Values-Centered Interventions: Setting a Course for Behavioral Treatment

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Purposes of Treatment in Behavior Therapy

What is the purpose of behavior therapy? Although skill-building components inform many behavioral treatments, goals and outcome assessments typically focus on reductions in psychological complaints of one sort or another. Behavior therapy, like medicine, has taken as its task, the reduction of suffering. Embedded in our choice of outcome measures is an assumption about the relationship between psychological complaints and psychological well-being. Behavior therapy, along with most of behavior health perspectives, has adopted the position that (a) psychological suffering is anomalous, and (b) that psychological health is inversely related to the number and intensity of psychological complaints.

Hayes, Strosahl, and Wilson call this the "assumption of healthy normality" (1999, p. 4). According to this assumption psychological health is the normal state affairs and is interrupted only when some abnormal pathological condition intervenes. The behavior therapy variant of this view differs in two significant ways from the traditional medical model. First, in terms of pathogenesis, the behavior therapist is more likely to point to learning history than to biological malfunction. Second, behavior therapy has typically understood behavior problems in terms of learning processes that are not unlike the learning processes that generate normal non-pathological behavior patterns. What it shares with the traditional medical model is that well-being is the normal state of affairs. However, rather than the intrusion of some biological malfunction, infectious agent, or toxic insult, the behavior therapist posits anomalous, pathogenic learning histories. From this perspective, such learning histories generate negative thoughts, emotions, memories, bodily states and behavioral predispositions—the behavioral equivalents of tumors, viruses, and bacteria—that must be excised in order for good psychological health to return.

Sources of Suffering

Learning History as Pathogen

Consider the standard behavioral approach to panic disorder, in which treatment is executed at the level of person/environment interaction. While acknowledging there may be genetic and/or physiological factors that predispose someone to develop panic disorder, traditional state-of-the-art behavioral treatments

focus on providing an individual with a new learning history that will reduce anxiety in what have been anxiety-producing contexts. Central to this new learning history is systematic exposure to feared events. The most promising new interventions include exposure to both feared external events, such as shopping malls, and also feared interoceptive events, such as accelerated heart rate (e.g., Bouton, Mineka, & Barlow, 2001; Carter & Barlow, 1993). The key marker for successful therapy is that the client be panic-free for some period following treatment.

An Alternative View

An alternative to this pathology-oriented view is described by Hayes, et al. as the "assumption of destructive normality" (1999, pp. 4-12). From this perspective, as with the traditional behavioral view, it is normal psychological processes that lead to suffering. In some instances, they may be the primary source; in other cases, such as schizophrenia, primary biological pathogenesis may be exacerbated by these normal psychological processes (see Bach & Hayes, 2002). Although the behavior therapy movement has always viewed psychological problems in terms of normal learning processes, as described above, psychological problems are thought to be the result of an anomalous learning history (e.g., Kanfer & Phillips, 1970). So, for example, a traumatic experience with a dog might cause a phobia. Recent developments in the behavioral analysis of language suggest that there are special properties of human language that generate suffering among humans over and above the suffering of nonhuman species (Hayes, Barnes, & Roche, 2001; Wilson & Blackledge, 1998; Wilson, Hayes, Gregg, & Zettle, 2001). As with predominantly biological pathogenesis, this perspective does not rule out the effects of problematic learning histories. It simply suggests that the possession of language alone will produce suffering, and that processes underlying language will compound the suffering that results from either anomalous biological processes or anomalous learning histories. If this is so, we ought to see psychological problems virtually everywhere we look, and indeed, the prevalence of psychological problems is staggering. The National Comorbidity Survey, for example, found that 29% of the nationally representative sample of 8,098 adults (ages 15-54) met criteria for at least one psychiatric disorder during the previous year, and 48% in their lifetime (Kessler, 1995). Fully 79% of those with lifetime disorders were comorbid for another DSM-III-R disorders (Kessler, et al., 1994).

Language and Suffering

We assume that language evolved as result of its survival value. There are a few methods of ensuring survival. Some creatures reproduce by the millions. Others with smaller reproductive capacity develop other means to serve this central evolutionary imperative. Over and above our need to reproduce, find food, and all else, we must avoid being eaten. Humans are relatively fragile creatures. We cannot tolerate cold as well as a polar bear. We are not as strong as an elephant. We are not as swift as a cheetah. Still, humans have come to dominate the planet. We have devised means to overcome many of the physical disadvantages that we have with respect to other more robust creatures. If we cannot live in an environment, we have the capacity to alter it dramatically. This success in protecting ourselves from a hostile world has made it possible for us to live in the most inhospitable places on the planet (and even off planet).

Language developed as an adaptation that fulfilled a central role in protecting humans from a hostile environment. One of the extraordinary outcomes of the basic processes underlying language is that they allow humans to compare, evaluate, and respond effectively to contingencies that are small and cumulative, temporally remote, of extremely low probability, or otherwise defective in ways that would not support effective behavior on the part of nonhuman organisms. For example, for consequences to be effective for nonhumans, they must (a) occur relatively close in

time to the behavior they produce and (b) be relatively large in magnitude. Lacking these two qualities, behavior is not altered. Even with relatively sophisticated nonhuman organisms such as primates, the negative health consequences of smoking, which are tiny, cumulative, and years away, would never overcome the short-term positive effects of tobacco because the basic processes underlying language in humans are absent (Hayes, Barnes-Holmes, & Roche, 2001).

Similarly, positive events that are much delayed or small and cumulative will not reinforce the behavior of animals lacking human language. A food pellet delivered fifteen minutes after a lever press will not increase the probability that a rat will press the lever again. The same is true of classical conditioning processes. In order for classical conditioning to be effective, the unconditioned stimulus must follow the neutral stimulus very closely in time. Additionally, in both operant and respondent conditioning, the order of

events must be correct. In operant conditioning, the reinforcer cannot precede the response, it must follow. In respondent conditioning, the UCS must follow the neutral stimulus or conditioning will not occur. Exceptions do exist. For example, some animals store food for the next winter. And, in the area of classically conditioned responses, taste aversions can be conditioned even though the illness does not follow for many hours. However, these exceptions tend to be very fixed patterns of behavior and cannot be established outside those narrow domains where they appear to be determined by millions of years of evolutionary history.

Humans, in the most extraordinary contrast, can respond effectively to a host of contingencies that would fail to control the behavior of nonverbal organisms. Events can be made present verbally and become psychologically present as dangerous (or desirable) even though they are not present, or at least not apparent, in the immediate environment. The ability to respond effectively to what would otherwise be an ineffective organization of contingencies is thought to be the result of relational conditioning processes (Hayes, et al., 2001). Through these processes, humans will avoid the verbally established event just as they would avoid the event itself because the actual event is psychologically present in the verbal event. Take, for example, death. If I were to ask the reader to think about the death of the person who they most love in the world—many would balk. We do not merely avoid death, which has genuine survival value; we also avoid thoughts about death, which has no apparent survival value. The Acceptance and Commitment Therapy (ACT) model, to be further discussed later, labels this tendency to avoid aversive psychological events "experiential avoidance". The creators and proponents of ACT see this avoidance as a natural outcome of relational learning processes (i.e., verbal processes), and, critical to this position, a primary obstacle to effective living (Hayes, et al., 1999; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Wilson & Luciano, 2002).

