Motherhood creates a yearning and sense of incompleteness when a woman wants a child and cannot have one because of infertility, leaving the woman and the couple in a state of despair (Greil, 1991; Remennick, 2000; Vikström, Jöreskog, Bladh, & Sydsjö, 2015).

Around 40% to 50% of infertility is due to a lack of viable sperm from the male partner as a result of low sperm concentration, poor sperm motility, or abnormal morphology (Kumar & Singh, 2015). Hormone therapy to increase the levels of serum testosterone is the usual treatment for men. As for expressing themselves, men tend to internalize feelings and avoid or deny what they
are feeling (Brody & Hall, 2008). Men experience sadness and low self-esteem, but when compared with the population at large, the rates of clinically significant mental health problems among this patient population are no higher than in the general population. If men are more isolated and avoidant in their relationships, they may find themselves feeling overwhelmed with anxiety (Fisher & Hammarberg, 2012).

Early research posited that stress, anxiety, depression, and/or emotional disturbance served as primary causes of infertility (Seibel & Taymor, 1982). This has been dispelled by more recent research indicating that infertility can cause stress, anxiety, and depression, but these factors do not cause infertility (Corley-Newman, 2017; Smeenk et al., 2001). Two thirds of infertility cases can be explained by physical problems (equally spread among men and women), and one third of cases can be attributed to issues experienced by men and women or from causes unknown (Mayo Clinic, 2018). Women undergoing fertility treatments are subject to taking several medications that cause side effects, including increased anxiety, sleep interruptions, mood swings, and depression (Carter et al., 2011). For women, infertile symptomatic can escalate to include paranoid ideation, interpersonal strain, major depressive and mood disorders, and dysthymia, which may leave women feeling helpless, alone, and barren physically and emotionally (Hämmerli, Znoj, & Barth, 2009). This can take a huge toll on a woman’s ability to deal with the stresses that accompany infertility. However, most men tend to be supportive of their partners, remaining silent and internalizing feeling, hoping the process will soon end in a pregnancy.

Stress is a nonspecific result of any demand upon the person and environment resulting in psychological and physiological distress (McEwen, 2005; Selye, 1982). How a person appraises the experience is central to defining stress. Couples struggling with infertility, regardless of the cause, can be characterized as experiencing stress and anxiety (Gibson & Myers, 2002; Hämmerli et al., 2009; Vikström et al., 2015). Carter and colleagues (2011) indicated that the stress levels of women undergoing fertility treatments are equal to those of people with chronic illnesses. If a couple believes there is no remedy to their infertility, then the situation can be overwhelmed by negative emotions, which can lead to anxiety, depression, and obsessive thinking (Clay, 2006; Corley-Newman, 2017; Jordan & Ferguson, 2006; Strauss, Hepp, Städing, & Mettler, 2001; Vikström et al., 2015).

The nonfulfillment of parenthood and prolonged exposure to invasive fertility treatments can result in numerous psychological and social problems, with women experiencing higher levels of distress than men (Greil, Leitko, & Porter, 1988; Verhaak, Smeenk, van Minnen, Kremer, & Kraaimaat, 2005; Wright et al., 1991). Couples struggling with prolonged infertility can experience a form of severe stress known as infertility stress syndrome, which includes intrusive thoughts, avoidance of associated stimuli, and persistent symptoms of increased arousal such as sleep disturbances, irritability, hypervigilance, and difficulty concentrating (Millard, 1993). With these increased levels of anxiety, there is a decreased chance of becoming pregnant (Smeenk et al., 2001).
Huang (2013) defined a failure to get pregnant as reproductive trauma, and indeed, it has been found that ART can cause women to experience symptomatology similar to that of PTSD (Haelyon, 2010; Lukse & Vacc, 1999). The increased level of stress on learning that she is infertile may trigger a woman to experience a traumatic event, setting off fears of never becoming pregnant (Gise, 1997; Jaffe & Diamond, 2011). Janoff-Bulman’s (1992) cognitive appraisal theory, known as “shattered assumptions,” explores beliefs about the self, the future, and the world and suggests that trauma events damage individual's benevolent perceptions of the self and world as they know it (Edmondson et al., 2011; Park, Mills, & Edmondson, 2012). Jaffe and Diamond (2011) indicated that the effects of being diagnosed with infertility set off not only cognitive but also physical and emotional reactions, similar to a person experiencing PTSD.

The shock of a diagnosis of infertility can cause a couple to experience posttraumatic stress; continued exposure to the stress of infertility can result in PTSD (Daugirdaitė, Van den Akker, & Purewal, 2015). When couples undergo infertility treatments but do not receive psychological interventions, PTSD symptomatology can increase (Frederiksen et al., 2015; Zaig et al., 2012). Spector (2004) noted that a lack of attention to psychological aspects of infertility is not uncommon. Dingfelder (2006) reported that most couples need some psychological assistance but not extensive treatment. Supportive and grief therapies are the interventions of choice when working with infertility (Neimeyer, 2010). The most important element is that the couple communicates with one another. Additionally, receiving support and positive regard enables them to find new meaning in their lives. Moreover, being capable of better coping mechanisms enables them to make plans on how to go forward in their infertility journey (Cobb, 1976; Lin et al., 2017).

Peterson, Newton, Rosen, and Skaggs (2006) noted that men and women with infertility stress syndrome use different types of coping mechanisms. Men tend to be more avoidant, whereas women take on more responsibility and thus experience higher levels of stress. For men and women, using distancing coping strategies to manage their infertility resulted in experiencing less stress. An interesting finding was that men who used avoidant coping skills to deal with the stress of infertility reported decreased marital adjustment in the long term. Avoidance may reduce the stress related to infertility, but because of the lack of communication, the relationship becomes compromised (Gottman, 2011).

In studies comparing the views of men and women regarding their respective infertility experience, women reported higher levels of anxiety and depression and viewed their infertility as significantly more stressful. Also, women’s self-esteem and depression levels were significantly impacted by a sense of stigmatization and feeling as though there was something defective with them (El Kissi et al., 2013). Men and women can share equal responsibility for infertility issues, but in the sample case in this chapter, Bob does not share this burden. Women often consider themselves more responsible for the
infertility, even if they are not the cause, to protect their spouse from feeling blame (Berg, Wilson, & Weingartner, 1991).

Women with infertility may struggle with lower self-esteem, higher sexual dissatisfaction, and increased depression relative to their male partners. Men are also affected by the stress associated with infertility, but research suggests they use different coping mechanisms, such as compartmentalization, that help them feel less overwhelmed emotionally and allow them to focus on other life pursuits. Many men problem solve and use self-control to deal with their emotions, whereas women accept responsibility, seek social support, and avoid the reminders of infertility (Hart, 2002; Peterson et al., 2006; Spector, 2004). Women report that they have difficulty seeing others pregnant, and they prefer to avoid these situations. In addition, friends and relatives may give advice that is not what the couple wants or feels they need. They desire understanding but want a child. The bottom line is that these women do not want to live in this state of involuntary childlessness (Shreffler et al., 2016).

Grief is an important part of infertility that seems to continue cyclically without end; a couple is disappointed each month by trying and failing to become pregnant and then is faced with the loss of hope of becoming parents. These cycles become chronic, and couples go through stages of grief with each passing month and disappointment. Each menstrual cycle becomes a trigger of stress that reminds the couple that they will not become parents. Grieving is an attempt to find meaning and solidity in the face of loss (Neimeyer, 2010). Menning (1980) indicated that couples go through stages of shock, denial, anger, isolation and guilt that parallel stages of grief similar to those described by Kübler-Ross (1969). In death, there is a body; with infertility there is no apparent loss, which leaves the couple feeling further isolated as they may feel people are not supportive, understanding, or compassionate to their hidden pain. They feel a level of shame and guilt that keeps them locked together. Infertility becomes a very private experience marked with no rituals and little or no outside support (Hanson, 1994; Ramezanzadeh, Noorbala, Abedinia, Rahimi Forooshani, & Naghizadeh, 2011).

The distress experienced by women with infertility can be compared with the distress experienced by women who have life-threatening illnesses like cancer, heart disease, or AIDS as well as victims of car crashes, abuse, or combat. This can create and be linked with PTSD, as mentioned earlier (Corley-Newman, 2017; Deka & Sarma, 2010; Frederiksen, Farver-Vestergaard, Skovgård, Ingerslev, & Zachariae, 2015; Greil, McQuillan, Lowry, & Shreffler, 2011; Mosalanejad & Khodabakshi Koolee, 2013; Zaig et al., 2012).

There are conflicting views as to the effect of infertility stress on marriage and sexual relations. One view is that it can be associated with lower quality of marriage and well-being (Abbey, Andrews, & Halman, 1994; Corley-Newman, 2017; Howarth, 2011; Ramezanzadeh et al., 2011), whereas another view indicates that it brings the couple together in a more intimate way because they feel they are “in this together,” such that their bond becomes stronger (Pasch & Sullivan, 2017).
RECOVERY FROM INFERTILITY TRAUMA

Seventy percent of the population will experience a trauma at some time in their lifetimes (Van Ameringen, Mancini, Patterson, & Boyle, 2008), and social support has been found to be one of the most salient factors in trauma recovery (Birkeland, Nielsen, Hansen, Knardahl, & Heir, 2017; Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003). The use of couple therapy can act as a supportive therapy during or after medical treatment for infertility, enabling couples to envision their world in a more positive manner. It can help couples cope and find more effective ways to navigate their journey toward parenthood (e.g., pursuing adoption, using a donor egg or sperm) or decide to live childless (Fredman et al., 2016).

The use of an integrative family therapy model known as assimilative family therapy (AFT; Pitta, 2014) is an effective way to enable couples with infertility to receive the mutual support they need. AFT was developed for treating couples and families to meet the needs of complicated families facing dilemmas that needed resolution. Therapy that is integrative can be more effective when addressing complex family and individual issues than a single modality (Norcross & Goldfried, 2005). Wampold and Imel (2015) indicated that an integrative model that holds a common factor lens when compared with a one-theory approach is more effective. The AFT model can also allow couples to open their perceptions, helping them to see the world as more benevolent and meaningful, so they will be able to manage the stresses, isolation, and emotions associated with infertility. In the case of Sandra and Bob, AFT can help them grieve the loss of their many attempts at trying to conceive, reconstitute their personal and couple meaning, and make the necessary decisions to adopt, try more ART attempts, consider surrogacy, or forgo parenthood.

ASSIMILATIVE FAMILY THERAPY MODEL

AFT (Pitta, 2014) is an integrative model that has its origins in assimilative integration (Messer, 1992, 2017; Stricker & Gold, 2006) and healing integrative family therapy (Pitta, 2005). The basic assertion in assimilative integration is that a “home theory” is identified and concepts and interventions from other theories are integrated into the home theory. It is important to note although integrating concepts and interventions with the home theory, the therapist needs to keep the goals of the home theory and those that the client has identified as top priorities. With assimilative integration, the concepts and interventions that are integrated become much more powerful when integrated with the home theory and create a new model that meets the client’s needs and goals (Messer, 1992, 2017). The uniqueness about assimilative integration model is that each clinician can choose his or her own home theory and integrate concepts and interventions from other theories with the home theory.
The AFT model differentiates itself from assimilative models (Messer, 1992; Stricker & Gold, 2006) in that the home theory is a systemic family therapy model. In working with couples and families, what is best suited to assist in addressing the needs and goals of the clients is a system’s model as the home theory and then integrating concepts and interventions from other theories. A therapist choosing to create their own AFT model can use a systemic theory of their choice as the home theory and then integrate concepts and interventions from other theories. In the case of Sandra and Bob, the therapist used the Bowen family systems therapy as the home theory. Concepts and interventions were integrated into Bowen family systems therapy from psychodynamic, cognitive behavior, communications, and other systems theories (Pitta, 2014). The goals of Bowen family systems therapy are to lower anxiety and reduce emotional reactivity and differentiation of the individuals and the system.

AFT enables a therapist to create a case conceptualization that considers the individual and systemic needs and goals. Context is identified with a contextual questionnaire (Pitta, 2014) given to clients before they enter treatment and then evaluated by the therapist before he or she meets with the clients. What is essential to AFT is a deep respect for contextual variables (age, ethnicity, cultural and racial background, sex, gender identity and marital status, life stage, life cycle, socioeconomic status, resilience, attachment, emotional regulation, optimism, chronic illness, religion, spiritual affiliation, and spiritual beliefs). Contextual variables for Sandra and Bob are depicted in Figure 1.1.

**FIGURE 1.1. The AFT Contextual Diagram for Sandra and Bob (Pretreatment)**

Levels of resistance are also measured by a questionnaire created by the therapist (Pitta, 2014) on the basis of works by Beutler and Harwood (2002) and Dowd, Milne, and Wise (1991). It is given to the clients before the first session and reviewed by the therapist to understand the levels of resistance of the clients, which will indicate resistant or cooperative behaviors with direction of the therapist. This is important when infertility is the presenting issue, because it may also affect how clients follow through with medical advice. The more resistant the clients are, the less directive the therapist will be initially, until necessary bonds and therapeutic alliances are formed and the therapist determines the clients’ willingness to accept his or her input.

The relationship patterns of the couple is evaluated by the creation of a genogram where information is secured about members of the family, relationship options, intergenerational transmission processes, overly close and distant relationships, deaths, births, and other important events. The genogram offers a pictorial view of membership and processes the generations use to relate (McGoldrich, 2016; McGoldrich, Gerson, & Petry, 2008) to help in the formulation of a case conceptualization and treatment plan that helps clients resolve their unique dilemmas.

Pitta (2014) created a questionnaire for the therapist that helps in creating a case conceptualization. These questions prompt the therapist to explore the reasons clients come to therapy, the results of other therapy attempts, the identification of systemic and individual patterns, the use of projection and defenses used to deflect responsibility, the choice to remain stuck in nonfunctional patterns or to avoid pain, the cognitive and behavioral patterns used, the role of secrets, and the way clients communicate that contribute to the formation and maintenance of dilemmas and presenting issues.

The AFT model emphasizes the use of common factors (Duncan & Miller, 2000; Spreenkle, Davis, & Lebow, 2009) that include the therapist and clients forming a bond that enables clients to feel understood, clients believing that the therapist can help, and clients committing to work in treatment and setting realistic goals to promote therapy effectiveness. One of the easiest ways to understand how clients are feeling about the therapy process is for the therapist to ask them directly. Pitta (2014) identified this process as “taking temperature checks” in which the therapist assesses clients’ level of comfort with what was discussed in the present session, whether the clients feel that the therapist is helping them, and what other issues need to be addressed in future sessions. This form of questioning enables the therapist and clients to recognize where changes need to be made in terms of therapy process or content and enables them to keep reevaluating goals. Temperature checks also keep the therapist in touch with the common factors that ensure the maintenance of the alliance with the clients and effective outcomes.

Psychoeducation is also an important tool that the therapist uses in the AFT model by offering knowledge about specific topic and concerns of the clients with the hope of empowering them to deal with their presenting dilemmas (George, Taylor, Goldstein, & Miklowitz, 2011). It is essential for the therapist
to inform clients about the processes they use to interact with others and how they share feelings, thoughts, and ideas. Psychoeducation helps the clients understand the presented information about their psychological symptoms and, when necessary, their medical issues as an important way to empower them to learn to help themselves.

**ASSIMILATIVE FAMILY THERAPY WITH SANDRA AND BOB**

Sandra has a poor attachment and conflict with her high-strung mother; her father was quieter and stayed on the periphery of family interactions. She feels her parents cannot be a source of support, which increases her feelings of isolation and sadness. Sandra’s two older brothers live out of state, and she sees them only at holidays. She does not have a close relationship with them, and they are not a source of connection or comfort for her.

Bob has a more connected relationship with his parents, and he feels he can communicate with them. He has two younger brothers who not yet married. The couple feels isolated because of the negative view of the world that Sandra has adopted and to which Bob has conformed for the sake of his wife’s well-being.

The couple has a negative view of their lives and realizes that there has been a great strain on their marriage. They are also struggling with sexual issues related to the on-demand sex they experienced while tracking Sandra’s ovulation cycles. The day-to-day pressures of monitoring hormone levels and adhering to strict windows of time for sex impeded their desire to have or even think about sex. The couple’s resilience is at the lowest levels they could remember, but they possess the desire to find resolutions to their dilemmas.

Sandra and Bob identified their goals as being able to decide whether to continue attempting IVF trials, to pursue adoption or surrogacy, or to give up the idea of becoming parents. The therapist noted that they needed to work through the emotional trauma related to their infertility experiences as well as their mutual levels of depression and loss of hope in seeing the world as a benevolent place where some of their dreams could be reached. The therapy was to provide each member of the couple an opportunity to deal with their personal feelings and couple interactions to provide support and healing for both.

**Concepts and Interventions Integrated With Bowen Family Systems Therapy**

When evaluating clients, the AFT therapist explores the use of defenses from psychodynamic theory such as repetition compulsion, denial, doing and undoing, distortion, splitting, projection, introjection and projective identification that clients use to avoid dealing with their pain and realities (Freud, 1959; Scharff & Scharff, 1991, 2005). For Sandra and Bob, the therapist selected the following interventions from cognitive behavior theory, which are effective for helping clients change their thoughts and behaviors: cognitive relabeling,
assertiveness training, relaxation skills, role play, modeling, and mindfulness (Bandura, 1977; Beck & Beck, 2011; Ellis, 1962, 1976; Jacobson, 1929; Kabat-Zinn, 2003, 2005, 2011; Lazarus, 1971, 1989; McCollum & Gehart, 2010). The therapist also integrated the sound house theory and its many concepts and interventions in teaching couples how to talk and listen respectfully to build trust and intimacy (Gottman & DeClaire, 2001; Gottman, Gottman, & DeClaire, 2006). In addition, other systems theories, concepts, and interventions are integrated, including parenting the parents (Kirschner & Kirschner, 1986), setting boundaries (Minuchin, 1974), and exposing family secrets (Imber-Black & Lerner, 2009).

**Initial Treatment Sessions**

Sandra and Bob presented with their struggles revolving around trying to become pregnant. The therapist worked on connecting with them in a meaningful way, so they would feel heard and realize they could be helped. The therapist assisted the couple in exploring their nuclear and extended family relationships to identify repetition of patterns in their present relationship as well as areas of support. Using psychoeducation, the couple learned about the repetition of patterns within the relationship between Sandra and her mother. A conversation ensued regarding changing their negative views over their ability to become parents. The therapist worked with the couple using mindfulness exercises to help with their anxiety levels and discussed the couple’s ability to relabel their situation as a struggle that will be remedied in some way. The therapist took temperature checks during and at the end of each session to fully evaluate the couple’s level of connectedness with the clinician, and to assess whether they felt they were understood and being helped to ensure that the use of common factors was monitored to promote effectiveness of treatment.

In the first two sessions, the therapist worked with Sandra and Bob to create an alliance where they could feel safe and related to, and together they identified goals for the treatment as well as talked about how therapy could help them. The therapist created a genogram where family relationships were tracked and family patterns identified. Isolation and conflict were a common occurrence for Sandra’s mother in her relationship with her own mother (see Figure 1.2). Sandra and her mother repeated this pattern in their relationship. With this pattern in mind the therapist explored how Sandra related to other family members and friends. It became obvious that Sandra tends not to trust others and removes herself from the support of other relationships making her vulnerable to depression and anxiety. The therapist used psychoeducation to help Sandra and Bob understand family patterns and how these patterns influenced their feelings and behaviors.

Before their third session, the therapist created a case conceptualization by answering the case conceptualization questionnaire for therapists (Pitta, 2014) and came up with the following summary of why they had come to treatment and what they hoped to accomplish. A case conceptualization can change as the therapy proceeds and new challenges arise and the couple’s growth is
The squiggly lines demonstrate conflict. The straight lines demonstrated a connected relationship. Lack of line demonstrated no relationship or not reported.
realized. The therapist shared this conceptualization with Sandra and Bob during the session.

**Case Conceptualization**

Sandra and Bob had come to therapy because of four failed attempts at IVF and were feeling hopeless and helpless. They had been struggling to have a baby for the last 4 years and had spent most of their financial savings on medical attempts to become pregnant. They were now at a crossroads to determine whether they should continue IVF treatments, look for alternative means of having a child, or give up the journey and resolve that they would not become parents. Throughout their efforts, they had been feeling isolated from those around them, resulting in a lack of social support for their heightened levels of stress and anxiety. The therapist envisioned therapy as one that freed them of their isolation and depression, starting with including the AFT therapist in their story, in the hopes that this would expand to include other necessary professionals, as well as ultimately reconnecting with family and friends.

During the third session, the therapist discussed the case conceptualization and identified what goals the couple hoped to achieve through therapy. Sandra talked about her anxiety at not being able to become pregnant and explored how she identified and introjected with her mother’s problematic coping skills. The therapist and the couple also explored how infertility had affected their sex life and discussed how they could change their thinking about having sex if they were free of the pressure of IVF procedures. The therapist used the technique of relabeling their thoughts and demonstrated how they could use mindfulness to lower their anxiety and to talk about their sex life before their journey of infertility. If Sandra and Bob could remember a time when they had a positive sex life before undergoing IVF procedures, they could feel hopeful about restoring this for themselves in the future. Sandra and Bob also expressed a concern from a religious perspective about what they would do with their remaining viable eggs if they decided not to pursue IVF or any other means of biological parenthood. The couple examined the available possibilities, and the therapist also suggested they speak with a priest regarding these concerns.

**Exploring Mind-Set and Options**

In the next few sessions, Sandra and Bob appeared more relaxed. They reported that they had gone to speak to a priest and found great comfort in the discussion that had ensued regarding their religious concerns and the IVF treatments. Talking about their experiences in trying to get pregnant with the priest further opened up their isolated lives and offered them solace around their anger with God. It also helped them realize they had choices in what to do next.

They shared that they had been having more open and honest communication regarding their intimacy, their sex life, and their ability to overcome difficult experiences as individuals and as a couple. Sandra was able to acknowledge that the trauma from medical interventions was overwhelming, and the
couple worked toward dealing with those feelings. They reviewed the stages of grief and talked about their anger, hopelessness, and hope for renewal. Sandra and the therapist continued to explore how her family had never appropriately dealt with anger and anxiety, and they worked on her differentiating from these patterns.

The couple also wanted to talk about the issue of money and whether it was realistic for them to put more money into this process. They truly wanted to buy a house, but also felt that a house without a child was meaningless. The therapist asked them to describe what having a child meant to them, and whether having a biological child through Sandra’s becoming pregnant was more important than rearing a child that was not biologically theirs. This was the therapist’s attempt to explore options and open the couple’s mindsets toward looking at childbearing versus childrearing. Ultimately, they decided to explore adoption as a possibility, because Sandra and Bob agreed that IVF treatments would be too much of a physical, mental, and financial strain.

In treatment, Bob revealed that he had a cousin with whom he had a close connection in the past. The therapist suggested that the couple reconnect with this cousin, but Sandra stated she was not ready for this step. Sandra was playing the role of the boundary guard (i.e., the person who gives permission to move forward on an issue; Bowen, 1978). She did not want to reconnect because she feared that Bob’s cousin would be critical of the couple’s medical choices or otherwise offer “advice” to them about parenthood. The therapist asked Sandra to think about her and Bob’s relatives differently and see them as avenues of support. The therapist also suggested that Bob contact his cousin and when Sandra was ready, she could join them. Bob could choose to share with her about the constructive aspects of his renewed relationship with his cousin and Sandra agreed.

Shortly after this, Sandra and Bob met a couple that had been through a similar IVF experience and ultimately adopted a child. They discussed the adoption process with Sandra and Bob and gave them the name of a lawyer who helped them. Sandra said she was not ready to say that would be their next step, because the cost of the adoption process would put their house hunting on hold. However, they seemed to be more open to different options. Importantly, although they still mourned the loss of not being able to have a child, they were better able to communicate these feelings. Throughout these sessions, the therapist regularly checked in to see how each member of the couple was feeling. They reported feeling comfortable and that they were making progress.

**Therapy Termination**

In the final session, the couple reported that they had met with the couple who had adopted, had lunch with Bob’s cousin, and Sandra had even reached out to one of her cousins. Sandra was feeling she was no longer a “barren woman,” and that there were options for rearing a child. She said that the concept of rearing a child rather than bearing a child made a difference in how she thought
about becoming a parent. The therapist talked about the role of secrets and how they bind people to stay stuck. The couple realized that there was nothing wrong with them and that they would achieve parenthood in a different way. Sandra informed me that she had also made a date with her parents to talk to them. She was able to see herself as separate from her mother’s emotional reactivity and had gained emotional support from others enabling her to feel more differentiated and not threatened by how her mom might choose to interact with her.

At this point, the couple felt they no longer needed therapy because they had made progress and could proceed. They also discussed returning if they ever felt stuck. The therapist conducted a final temperature check and agreed with the couple to terminate the sessions with the acknowledgement that if they wanted to come back it was not a sign of failure, but a mental health check-in to evaluate their next steps.

Before Sandra and Bob left, the therapist reviewed the many doors that had opened for them while in treatment: They had worked on reconnecting with their support network in their families, they found new relationship options (a couple with a similar journey infertility), and Sandra differentiated from her mother by recognizing she did not need to continue her mother’s interaction patterns nor adopt her negative perspectives. The couple realized that isolating themselves to keep their secret (IVF struggle) had set them up for increased anxiety and depression and resulted in their becoming stuck in their functioning. They had learned to relabel their thoughts about their dilemma, and practiced mindfulness to get them in touch with their inner strengths to change their perceptions. Most important, they had reframed their thoughts about having a child versus rearing a child. Their treatment and the theories and techniques assimilated within it is summarized in Table 1.1.

### TABLE 1.1. Assimilative Family Therapy Interventions

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Bowen family systems</th>
<th>Creation of genogram, exploring inter-generational patterns and how Sandra’s family dealt with traumatic events, working on differentiation, opening up relationship options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychodynamic</td>
<td>Identification and introjection of Sandra’s mother’s reactions to life’s disappointments, focus on repetition of mother’s coping</td>
<td></td>
</tr>
<tr>
<td>Cognitive behavior</td>
<td>Mindfulness and visualization tasks, relabeling Sandra’s identification with her mother, relabeling the couple’s thoughts about sex and parenthood</td>
<td></td>
</tr>
<tr>
<td>Tools</td>
<td>Temperature check, psychoeducation around family patterns and context</td>
<td></td>
</tr>
</tbody>
</table>

CONCLUSION

AFT is a model of couple and family therapy integration that enables a therapist to create a treatment that identifies clients' unique contexts and levels of resistance with a deep respect for context and common factors. This chapter demonstrated the integration of the Bowen family therapy systems as a home theory while integrating concepts and interventions from psychodynamic, cognitive behavior, communications, and other systems concepts to enable a couple to reach their stated goals and resolve their dilemmas.

Couples with infertility often experience it as a type of trauma. Supportive therapy is found to be very helpful in working through infertility stress syndrome. The AFT model, when applied to couples, is a supportive treatment that provides a new perspective on their issues and offers them the ability to find resolutions they could not imagine before the treatment. The AFT model enables clients to change their perceptions and become mindful, helping them reduce their anxiety and depression levels. It also allows them to work through their individual contributions and reevaluate the defenses they use to deal with their challenges. The AFT model looks at family patterns and how they help clients stay stuck or move forward to resolve dilemmas.

The AFT model reinforces the couple's strengths and helps them develop coping skills as well the ability to deal with systematic and individual patterns that contribute to the nonresolution of dilemmas. The AFT model enables clients to differentiate and reconnect to their family of origin as part of their support network: to work toward lowering their emotional reactivity, depression, and anxiety levels; and to visualize their dilemmas in different ways.

The struggles to become pregnant will be an ever-present issue—many people are marrying later, same sex couples are choosing to have children, and some women are choosing to have children without the support of a partner. The AFT model helps individuals support each other and identify other sources of support around them. It can be useful in helping couples that are struggling with infertility as they attempt to become pregnant via traditional or nontraditional means. The AFT model already has been applied to couples and families throughout the life cycle struggling with various health, personal, couple and family relating issues (Pitta, 2014).

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Rethinking Adult ADHD

Helping Clients Turn Intentions Into Actions

J. RUSSELL RAMSAY
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Introduction

The seed for this book was planted in Catania, Sicily, in 2002 at the Vulcanica Mente (Volcanic Mind) conference during a workshop I conducted with my colleague, collaborator, and friend, Dr. Anthony Rostain. We were presenting an early iteration of our integrated cognitive behavior therapy (CBT) and medical approach to treating adults with attention-deficit/hyperactivity disorder (ADHD). It was this sparsely attended workshop that led me to quip that these early days of our work suffered from “attendance deficit.”

