

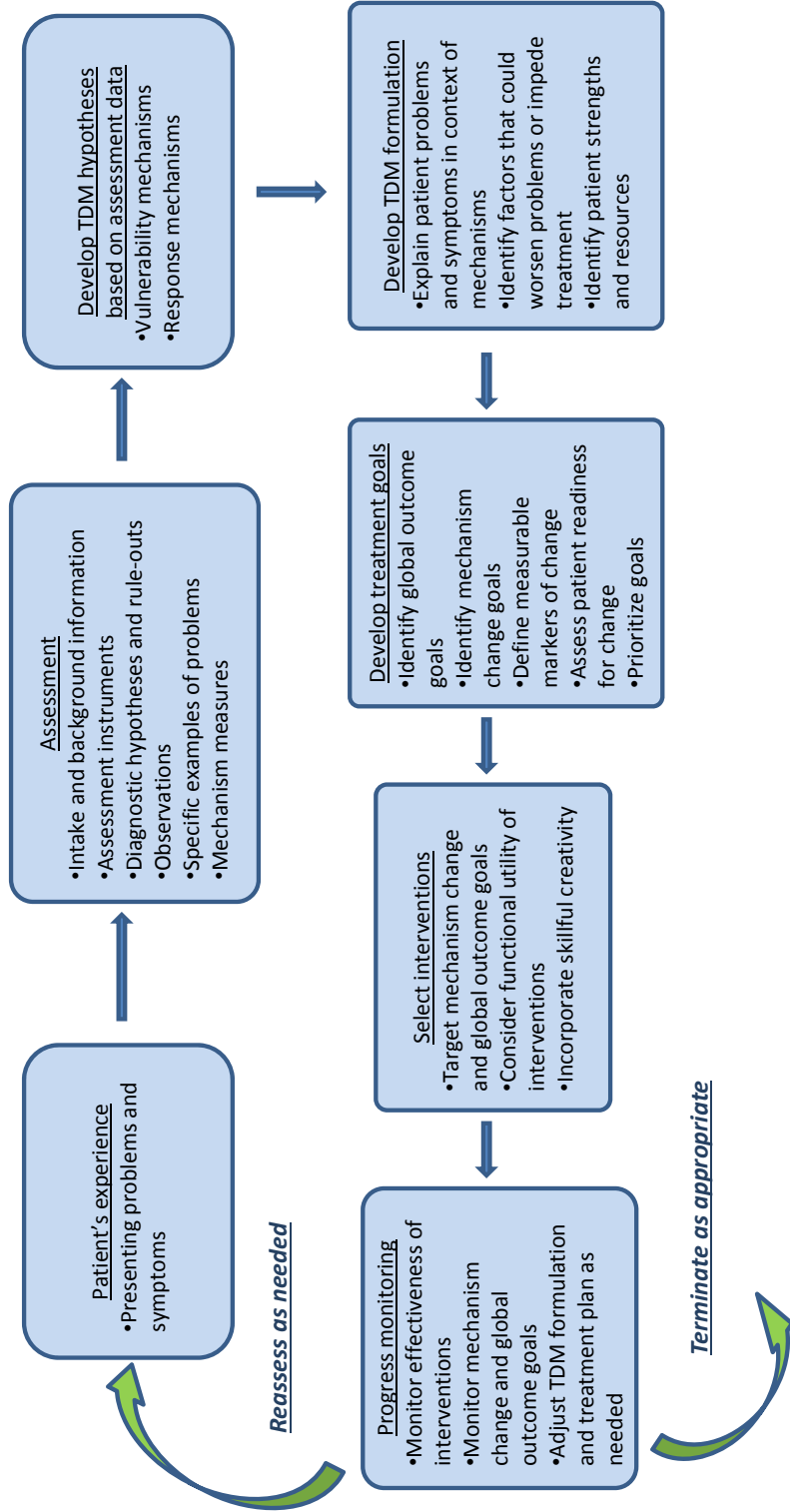
from both transdiagnostic and disorder-specific models) underlying patients' problems; and selecting interventions to effectively target those mechanisms, facilitate achievement of treatment goals, and improve patients' functional abilities and quality of living. The transdiagnostic road map offers this long-awaited and much-needed solution.

A Transdiagnostic Road Map to Case Formulation and Treatment Planning

Like most evidence-based practitioners, we have struggled to stay abreast of the scientific literature in figuring out which psychological mechanisms might be driving presenting problems and which interventions are most effective and appropriate for any given patient. To meet this need, we developed the construct of transdiagnostic mechanisms (TDMs), which integrates principles from the literature on transdiagnostic processes and psychological mechanisms with current knowledge about theory-driven and disorder-based treatments. We define TDMs as underlying vulnerabilities and patterns of responses that are hypothesized to trigger and maintain cognitive, behavioral, emotional, and physiological symptoms and functional impairments across diagnostic categories. TDMs are psychological processes that may be targeted in treatment using our unique classification system, which enables clinicians to select interventions based on the actions needed to target mechanisms identified in the transdiagnostic formulation and achieve each patient's desired outcome goals.

Identification of TDMs is the driving force of transdiagnostic case formulation. Our clinical road map guides clinicians through the psychotherapy process from intake through termination and incorporates therapist and patient creativity to enhance interventions and further refine treatment planning. We illustrate how to conduct clinical assessments that generate TDM hypotheses to explain patients' presenting problems, and we teach therapists how to use mechanism hypotheses for guidance in collaborating with patients to develop goals, choose interventions from evidence-based options, and individualize treatment plans to best meet patients' needs, help them resolve problems, and improve their lives. Here we present a schematic of the transdiagnostic road map that highlights the central role of mechanism identification in case conceptualization and treatment planning.

The Role of TDMs in Treatment Planning



Transdiagnostic Mechanisms

Vulnerability Mechanisms

Neurophysiological predispositions

Deficits in:

- Arousal regulation and inhibitory control
- Executive functioning
- Information processing, storage, and retrieval
- Emotion regulation
- Sleep regulation

Learned responses

- Respondent (classical) conditioning
- Operant conditioning
- Modeling

Pervasive beliefs

- Negative schemas
- Metacognitive beliefs

Specific cognitive constructs

- Anxiety sensitivity
- Perceived control
- Intolerance of uncertainty
- Perfectionism
- Fear of evaluation
- Negative problem orientation
- Inflated responsibility and threat estimation
- Sensitivity to illness or injury

Multidimensional construct

- Distress tolerance

Response Mechanisms

Experiential avoidance

- Avoidance and escape strategies
 - Safety seeking
 - Reassurance seeking
 - Compulsions
- Behavioral (situational) avoidance
- Cognitive avoidance
 - Thought control
 - Thought suppression
 - Worry (as a function)
- Interoceptive (somatic) avoidance
- Emotional avoidance
- Emotion-driven behaviors

Cognitive misappraisals

Attentional focus

Attributional bias

- Internalizing (self-attacking)
- Externalizing (attacking others)

Repetitive negative thinking

- Worry (as a process)
- Rumination
- Post-event processing

We view TDMs as representing both vulnerability and response components of problems, which are interconnected and contribute to continuous feedback loops that further perpetuate those problems—and often give rise to additional difficulties. Developing hypotheses about how vulnerability and response mechanisms collectively may influence each other furthers therapists' understanding of the larger clinical picture. While transdiagnostic formulation centers around TDMs, it also includes internal variables, such as genetic risk for certain problems, environmental stressors, and cultural considerations.