Language, Psychopathology, and Experiential Avoidance

A great deal of suffering emerges from persistent and uniquely human attempts to control different aspects of experience. Here, we are not speaking of events in the world, but instead the experiential precipitants of those events. Our culture teaches us that positive thoughts and feelings are good; negative thoughts and feelings are bad and ought to be removed, diminished, or at least minimized. We expend

enormous effort in our schools and workplaces teaching people to feel more confident, to have higher self-esteem, to be cheerful and optimistic. Negative thoughts and feelings, by contrast, are actively punished—unless they are relatively transient.

From the time we are little children we are taught that we can and should control negative cognition and emotion. The little girl who cries out in the night is told that there is nothing to be afraid of. The little boy who cries on the playground is called a baby. A lonely adult who tells a friend that they do not believe anyone will ever love them will be told that they ought not think that. The well-meaning friend will likely try to convince the lonely person that it either is not true now or that it will not be true forever. It is as if feelings of fear and thoughts of rejection are the enemy as much as are frightening and rejecting circumstances. The underlying assumption is that one must feel courageous to be courageous, and that one must believe love is possible in order to find love. Thus, we learn to fight not only aversive circumstances, but also our own reactions to those circumstances. And further, we fight not only the present circumstances, but also those that occur in our imagined futures and remembered past.

Models of psychopathology also frequently accept the assumption that negative thoughts and emotions must be supplanted with positive thoughts and emotions in order for our clients might move on with their lives. In a number of therapies, clients are taught to dispute irrational thoughts (Beck, Rush, & Shaw, 1979; Ellis, 1962). Some treatments focus on elimination or reductions of problematic emotional states, such as anxiety, through exposure (e.g., Barlow et al., 1989; Borkovec et al., 1987). In the area of substance abuse, attempts are made to reduce conditioned cravings through cue exposure (Monti, et al., 1989). All of these treatments appear to share the view that certain cognitions, emotions and bodily states lead to bad behavioral outcomes and that in order to improve the behavioral outcomes, an array of problematic private events must be eliminated, or at least reduced.

Paradoxical Effects of the Control of Negative Cognition and Emotion

Although evidence is not wholly uniform, there is considerable evidence in the experimental literature on thought suppression (Purdon, 1999 for recent review); in the coping literature among depressives (Bruder-Mattson, & Hovanitz, 1990; DeGenova, Patton, Jurich, & MacDermid, 1994), survivors

of child sexual abuse (Leitenberg, Greenwald, & Cado, 1992; Polusny & Follette, 1995); alcoholism (Cooper, Russell, Skinner, Frone, & Mudar, 1992; Moser & Annis, 1996), and recovery from traumatic events (Foa & Riggs, 1995) suggesting that avoidant means of coping predict poorer long-term outcomes.

There is also a rapidly expanding clinical literature on treatments that emphasize a focus on acceptance and valued-living as an alternative to pure change-oriented treatments. Linehan for quite some time has argued theoretically and empirically for the role of acceptance in the treatment of borderline personality disorders (Linehan, 1987). Christensen and colleagues have pursued the implications of acceptance in the treatment of couples (Christensen, Jacobson, & Babcock, 1995). Others have developed acceptance and/or mindfulness-oriented strategies in the treatment of depression (Segal, Williams, & Teasdale, 2002), anxiety (Forsyth & Eifert, 1998; Roemer & Orsillo, 2002), substance abuse (Marlatt, 2002), and eating disorders (Wilson, 1996).

Experiential Avoidance and Valued Living

Experiential avoidance is not bad in and of itself. If the experiences avoided are relatively discrete and time limited, few or no problems may arise. So, for example, if my daughter is out on a date and is a little late getting home, I might distract myself by working on a book chapter and moderate my contact with worries associated with her whereabouts, the character of her boy friend, possible car accidents, et cetera. In all likeliness, she arrives home safe and sound that evening and the outcome is a completed chapter. The problem arises when the avoided experiences are more or less permanent fixtures of an individual's life. If what are avoided are thoughts, memories, and bodily states related to a sexual abuse history, that history is permanent. When the source of the troubling aspects of experience is permanent, the avoidance may also be permanent—to the extent that the individual is unwilling to remain in psychological contact with those thoughts memories and bodily states. Experiential avoidance can also be detrimental when the experiences avoided are likely to occur in the pursuit of some value. So, for example, if the sexual abuse survivor is <u>wholly</u> committed to avoiding distressing thoughts, emotions and memories connected to the abuse, they may act in the service of the reduction of these aversive aspects of experience at the expense of rich intimate interactions.

Management of aversive private events can become a sort of occupation. It is not a pleasant occupation, but like a lot of not-so-pleasant occupations the person may comfort themselves with the thought that once the job is done, they will be able to do what they really want to do in their lives. In this way, lives are put on hold in the service of managing thoughts and emotions. And, a life that is lived outside a person's most closely held values feels lousy.

Purposes of Treatment in ACT

From an ACT perspective, negative cognition and emotion may, but need not, produce bad behavioral outcomes. ACT adopts a somewhat different focus than has been traditional in the behavior therapy movement. Because we believe that suffering is a natural byproduct of language, we see the removal of suffering as futile. Complete removal of suffering would only be possible by the removal of language (in addition to the non-language sources of suffering). So instead, ACT is aimed at finding a way to live with the dark side of language processes, even while taking advantage of what language offers us. The core ACT goal, in the most abstract sense, is to help a client live a rich and meaningful life in and with the suffering that will surely come to all of us. Of course, few therapeutic schools or individual therapists would claim otherwise, but how to approach that goal might be very different depending on the specifics of the underlying theory.

From the pathology-oriented perspective described above, removal of pathology frees the individual to pursue whatever life direction they might take. From an ACT perspective, psychological suffering is not anomalous. It is normal and pervasive. The struggle to remove psychological adversity fixes, and intensifies, that adversity in an individual's experience. Even more importantly, it is a struggle that interferes with a life lived persistently in the pursuit of one's values. ACT is aimed squarely at helping clients to relinquish this struggle in order to live a life in pursuit of their most deeply held values.

Values-Directed Behavior Therapy

Behavior therapy has made extraordinary progress over the past 40 years. In what follows, we will examine two mainstay behavior therapy interventions. We will discuss underlying mechanisms of change, and finally, we will describe the ways that these interventions can be refined and directed by the addition of a strong, systematic values-orientation.

Exposure Procedures in Behavior Therapy

Our largest effect sizes in behavior therapy can be found among treatments that use exposure-based interventions for anxiety disorders. These interventions are an excellent example of the translation research that defined the development of the early behavior therapy movement (Wilson, 1997). Early on in the behavior therapy movement, we asked whether our knowledge base on conditioned fear and avoidance in the laboratory could be applied to clinical cases of fear and avoidance. The answer has been an unmitigated yes. Although some fear and avoidance has been refractory, exposure-based procedures have revolutionized the treatment of anxiety disorders. Simple phobias, for example, can be successfully treated in less than one day (Öst, 2001). We believe that the applicability of exposure-based procedures may be even broader if we broaden our understanding of the nature of conditioning and extinction and the ways that respondent and operant contingencies interact.