During a question-and-answer session with a small but enthusiastic group of attendees, Dr. Dominic Lam, an expert in CBT for bipolar disorder, asked a very reasonable question: “What is the main cognitive theme in adult ADHD?” He noted that other disorders (e.g., depression, anxiety) that fit within the overarching CBT model display cognitive specificity and distinctive themes in the thoughts of those with a particular diagnosis, and this can guide interventions. Indeed, a tenet of the cognitive component of CBT is that information processing problems play a central role in the vulnerability for, onset of, and persistence of many psychiatric disorders and other forms of emotional distress, even if they do not play a direct etiologic role. At that point in the evolution of CBT for adult ADHD, this question had not yet been addressed by us or our colleagues specializing in the psychosocial treatment of this clinical population. Low self-esteem and maladaptive thinking patterns were observed in adults with ADHD, but no central theme was put forth by anyone. After watching me stumble over observations about the common thinking errors

http://dx.doi.org/10.1037/0000158-001
Rethinking Adult ADHD: Helping Clients Turn Intentions Into Actions, by J. R. Ramsay
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seen in adults with ADHD, Dr. Arthur Freeman, an authority in CBT, leapt to my rescue and noted that CBT and the common distortions offer a model that can be flexibly applied to a variety of disorders. The matter seemed to be settled.

In the intervening years, every workshop I led and every journal article or chapter I authored on CBT for adult ADHD included a disclaimer that ADHD is not the result of negative thinking; it creates life problems that create maladaptive thoughts. Even though CBT approaches have since been well adapted to adult ADHD, as demonstrated in many outcome studies and meta-analyses, the role and relevance of cognitive interventions for adult ADHD has been questioned over the years (Ramsay, 2017b). ADHD can be understood as a performance or implementation problem of difficulties organizing and following through on viable actions and plans (Ramsay & Rostain, 2016a). CBT interventions promote skill-based compensations, coping strategies, and other workarounds for the core difficulties associated with the disorder (e.g., time management, organizational skills, procrastination). There are no “trade secrets” about how to manage ADHD. These behavioral skills, when used, will most definitely improve coping and functioning; and cognitive interventions are helpful as ADHD coexists with mood and anxiety issues and low self-esteem, which are matters within the scope of CBT but that do not necessarily offer distinctive and targeted interventions for ADHD.

THE COGNITIVE THEME IN ADULT ADHD

So, what is the use of a book-length discussion on the role of thoughts and beliefs in the understanding and treatment of adult ADHD? It seems that the issue was decided by my meager response to Dr. Lam’s query nearly 2 decades earlier and a circumscribed role for the cognitive domain of CBT for adult ADHD, mainly for cases with coexisting anxiety and depression.

However, the issue is more complex than that. I fully subscribe to the fact that the chief aim of CBT for adult ADHD and its main outcome measure is behavioral; clients can improve functioning and well-being using known coping skills. The cognitive domain, however, provides an essential mediating ligament between the intention and the action in adult ADHD, especially (but not exclusively) for these behavioral coping strategies. Cognitive interventions operate by targeting the implementation deficit that is a defining characteristic of the disorder. It is maladaptive cognitions that often interfere with the deployment of necessary coping strategies for addressing the self-regulatory problems characteristic of ADHD that then set off the cascade of life problems and impairments that necessitate treatment.

A lifetime diagnosis of ADHD is associated with an increased risk for impairments in most domains of life (e.g., school, work, health and well-being, relationships) and, on the basis of recent data, an increased risk of shortened life expectancy. In addition to the day-to-day stress that comes by way of
living with ADHD, these domains represent the spheres of life from which one derives a sense of self and belonging. The thoughts, beliefs, and attitudes that develop when clients face these recurring difficulties can affect their identity, perceived opportunities, and sense of effectiveness and hope, all of which stem from the “consistent inconsistency” in the ability to organize behavior across time, which is a recurring theme in the lives of adults with ADHD.

Apart from making the case that the cognitive domain in CBT for adult ADHD is an essential one (though not sufficient) for fostering improvements in clients, a goal of this book is to offer a much-delayed answer to Dr. Lam’s question and propose that, indeed, there is a central cognitive theme in adult ADHD. This theme relates to a facet of self-efficacy (i.e., self-regulatory efficacy; Bandura, 1997), which is a circumscribed, relatively unsung factor that is a footnote nestled within the broader self-efficacy construct. Impaired self-regulatory efficacy in the cognitions of adults with ADHD sheds light on the cognitive domain as an important mediator of the behavioral strategies by its focus on their implementation, which enables clients to convert intentions into actions, particularly with their proneness for escape–avoidance.

Procrastination is one of the most common problems for adults with ADHD. When recounting examples of missed deadlines or last-minute work binges to beat the clock, adults with ADHD describe knowing full well how to manage such tasks. Maladaptive negative thoughts about a task (or maladaptive positive thoughts) are part of a sequence that gives rise to avoidance despite this know-how, whether it is at the planning stage, how tasks are defined, or the mind-set about the various factors involved in actual engagement and follow-through. These and similar “pivot points” provide high-yield junctures for intervention where the cognitive domain of CBT plays an acutely important role in the use of coping skills for effectively managing and living with ADHD.

INTENDED READERSHIP

This book is written for practicing mental health professionals, clinician–researchers, and clinicians-in-training who are seeking credible and clinically useful approaches that deliver demonstrable improvements in lives of clients with adult ADHD. Related professionals (e.g., educators, advisors, counselors) working with college students with ADHD or ADHD coaches may also find insights and tips helpful to their work. I hope this book is written in a manner such that interested lay readers will also find helpful insights for managing ADHD.

The focus on the cognitive domain of treatment offers a heretofore unique adjunct to and support of the useful coping strategies in existing treatment manuals, client workbooks and guidebooks, and popular self-help approaches. Although this book will deal with adult ADHD through the prism of the cognitive domain, its relevance for behavioral and other interventions is
evident throughout the chapters and case examples. The overarching goal is to "see the world through the eyes—and mind-sets—of our clients" to guide and personalize treatment to make it optimally effective.

**OVERVIEW OF THE BOOK**

Each chapter of this book is devoted to the understanding of an aspect of the role of the thoughts and beliefs observed in adults with ADHD. This understanding is used to inform targets for therapeutic interventions, illustrated with case examples. Chapters 1 through 6 offer a Key Clinical Points section that provides useful notes for therapists and models the types of externalized coping reminders provided to adults with ADHD that increase the use of skills outside the session.

Because most therapists have limited knowledge of the ins and outs of ADHD, Chapter 1 provides a therapist-friendly review of the contemporary understanding of ADHD in adulthood. This primer goes beyond diagnostic symptoms and criteria, underscoring ADHD as a neurodevelopmental syndrome of self-dysregulation. Facets of a broader, unified theory of psychology are introduced that are consistent with and reinforce this contemporary view of ADHD, and these facets shed light on other underlying difficulties faced by adults with ADHD. This foundation provides a way for therapists to better understand and discern the manifestation of ADHD in their clients’ experiences—to “see” ADHD—and better understand their struggles. Research summaries of the prevalence, persistence, and impairments of ADHD in adulthood underscore the need for treatment. More specifically, CBT for adult ADHD is better understood as targeting and operating at the level of the functional impairments than as directly treating the core symptoms.

Chapter 2 outlines the research relevant to CBT for adult ADHD, including cognitions and beliefs typically encountered in clinical practice. The chapter starts with a review of evidence-supported medical and psychosocial treatments, which are focused on outcome studies of CBT for adult ADHD. Recent research on cognitive distortions and maladaptive schemas in samples of adults with ADHD that support a CBT model of adult ADHD and its constituent interventions are then reviewed.

The overarching CBT model for the conceptualization and treatment of adult ADHD is presented in Chapter 3. The CBT case conceptualization is discussed first, which itself is a clinically informed synopsis of the overarching CBT model of psychotherapy. The discussion of the adaptation of this model to adult ADHD, particularly the cognitive domain, is achieved through the introduction of the contemporary generic cognitive model of emotional disorders. This introduction highlights recent modifications to the generic model pertinent to (though not mentioning) ADHD and clarification of points where CBT specifically designed for adult ADHD has been adapted to the unique features of this clinical population. This chapter will draw on the aforementioned models and research to introduce the ways in which cognitions
and beliefs are clinically relevant in the psychosocial treatment of adult ADHD, including the proposal of self-regulatory efficacy as the central cognitive theme followed by an outline of the premises about adult ADHD that inform a set of premises about psychosocial treatment of adult ADHD.

Chapter 4 takes this adapted CBT model and self-regulatory efficacy cognitive theme and reviews the cognitive interventions within CBT for adult ADHD. This chapter uses classic cognitive interventions that are tailored for use with adults with ADHD. In addition to assessing and modifying the cognitive patterns and distortions of adults with ADHD, the role of these approaches to frame/reframe tasks, promote implementation and follow-through on behaviors, and deal with maladaptive positive thoughts are among the clinical topics.

Building on this, Chapter 5 illustrates these cognitive interventions “in action” to provide therapists with frameworks for helping clients who have difficulties organizing behavior over time and deploying tried-and-true coping strategies that improve functioning. CBT for adult ADHD can be considered extended release CBT or implementation-focused insofar as the goal is to make interventions portable or “sticky”; the aim is to increase the use of these strategies by clients outside the consulting room at the time and place when they are needed most. Topics in this chapter include helping clients address the common presenting issues of procrastination, time management problems, and disorganization as well as dealing with ambivalence about starting treatment, handling setbacks, and other essential coping issues for adults with ADHD.

Chapter 6 covers several miscellaneous “special case” clinical issues relevant for therapists. Topics include managing comorbid mood and anxiety problems (and suicidality), excessive technology use, phase of life problems for young adults and older adults with ADHD, attitudes about medications, and others. The thoughts and beliefs of loved ones and other stakeholders in the lives of adults with ADHD are also reviewed, including reactions by therapists when working with adults with ADHD.

Although case examples are used to illustrate interventions and principles throughout the book, Chapter 7 provides three extended case examples to give readers a sense of how everything fits together. Common issues are discussed related to procrastination, implementation of coping skills, emotion regulation and comorbidities (including substance use), and automatic thoughts and core beliefs, among others, and therapist commentary is interspersed throughout the case examples.

In addition to the various sources cited throughout the book, the reference list provides interested readers with manuals and client guidebooks for CBT for adult ADHD, which are denoted with an asterisk. The Appendix provides a list of additional credible resources, including client- and therapist-oriented websites and organizations.

1All clinical case material has been altered to protect client confidentiality.
CONCLUSION

ADHD is a uniquely and disturbingly mystifying condition for those affected by it. It is not a knowledge deficit. Advising clients struggling with procrastination to “start earlier” is like telling people with depression to “cheer up.” ADHD is an implementation problem—a problem efficiently organizing and carrying out viable actions toward desired, viable, but deferred goals. An insidious aspect of ADHD is that the very problems for which clients seek help are the ones that could undermine psychosocial treatment—poor follow-through on coping skills and use of the skills outside the consulting room.

The model reviewed in this book is designed to help adults with ADHD define and navigate small, achievable pivot points for taking small behavioral steps with which to implement their skills and plans. This model also provides a template with which they can understand their setbacks in behavioral terms (“I did not break down that task into small enough steps”) rather than in characterological terms (“I’m a failure”). This template turns coping with ADHD into something actionable clients can “do.”

I hope that practicing clinicians who read this book will come away with a similarly useful template with which to “see” the challenges faced by their clients with adult ADHD, “hear” the inner self-talk of cognitions and beliefs, and collaborate with clients to establish specific therapeutic skills and strategies that they can “do” to good effect in their lives. These approaches, often used in combination with coping tools and strategies developed and disseminated by many professionals in the specialty of adult ADHD, hold the promise of helping clients achieve newfound improvements and outlooks about their worlds, their futures, and themselves.

For a clinical demonstration of many of the ideas described in this book, see Adults With ADHD, an American Psychological Association video now available at https://www.apa.org/pubs/videos/4310004.html.
Before the role of thoughts and beliefs in the experience and treatment of adults with attention-deficit/hyperactivity disorder (ADHD) is addressed, it is important to establish a shared foundation of the contemporary view of ADHD. This step is necessary to grasp what adults with ADHD have faced in their lives and what is being targeted in treatment. Unlike mood and anxiety disorders, which are staples of clinical training for mental health professionals, most clinicians and clinicians-in-training have had scant, if any, exposure to adult ADHD (Willer, 2017).

The goal of this chapter is to provide a clinician-friendly overview of the current state of the field in terms of understanding ADHD, its etiologies, and how this translates into clinical presentations and difficulties faced by adults seeking help. The first section of this chapter reviews the modern-day view of ADHD as a neurodevelopmental disorder of impaired self-regulation. This definition moves beyond the symptom criteria listed in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5; American Psychiatric Association, 2013) and other classification systems and instead focuses on sound models that are more clinically useful in terms of recognizing the central features of ADHD. These models help therapists better detect or “see” ADHD and its effects on functioning rather than merely try to determine whether a client’s attention, hyperactivity, and/or impulsivity reflect levels that are too much, too little, or just right. Within this framework, therapists are better equipped to understand and treat adult ADHD more effectively. Interacting neurobiological systems that underly these self-regulation difficulties...
are introduced to provide a sense of what drives the symptoms and downstream functional impairments. The relevance of these aspects of self-regulation will also be examined through the lens of a broader, similarly evolution-based theory of psychology to further illustrate the effects of self-regulation deficits characteristic of ADHD on some important behavioral, social, and cognitive psychological mechanisms.

After reviewing the nature of the disorder, the discussion moves to the real-world effects of ADHD on “free range humans”—individuals who seek treatment for the life difficulties presented in these last sections. Information is presented about the prevalence and persistence of ADHD into adulthood and factors most germane to this population. In particular, the common life problems faced by adults with ADHD are reviewed, as these are the sources of distress that lead most people to seek help. Indeed, it is these struggles that shape and are shaped by the thoughts and beliefs observed when helping adults with ADHD.

**CONTEMPORARY FORMULATION OF ADULT ADHD**

ADHD has gone through several name changes over the years, and the assumptions about the essence and etiologies of this disorder also have changed (see Barkley, 2015a, for a review of this history). Although the official symptoms comprising a diagnosis have been relatively stable, there is now a broader understanding of the clinical features, the underlying mechanisms driving these features, and their relevance for the functioning and well-being of adults with ADHD. This discussion begins with the current diagnostic criteria for ADHD.

**Symptom Definition**

The *DSM–5* (American Psychiatric Association, 2013) places ADHD in the Neurodevelopmental Disorders section. The diagnosis is defined by a list of 18 symptoms evenly divided between the hyperactive/impulsive and inattentive domains, with symptom defined as developmentally inappropriate levels of any features that individually and cumulatively create impairments. The two symptom domains yield three possible presentations of ADHD: predominantly hyperactive/impulsive presentation, predominantly inattentive presentation, and combined presentation.

There have been some changes in the *DSM–5* relevant to the diagnosis in adults. The symptom threshold for diagnosing ADHD in adults has been lowered. Previous criteria required the presence of six of nine symptoms in either of the symptom domains as the diagnostic threshold for clients of all ages, which remains the threshold for children and adolescents. The cutoff for adults has been lowered to five of nine symptoms because some symptoms are less applicable to adults, and a lowered threshold is a better
marker of developmental deviance in adults (Barkley, Fischer, Smallish, & Fletcher, 2002).

In addition, a long-awaited change to the age-of-onset criterion was made, now requires several symptoms be present before 12 years old rather than 7 years old. Full diagnostic criteria in childhood is not required for a diagnosis in adulthood, rather it is the emergence and persistence of symptoms that have been observed in childhood. Several studies indicate that an age of onset by late adolescence is adequate (Barkley, Murphy, & Fischer, 2008; Polanczyk et al., 2010), as there is no clinical difference between adults diagnosed with ADHD and those who fulfill all other diagnostic criteria except for age-of-onset (Faraone et al., 2006).

There is no separate symptom list for adult ADHD as the existing symptom criteria is unchanged since the fourth edition of the DSM (DSM-IV; American Psychiatric Association, 1994). The recently updated 11th edition of the International Classification of Diseases (ICD-11; World Health Organization, 2018) uses the term ADHD as well as the same three presentation types and age-of-onset criteria as the DSM-5.

Several recent studies have cited the phenomenon of adult-onset ADHD (Agnew-Blais et al., 2016; Caye et al., 2016; Moffitt et al., 2015), which are cases in which diagnostic levels of symptoms and impairments arrive de novo in adulthood with no previous evidence of any signs of ADHD. Typical adult ADHD represents either individuals diagnosed in childhood who continue to manifest symptoms in adulthood or individuals not identified with ADHD until adulthood but for whom retrospective review establishes the earlier emergence of symptoms, which is considered standard practice in the evaluation of ADHD (Ramsay, 2017a).

The notion of adult-onset ADHD stems from studies using retrospective assessment of childhood symptoms along with assessment of current symptoms and documenting the presence of ADHD in adults who did not show symptoms in childhood. In a couple of studies (Agnew-Blais et al., 2016; Caye et al., 2016), the adult samples comprised 18- and 19-year-olds, which represents a blurry developmental line between adolescence and adulthood (Faraone & Biederman, 2016). However, another study (Moffitt et al., 2015) comprised developmentally mature adults and provided preliminary data that call into question the age-of-onset criterion.

On the other hand, a study with rigorous, repeated evaluations of children (those with ADHD and those without ADHD) tracked into young adulthood indicated that adult-onset cases were the result of ADHD-like symptoms associated with other clinical factors (e.g., the effects of substance use, a comorbid disorder, cognitive fluctuations that were not deemed impairing) and not ADHD itself (Sibley et al., 2018). A more recent study failed to find evidence supporting adult-onset ADHD in a longitudinal sample of women with similar alternative explanations for emerging attention deficits (Ahmad, Owens, & Hinshaw, 2019). The practice standard continues to be a thorough review of the timing of symptom onset and persistence in all adult cases, including
retrospective accounts of prominent subthreshold symptoms of ADHD or difficulties in childhood for which treatment was not sought until adulthood because of attenuating factors (e.g., intelligence, dismissive attitudes toward diagnosis; Kooij et al., 2019; Mitchell et al., 2019; Ramsay, 2017a). These cases are better referred to as late identified rather than adult onset.

With the advent of these modifications, there is now a corresponding adult ADHD module included in the Structured Clinical Interview for DSM–5 (First, Williams, Karg, & Spitzer, 2016). There are several other structured interviews, symptom checklists, and norm-based adult ADHD inventories that include DSM symptoms but cast a wider net to cover a range of symptom and functional issues experienced by adults with ADHD. Use of structured interviews, inventories, and assessment for and ruling out other psychiatric and medical conditions that could mimic symptoms of ADHD remains the diagnostic standard. The notion of neuropsychological testing as a central means for assessing ADHD and impairments is appealing but poses a risk for false negative cases insofar as time-limited, office-based tests do not capture the temporal challenges of organizing and managing the affairs of daily life. (See Barkley, 2019; Mapou, 2019; Ramsay, 2015, 2017a, for reviews of issues related to the assessment of adult ADHD.)

The diagnostic category and acronym of ADHD is well-established and will likely not soon change. However, futile arguments over the attention and hyperactivity aspects get in the way of distinguishing the essential nature of the condition. Characterizing ADHD based solely on the current list of symptoms is akin to branding panic disorder as a “tachycardia disorder” (Ramsay & Rostain, 2015b) or autism as an “eye-gaze disorder” (R. A. Barkley, personal communication, June 5, 2019) as these views reflect discrete features of each disorder but do not embody their essence. The next section moves beyond DSM symptoms to review the prevailing view of the essence of the ADHD syndrome.

ADHD as a Neurodevelopmental Disorder of Impaired Self-Regulation

A parsimonious description of the contemporary view of ADHD is that it is a neurodevelopmental disorder of impaired self-regulation—a chronic, persistent delay in the acquisition of various normative and interacting self-control and self-management faculties in age-appropriate roles and settings and a corresponding deficit in the operation of these faculties. ADHD reflects a quantitative rather than a qualitative difference in course and presentation compared with other conditions (R. A. Barkley, personal communication, September 30, 2017).

ADHD is a dimensional disorder in that its symptoms, features, and impairments fall at the disordered end of a normative continuum of self-regulation and functioning (Asherson & Trzaskowski, 2015; Katzman, Bilkey, Chokka, Fallu, & Klassen, 2017). By definition (American Psychiatric Association, 2013),
adults diagnosed with ADHD experience more symptoms with a greater degree of severity and magnitude of interference than adults who encounter typical, fleeting, circumscribed fluctuations in self-regulation. A thought disorder or a manic episode, by comparison, represent a qualitatively different thought process or mood state, respectively, each signifying dysfunction in an otherwise adaptive neurologic system and process.

A framework that has emerged over the past few decades for understanding the different facets of self-regulation in adult ADHD has been centered on the executive function (EF) construct. Definitions of EFs cluster around the ability to persist on goal-directed plans by which clients choreograph higher-order cognitive skills of planning, problem-solving, and information management and orchestrating thoughts, emotions, and behaviors to achieve these ends (Barkley, 2001, 2012; Goldstein & Naglieri, 2014). These capacities are considered as top-down regulatory skills needed to manage or override automatic, competing inclinations in order to persist on deferred, valued goals and benefits. There is a bidirectional link of these sort of top-down, self-directed actions and bottom-up processes, such as alertness/detection (which allows humans to orient to key signals in the environment) and information filtering/accumulation (which allows for the processing and sorting of these signals and data); this information is used to determine which actions are appropriate (Nigg, 2018a). The operations of these processes are further influenced by personal experience (Barkley, 2016; Blair, 2016).

An elegantly simple description of EFs and other operations of the frontal cortex (where EFs reside) is that they are what “makes you do the harder thing when it’s the right thing to do” (Sapolsky, 2017, p. 45). This depiction captures how a history of ADHD and related frustrations create negative outlooks and, conversely, how cognitions can be marshalled to foster implementation of strategies designed to promote adaptive change for adults with ADHD. The next section reviews EFs and their relevance to ADHD with attention paid to their effects on the cognitions of adults with ADHD. This discussion is followed by a therapist-friendly review of prominent underlying etiologic factors for EFs and other features of ADHD.

**Executive Functions**

EFs have been particularly relevant to the evolving conceptualization of ADHD (Barkley, 1997, 2012, 2016; Brown, 2013, 2017; Kooij et al., 2019); in fact, ADHD is often viewed as an executive dysfunction disorder. EFs are defined as self-regulation in the form of self-directed behaviors used to specify and organize goal-directed plans; to implement and sustain actions over time toward these goals; to achieve the personally salient outcomes that will benefit individuals by requiring interaction with others and social or cultural institutions; and for which there is deferred outcome or reward and, very often, short-term costs (Barkley, 2012). This definition encompasses the presenting complaints of most individuals with ADHD.
EFs emerged as the most reliable diagnostic factor in adult ADHD, followed by inattention/hyperactivity and impulsivity when using DSM–IV criteria (Kessler et al., 2010). A study using DSM–5 criteria again found that EFs (now coupled with inattention) emerged as the most discriminating factor ahead of hyperactivity, impulsivity, and emotional dyscontrol (Adler et al., 2017). EFs are highly correlated with DSM–5 symptoms (Silverstein et al., 2018), although they do not appear in the diagnostic criteria. More to the point of clinical practice, the EF model provides a useful lens through which to detect and target ADHD and its effects.

Everyone has EFs—it is a distinctively human feature (other social animals, particularly the more social ones, such as dolphins, chimpanzees, and some species of monkeys also show rudimentary EFs; Barkley, 2012). People who experience a depressive episode, deal with the effects of a concussion, or are sick with influenza will experience diminished executive functioning. The issue at hand for adults with ADHD is that they face a persistent, unremitting lag in the development, maturity, and application of these skills compared with same-age peers.

There is a developmental progression of the unfolding of EFs that is beyond the purview of this book (see Antshel, Hier, & Barkley, 2014; Barkley, 1997, 2012, 2016, for extended discussions). However, aspects of these distinct EF domains are reviewed next (in the order of their developmental unfolding; Barkley, 1997) to highlight their relevance for cognitive behavior therapy (CBT) for adult ADHD, particularly the cognitive domain.

**Behavioral Inhibition**

The ability to stop responding to the environment is the first EF to emerge (after an awareness of self; Antshel et al., 2014; Barkley, 2016). This pause in the flow of experience and action creates a space in which individuals can act proactively with intention, rather than reactively to prepotent stimuli, which represent compelling, habitual urges. This pause allows for a prolongation of a moment, which provides an opportunity for the companion operations of reflection, the mental review of the sequence of events, and **proflection**, or envisioning different action scenarios or simulations to achieve a desired future outcome.

For children with ADHD, behavioral disinhibition manifests in difficulties managing observable behaviors. Although motoric inhibition generally improves with age (and brain maturation), adults with ADHD still often struggle with other forms of disinhibition, such as impulsive spending, excessive or inappropriate verbal behavior (e.g., saying the wrong thing at the wrong time), and an internal sense of restlessness (e.g., a constantly bouncing foot). The adaptive nature of self-inhibition for coordinating intentions and actions was captured by Friedman (2016): “When you press the pause button on a machine, it stops. But when you press the pause button on human beings they start” (p. 4).

From a standpoint of CBT, behavioral inhibition is needed to organize said intentions and actions, including interrupting a behavioral sequence to
switch to another one. As mentioned previously, this mental and behavioral space provides an opportunity to act with a directed purpose. The inhibitory step of the prolongation of this time and mental space is a necessary one to identify and assess thoughts and behaviors and their relationship to future-focused intentions. CBT sessions serve an inhibitory function, which creates a space in time for clients to reflect and proflect to coordinate their thoughts, feelings, and behaviors with desired outcomes, rather than succumbing to impulsivity. This process is an aspect of strategic metacognition, developing and externalizing skills and plans to increase the likelihood they will be implemented at the point of performance.

**Nonverbal Working Memory**
Nonverbal working memory (NVWM) is the capacity to hold events in mind in the form of visual images, like a video replay of events. NVWM is essential for the organization of behavior and synchronizing it with time (Barkley, 1997, 2016). This capacity allows individuals to hold and process different possible scenarios in their minds and fix a desired course of action rather than relying solely on trial-and-error learning. NVWM supports cognitive-imaginal rehearsal of potential future actions, which is helpful for anticipating, practicing, and ultimately handling potential difficulties, such as mentally preparing for a job interview, or keeping in mind a goal to guide action toward it.

Visual images fall within the realm of cognitions in CBT. For example, when a client describes putting off a monthly report for work, her thought about it may appear as an image of herself “sitting there for an hour, stuck, frustrated, and unable to get anything done.” This image contains a wealth of information that provides targets for intervention, including reenvisioning her ability to handle the task backed up with a personalized action plan for doing it.

**Verbal Working Memory**
Verbal working memory (VWM) reflects internalized speech or self-talk that guides behavior, including automatic thoughts. The VWM model, as outlined in Barkley’s (1997, 2016) hybrid model of the EFs for ADHD draws on a Skinner’s (1957) behavioral model of the internalization of speech. What starts out as babble and baby talk in infancy progresses through phases of overt commentary on what a child sees or does to semicovert, self-guided instruction such as talking through the steps of learning to tie shoes (“The bunny goes through the hole and then pull the ears tight”). This commentary ultimately matures into fully internalized and privatized self-talk in adolescence such as an adolescent mentally cursing out his or her parents while remaining stone-faced as he or she is grounded. Cognition in this view is treated as a verbal behavior derived from individuals’ conditioning history, the same as any overt behavior, and is modified in the same manner as any other behavior.

This Skinnerian (1957) model of self-directed speech is useful for understanding the internalization of speech across development and its
role in rule-governed behavior and cognition (see Hayes, Blackledge, & Barnes-Holmes, 2002, for a modern behavioral view of language and cognition). Critiques of this model (Chomsky, 1959) and cognitivist frameworks (A. T. Beck, 1976; Mahoney, 1974; Meichenbaum, 1977) pose internal meaning-making and justification processes as emergent features from this base. Cognitivist models move beyond a strict conditioning model and impart an inventive, creative, and constructive influence of cognitions as valued goals that guide behaviors.

Suffice it to say, VWM extends to rule-governed behaviors and cognitions, and is a facet of self-regulation. These cognitions affect how adults with ADHD view their endeavors and themselves and thereby inform cognitive interventions.

**Emotion Regulation**

Emotions have never been mentioned in the criteria for ADHD in any edition of the *DSM*, ICD, or other classification system. However, clinical observations that inform ongoing research have established emotional dyscontrol as a core feature (Adler et al., 2017; Barkley, 2015b; Kooij et al., 2019).

The emotional features characteristic of adult ADHD are not those of disordered mood or anxiety, which may coexist with ADHD. Rather, emotional dyscontrol seen in clinic-referred adults with ADHD represents maladaptive reactions to the same emotionally charged triggers that affect everyone (Barkley, 2015b). The triggering events (external or internal), however, are more distracting and disruptive for adults with ADHD and it takes them longer to tone down these feelings (positive or negative). This dyscontrol reflects deficient top-down regulatory skills for managing and modifying bottom-up emotional reactions that are typically encountered in the course of managing adult life. This usually manifests in adults with ADHD as repeated instances of overreacting to relatively minor stressors, with the consequences of these reactions often magnifying or adding to the original stressor.