It is beyond the scope of this book to provide detailed literature reviews of the mechanisms described herein. Research on mechanisms is advancing at a rapid rate, and it is virtually impossible to create an exhaustive list. We encourage you to stay abreast of these developments to enhance your understanding of patients' problems and the forces driving them. By focusing on TDMs, we seek to bridge the gap between clinical science and practice, facilitate achievement of patients' goals, and improve clinical outcomes.

We discuss vulnerability mechanisms in this chapter and address response mechanisms in chapter 3, including measures of these constructs where possible. These chapters provide the empirical foundation for our compilation of TDMs and serve as a quick reference to help you learn about specific mechanisms, facilitate assessment of patients' problems, and guide your decisions about TDMs and how to best treat them. Many vulnerability mechanisms evolved from research on distinct disorders and problem-specific symptoms, though their transdiagnostic nature is becoming increasingly apparent. While vulnerability constructs such as “neuroticism,” a dimension of temperament involving the propensity toward negative emotional states (e.g., anxiety, depression), have been implicated as biological vulnerabilities contributing to the prediction of psychological disorders (Barlow, 2002; Brown & Naragon-Gainey, 2013), the TDMs described below represent specific vulnerability components of problems that are most amenable to direct clinical interventions.

Neurophysiological Predispositions

Some vulnerability mechanisms are neurophysiological, reflecting deficits in regulatory factors involved in arousal and inhibition, executive functioning, emotion and sleep regulation, and information processing, storage, and retrieval. Neurophysiological mechanisms have been identified as potential mediators of symptom change, and targeting them directly in treatment can yield significant improvements in patient functioning across multiple disorders,

including anxiety, depression, addiction, and psychosis (Siegle et al., 2007). They often evoke response mechanisms, such as emotion-driven behaviors (e.g., cutting), related to limbic hyperarousal and cortical disinhibition. Targeting neurophysiological mechanisms and explaining them to patients can reduce patients' sense of failure and help therapists understand potential treatment roadblocks, such as when patients experience difficulty completing homework or do not respond to interventions as anticipated. For example, impaired executive functioning might prevent a highly motivated patient from completing a thought record, and deficits in information processing, storage, or retrieval could interfere with the ability to learn and implement strategies to tolerate uncertainty. Often, multiple vulnerabilities maintain presenting problems, and treatment frequently involves teaching compensatory strategies rather than eradicating deficits (Solanto, 2011).

Arousal Regulation and Inhibitory Control

Deficits in arousal regulation and inhibitory control disrupt self-regulation and behavioral inhibition and are implicated in ADHD (Barkley, 1997; Solanto, 2011). Disinhibition also is associated with anxiety and mood disorders, substance abuse, antisocial behavior, schizophrenia, and PTSD (see Nigg, 2000, for a review). Impulsivity correlates with neural substrates for multiple disorders (Moeller et al., 2001) and with increased suicidal behavior in bipolar and other patients (Swann et al., 2005). Emotional hyperarousal has been linked transdiagnostically with worry (Turk et al., 2005), and emotional and physiological hyperarousal can lead to insomnia, especially in the absence of effective coping skills to downregulate arousal (Morin & Espie, 2012). Poor arousal regulation after stressful life events appears to be correlated with sleep disturbances and increased manic symptoms in bipolar patients (see Levenson et al., 2013, for a review).

Craske and Barlow (2008) suggest that the seemingly heightened awareness of somatic sensations of arousal accompanying panic attacks (Ehlers & Breuer, 1992) may be a predisposing factor in panic disorder. This seems related to problematic respiratory control mechanisms, which reduce blood levels of carbon dioxide, a condition known as hypocapnia (Klein, 1993; Ley, 1985), triggering multiple physiological changes that contribute to cognitive misappraisals of panic sensations (Meuret et al., 2010). Similarly, inadequate modulation of cardiac function during respiration has been implicated in emotion dysregulation across a range of problems, including antisocial behavior (Crowell et al., 2006), parasuicidal behavior (Crowell et al., 2005), anxiety and worry

(Thayer et al., 1996), depression (Rottenberg et al., 2002), and panic (Yeragani et al., 1993). The rapid spike in emotional arousal and slow return to baseline commonly seen in borderline personality disorder (BPD) have been linked to deficits in downregulation of limbic structures and poor modulation of maladaptive behavioral action urges (Linehan et al., 2007).

Executive Functioning

Executive functioning includes navigating new situations, analyzing problems and selecting strategies to solve them, inhibiting incorrect and inappropriate behaviors, and assessing performance and adjusting future planning accordingly. While executive functioning deficits are most notably associated with ADHD, which involves impairments in motivation, working memory, and self-regulation (Barkley, 1997), they also occur in depression, anxiety, eating disorders, and substance abuse (which often accompany ADHD) and may be directly targeted in treatment (Solanto, 2011).

Anxiety has been shown to decrease executive functioning (Eysenck et al., 2007). Executive functioning deficits also occur in schizophrenia and OCD (see Gotlib & Joormann, 2010, for a review), as well as in compulsive hoarding (Grisham et al., 2007) and PTSD (Aupperle et al., 2012). Frontal brain regions that govern cognitive and emotional executive functioning and are involved in emotion regulation have been implicated in BPD psychopathology (Salavert et al., 2011) and seem related to widespread impairments in executive functioning in those patients (Quiraishi & Frangou, 2002).

Information Processing, Storage, and Retrieval

Information processing deficits are linked with multiple psychological problems. For example, impaired visual organization and problem solving occur in OCD (Rampacher et al., 2010). Memory biases involving encoding and retrieval of emotionally significant information have been demonstrated across anxiety and mood disorders, including depression, social phobia, and panic (Matthews & MacLeod, 2005). Faulty neural networks governing visuo-spatial working memory have been implicated in intrusive images and visual memories across anxiety disorders, eating disorders, depression, and psychosis (Brewin et al., 2010), and increased limbic activation during encoding of trauma-related information is associated with development of flashbacks (Bourne et al., 2013).

Negative information-processing biases are characteristic of both unipolar and bipolar depression and create cognitive risk factors for higher lifetime rates of depression (see Alloy et al., 2006, for a review). These biases deplete cognitive resources and prevent reflective processing that could provide corrective information (Beevers, 2005). Depressed individuals also demonstrate deficits in inhibitory control of irrelevant information, which interferes with selective attention and working memory and may explain the characteristic proneness toward rumination, difficulties disengaging from negative material, and emotion regulation problems (Gotlib & Joormann, 2010).

The hallmark symptoms of PTSD (e.g., intrusive memories and images, dissociation) have been linked to faulty information processing and retrieval, which may explain why many trauma survivors experience significant gaps in autobiographical memory and are prone to selective attention toward threat-related cues (Brewin et al., 1996; Ehlers & Clark, 2000). Similar disruptions occur in social phobia: recurrent intrusive images of negative social events accompany the development or worsening of symptoms and lead to avoidance of social stimuli or situations, which prevents appropriate encoding of this information into autobiographical memory and further exacerbates symptoms (Wild et al., 2007). Intrusive memories and images occur in bipolar depression, and intrusive and vivid positive images seem to disrupt circadian rhythms and trigger hypomania (Gregory et al., 2010). Foa and Kozak (1986) proposed a “fear network” of trauma-related memory structures that colors schemas of the self (as incompetent) and the world (as dangerous), interrupting assimilation of new information. The efficacy of CBT in treating PTSD has been linked to its ability to create alternative mental representations that compete with trauma-related negative memories and images (Brewin, 2006).