What occurs in exposure based treatment

The ways that we assess the efficacy of exposure-based treatments has been strongly influenced by the laboratory preparations from which these procedures were derived. Laboratory studies on classical conditioning and extinction, require readily accessible dependent measures in order to know whether conditioning has occurred, or in an extinction preparation, whether the effects of conditioning have been extinguished. Heightened autonomic arousal and avoidance are readily assessed dependent measures that change reliably in aversive conditioning procedures. In the clinic, we use actual avoidance (e.g., behavioral approach tasks) and proxies for avoidance (e.g., questionnaires about avoidance) and direct or proxy measures of autonomic arousal as measures of the severity of the anxiety disorder, or alternately, as a measure of treatment efficacy.

It is unquestionable that aversive conditioning increases avoidance and autonomic arousal, and that extinction procedures reduce them. However, these two effects do not exhaust the effects of aversive conditioning. Conditioned aversives have effects on operant behavior that go beyond avoidance and have implications for psychological problems. We know from the basic behavioral science literature that when conditioned aversives are superimposed on a free operant baseline, we will see *conditioned suppression* of operant

responding. This occurs even though the operant behavior that is suppressed has no connection to the production of the conditioned aversive stimulus. For example, Geller (1960) established key pecking in a pigeon under a variable interval schedule. He then superimposed a tone that lasted 3 minutes that was followed by an electric shock. Over a series of trials, the pigeon's key pecks were entirely suppressed during the period in which the tone was sounding, even though key pecking had no effect on either the tone or upon the subsequent shock.

In short, aversive conditioning has three primary effects on behavior that are of interest for understanding psychopathology: (a) it produces conditioned elicitation (i.e., arousal, tension); (b) it increases behaviors that terminate the aversive stimulus (i.e., avoidance); and, (c) it suppresses other operant responding, except those operant responses that terminate the aversive (conditioned suppression). Taken together, aversive stimuli, including conditioned aversives, generate a sharp narrowing of behavioral response patterns. In the presence of aversives, or events correlated with aversives, organisms become physically ready to act, and their voluntary behavior narrows to responses that terminate the threat.

Consider an example in nature that demonstrates the evolutionarily sensible advantage afforded by this response to aversive events and their correlates. If a rabbit were to see a lion on the savannah, it would not be advantageous, from a survival perspective, for the rabbit to continue foraging or to notice the flowers and other features of the landscape. The evolutionary advantage would go to the rabbit who had an immediate and narrow pattern of response—that is, the rabbit who showed high autonomic arousal, the immediate suppression of less critical behaviors, (conditioned suppression), and rapid movement to its hidey-hole (avoidance). Likewise, if some sound or smell reliably preceded the appearance of the lion, the adaptive advantage would go to the rabbits that showed the same pattern of behavior with respect to the sound or smell as they did to the actual lion. It is important to note that these correlated events need to occur both close together in time, and also in a particular order. Events that follow the presence of the lion do not take on the threatening psychological functions of the lion. If backward conditioning were robust, the hidey-hole might take on the functions of the lion, causing the rabbit to run from the hidey-hole. To the contrary, the hidey-hole precedes the removal of threat and so takes on those safety functions.

In the world outside human language, this is a pretty neat evolutionary trick. Unfortunately, the emergence of language, which has provided many adaptive advantages, also has a dark side. The dark side of language is that through relational conditioning processes events can come to have aversive properties even without the close temporal pairing that is necessary for all of the other creatures of the earth. As described in the above section on experiential avoidance, we humans avoid not only that which is dangerous, but also anything that is conditioned relationally to events that are dangerous. If you were an early language capable hominid, for example, another hominid might say to you "That was a lion." Because of the special properties of relational conditioning (Hayes et al., 2001; Wilson & Blackledge, 1998; Wilson, et al., 2001) the word "lion" would take on some of the threatening psychological functions of the lion, even though it occurred far beyond the temporal bounds necessary for good classical conditioning, and even though the word "lion" followed, rather than preceded, the presence of the actual lion. Now if you heard someone say the word lion, you might become aroused, stop what you are doing (conditioned suppression), and run to a safe place (avoidance). This is all to the good if it helps us avoid lions, but what happens when the thing we avoid is not some external event, like a lion, but instead an aspect of experience, like a disturbing memory, thought, or emotion.

The upshot of this relational conditioning process is that we have the capacity to develop narrow and inflexible patterns of behavior with respect to many, many events, including many of the contents of our own conscious experience. We are quite clear, as behavior therapists, about what to do when some external event generates these narrow and inflexible patterns of behavior—we do exposure. We are somewhat less clear when the events generating these patterns are aspects of our own experience. When a thought of failure is the event that generates a narrow and inflexible pattern of behavior, we often work to refute the thought. Why? It does little good to refute fears about phobic objects. In fact, the DSM requires there to be some insight into the excessiveness of the fears in order to qualify as a phobia rather than as a delusion. When someone is fearful of an object, the best treatment is to get them interacting with the feared object in a variety of ways (except ways of interacting that involve avoidance). We don't simply ask the snake phobic to peer at the snake. We ask him to approach the snake, to notice the colors of the snake, observe the way it moves, to

touch the snake. In other words, we attempt to establish a broad and flexible repertoire with respect to the snake. Why would we not use exactly the same procedures with thoughts, memories, bodily states, emotions, and other aspects of experience? Bouton and colleagues have noted the inconsistency in treating personal experiences such as thoughts by attempting to refute them (Bouton, et al., 2001). Their view that panic disorder, for example, is the result of conditioned anxiety to both interoceptive and exteroceptive cues, allows for a broadened use of exposure. In fact, the single most significant addition of Barlow's treatment of panic has been the systematic application of exposure procedures to interoceptive cues (Bouton, et al., 2001).

This perspective on aversive conditioning suggests that the primary problem with conditioned aversives is not that the individual avoids or becomes aroused. The problem is that they only become aroused and avoid. We do not want the snake phobic to become incapable of arousal and avoidance; sometimes these are just the right responses. What we seek is a broad and flexible repertoire with respect to snakes. Using the snake phobia example, we can think of the difference between pre and post exposure as a change in a population of potential responses. Pre-exposure, the individual has a very narrow, high probability set of responses (see Figure 1). Almost regardless of context, the snake phobic has a 100% probability of becoming alarmed and acting to minimize contact with the snake. Post-exposure, the snake phobic shows a broad and flexible repertoire (Figure 2). With the post exposure repertoire, whether, for example, the phobic stopped to look in the window of a shop pet store would be controlled not *merely* by the presence or absence of snakes, but by contextual factors such as available time, whether they were with a friend interested in snakes, whether or not there were colorful examples of snakes displayed, et cetera.

INSERT FIGURES 1 AND 2 ABOUT HERE

Implications for Treatment

Taking this view of exposure, we might intervene when an event, either external or internal, generates a narrow and inflexible pattern of behavior. The purpose of the intervention is not merely to lessen arousal and avoidance, but instead to build a broad and flexible repertoire with respect to the avoided event. Although elicitation and avoidance will generally be reduced given such treatment, these reductions are not the goal of the treatment. At a practical level, it means that anything we do with avoided events that is not

avoidance is good in that it broadens the individual's repertoire. Our negative thoughts, memories, bodily states, and emotions are calls to action. When they arise, we have a characteristic pattern of response with respect to them. Whatever the pattern observed, our concern as clinicians is not so much with its form as much as with its fixedness. Exposure procedures are aimed at making these patterns of behavior broad and flexible.