Emotion regulation is also tied to motivation, which is relevant to ADHD. An EF definition of motivation is the ability to generate an emotion about a task in the absence of an immediate consequence (Barkley, 1997). This is the knack of being able to change an emotional state by shifting attention, conjuring up images, thoughts, and other behavior-facilitating drives to perform an action. This is the emotional skill used by students to make them “feel enough” like studying 3 days before an exam rather than waiting until the night before when the motivating emotion is panic.

Emotion regulation is important for CBT, as the ability to modify emotions is an overarching therapeutic component. A more specific issue in CBT for adult ADHD is manufacturing motivation for various tasks (Ramsay & Rostain, 2015a). Task demands often trigger visceral feelings of discomfort, even subtle ones. These are often described as gut feelings distinct from sadness or worry, but rather the sense of “I know I have to do this but I do not want to do this,” which can be potent enough to provoke escape-avoidance. An essential facet
of motivation and overcoming procrastination is to deal with an individual’s thoughts about tasks, including the relationship with emotions and discomfort. Indeed, procrastination and other forms of disengagement are often fueled by feelings of demoralization that originate from past failures and setbacks.

Reconstitution
The last EF to emerge is reconstitution, which derives from the childhood capacity to play and explore. What starts as play in the form of discovering how things work (e.g., taking things apart and putting them back together) or role-playing cultivates a capacity to analyze, deconstruct, and synthesize information and adopt different perspectives. This skill provides a platform for innovation and problem-solving such as drawing from past experiences that approximate newly encountered challenges (Barkley, 1997, 2016).

Reconstitution is relevant for cognitive interventions in CBT as it involves recognizing and analyzing clients’ responses to events and synthesizing alternative interpretations, reframes, and plans. Combined with NVWM and VWM, these skills are used to anticipate situations and engage in prospective problem-solving. This is particularly relevant for breaking down tasks into discrete steps and fostering the execution of these steps over time. Again, the ultimate outcome is behavioral (i.e., goal-directed behaviors), but cognitions play an important mediational role in the process. Task-promoting thoughts (and mitigating task-demoting thoughts) foster the application of coping strategies and behavioral follow-through that furnish adults with ADHD with novel experiences, improved well-being, and new outlooks.

Summary
Each successive EF draws on the foundation established by the previous one. Relative deficits and delays in EF skills have effects on subsequent skill acquisition and execution. In addition to their direct role in functional problems, EF deficits have secondary effects on the ongoing acquisition and use of coping skills, including compensatory skills for ADHD (see Barkley, 2012).

ADHD is increasingly viewed as an EF-deficit disorder, but with an assortment of processes underlying these executive skills (Castellanos & Proal, 2012; Kooij et al., 2019; Sonuga-Barke, 2010). Although tethered by common and overlapping symptoms and self-regulation difficulties, there are other factors at work in self-regulation and the observable features of ADHD, which are summarized next.

Etiologic Models of Self-Regulation and ADHD

*Genetic research* consistently shows that heredity, on average, accounts for about 80% of individual differences in ADHD symptoms, including studies of identical twins reared together versus those reared apart and adopted children’s environment versus the traits of birth parents (Barkley, 2015a;
Brainstorm Consortium, 2018; Demontis et al., 2019; Faraone & Larsson, 2019). ADHD and its features cluster within families, both immediate and extended. ADHD is one of the most highly heritable conditions seen in clinical psychiatry and psychology, though this fact only establishes a propensity or relative risk for manifesting symptoms or the full disorder. Genetic unfolding most definitely interacts with environmental or epigenetic factors (see Neuman et al., 2007; Nigg, 2018a, 2018b) and a recent genome-wide meta-analysis (Demontis et al., 2019) has yielded a specific set of genetic risk factors for ADHD.

Similarly, neuroimaging research offers compelling details about neurobiological underpinnings of ADHD (see Barkley, 2015a; Bush, 2010; Cortese & Coghill, 2018; Konrad & Eickhoff, 2010; Kooij et al., 2019; Purper-Ouakil, Ramoz, Lepagnol-Bestel, Gorwood, & Simonneau, 2011 for reviews). Inefficiencies in the prefrontal cortex and anterior cingulate are familiar leading players, but structural studies have also implicated alterations in the basal ganglia and subcortical reward networks. From a functional standpoint, hypoactivity in the frontoparietal and ventral attention networks has been documented in studies of ADHD, as has hyperactivity in the default mode network and the visual network. Studies have shed light on differences in the growth, size, and volume of different brain regions (Proal et al., 2011; Shaw et al., 2007, 2012, 2018), comparing individuals with ADHD with individuals without ADHD and, among individuals with ADHD, comparing those with better function with those with worse functioning (Mackie et al., 2007). This line of research helps explain the heterogeneity of ADHD cases as some individuals experience symptom reduction or remission by adulthood, whereas others have persistent symptoms (e.g., Barkley et al., 2008).

Dopamine deficiency models are based on studies of dopamine availability in the subcortical reward networks of the brain, with less availability (fewer dopamine receptors and transporters) seen in imaging studies of adults with ADHD compared with adults without ADHD (Volkow et al., 2009, 2011). Dopamine availability correlates with self-reported ADHD symptoms and self-ratings of trait motivation, with low dopamine associated with higher ADHD symptom ratings and lower trait motivation ratings. This finding is relevant to clinical issues of procrastination and poor task initiation, as well as proneness for addictive behaviors, including excessive gaming and technology use. In fact, the dopamine reward system is as much, if not more about the anticipation of a reward as its pursuit and attainment (Sapolsky, 2017), which is directly relevant to adult ADHD and cognitions about task plans and coping strategies versus succumbing to distractions and avoidance.

The dopamine deficiency model is consistent with wider ranging reward-deficiency models of ADHD (Sonuga-Barke, 2010, 2011; Willcutt, 2015), which may be more precisely viewed as differences in responsiveness to typical rewards and their presentations among adults with ADHD, such as stimulus seeking and greater sensitivity (irritability) to reduction in rewards. Tied to reduced reward signals in the ventral striatum, such reward deficiency
manifests as problems orienting to sources of rewards and being less responsive to rewards that are sufficiently reinforcing for nonclinical groups; these factors present as delay aversion, proneness to boredom, and temporal discounting (i.e., impulsivity in chasing more immediate rewards over more valued but deferred rewards). These factors all undermine typically advisable behavioral interventions if not modified for ADHD. Individuals with ADHD require more timely, frequent, salient, and stronger rewards to shape behavior.

The default mode network (DMN) is in the precuneus, a structure buried deep in the brain that is the seat of resting-brain activity (Utevsky, Smith, & Huettel, 2014). The DMN plays a crucial role in the attention difficulties seen in adult ADHD. The DMN refers to the resting mental state and task-irrelevant mental processes of the brain in an idling mode, such as mind-wandering (Franklin et al., 2017). Problems in ADHD occur when the brain must shift out of this resting state. This shifting process requires that the default network be suppressed while the brain engages in concentrated attention. The requisite degree of suppression (default mode deactivation) is positively associated with the difficulty of a task at hand (McKiernan, Kaufman, Kucera-Thompson, & Binder, 2003). Default-mode interference when shifting modes is likely a key source of attention problems and inconsistent reaction times for adults with ADHD (Castellanos et al., 2008; Sonuga-Barke & Castellanos, 2007). Connectivity patterns between the DMN, saliency network (bilateral insula and anterior cingulate cortex), and the twofold dorsal and ventral attention networks (the where and to what an individual attends, respectively) may play a central role in the proneness for distractibility and mind-wandering problems seen in ADHD (Bozhilova, Michelini, Kuntsi, & Asherson, 2018; Sidlauskaite, Sonuga-Barke, Roeyers, & Wiersema, 2016; Silberstein, Pipingas, Farrow, Levy, & Stough, 2016).

ADHD has many strong genetic and neurobiological underpinnings (interacting with epigenetic factors) that are associated with the operations of a variety of interrelated brain networks. These networks have downstream effects on functioning in daily life; aspects of life that those without ADHD may take for granted become much more difficult for individuals with ADHD. In real time, these neurobiological inefficiencies conspire to interfere with initiating and shifting between tasks that is made even more difficult by an impaired ability to motivate and sustain effort toward a deferred goal, particularly in the face of dissuading factors competing for time, attention, and effort.

Before examining the prevalence of adult ADHD and specific domains of impairment in the modern world, the self-regulation/EF view of ADHD is reviewed within a broader theory of psychology to examine the effects of ADHD on some relevant psychological mechanisms. Advances in understanding ADHD have come from adopting a wider scope that includes neurobiological and evolutionary models (Barkley, 2001, 2012). The next section will use the unified theory of psychology (Henriques, 2011) as a theoretical
context for understanding the relevance of ADHD to some broader psychological mechanisms, which will also have implications for later discussions of the CBT model of and treatment for adult ADHD.

**ADHD WITHIN A UNIFIED THEORY OF PSYCHOLOGY**

Coming from a background in the study and practice of professional clinical psychology, Henriques (2011) took on the ambitious task of proposing a unified theory of psychology comprising four broad facets: First, human psychology derives from an evolutionary context. This facet is consistent with advances in understanding EFs as an example of an extended phenotype or how certain behaviors are genetically maintained in a species by their advantageous effects on an organism’s environment (Barkley, 2001, 2012; Dawkins, 1982/1999). The remaining three facets of the unified theory of psychology include the behavioral investment theory, the influence matrix, and the justification hypothesis. These facets are relevant for further understanding and appreciating the effects of ADHD and EF deficits on functioning, namely, their effects on behavior, relationships, and cognitions, which correspond with different domains of CBT for adult ADHD.

**Behavioral Investment Theory**

Within behavioral investment theory, the nervous system treats behavior as commerce or an investment (Henriques, 2011). There is a largely nonconscious cost–benefit calculation of the time, effort, and energy costs associated with any particular action. This calculation is associated with innate propensities toward certain stimuli as well as those tied to individual issues of heredity and experience, like behavioral selection (Skinner, 1981).

The primary relevance of behavioral investment theory is the effect of ADHD on these cost–benefit calculations of intentions/actions, which operate as a sort of behavioral loan officer. The EF deficits associated with ADHD make many pursuits and endeavors in life more difficult to manage for adults with ADHD. There are many endeavors, including those highly valued and otherwise deemed as “good” investments from a logical standpoint, for which the nonconscious cost–benefit of the investment of time, effort, and energy expenses by adults with ADHD yield reflexive conclusions that they are “bad” investments. This ambivalence, the battle between logically knowing what needs to be done and a nonconscious calculation of it as untenable because of EF deficits, represents a difficulty voiced by most adults with ADHD, the maddening, seemingly self-defeating escape–avoidance, procrastination, and disengagement seen in ADHD despite valued intentions. The repeated fatigue and demoralizations from this tug-of-war between the rationally defined good investments and the visceral, emotionally defined bad investments set the stage for negative cognitions and emotional frustrations. These
cognitive and emotional factors (and untreated EF deficits), in turn, further magnify problems with such cost–benefit analyses. Consequently, there is an important mediating cognitive element for adults with ADHD that affects these calculations of plans (intentions) and efforts to reconcile them with individuals’ values and goals (actions).

The Influence Matrix

The influence matrix (Henriques, 2011) extends behavioral investment theory to the social world where most ADHD difficulties occur. The social context represents its own commerce of social capital that affects human motivation, emotion, behavior, and cognition. From an evolutionary view, the gamut of social relationships and transactions are themselves resources and raw materials for survival.

The ability to wield social capital, such as to influence others in accordance with personal interests, is a key skill, which includes reciprocity and a balance between generating and spending this capital. There are several distinct but interrelated vectors of social influence. These include social rank in terms of useful contributions that benefit the group; altruism, cooperation, and other forms of self-sacrifice as means to build status and collateral with others; and self-sufficiency, which is a balance between autonomy and interdependence, being able to manage alone but still nurturing a standing with the group. Each of these facets represent a relative ratio that is constantly recalibrated, including striking the right balance of self-to-other-focus.

The relevance of the influence matrix is that the difficulties faced by adults with ADHD have a social, public element to them. Adults with ADHD are prone to inconsistency and poor follow-through on plans and promises, which have ripple effects on social capital and social standing for self and others. The interpersonal effects of poor follow-through often are described by adults with ADHD in emotional terms of guilt and shame, and thoughts that others are frustrated and disappointed with them, not to mention accounts of relationship disruptions. These issues are relevant in CBT for adult ADHD, which focuses on clients’ social functioning as well as the role of a strong therapeutic alliance that provides a safe, supportive place to address these issues.

The Justification Hypothesis

The justification hypothesis is a framework for a meaning-making aspect of cognition as self- and other-directed explanation of what happens and why it happens. The hypothesis is that this idea proposes a structure and function of the coevolution of self-consciousness and culture (Henriques, 2011). The evolution of human consciousness provided humans with a distinct sense of a self apart from others, the foundational EF (Barkley, 2016) providing a self to regulate. The cognitive, narrating capacity to account for the what feature of events and the associated causal why of events also includes
the self and other justification of an individual’s actions or inactions. These internal dialogues have a private component in terms of sense of self and identity and a public component of the presentation and explanation of the self to others.

Considered through the lens of the justification hypothesis, cognitions serve an explanatory function which, at least partly, can be viewed as justifications for actions and inactions, consistent with facets of CBT (A. T. Beck, 1976; Dobson, Poole, & Beck, 2018; see Chapter 3, this volume). This cognitive, explanatory function ties together the behaviors to be explained (behavioral investment theory), the explanations communicated to stakeholders in an individual’s life to maintain social standing (influence matrix), and the internal processing and sense-making of events in the context of an individual’s identity (or sense of self) and other cognitive factors, including risk for cognitive distortions. In fact, adults with ADHD often report being unable to make sense of their consistent inconsistency themselves, much less being able to explain it to others (“How can I ask the professor for another extension on the same assignment?”).

This review highlights the deep-seated nature of self-regulation and the complex behavioral, social, and cognitive mechanisms that affect human functioning. The effects of ADHD and EF deficits cut deeply through each of these facets and, in turn, through the roles, relationships, and domains of life for adults with ADHD in a persistent and wide-ranging manner. Although this overview is a far cry from some of the typical clinical material encountered with adults with ADHD (“Yes, very interesting for the early humans, but I cannot find my keys and I’m already late for work”), these insights highlight the recurring struggles and their effects on this population.

PREVALENCE, PERSISTENCE, AND COMORBIDITY AND IMPAIRMENTS OF ADULT ADHD

As ADHD is a neurodevelopmental syndrome, there are many questions related to its manifestation, appearance, and effects at different points along the developmental trajectory. More specifically, it can be confusing to sort through various reports on the numbers of individuals with ADHD in different age groups and the degree to which children and adolescents grow out of it. From a clinical standpoint, it is important to appreciate the complexity of coexisting factors faced by clinic-referred adults with ADHD and the life problems they face that necessitate treatment. Reviews of each of these factors are provided below.

Prevalence of ADHD

The diagnostic prevalence for ADHD cited in the DSM–5 on the basis of expert consensus derived from the literature is 5% of children and 2.5% of
adults (American Psychiatric Association, 2013). The international prevalence of childhood ADHD is estimated at 6.5% (Polanczyk, de Lima, Horta, Biederman, & Rohde, 2007).

Comprehensive surveys conducted in the United States and in international samples provide corroborative support for DSM–5 prevalence rates. Adult ADHD rates in the United States are 4.4% and among international samples (Americas, Europe, and the Middle East) are 3.4% (Fayyad et al., 2007; Kessler et al., 2006). A secondary analysis of the U.S. sample that examined adult ADHD in the workforce yielded a prevalence of 4.2% (Kessler, Adler, Ames, et al., 2005). These prevalence rates translate to about 8 to 10 million adults in the United States are affected by ADHD. There are published reports of increased rates of diagnosis, which are based on diverse ways in which a diagnosis was determined, including health care providers simply stating a child or adolescent had ADHD (Visser et al., 2014). These are important issues, but these prevalence rates are generally accepted (Kooij et al., 2019).

**Persistence of ADHD**

Persistence rates of childhood ADHD into adulthood can range from 4% to 77% depending on the manner in which ADHD is assessed in adulthood (Sibley, Mitchell, & Becker, 2016). Most estimates of persistence fall around 50%, though the persistence of residual symptoms that cause some form of functional impairment often falls in the range of 65% to 85% (Barkley et al., 2008; Biederman, Petty, Clarke, Lomedico, & Faraone, 2011; Biederman, Petty, Evans, Small, & Faraone, 2010; Sibley et al., 2016; Volkow & Swanson, 2013). A national comorbidity survey indicated that 36.3% of respondents who had met DSM–IV (American Psychiatric Association, 1994) criteria for ADHD in childhood continued to meet strict diagnostic criteria in adulthood on the basis of self-report (Kessler, Adler, Barkley, et al., 2005). Because of limitations of DSM–IV criteria for adults, namely the lack of EF items and age-of-onset criterion of 7 years old at the time, this rate is likely an underestimation. A review of studies indicated persistence rates as low as 4% when full diagnostic criteria were used (including strict age-of-onset criterion). When defining persistence as clinically significant symptoms of ADHD or partial remission, rates were between 36% and 86% (Faraone et al., 2006).

**Psychiatric Comorbidity, Functional Impairments, and Adult ADHD**

Psychiatric comorbidity is the rule rather than the exception in clinic-referred adults with ADHD. Upward of 80% of adults diagnosed with ADHD will have at least one comorbid diagnosis (Barbaresi et al., 2013; Barkley et al., 2008; Biederman et al., 2012; Brook, Brook, Zhang, Seltzer, & Finch, 2013; Faraone et al., 2015; Kessler, Adler, Barkley, et al., 2005; Kessler et al., 2006; Klein et al., 2012; Kooij et al., 2019).
The most common co-occurring disorders seen in adults with ADHD, in descending order of prevalence, are anxiety, depression, and substance use disorders (Barkley, 2015c; Kessler et al., 2006; see also Chapter 6, this volume). Nicotine (cigarettes), alcohol, and marijuana are the most common substances of abuse for adults with ADHD (Upadhyaya & Carpenter, 2008) with substance use disorders occurring in ADHD samples at twice the rates seen in the general population (Barkley, 2015c).

Adults with ADHD, compared with adults without ADHD, experience academic difficulties (e.g., increased educational disruption and lower academic attainment), occupational problems (e.g., lower levels of employment, more frequent job changes, lower salaries, poorer job performance ratings), relationship difficulties (e.g., lower relationship satisfaction, higher marital discord), and higher risk for psychiatric and substance use diagnoses. There are various other functional difficulties that affect health and well-being, such as sleep problems, poorer driving records, financial difficulties, and higher rates of injuries and various sexual and health risks, including unplanned pregnancy and obesity (see Barbaresi et al., 2013; Barkley et al., 2008; Biederman et al., 2006; Brook et al., 2013; Cortese, Faraone, Bernardi, Wang, & Blanco, 2013; Galéra et al., 2012; Klein et al., 2012; Kooij et al., 2019; Nigg, 2013). Recent evidence indicates that health and lifestyle patterns associated with a childhood history of ADHD persisting into adulthood predicts shorter life expectancy (by up to 13 years) on the basis of actuarial calculations of health-related variables measured at 27 years old (Barkley & Fischer, 2019).

There is virtually no area of adult life that is immune to the effects of ADHD. Data on life impairments derived from longitudinal and cross-sectional studies on adult ADHD land it near the top of the list of the most impairing conditions seen in outpatient clinical psychology and psychiatry. It is likely that these life frustrations and disruptions play a formative role in the common maladaptive thoughts and beliefs held by adults with ADHD and other psychological effects.

**Psychological Effects of ADHD**

A lifetime diagnosis of ADHD has negative effects on sense of identity, satisfaction, perceived life options, and self-esteem (Cook, Knight, Hume, & Qureshi, 2014; Harpin, Mazzone, Raynaud, Kahle, & Hodgkins, 2016; Newark, Elsässer, & Stieglitz, 2016). When recalling childhood and adolescent experiences, adults with ADHD (compared with adults without ADHD) rated themselves as less likely to have engaged in common academic, extracurricular, social, and family activities (Biederman et al., 2006). Among adults with ADHD, 72% reported that their symptoms have had lifelong effects on them and endorsed current work and relationship impairments. Lastly, adults with ADHD were significantly more negative in their outlooks on life and endorsed lower ratings of self-acceptance than adults without ADHD.
A review of studies of self-esteem indicates that this is a significant therapeutic factor for adults with ADHD (Cook et al., 2014). Self-esteem ratings are inversely correlated with symptomatology and, in one study, with overall psychological distress; there were no gender differences or differences by ADHD presentation. Self-esteem may be a mediating factor between ADHD symptoms and functioning in various life domains. It is increasingly clear that ADHD has corrosive effects on functioning and sense of self.

CONCLUSION

The essence of ADHD as a problem of self-regulation, and what is so insidious about its effects, is that it impairs and inhibits self-expression and self-determination by repeatedly punctuating and fracturing an individual’s sense of agency—it unduly limits viable options for how adults with ADHD elect to “spend themselves” in their lives. Indeed, although such endeavors can be defined in behavioral, actionable, and achievable terms, the catalytic role of outlooks, thoughts, and beliefs is necessary (but not sufficient) to turn intentions into actions, as argued in the following chapters.

Although ADHD is among the conditions that cause the most impairment, it is among the most treatable. The next chapter provides a brief review of medication and psychosocial treatments, focused on outcome studies of CBT for adult ADHD. Research on the relevance of cognitive distortions and maladaptive schema in understanding ADHD is also presented.

KEY CLINICAL POINTS

- The age-of-onset criteria for diagnosing adults with ADHD using the *DSM-5* has been adjusted to 12 years old and the symptom threshold has been adjusted to require five of nine symptoms from either domain; the 18 symptoms themselves are unchanged.

- The contemporary view of ADHD is that it as a neurodevelopmental disorder of impaired self-regulation. The executive function model of ADHD provides a framework for understanding the core difficulties associated with ADHD along with closely aligned models of self-dysregulation (e.g., default mode network), the role of dopamine and reward-deficiency, and findings from genetic and neuroimaging research.

- Various issues related to the self-dysregulation model of ADHD are consistent with features of a unified theory of psychology (Henriques, 2011). Specific facets of this model relate to nonconscious factors that affect behavioral selection, factors that gain and wield social capital, and the role of cognition as self- and other-justification for action or inaction.
• Rates of childhood ADHD fall at about 5% and rates of adult ADHD at about 4%. About 66% of children with ADHD continue to exhibit the full diagnosis into adulthood, though those with residual symptoms may still have clinical difficulties. So called late-identified adults who meet current criteria for ADHD are established retrospectively with emergence in childhood but were not diagnosed in childhood.

• The coexistence of other conditions with ADHD is the rule rather than the exception. Anxiety, depression, and substance use problems (e.g., nicotine, alcohol, marijuana) are the most common coexisting diagnoses.

• Studies of the impairments associated with a lifetime history of ADHD indicate that they may occur in virtually any category of adult functioning, most notably work, academics, relationships, health and well-being, driving, and financial status, though there are many others.

• A lifetime history of ADHD also has potentially negative effects on psychological functioning, including sense of identity, satisfaction (past and present), perceived life options, and self-esteem.
Psychological Treatment of Medical Patients Struggling With Harmful Substance Use

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CLINICAL HEALTH PSYCHOLOGY SERIES
ELLEN A. DORNELAS, Series Editor
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“Because of the prevalence of substance abuse in general clinical populations, it is important for psychologists to have knowledge and skill in this area” (p. 1269). This is the first line of the abstract for Miller and Brown’s (1997) article, “Why Psychologists Should Treat Alcohol and Drug Problems,” published in American Psychologist. Flash forward more than 20 years and many psychologists still receive little to no training in substance use disorders or other forms of harmful substance use. Findings of a longitudinal survey of directors of clinical training in American Psychological Association (APA)–accredited U.S. clinical psychology doctoral programs published in 2017 in American Psychologist found that “less than 40% of programs had even 1 faculty member studying addiction, and less than one third offered any specialty clinical training in addiction,” and that number had not increased over the 14-year study period (Dimoff, Sayette, & Norcross, 2017, p. 689). There is evidence that a similar situation exists in counseling and counseling psychology programs (Madson, Bethea, Daniel, & Necaise, 2008; J. L. Martin, Burrow-Sánchez, Iwamoto, Glidden-Tracey, & Vaughan, 2016).

Clinical health psychologists and other mental health professionals working in a variety of medical settings from primary care to the emergency
department are very likely to encounter patients who would benefit from interventions for substance use. Even patients engaging in substance use who might otherwise be considered low risk may be placing themselves at risk; almost 42% of U.S. adults who drink also report taking medications known to interact with alcohol (Breslow, Dong, & White, 2015). In addition, a number of medical conditions increase risk for or complicate treatment of substance use problems or are caused or worsened by substance use. Moreover, one of the fastest growing areas of harmful substance use in the United States is nonmedical prescription drug use (Substance Abuse and Mental Health Services Administration, 2013), which may begin with a therapeutic prescription (Canfield et al., 2010). For these reasons, it is essential that clinical health psychologists and other mental health professionals working in medical settings have some comfort with assessing and addressing substance use issues.

The goal of this book is to equip such professionals with a basic level of knowledge and skills in the spectrum of substance use encountered in a variety of outpatient medical settings. Although written specifically with clinical health psychologists in mind, given the varied and overlapping roles of mental health professionals in medical settings, particularly in rural areas, this book is also relevant for other psychologists and mental health professionals in medical settings. The book provides information to help providers (a) speak more knowledgeably with their patients and other providers about various aspects of alcohol and drug use; (b) recognize variations in alcohol and drug use etiology and epidemiology in different clinical settings; and (c) adequately assess alcohol and drug use and make appropriate referrals when intervention is necessary. For providers who already have some background knowledge, this book provides ideas about how to incorporate interventions for alcohol and drug use into other treatment plans when specialty care is not necessary and to assess and treat three commonly co-occurring conditions: depression, anxiety, and sleep problems. More generally, this book seeks to bolster providers’ awareness of and confidence in addressing alcohol and drug use in whatever setting they practice. This will increase the chances that patients who are engaging in harmful substance use do not fall through the cracks and instead receive the types of care they need.

Topics beyond the scope of the current book are harmful substance use in the context of pain management, harmful substance use in adolescents, sexual dysfunction, and co-occurring personality disorders and serious mental disorder. We also decided to exclude tobacco use even though it is included in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*) as a substance-related disorder.

**OUR MOTIVATION FOR WRITING THIS BOOK**

Our personal motivation for writing this book comes from our own professional journeys as psychologists working with individuals experiencing various harms related to alcohol and drugs. We’ve seen individuals with multiple nonfatal overdoses who find themselves in treatment once again trying to gain the knowledge and skills that will help them avoid falling back into the trap of addiction, perhaps while also trying to manage chronic pain. We’ve seen individuals who have experienced a driving under the influence arrest and are grappling with the substantial legal, financial, and social ramifications of this one event and hoping to prevent a recurrence. We’ve seen individuals who have been told by their physician that if they do not stop drinking, they will likely die from alcohol-related disease. We’ve seen individuals who smoke marijuana daily because they believe it is a completely safe drug with no risk for addiction or other ill effects. Through these and many other individuals with whom we’ve had the privilege to work, we’ve seen the alcohol and drug epidemiology come to life in real human beings. We have learned that in every clinical setting, if we ask the right questions and know what to look for, we will find individuals who are at risk for harms related to alcohol and drugs, individuals who are already experiencing harms related to alcohol and drugs, and individuals who are held tight within the grip of a severe substance use disorder. Most importantly, we know firsthand that psychologists in medical settings have tremendous potential to improve the lives of these individuals through direct care, appropriate referral, advocacy, and teaching.

**OVERVIEW OF THE BOOK**

Below we provide a brief overview of each of the chapters in this book for readers who are interested in using the book as a quick reference guide rather than reading it in its entirety. Readers who have limited experience
with harmful substance use are encouraged to read the first three chapters before proceeding to subsequent chapters.

**Part I: Overview of Substance Use**

Part I provides a broad overview of substance use and substance use disorders that is specifically tailored for psychologists working with medical patients.

Chapter 1 is an easy-to-read reference guide that will give mental health professionals a basic working knowledge of the distinction between substance use and harmful substance use as well as the signs and symptoms of substance use disorders.

Chapter 2 includes an introduction to epidemiology and current models of the biological and sociocultural causes of and contributing factors to harmful substance use, with an emphasis on cardiac, cancer, women's health, and primary care settings, where clinical health psychologists are commonly involved in patient care.

Chapter 3 provides an overview of best-practice assessment strategies and typical psychological, self-help, and pharmacological treatment for harmful substance use, including information about the research support for these treatments and referral guidelines.

Chapter 4 concludes this first section with detailed information about implementing assessment and brief intervention for harmful substance use in medical settings, including practical guidance for implementing Screening Brief Intervention and Referral to Treatment (SBIRT), an evidence-based tool for addressing harmful substance use and addiction in nonspecialty settings.

**Part II: Psychological Assessment and Intervention for Common Comorbid Problems**

Part II of the book focuses on strategies for addressing psychological problems that commonly co-occur with harmful substance use, as well as strategies for addressing the needs of families and addressing the needs of patients who have completed specialty substance use disorder treatment. Each of the chapters ends with a clinical vignette to illustrate application of key concepts and strategies in a patient receiving treatment in a primary care, cancer, cardiac care, or women’s health setting. The vignettes are fictional composites of typical patients.