Emotion Regulation

Emotion regulation (ER) deficits are core features of bipolar spectrum conditions (Goodwin & Jamison, 2007) and borderline personality disorder (Linehan, 1993a). Disruptions in dopamine and serotonin systems responsible for regulating emotion are associated with many of the hallmark symptoms of bipolar disorder, including depression, mania, and increased appetitive behavior (Miklowitz & Johnson, 2006). The characteristic emotional hypersensitivity and associated behavioral dysregulation in BPD have been linked to increased amygdala activation (Herpertz et al., 2001). Trauma-related changes in neural structures are associated with hyperarousal, dissociation, and emotional numbing and dysregulation in PTSD (Malta, 2012). ER deficits predict

symptom severity and functional impairments in PTSD (Cloitre et al., 2005), and identifying and targeting the mechanisms underlying emotion dysregulation may improve treatment outcomes for complex PTSD (Bryant, 2010). Problems with experiencing, differentiating, attenuating, and modulating emotions occur in anorexia nervosa and major depression and can distinguish patients in both groups from nonclinical controls (Brockmeyer, Bents, et al., 2012). ER deficits have been implicated in patients with skin-picking problems and trichotillomania (Snorrason et al., 2012), supporting the utility of DBT-enhanced habit-reversal treatments that improve emotion regulation (Keuthen et al., 2012).

Sleep Regulation

Emotion regulation and sleep regulation are closely related. For example, excessive emotional reactivity may be an underlying mechanism in insomnia and other sleep disorders (Gehrman et al., 2012). Deficits in sleep architecture and regulation have been linked with ER problems in bipolar illness, major depression, ADHD, and psychosis, suggesting sleep as a causal transdiagnostic mechanism and supporting therapies that target circadian rhythms and light exposure and restriction to reduce psychiatric symptoms (Harvey et al., 2011). Sleep disturbances have been linked with increased mania via multiple pathways (Levenson et al., 2013). Sleep disruptions and regulatory dysfunction also are associated with schizophrenia, often preceding psychotic episodes, and may play a role in its etiology (Lunsford-Avery & Mittal, 2013).

Learned Responses

Learned responses are acquired throughout life and can be specific to certain events or generalized across situations. Therapy includes identifying consequences of learned responses to reveal contextual and functional patterns of problematic behavior, and to encourage and test new learning to reduce distress and improve functioning and quality of living. Understanding learned responses can contribute to hypotheses about other vulnerability mechanisms (e.g., schemas, perceived control, intolerance of uncertainty) and associated response mechanisms (e.g., avoidance, safety seeking, cognitive misappraisals), further informing treatment decisions.

Barlow's triple vulnerability model of emotional disorders (2000, 2002) highlights the role of early learning experiences in a diminished sense of the predictability or controllability of stressful events, which is a general psychological vulnerability to developing chronic anxiety or depression. For example, children learn from their parents (and others) to fear physiological sensations, seek medical reassurance, avoid uncomfortable situations, or strengthen certain dysfunctional thoughts or beliefs. Early learning influences the focus of patients' distress and the development of distinct psychological vulnerabilities that underlie specific disorders (e.g., anxiety sensitivity in panic, fear of negative evaluation in social anxiety). Understanding how problematic behaviors are learned helps clinicians choose interventions that will best address patients' experiences. Three major learning theories inform these efforts: respondent (classical) conditioning, operant conditioning, and observational learning. (For a comprehensive review of behavioral principles and their application to clinical practice, see Ramnerö & Törneke, 2008.)

Respondent (Classical) Conditioning

Respondent (classical) conditioning underlies many psychological problems, especially maladaptive fear responses that result when a previously neutral stimulus gets paired with aversive stimuli. For example, when fear is elicited during a panic attack, previously neutral physiological sensations such as respiration and heart rate subsequently can evoke fear via interoceptive conditioning. Thus, a panic attack on a particular bridge may lead to the avoidance of all bridges because of their generalized association with panic sensations, and a seemingly innocuous object such as a baseball cap can elicit fear if an assailant was wearing one during a robbery. Many PTSD symptoms result from the association of previously neutral stimuli with fear and anxiety due to the trauma-related context of their initial pairing (Foa & Kozak, 1986).

Operant Conditioning

Operant conditioning affects behaviors via the types of consequences received for engaging in them. Mowrer's two-factor theory (1960) often is cited to explain coping responses in anxiety disorders, highlighting the role of respondent conditioning in the development of feared associations, and that of operant conditioning in reinforcing avoidance and escape behaviors. In Lewinsohn's theory of depression (1974), either a reduction in positive

reinforcement or an increase in aversive consequences may lead to depression by triggering response mechanisms such as behavioral withdrawal. (Positive reinforcement increases occurrences of a behavior by adding something appetitive, whereas negative reinforcement does so by removing something aversive.) Negative reinforcement maintains avoidance of situations that evoke fear, anxiety, and other unpleasant emotions. Punishment adds an aversive consequence for the purpose of decreasing or eliminating behaviors. Recognizing patterns of problematic behaviors increases therapists' understanding of how patients learn them (e.g., not being able to assert personal limits because speaking up as a child resulted in ridicule and withdrawal of affection) and suggests possibilities for interventions to achieve desired behavioral objectives (e.g., skills training to increase assertiveness and interpersonal effectiveness).

Modeling

People also learn by observing and imitating behaviors modeled by others (A. Bandura, 1977). Consequently, observing how caregivers and other significant individuals respond to situations can contribute to the development and maintenance of problematic behaviors and coping styles. For example, witnessing parents yell and hit others when they are frustrated and angry serves as a model for children to use similar verbal and physical responses to such feelings. Likewise, if a caregiver avoids speaking up for herself when blamed or criticized, her children may learn to imitate her behavior in similar situations. Modeling is one of several ways that family context has been shown to affect children's emotional adjustment and development of emotion regulation skills (Morris et al., 2007). Learning also can occur outside of direct experience (e.g., via what individuals are told by others or read in the media). The developmental, familial, and social context of observational learning sheds important light on patients' learned responses and coping style.

Pervasive Beliefs

Pervasive beliefs are deeply entrenched core ideas influencing thinking patterns, behaviors, mood, and interpretations of events. When activated, these constructs elicit response mechanisms, symptoms, and functional impairments.

Negative Schemas

Aaron Beck's model of depression (1964) identifies schemas as underlying cognitive structures that develop early in life and affect people's interpretation of their experiences. Schema content can include core negative beliefs about oneself (e.g., *I'm worthless and unlovable*), others (e.g., *People are uncaring and judgmental*), the world (e.g., *The world is dangerous and punishing*), and the future (e.g., *Things will never get better*). Schemas typically are activated by external life events, though internal experiences such as emotional responses (e.g., shame) also can trigger and strengthen them (e.g., *I am bad*). Negative core beliefs generally fall into three broad categories: helplessness, unlovability, and worthlessness (J. S. Beck, 2011), and a person's schema content can span multiple categories. Negative schemas have been linked with trauma disorders (Foa et al., 2007), anxiety disorders (A. T. Beck et al., 1985), and personality disorders (A. T. Beck et al., 2006).