Cognitive Defusion, Mindfulness and Their Relation to Exposure

When thoughts are responded to in terms of their literal content, we call this *ccognitive fusion.* Interventions that attenuate the relationally conditioned functions of thoughts can be considered effusion strategies. Cognitive defusion and mindfulness can be considered special cases of exposure. The language of classical conditioning and extinction, from which exposure-based treatments were derived, is adequate in the analysis of directly conditioned aversive stimuli. *Cognitive defusion, by contrast, refers to procedures that broaden repertoires with respect to stimuli that have their psychological functions through relational (or verbal) conditioning processes.* From this perspective, procedures such as mindfulness can be seen as activities that violate the narrowness of the avoidant repertoire. Considered as a type of defusion strategy, being mindful is not part of the narrow pattern of responses that are typical with respect to thoughts and feelings, especially not aversive thoughts and feelings. Kabat-Zinn, for example, states that mindfulness involves "paying attention in a particular way: on purpose, in the present moment, non-judgmentally" (1994, p. 4). Two things occur when we can shape such a response. First, the client's repertoire has broadened. This is a new pattern of behavior with respect to their thoughts. Second, the client has the direct experience (not merely the insight) that broadening is possible. The latter is probably the most critical feature of the defusion experience.

Behavioral Activation

Behavioral activation is likewise an old and venerable weapon in the behavior therapy armamentarium. Like exposure-based procedures, it represents a translation from laboratory science to clinical science.

The Reinforcement Deprivation Hypothesis

We can readily generate something that looks like depression in a laboratory animal. If an organism is in an environment that is free from threat, rich in sources of food, water, and opportunities to explore and exercise, the organism will be quite active in the environment. If opportunities for positive reinforcement are systematically stripped from the environment, the animal will initially explore the available space, foraging for food, water, and other necessities. Perhaps it will attempt to escape, if possible. Eventually, however, the animal will greatly reduce its activities. In a manner of speaking, it waits for something in the environment to change. Again, this can be seen as an evolutionarily sensible response to a very impoverished environment. Pervasive threat has the same effects.

Consider, for example, the series of experiments carried out to produce what has been termed "learned helplessness" (Seligman & Maier, 1967; see Miller & Norman, 1979 for review). When animals are subjected to uncontrolled aversive conditions, they initially attempt to escape. However, over time, these operant responses extinguish because they do not eliminate the aversive events. Again, this is a sensible response from an evolutionary perspective. The evolutionary imperative to survive suggests that energy be conserved for a time when action might make a difference. Until there is a change in context, activity is wasteful of resources (Ferster, 1973). As with aversive conditioning, described above, such conditions produce narrow and inflexible patterns of behavior. Rats in Seligman's work, for example, did not attempt to escape, even when escape became possible (Seligman & Beagley, 1975). In order to change this state of affairs, something in the psychologically present environment of the organism must change. This can be brought about either by a perceptible change in the environment, or by compelling the organism to produce the behavior that terminates the aversive event (e.g., Seligman, Maier, & Geer, 1968).

The necessary change in the environment is much more complex for humans. Humans may have a seemingly safe and rich environment—one that it is free from physical threat and is full of food, water, and opportunity—and still suffer. In our world, unlike the rat's, these primary reinforcers are not enough. Verbal conditioning can lead to a deprivation of a different sort. For example, humans may experience an apparently rich environment as one in which they lack a sense of adequacy or one in which their suffering has no meaning. These deprivations are not eliminated when physical needs are met, or with material wealth. There

are people who seem to have everything who can barely live through one day—and there are those who choose not to. Something very powerful must become psychologically present in order for a human to become active under these conditions.

Early Clinical Application of the Reinforcement Deprivation Hypothesis

Intervention strategies have been developed that capitalized on the relationship between depressive symptomology and availability of positive reinforcement. Lewinsohn and colleagues (Lewinsohn, Sullivan, & Grosscup, 1980) applied this perspective by collecting a list of potentially pleasant activities. They focused treatment on increasing the frequency and variety of pleasant events in the depressed person's life. Increases in activity do appear to make a difference in depression and some recent studies suggest that behavioral activation may be a critical, if not the most important, component in cognitive therapy for depression (Jacobson, et al., 2000; Martell, Addis, & Jacobson, 2001).

Applying Exposure, Defusion, and Behavioral Activation

Given these behavioral technologies, we will now focus on two problems that can be addressed by values-centered interventions. First, what will the targets of these interventions be? What activities will we seek to increase? What events will we target with our exposure and defusion strategies? The second problem relates to issues of motivation. That is, having selected targets for exposure, defusion and activation, how will we motivate our clients to expose themselves to difficult psychological material? How will we motivate them to increase their activity?

Therapy and Its Targets

We do not apply exposure to just any conditioned aversion. For example, I have a conditioned aversion to images of Swastikas (probably relational conditioning, since I have no direct conditioning history). Should I opt to defuse this conditioned aversion? Of course not. With regard to behavioral activation, is pleasantness the right dimension to direct activation? No. There are many, many activities that are highly reinforcing, but entirely incompatible with what I, you, or our clients, would consider "the good life." Persistent drug use might, for example, be pleasant and incompatible with important valued activities. Although pleasant and valued activities may overlap, we are careful in ACT about the propensity to seek

pleasantness and avoid pain. We pursue values and take our pleasure when it occurs along the way. Values can provide us with the targets for exposure and guide the choice of what activities to pursue in behavioral activation.

Therapy and Motivation

Having selected targets for exposure, defusion, and behavioral activation, how do we get our clients to participate? It is no surprise to the client with obsessive-compulsive disorder that they need to touch the doorknob and stop washing their hands. Likewise, it is not news to the person who is depressed that he or she needs to get out of bed and meet the world. But why would these individuals engage in treatment that is promised to provide benefits later, instead of engaging in behavior that provides some relief immediately. Exposure-based procedures are quite aversive. The client may do them so that anxiety eventually goes down. However, terminating the treatment will make anxiety go down immediately. Likewise for the depressive, the comfort of sleep provides immediate respite from ongoing thoughts of hopelessness and despair. Not only do we need to provide motivation for treatment, we need this motivating factor to be more substantial then the motivation provided by ongoing participation in fixed patterns of behavior that provide a modicum of immediate relief.

Values-Centered Behavior Therapy

Client values can provide both direction and motivation for the hard work of treatment and thus may offer solutions to the issues raised above. From an ACT perspective, exposure and defusion are done when there is any event that generates narrow and inflexible patterns of behavior, and where these inflexibilities are obstacles to our clients moving actively in the direction of a chosen value. Values interventions direct therapy by targeting for exposure and defusion events that occur as barriers to valued living. Likewise, the dimension that directs behavioral activation is not pleasantness, but is instead deeply held personal values. Simply put, this perspective generates what might be thought of as "valued-events scheduling," in contrast to the pleasant-events scheduling in earlier forms of behavior therapy.

When obstacles prevent movement in a valued domain, we target those obstacles with exposure and defusion strategies aimed at building a broad and flexible repertoire with respect to those obstacles (including

both external and internal psychological obstacles). If events that "must be avoided" can be transformed though exposure and defusion into events with which clients have behavioral flexibility, new options open up for the client. Consider the example of the sexual abuse survivor who has high elicitation and avoidance with respect to memories of her abuse history. If a memory arises during an intimate interaction with a partner, she becomes anxious. Her attention narrows to the memory. Other behaviors are suppressed, including her intimate interactions with her partner, and, avoidant repertoires are activated. If she developed great flexibility with respect to these memories her ability to interact effectively in intimate contexts would be increased.