Chapter 5 describes the complex, reciprocal relationships between depression and harmful substance use and provides practical guidance
on assessing depression in patients with harmful substance and a summary of evidence-based psychotherapeutic approaches to treating patients with these co-occurring problems.

Chapter 6 provides recommendations for assessing anxiety and trauma-related disorders that co-occur with harmful substances, discusses mechanisms of co-occurrence among these disorders, and presents a continuum of evidence-based treatments for anxiety and related disorders for patients with harmful substance use.

Chapter 7 focuses on assessment and treatment of sleep dysregulation, which is common in patients with harmful substance use and can persist after substance use ceases, and offers information on how to assess and treat co-occurring sleep problems.

Chapter 8 turns attention to psychological treatment of family members who are dealing with a loved one’s harmful substance use including information about the efficacy of widely available and lesser known approaches.

Part II concludes with a focus on relapse prevention and continuing care in Chapter 9 and presentation of common evidence-based behavioral relapse prevention approaches.

The book concludes with a more detailed description of why clinical health psychologists and other mental health professionals who work with medical patients need to become more adept at addressing harmful substance use, and it addresses aspects of care delivery that would promote better integration between the psychological and medical care of the medical patient with harmful substance use. Future directions for practice and training are also discussed.
PART I
OVERVIEW OF SUBSTANCE USE
Confusion is common about what constitutes harmful substance use and addiction. On the one hand, there are some reports that moderate amounts of alcohol can be beneficial. More and more states are legalizing marijuana for medical or recreational use. Heavy drinking is common on college campuses. On the other hand, the dangers of alcohol and drugs are readily apparent in society, through drug overdoses, drunk driving, and health problems. It’s not surprising, then, that most laypeople are unsure of the guidelines surrounding low-risk drinking and drug use. Many providers are also unsure of what to recommend to patients with the literature and popular media filled with seemingly contradictory points of information.

This chapter is written with clinicians who are not experts in substance use assessment and treatment in mind. It is intended as an easy-to-read reference guide that will give mental health professionals a basic working knowledge of the distinction between substance use and harmful substance use as well as the signs and symptoms of substance use disorders.
TERMINOLOGY

We begin with definitions of terms that are used in substance use treatment. Terms such as alcoholic and addict are commonly used in everyday language, but they are likely to feel judgmental to patients. The exception to this rule is that some patients, many of whom are actively involved in 12-step programs, have embraced these terms as part of their recovery. We recommend allowing patients to dictate the terms by which they are identified.

Other terms that are used in the literature are defined here for your reference:

- **Substance use disorder**: Meeting Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5; American Psychiatric Association, 2013a) criteria for a substance-related disorder.

- **Substance abuse**: Old DSM–IV (American Psychiatric Association, 2000) terminology, now referred to as a use disorder.

- **Substance dependence**: Old DSM–IV terminology, now referred to as a use disorder. Currently used by the International Statistical Classification of Diseases and Related Health Problems (ICD–10; World Health Organization, 1992) for a use disorder.

- **Physiological dependence**: Alcohol, most illicit drugs, and some medications, even when taken as prescribed, can lead to tolerance and withdrawal.

- **Binge drinking**: Males consuming five or more drinks per occasion, females consuming four or more drinks per occasion.

- **Low-risk drinking**: Males consuming no more than four drinks per day, 14 drinks per week. Females consuming no more than three drinks per day, seven drinks per week.

- **At-risk substance use**: For alcohol, drinking more than the low-risk drinking guidelines. For drugs, any use of illicit drugs, taking medications not as prescribed.

- **Hazardous substance use**: A term used by the World Health Organization for use that increases the risk of negative consequences to the user, but sub-threshold for a substance use disorder.

- **Harmful substance use**: A term used by the ICD–10 for a pattern of use that is causing damage to health physically or mentally.
SUBSTANCE USE DISORDER DIAGNOSTIC CRITERIA

Many psychologists who have been in practice for some time are familiar with the distinction within *DSM–IV* between *substance abuse* and *substance dependence*. Previously, substance use disorders were thought to fall within two categories—abuse and dependence—with abuse being less severe and dependence being more severe. Research on substance use and the problems that develop as a result of chronic substance use, however, did not support this binary distinction (Hasin et al., 2013). Instead, research supports thinking of substance use disorders on a continuum—a conceptualization that was adopted for *DSM–5*. Within this framework, the severity level is determined on the basis of the number of diagnostic criteria met: Two to three criteria are classified as a mild disorder, while four to five is considered moderate, and six or more is classified as severe. Although the overarching conceptualization of substance use disorders transitioned from a categorical to a continuous framework, with two exceptions noted below, the symptom criteria are largely identical between *DSM–IV* and *DSM–5*.

According to *DSM–5*, the 11 criteria for diagnosing substance use disorders can be thought of as grouping within four broad categories: impaired control, social impairment, risky use, and pharmacological symptoms. Craving, long recognized as an associated feature of substance use disorders, is a new symptom criterion in the impaired control category introduced in *DSM–5*. Craving is a key reason that the continuing care and relapse prevention strategies discussed in Chapter 9, this volume, may be important for many patients following initial treatment for a substance use disorder; craving is a symptom that may persist well into periods of abstinence. Recurrent substance-related legal problems, which were a symptom criterion for *DSM–IV* substance abuse, are excluded from the *DSM–5* social impairment category. The criteria in the risky use and pharmacological symptoms categories were all maintained from *DSM–IV*.

As in *DSM–IV*, assigning the symptom criterion of withdrawal requires that either the individual meets the criteria for the withdrawal syndrome for that substance as specified in *DSM–5* or the individual takes a substance to relieve or avoid withdrawal. Withdrawal syndromes are specified for alcohol and all drugs except inhalants and hallucinogens. Knowledge of withdrawal symptoms is an important competency for psychologists and all mental health providers given the high prevalence of substance use disorder and the risk for serious and even life-threatening withdrawal symptoms associated with substances such as alcohol and benzodiazepines.
withdrawal is not completed under appropriate medical supervision. When in doubt, refer to a medical colleague for evaluation of withdrawal symptoms (see Wood et al., 2018, for a medical review of alcohol withdrawal assessment).

In considering whether a patient meets criteria for a substance use disorder, it is important to note that tolerance and withdrawal are expected to occur with appropriate medical use of some prescription medications, such as benzodiazepines and opioid analgesics. When these symptoms occur within the context of appropriate medical treatment, they are not considered toward diagnosing a substance use disorder. For example, if a patient with panic disorder is prescribed a benzodiazepine and takes it consistently, it would be expected that over time the original dose would not have the same anxiolytic effect and the patient may require higher doses to maintain the original response. It would also be expected that if the patient abruptly stopped taking the medication, there would be physiological withdrawal symptoms, such as sweating, insomnia, anxiety, agitation, and even seizures (American Psychiatric Association, 2013a). However, in the absence of use of the benzodiazepine that was in excess of prescribed amounts or that resulted in other symptoms of substance use disorder, a substance use disorder would not be diagnosed.

Given that the International Classification of Disorders (ICD; World Health Organization, 1992) is used for billing purposes, it also is important for clinicians to be familiar with their classification system as well. The ICD is created by the World Health Organization in order to have a universal diagnostic classification system and classifies substance use disorders as “mental and behavioral disorders due to psychoactive substance use.” ICD terminology is different than both DSM–IV and DSM–5 classifications, instead using the term harmful use to refer to DSM–IV abuse and the term dependence syndrome to refer to DSM–IV dependence.

HAZARDOUS AND HARMFUL SUBSTANCE USE

The DSM–5 does not have any criteria related to quantity of use or specify guidelines for low-risk alcohol or drug use. Nonetheless, many patients who do not meet diagnostic criteria for a substance use disorder may use drugs and alcohol in ways that place them at risk for acute accidents or injuries, chronic diseases, or developing substance use disorders. They also may use substances as a way of regulating their emotional responses to other psychiatric disorders or previous traumatic experiences. Thus, it is also important
for clinicians to be able to identify and intervene with patients engaging in hazardous or harmful substance use who do not meet DSM–5 diagnostic criteria.

**Alcohol**

Because there is general consensus that for most patients some amount of alcohol may be consumed without substantially increasing risk for alcohol-related problems, several factors must be considered in determining whether a particular patient’s alcohol use is problematic. Next, we outline the factors and guidelines that must be considered in evaluating a particular patient’s risk level.

**Standard Drink Conversion**

Different kinds of alcoholic drinks containing different amounts of alcohol can be consumed in a variety of different quantities. To have a standardized metric for comparison, a “standard drink” has been established (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2010). One standard drink is equivalent to 14 grams of ethanol, which is 12 ounces of beer (5% alcohol content), 5 ounces of wine (12% alcohol content), or 1.5 ounces of liquor (40% alcohol content or 80 proof). The drinking guidelines presented here use standard drinks as the basis for their recommendations (see Exhibit 1.1).

**Low-Risk Drinking Guidelines**

NIAAA (2010) has established low-risk drinking guidelines. These guidelines are adjusted for age and sex and focus on both daily and weekly limits for drinking. For men between ages 21 and 65, low-risk drinking is defined

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**EXHIBIT 1.1. Tips for Assessing Alcohol Consumption**

When assessing for alcohol use, it is important to translate what a patient considers one drink to standard drinks to objectively determine whether the patient is drinking within recommended limits. If a patient reports drinking “three beers,” but each beer is 22 ounces, then the patient is actually consuming nearly six standard drinks. Here are a few practical tips when working with patients:

- When asking about alcohol use, show a picture of standard drink conversions so that the patient can visually understand.
- Mixed drinks contain other beverages, such as soda or juice, in addition to alcohol. If you don’t subtract the other beverages from the alcohol in your calculation, you will overestimate the amount of alcohol in the drink.
- “Solo” cups—the colored cups often used at parties—have lines designating standard drinks and can be a useful comparison for estimating alcohol with patients.
as no more than four standard drinks per day and no more than 14 standard drinks per week. For women, low-risk drinking is no more than three drinks per day and no more than seven drinks per week. For men 65 and older, low-risk drinking guidelines reduce in quantity to no more than three drinks per day and no more than seven drinks per week. Research shows that drinking at this level, only 2% of individuals will develop an alcohol use disorder (NIAAA, 2010).

To stay within low-risk drinking guidelines, both the daily and weekly limits must be kept. The daily limits are primarily focused on the dangers inherent in physical and cognitive impairment resulting from increasing blood alcohol levels and are designed to prevent drinkers from reaching blood alcohol concentration at the 0.08 level. Drinking at this level increases risk for injuries, such as car accidents, falls, burns, and drownings. It also increases risk for risky behaviors, such as unprotected sex, sexual assault, and violence. The weekly limits, on the other hand, are focused on the accumulative negative effects from drinking. These include a variety of health problems, such as liver and heart disease, sleep disorders, stroke, cancer, and the management of chronic conditions such as diabetes or hypertension. Chronic violation of the low-risk guidelines also increases risk for developing an alcohol use disorder.

**Binge Drinking**

Binge drinking, according to the NIAAA (2010), is defined as drinking that leads to a blood alcohol concentration of 0.08g/dL, which is generally the DUI limit in many states (NIAAA, 2010). The National Survey on Drug Use and Health defines binge drinking as four or more standard drinks for women, and five or more standard drinks for men, on the same occasion (Center for Behavioral Health Statistics and Quality, 2016). Binge drinking is associated with a variety of health complications and injuries (World Health Organization, 2014), such as car accidents, falls, burns, domestic violence, sexual assault, sexually transmitted diseases, fetal alcohol spectrum disorders, a variety of cancers, chronic health conditions such as diabetes and hypertension, cognitive problems, and alcohol use disorder.

**People Who Should Not Drink at All**

For individuals with some health conditions, abstinence from drinking is recommended. That includes individuals under age 21, pregnant women, and individuals with liver problems such as hepatitis C or cirrhosis. Individuals who plan to operate a vehicle or engage in activities that require full levels of coordination should abstain from alcohol. Also, a large number of
medications—both prescribed and over the counter—interact with alcohol in dangerous ways. Common classes of medications, which interact with alcohol in problematic ways, include nonsteroidal anti-inflammatory drugs, antibiotics, anticonvulsants, antihistamines, anticoagulants, benzodiazepines, and antidiabetic agents (Weathermon & Crabb, 1999). For example, alcohol and acetaminophen interact to increase toxicity to the liver. Patients prescribed medications with negative alcohol interactions are commonly unaware of this potential problem (R. L. Brown, Dimond, Hulisz, Saunders, & Bobula, 2007).

**Underage Drinking**

Findings from the Youth Risk Behavior Surveillance System (Grunbaum et al., 2004) show that drinking under the age of 21 is common in the United States with 74.9% of students in Grades 9 through 12 having had one or more drinks of alcohol on at least one day in their lifetime and 44.9% within the past month. Having five or more drinks of alcohol within a short period of time occurred in the past month for 28.3% of ninth-graders through 12th-graders surveyed. Underage drinking is particularly risky for the developing brain (Crews, He, & Hodge, 2007) and is associated with a variety of negative consequences (Hingson & White, 2014), such as increased risk of dying in a car accident, substance overdoses, cognitive impairment, and substantial economic costs. Underage drinking that exceeds guidelines for adults greatly increases the odds of having clinically significant anxiety, depression, and suicidal ideation (Richter, Pugh, Peters, Vaughan, & Foster, 2016).

**Moderate Drinking Guidelines**

In addition to the NIAAA low-risk drinking guidelines, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture (2015) have developed guidelines for moderate drinking. These guidelines are embedded within a broader set of dietary guidelines designed to prevent chronic health-related problems. Given the caloric content of alcohol and the health-related problems that excessive alcohol use can cause, moderate drinking guidelines have been developed in order to maintain a healthy lifestyle. One standard drink, based purely on alcohol, contains 98 calories. Most alcohol beverages contain more calories due to the addition of other ingredients. For example, a 12-oz beer has about 150 calories, 5 oz of wine has about 120 calories, and adding fruit juice or soda to liquor (e.g., rum and coke) adds additional calories. As a result, drinking can easily lead to unhealthy caloric intake if not monitored.

Based on these dietary factors, moderate drinking is defined as one standard drink per day for women and two standard drinks per day for men.
They also recommend that nondrinkers don’t start drinking for any reason. They define high-risk drinking as any drinking higher than the daily or weekly limits outlined by NIAAA above.

**Drugs**

While drug use disorders occur much less frequently than alcohol use disorders, drug use is much more common than many realize. Nearly half of all individuals ages 12 and older, in the United States, have used illicit drugs or misused prescription medications in their lifetime (Center for Behavioral Health Statistics and Quality, 2016). The remainder of this chapter briefly reviews the use of illegal drugs and the misuse of over-the-counter drugs and prescription medications. Currently established guidelines encourage abstinence from all illicit drugs, including marijuana, or misuse of over-the-counter or prescription medications (National Institute on Drug Abuse, 2012b).

**Illicit Drug Use**

We use the term *illicit drugs* to refer to drugs that are illegal to use or possess according to U.S. law. At the writing of this book, that includes marijuana under most circumstances. Illicit drug use is highest among emerging adults (ages 18–25; Substance Abuse and Mental Health Services Administration, 2017).

**Marijuana.** The mostly commonly used illicit drug is marijuana. As reviewed in the recent landmark report of the National Academies of Science, Engineering, and Medicine (2017) titled *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*, marijuana is derived from the Cannabis sativa plant. This plant contains more than 100 chemical compounds called cannabinoids. The only compound in marijuana that makes people feel “high” is tetrahydrocannabinol (THC). The potency of cannabis has been increasing over the past 2 decades from approximately 4% THC in 1995 to 12% THC in 2014, and strains of cannabis with higher THC levels are increasingly available. The term *medical marijuana*, particularly when it appears in popular media, is somewhat confusing because it is often used to refer to marijuana, specific cannabinoids or cannabinoid combinations, and even synthetic cannabinoids. Most studies of the potential medical uses of marijuana or marijuana derivatives do not focus on smoked marijuana. Instead, much of this research focuses on one to two isolated cannabinoids or synthetic cannabinoids, which may
or may not include THC (National Academies of Science, Engineering, & Medicine, 2017). Thus, it is important for psychologists and other healthcare providers to read this research carefully, so they are equipped to address the many questions patients may have or comments they may make about “medical marijuana.”

Attitudes toward marijuana use have evolved over time, with many states loosening regulations for medical or recreational use of marijuana. Nonetheless, there are a variety of risks associated with marijuana use (National Academies of Science, Engineering, & Medicine, 2017; Volkow, Baler, Compton, & Weiss, 2014). Short-term negative effects include impaired short-term memory, impaired motor coordination, increased risk of acute myocardial infarction, altered judgment, and paranoia and psychosis in high doses. Long-term consequences include altered brain development, increased likelihood of dropping out of school, cognitive impairment, diminished life satisfaction and achievement, symptoms of chronic bronchitis, and increased risk of a chronic psychotic disorder in individuals predisposed to psychosis. There is also evidence that regular or heavy marijuana use may increase symptoms of mania and hypomania in individuals with bipolar disorders and increase suicide attempt and completion. Despite its reputation as a “safe drug,” the risk of addiction exists as well, with about 10% of individuals who experiment with cannabis becoming daily users, and 20% to 30% becoming weekly users (Hall & Degenhardt, 2009). While the risk for developing a cannabis use disorder is lower than other drugs, it is still significant. Research shows that about 9% of cannabis users in the United States will eventually develop a cannabis use disorder (Anthony, 2006; Anthony, Warner, & Kessler, 1994). Rates increase to 16% for those who initiate use as an adolescent (Anthony, 2006), and a 3-year prospective study of daily cannabis users 18 and older revealed that 37% developed dependence (van der Pol et al., 2013). This stands in stark contrast to public perceptions of the safety of cannabis use, where only 34% of people age 12 and older perceive weekly use of marijuana to be a “great risk” (Lipari, Ahrnsbrak, Pemberton, & Porter, 2017).

**Hallucinogens.** Hallucinogens are substances that create significant distortions in a person’s perceptions of reality (National Institute on Drug Abuse, 2015). This class includes classic hallucinogens, such as d-lysergic acid diethylamide (LSD) and mescaline (peyote), as well as dissociative drugs such as phencyclidine (PCP), salvia, and ketamine. Some hallucinogens do not have an established withdrawal syndrome, but tolerance is often quickly
developed. Although some of the short-term effects of hallucinogens are described as pleasurable, aversive psychological and physiological reactions may occur, including panic and fear, anxiety, paranoia, and aggression. Negative long-term effects include ongoing psychotic symptoms (e.g., disorganized thinking, paranoia), as well as hallucinogen persisting perception disorder (i.e., ongoing reexperiencing of hallucinogen-related perceptual symptoms; American Psychiatric Association, 2013a).

**Stimulants.** Cocaine and methamphetamine are stimulants—meaning they enhance activity in the central nervous system. Stimulants create a sense of euphoria, with the fastest administration routes being smoking and injecting, whereas snorting has a slower onset of euphoria but a longer euphoric episode (National Institute on Drug Abuse, 2013, 2016). In addition to euphoria, stimulants may be used for the purpose of losing weight, increasing energy, and improving attention and concentration. Stimulant use can lead to acute medical problems, such as heart arrhythmia and attacks, seizures and strokes, and death. Paranoia, disorganized thinking, mood swings, and aggressive behavior may occur.

**Inhalants.** Inhalants cover a variety of different substances that produce vapors that can be inhaled and used in harmful ways (National Institute on Drug Abuse, 2012a). Inhaling these substances results in rapid absorption into the bloodstream, leading to quick but short-lasting euphoric effects. The effects of inhalants most closely resemble those of alcohol intoxication. Inhalants are extremely toxic and can lead to significant impairment in cognitive functioning, neurological problems, and death. The acute effects of intoxication (Humeniuk, Henry-Edwards, Ali, Poznyak, & Monteiro, 2010a) can include dizziness, drowsiness, disorientation, blurred vision, poor coordination, gastrointestinal problems (nausea and vomiting, ulcers, diarrhea), and unpredictable behavior. These effects increase the risk of accidents and injuries resulting from use.

**Over-the-Counter Drugs**
In addition to alcohol and illicit street drugs, some over-the-counter medications can be used in harmful ways. Dextromethorphan is a cough suppressant that creates a dissociative hallucinogenic effect (Conca & Worthen, 2012). Caffeine is a stimulant consumed by most children and adults on a regular basis. While the *DSM–5* does not recognize a caffeine use disorder, it does recognize caffeine intoxication, withdrawal, and caffeine-induced disorders. Excessive caffeine consumption can result in nausea, vomiting, abdominal
pain, diarrhea, headache, insomnia, agitation, tremor, abnormally high muscle tension, tinnitus, elevated heart rate, and delirium (Conca & Worthen, 2012). Caffeine, particularly in energy drinks, is also mixed with alcohol to counteract the sedative effects of alcohol, making users subjectively feel less intoxicated and maintaining desire to continue drinking (Heinz, de Wit, Lilje, & Kassel, 2013). While newer antihistamines (e.g., loratadine, cetirizine) are not often associated with misuse, older ones such as diphenhydramine, pheniramine, and cyclizine are often implicated in misuse (Conca & Worthen, 2012).

**Prescription Drugs**

Whereas all illegal drugs are designated as Schedule I substances by the Drug Enforcement Agency, indicating that they have high potential for harmful use and no established medical use in the United States (e.g., heroin, gamma-hydroxybutyrate), drugs that have scientifically established medical use but also have potential for harmful use are designated Schedule II to V based on the potential for harmful use and public health risk tied to each substance (Drug Enforcement Agency, 2017). Lower numbers indicate increasing abuse potential and decreasing legal access than higher numbers, so drugs such as morphine and cocaine are Schedule II, whereas cough medicines with codeine are Schedule V. In Chapters 6 and 7, we discuss implications for treatment of anxiety and sleep problems in patients with co-occurring harmful substance use, given that some of the most widely prescribed medications for anxiety and sleep are Schedule IV drugs.

Detecting and understanding harmful use of prescription medications is more complex than with illicit drugs because often these medications are originally prescribed for legitimate medical conditions and the typical transition from appropriate medication use to a drug use disorder can be gradual. There are a variety of somewhat contradictory definitions for various types of inappropriate use of prescription drugs (Zacny et al., 2003). According to the National Institute on Drug Abuse (2018c), prescription drug misuse means “taking a medication in a manner or dose other than prescribed; taking someone else’s prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high)” (p. 3).

The most commonly abused prescription medications include opioid analgesics (i.e., pain medications such as Percocet [oxycodone/acetaminophen] or Norco [hydrocodone/acetaminophen]), benzodiazepines (i.e., antianxiety medications such as Xanax [alprazolam] and Valium [diazepam]), sleep aids that are similar chemically to benzodiazepines
(e.g., Ambien [zolpidem]), and stimulants (i.e., ADHD medications such as Adderall [dextroamphetamine/amphetamine]). Problems related to misuse of opioids have gained national attention as rates of opioid overdose deaths have grown significantly, with 46 individuals dying every day due to prescription opioid overdoses (Hedegaard, Warner, & Miniño, 2017). About 85% of treatment-seeking heroin users began opioid use with a prescription opioid (Cicero, Ellis, Surratt, & Kurtz, 2014). Opioids disproportionately account for the highest number of deaths due to risks for respiratory depression, particularly when samples are tainted with extremely powerful opioids such as fentanyl and carfentany. The acute effects of opioid misuse include nausea and vomiting, drowsiness, poor memory and concentration, and reduced sexual functioning. Misuse of prescription opioids frequently results in financial difficulties and criminal behavior to obtain opioids.

Sedatives, such as benzodiazepines and sleep aids, are prescribed as anti-anxiety and sleep medications, as well as for seizures, muscle pain, and surgical procedures (Humeniuk et al., 2010a). These medications can quickly lead to tolerance and extremely aversive withdrawal syndromes. When combined with alcohol, opioids, or other respiratory depressants, the risk of death from overdose rises significantly. The acute effects of misuse include drowsiness and confusion, poor memory and concentration, and poor coordination.

Prescription stimulants are generally prescribed for attention-deficit/hyperactivity disorder and include drugs such as Adderall [dextroamphetamine/amphetamine], Ritalin [methylphenidate], and Concerta [methylphenidate] (National Institute on Drug Abuse, 2018a). These drugs are sometimes misused by students to improve performance on exams or reduce need for sleep. They also may be misused as diet aids. Crushing the pills to snort or inject can lead to intense euphoric reactions and increased alertness and energy, similar to illicit stimulants such as cocaine. Health-related problems are similar as well, including heart arrhythmia and failure, seizures, paranoia, and psychotic symptoms.

SUMMARY

Alcohol and drug use occur on a continuum. Given how common drinking and drug use are, it is important for psychologists and other mental health professionals to be able to identify whether a patient’s use of alcohol and drugs is placing them at risk, already causing problems, or needs specialized
treatments. Some patients stay within low-risk or moderate drinking guidelines and do not take any medications or have medical conditions that contraindicate alcohol use. Others are not yet having any significant problems but are using alcohol or drugs in ways that are risky or hazardous. Still others are using in ways that have begun to cause problems ranging from mild and infrequent to severe and recurrent and may need specialty care. The next three chapters provide further guidance on how and why harmful substance use develops, how to determine what type of treatment a patient needs, and how to talk to patients about their alcohol and drug use.
Brief Strategic Family Therapy

José Szapocznik and Olga Hervis
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It is as if I were trapped with a stinking skunk in a room, and we are chained to each other, and we each have a part of the key that keeps us trapped. Our impulse is to pull away from each other, but when we pull away from each other, we move away from finding a solution to our captivity. We must change our relationship and come together to put the parts of the key together to release us both.

This story is a way of illustrating for the reader that systems are made of interdependent parts, and solutions to their problems are best developed when all the parts (family members) collaborate. We would like to tell you how we arrived at this conclusion.

We, the authors, and our mentor, Mercedes Arca Scopetta, come from the Hispanic culture that places families at the center of our world. We came together in 1974, at a time when the art of family therapy was exploding and many family therapy schools were emerging. When we opened our clinic in the Little Havana neighborhood of Miami, Florida, we recognized that a family focus was essential. We knew that in our Latin population, even when the child is going to have a tooth extracted, the whole family shows up. We then actively sought to identify among the various family therapy schools the one that was most congruent with our cultural values and customs. After visiting many masters in family therapy, we resonated with the work of Salvador Minuchin at the Philadelphia Child Guidance Clinic and that of his other Hispanic colleagues, also family therapy leaders, including Braulio Montalvo and Harry Aponte.

In structural family therapy, we found an approach that was consistent with what we had learned were the cultural characteristics of our population. First and foremost, families were the center of the world for our population. Our families came in crisis, were present oriented, and had an urgency for problem
resolution. Our research also showed that they valued a directive therapist who could assume leadership in helping them solve their problems. In structural family therapy, we found an approach consistent with these values and expectations, with a therapist who takes charge, who works in the present to help families solve their "now" problems. Structural family therapy's focus on hierarchy was also most helpful in providing us with an understanding of the intergenerational and intercultural conflicts that occurred in acculturating families in which youth acculturated to individualist values more quickly than their parents. And most important, it provided us with a framework on which to build our Brief Strategic Family Therapy® (BSFT®) model. At the time when we were studying structural family therapy, Jay Hayley joined the staff of the Philadelphia Child Guidance Clinic. Hayley's contributions to the group's work helped us recognize that a strategic approach that was problem focused and brief was a great fit for our families who wanted quick solutions and did not have the orientation to stay in therapy long. They wanted their problems fixed quickly and to go on their way.

Even before we had developed BSFT, we began our program of research, initially studying the population and then looking at adaptations to our therapy that were needed to serve our families better (Szapocznik, Foote, Perez-Vidal, Hervis, & Kurtines, 1985; Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1986; Szapocznik, Rio, et al., 1986; Szapocznik, Santisteban, et al., 1989; Szapocznik, Scopetta, Aranalde, & Kurtines, 1978; Szapocznik, Scopetta, & King, 1978; Szapocznik, Scopetta, Kurtines, & Aranalde, 1978). Shortly after developing our first version of BSFT, we began efficacy trials to evaluate outcomes. After many studies (e.g., Santisteban et al., 2003; Szapocznik, Rio, et al., 1989) that led to the refinement of BSFT and the development of additional modules such as BSFT Engagement (Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Robbins, Feaster, Horigian, Rohrbaugh, et al., 2011; Santisteban et al., 1996; Szapocznik et al., 1988) and the inclusion of other racial and ethnic and cultural groups, we were ready for an effectiveness study. In the first decade of the 21st century, we conducted a national multisite study with a multiracial and ethnic population (Horigian et al., 2015; Robbins, Feaster, Horigian, Rohrbaugh, et al., 2011; Robbins et al., 2009).