When triggered, schemas can act as a lens that distorts reality to conform with and confirm existing schemas. Schema activation evokes negative emotions and response mechanisms such as cognitive distortions and avoidance behaviors. For example, if Tim believes he is unlovable and others always reject him, a delayed response from a friend whom he texted might lead Tim to conclude that his friend no longer likes him, thus "proving" the schemas *I'm unlovable* and *Others are rejecting*. Tim may then withdraw from the relationship, avoid other friends, or selectively scan for evidence of other perceived rejections, potentially leading to depression, social anxiety, conflicts with coworkers, or a slew of other emotional and behavioral problems. Therapists often can identify schemas through patients' automatic thoughts affiliated with negative emotional experiences (A. T. Beck et al., 1979; J. S. Beck, 2011).

Metacognitive Beliefs

Metacognition involves beliefs about one's own cognitions (Wells, 2000) and influences how individuals respond to their thoughts and feelings. Wells (2009) describes how metacognition drives repetitive styles of thinking that maintain a sense of threat (e.g., worry, rumination, attention to threat) and contribute to efforts (i.e., response mechanisms) aimed at controlling, suppressing, or undoing thoughts. For example, both positive beliefs about worry (*Worry is helpful; I need to worry so I'll be prepared and not taken by surprise*) and

negative beliefs about worry (*Worry is harmful; I need to stop worrying*) can maintain worry and fuel attempts to control or suppress it. Metacognitive beliefs about emotions are also targeted in treatment (e.g., Greenberg, 2002; Linehan, 1993a). Manser and colleagues (2012) examined beliefs about emotions, revealing six dimensions: overwhelming and uncontrollable; shameful and irrational; invalid and meaningless; useless; damaging; and contagious.

Metacognitive beliefs about the meaning and danger of thoughts and the usefulness of rituals are a central feature of OCD (Wells, 1997). Importance and control of thoughts is one of three cognitive constructs associated with OCD (Obsessive Compulsive Cognitions Working Group [OCCWG], 1997, 2005) and is measured using the Obsessive Belief Questionnaire – 44 (OBQ-44; OCCWG, 2005). Patients interpret intrusive thoughts as meaningful and significant and fuse thoughts with actions and moral equivalents, such as *If I have a bad thought, it means that I might act on it, or that I'm a bad person* (Rachman, 1993). These interpretive beliefs are referred to as thought-action fusion (TAF), in which having a disturbing thought is believed to increase the probability of its occurrence or is the moral equivalent to carrying it out (Rachman et al., 1995); this construct can be assessed using the TAF Scale (Shafran et al., 1996). While TAF is an important construct in OCD symptomatology, its superstitious quality reflects its broader reach to other disorders as well, including GAD, panic disorder, and eating disorders (Shafran & Rachman, 2004).

Specific Cognitive Constructs

Mostly derived from investigation of psychological mechanisms underpinning singular disorders, specific cognitive constructs are trait-like attributes that increasingly are the focus of transdiagnostic study. These TDMs interact with environmental, developmental, interpersonal, and physiological variables to increase the risk of developing numerous emotional and behavioral problems (Alloy & Riskind, 2006). Moreover, they appear amenable to clinical intervention and may be targeted as stand-alone psychological problems in individuals who are predisposed to react to them with heightened anxiety, shame, and other potentially problematic emotions (e.g., anger) and associated behaviors (e.g., avoidance, checking, criticism of self and others).

Anxiety Sensitivity

Anxiety sensitivity (AS) is the fear of anxiety-related sensations due to beliefs that experiencing anxiety can have negative implications (Reiss et al., 1986). It involves fears of somatic, cognitive, and social consequences of anxiety, though some dimensions are more specific to certain disorders, such as somatic fears in panic disorder, and fears of publicly observable anxiety reactions in social phobia (Deacon & Abramowitz, 2006). AS can be assessed via the Anxiety Sensitivity Index – 3 (ASI-3; Taylor et al., 2007).

AS is one of three fundamental fears within Reiss and McNally's expectancy model of fear (1985): fear of anxiety or fear itself (AS), fear of injury or illness, and fear of negative evaluation. That model expanded anxiety research beyond learning theory to include expectancy and information processing. For example, avoidance can be motivated by expectations of what individuals think will happen and why they are afraid of anticipated events. Thus, AS may be a risk factor for anxiety disorders, and not just a consequence of experiencing panic or anxiety (Reiss, 1991). AS is associated with fearfulness, phobias, and substance abuse (Reiss, 1991), and consistently strong correlations occur with agoraphobia, GAD, panic, and PTSD (Naragon-Gainey, 2010).

AS can predict depressive symptoms (Reardon & Williams, 2007) and has been demonstrated as a vulnerability factor for compulsive hoarding (Medley et al., 2013). It correlates with thought suppression to additively predict anxiety symptoms (Keough, Timpano, et al., 2010) and raises the risk for substance use disorders (Schmidt, Buckner, et al., 2007). AS also increases drug withdrawal symptom severity and relapse risk, and decreases tolerance of withdrawal symptoms (Stewart & Kushner, 2001). Based on its role in the etiology and maintenance of anxiety disorders, substance abuse, and mood disorders, Schmidt, Eggleston, and colleagues (2007) developed a prevention program to target AS as a transdiagnostic cognitive vulnerability. CBT interventions are efficacious in reducing AS, although the mechanisms of change remain unclear (Smits et al., 2008).

Perceived Control

Barlow (2000, 2002) posited a diminished sense of control over aversive events and emotional experiences (due to early learning) as a general psychological vulnerability factor for emotional disorders, including chronic anxiety and depression. Perceived control is implicated as a vulnerability factor for

anxiety, based on the contributing role of early experiences of diminished control in increasing the likelihood of interpreting future events as being out of one's control (Chorpita & Barlow, 1998). The Anxiety Control Questionnaire – Revised (ACQ-R; Brown et al., 2004) assesses perceived emotional control and its specific factors: control of emotion, threat, and stress control. Both AS and deficits in perceived control have been shown to predict panic disorder symptoms, and their interaction may increase symptom severity (Bentley et al., 2013). Perceived threat control seems to moderate the relationship between AS and agoraphobia, and perceptions of emotions and situations as being uncontrollable and unpredictable may be a generalized psychological vulnerability factor (White et al., 2006).

Perceived control is receiving increasing support as a treatment target that may enhance treatment outcomes. For example, perceived control was demonstrated as a mediator of change in panic disorder symptoms in both capnometry-assisted respiratory training and cognitive training, suggesting that treatment aiming to enhance perceptions of control over external and internal experiences may yield greater reductions in panic symptoms (Meuret et al., 2010). An acceptance-based protocol targeting mechanisms associated with GAD yielded significant improvements in perceived control over anxiety and tolerance of uncertainty, and decreases in emotion regulation difficulties and fears of emotional responses, suggesting that perceived control may be multifaceted and that learning to accept and cope with anxiety may increase a sense of efficacy (Treanor et al., 2011).