Thus, from this perspective, decisions about the targets for exposure, defusion, and behavioral activation are determined by a close examination of this fundamental question: "In a world where you could choose to have your life be about something, what would you chose?" In what follows, we will examine the ways that we have implemented the asking of this question in the context of psychotherapy. ACT is an evolving treatment technology (Hayes et al., 1999), and we are not sure if this approach to values-directed treatment is "right." Data will ultimately tell the story. Although we do not know the endpoint of the development of values intervention technology, we offer this as one potential starting point.

Values Assessment

Values Assessment: The Valued-Living Questionnaire

We have developed a short instrument called the Valued-Living Questionnaire (Wilson & Groom, 2002) that taps into ten domains that are often identified as valued domains of living. Clients are asked to rate, on a scale of 1-10, the importance of the ten domains, including (1) family (other than parenting and intimate relations), (2) Marriage/couples/ intimate relations, (3) parenting, (4) friendship, (5) work, (6) education, (7) recreation, (8) spirituality, (9) citizenship, and (10) physical self-care. We make considerable effort in the instructions to remove conventional constraints on answering, by emphasizing that not everyone values all of these domains, and that some areas may be more important, or important in different ways at different times in an individual's life. On the second page of the assessment we ask clients to make an estimate, using the same 1-10 rating scale, of how consistently they have lived in accord with those values over the past week. The instrument has shown good test-retest reliability (Groom & Wilson, 2003), and we

are currently collecting validity data. Regardless of the merit of this instrument in terms of its psychometric properties, it provides a systematic means to approach values interventions and so remains a sensible clinical tool.

Introducing the VLQ in Treatment

Because clients typically come to therapy with "a problem," like depression or anxiety, they can sometimes be perplexed by our interest in the importance they place on these different valued domains. We explain to clients that the perspective we work from seeks to understand people's difficulties in the context of a whole life. Sometimes problems become so overwhelming that it is easy to lose contact with the "big picture." We do want to know how the client has struggled, but seek an understanding of that struggle in the context of a whole person with hopes, desires and aspirations. Our experience has been that clients find this aspect of treatment useful and important (Dahl, Wilson, & Nillsen, under submission; Greco, 2002; Heffner, Sperry, Eifert, & Detweiler, 2002; Orsillo, Roemer, Block, LeJeune, & Herbert, in press).

Examining VLQ Scores

We seek out domains of living in which the client feels a loss of freedom to act, and where that loss of freedom generates suffering. Our general strategy will involve the two major components discussed in the previous section: behavioral activation and exposure (along with special cases of exposure such as defusion and mindfulness). First, we will look for valued activities in these domains for valued-events scheduling—values-directed behavioral activation. Second, we will look for obstacles to increasing valued activity and target those with exposure and defusion strategies. Below are some profiles that we have observed clinically and that seem like fruitful ground for values discussions with our clients as well as for theoretical analyses. The reader should keep in mind that these profiles may or may not underlie clinically relevant clusters. The therapist should assume a mindful posture with respect to interpreting profiles prior to interaction with the client.

Clinically and Theoretically Interesting Profiles

High discrepancy between rated importance and rated consistency. Theoretically, this should be correlated with a lot of distress and what we think of as core pathological functioning from an ACT perspective. We view these

discrepancies as a core source of distress that could be altered by increased engagement in discrepant domains. We have found clinically that clients experience these discrepancies as very disturbing. They tend to be associated with a great deal of negative self-evaluation, guilt, sadness and anxiety. In the examination of these discrepant domains it can very difficult for our clients to even speak about them. If the client is sufficiently immobilized, even by the thought of activity in these discrepant domains, we have discovered a target for exposure and defusion exercises. We could move directly to advocating activity; but often exposure and defusion can generate more flexibility and a greater probability of successful engagement in the proposed activities.

Extreme high total importance and consistency scores. This appears to be pretty common, but bears examination. Such endorsement may be related to excessive concerns about social acceptance. If social acceptance is the central value directing a client's life, they will be likely to find it in conflict with other values. When we encounter extraordinary concerns about social acceptability, we may do exposure and defusion exercises around both instances in the client's history in which they experienced disapproval and also imagined future disapproval. We do so in order to help the client have a broader and more flexible repertoire with respect to thoughts about disapproval, as well as actual disapproval. We have also found clinically that these ratings change upon greater scrutiny. Sometimes clients answer these questions with little careful thought about the domain of interest. This does not necessarily involve deceit. The phenomenon appears to be more akin to an answer of "fine" when we ask someone how he or she is. We have found in the process of inquiring about the particular things valued within these domains, that "fine" sometimes changes to something a bit less than fine. Problems can also be revealed by discussion of symptoms. When the depressed client talks about the costs of depression within their family, a high rating on consistency may drop.

Extreme low total importance score. We have seen this profile in a several client groups with whom we have worked. Among nurses treated for chronic pain, we have found very low importance scores that upon examination reflected adaptation to the perceived impossibility of obtaining anything worthwhile within the domain (Dahl, Wilson, & Nilsson, in preparation). For example, in the area of education, when asked about a low importance scores, some of the nurses scoffed about being smart enough to pursue anything educational.

Note that "not smart enough" is unrelated to how one experiences the importance of the domain. (Whether it is possible is a different question and one that we will explore. Here we are just looking for importance.) Some of these nurses valued this domain quite highly. "Not caring" was a way to distance themselves from disturbing thoughts about past and potential future disappointments. We have also seen this among some college and high school students at-risk for academic failure. Again, we assess for thoughts, memories, emotions and other aspects of experience that the client experiences as barriers to moving forward in a given domain.

The Need for Systematic Values Assessment

Systematic reinforcer preference procedures are often used in interventions with developmentally disabled individuals and with children who have behavior problems (Fox, Rotatori, Anthony, & Faye, 1983; Northup, 2000; Tighe & Tighe, 1969), but less commonly in other populations. These efforts have largely focused on the identification of relatively discrete reinforcers for use in relatively tightly controlled environments. Although there have been some efforts to assess reinforcers for other populations, they have typically involved the development of reinforcer surveys (e.g., Houlihan; Rodriguez, & Levine, 1990). When direct reinforcement-based technologies have been used among outpatient adults, such as in the treatment of substance abuse, they have still focused on relatively discrete reinforcers that are provided for relatively discreet behaviors such as using monetary rewards for clean urinalyses among substance abusers (e.g., Higgins, Wong, & Badger, 2000). However, for most adults, the most powerful values in our lives are not discrete reinforcers. We like $100 bills, but if we were asked about the relative value of a $100 as compared to, say, a rich relationship with our children, money suddenly becomes pretty unimportant. There is no good science that tells us precisely how, in behavior therapy, we can assess the relative importance of these valued domains and harness them fully to our treatments.