TO OUR READERS

This book is written for clinicians who provide services to families of children between the ages of 6 and 18 who present with behavioral or emotional problems. This includes family therapists and their supervisors, those in private practice and in community service agencies. The book will also be of interest to persons responsible for making programmatic decisions for children and adolescent service programs, including family service agencies, mental health clinics, departments of welfare, juvenile justice diversion programs, school counseling departments, and substance use treatment clinics. BSFT can be delivered in various settings, including homes, office, schools, and other community...
settings. It has been used with youth in rural, urban, and suburban communities in a range of service settings such as psychiatric or substance abuse inpatient and outpatient settings, as well as welfare, juvenile justice, mental health, and children service systems.

Standing on the lessons we have learned over the past 40 years, we feel we have much to share with our readers. Above all, however, we want to share a bottom-line lesson: BSFT is a love therapy. Families change when the love that is trapped behind the anger is allowed to flourish. Our job as BSFT therapists is to transform family interactions from anger to love, from negative to positive, from conflictive to collaborative, and from habitual to proactive.

We offer in this book a level of instruction about BSFT that we think will help currently practicing clinicians as well as trainees looking to enter clinical fields that involve working with families. This manual represents over 40 years of work, funded mostly by the National Institutes of Health, including the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Mental Health. The work was also funded by the Substance Abuse and Mental Health Services Administration through the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention.

ACKNOWLEDGMENTS

The initial inspiration for the development of BSFT we owe to Mercedes Arca Scopetta, PhD. Although the model stands on the shoulders of many giants in the family therapy field, we owe our greatest debt to Salvador Minuchin, MD; Jay Haley, MA; and Marianne Walters, MSW. Over the years, many professionals have contributed their effort, imagination, and clinical skills to the development of the intervention and many others to its evaluation. We would like to thank especially Angel Perez-Vidal, PsyD; Daniel Santisteban, PhD; and Michael Robbins, PhD.

The largest debt of gratitude we owe is to the tens of thousands of families who participated in our development efforts, efficacy studies, and research-to-practice activities. The families were our ultimate teachers, and our outcomes in working with them were the ultimate judges of the usefulness of the work.
Are you searching for an approach that will make you more effective in treating families of children and adolescents between the ages of 6 and 18 who present with behavioral and emotional problems? An approach that helps families regain their parental competence and leadership and that brings love, nurturance, and caring back to families who sorely need it? An approach that defines families functionally to respect the broad diversity of family cultures and compositions?

Forty-five years ago, we were looking for such an approach, and we spent the intervening 4 decades developing a model for clinicians working with such families. Our journey began in 1974 when parents came to our clinic not knowing how to help their teens who were out of control—teens who were delinquent, depressed, using drugs, constantly fighting with their parents, uninterested in school, and hanging out with other troubled teens. Their parents felt they had run out of options.

These families were in crisis and thus had a sense of urgency about getting a resolution to their troubles. Feeling they had no other options, they were looking for therapists who would take charge and give them relief. These parents had lost their ability to manage and guide their children. They were looking for a treatment that would eliminate the problems at home quickly and empower them to manage and guide their youth to become productive members of society. This is what the parents wanted. As for the teens, they simply wanted to “get their parents off their backs.”
When we started our clinical work in 1974, we recognized the powerful influences of environment, and the family, in particular, on child and adolescent behavior. Much research has documented the role that families play as risk and protective factors for child and adolescent outcomes (Bögels & Brechman-Toussaint, 2006; Donovan, 2004; Hawkins, Catalano, & Miller, 1992; McComb & Sabiston, 2010; Morris, Silk, Steinberg, Myers, & Robinson, 2007; Pinquart, 2017; Repetti, Taylor, & Seeman, 2002; O. S. Schwartz, Sheeber, Dudgeon, & Allen, 2012; Wight, Williamson, & Henderson, 2006). Since then, a body of research in the field of epigenetics has revealed how environment “gets under the skin” of adolescents through the continuous interplay between biology and environment (National Academies of Sciences, Engineering, and Medicine, 2019). Although many laypersons believe that the impact of heredity is unchangeable, research into gene–environment interactions and epigenetics shows that the way heredity is expressed in behavior depends dramatically on environmental influences (Halfon, Larson, Lew, Tullis, & Russ, 2014), of which the family is the most impactful (Fraga, Ballestar, Paz, Ropero, & Setien, 2005). It follows that positive experiences in the family will produce flourishing child and adolescent development, whereas adverse experiences in the family lead to at-risk or poor development. According to the National Academies of Sciences, Engineering, and Medicine (2019) recent consensus report on adolescence, intervention in the present can remedy past adverse experiences. We thus propose that changing families’ patterns of interaction from conflictive to collaborative and from angry to loving in the present will have a positive impact on the development of its children in the future.

WHAT IS BRIEF STRATEGIC FAMILY THERAPY?

To address this challenge, we decided to develop a flexible approach that can be adapted to a broad range of family situations in a variety of service settings (as mentioned in the Preface). We started by combining two important schools of family therapy: the structural, led by Salvador Minuchin, and the strategic, learned from Jay Haley. The therapy we developed by combining these two approaches, Brief Strategic Family Therapy® (BSFT®), is brief, problem focused, and practical. We incorporated the structural model because our families were overwhelmed with multiple problems, and one of the extraordinary features of structural family therapy is that it provided us with a formula for focusing not on each separate problem but on the ways that the family organizes itself in managing the lives of its members. Although problems are many, the interactional patterns that give rise to and maintain these problems are few. Among these few, to create a brief intervention, we focused on changing only those interactional patterns that were directly related to the youth’s presenting symptoms. That made our work as therapists manageable. When we focused on family interactional patterns, we were clear on what we needed to change to correct the families’ ways of managing their multiple problems. By changing
the family’s interactional patterns, we created self-sustaining changes in the lasting family environment of the child or adolescent. The “treatment environment” is thus built into the child’s daily life.

BSFT builds on universal principles across cultures, such as the importance of the family and the focus on relational health (Kaslow, 1996; Walsh, 2012; Wynne, 1984) as reflected in patterns of interactions. In all cultures, the family’s job is to be supportive and encouraging of each family member’s well-being as well as to raise children to be productive members of their particular culture or society. However, cultures differ in the manner in which they accomplish these tasks. For example, regardless of culture, patterns of interactions occur in all families, although specific family patterns are more likely in some cultures than others (Herz & Gullone, 1999; Poasa, Mallinckrodt, & Suzuki, 2000; Shearman & Dumlaø, 2008). BSFT’s focus is to identify those patterns of interactions that are creating problems for the family, fully understanding the cultural tradition in which these patterns of interactions occur. The therapy itself is also conducted in a way that takes into consideration each family’s cultural style and tradition. In this book, we use clinical vignettes to demonstrate the cross-cultural applicability of BSFT.

**An Evidence-Based Intervention**

BSFT is an evidence-based intervention that has been extensively evaluated for more than 45 years and is efficacious in the treatment of children and adolescents with internalizing and externalizing problems. With adolescents, much of the work has focused on acting-out behaviors that include alcohol or drug misuse, delinquency, associations with antisocial peers, and impaired family functioning.

BSFT is a brief intervention that can be implemented in approximately 12 to 16 sessions. The number of sessions depends on the severity of the presenting problem and the number of family members with problems that intersect with the youth’s presenting complaint.

**A Strengths-Based Approach**

BSFT is the ultimate strengths-based therapy. BSFT uses strengths to transform problematic family behaviors into constructive interactions. For example, when a family presents with pain, we help the family to uncover the concern, caring, and love that is behind the pain. When families fight, we talk about the strong connections among family members. When a mother is caring toward one child and not another, we help the mother to own her ability for caring and transfer it to her interactions with all her children. When a father is angry at his son, we redefine and relabel the anger as caring for the son’s future and encourage the father to tell his son about his caring: “Your son knows you are angry, but tell him the other story about what is behind your anger because you care for him. Tell him the ways you care for him, the
Brief Strategic Family Therapy

reasons you care for him, and the hopes you have for him.” Thus, BSFT is an optimistic and strengths-based approach. In real time, we transform negative interactions into positive ones.

We are able to do this because we know that behind the negative interactions, there are bonds of love. We remind the reader of Nobel laureate Elie Wiesel’s (1986) words: “The opposite of love is not hate, but indifference” (p. 68). As long as family members are fighting with each other, they are powerfully connected and far from indifferent. In BSFT, we give family members the opportunity to change their interactions in ways that free them to move toward happiness. We believe that all families have the potential to be caring, and all people have an inherent desire to be happy but may not know how to achieve happiness. In BSFT, we help families remove impediments to happiness and mental health such as fear, anger, insecurity, distrust, lack of self-efficacy, and inexperience, among others. In the upcoming chapters, we unpack the theory and research that supports our experience and deeply held beliefs about love and anger.

The James family came to therapy because the teenage granddaughter was disregarding curfew, failing her classes, and fighting with her grandmother. She was arrested and referred for therapy by her probation officer. When the session opened, Grandma immediately told her granddaughter that she was a disgrace who brought her nothing but sorrow. When the therapist asked the granddaughter to respond to her grandmother, the granddaughter said, “You don’t even care that I lost my mother.” It was clear to the therapist that no one was listening to her pain. The task of the therapist was to help Grandma attend to her granddaughter’s pain.

For Grandma to be able to do this, the therapist had to help her view her granddaughter as someone in pain. Grandma had a long list of complaints about her granddaughter. With anger and disdain, she said to her granddaughter, “I am sick of you. You only bring me sorrow. I am too old to be saddled with raising you.” The therapist told Grandma, “I hear your pain and frustration. You are two women in profound pain. You are both in great pain because you lost your daughter, and she lost her mom [cognition and affect]. Grandma, tell your granddaughter about what you are going through, how you miss your daughter [behavior].” After Grandma did so, the therapist was able to ask the granddaughter to speak about how much she missed her mom. The therapist highlighted the granddaughter’s suffering and said to Grandma, “Grandma, you are more experienced [cognition]; you, unfortunately, have lost loved ones before [affect]. What can you tell your granddaughter to help her with her loss [behavior]?”

In this example, it is apparent that the therapy not only builds on strengths but also works in the here and now to change the way grandma and granddaughter interact and behave with each other in the moment. The focus of the therapy is to change how family members behave toward each other. In this case, we used cognitive restructuring (Beck, 2011) to change the way family members perceive each other, which changes the affect between them, thus facilitating a new way for them to interact. Ultimately, the job of BSFT
is to rebond family members with each other in a loving and mutually caring relationship.

Another aspect of BSFT that reveals its strength-based foundation is our diagnostic approach. Whereas most diagnostic approaches in the health and mental health fields, such as the *International Statistical Classification of Diseases and Related Health Problems* (10th rev.; World Health Organization, 1992) and the *Diagnostic and Statistical Manual of Mental Disorders* (fifth ed.; American Psychiatric Association, 2013), focus on disorders, BSFT diagnoses both adaptive and maladaptive interactions. BSFT uses adaptive interactions or strengths to support the therapist’s efforts to transform maladaptive interactions.

**WHAT ARE THE GOALS OF BRIEF STRATEGIC FAMILY THERAPY?**

BSFT has three major goals:

- to eliminate the presenting problem or to reduce it to where the behavior is no longer problematic for the family;

- to increase mastery and competence, where *mastery* is defined as the skill level family members need to competently manage family life; and

- to improve family functioning by correcting interactional patterns in ways that allow the family to reduce chronic negativity resulting from unresolved conflicts, increase the family members’ sense of belonging and cohesion, and improve the family members’ ability to cooperate in parenting and other aspects of family life.

Ultimately, the goal of BSFT is to transform interactions from conflictive to collaborative, from anger to love, from negative to positive, and from habitual to proactive. Families change because the love that is trapped behind the anger is allowed to flourish.

**WHAT ARE SOME KEY COMPONENTS OF BRIEF STRATEGIC FAMILY THERAPY?**

Several aspects that are key to understanding BSFT we explain in forthcoming chapters. Here, we review some key aspects of BSFT to give the reader a sample of the tools available to a BSFT therapist, including a focus on family interaction patterns; identifying who the family comprises; the systemic diagnostic approach; the role of strategy; congruency in changing affect, cognition, and behavior; and BSFT Engagement.

**A Focus on Family Interactional Patterns**

Perhaps the single most important lesson we would like our readers to take away from our work is to focus on how families interact and not on what they
interact about. This is an important theoretical foundation of BSFT with many practical applications. A corollary of this lesson is that if the therapist focuses on the family's content and the many problems they enumerate, the therapist will be unable to help the family, just as the family is unable to help itself because it becomes overwhelmed by its many content issues. Whether the family talks about their kid's drug use or what they will have for lunch, the way family members interact with each other does not change.

For example, Dad says that he wants to have steak for lunch, and Mother says that she wants fish. The challenge is not in that they want different foods but in how they go about negotiating their differences (or fail) to come to an agreement. During the argument about what to eat, Mother may say to Father, “You never go along with me.” What Mother has done with that statement is to change the topic of conversation from what are we going to eat to what is our personal relationship. When a family member changes the topic of conversation, the family is unable to come to an agreement on the original topic. Then, the family ends the discussion frustrated and angry and with no resolution to what to eat on which they can all agree.

This same pattern of how the parents interact repeats itself regardless of the topic of conversation, such as agreeing on a curfew for their drug-using youth. In BSFT, we let families resolve their own content problems, while we as therapists stay focused on helping them to improve how they go about solving their problems. The therapist’s job in this example is to help the parents learn to resolve their differences of opinion by staying focused on the topic of discussion.

In BSFT, our job as therapists is to help family members interact (i.e., to behave with one another) in ways that are adaptive and result in symptom elimination. (We unpack these later in the book).

**Identifying Who the Family Comprises**

We consider the family to include all the individuals who are functioning in family roles that involve the identified patient (Pequegnat & Szapocznik, 2000). For this reason, we clarify that when we use terms such as mom and dad in BSFT, we are always referring to the persons who function in these roles. In 21st-century America, families come in many shapes and sizes. Many families are not made up of biological fathers, mothers, and children. Rather, families include a variety of persons who may function in specific roles, including stepparents, stepchildren, grandparents, aunts, cousins, and so forth. In some cultures, godparents can have an important relational role in the family as well. Among Latinxs, for example, the godmother is referred to as comadre or comother to the child’s mother. In BSFT, we are always referring to the roles people play when we use terms such as mom and dad.

When we work with the families of children and adolescents, we define family as all the individuals who are significant contributors to the everyday life of the identified problem youth. These might include those persons who live under the same roof but excludes those who are transient—for example,
an aunt or a friend who frequently “crashes” at the house. We include, however, other persons not living in the same household as the child who contribute to parenting and sibling functions—such as might occur with a remarried father and stepsiblings or a grandma who cares for the children until the single parent comes home from work. In our view, all these individuals who interact on an ongoing basis with the identified problem youth functionally compose the family and must be involved in therapy. All family members may not have to come to all the sessions, but we must bring them to the first session to enable us to diagnose how the family system functions with all the parts of the puzzle present. Thereafter, some may be excluded from some sessions, depending on the treatment plan.

**Systemic Diagnosis**

BSFT is a diagnostically driven therapy with a focus on interactional patterns. In BSFT, interactional patterns are what gets diagnosed and treated. This means that individuals are not diagnosed; rather, family interactional patterns are diagnosed. These are not static labels but dynamic descriptions of the repetitive patterns of interactions that occur among family members—that is, how family members behave with each other in interlinked sequences of behaviors that repeat over time. These patterns, unfortunately, are fairly rigid in families that make up our clinical population, and this is one of the reasons they are relatively easy to diagnose through any content that the family may bring up. In support of our therapeutic focus on interactional patterns, these diagnoses describe how the family interacts. The treatment, then, is simply to change the interactional patterns that have been identified and that are linked to the presenting problem. Our systemic diagnoses contribute to BSFT’s brevity because treatment is fully guided by the diagnosis. The diagnosis provides a clear road map for the therapist to design specific treatment plans and allows the therapist to assess progress or the lack thereof. Moreover, because interactions are few (whereas contents are many), treatment has a small number of interactional targets.

When we diagnose family interactions, we choose to use the terms *adaptive* and *maladaptive* to connote that in BSFT, we view interactional patterns as malleable. That is, interactional patterns change as a function of therapy. We choose not to use terms such as *functional or healthy* and *dysfunctional or unhealthy* because these terms are often viewed more statically. A static view of interactional patterns is inconsistent with our philosophy and experience that family interactions can be changed, and in fact, changing them is the bread and butter of our work.

**Strategy as a Theoretical Foundation**

There are three major aspects to strategy in BSFT: It is planned, problem focused, and practical. The treatment plan that is designed to treat the maladaptive interactions diagnosed for each specific family is *planned*, which
means that from session to session, therapy is planned to achieve the overall changes required to overcome each specific family’s maladaptive interactions. Second, strategy also demands that plans are specifically designed to be problem focused, which means that we do not attempt to treat all maladaptive aspects of the family but only those that are directly related to the presenting symptom. In focusing on the problem or symptoms that bring the family into treatment, we typically have to treat a range of interactions that are linked to the presenting problem. For example, parents’ ability to collaborate is required for them to parent effectively. This is intimately related to the couple’s interactions, which have to be corrected to improve their collaborative parenting activities. The third aspect of strategy is that BSFT is practical, which means that for each specific family, treatment is planned to be most effective given that family’s culture and idiosyncrasies. Practicality requires us to customize the therapy for each family. For example, if two families are both diagnosed as having an imbalance in the parental subsystem, and in one family, Dad has more power than Mom, we thus need to empower Mom, whereas in another family, Mom may have more power than Dad, and thus we need to empower Dad. In doing this, we have to carefully consider clinical, cultural, and other contextual realities of the family.

**Congruency in Changing Affect, Cognition, and Behavior**

In the years that we spent developing and refining BSFT, in addition to addressing behavior, we learned that achieving long-lasting change depends on a dance that includes cognition, affect, and behavior (Beck, 2011; Greenberg & Safran, 1987; Strümpfel & Goldman, 2002). For family members to behave differently, changes in cognitions and affect must always accompany behavior in a manner that makes the new behavior syntonic with the way family members are thinking and feeling at the time they behave in new and more adaptive ways.

**Brief Strategic Family Therapy Engagement**

All of this is well and fine when families come to therapy, but what if they do not? Early on, we learned that bringing families of troubled—and, in particular, acting-out—adolescents into treatment was hugely challenging. We also learned that many community agencies around the country had the same challenge. Thus, in the 1980s, we set out to understand what makes it so difficult to bring families into therapy, particularly when families members are in conflict with each other.

To address this challenge, we developed BSFT Engagement. Using what we had learned in building BSFT, we recognized that the kinds of family interactions that resulted in the presenting problem were identical to the interactions that resulted in the symptom of “resistance” to treatment. Families, in fact, are very consistent. Families have overlearned patterns of interactions
that repeat themselves in all the content issues the family has to navigate in life. If family members have a set way in which they sit at the dinner table, which is inviolable, then other habits are similarly ingrained, and it is that consistency in the way family members behave with each other that becomes central to how we both diagnose and treat the family system. Hence, in BSFT Engagement, our first interaction with a family member who calls for help is directed at diagnosing whether the family’s patterns of interactions will interfere with the family’s ability to become involved in therapy as a whole family. We discuss BSFT Engagement in detail in Chapter 7.

Ms. Roura was referred by her son’s probation officer to BSFT. When she called for an appointment, the therapist validated Ms. Roura’s eagerness to help her son (this is part of what we describe later as joining), expressed the importance of the whole family coming to the first session, and explored and verified which members of the family are or should be involved in the son’s life and whether she could foresee any impediments to any family member attending the first therapy session. The therapist emphasized the importance of each family member’s participation and explained that the treatment can only be effective with everyone involved, and though it was possible that not everyone would have to come to every session, everyone did have to come to the first session: “Is it going to be OK with everyone to come to the first session?” Only with Ms. Roura’s reassurance would the therapist go on to make the appointment, ending with an encouraging and motivational comment such as, “I am looking forward to working with you and your family. You will see that by working together, we will help your son.”

If Ms. Roura indicated she expected that some family member(s) would be unlikely to want to or be unable to attend or that she did not want a specific family member to be involved or expressed hesitation in involving any family member, this is when the therapist would implement the BSFT Engagement model.

**HOW DO FAMILIES TYPICALLY PRESENT FOR BRIEF STRATEGIC FAMILY THERAPY?**

In our experience, a family typically brings a child or adolescent to treatment asking the agency “to fix him (or her).” If we look beyond the youngster, we readily see that the family is in turmoil. Emotions such as anger, guilt, pity, hopelessness, and despair are running rampant. Communication lines have collapsed. The family approaches the agency out of desperation and perhaps because it was ordered to do so by, for instance, the juvenile justice, welfare, or school system.

A family comes into the agency asking that changes be made because they are in pain. They typically demand that the youngster—the one the family views as responsible for inflicting all this pain—be cured. Having decided that this young person is the one with the problem, they ask the agency staff to
“fix him, make him stop, or just send him somewhere for a long time and send him back when he is fixed.”

Adolescents often present with more than one problem. Research has shown that many adolescent behavior problems co-occur (Donovan & Jessor, 1985; Donovan, Jessor, & Costa, 1988, 1991; Kazdin, 1992). Research has also suggested that families, in particular, play an important role in preventing, giving rise to, and maintaining the adolescent’s problem behaviors (Coatsworth et al., 2002; Donovan, 2004; Hawkins et al., 1992; McComb & Sabiston, 2010; Pinquart, 2017; Stone, Becker, Huber, & Catalano, 2012; Szapocznik & Coatsworth, 1999; Wight et al., 2006). Some of the family interactional problems that have been identified as linked to adolescent acting out include

- parental under- or overinvolvement,
- parental over- or undercontrol,
- poor quality of parent–child communication,
- lack of clear rules and consequences,
- lack of consistency in the application of rules and consequences,
- inadequate supervision or monitoring of peer activities,
- poor parent–child bonding,
- poor family cohesiveness,
- lack of nurturance and guidance, and
- high negativity.

Many of these interactional patterns are also found in internalizing youth (Bögels & Brechman-Toussaint, 2006; Morris et al., 2007; Repetti et al., 2002; O. S. Schwartz et al., 2012). Because these family interactional problems are an integral part of the profile of internalizing and externalizing youth and because many of these family problems have been linked to the initiation and maintenance of youth symptoms, it is necessary to correct the family interactions to achieve a family context that discourages self-defeating symptoms and promotes the youth’s positive development. BSFT targets all the family problems listed earlier.

**THIS BOOK**

This book introduces therapists to concepts needed to understand the family as an organism or system that may show symptoms in one of its members. The book describes strategies for gaining entry into families, assessing and diagnosing maladaptive patterns of family interactions, and changing patterns of family interactions from maladaptive into adaptive. The book also presents our strategies for engaging families whose members are reluctant to become involved in family therapy.

In Chapter 1, we discuss the basic theoretical concepts of BSFT. Chapter 2 explains how to join the family in such a way as to create an effective collaborative therapeutic system. Chapter 3 presents the BSFT systemic (relational) diagnostic approach, whereas Chapter 4 explains how to apply it clinically.
Chapters 1 and 2 each conclude with a section called Advice for Therapists, which gives practical pointers or indicates a key skill for prospective BSFT therapists to learn. From Chapter 3 to the end, all material is geared toward practical application; thus, our specific advice is incorporated within the body of the chapters.

Chapter 5 describes how to change the maladaptive patterns of family interactions that are associated with the youth’s presenting problems. Through this process, maladaptive interactions are restructured into adaptive interactions. Chapter 6 discusses the kinds of pitfalls that prevent therapists from being successful in correcting maladaptive interactions. Chapter 7 provides a detailed discussion of how to engage families when some members are reluctant to become involved in family therapy. Chapter 8 discusses the application of BSFT to different practice settings, family compositions, and aggravating family circumstances. Finally, Chapter 9 presents an extended case vignette to provide an additional opportunity for readers to consolidate the lessons from the book and mentally rehearse how they might apply BSFT principles in their practice. In all case material we present in this book, we have taken steps to conceal individuals’ identities and the details of their family situation to protect their privacy.

BSFT is manualized in this book with well-specified theory and intervention techniques. However, it requires the ability to use clinical judgment in its implementation. Clinical creativity and flexibility are needed to implement BSFT in an effective manner, so for readers who are trainees or early-career practitioners, we recommend undergoing a training program before offering BSFT in your practice.
In this chapter, we describe the basic principles and theoretical concepts that provide the foundation of Brief Strategic Family Therapy® (BSFT®). Before presenting these, we discuss our philosophy of human behavior and human behavioral change.

First and foremost, we believe that the family is the center of a child’s world. Although we recognize that contextual social systems influence the child’s well-being, we consider the family as the single most important influence in a child’s life.

Second, we believe the definition of a family that functions adaptively is one that consistently provides the conditions needed for every person to be the best they can be while adjusting to changing circumstances. However, a family functions maladaptively when at least one of its members develops behavioral or affective symptoms as a way for the family system as a whole to remain unchanged. Obviously, there is a circularity embedded in this statement because the family maintains the symptom, and the symptom maintains the family system as is. This has been referred to by Minuchin and colleagues (1975) as the functionality of symptoms theory—that is, symptoms play a role in maintaining the family’s maladaptive interactional patterns.

Third, we believe that symptoms are linked to maladaptive family patterns of interactions. Therefore, to get rid of the symptoms, the most effective approach is to change those families’ maladaptive interactions linked to the symptom. The remainder of this chapter explains how our approach works and is organized.
into five sections—the first two focusing on family systems and structure and the others on therapy strategy, context, and attending to family process versus content.

**FAMILY SYSTEMS**

Family systems theory (Bowen, 1974; Broderick, 1993; Galvin, Dickson, & Marrow, 2006; Titelman, 2014) holds that family members are interdependent. That is, family members are interconnected with action–reaction sequences in which the behavior of one sequentially triggers the behavior of another. Therefore, family systems theory views the youth’s behaviors as related to what else is going on in the family.

A system is made up of components that are interdependent and interrelated. Families are systems that are made up of individuals (parts) who are responsive to each other’s behaviors. Thinking about human problems from a systems orientation helps us understand the complex relationships and interdependence of family members. There are many examples, both in the physical and social world, that illustrate how systems work.

Think of your body’s circulatory system. When the heart speeds up, your blood pressure goes up, your face flushes, and your breathing may accelerate. Why is this? Because the way systems operate is that when one part changes, it affects other parts of the system. When a balloon is blown up and its opening is tied into a knot so that the air stays inside, the balloon and the air (parts) become interdependent. If you squeeze a part of the balloon, the air moves from that side to the other side, thus overstretching that other side of the balloon by putting pressure on it. If too much of the balloon is squeezed, the air trapped inside will stretch the remainder of the balloon until it forces it to explode. The earth and the moon are in a gravitational system with each other. The earth keeps the moon in its orbit, and the moon makes the sea rise and ebb on earth. Systems are the way of the universe.

These examples make it easy to understand that systems are made up of parts that are in constant interaction with each other, and any change in one of the parts of the system triggers a change in the others. It is the same way with families.

Families are systems made up of people who are cognitively, emotionally, and behaviorally connected. If a child becomes severely ill, the family has to make accommodations so that a parent will be able to take the child to the doctor and care for the child. That means that the parent will have less time to do what she usually does for the family, such as cook and care for the house. The other children may feel neglected and overburdened by new chores they must take on for the family to continue to function effectively. When a parent feels unsupported and stressed by unfavorable environmental circumstances (e.g., poverty, job stress, discrimination, abandonment, immigration, infidelity), the most vulnerable members of the family—the children—will experience the stress and are most likely to develop symptoms.
The Family Is a Whole Organism

The important concept that systems theory teaches is that the family is one whole organism. That is, it is much more than merely the composite of the individuals it comprises. Over the many years that a family is together, the family system is formed as each of its members behaves in expected ways thousands of times. Hence, each member has become accustomed to act, react, respond, feel, and think in a specific manner in the context of the family. Each family member’s actions elicit a specific set of reactions from the other family members, and this occurs over and over again over time. These sequences give the family its form and style. Individual members behave in unique ways that are predictable because they have been repeated and molded over time. Consequently, the whole organism (i.e., the family) grows out of the repeated behaviors of family members over the years in ways that each individual’s behaviors fit with the rest of the family like a piece fits in a puzzle.

Consider an analogy. When we think about a book, say Mark Twain’s Adventures of Huckleberry Finn, what makes the book (i.e., the whole organism) memorable is not just the characters but also how the characters interact to create a beloved story. In the same way, the family is a whole organism that comprises its members and the repeated sequences of behaviors that create the family’s story.

Let us look at some examples. Whenever Mother and Stepfather argue, 5-year-old Jason gets nervous, so he begins to make a lot of noise and throws a fit. Mom and Stepdad then stop their argument and attend to Jason to calm him down. As this sequence repeats itself over time, Jason inadvertently learns that he can interrupt his parents fighting by calling their attention to his negative behavior. Soon, to avoid trouble arising between the parents, Jason learns to be the center of attention when his parents are together, and his distraction tactics have become a part of his way of behaving in systems, whether it be his family of origin, his school, or later on in life, his work or family of choice (Burkett, 1991; Halford, Sanders, & Behrens, 2000; Koerner & Fitzpatrick, 2002; B. E. Robinson & Post, 1995; Whitton et al., 2008). However, Jason’s distracting behavior when Mom and Stepdad fight prevents the parents from resolving their conflicts. Over time, the parents grow apart: Mom spends a lot of time dealing with Jason’s problems in school, and Stepdad gets busy with friends, work, and his carpentry hobby so he does not have to hear about them.