Intolerance of Uncertainty

Considerable evidence points to intolerance of uncertainty (IU) as a trans-diagnostic vulnerability and maintaining factor across anxiety disorders (social anxiety, panic, agoraphobia, GAD, and OCD) and depression (e.g., Boelen & Reijntjes, 2009; Carleton et al., 2012; Mahoney & McEvoy, 2012). Varying definitions and conceptualizations of IU exist, including a view of it as “the tendency to react negatively on an emotional, cognitive, and behavioral level to uncertain situations and events” (Dugas et al., 2004, p. 143). Given that some degree of uncertainty exists in everyday life IU “is likely to lead to heightened distress and worry” (Buhr & Dugas, 2006, p. 223). Some dimensions of IU overlap with intolerance of ambiguity (IA; Grenier et al., 2005), though the constructs are different: IA involves experiencing *current* situations as threatening due to their ambiguous features; IU involves a sense of threat related to the unpredictability of *future* events (Grenier et al., 2005). This distinction

may be helpful when determining the content and triggers of core fears or beliefs underlying problematic behaviors.

IU has been implicated in the development and maintenance of worry (Behar et al., 2009; Buhr & Dugas, 2006; Meeten et al., 2012) and may pose a cognitive vulnerability to worry via biased information processing (Koerner & Dugas, 2008; van der Heiden et al., 2010). The IU model of GAD (Dugas et al., 1998) also implicates positive beliefs about worry, negative problem orientation, and cognitive avoidance as constructs contributing to clinical worry (Dugas et al., 2005). A cognitive behavioral protocol (CBT-IU) targeting IU and its related constructs (worry, metacognitive beliefs about worry, negative problem orientation, cognitive avoidance) has been shown to be efficacious in treating GAD (Robichaud, 2013).

The Intolerance of Uncertainty Scale – 12 (IUS-12; Carleton, Norton, et al., 2007) assesses reactions to uncertainty, ambiguous situations, and the future. It has two factors: prospective anxiety (anticipation of uncertainty) and inhibitory anxiety (inaction in the face of uncertainty). Prospective anxiety has been associated with GAD and OCD symptoms, while inhibitory anxiety shows associations with social phobia, panic disorder, agoraphobia, and depression (McEvoy & Mahoney, 2011). Specific components of IU, including situation-specific IU, may play important roles in the maintenance of different disorders (Mahoney & McEvoy, 2012).

IU and perfectionism combine as a factor underlying OCD symptomatology, which is measured using the Obsessive Beliefs Questionnaire – 44 (OBQ-44; OCCWG, 2005). This measure defines IU as the “belief that uncertainty, newness, and change are intolerable because they are potentially dangerous” (OCCWG, 1997, p. 669). Because IU correlates with GAD, OCD, and major depression, it potentially sheds light on comorbidity among those conditions and implicates IU as a general cognitive vulnerability to disorders of negative affect (Gentes & Ruscio, 2011).

Perfectionism

Perfectionism is a transdiagnostic risk and maintaining factor for anxiety disorders, depression, and eating disorders and is associated with poorer treatment outcomes for those conditions (Egan et al., 2011). Perfectionism also has been linked to body dysmorphic disorder, chronic fatigue syndrome, bipolar disorder, and suicidal ideation (Egan et al., 2012), as well as OCD (see Frost et al., 2002, for a review), social anxiety (see Frost et al., 2010, for a review), and eating disorders (see Bardone-Cone et al., 2007, for a review). In PTSD,

elevated perfectionism seems to be mediated by rumination (Egan et al., 2013), demonstrating one of many ways that vulnerability and response mechanisms interact.

Definitions of perfectionism vary according to the measures used to assess the construct. In OCD it has been defined as “the tendency to believe there is a perfect solution to every problem, that doing something perfectly (i.e., mistake-free) is not only possible, but also necessary, and that even minor mistakes will have serious consequences” (OCCWG, 1997, p. 678). In the OBQ-44, perfectionism is measured in conjunction with IU (OCCWG, 2005). Other measures that assess perfectionism outside the context of a specific disorder include the Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990) and the Multidimensional Perfectionism Scale (MPS; Hewitt & Flett 1991), which incorporate different and overlapping dimensions of perfectionism. Personal standards and evaluative concerns best capture the two factors supported in the literature, with self-critical evaluative concerns being an important focus of clinical attention (Dunkley et al., 2006).

Shafran and colleagues (2002) proposed a clinical definition of perfectionism emphasizing “overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed, standards in at least one highly salient domain, despite adverse consequences” (p. 778). This construct incorporates self-criticism when those standards are not met, differentiating it from individuals’ healthy desire to excel and achieve high standards. The Clinical Perfectionism Questionnaire (CPQ; Fairburn et al., 2003) assesses the degree to which self-worth is established through achieving high standards, avoidance of performance-related goals, and feelings of failure. Because it is both a TDM and stand-alone problem, clinical perfectionism often is a primary treatment target. Treatment outcomes for clinical perfectionism, including reduced anxiety, depression, and eating disorders, underscore its relevance as a transdiagnostic mechanism (Egan et al., 2012; Riley et al., 2007; Steele et al., 2013).

Fear of Evaluation

Evaluative concerns often accompany presenting problems, such as transdiagnostic worry, shame, and embarrassment related to psychological symptoms. Biopsychosocial conceptualizations of shame frame it in the context of feared rejection by others (Gilbert, 2005). Socially prescribed perfectionism, which involves concerns that others have high standards and one will be criticized or rejected if not perfect, can play a role in depression and other clinical problems (Hewitt & Flett, 2002).

Fear of negative evaluation (FNE) is a core feature of social anxiety disorder (D. M. Clark & Wells, 1995; Rapee & Heimberg, 1997) and may be assessed using the Brief Fear of Negative Evaluation Scale – 2 (BFNE-2; Carleton, Collimore, et al., 2007). Fear of positive evaluation (FPE) involves a sense of dread associated with favorable and public evaluation due to social comparisons between self and others and can be measured by the FPE Scale (FPES; Weeks et al., 2008). FPE seems to be a distinct yet related component of social anxiety disorder (Rodebaugh et al., 2012; Weeks et al., 2010), highlighting a general fear of evaluation in social anxiety disorder (Weeks et al., 2012). FPE may play a role in cognitive misappraisals (e.g., discounting positives) that can strengthen negative self-beliefs (Weeks et al., 2008).

FNE has been shown to increase the risk and symptoms of bulimia via its association with an internalized standard of ultraslenderness and the feared criticism and negative affect experienced when that standard is not achieved (Utschig et al., 2010). FNE and social appearance anxiety related to body shape (Hart et al., 2008) may act as vulnerabilities for social anxiety and eating disorders, and interventions targeting FNE may reduce risks for developing those problems (Levinson et al., 2013). Strong correlations between FNE and probability of developing PTSD have been demonstrated among individuals exposed to trauma (Collimore et al., 2009) and may explain why PTSD patients who also have social anxiety disorder report more guilt and shame than those without that disorder (Zayfert et al., 2005).