Intervening with Material from the Values Assessment

Having collected the client's VLQ ratings, we examine them in detail. Whether across areas, or in a single area, we want to understand the client's stake in the valued domain. The intervention involves two key components. First, we want a deep sense of what it would mean to the client to make a difference in the

selected domain. Second, we want the client to experience nothing less than a personal commitment from the therapist to understand what the client feels for that domain and to work with them to make a difference in that area of their life. The goal may not be completely achievable, but the aspiration should be made clear to the client.

What we are seeking is a client value that can inspire both the therapist and the client. Consider a case in which a woman presents for treatment for panic disorder with agoraphobia. Using the VLQ we find a large discrepancy in rated importance and rated consistency in the domain of parenting. We find among the precipitants for treatment the fact that the woman's daughter will soon graduate from high school. Because the commencement is to be held in a large auditorium, the woman fears she will not be able to attend. We elicit from the woman other such events that have been missed in the past and that she fears missing in the future. We look for thoughts, memories, and emotions related to her role as a mother. If these topics are difficult, they become targets for exposure and defusion.

When flexibility increases, we press forward. When we are able to connect with the client around the central value, we repeat it to the client: "I can see how meaningful it would be to you to participate fully in your daughter's life. I can see how much it would mean to her and to you to really be there—not off in your head, checking your pulse and monitoring the exit routes—but really <u>there</u>, with her at that moment she walks across the stage to get her diploma. What if our work here could be about making that possible?" It may also be useful, in order to focus the treatment, to contrast this with a panic control agenda. To do so we can ask the client to imagine that the therapist is able to offer two choices:

Therapist: I want to be sure that treatment connects to what you most care about. So, imagine I could offer you two choices. In this hand, I offer a guarantee of no panic attacks. And, I mean none, never, ever. In order to get this, however, you have to give something up. You have to give up any meaningful relationship with your daughter. She graduates, moves away, and that is the end of it. You never really connect again. I am offering you another choice in this hand though. With this choice, you get to have an extraordinary, rich relationship with your daughter. You are there for this and many, many other important times— college, marriage, grandchildren—a lifetime of connection. But again, there is a cost: with this choice, you continue to

have panic attacks, but they do not stop you from doing any of the things you want to do. Which would you choose?

Client: I don't like this. Can't I have both—I mean no panic and the relationship?

Therapist: Let me be clear. I am not saying that I can promise you either. I do not know the future. I am just asking you to *imagine* that I can absolutely guarantee either one or the other, but not both.

Client: But I don't like it. I don't like the choice. I don't think I could do it.

Therapist: Yes, of course, I don't know anyone who has ever had a panic attack who likes them. There is not much there to be liked. And be clear, that I am absolutely not asking whether you <u>can</u> do it. That is another issue and we will cross that bridge when we come to it. I am only asking one thing: In a world where it was possible for you to make this choice and follow through—would you choose it?

Client: OK. Well, I'd choose my daughter. But I <u>really</u> don't think I can do it.

Therapist: Yes, I get that you really think that, and it is absolutely OK to think that. In fact, I cannot imagine you would think anything else. There are a couple things that I can guarantee you. I guarantee that that therapy will be difficult, but that we will not do anything difficult that does not connect directly to what you hold most dear in life. I hear how much your daughter means to you. To be willing to have panic in order to be there for your daughter inspires me. I want you to know that if you agree to this work, I will devote myself to working toward the realization of that value. So, if therapy could be about moving towards that relationship, would you be willing to have therapy be about that?

Client: Yes, but I don't see how that can happen unless the panic attacks stop.

Therapist: Sure, and I am not asking you to take this on faith. Give me a period of time, and we will stop and evaluate how things are going. You will look at your own experience and tell me if it feels as though therapy is moving you in a direction that resonates with your deepest desires.

This intervention would be likely to occur within the first session or two. Although the interventions emerging from this session may focus on exposure, defusion, or behavioral activation, the seeds of the therapeutic contract have been planted in this short conversation.

Values and the Therapeutic Contract

ACT is a client-centered treatment in the sense that it is the client's values that direct the therapy. A solid therapeutic contract is consistent with such an approach. The client should never feel that the treatment is being done to them. Equally, the therapist should never feel that he or she is doing something do the client. Exposure is often difficult for therapists as well as clients. It is painful to see clients suffering while participating in work that the therapist asks them to do. Exposure in the context of values gives both the client and the therapist something meaningful to dignify the suffering that treatment produces.

Theoretically, it should make a difference that doing painful therapeutic work is explicitly chosen by the client. Data tell us that people prefer aversives that they control over aversives that they do not control (e.g., Zvolenski, Lejeuz, & Eifert, 1998). Animal studies have also demonstrated less activation of endogenous analgesia, less self-administered drug consumption, less fear, and less perseveration when painful events are controllable as compared to when they are not controllable (Anisman, Hahn, Hoffman, & Zacharko, 1985; Anisman, Hymie, & Waller, 1974; Drugan, Ader, Maier, 1985; Warren & Rosellini, 1988). Taken together, the basic behavioral science evidence suggests that we should make the client's choosing as salient as possible. In the therapeutic contract we are advocating here, the difficulty of treatment is made explicit. However, the adversity the therapist predicts is placed squarely in the context of what the client wants in life, and in so doing, there is a smaller chance that the client will feel victimized by the therapist when the treatment becomes painful. Nietzsche said that a person could stand almost any "how" if they have a "why." The why for the hard work that will follow is supplied by the client's own values and the control that derives from an uncoerced agreement to proceed.

Values, Motivation, and the Hard Work of Treatment

If you went to a dentist with a bad tooth, and the dentist looked around in your mouth, poked, prodded and scraped, but only touched teeth that were healthy, the appointment would be painless, but not particularly useful. Although the dentist may have kept you comfortable, if you paid the dentist for that appointment, your money was stolen, and you walk away with the same troublesome tooth. We use metaphors such as this to illustrate to clients the point that pain is inherent in addressing problems. We do not undersell it. If it turns out to be less painful, no one will complain. But if it turns out to be very painful,

which it well may, they should know at the outset. This should be part of the contract the client has made with the therapist. When the treatment gets painful we ask: "If this pain was between you and the life you want, would you be willing?"

Although there are phases of treatment in which the exploration of values is the focus of treatment, they ought to be touched upon in every session, even if only to remind the client of the valued domain being pursued. If the client's values are obscured by years of struggle with anxiety, depression, alcoholism, or the like, the therapist can still suggest that the therapy will be about revealing this obscured personal sense of life-direction. Therapists should not allow clients to leave the session without it being entirely clear: the treatment is about them and a life they value.

Valued-Events Scheduling

In its simplest form, work with material generated by the VLQ might look like behavioral activation with deeply held personal values as the guiding force. Depending on the nature and intended duration of treatment, the scope of valued events scheduling might be narrow or broad. In the domain of parenting, for example, as described with the agoraphobic case above, we might generate a list of activities that are consistent with the stated value. We might explore what depressed clients have been doing in their interactions with their children. Have they been withdrawn, disengaged, or unavailable? What have they not done, that they would do, if only they were not anxious? How does it feel to be psychologically absent? What would it mean to the aforementioned client and to her daughter for her to be really present? As we examine these sorts of questions, we look for areas where the client's experience is restricted—where they do not feel free to live their values fully. If obstacles emerge such as "this is too painful" or "I just can't do it," we target those negative thoughts and emotions with exposure and defusion exercises. If the client cannot have these thoughts and act effectively in their lives, initiating values-driven commitments will be impossible.