The patterns that develop in a family shape the behaviors and styles of each of its members. There are ways in which each family member has become accustomed to behaving in the family—behaviors that have occurred so many times they have shaped the members to fit together like pieces of a puzzle, a perfect, predictable fit. For this reason, when a therapist wants to help the family rid itself of a troublesome symptom, the therapist must understand how the family operates as a whole and the role that the member with the symptom plays in the whole of the family organism.
Every morning, Grandma goes to the kitchen to make breakfast, Mom wakes up the children, and Tommy, the eldest, takes the dog out for a walk. One morning, Mom wants to sleep late, and she asks Tommy to wake up the littler ones. Tommy complains that he hates to do that: “They don’t do what I ask them.” With that in mind, Grandma leaves the kitchen to get the little ones up and dressed. They want their mother, as usual, to do this job, and so they give Grandma a hard time. Grandma does not get to make breakfast in time, everyone is late for school, and the dog has an accident on the carpet.

The pattern has been disturbed. Tommy, Mom, and Grandma might figure out a better way to allow Mom to sleep in late that does not make every morning fall apart. Or they might not. It could be that the pieces of this puzzle (family members) are unable to adapt to a new situation in ways that achieve a successful resolution. Families are frequently confronted with new situations. Those families that are unable to adapt across novel situations as they emerge are the families that are most likely to develop symptoms and, thus, are most likely to need therapy.

The influence of the family on behavior is powerful. In part, this influence is so powerful because it has been reinforced hundreds and thousands of times in the past and because it continues to be reinforced. It is powerful enough to give shape to an individual’s personality, to how a person sees herself and how she sees her place in the world. How a person has come to see her role in the family exerts a great deal of influence on how she sees her role in life altogether. A person who has always played the role of peacemaker in family arguments may go on to do that in other stations in life, such as at the office, among friends, or even as a career (she may decide to become a diplomat or a mediator). However, if a person’s experience in the family was extremely unpleasant, she may become someone who appears insensitive and uncaring because she refuses to get involved in the problems other people have.

**Complementarity**

Given this tremendous influence and power that is exerted by the family system, it is not surprising that it is difficult for an individual who remains inside the sphere of their family to change in a lasting way unless the family changes along with the individual. This happens because change in one member requires change in other family members. If one piece of the puzzle changes its shape, some other pieces have to change their shape for the puzzle to continue to fit together.

Conversely, the family’s power can be nearly irresistible when the family behaves in more adaptive ways that, in turn, elicit more adaptive or pro-social behaviors in the individual. After all, the influence that is effective in one direction (e.g., enabling) can be just as effective in the opposite direction too (e.g., setting limits). Typically, a family member, especially a child or adolescent, will readily respond to the family system’s influence to behave
adaptively. A youngster's behavior can drastically change when a parent or parents learn how to behave differently. This happens because family members who are linked emotionally are behaviorally responsive to each other's actions and reactions. This is the way complementarity operates (Minuchin & Fishman, 1981): For every action on the part of one family member, there is a complementary reaction on the part of the others. For this reason, family is a powerful change agent. However, when only the youth is in therapy, the family can unknowingly sabotage any changes that are brought about through individual therapy.

Complementarity teaches us that the behaviors of the family members are like the gears that make up the inner workings of a clock. For the clock to keep ticking and keeping time, all the gears must turn in a specific way. Similarly, for the family to continue to work in a certain way, whether it is adaptive or maladaptive, everyone’s behavior must contribute to maintaining the family’s particular pattern. The good news is that just as one member’s actions can negatively influence another member, the opposite is also true. When one or more family members, especially parents because of their power and leadership role in the family, change their behaviors, this creates a new situation to which the youth has to respond, typically by either complying or pushing back. The parents’ new behavior creates an opportunity for the youth to behave differently as well. As we discuss later in the book, the dance that occurs as changes take place in some family members creates opportunities for new behaviors in other members. Positive changes on the part of the parents will produce an opportunity for positive changes in the behavior of their youngsters. For example, often children may have learned to coerce parents into reinforcing negative behavior (e.g., throwing a temper tantrum and stopping only when the parent(s) give in; Patterson, 1982; Patterson, Reid, & Dishion, 1992). Only when the parent(s) change their behavior and stop complementing the child’s negative behavior will the child change.

**Homeostasis**

Homeostasis (Anderson, Goolishian, & Winderman, 1986; Chrousos & Gold, 1992; Minuchin et al., 1975; Tononi & Cirelli, 2006; Wynn, Chawla, & Pollard, 2013) is the systemic force that operates to maintain the permanence of systems, thus preventing systems from changing. Homeostasis combines homeo, meaning same, with stasis, meaning status. To illustrate, gravity functions to keep us all grounded on Earth, and like gravity, homeostasis is a force that cannot be seen but is nevertheless operational in keeping systems from changing. For a person to overcome the pull of gravity, that person has to use exceptional force. In the same way, for therapy to overcome the pull of the family system attempts to stay the same, therapy has to overcome the pull of homeostasis. Homeostasis serves an important purpose for systems: It maintains them unchanged. However, when we are working to change the system, we fight against homeostasis to bring about change.
STRUCTURE: THE SCRIPT FOR THE FAMILY PLAY

As we noted previously, the family is a whole organism that includes its members and the wholeness that emerges as the family’s repeated sequences of behaviors come together. Structure is the wholeness that emerges as a specific family’s repeated sequences of behaviors come together in a way that is unique for each family. Individual patterns of interactions can be seen across different families (e.g., parents do not collaborate in parenting), but the way the various patterns of interactions come together is unique to each family and thus defines that family’s particular structure. Structure (Minuchin, 1974; Szapocznik, Hervis, & Schwartz, 2003; Szapocznik & Kurtines, 1989) is the sum of all the repetitive interactional patterns that exist in a family and how they come together in a unique way for each family. In our discussion thus far, we have tended to identify one or another family interactional pattern, but in families, several interactional patterns co-occur, and the sum of the aggregation of all interactional patterns within a family is referred to as the family’s structure. Likewise, in a play, the sum of all the interactions among the various characters constitutes the script. In dance, the sum of the sequence of steps and movements of all the dancers is referred to as the choreography. Structure explains how the family system has an impact on its members. Patterns of interactions are defined as the linked behaviors among family members that become habitual and repeat over time. It is a universal principle that occurs across eras and cultures, given that across eras and cultures, families are composed of members who interact with each other in some way. The role of the BSFT therapist is to identify those patterns of family interactions that are associated with the youth’s problems and therefore have to be corrected.

Families and their members are interactive and interdependent. Thus, family patterns of interactions and individual family member’s behaviors are interactive and interdependent. The family impacts, shapes, and determines the behavior of each of its members. Similarly, the individual family members impact, shape, and determine the family system.

Patterns of Interactions

When Maria and Lila meet, Maria acts in a certain way toward Lila. Lila, in turn, responds in a certain way toward Maria, who then responds to Lila’s response. These linked behaviors of one person responding to another—either through actions or conversation—are called an interACTION (an interplay of interlinked actions) or, more precisely, a series of interACTIONS. In time, Lila and Maria’s interactions become patterned and thus are referred to as patterns of interactions. Patterns of interaction are typically characterized by their repetitive nature. Two or more people who often have contact with each other (e.g., family members) form habits according to the way they interact with each other. As we mentioned in the Introduction, a simple type
of repetitive pattern is found in how family members choose to sit in the same places at the dinner table every day. Where people sit may facilitate certain persons interacting with each other and not with others. Consequently, we would say that a repetitive pattern of interactions has emerged—a sitting pattern that may reflect an interaction pattern.

Patterns of interactions develop in any system—for example, among people who hang out together in school or the neighborhood. With older, more established systems such as families, the interactions that occur are over-practiced and thus become predictable. They are predictable in that, in a family, these interactions have occurred in just the same way thousands of times. They have become repetitive. Figure 1.1 shows, albeit in simplified form, that a family’s patterns of interactions, or systems, shape the behaviors of its members and vice versa.

Every time Ron nagged his wife, Fran, for not taking adequate care of the home and children, Fran ignored him. The more he nagged, the more she ignored him; the more she ignored him, the more he nagged. Ron and Fran could be said to be stuck in a repetitive pattern of interactions in which they lost their ability to cooperate, and neither one of them feels satisfied.

In their family, father and daughter Nora became close and shared their unhappiness about Fran, Nora’s stepmother. As Nora got a little older, Ron turned to her for emotional support instead of to Fran. Ron developed a close emotional tie to his daughter. Fran, in turn, remained distant from Nora because she sensed that her stepdaughter always sided with Ron. When Nora needed help with something, she instinctually knew she had to turn to her father, not her stepmother. This is another repetitive pattern of interactions—interwoven with the first—that developed in the family.

**FIGURE 1.1. Patterns of Interactions in Family Systems**
In this example, if Nora developed behavior problems when she became an adolescent, the family would be unable to manage her behavior effectively. Ron still turned to his daughter for emotional support. In doing so, the relationship between father and daughter was strengthened at the same time that the coalition between father and daughter against Fran was strengthened. This elevated the daughter in the family hierarchy to the level of her father. When Fran attempted to set limits on the daughter, her efforts were ineffective. Mother and father were unable to discuss, much less agree, on how to handle Nora’s misbehavior. In families, we often see a linking of several patterns of repetitive interactions, where one pattern is likely to maintain and be maintained by another. As we discuss later in this book, the inability of parental figures to negotiate and agree on rules and consequences and to present a united and consistent front is perhaps one of the most frequent manifestations of a troubled family associated with disruptive problem behaviors in adolescents.

All families develop patterns of interactions that repeat over time and across topics. However, not all families develop symptoms because not all repetitive patterns of interactions are maladaptive. For example, a repetitive pattern of interactions that is nearly always adaptive is when father and mother collaborate about parenting issues. When a family has certain repetitive patterns of interactions that are unsuccessful in achieving the goals of the family or its members, these patterns of interactions are said to be at the root of the kinds of problems that are called symptoms that bring the families into treatment. Families that tend to have problems have them precisely because they continue to interact in fastidiously repetitive ways that are maladaptive. Families with problems tend to have less flexibility to adapt to new conditions and new circumstances. This lack of flexibility does not allow the family to solve problems effectively, thus explaining the family’s inability to correct their maladaptive interactions or eliminate the symptoms that arise in its members.

For the BSFT therapist, that “something” that a family is doing that maintains the problem and that something that the family could do differently to eliminate the problem is always an interaction. In other words, what has to be changed is always a part of the family’s structure (repetitive patterns of interactions) that does not work well and is maintaining the symptom(s).

**Adaptive and Maladaptive Interactions**

As noted earlier, we define the terms *adaptive* and *maladaptive* in reference to interactional patterns by whether these result in positive outcomes or symptoms. Hence, this definition has two important components: (a) the family’s ability to adapt to changing conditions or circumstances and (b) that these changes result in positive outcomes for all members. In our definition of adaptive and maladaptive, we have thus been pragmatic, linking our definition of maladaptiveness to outcomes that families and society define as undesirable.
Through research and clinical experience with thousands of families, we have come to identify that certain patterns of interactions, particularly in families with children and adolescents, tend to result in negative or symptomatic outcomes (Szapocznik & Kurtines, 1989; Szapocznik et al., 1988, 2003). In this book, we discuss the role of culture, which is complex. Whether or not culture supports a certain pattern of interactions, if the result is negative outcomes for individual family members, we propose that these family interactional patterns have to be adjusted to improve a family member’s individual well-being. However, this has to be done with the utmost respect and deference to culture.

An example of an interactional pattern that is always adaptive is family members collaborating in solving differences of opinion in such a way that the needs of all concerned are addressed. As long as these negotiations consider the age and circumstances of all concerned, these types of family interactional patterns are likely to be adaptive.

However, some interactions are adaptive at one point in the family’s history and development but have to be adjusted over time and in response to new circumstances. A parent who was used to telling a young child what to do will not be as successful simply using this tactic when the child becomes a teenager because, at that age, the teenager is developing a sense of autonomy (McElhaney, Allen, Stephenson, & Hare, 2009; Noom, Dekovic, & Meeus, 1999). Parents are unable to “control” teenagers. Provided there is a good foundation for the relationship between the parent and teenager, negotiation is typically effective in managing a teenager (Gray & Steinberg, 1999; C. C. Robinson, Mandleco, Olsen, & Hart, 1995). If the parent is unable or unwilling to make a transition to negotiation, it is unlikely that the family will be able to reach a resolution that accommodates the goals of all family members involved.

Another example of an adaptive interaction that can become maladaptive over time occurs when the family composition changes. The mother who passed away had more time to spend in guidance and nurturance than the mother who was the primary breadwinner and thus spent long hours outside the home. How does the system adapt to this loss while still providing the amount of nurturance and guidance the children need? The breadwinner now has to make time to care for her children and possibly involve extended family members to support her in this role because she must continue to work. If reassignment of the roles that the deceased mother played does not happen, the children may feel and/or be neglected.

Some interactional patterns are never adaptive. A typical example of a maladaptive interaction that is frequently seen in families of acting-out teens is a triangulated relationship (Dallos & Smart, 2011; Dallos & Vetere, 2012; Franck & Buehler, 2007). A triangle is formed when two people are in conflict and a third one is brought in or brings himself into the conflict. When this happens, the triangulated person finds himself involved in a conflict between two other persons. In the case of adolescents, this pattern often starts in early childhood. This interaction usually involves the youngster in ongoing conflicts between
two parental figures, (e.g., mother and grandmother) who are involved in parenting the child. It may have started as follows.

The mother takes a drink, and the grandmother (the second parental figure) admonishes her that she is going to kill herself with so much alcohol. The 6-year-old begins to cry and interrupts the argument. The mother is angry because she has been scolded by her own mother and takes her anger out on the child by spanking him and yelling at him to “shut up.” The grandmother is then even more angry with her daughter, and the fight escalates as she calls her daughter an unfit mother. Mother claims that Grandmother spoils the child. Grandmother defends herself by assuring her daughter that the child is not spoiled and that she is not one to spoil a child. The child has now unfairly become the center of the parental fight—a fight that initially had nothing to do with the child. Meanwhile, the conflict has shifted from focusing on the mother’s drinking to focusing on how to raise the child, which conveniently leaves the mother off the hook about her drinking.

As the child grows, the triangle evolves to the grandmother and child forming a coalition (supporting each other) against the drinking mother. Typically, this leads to the mother losing power in her parental role, with the child acquiring additional power through his coalition with Grandma. As this pattern repeats itself over the same and different parenting arguments, the child will grow up to learn that (a) he does not have to listen to his mother, (b) his grandmother will defend him no matter what he does, and (c) he has become more powerful than his mother. As this pattern repeats over time, it becomes responsible for the maintenance of symptoms such as alcohol use in the mother and drug abuse in the youth. When the family comes into therapy because of the youth’s drug use, these maladaptive patterns of interactions must be a target of BSFT treatment.

In sum, the concept of family systems teaches that family members are interdependent. The interplay of behaviors among family members is defined as an interaction. Structure (i.e., the aggregation of the sum of the family’s repetitive patterns of interactions) teaches that the patterns of interactions are repetitive and thus predictable. It also teaches that, in some instances, the repetitive patterns of family interactions do not result in desired cognitive, emotional, and behavioral outcomes for all its members. Instead, these patterns of interactions succeed only in frustrating the family members and in eliciting or allowing problematic behavior that becomes the symptom of the family’s inability to solve its interactional problems.

**STRATEGY**

The third foundational concept of BSFT is strategy (Haley, 1963, 1971; Madanes, 1991; Nardone & Watzlawick, 2005; Rabkin, 1977; Zeig, 1980). Strategic therapy designs for each family the best method to achieve treatment goals. There are two concepts of strategy that we use in BSFT. One (with a capital S)
refers to the nature of the overall approach to treatment that is diagnostically driven and is unique to each family. We present our systemic diagnostic schema in Chapter 3. The overall Strategy for the direction of therapy with a specific family is driven by the unique diagnosis of the adaptive and maladaptive interactional patterns that characterize it. In this case, Strategy refers to the overall direction of changing the specific maladaptive patterns of interactions that are linked to the presenting problem. Such a Strategy is used from the first to the last session and drives the treatment plan throughout the full therapy process. The Strategy is also used to plan the specific changes that will be pursued across all sessions that will transform the targeted patterns of maladaptive interactions linked to the presenting symptoms. For this reason, every session always looks to the bigger plan of Strategy for the interactional patterns that have to be changed. Figure 1.2 illustrates this idea.

**Practical**

The other aspect of strategy (with lower case $s$) in BSFT refers to the practical approach to selecting those particular tactics or interventions that are best suited to a family’s idiosyncrasies (of organization, values, language usage, culture, content, etc.), with the ultimate goal of successfully pursuing the overall Strategy. In Chapter 5 of this volume, we explain the considerations involved in selecting the specific tactics and interventions targeted at each family at each moment.

To be practical in BSFT means that the therapist may use any technique, approach, or tactic that will help her achieve the objective of changing specific
maladaptive interactions that are contributing or maintaining the symptom(s) and thus eliminate the symptom(s). The tactic is the particular method used for a specific family to achieve the desired interactional change. In BSFT, practicality is based on the belief that more importance should be placed on the achievement of interactional change rather than on the use of any particular approach or tactic. Thus, the BSFT therapist uses the tactics or approaches that are most likely to achieve the desired changes in interactional patterns with maximum speed, effectiveness, and permanence. An example of the practical aspect of BSFT is found in the use of reframing (also explained in more depth in Chapter 5): Rather than portray the entire reality of a situation, reframing emphasizes only a particular aspect of reality, the one that will best serve to move the family from a maladaptive interactional pattern to a more adaptive set of interactions.

In the case of a father who is berating his son for skipping school, the therapist may choose to either focus on Dad’s concern for the future well-being of his son as a way of building a positive affective bridge between father and son or to point out that the son appears to be depressed, which may be the reason the son is not going to school. Each of these frames is intended to elicit from the father a more nurturant response, which in turn moves the family from negativity from father toward the son to more positive, nurturant, and constructive interactions. The practical aspect of BSFT in this instance will inform the decision of which one to use. This will depend on the clinician’s assessment of which has the best likelihood of being accepted by the father and the son and thus to be successful in transforming the quality of the interaction.

**Problem Focused**

A problem focus is characteristic of strategic family therapies (Nardone & Watzlawick, 2005). BSFT, like other strategic approaches, emphasizes changing those family interactions that are most directly related to the youth’s presenting problem. The BSFT strategic plan aims to bring about change only to those family interactional patterns that give rise to or maintain the youth’s problems. In all families, there will be other problems that the therapist will observe, but if they are not directly impacting the youth’s presenting problems, these other family problems do not become the target of BSFT treatment. It is not that BSFT cannot handle these other problems; rather, we are making choices about what problems to handle first as part of a time-limited intervention that prioritizes eliminating the most urgent symptoms.

However, there might be necessary changes that appear to be outside of the presenting problem but are not. These changes are undertaken only to the extent that they are necessary for a resolution of the focal problem. For example, it may be determined that the youth’s parents are not setting and enforcing clear limits on the youngster’s behavior. In trying to get them to decide on a plan for discipline management, it becomes obvious that the parents are not able to work together as a team because of underlying marital issues that keep them angry and distrustful of each other. In this case, the
marital problem has to be addressed to the extent that it is necessary to get them to cooperate in managing their child’s behavior. The parental couple can be helped to successfully handle their parenting functions, although not all their marital problems might have been solved.

Several aspects of being problem focused deserve more attention. One of these is that families do indeed come to therapy presenting with many different problems. Frequently, therapists complain, “This family has so many problems that I don’t know where to start.” One aspect of problem focus is that the attention of the therapy is in interactional patterns linked to the presenting symptoms. However, the pattern of interactions that may underlie the presenting symptoms are most likely the same interactional patterns that underlie other presenting problems.

**Planned**

As we noted, there is an overall Strategy that provides the direction for the treatment plan and is based on the systemic diagnosis—that is, what interactional patterns linked to the presenting problem have to be changed. The larger Strategy defines the overall treatment plan. However, each session is planned so that all sessions in the aggregate take us from where we are to where we want to go. For this reason, for each session, the therapist makes deliberate plans that move the family toward accomplishing the overall Strategy or treatment plan. Before each session, then, the therapist knows exactly what she is going to do (i.e., what interactions to change, such as creating a parental alliance with the goal of improving parental collaboration, leadership, and practices) and how she is going to do it. Therefore, BSFT sessions are purposeful in transforming interactional patterns from maladaptive to adaptive. The BSFT approach is a dance between “strategy with a small s,” which is practical by capitalizing on the emerging process while intervening in a deliberate fashion to pursue the “Strategy with a large S.” Hence, the therapist must flow and yet be able to move from a diagnosis—point A—to a planned outcome—point B.

As will be evident in later chapters, BSFT is like using a river current to get to a specific target: It is fastest and most effective to take advantage of its flow. However, the therapist always knows where she wants to arrive.

**CONTEXT**

*Context* is the circumstances that envelop us. We are enveloped by our past and present circumstances. Our circumstances define who we are and what we think, feel, believe, and do. For a person, our context ranges from our biology to our family to our society and our political and physical environment. We think of context as a series of circles of influence on our behavior (e.g., family, friends, school or work, support systems, neighborhood, and macrosocial influences such as culture, economics, and policy; see Figure 1.3).
In our work, we focus primarily on the family, a person’s most immediate and influential context (Bronfenbrenner, 1996, 2005).

Bronfenbrenner (1996, 2005) recognized the enormous influence of the family, suggesting that the family is the primary context for the child for learning and development. Much research since Bronfenbrenner’s early work has supported his contention that the family is the primary context for the socialization of children and adolescents (Laible, Thompson, & Froimson, 2015; Perrino, González-Soldevilla, Pantin, & Szapocznik, 2000; Szapocznik & Coatsworth, 1999). Beyond the family context, a broad range of contextual influences operates on the family and individual. A contemporary understanding of the role of social context reveals that social influences on the

FIGURE 1.3. Relationship Among Ecological Systems

individual have an important impact on her behavior (Espelage, Bosworth, & Simon, 2000; Sallis, Owen, & Fisher, 2008; Szapocznik & Coatsworth, 1999). Such influences are particularly powerful during childhood and adolescence because childhood and adolescence represent developmental periods when children are critically dependent on their social context, particularly their family (Steinberg & Morris, 2001).

Our work with youth includes individuals and families from a broad spectrum of cultural and historical backgrounds. Research on culture and the family has been extensive, demonstrating that the family and the child are influenced by their cultural contexts (Boyd-Franklin, 2003; Chen, Fu, & Zhao, 2015; Kagıtçibaşı, 1996; Szapocznik & Kurtines, 1993). We have examined the role of cultural context in influencing families’ values and behaviors and how these, in turn, influence the relationship between parents and children in ways that affect adolescents’ development toward or away from problem behaviors (Cano et al., 2015; S. J. Schwartz et al., 2015, 2016; Sullivan et al., 2007).

What does this mean for the therapists working with troubled youth? Most important, it means that the clinician will not be able to understand the behavior of the child and his family without understanding the context to which a family is exposed. In this case, by context, we are referring both to the social and the cultural context. Behavior does not happen in a vacuum but instead exists within an environmental reality that shapes the rules, values, and behaviors of the youth and her family and defines the universe of options that are available to a family and its members. Therapists who ignore these contextual factors in developing an understanding of the youth’s problems and the challenges facing her parents will be handicapped in their ability to help these families. An example of a contextual issue is found in a family living in a dangerous neighborhood where stray bullets have killed children playing on the sidewalk. The family comprises a mother, grandmother, and three children, ages 10, 13, and 15. The mother does not allow the children to leave their apartment when they come home from school, for good reason. However, the context is preventing children from developing neighborhood friends, playing team sports in the neighborhood, and getting to know the families of their friends. The parents’ unusually high protectiveness is a direct function of their context.

Another aspect of context is therapy itself, where the culture of the client, the therapist, the agency, and the funding source can all affect the nature of therapy. For example, an agency’s perspective could be that a family in which members are constantly screaming and cursing each other may not be appropriate for family therapy and that the youth should be in treatment by himself. From a family therapist’s perspective, however, the best families with which to work are those families in which there is a strong connection, even if that connection is manifested in negative ways. In our experience, an angry family is easier to work with than a family in which there is not much interaction because the negativity can often be easily transformed into positive interactions. Negativity is a form of caring, odd as that may sound. As we
cited earlier, in the words of noted Nobel laureate Elie Wiesel, the opposite of love is not hate, it is indifference.

PROCESS VERSUS CONTENT: A CRITICAL DISTINCTION

The distinction between process and content is vital to BSFT (B. L. Duncan, Parks, & Rusk, 1990; Held, 1986; Prochaska & Norcross, 2014; Szapocznik et al., 2003). As noted earlier, content refers to the topic of the family’s interactions, whereas process refers to the interactions that emerge when the topic is brought up. Content is what are we going to eat for dinner today, and process is how the family goes about deciding (or failing to decide) what to eat. It is not which movie they selected but how they went about selecting the movie and who was going to go to see the movie. Content is the obvious aspect of what we observe when we hear families talk. It is what people are actually saying when they are interacting. Content refers to the specific or concrete facts used in communication. Content includes the reasons families give for a particular interaction (e.g., I was late because I missed the bus).

The approach proposed here for understanding families is based strictly on an understanding of the patterns of interactions (process) that occur among family members. To identify these repetitive patterns of interactions, it is essential for the BSFT therapist to understand the difference between the process and the content of the family—because patterns of interactions, the target of BSFT, is always process. Process is like the software that operates your email. Content is the subject and text of each email. The process never changes, but the content can change all the time, although some of us will prefer to email about relationships and others about sports. When the spelling checker of your email is set for French, and you write in English, it will misdirect words and thus prevent you from communicating effectively. In this regard, it does not matter what the content of any one email is. Rather, what had to be corrected was the spelling checker settings to allow the family to communicate effectively. BSFT helps the family system select a more adaptive process to improve the family communication—like switching from a French to English spelling checker to write in English.

Process is the how, and content is the what. Process is how family members relate to each other. What is the form that their interaction takes? When one person does something, how does the other person respond? It is also the “what happens when” in an interaction. What does John do when Michele does this thing? What does Michele say when John says this? Process describes the flow of actions and reactions between family members. The how of the flow of actions and reactions between and among family members typically repeats for a particular family, even as the content varies.

Process is what happens when we respond automatically according to long-established patterns of interactions. All families behave in ways that are overlearned and have happened thousands of times. Amazingly then, process typically is stable and predictable, whereas content changes all the
time. When Mother says, “Let’s pick up our clothes,” Mother’s sister may say, “Oh, let them watch TV a little longer,” thus undermining Mother’s leadership in the family. Two days later, Mother says to the children, “Pick up your plates,” to which Aunt responds, “They are too tired from school; leave them alone. I will pick them up.” Those are the kind of interactional patterns (Aunt undermining Mother) that will be overlearned, stable, and predictable. However, what Aunt undermines Mother about, the content, changes all the time across situations and time (see Table 1.1 for examples).

In Conversation 2 in Table 1.1, regardless of whether the content is taking out the garbage or what to have for lunch today, the process is going to be the same. That is, when a disagreement occurs, the couple will fail to resolve the disagreement because the partners will conspire to change the focus from the particular topic being discussed by using a personal attack (i.e., diffusion—see Chapter 3).

**Process Can Be Nonverbal**

Sometimes the process occurs in a nonverbal fashion. This is because the process is how people relate to each other. A nonverbal process might be a certain look, gesture, or intonation. Some of the most important processes that show up in family interactions are nonverbal—for example, people hugging each other as a demonstration of affection and closeness or a smirk from an adolescent to show disrespect when a parent speaks. Nonverbal messages always

<table>
<thead>
<tr>
<th>TABLE 1.1. Distinction in Communication Between Process and Content</th>
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</thead>
<tbody>
<tr>
<td><strong>Communication</strong></td>
</tr>
<tr>
<td>John to Michele: “Let’s go to the movies.”</td>
</tr>
<tr>
<td>Michele: “OK, that sounds good.”</td>
</tr>
<tr>
<td>Michele: “What would you like to see?”</td>
</tr>
<tr>
<td>John: “How about the new Star Wars movie?”</td>
</tr>
<tr>
<td>Michele: “Great, I hear it is a lot of fun.”</td>
</tr>
<tr>
<td>They go to the movies and have a good time.</td>
</tr>
<tr>
<td>Conversation 2—confictual</td>
</tr>
<tr>
<td>Wife to husband: “Take out the garbage.”</td>
</tr>
<tr>
<td>Husband: “No way, housework is women’s work.”</td>
</tr>
<tr>
<td>Wife: “You are just a low life.”</td>
</tr>
</tbody>
</table>
brief strategic family therapy.