Negative Problem Orientation

Problem orientation is defined as “the set of relatively stable cognitive-affective schemas that represent a person’s generalized beliefs, attitudes, and emotional reactions about problems in living and one’s ability to successfully cope with such problems” (Nezu et al., 2013, p. 11). One component of problem solving, negative problem orientation (NPO), has been defined as a tendency to perceive problems as threats, to expect problems to be unsolvable, to doubt one’s ability to successfully cope with problems, and to become frustrated and upset when faced with problems or negative emotions—all of which can undermine motivation and the ability to engage in effective problem solving in various life domains (Nezu et al., 2013).

The Social Problem-Solving Inventory – Revised (SPSI-R; D’Zurilla et al., 2002) assesses NPO as one of five social problem-solving factors, including positive problem orientation (Maydeu-Olivares & D’Zurilla, 1996), whereas the Negative Problem Orientation Questionnaire (NPOQ; Robichaud &

Dugas, 2005) measures NPO as a sole construct reflecting a set of negative beliefs pertaining to problems and problem-solving ability.

Problem-solving therapy has been effective in treating depression, especially when it includes training in positive problem orientation along with training in problem-solving skills (Bell & D’Zurilla, 2009). NPO is seen as a cognitive vulnerability to GAD (Koerner & Dugas, 2006) and correlates with both GAD and OCD symptoms (Fergus & Wu, 2010). NPO has been identified as the single cognitive variable that correlates with mood and anxiety symptoms, including depression, social anxiety disorder, GAD, and OCD, pointing to the possibility that it may confer a general vulnerability to mood and anxiety symptoms (Fergus & Wu, 2011).

Inflated Responsibility and Threat Estimation

Multiple pathways have been proposed in the etiology of inflated responsibility beliefs (Salkovskis et al., 1999), which influence interpretation of intrusive thoughts and relate to rumination in obsessional problems (e.g., Julien et al., 2006; Salkovskis et al., 2000). Together, inflated responsibility and overestimation of threat are a core factor in OCD, and this factor is measured by the OBQ-44 (OCCWG, 2005). Salkovskis and colleagues (2000) developed the Responsibility Attitude Scale (RAS), which measures general beliefs about responsibility, and the Responsibility Interpretations Questionnaire (RIQ), which measures frequency of and belief in interpretations of intrusive thoughts about possible harm. Rachman and colleagues (1995) developed the Responsibility Appraisal Questionnaire (RAQ), which assesses multiple aspects of inflated responsibility beliefs, including responsibility for harm, responsibility in social contexts, positive outlook toward responsibility, and thought-action fusion. Inflated responsibility is multifactorial, with only one factor (TAF) being especially relevant to certain aspects of OCD (Rachman et al., 1995). Some have argued that responsibility beliefs should be subsumed under metacognition as a factor contributing to OCD (Myers & Wells, 2005).

The factor of inflated responsibility and overestimation of threat (as measured by the OBQ-44) has been shown to be a predictor of the tendency to worry about possibly having an illness (Wheaton et al., 2010). This correlation with health anxiety is consistent with the finding that inflated responsibility and threat estimation is not specific to OCD but applies to anxiety in general (Tolin et al., 2006). Several beliefs implicated in OCD (intolerance of uncertainty, threat estimation, responsibility, and perfectionism) were more inflated in a medical sample than in OCD patients, suggesting that dysfunctional

beliefs in these domains are associated with other stressors, including physical illness (Baptista et al., 2011). Considering mechanisms of threat bias and responsibility for harm is relevant to case formulation approaches to treating anxiety, depression, and worry (Persons et al., 2013).

Sensitivity to Illness or Injury

Reiss's expectancy model of fear (Reiss & McNally, 1985) identified fear of injury or illness as one of three fundamental fears that "are believed to underlie sensitivities to inherently aversive threats, and therein, to represent the vulnerabilities from which common fears (e.g., fear of flying, fear of hospitals) arise" (Carleton et al., 2006, p. 340). The Illness/Injury Sensitivity Index – Revised (ISI-R; Carleton et al., 2006) assesses fears or catastrophic appraisals related to illness and injury, which may be vulnerability factors contributing to fears and beliefs in health anxiety and specific phobias. Other assessment measures (reviewed in Taylor & Asmundson, 2004) are available to assess multiple facets of health anxiety, which include different vulnerability and response mechanisms related to health anxiety concerns. When patients present with certain phobias (e.g., germs, air travel), health anxiety, and chronic pain, it is prudent to assess sensitivity to illness or injury as a potential TDM.

Multidimensional Construct

The degree to which individuals can regulate emotions involves a complex interplay of affective, cognitive, behavioral, and physiological processes and has been tied to numerous developmental tasks across the life span (Diamond & Aspinwall, 2003; Gross & Thompson, 2007). Related to emotion regulation, distress tolerance—or, more accurately, intolerance—is implicated as a risk and maintaining factor underlying disorders of anxiety (Keough, Riccardi, et al., 2010), mood (Clen et al., 2011), personality (Gratz & Tull, 2011), substance use (Richards et al., 2011), and eating (Anestis et al., 2011). For example, low distress tolerance (DT) may amplify the experience of anxiety in clinical presentations (Schmidt et al., 2011) and is associated with response mechanisms such as behavioral withdrawal, depressive rumination, and suppression or avoidance of emotions (Clen et al., 2011; Vujanovic, Bonn-Miller, et al., 2011). Regardless of presenting problem, targeting DT is an important aspect of treatment planning.

Distress Tolerance

DT refers to the ability to tolerate aversive internal states such as negative emotions and physical discomfort (Leyro et al., 2010). It may be assessed via the Distress Tolerance Scale (DTS; Simons & Gaher, 2005) or the Distress Intolerance Index (DII; McHugh & Otto, 2012). DT is associated with limited availability of emotion regulation strategies, collectively contributing to experiential avoidance (McHugh et al., 2013). While experiential distress may include states that are cognitive (e.g., intrusive thoughts or images), behavioral (e.g., action urges), and physiological or somatic (e.g., panic-related interoceptive arousal), intolerance of negative emotional states is a common thread that seems to bear the most relevance to psychopathology (A. Bernstein et al., 2009; Simons & Gaher, 2005).

Appraisals of emotional experiences and individuals' perception of their inability to tolerate distress or distress-inducing contexts influence how they respond to those emotions and contexts (Leyro et al., 2010). Thus, the perception *I can't handle this*, where "this" is one more minute of depression, trauma flashbacks, or excruciating withdrawal from alcohol, often elicits response mechanisms that perpetuate a repeating pattern of psychological problems, such as behavioral withdrawal (e.g., social isolation), emotional avoidance (e.g., dissociation), cognitive avoidance (e.g., thought suppression), or emotion-driven behaviors (e.g., self-harm). Trafton and Gifford (2011) postulated that neural substrates underlying reward-based learning and responding may mediate distress tolerance and contribute to maladaptive behavioral responses (e.g., drinking, bingeing and purging, cutting). Low DT has been correlated with nonsuicidal self-injury, whereas high DT may actually potentiate suicide attempts by increasing the ability to consider death and dying by one's own hand (Anestis et al., 2013), highlighting the importance of targeting DT in treatment.