Values-Centered Exposure, Defusion, and Mindfulness

We have sometimes had difficulty getting clients engaged fully in the values work. In previous descriptions of this treatment (Hayes, et al., 1999), we have given written assignments to clients, asking them to discuss their personal values. The problem we sometimes see with this approach is that when addressed

directly, clients will produce a relatively lean, conventional endorsement of valued domains. In the area of parenting, for example, who doesn't want a rich relationship with their children? In order to help the client connect with these values in the context of avoided fearful thoughts and memories, we have devised some therapy sessions that incorporate experiential exercises and emotionally expressive writing as a bridge to discussion of valued ends that will ultimately direct the treatment. The sessions involve exposure, defusion, and mindfulness all centered on creating more flexibility in a valued domain of living. Below is a session strategy constructed for use with the agoraphobic client described above, but it could be readily adapted to other client difficulties.

One of the obstacles expressed by this client upon initiation of the therapeutic contract was her certainty that she would not be willing to experience panic. The words "I can't do this!" occurred as a formidable psychological obstacle to making and keeping commitments to her daughter. In responding literally to the thought that she cannot tolerate panic, she must do what is necessary to avoid panic. To intervene, we chose an event from the client's history that was reminiscent of the upcoming graduation—a missed dance recital. We told the client that we were going to walk her through the missed recital in great detail. If the client balks at a similar exercise, we might ask, "If this exercise could make a difference for you and your daughter, could you be willing to do it? If this exercise could put you in that auditorium, completely present for that graduation, would you be willing?" Prior to the exercise, we gathered detailed information about the phenomenology of panic attacks for this woman—how they begin, thoughts that occur, and any other details that can enhance the exercise.

The form of this exercise is quite flexible. The function is to do exposure, defusion and mindfulness with respect to difficult and avoided psychological material, such as fears about the future and regrets about the past. The purpose of this work is to generate sufficient flexibility to engage in more challenging and more personally meaningful activities. We begin the exercise by asking the client to sit upright with their legs and arms uncrossed and their feet flat on the ground. This posture tends to remain reasonably comfortable and makes interference from the need to adjust positions less likely. The exercise is delivered in a slow, deliberate,

and somewhat sedate tone of voice, with plenty of pauses. Eventually the client is asked to imagine certain details of the experience. The following description offers a brief example:

I want you to notice the sound of my voice. I would like you to follow my instructions. If you find yourself drifting off, thinking of other things, or distracted in any other way, simply return to the sound of my voice. First, I want you to notice the different sounds you can hear around you. (Here, the therapist should pause and listen intently, then slowly catalogue the various sounds heard.) Perhaps you hear voices from other offices around us. Listen to the faint hum of the air conditioning. As you draw your attention inward, see if you can picture the room around you. Try to picture where the chairs are, the carpet, the door. See what else you can notice as you imagine looking around the room. Drawing your attention further inward, notice the position of your body, notice the feel of your clothing, where it touches your skin. See if you can notice slight differences in the temperature of your skin in different places on your body. Notice your breathing. Notice the temperature of your breath…notice that it is warmer as you exhale and cooler as you inhale. Now take three very slow deep breaths and try to picture the path of the air as it enters and leaves your body. If you notice any tension anywhere in your body, imagine that each breath carries a bit of that tension away.

Now I want you to picture yourself on the night before your daughter's dance recital. You are in a room with your daughter. You are telling your daughter that you are very proud of her and that you will be there. I want you to picture her face as you say this. I want you to imagine allowing yourself to slip into the skin of that the woman in this image—talking to her daughter. Notice the look on her face as you speak these words. 'I am proud and I will be there.' Notice things you feel, what you are thinking. Now I want you to imagine that you are at the dance studio on the night of the recital. Your daughter has already gone into the building. Look around and notice who else is there—other parents, dressed up, carrying cameras. As you move towards the entrance, you notice your heart begin to beat more rapidly. It feels as though your temperature is beginning to rise. Notice the feeling of perspiration under your arms. You have a pretty good idea what is coming, but still….let yourself feel the weight of it. Imagine that you decide that you will not go in. Notice how sick you feel as you make that decision. Let yourself imagine your daughter's face as she scans the crowd looking for you. As you walk back to your car, and sit down, let yourself notice how your body

feels. Let yourself notice any emotions you are experiencing. Let yourself notice memories. Perhaps you remember other times that were like this. Let yourself notice any thoughts you are having.

Now allow yourself to imagine that you are at home. Your daughter is there and you tell her that you just couldn't stay. Picture the face of your daughter as you say this. Can you see the pain in her face? Notice how it feels as you see that. Notice the thoughts that you are having. Notice how your body feels. Let yourself picture your daughter. Let yourself notice the way her eyes fill with tears. Let yourself see her as she turns and walks away. Notice the thoughts that you are having. Notice how your body feels. Now stop and spend a moment, allow the thoughts, memories, emotions, and feelings in your body to be there. Just take a moment and allow yourself to feel them all.

After a few moments ask the client to gently, slowly, open their eyes. Without further discussion, hand them the writing materials and ask them to begin writing and leave the room. The therapist should say something like, "I would like for you to write for fifteen minutes. Really let go- write your deepest thoughts and feelings. Also write about any memories, experiences, or worries that showed up during the exercise. Write in as much detail as you can. Allow yourself to really experience your thoughts and feelings. If you can't think of anything to write, just write the same thing over and over until something new shows up. Don't worry about what it looks like, or how things are spelled. If you wish, no one will read what you have written, although it might be helpful for us to talk about together." Without further discussion, hand the client some paper and a pen or pencil and leave the room for fifteen minutes. Ideally, the therapist could observe the client during the writing process. If an observation room is not available, however, the therapist should assess level of engagement during the debriefing process (writing process adapted with permission from James Pennebaker, personal communication, 2001).

Debriefing the exercise. After the writing period, the balance of the session is devoted to mindful exposure to whatever was generated in the exercise and writing. Themes that should be sought are the client's sense of what they hope for in the area of interest (parenting in this instance). Critical themes relate to the client's values (e.g., what she hoped for in the area of parenting). The questions eventually asked of the client

include: “What if it were necessary for you to be willing to feel this pain in order to succeed as a parent? Would it be worth it? Would you be willing?”

Success is not guaranteed. However, we can guarantee that pursuing parenting challenges will bring up thoughts of parenting failures, both recollected from the past and projected into the future. If one cannot tolerate thoughts, emotions, and memories related to failure, one must give up parenting challenges. If, by contrast, one can “make room” psychologically for feelings of failure, taking up challenges, and therefore success, becomes possible (not guaranteed, but possible).

Additional sessions of this exposure/values exercise involved the identical session structure. The only difference was that instead of focusing on memories of past failures, the additional sessions of this exposure/values exercise focused on thoughts of future failure. So, for example, a session involved an exercise where the identical thing happens on graduation night. It is important in doing this work, just as with any exposure work, that the duration of the session be dictated by the client’s reaction to the material. Just as in an exposure session, we don’t expose the client to the snake and then terminate the session at the point where they are most aroused and most want to leave. Instead, we ride the wave of arousal and disposition to avoid to the crest of the wave, and down the other side. Although these exercises are extraordinarily painful, the exposure they contain can generate the same flexibility we see when we do exposure to external phobic objects. Willingly remembering painful events, in the service of a worthy cause, fundamentally alters the client’s relationship with those aversive events. This is suffering, but with a purpose. We have seen clients leave sessions such as these and spontaneously engage in activities that they have been avoiding for years. It is not so much the places and activities they fear, but their reactions to these places and activities. If we can use these technologies to build a broad and flexible repertoire with respect to the client’s reactions, they become free to pursue the sort of activities we prescribe in the behavioral activation component of the treatment.