Fall under the category of process communication. We suggest, however, that body language be corroborated before making assumptions.

Process and content can, at times, be at odds with each other. They can send contradictory messages. Although the words may be, “Sure Mom, I’ll come home early,” the daughter’s sarcastic gesture and intonation indicate, “When hell freezes over.” In this case, the words are the content, and the process is how it is said. Which one do you think is more reliable? Which one does the better job of letting a therapist know just exactly what is going on and what the daughter intends to do? More important, which one more clearly describes the nature of the relationship between the mother and daughter?

If a father and son have a conflictual relationship, they may fight on Monday about school, on Tuesday about chores, and on Friday about coming home late. The BSFT therapist must focus on the process—that they fight—and not the content—what they fight about. The strategies that are designed for change are those that can alter the fighting between the father and son, such as reframing that dad is concerned about his child, and guiding them to negotiate and collaborate in resolving their differences.

The family is focused on the content, whereas the BSFT therapist is always interested in the process—that is, the interactional sequences of behavior that occur as a content is being discussed. The content is the concern of the family, whereas the BSFT therapist is only concerned with identifying and changing those processes that are maladaptive and create symptoms for the family.

**Separating Process From Content in Therapy**

The focus of BSFT is to change the nature of those interactions that constitute the family’s maladaptive processes. The family comes to therapy because it needs help in developing the skills it requires to manage effectively the multiple contents that emerge daily. The therapist who attends to content and loses sight of the process will be unable to bring about the kinds of process changes that the family needs to manage effectively the multiple contents that emerge on a daily basis. In BSFT, these process changes are always in the form of changes in patterns of interactions that are linked to the family’s symptoms.

One useful tip may be helpful to the therapist in separating process from content. Frequently, a family member will want to tell the therapist a story about something that happened with another family member. Whenever the therapist is being told a story about another person, the therapist is allowing the family to trap him in content. For example, Mom says to the therapist, “Let me tell you what my son did yesterday. He came in at two in the morning . . .”

If the therapist wants to refocus the session from content to process, when Mom says, “Let me tell you what my son did,” the therapist would say, “Please tell your son directly so that I can hear you now and help you with this.” When Mom talks to her son directly, how they talk with each other is process. In observing what happens when Mom talks to her son directly, the therapist can identify the interaction that happens between them.

For example, Mom could say, “You came home at two last night, and that is not allowed, and as we had agreed, when you break your curfew, the
consequence is that you will not be allowed to go out the rest of this week.” That would be a healthy and direct communication that clarifies the rules and their relationship to the consequences. However, when the therapist asks Mom to talk to her son, the interaction could be very different. For example, Mom may be unwilling to talk to her son; instead, she turns to Dad and says, “How can I tell him to come home on time if I know that he doesn’t want to be home because you are drunk?” The process observed will be the triangle of mother, father, and son.

Another aspect of this process is that mother protected the misbehavior of the child by giving a justification for the child’s lateness (of course, the youth did not want to come home—his father is drunk). Thus, a single interaction can reflect more than one maladaptive interactional process. As we can see, our diagnostic approach is rich because so much can be learned about the family process even from a short interaction. This is one of the reasons BSFT is brief: because the diagnosis of the problem interactions can be done quickly.

Because diagnosis is critical to knowing what should be changed in a family, it is essential for the therapist to choreograph the opportunity for the family to interact. This is so that the therapist can observe how the family interacts because the root of the problem is how the family interacts. It has been said that one picture (seeing a single interaction) is worth a thousand words (stories). That was never truer than in family therapy. In BSFT, one interaction among family members is more useful to the therapist than a thousand stories. Stories may not truly explain what goes on in the family, whereas directly observing interactions never lies.

It should be clear from this chapter that in BSFT, complete attention is devoted to understanding family process—the interplay of behaviors between family members that we call interactions. Content plays a minimal role in BSFT. Although content is important to the family because it represents the issues the family has to manage, what is important to the therapist is how the family interacts regarding these issues. The therapist’s job is to help the family learn more effective and competent ways to manage their issues to allow the family to resolve their content issues, both during and beyond therapy. This reminds us of the Chinese proverb “Give a poor man a fish, and you feed him for a day; teach him to fish, and you give him an occupation that will feed him for a lifetime.” In BSFT, we teach families how to effectively resolve their problems so that they can resolve their many content issues using the new skills we have helped them develop—for a lifetime. One of the features that makes BSFT brief is that rather than having to help the families with their multiple content problems, in BSFT we focus on correcting just a few interactional patterns (often less than a handful). This empowers the family to solve its many content problems in the present and the future.

As will be seen in the chapters that follow, the interventions recommended are oriented entirely toward changing the family’s process. Content will be used in these interventions as the vehicle by which interactions are changed. This allows us to be responsive to the family’s content while using that content to transform interactional patterns. From the therapist’s perspective,
it does not matter which content is used. Rather, any content can be used to help families develop and practice new ways of interacting.

**ADVICE TO THERAPISTS**

If you want to waste your time as well as the family’s, let family members tell you stories. If, however, you want to know what the family’s interactions are (process) instead of allowing family members to tell you stories, encourage them to talk with each other. When you see how the family interacts, you see the family’s process, which is the bread and butter of BSFT—what you will diagnose and what you will change. Of course, the therapist sometimes allows a story as a way of establishing rapport with a family member. However, listening to a story should be brief (i.e., less than 5 minutes) as a matter of strategy to provide the therapist with sufficient rapport to permit him or her to move the conversation back where it belongs: among family members.

As discussed in Chapters 3 through 5, the BSFT therapist has a decentralized role in both diagnosis and restructuring. To diagnose, we allow the family to behave as it usually would when the therapist is not present. In restructuring, the focus is on changing the patterns of interactions within the family, which means that the therapist is a choreographer, not a dancer. The therapist guides the family, but the interactions, old and new, occur among family members.

**KEY TAKEAWAYS**

- Family members are interconnected with action–reaction sequences in which the behavior of one sequentially triggers the behavior of another.
- The BSFT approach is a method of empowering families to adapt to new situations in ways that achieve successful outcomes for the family.
- There is a constant tension between family homeostasis and therapy. Homeostasis is about staying unchanged, whereas therapy is about change.
- The family’s structure is the script for the family play.
- Strategy (with a capital S) refers to a diagnostically driven therapy that sets the overall course for treatment.
- Rather than portray the entire reality of a situation, the BSFT therapist emphasizes the particular aspect of reality that will best serve to move the family from a maladaptive interactional pattern to a more adaptive set of interactions.
- Content plays no role in the diagnostic process, nor in treatment; if you want to waste time, let the family members tell you stories.
Cognitive Behavior Therapy for OCD in Youth

A Step-by-Step Guide

Michael A. Tompkins, Daniela J. Owen, Nicole H. Shiloff, and Litsa R. Tanner
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Introduction

Obsessive–compulsive disorder (OCD) affects an estimated one of every 200 children in the United States, and as many as 50% to 60% of the youth diagnosed with OCD experience severe impairment in their personal, social, and academic life. Although researchers and clinicians have recognized for many years that cognitive behavior therapy (CBT) is an effective treatment for adults with OCD, the application of this treatment to youth lagged until 1989, when John March and his colleagues developed a CBT protocol specifically for the unique needs of youth with this debilitating disorder. In 1998, March (with Karen Mulle) published the treatment protocol and his findings from the research study in the book titled *OCD in Children and Adolescents: A Cognitive-Behavioral Treatment Manual*. The book is a landmark in the treatment of pediatric OCD and is responsible for introducing clinicians around the world to the power and benefits of this approach.

However, treatment protocols, such as the one designed by John March and his colleagues, are primarily for researchers, not necessarily for clinicians. To test the efficacy of a psychological treatment, researchers ensure that all subjects in a study receive the psychological interventions at the same intensity, in the same order, and in the same manner. The process of standardizing treatment results in protocols that limit to some degree the clinician’s flexibility and creativity. The view of many clinicians that they must “follow the book” to provide evidence-based treatment often prevents them from accepting these treatments into their clinical practice. At the same time, although many clinicians hold this view, we know that this view is not quite accurate.
Our experience is that clinicians (outside of standardized treatment studies) who provide evidence-based treatments rarely follow the book and instead flexibly and creatively apply the components or interventions within the treatment approach based on a comprehensive case conceptualization. In other words, flexibility and creativity are between the lines of every treatment protocol, but most clinicians are not aware of this. We have written this book to reach these clinicians and to describe explicitly the flexibility and creativity inherent in CBT for pediatric OCD.

What do we mean by **flexibility** and **creativity**? By **flexibility**, we mean the thoughtful selection and application of the core strategies that are part of CBT for pediatric OCD. These evidence-based core strategies include prolonged exposure and response prevention primarily, but also other strategies such as engagement, decreasing family accommodation behaviors, and relapse prevention. At the same time, most treatment protocols do not, in our opinion, provide clinicians with sufficient guidance to understand when and how to apply these core strategies. This is the job of case conceptualization. A comprehensive case conceptualization enables the clinician to pick and choose, in a thoughtful and flexible manner, what to include in the treatment and to what degree. Most protocols or treatment manuals assume clinicians have a firmer and more comprehensive understanding of CBT and cognitive behavior conceptualization than many clinicians do. We have written this book not only to underscore the importance of a case conceptualization-driven modular approach and the value it brings to the treatment of pediatric OCD, but also to explain how to do it, particularly across a range of symptoms, co-occurring conditions, and developmental ages of youth.

By **creativity**, we mean the ability to think on one’s feet, that is, to creatively apply the core evidence-based strategies to the unique strengths and weakness of a particular youth while engaging the youth in the active application of these strategies to the problem at hand. Many clinicians believe that a treatment protocol limits their creativity with youth. They believe a treatment protocol boxes them into thinking about OCD in a certain way and doing CBT for it in a lockstep fashion. However, we know that to be effective, clinicians need to feel free to think outside the protocol box and to do what they love to do—to be creative and do what makes clinical sense while at the same time applying the evidence-based core strategies. We want clinicians to focus less on doing the steps of the treatment “right,” and instead focus on engaging the child in a treatment approach we are confident can help. Above all, we want clinicians to feel as if they can still have fun with the child while using an evidence-based approach.

**ORGANIZATION OF THE BOOK**

We have divided the book into three parts. This is a nuts-and-bolts book, and the parts mirror our clinical approach to the problem of pediatric OCD. We diagnose and assess the condition, develop a case conceptualization that results in a treatment plan, then apply the core strategies based on that plan.
In Chapter 1, we review the nature of pediatric OCD and review the efficacy of CBT and medications for the condition in youth. In Chapter 2, we summarize the treatment plan described in this book, describe key intervention modules and the empirical evidence that supports them, and describe case conceptualization and the structure of sessions. We intentionally separated Chapters 1 and 2 from Parts I through III that focus on assessment and treatment of the condition. Although it is important that clinicians understand the nature of OCD, we also recognize that busy clinicians may have little time to read information about the phenomenon of pediatric OCD (and there is a great deal of it). Fortunately, it is not necessary for clinicians to know all of the research literature on pediatric OCD to treat the condition effectively. Therefore, we limit the information to what we believe is necessary to answer the typical questions that youth and parents ask regarding the condition and its treatment.

In Parts I and II, we walk clinicians through the diagnostic and assessment processes and describe how to implement the core strategies for a wide range of symptoms and with a variety of youth and their families. In Chapters 3 to 9, we introduce the core strategies in a manner that builds on skills and concepts. Although engagement is crucial early in treatment, engagement is an ongoing process that is sensitive to the ups and downs of motivation on the part of both youth and parents as well as to the developmental age of youth.

In Part III, starting with Chapter 10, we present three cases to illustrate the evaluation and treatment process, from assessment, case formulation, and treatment planning, and from the beginning to the end of treatment. We have selected these cases to illustrate the flexible and creative application of the approach across a range of symptoms, and developmental, cultural, and family factors. In Chapter 11, we describe the commonly prescribed medications for pediatric OCD and how clinicians can include medications in CBT for the condition. Again, we present only the information we believe is necessary to answer the typical questions that youth and parents ask regarding medications for the condition and guidelines for clinicians who wish to include medications within CBT for pediatric OCD. Last, in Chapter 12, we describe typical problems that arise when providing CBT for pediatric OCD and offer ways to overcome them.

The descriptions of youth and parents in this book are composites or contrived and do not describe any particular real-life youth, parent, or particular circumstance. Throughout the book, we refer to materials that we have found helpful in our own clinical practice. They are available for download at http://pubs.apa.org/books/supp/tompkins.

CONCLUSION

The American Academy of Child and Adolescent Psychiatry recommends CBT as the first-line treatment for youth with OCD, whether alone or in combination with medications for the condition (Geller, March, & AACAP Committee on Quality Issues, CQI, 2012). At the same time, parents can search
many years before they find a clinician with sufficient experience and training to provide CBT for the condition. Why is that? The answer to this question is complicated, as are most questions about mental health and mental health services, but part of the answer may be that more clinicians would learn CBT for pediatric OCD if it were a better fit for the way they work. In this book, we describe a treatment approach for pediatric OCD that is effective yet flexible, fun yet focused, and based on solid clinical science yet speaks to the innate creativity, genuineness, and personal style of clinicians. In describing this approach, we hope to encourage more clinicians to treat pediatric OCD and thereby help more kids.

We now move to the first chapter of the book, in which we present the epidemiology and phenomenology of the disorder in youth, including the range of symptoms, typical co-occurring conditions, and the developmental and cultural factors that influence the expression of OCD in a pediatric population. We believe clinicians who have a basic understanding of the condition can more effectively diagnose and treat it.
Overview of Obsessive–Compulsive Disorder in Youth

In this chapter, we describe the features of obsessive–compulsive disorder (OCD) in general and how the condition presents in youth in particular. The extant literature on pediatric OCD is quite extensive; therefore, we limit the information regarding the condition and its treatment to that we view as necessary for clinicians to answer with confidence and clarity the typical questions parents or youth ask about the condition and how cognitive behavior therapy (CBT) might help, such as “How much improvement can we expect in our child’s condition?” “How long can we expect our child’s improvement to last?” “How does the treatment you provide compare with other treatments like [medication, family therapy] in terms of response?” “What are the risks of your treatment?” “Could my child’s condition get worse?” “What happens if we don’t treat my child’s problem now?” and “Might my child get better without treatment?”

To that end, we present up-to-date epidemiology and phenomenology of the disorder in youth, including the range of symptoms and typical co-occurring conditions. In addition, we describe cultural, familial, and temperamental factors that influence the expression of behaviors, as well as developmental factors.

1Throughout this book, we use the term youth to refer to children and adolescents.
2Throughout this book, we use the term parent to refer to caretakers, which can include biological, adoptive, and foster parents, or other caretakers who act as parents even though they are not the youth’s actual parents.

http://dx.doi.org/10.1037/0000167-002
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that clinicians can misattribute to OCD but are features of typical child development. It is essential that clinicians understand the epidemiology and phenomenology of pediatric OCD in order to diagnosis the condition accurately and efficiently. For example, it is rare for a young child to exhibit sexual obsessions, and the clinician who identifies thoughts and images with a sexual content from a youth may wish to rule out other conditions or circumstances that could account for this. Similarly, because children with OCD are more likely than adults to have concomitant attention-deficit/hyperactivity disorder (ADHD), the clinician may wish to screen carefully for these conditions in youth with OCD.

**DIAGNOSIS**

Although OCD affects 2% to 3% of children (Rapoport et al., 2000), many clinicians fail to accurately detect and diagnosis the condition (Fireman, Koran, Leventhal, & Jacobson, 2001). OCD is highly disruptive to the typical psychosocial development of youth and can result in impairment in academic performance, friendships, and family relationships, and it can place youth at risk of developing other serious problems, such as substance abuse and self-harm behaviors (Adams, Waas, March, & Smith, 1994; Piacentini, Bergman, Keller, & McCracken, 2003).

In the fifth and most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*; American Psychiatric Association, 2013), OCD is under the broader category termed obsessive-compulsive and related disorders, along with body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), and excoriation (skin-picking) disorder. OCD is characterized by recurrent obsessions and/or compulsions that cause marked distress and/or interference in the youth’s life. To merit a diagnosis of OCD, the youth can have obsessions or compulsions, although most youth have both (Storch et al., 2004).

*Obsessions* are recurrent and persistent thoughts, images, doubts, or impulses that intrude into the youth’s awareness that they, for the most part, view as senseless. Obsessions tend to trigger negative affect, such as fear, disgust, anxiety, or a feeling of incompleteness and distress. *Compulsions* are observable repetitive behaviors, such as washing or checking, or unobservable mental acts, such as counting or replacing an undesired thought with a positive or neutral one, to neutralize or alleviate the distress youth experience because of the obsession. *Rituals* are compulsions performed in an exact way or according to certain rules, such as the youth who washes her hands by starting with the thumb on her left hand and repeats the process for each finger before moving.

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Throughout this book, we use the term *family* to refer to the many constellations that constitute the families of today, from nuclear families to extended unrelated people who support and care about the youth.
to the right hand. In addition, youth attempt to ignore, suppress, or conceal from others the obsessions and overt neutralizations. To reiterate, we use the term neutralization rather than compulsion throughout this book to refer to any internal or external action youth consciously use to neutralize an obsession and the accompanying distress it causes. Over the years, we have observed clinicians who are new to the assessment and treatment of pediatric OCD assume that compulsions are only observable behaviors and thereby miss the many internal mental actions youth with OCD use to neutralize distress. In the past, clinicians described this presentation as “pure O,” or purely obsessional. However, by definition OCD includes both obsessions and compulsions or neutralizations, and for some youth, mental actions dominate the clinical presentation.

Because many youth, particularly young children, engage in compulsive-like behaviors, such as counting their steps or repeating phrases or snippets of songs, clinicians would not give these youth a diagnosis of OCD unless their symptoms are distressing, are time-consuming (e.g., taking up more than 1 hour per day), or are significantly interfering with their ability to participate in school, social activities, or important relationships. Unlike adults, youth do not have to recognize the senselessness of their obsessions and compulsions, although most do, to meet criteria for the diagnosis. Many youth with OCD, particularly developmentally young people, view their OCD symptoms as reasonable more often than do adults (Geller et al., 2001). At the same time, to receive a diagnosis of OCD, the youth must recognize at some point in the illness that the obsessions originate within his mind and are not simply excessive worries about real problems. Similarly, the youth must see that their compulsions are excessive and unreasonable. Youth need to have adequate “insight” regarding the unreasonableness of their obsessive and compulsive symptoms to benefit from CBT for the condition. In addition, clinicians would not give a youth the diagnosis of OCD when the content of the obsessions is a feature of another disorder, such as guilty thoughts because the youth is depressed, or delusional thoughts because the youth has a psychotic disorder.

**PREVALENCE, ONSET, AND COURSE**

The prevalence of OCD among youth in Western countries, particularly Anglo-Saxon and Anglo-Celtic ones, is quite consistent at 1% to 3% (Shaffer et al., 1996; Zohar, 1999), whereas rates across Asians and other ethnic groups vary considerably. The lack of data from many countries (e.g., Africa, South America, Western Europe) and different assessment methods make it difficult to determine categorically that there is a relationship between the prevalence of OCD and culture and sociodemographic factors (Sica, Novara, Sanavio, Dorz, & Coradeschi, 2002). Among adults with OCD, one third to one half develop the condition during childhood (Rasmussen & Eisen, 1990), and about 20% of all affected persons in the United States suffer from manifestations of the disorder at age 10 or earlier, although children as young as 5 or 6 years
old can develop the condition (Kessler, Berglund, et al., 2005; Kessler, Chiu, Demler, & Walters, 2005). In a clinical sample, the modal age of onset of OCD was 7 years and the average age at onset was 10 years (Swedo, Rapoport, Leonard, Lenane, & Cheslow, 1989), with a possible age distribution that includes a first peak at age 11 years and a second peak in early adulthood (Delorme et al., 2005). For boys, onset of OCD is more likely to occur prior to adolescence, whereas for girls onset is more often during adolescence (Tükel et al., 2005). Typically, more boys than girls suffer with OCD (in a ratio of about 3:2; Chabane et al., 2005), but by adolescence, the prevalence in boys and girls is the same. There appear to be no differences in prevalence as a function of ethnicity or geographic region for adults (Flament et al., 1988), although the discrepancy between prevalence rates for OCD in clinical and epidemiological samples may be due to the difficulty recruiting minority families into child mental health treatment centers. European American youth are diagnosed with OCD more often than are African American youth (Rasmussen & Eisen, 1990).

The typical course of OCD without treatment is chronic and deteriorating. Symptoms routinely wax and wane over time and may even disappear completely with or without treatment, although sustained remission is rare (Leonard et al., 1993; Riggs & Foa, 1993). With well-delivered treatment, most youth achieve meaningful symptom relief that can substantially improve functioning and positively influence the developmental trajectory of youth with the condition (Pediatric OCD Treatment Study [POTS] Team, 2004).

**TYPICAL SYMPTOMS IN YOUTH**

Common obsessions for youth with OCD are fears of contamination, fears of harm to self, fears of harm to a familiar person, and urges for symmetry and exactness (Garcia et al., 2009). Common and corresponding compulsions in youth are washing and cleaning, followed by checking, counting, repeating, touching, and straightening (Swedo et al., 1989). Hoarding compulsions appear to be common in youth too (Geller et al., 2001). One or more negative affects drive these compulsions or other neutralizations and include fear, doubt, disgust, urges, and “just so” feelings, which some have labeled *sensory incompleteness* (Goodman, Rasmussen, Foa, & Price, 1994). Furthermore, to treat OCD effectively, it is essential that clinicians clearly identify the functional relationships and the affect that drives neutralizations. For example, a child may wash her hands because she fears that she will become sick or make others sick. In that case, the compulsion is in response to anxiety or fear. Another child, however, may wash her hands in response to a sensory-affective experience, feeling “sticky,” rather than to fear and without an obvious obsession or cognitive trigger. Both children, however, may feel anxious prior to encountering the triggering situation or object. In the first case, the
child is anxious about triggering the cognition or obsession. In the second case, the child is anxious about triggering the sticky feeling.

Most youth have more than one OCD symptom at any time, and many youth experience nearly all the classic OCD symptoms by the end of adolescence (Rettew, Swedo, Leonard, Lenane, & Rapoport, 1992). It is rare that youth have only obsessions (Swedo et al., 1989). More likely, children without overt neutralizations (i.e., compulsions) have instead covert internal mental neutralizations, such as praying, counting, and “do-overs” by which the youth attempts to “undo” a feared harm in some way. Other subtle mental neutralizations may include attempting to reason an obsessive doubt away, such as an adolescent who says to himself repeatedly “it’s just my OCD” in response to an obsession. In addition, young children may have trouble distinguishing between an obsession and a mental neutralization because both are mental events. For this reason we recommend that the clinician assume youth have mental neutralizations even if they cannot report them.

**INSIGHT AND OVERVALUED IDEATION**

To meet criteria for a diagnosis of OCD, youth must view their obsessional fears and compulsive behaviors as unreasonable (American Psychiatric Association, 2013); in these cases, the diagnosis includes a specifier “with poor insight.” Many children lack insight about their obsessions and compulsions and attribute a “magical” quality to them. For example, a 6-year-old girl insisted that her shoes felt lonely and that was why she arranged them (and rearranged them) so that they touched: “That way they know a friend is close by.” The tendency to anthropomorphize objects is common in young children and is even encouraged through children’s literature and films. Teacups talk and dance, and trains talk to passengers and to one another. At the same time, the extent to which children view their thoughts and behaviors as unreasonable varies considerably (Snider & Swedo, 2000).

Although the research suggests that children with OCD exhibit diminished insight (Geller et al., 2001), this observation may reflect several factors. For example, very young children may have poor emotion regulation skills that make it difficult for them to tolerate anxiety and regulate their emotional state. In the presence of high underregulated negative affect, youth may have difficulty maintaining adequate insight during acute episodes of OCD symptoms. Also, youth may fear disclosing particular thoughts because they fear that parents, teachers, peers, or the clinician might ridicule or criticize them for having nonsensical thoughts and fears. In addition, youth may feel embarrassed and even ashamed that they have thoughts or actions that they cannot stop or resist. Careful, developmentally appropriate and sensitive assessment of the youth’s true level of insight is essential to an effective case conceptualization and treatment plan for pediatric OCD (Storch, Geffken, & Murphy, 2007).
PSYCHOSOCIAL FACTORS THAT INFLUENCE ONSET AND MAINTENANCE OF PEDIATRIC OCD

A number of factors influence the development and expression of OCD in youth; they include both biological and psychosocial factors. Later in the chapter, we also describe common co-occurring conditions that not only affect a youth’s risk of developing the disorder but also can affect the course of the condition. Furthermore, a comprehensive treatment plan will include these factors and enable the clinician to respond flexibly and effectively to the many nuances that arise when providing CBT for pediatric OCD.

Developmental Influences

Identifying OCD in youth is particularly challenging because of developmental influences on the expression of the condition. Ritualistic and superstitious behaviors are common in early childhood (Snider & Swedo, 2000; Zohar & Felz, 2001). For example, a child may want a parent to read the same book to her and in the same manner before bed, or she may pray that her parents, siblings, or pets sleep safely through the night. These behaviors are similar to obsessive–compulsive symptoms in youth and seem to peak between the ages of 2 and 5 years, although they may continue in some form throughout childhood and adolescence (Rutter & Sroufe, 2000). For this reason, it is essential that clinicians tread with caution when diagnosing youth with OCD, particularly very young children.

Cognitive processes, such as abstract and causal reasoning, can influence the expression of the condition in youth. For example, very young children (less than 5 years of age) may have low insight into the reasonableness of their obsessions and compulsions. That may be because of the limited ability of young children to think abstractly and to understand what is meant by reasonable or unreasonable. In addition, the limited verbal ability of developmentally very young children can make it difficult for them to describe their symptoms clearly. Therefore, young children may have trouble stepping back from their compulsions and stating that they are inappropriate. However, beliefs about personal responsibility appear to develop early in youth (5 to 7 years), and for this reason children at this age are susceptible to beliefs of inflated responsibility that can play a role in the development of childhood OCD (Sameroff & Haith, 1996). At the same time, the ability to think about one’s thoughts (i.e., metacognition) develops over a wide developmental age range (perhaps not fully until early adolescence) and often is a function of broader intellectual development (Alexander, Fabricius, Fleming, Zwahr, & Brown, 2003). Therefore, the cognitive development of very young children may not be adequate to fuel the beliefs that certain thoughts are important and for that reason must be controlled.

Other neurodevelopmental factors may influence both the expression of the condition as well as the treatment itself. Because young children may lack
adequate abstract and inferential reasoning, they may not benefit from meta-cognitive interventions for their OCD. Furthermore, the prognosis is poorer for youth with poor insight because these youth may be less willing to resist an urge to perform a neutralization during CBT for the condition (Storch et al., 2008) or to participate in exposure tasks.

Development seems to influence the presentation of symptoms, patterns of co-occurring conditions, and sex differences (Geller, 2006; Kalra & Swedo, 2009). For example, harm and sexual obsessions and hoarding compulsions are less common in youth with OCD than in adults with OCD (Geller et al., 2001). A young boy may first exhibit harm obsessions and later, at the time of puberty, exhibit harm obsessions with a sexual quality, such as fear of impregnating a girl or acting on a sexual urge to fondle or kiss her. This shift in symptom expression may reflect the youth’s typical sexual development as he experiences developmentally appropriate sexual urges, fantasies, and images. Similarly, as a child matures and becomes aware of the concept of death, she may exhibit existential obsessive doubts about death, such as what happens to our soul when we die. Obsessions that center around sexuality, morality, or death require higher order reasoning not available to young children (Rachman, 2003). In addition, youth on the autism spectrum often exhibit stereotypical movements and self-stimulating behaviors, and they rigidly follow specific routines. It is important for clinicians to distinguish these core features of a developmental disorder from the rigid compulsions in which youth with OCD engage.

Development seems to play a role in the expression of other conditions that tend to occur in pediatric OCD. For example, ADHD and tics are most often associated with childhood onset of OCD, whereas depression and other anxiety disorders more often develop during or after puberty (Mancebo et al., 2008). Males with childhood-onset OCD have higher rates of comorbid tic disorders (Swedo et al., 1989), a higher frequency of compulsions not preceded by obsessions (Geller et al., 1998), and a greater genetic contribution to the disease than adults with the condition as shown in monozygotic and dizygotic twin studies (Pauls, Alsobrook, Goodman, Rasmussen, & Leckman, 1995).

**Temperamental Influences**

*Temperament* refers to aspects of a youth’s personality that are innate rather than learned. Youth with OCD may exhibit certain temperamental features (Carter & Pollock, 2000). For example, in a study of temperament of youth with OCD, investigators identified elevated levels of emotional reactivity and behavioral inhibition compared with a nonclinical sample of youth of the same age and sex (Ivarsson & Winge-Westholm, 2004). *Emotional reactivity* refers to the characteristics of an emotional response, including the intensity of the response and the threshold of stimuli required to generate the emotional response (Davidson, 1998). That is, for youth with high emotional reactivity, it takes less to trigger an emotional response, and, once triggered,
the emotional response is more intense than for youth with low emotional reactivity. These data suggest that although certain temperamental profiles may be more likely in youth with OCD than in control subjects, youth with OCD exhibit considerable variability with respect to the temperamental variables in the study. These findings suggest that the interaction of temperament and environmental stress may better predict the development of OCD in youth than temperament alone.