DT has been conceptualized as an overarching construct encompassing distinct domains of varying ability to tolerate uncertainty, ambiguity, frustration, negative emotion, and physical discomfort (Leyro et al., 2010). These lower-order constructs have been implicated in the etiology of numerous psychological problems. For example, intolerance of negative emotional states correlates with substance abuse (Richards et al., 2011), bulimia (Anestis et al., 2011), and PTSD (Vujanovic, Bernstein, et al., 2011). The contribution of intolerance of uncertainty to DT (Leyro et al., 2010), along with its role in OCD (OCCWG, 1997), may explain why lower DT is associated with increased obsessions in both clinical and nonclinical samples (Macatee et al., 2013).

Discomfort intolerance (Schmidt et al., 2006), or the inability to tolerate unpleasant (not necessarily painful) physical sensations, and DT seem to be distinct yet related processes (Mitchell et al., 2013), and discomfort intolerance has been implicated as a risk factor in panic and other anxiety disorders (Schmidt, Richey, et al., 2007).

CHAPTER 3

Response Mechanisms

We view response mechanisms as patterns of responses to the activation of vulnerability mechanisms. Many response mechanisms reflect attempts to cope with or avoid unpleasant emotional states, compensate for perceived deficits, or control outcomes. They reinforce and contribute to feedback loops with vulnerability mechanisms to maintain and exacerbate presenting problems. For example, a response such as avoiding a feared situation can strengthen negative self-schemas, negative problem orientation, vigilance for threat cues, and numerous other mechanisms, promoting avoidance as a strategy for coping with other stressors. Many response mechanisms represent defining symptoms of disorders, such as avoidance in phobias, worry in GAD, compulsions in OCD, and emotion-driven behaviors such as self-harm in BPD.

Experiential Avoidance

Experiential avoidance (EA) is defined as “the phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them, even when doing so creates harm” (S. C. Hayes

et al., 1996, p. 1154). While EA incorporates the interconnectedness of all private experiences, specific aspects (e.g., emotions, cognitions) often are the focus of treatment (S. C. Hayes et al., 1996). Acceptance-based interventions were developed to reduce EA by targeting behavioral regulation strategies aimed at controlling distressing emotions, thoughts, and bodily states, and increasing willingness to remain in contact with those internal experiences (S. C. Hayes, 1994). Many psychological problems can be viewed as expressions of EA (S. C. Hayes et al., 1996) and psychological inflexibility, both of which can be assessed with the Acceptance and Action Questionnaire – 2 (AAQ-2; Bond et al., 2011).

Avoidance and Escape Strategies

Avoidance and escape behaviors are a defining feature of many anxiety disorders. They contribute to multiple psychological problems via negative reinforcement by allowing individuals to discontinue or avoid unpleasant or threatening situations, sensations, thoughts, or feelings. For example, if a person becomes highly anxious when exposed to spiders, then escaping the situation provides an immediate reduction in emotional and physiological discomfort, which negatively reinforces future avoidance of other situations where the likelihood of encountering spiders is high. Understanding cognitions related to avoidance, such as the feared outcomes of encountering whatever is being avoided, provides important information about the maintaining factors underlying specific avoidance behaviors (Salkovskis, 1991). Thus, elucidating what is being avoided and why (e.g., *If I attend the party, no one will talk to me and I'll look like a loser*) sheds important light on the function of avoidance in maintaining patients' problems.

Any avoidance behavior can have multiple explanations depending on its intended functions. For example, procrastination behaviors arise in the context of avoiding aversive experiences such as emotional states associated with a specific task, activation of incompetency schemas, perfectionism beliefs, or discomfort associated with uncertainty or negative problem orientation. It also is conceivable that individuals avoid or delay certain tasks because of emotion dysregulation and low distress tolerance (e.g., signing divorce papers, discussing a job performance review) or executive functioning deficits (e.g., completing homework, filing a tax return). Thus, identifying the reasons for avoiding situations and their feared consequences elucidates the functional properties of avoidance and escape behaviors in those contexts, which informs treatment decisions.

Safety Seeking

Safety-seeking behaviors are avoidance responses that are also related to feared consequences (Salkovskis, 1991). They reduce discomfort and are perceived as contributing to the prevention of unwanted and, in some cases, potentially disastrous consequences. For example, someone with social anxiety may avoid eye contact, overprepare a speech, or choose clothing to avoid showing red or blotchy skin in efforts to avert negative attention and embarrassment. Patients with body dysmorphic disorder engage in checking behaviors and efforts to camouflage perceived deficits (Neziroglu et al., 2008). Individuals prone to panic often carry prescribed benzodiazepine medications when engaging in feared situations (e.g., air travel), even though they may not actually take them.

Safety-seeking behaviors traditionally have been viewed as countertherapeutic because they impede learning that feared negative outcomes, including feared consequences of experiencing anxiety, are highly unlikely (Salkovskis, 1991). Exposure-based treatments seek to extinguish safety behaviors, yet Rachman and colleagues (2008) found that judicious use of safety behaviors, especially early in treatment, may actually facilitate approach toward feared stimuli, promote self-efficacy, and allow greater integration of corrective information via disconfirmatory experiences.

Reassurance Seeking

Reassurance-seeking behaviors aim at reducing and escaping anxiety. Patients with OCD often seek reassurance to relieve anxiety related to uncertainty, feelings of responsibility, or beliefs about the meaning of their thoughts. Individuals with GAD may seek reassurance to relieve anxiety associated with uncertainty and the content of their worry thoughts. Reassurance seeking also occurs in the context of panic sensations, health concerns, and perceived negative evaluation by others. As with all avoidance and escape behaviors, reassurance seeking may provide temporary relief through negative reinforcement, prompting and strengthening further reassurance seeking, but since certainty is unattainable and relief quickly dissipates, these responses are not a long-term solution and only worsen problems.

Compulsions

Compulsions are defined as repetitive behaviors or mental acts performed in the service of reducing anxiety or distress and are central to OCD (American Psychiatric Association, 2013). Behaviors such as checking, counting, and

repeating are responses to perceived threat and reflect attempts to escape distressing emotional states or potentially avoid a range of feared negative consequences. Compulsions often are performed in a ritualistic manner and have specific structural requirements (e.g., checking the stove five times before leaving for work, wearing a prescribed outfit on a given day of the week).

Behavioral (Situational) Avoidance

Behavioral avoidance of situations that activate feelings of discomfort is a common transdiagnostic mechanism; it may involve diverse stimuli, such as public restrooms, “dirty” objects, public speaking, freeways, trauma cues, and more. Behavioral avoidance may be due to beliefs and cognitive misappraisals regarding self, others, or situations, with patients thinking that joining activities will not yield relief or others will view them negatively (A. T. Beck et al., 1979). Assessment focuses on the feared consequences of engaging in situations that trigger distress. For example, avoiding air travel could be due to fears of dying in a plane crash, having a panic attack and feeling uncomfortable for long periods of time, or having a panic attack and feeling embarrassed when other passengers notice. Sometimes patients fear any situation that might evoke anxiety or other distressing emotions due to beliefs that experiencing those feelings means they are weak or will be unable to handle the emotions. Although behavioral avoidance is not considered a primary component of GAD, patients with GAD often engage in avoidance behaviors such as not watching the news and avoiding certain social situations because of their propensity to worry (Beesdo-Baum et al., 2012).