Values, Choice, and Freedom

I will conclude with a comment about the client who cannot decide what to do. At times, values seem to rage as if at war with one another. A recent case of this sort involved a woman trying to decide whether to stay in a 30-year marriage or to take her children and leave. Her question was “Should I or

shouldn't I divorce?" My posture in session on this was—"I believe that you could divorce with integrity, or divorce without integrity, or stay with integrity, or stay without integrity. My commitment is to coach you in doing whatever you do with integrity." Integrity, or the lack of it, is not to be found in the properties of the response. Instead, it lies in the functional relation between the response and deeply held values--or conversely, a functional relation to deeply held fears. I expect little benefit for someone who has lived without integrity in a marriage if they leave the marriage blaming their partner for a screwed up life. That will function in ways similar to staying and blaming the partner for a screwed up life (and will be equally non-vital).

Now, that said, there is suffering inherent in every choice, including the choice not to choose. We may cut off something of extraordinary value in a choice. We may feel that we are making a values-driven choice and find later that we were completely blind and acting in a self-righteous and mean-spirited way. (We sweat as we recollect such events in our own histories.) The possibility of one of these negative outcomes is psychologically inherent in the choice—it is why the choice is hard (and avoided). Now the issue of living with integrity falls back a step and we need to examine the integrity of not choosing in the service of fear—is that what we want our life to stand for? We may need to do exposure and defusion in this frightening region where delightful and tragic possibilities dance—that place on the brink of choice.

This is a hard place to stay. Two inclinations predominate. One is to back up from choosing and dwell in the land of should I/shouldn't I, making little lists in our head of the reasons we should and reasons we shouldn't in vain hope that the scales will finally tip decisively and will tell us the truth about the choice we should make. A second option is to just choose--but in the service of ending the burden this frightening psychological space engenders. But is that what we want our life to stand for? We explore both of these with clients. We first take imaginal trips in expeiential exercises where we walk up to the edge of choice, experience the anxiety, the pressure; we then back up into rumination and worry and add up the pluses and minuses. We examine the vitality of that act. Then, again, we walk, in an experiential exercise, to the edge of choice. Again, feel the anxiety, notice the memories, how the body feels, this time, at the peak of anxiety, we choose a direction—explicitly in the service of ending the anxiety. And then, notice what happens. Relief, but also, the thought, "What if I would have chosen the other way?" In both of these scenarios, the choice occurs

psychologically as a "must" and as a "must do correctly"--these are both psychological aspects of the choice that beg for defusion and exposure. They occur psychologically as a lack of freedom. There is a third path. Camus describes it best in The Absurd Reasoning: "The real effort is to stay there, rather, in so far as that is possible, and to examine closely the odd vegetation of those distant regions. Tenacity and acumen are privileged spectators of this inhuman show in which absurdity, hope, and death carry on their dialogue" (Camus, 1955, p. 8). What if we can, by defusion and exposure, create a psychological space where the client can stand rather than have to jump forward or backward? To me that is the place from which choices with the most vitality emerge—that place where even whether to choose occurs psychologically as a choice.

The Role of Values in Acceptance, Mindfulness, and Relationship

This chapter has focused on the potential relationship between values-oriented interventions and behavior therapy procedures. Throughout, we have attempted to make the connection between values and emerging issues in the behavior therapy movement. Values work has the potential to fundamentally alter our client's relationship with adversity. Answers to questions about acceptance are always context dependent. When acceptance of adversity is placed in the context of making a difference in an important life domain, acceptance becomes more acceptable. Mindfulness can be practiced for its own sake, but we do therapy to make a difference in people's lives. Values work can provide targets for mindfulness, when "mind traps" obstruct our client's ability to move forward in their lives. Finally, in the domain of relationships, both the therapeutic relationship as well as other relationships in our client's lives, focusing on values can make the hard work inherent in relationships possible.

If we are correct in our assessment of the need for such interventions, we are left with the task of producing a robust science of human purpose, meaning and values. Such a science could potentially help us to open up our clients' lives. Individuals live in a psychological world. In that world they "couldn't" have done anything except what they have been doing. When we teach mindfulness, or do exposure or defusion of other sorts, the client's psychological world expands. They come to inhabit a world with more flexibility and therefore more possibilities. It may seem odd to speak of liberation and behavior therapy in the same

sentence. However, the client who has two options instead of one has been liberated in a very real sense. Such liberation is the aim of this work.

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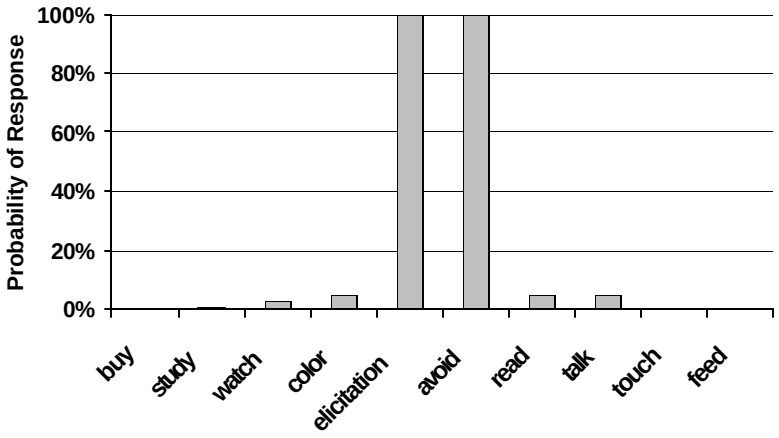

Figure 1. Pre-exposure, the snake phobic shows a narrow set of responses with a near 100% probability of occurrence.

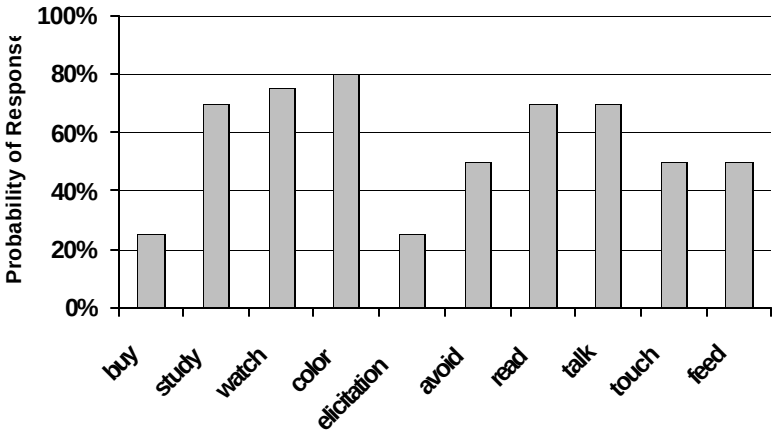

Figure 2. Post-exposure, the snake phobic shows a broad and flexible set of responses. The breadth of potential responses allows for other features of context to exert control over the actual response emitted.