Temperamental factors may influence the course of treatment in CBT. For example, youth with high emotional reactivity may benefit from less anxiety-evoking exposure stimuli and greater control over the exposure process than youth with lower emotional reactivity. Similarly, the interaction between the youth’s temperament and temperament of his parents may influence how the clinician works with the youth’s parents, who coaches the youth’s exposure tasks, and the extent with which the clinician works with parents to adjust their parenting styles relative to their child (see Chapter 6, this volume).

**Cultural, Social, Family, and Peer Influences**

Although the phenomenology of OCD appears to be relatively consistent across cultures (Weissman et al., 1994), cultural, social, and familial factors may play a role in shaping the content of a youth’s obsessions and compulsions. **Culture** refers to past learning that results in shared patterns of behavior that overlap more with behavior of members of a particular culture than with members of another culture. That is, culture refers to behavior patterns and value systems shared by a group of people (Seiden, 1999). Culture may influence the content of obsessions and the form compulsions take (Tseng, 1997). For example, 20 to 30 years ago in the United Kingdom, people with OCD commonly reported fears of contamination by asbestos, and in more recent years they were more apt to report fears of HIV/AIDS (de Silva, 2006). Similarly, researchers reported a predominance of aggressive obsessions in Brazil and speculated that the rates of violence there may influence the rise in aggressive obsessions in people in Brazil with OCD (Fontenelle, Mendlowicz, Marques, & Versiani, 2004).

The central religious themes and practices within certain religions within cultures can also shape the nature of obsessions and compulsions for individuals with OCD. For example, in India, purification rituals are common to the Hindu faith and reflect a preoccupation with matters of purity and cleanliness. Thus, people in India more often exhibit obsessions and compulsions that reflect themes of dirt and contamination (Chaturvedi, 1993). Similarly, according to their faith, Muslims must pray five times each day, preceded by a ritualized ablution or cleansing. People with OCD in Egypt were more likely to exhibit symptoms that reflected this preoccupation with purity and cleanliness within their Muslim culture (Okasha, Saad, Khalil, El Dawla, & Yehia, 1994).

Unlike with adult-onset OCD, the family environment, among other factors, may play a role in the development of OCD in childhood (Steketee & Van Noppen, 2003; Waters, Barrett, & March, 2001). Family factors, however, likely
play a more significant role in maintaining the condition (Allsopp & Verduyn, 1990; Amir, Freshman, & Foa, 2000). Research consistently supports that the family context affects the nature of the youth’s OCD and that the youth’s OCD affects the family context (March, 1995). The families of youth with OCD are often characterized by high levels of expressed emotion (e.g., high levels of expressed criticism and overinvolvement; Hibbs et al., 1991) and with low levels of emotional support, warmth, and closeness (Valleni-Basile et al., 1995). In addition, parents of youth with OCD may have less confidence in the youth’s abilities, less often reward the youth or encourage his or her independence, and less often orient the youth to problem-solving strategies than parents of youth with a non-OCD anxiety disorder (Barrett, Shortt, & Healy, 2002). Instead many parents, particularly anxious parents, step in too quickly to assist youth to escape their distress, or they accommodate or participate in the youth’s compulsions and pleas and demands for relief.

The family may also shape the nature of obsessions and compulsions for youth with OCD. According to social learning theory, people learn vicariously, without direct experience (Bandura, 1977). Caregivers may communicate to the child through their actions or their words that certain situations or objects are dangerous and must be avoided at all costs. For example, a child with a biological predisposition to OCD may develop germ obsessions and washing compulsions if one or both parents are physicians and insist on scrupulous handwashing and hygiene. In this way, the parents model an overanxious response to germs and fail to model for the child that the body, particularly a young body, has a robust protective response to germs.

The role of peers in the development and maintenance of pediatric OCD is not well understood, although the negative effect of OCD on peer relationships is well documented (Langley, Bergman, McCracken, & Piacentini, 2004; Piacentini et al., 2003; Storch et al., 2006). Furthermore, it is not clear whether the observed negative effects on peer relationships is primarily because of OCD or other anxiety disorders, or temperamental attributes of the youth, or other common comorbid conditions, such as ADHD. Therefore, it is unlikely that peer difficulties are a risk factor particular to OCD; more likely it is a common feature of most childhood psychiatric disorders. At the same time, youth with disabilities are highly vulnerable to bully victimization (Blake et al., 2016). Bullying by peers may influence the extent and severity of OCD symptoms as well as the development of other emotional and behavioral problems and conditions that can complicate the treatment (Storch et al., 2006).

**Stress and Trauma Influences**

Although there is some evidence for the relationship between exposure to stress and increases in intrusive thoughts (Rachman, 1997), trauma and stress are nonspecific risk factors for the development and aggravation of a great number of psychiatric conditions. It is unlikely that these risk factors are specific to the development of OCD, as many youth experience stress and trauma
without developing OCD. Similarly, certain psychiatric conditions, such as bipolar disorder or schizophrenia, increase the likelihood that individuals will experience trauma when they are in an acute phase of their illness where their judgment is poor and their impulsivity is high (Assion et al., 2009; Cusack, Grubaugh, Knapp, & Frueh, 2006). Therefore, it appears that trauma and stress play a role in the onset of some cases of pediatric OCD, but not in all cases.

**COMMON CO-OCCURRING CONDITIONS**

Comorbid conditions are common in youth with OCD (Geller et al., 2001). Differential diagnosis between OCD and other psychological conditions can be difficult because OCD shares some features with other conditions (March, Franklin, Leonard, & Foa, 2004). For example, the attempts of youth with OCD to suppress obsessions or to resist engaging in compulsions can drain attentional resources. This can result in the youth’s attention problems misdiagnosed as features of ADHD. Although the youth may have ADHD in addition to OCD, it is important that clinicians not diagnose a youth with ADHD without a careful and comprehensive diagnostic evaluation.

Similarly, clinicians may misdiagnose youth with OCD who avoid a range of social situations with social anxiety disorder. However, following a careful evaluation, the clinician may determine that the youth avoids social situations because people trigger obsessive fears that he might hurt someone.

**Attention-Deficit/Hyperactivity Disorder**

ADHD is common in youth with OCD. Perhaps 30% of youth with OCD also meet criteria for ADHD (Geller, Biederman, Griffin, Jones, & Lefkowitz, 1996), and the onset of ADHD precedes the onset of OCD for more than 80% of youth with both conditions (Geller et al., 2002). Furthermore, youth with both OCD and ADHD experience greater impairment than youth with only OCD, particularly in the areas of school problems, social functioning, and depression (Sukhodolsky et al., 2005). Youth with OCD and ADHD present additional challenges to clinicians treating pediatric OCD. Youth with significant attentional difficulties may have trouble engaging fully in imaginal exposures, for example, or remembering to engage in other treatment strategies and therefore may benefit from treatment of the comorbid ADHD prior to beginning treatment for the OCD.

**Other Anxiety Disorders**

The prevalence of other anxiety disorders in youth with OCD may be 50% to 60% (Geller et al., 2001; Zohar, 1999). Generalized anxiety disorder (16%) and separation anxiety disorder (7%; Geller, 2006; Leonard et al., 2001) are
the most common anxiety disorders (Geller et al., 1996). Other anxiety disorders often precede the onset of OCD in youth (Rasmussen & Eisen, 1990). Social phobia appears also to be common in youth with OCD and its prevalence may range from 2% to 25%, depending on the age of the youth. Interestingly, the longer youth have struggled with OCD, the more likely they are to develop social phobia, perhaps because of the shame and secrecy that are common experiences of youth with OCD (Diniz et al., 2004).

Mood Disorders

Children with OCD are at considerable risk of experiencing depressive symptoms and the onset of mood disorders (Peterson, Pine, Cohen, & Brook, 2001). Rates of major depressive disorder in youth with OCD in clinical samples range from 10% to 26% (Hanna, 1995; Swedo et al., 1989), and depression in early adolescence is a possible predictor of risk for developing OCD in young adulthood (Douglas, Moffitt, Dar, McGee, & Silva, 1995). This is not surprising, because OCD can significantly derail the social, emotional, and academic development of youth with the condition. Furthermore, researchers suggest that the ruminative nature of OCD may place youth at risk for developing the depressive cognitions associated with a mood disorder (Carter & Pollock, 2000; Douglas et al., 1995). In addition, pediatric clients that develop both OCD and bipolar disorder tend to have earlier onsets of OCD than do pediatric clients without a bipolar mood disorder (Masi et al., 2004).

Tourette and Tic Disorders

The rate of occurrence of tic and Tourette spectrum disorders (TSDs) in youth with OCD is quite high. For example, 20% to 60% of youth with TSD have a comorbid OCD, whereas 7% of youth with OCD have comorbid TSD and 20% have tics (Coffey & Park, 1997). Tics and TSD are the most common comorbid psychiatric illness for pediatric OCD (Leonard, Lenane, Swedo, Rettew, Gershon, & Rapoport, 1992). Researchers have found a strong association between tic disorders and OCD (Peterson et al., 2001) and therefore have argued that tics and TSD and OCD may have a common genetic substrate (genotype) that in interaction with other factors may influence the expression of the genetic substrate (phenotype) as one disorder or the other (Pauls et al., 1995). In other words, OCD and Tourette disorder may be different expressions of the same underlying genetic abnormality (Zohar, 1999). In addition, because of the high rate of co-occurrence of tics and OCD in pediatric populations, researchers have proposed that childhood-onset OCD may be a tic-related subtype of OCD (Eichstedt & Arnold, 2001). Furthermore, the presence of tics in childhood and early adolescence predicts an increase in obsessive–compulsive symptoms in late adolescence and adulthood (Peterson et al., 2001; Leckman & Cohen, 1999).
Oppositional Defiant and Conduct Disorders

Many youth with OCD exhibit disruptive or “pushback” behaviors, and perhaps 25% of these youth exhibit behavioral disorders, such as oppositional defiant disorder (ODD) and conduct disorders (Geller et al., 1996; Hanna, 1995). The prevalence of behavioral disorders in this population may reflect the difficulty parents have in managing pushback from youth who are desperate to avoid situations that evoke their anxiety, or who are unwilling to “go with the flow,” in general, but particularly when a situation triggers their OCD. It is not easy to differentiate OCD and ODD, as the rigidity of compulsive behavior can mimic oppositional behavior of youth with ODD. However, a diagnosis of ODD in youth with OCD predicts for poorer response to pharmacotherapy (Geller, Biederman, Stewart, Mullin, Farrell, et al., 2003) and can complicate cognitive behavior treatment as well.

Eating Disorders, Impulse-Control Disorders, and Autism Spectrum Disorders

Eating disorders co-occur in youth with OCD (Becker, Jennen-Steinmetz, Holtmann, El-Faddagh, & Schmidt, 2003). The lifetime prevalence of anxiety disorders (particularly social anxiety disorder) and OCD is 30% to 65% in youth with anorexia nervosa and bulimia nervosa (Herzog, Nussbaum, & Marmor, 1996; Johnson, Cohen, Kotler, Kasen, & Brook, 2002). In addition, pediatric anxiety disorders, in general, predict substance abuse in later adolescence and adulthood (Essau, Conradt, & Petermann, 2002). For this reason, we recommend that clinicians routinely screen for substance use and abuse in youth with OCD.

Impulse-control disorders and OCD share an excessive preoccupation with certain thoughts and accompanying urges to act in order to decrease tension and physiological arousal (Grant & Kim, 2007). Unlike with OCD, youth with impulse-control disorders also experience pleasure or gratification when carrying out impulsive acts. For example, pyromania is an impulse-control disorder that involves intentionally setting a fire for gratification. Prior to setting the fire, youth experience intrusive thoughts or images that result in tension and then relief once they set the fire. The prevalence of pyromania in youth is unknown, but over 60% of cases of fire-setting in the United States occurred before the youth reached 15 years of age (Blanco et al., 2010). Kleptomania, another impulse-control disorder, is characterized by strong urges to steal. Youth with kleptomania do not steal for personal gain, such as revenge or money, nor do they steal because of another disorder, such as bipolar disorder. Kleptomania appears to be rare and is more common in females than in males (Grant & Odlaug, 2008).

Autism spectrum disorders (ASDs) are pervasive developmental disorders that begin in early childhood and are characterized by significant deficits in the ability to communicate and interact effectively with others. Many individuals with ASD exhibit repetitive and stereotypic behaviors that may be linked to fixed interests common to youth with ASD, but they can also exhibit
obsessive–compulsive symptoms common to OCD, particularly somatic obsessions (overawareness of body sensations or functions, e.g., blinking, breathing) and repeating compulsions (Russell, Mataix-Cols, Anson, & Murphy, 2005). The prevalence of OCD in youth with ASD is near 37% or higher (Lewin, Wood, Gunderson, Murphy, & Storch, 2011).

OBSESSIVE–COMPULSIVE SPECTRUM DISORDERS

Researchers recognize that OCD is likely a heterogeneous condition. Attempts to classify symptoms into homogeneous and mutually exclusive types or categories related to neurobiological variables, genetic transmission, and treatment response have yielded mixed results. At the same time, investigators suspect that OCD and other obsessive–compulsive spectrum disorders may share a similar underlying neurobiological substrate (Mataix-Cols, Rosario-Campos, & Leckman, 2005). In recognition of the common features of obsessive preoccupation and repetitive behaviors of certain disorders, as well as their distinction from anxiety disorders, researchers have subsumed OCD and several other conditions under the broad class of obsessive–compulsive spectrum disorders (American Psychiatric Association, 2013). Along with OCD, disorders in this class include body dysmorphic disorder (BDD), trichotillomania (TTM; hair-pulling disorder), excoriation disorder (skin-picking disorder), and hoarding disorder.

BDD is characterized by persistent and intrusive preoccupations with a perceived defect in appearance. Youth with BDD can dislike any part of their body, such as their hair, skin, nose, chest, or stomach. Typically, the perceived defect is only a slight imperfection or irregularity in size, shape, or color. Nonetheless, youth with BDD are very distressed by the perceived imperfection and may avoid social encounters, refuse school, or plead parents for plastic surgery or other interventions. BDD most often develops in adolescence. The prevalence is approximately 1% and appears to be about equal in both males and females (Becker et al., 2003; Grant, Kim, & Crow, 2001). Research suggests that BDD is not a clinical variant of OCD and often has relationships with other disorders, such as mood, social anxiety, and eating disorders (Frare, Perugi, Ruffolo, & Toni, 2004). Furthermore, key differences between OCD and BDD directly influence the course and treatment of the condition (Phillips, Menard, Pagano, Fay, & Stout, 2006). For example, the beliefs about defects in appearance for youth with BDD are ego-syntonic (consistent with sense of self), whereas for the vast majority of youth the OCD-related beliefs are ego-dystonic (alien to sense of self). Furthermore, in BDD there is a high rate of delusional conviction in the beliefs about defects in appearance that are not typically present in OCD (Castle & Groves, 2000; Jefferys & Castle, 2003).

Trichotillomania, or hair-pulling disorder, is characterized by recurrent and compulsive hair pulling, leading to noticeable hair loss and significant distress and functional impairment. Youth primarily pull hair from the scalp, eyebrows, and eyelashes, although they can pull hair from any part of the body with...
hair. Youth may use their fingernails to pull, as well as tweezers, pins or other devices. Typically, but not always, adults report a sense of tension before pulling hair that leads to strong urges to pull and gratification or relief after pulling. Most children, on the other hand, deny feeling this sense of tension (Oranje, Peereboom-Wynia, & De Raeymaecker, 1986). The prevalence of TTM in youth with OCD is significant (Fontenelle, Mendlowicz, & Versiani, 2005; Stewart, Jenike, & Keuthen, 2005), although the rates among younger children are largely unknown (Tolin, Franklin, Diefenbach, Anderson, & Meunier, 2007). The peak age of onset of TTM is 9 to 13 years of age, and the lifetime prevalence of the disorder is 0.6% to 4.0% in the general population (Huynh, Gavino, & Magid, 2013). The condition is generally chronic, although symptom severity tends to wax and wane (Christenson, Mackenzie, Mitchell, & Callies, 1991). Most cases of TTM begin in childhood (Schlosser, Black, Blum, & Goldstein, 1994).

Developmental age may play a role in the progression of the disorder as well as the presentation of particular features of the condition. For example, there appears to be a progression across developmental age in the type of pulling itself. There are two distinct types of hair pulling: automatic and focused (Franklin et al., 2008). Automatic pulling is pulling that occurs outside awareness. Focused pulling, by contrast, is pulling with awareness and typically occurs in response to negative emotional states (e.g., sadness, anxiety, anger), intense thoughts or urges, or as an attempt to establish symmetry. Younger children more often engage in automatic unfocused pulling, with little awareness of the behavior and its antecedents. As youth mature, they experience more focused and frequent urges to pull and greater awareness that they are engaged in hair pulling (Panza, Pittenger, & Bloch, 2013). In addition, younger children are much more likely to pull from one site than are adults, and many younger children do not describe urges before, and relief after, hair-pulling behavior (Panza et al., 2013).

Excoriation disorder (ECD) is characterized by recurrent skin picking that results in skin lesions and clinically significant distress or impairment in functioning (Wilhelm et al., 1999). The primary location of skin picking is usually the face, but any part of the body can be involved. Youth may pick at normal skin variations, such as freckles and moles; at pre-existing scabs, bumps, or blemishes; or at imagined defects in the skin. Youth typically pick the skin with their fingernails, but they can use their teeth, tweezers, or pins. Skin-picking behavior can result in bleeding, infections, or permanent disfigurement of the skin. The lifetime prevalence of ECD in adults is at least 1.4% to 5.4% of the general adult population (Lang et al., 2010; Odlaug & Grant, 2010), and approximately 75% of individuals with ECD are female (Odlaug & Grant, 2010). It is not clear what the prevalence of ECD in youth is, although adolescence may be the most common age of onset of the condition (Andreoli, Finore, Provini, & Paradisi, 2008). As in the case of TTM, skin picking is sometimes preceded by tension and strong urges to pick and can be followed by a sense of relief or pleasure. Skin picking, as in the case of hair pulling, can be focused or unfocused.
Hoarding disorder (HRD) is characterized by persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions. The large number of possessions and the difficulty organizing and discarding them results in highly cluttered living spaces; at times, those living in the residence face significant health and safety risks. While some people with HRD may not be particularly distressed by their behavior, their behavior can be distressing to other people, such as family members or landlords.

Investigators estimate the prevalence of HRD in the general population to be between 2% and 5% (Iervolino et al., 2009; Timpano et al., 2011). Hoarding symptoms typically appear in childhood (Tolin, Meunier, Frost, & Steketee, 2010), with hoarding symptoms relatively prevalent in adolescents, particularly in girls, which cause distress and/or impairment. Exclusion of the clutter criterion (as adolescents do not have control over their environment) increased the prevalence rate to 3.7%. Approximately one third of youth with clinically significant hoarding symptoms reported excessive acquisition (Ivanov et al., 2013).

**PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS**

Pediatric autoimmune neuropsychiatric disorders associated with streptococcal (PANDAS) infections refers to a subset of prepubertal children with rapid onset or exacerbation of OCD or tic disorders following group A beta-hemolytic streptococcal (GABHS) infection (an infection of a beta-hemolytic species of Gram-positive bacteria that is a response for a wide range of infections). Researchers propose that an initial autoimmune reaction to a GABHS infection produces antibodies that interfere with basal ganglia function, causing symptom exacerbations (Snider & Swedo, 2004). This autoimmune response can result in a broad range of neuropsychiatric symptoms. In addition to OCD or tic disorder symptoms, youth may exhibit increased emotional lability (rapid and tense fluctuations in mood), enuresis (involuntary urination), anxiety, and deterioration in handwriting (Boileau, 2011; de Oliveira & Pelajo, 2010; Moretti, Pasquini, Mandarelli, Tarstiani, & Biondi, 2008). Although there is some evidence to support the link between streptococcus infection and onset in some cases of OCD and tics, this causal link is by no means established, making the diagnosis of PANDAS controversial (Maia, Cooney, & Peterson, 2008; Murphy, Kurlan, & Leckman, 2010; Shulman, 2009). Furthermore, debate continues whether PANDAS is a distinct entity that differs from other cases of Tourette syndrome disorder and OCD (Boileau, 2011; Felling & Singer, 2011; Robertson, 2011; Singer, 2011). Adding to the debate, researchers have raised concerns that clinicians may be overdiagnosing PANDAS in pediatric populations without conclusive evidence and clear diagnostic criteria (Shulman, 2009). At this time, PANDAS is not considered a disease entity and therefore is not listed as a diagnosis by the International Statistical Classification...
of Diseases and Related Health Problems (ICD) or as a syndrome in the DSM (Pichichero, 2009).

Given the controversy regarding the etiology of PANDAS and the absence of clear and agreed-upon diagnostic criteria, researchers proposed pediatric acute-onset neuropsychiatric syndrome (PANS) as an alternative to PANDAS (Swedo, Leckman, & Rose, 2012). PANS includes youth with acute-onset OCD, but also acute-onset neuropsychiatric disorders without an apparent environmental precipitant or immune dysfunction. Researchers hope that the new criteria captured within PANS will assist researchers and clinicians to discriminate better between traditional childhood-onset OCD and the sudden and severe onset of symptoms that characterizes youth with PANS (Swedo et al., 2012).

The research on the topic of PANDAS/PANS is limited, and what is known about its diagnosis and treatment is speculative at best. For example, we do not know if OCD-like symptoms for children with an acute onset are always PANDAS/PANS or are never PANDAS/PANS. We do not know if PANDAS/PANS symptoms remit spontaneously later in adolescence, nor do we know whether these symptoms result in treatment-resistant OCD secondary to permanent damage to the basal ganglia. At this time, we have many more questions about acute-onset pediatric OCD than we have answers. Current treatment recommendations for PANS/PANDAS include simultaneously treating the infection with medication and the OCD symptoms with exposure and response prevention therapy (a form of CBT that involves youth with OCD facing their fears and refraining from engaging in compulsions or rituals; see Chapter 2), with or without psychotropic medication (Thienemann et al., 2017). For additional information on PANS/PANDAS, check the NIMH website (http://www.nimh.nih.gov/health/publications/pandas/index.shtml) and the International OCD Foundation (IOCDF) website (http://www.iocdf.org). Also, when discussing PANS/PANDAS with parents, clinicians can download the PANS/PANDAS handout (see http://pubs.apa.org/books/supp/tompkins, Web Form 1.1).

COGNITIVE BEHAVIOR MODEL OF OCD

Conceptualization of pediatric OCD begins with the nomothetic conceptualization of the disorder in general. A nomothetic conceptualization is a theory about the primary variables that maintain OCD for anyone. That is, nomothetic conceptualization is a general theory about the mechanism that drives and maintains the condition. Fortunately for clinicians, to treat the condition it is not necessary to know what caused a child to develop OCD. It is only necessary to know the hypothesized factors that maintain the symptoms. These hypothesized factors are the targets of CBT for pediatric OCD. The goal of CBT is to reverse or undercut these factors and thereby weaken the existing mechanism thought to maintain the condition.

The cognitive behavior nomothetic conceptualization of OCD proposes that dysfunctional beliefs and interpretations of normally occurring intrusive
thoughts result in obsessions and compulsions (Rachman, 1997). That is, although thoughts, images, or impulses that intrude into consciousness are normal mental events (Rachman & de Silva, 1978), youth with OCD transform these normal intrusions into highly distressing obsessions through a series of maladaptive evaluations, primarily evaluating these thoughts as highly significant and a threat that only they can prevent. For example, the belief that one has the special power to cause, or the duty to prevent, negative events or outcomes (i.e., inflated responsibility) and the belief that it is necessary and possible to be completely certain that negative events or outcomes will not occur (i.e., intolerance of uncertainty) are two of the most common maladaptive OCD beliefs. These misinterpretations cause individuals to become preoccupied, overly focused, and desperate to control normal thoughts. For a comprehensive list of maladaptive OCD beliefs, see Abramowitz, 2006 (Table 3.2, page 68).

Youth without OCD think very little about their thoughts. They consider most thoughts to be meaningless: “It’s just a thought.” They understand or believe, although they are likely to be unaware of this, that thoughts are random mental events that do not influence outcomes or one’s actions and in themselves are meaningless and harmless (i.e., mental noise). However, youth with OCD attach a high degree of importance to a thought. For example, as James, who does not have OCD, speaks to his math teacher, he has the urge to spit in the teacher’s face. James immediately labels the thought as silly and does not assume that thinking the thought means that he may spit in his teacher’s face. Nor would James assume that the thought meant anything about the teacher. However, his best friend, George, who has OCD, labels the thought that he might spit in his teacher’s face as significant. He then feels very anxious and leaves the classroom abruptly before he acts on the thought, as he believes he might do. As he exits the classroom, he touches the right and left sides of the doorway with his right and left shoulder to get the thought out of his mind.

Repeated appraisal of normal intrusive thoughts in this way triggers anxiety and distress. The youth then attempts to suppress the unwanted thought or, through actions and mental actions, attempts to prevent the feared event from occurring. George both escaped the classroom and engaged in a compulsive behavior to prevent the feared outcome (i.e., spitting in his math teacher’s face).

According to the cognitive behavior model of OCD, avoidance and escape behavior, as well as mental and behavioral neutralizations (e.g., compulsions), maintain the condition in several ways (see Figure 1.1). First, because avoidance, escape, and neutralizations do indeed result in an immediate decrease in distress and anxiety, these actions (both mental and behavioral) are reinforced and maintained through operant conditioning (negative reinforcement). For example, if you enter a room that is hot and stuffy and you adjust the thermostat in the room until you feel cool and comfortable, the next time you enter the room when it is hot and stuffy, you will go immediately to the thermostat to adjust it. The immediate relief you experience increases “go to the thermostat” behavior when you are uncomfortable in that way.
Second, because avoidance and neutralizations result in an immediate, although temporary, reduction in anxiety, these maladaptive anxiety management strategies interfere with the natural attenuation of the fear response that occurs when individuals remain in the feared situation for longer periods. Also avoidance and active neutralizations preserve dysfunctional beliefs and misinterpretations of obsessional thoughts. That is, when the feared consequence does not occur after completing a neutralization, the individual attributes this outcome to having engaged in a neutralization. For example, if George leaves the classroom quickly or engages in compulsions (e.g., touches the doorway with his right and then his left shoulder), he will not learn that
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having the thought and urge to spit in his teacher’s face does not mean that he will do it, whether he engages in the compulsive behavior or not. To learn that his expectations are incorrect, George must remain in the situation without engaging in any neutralization.

Third, attempts to avoid, suppress, and neutralize intrusive obsessions increase the frequency of obsessions. This is quite counterintuitive to most individuals with OCD who believe that these maladaptive actions decrease the frequency of their obsessions. Instead, avoidance and neutralizations serve as reminders of obsessional intrusions and thereby prompt their occurrence. For example, George repeatedly swallows the saliva in his mouth. He believes by keeping his mouth free of saliva, he will not be able to spit in his teacher’s face. However, each time George swallows, the act of swallowing triggers intrusions about spitting in his teacher’s face.

To summarize, the cognitive behavior model hypothesizes that the process of maintaining OCD begins with an evaluation of normal intrusions as highly meaningful (e.g., posing a threat to oneself or to others for which the individual with OCD is responsible). This evaluation results in the individual feeling anxious, who then attempts to remove the intrusive thought from consciousness or prevent the feared consequence. This process paradoxically results in an increase in the frequency of the intrusions and the perpetuation of these mental events. Neutralizations (actions and thought actions) maintain the frequency and intensity of the undesired intrusions and prevent the individual from learning that the appraisals, including the predictions of catastrophic events, are incorrect. Clinicians can download an illustration of the model (see http://pubs.apa.org/books/supp/tompkins, Web Form 1.2) to use when discussing the model with older youth and parents.

CONCLUSION

Nearly half of all cases of OCD arise in childhood (Rasmussen & Eisen, 1990). Pediatric OCD appears to be a heterogeneous disorder with a variety of factors that influence the onset, expression, and maintenance of the condition and thereby challenge the clinician’s ability to diagnosis, conceptualize, and treat the condition. For this reason, it is important that clinicians understand the particulars of the condition, as well as the developmental and environmental factors that can influence the course of the disorder and the youth’s response to CBT for it. When pediatric OCD is untreated, its course is chronic and deteriorating (Stewart et al., 2004), which places many youth at greater risk to develop other psychiatric disorders in adulthood (Bolton, Luckie, & Steinberg, 1995; Hanna, 1995). However, with appropriate treatment, either CBT alone or in combination with medication, conducted by knowledgeable and qualified clinicians, most youth exhibit significant long-term improvement (Stewart et al., 2004).

In the next chapter, we describe the modular treatment that is the focus of this book.