Escape and avoidance behaviors such as inactivity, withdrawal, and inertia often accompany depression (N. S. Jacobson et al., 2001) and are the focus of behavioral activation strategies used to improve mood and build a sense of mastery (Martell et al., 2010). Escape from emotional pain may include exiting events, sleeping excessively, and using substances. Depression and shame related to mood, trauma, eating, personality, and other disorders may lead to isolation and social withdrawal to avoid shame-evoking and distressing stimuli (Gilbert & Irons, 2005; Tangney & Dearing, 2002; Zayfert et al., 2005). Individuals seeking to avoid emotional pain often narrow their behavioral repertoires to an extent that impedes valued living and intensifies negative affect (S. C. Hayes et al., 2012). This is consistent with findings that avoidance of important life tasks, pleasurable activities, and social interactions worsens emotional distress and functional impairments via decreased opportunities for positive reinforcement (N. S. Jacobson et al., 2001).

Cognitive Avoidance

Cognitive avoidance strategies seek to reduce distress associated with disturbing thoughts and include maladaptive efforts to control, suppress, distract from, neutralize, or replace thoughts.

Thought Control

Thought control strategies are used by patients across a range of emotional disorders (Purdon, 1999). Metacognition plays a key role in interpreting thoughts as significant and important to control, and the Metacognitions Questionnaire – 30 (MCQ-30; Wells & Cartwright-Hatton, 2004) may be used to assess beliefs about the consequences of not controlling thoughts (and other metacognitions). Thought control strategies are common to patients with OCD (Abramowitz et al., 2003), and beliefs that thought control is possible and necessary appear in association with OCD more than with other anxiety disorders (Tolin et al., 2006). When patients experience cognitive intrusions as threatening, such as in OCD and PTSD, responses may be evoked to control, neutralize, or replace them in an effort to regulate emotions and reduce distress. The Thought Control Questionnaire (TCQ; Wells & Davies, 1994) measures strategies used for coping with unwanted thoughts.

Thought Suppression

Many individuals try to suppress unwanted thoughts to reduce the emotional distress accompanying them, though this typically yields a paradoxical effect: suppression efforts actually increase thoughts (Wegner et al., 1987). The White Bear Suppression Inventory (WBSI; Wegner & Zanakos, 1994) measures dispositional tendency to suppress unwanted thoughts. Reviews on thought suppression and its relation to psychopathology (most notably anxiety and depression) have underscored the clinical relevance of elucidating motivations for thought suppression, responses to thought recurrence, and interpretations of unsuccessful efforts at thought suppression (Abramowitz et al., 2001; Magee et al., 2012). Thought suppression is associated with increased emotional distress across multiple problems (see Wenzlaff & Wegner, 2000, for a review). Negative interpretations of post-traumatic intrusions (e.g., *I'm going crazy*) predict behavioral avoidance, thought suppression, and rumination—all of which increase emotional distress and arousal, interrupt emotional processing, and intensify PTSD severity (Steil & Ehlers, 2000). Efforts to suppress

trauma-related cognitions are linked with increases in anxiety, depression, and negative affect (J. G. Beck et al., 2006) and mediate the relationship between negative mood and PTSD in sexual trauma (Rosenthal et al., 2006).

Worry

Borkovec's avoidance model of worry and GAD (Borkovec et al., 2004) posits worry as a cognitive avoidance mechanism that inhibits mental imagery and somatic and emotional activation, preventing emotional processing of fear. Worry acts as a cognitive avoidance strategy to remove a sense of threat, and in GAD it often helps individuals avoid more distressing emotional experiences (Borkovec & Roemer, 1995). The intolerance of uncertainty model of GAD postulates that cognitive avoidance, along with worry and negative problem orientation, is triggered by intolerance of uncertainty and is negatively reinforcing, thereby preventing modification of threat appraisals (Dugas et al., 2005).

Interoceptive (Somatic) Avoidance

Interoceptive avoidance is the avoidance of somatic sensations that could trigger panic attacks (Barlow, 2002). Patients often go to great lengths to avoid uncomfortable and feared somatic sensations and physiological arousal. Feared consequences fueling avoidance seem related to distress tolerance (Leyro et al., 2010) and include beliefs that the individual will not be able to tolerate uncomfortable sensations or that the sensations, once provoked, may not remit (Schmidt et al., 2011). Patients may fear imminent health threats (e.g., heart attack), loss of cognitive functioning, or incapacitation due to beliefs that physiological sensations indicate threat or danger. To avoid physiological sensations, patients may avoid exercise, sex, caffeine, or any substance that may alter their perception of control over physiological sensations.

Emotional Avoidance

Emotions provide important information about organisms and their internal and external environment, functioning to motivate and guide behavior (Gross, 1998). Emotions and their regulation involve complex multisystemic processes spanning subjective experience, cognition (attention and appraisal), physiology (stimulus-controlled limbic responses and cortical regulatory

processes), and behavioral responses (Gross & Thompson, 2007). Most patient problems involve an inability to regulate emotions within one or more of these domains. Emotional avoidance targets unpleasant emotional states, often due to fears about the consequences of experiencing negative emotions, and may be expressed via attempts to suppress emotions, dissociate from them, or substitute different emotions (e.g., anger instead of shame or disappointment).

The Affective Control Scale (ACS; Williams et al., 1997) measures distress about and fear of losing control while experiencing strong affective states. Exposure-based cognitive therapy was developed to target emotional avoidance in depression (A. M. Hayes et al., 2005), though its principles also seem relevant to avoidance of other emotional states. Patients are encouraged to tolerate the fear of sadness (Taylor & Rachman, 1991), rather than avoid negative emotions, so themes of helplessness, defectiveness, and failure can be addressed (A. M. Hayes et al., 2007). Emotional avoidance driven by fears of relapse can reinforce escape and avoidance behaviors in previously depressed patients (Persons & Davidson, 2010). Similarly, formerly depressed patients report greater emotional avoidance than patients without histories of depression (Brockmeyer, Holtforth, et al., 2012), which is consistent with the finding of reduced emotional acceptance in depressed patients (Campbell-Sills et al., 2006).

Emotional avoidance is intricately related to emotion regulation difficulties (Campbell-Sills & Barlow, 2007; Gross & Thompson, 2007). For example, deliberate self-harm may reflect strong experiential avoidance-response tendencies, which are strengthened and exacerbated by poor distress tolerance and deficits in emotion regulation (Chapman et al., 2006). Not surprisingly, individuals who believe they can regulate mood and negative emotions do not perceive the need to avoid emotional states, therefore demonstrating less experiential avoidance (Brockmeyer, Holtforth, et al., 2012).

Dissociation is an extreme form of emotional avoidance that results in fragmented experiences of the self (S. C. Hayes et al., 2012). It can be assessed with the Trauma Symptom Inventory – 2 Dissociation Subscale (Briere, 2011) or the Dissociative Experiences Scale (DES; E. M. Bernstein & Putnam, 1986). Dissociation is highly correlated with alexithymia (Grabe et al., 2000) and serves the function of avoiding emotional distress and trauma-related cues in PTSD (Foa et al., 2007). Peritraumatic dissociation and experiential avoidance predict PTSD and associated problems (Kumpula et al., 2011). BPD patients also dissociate to avoid aversive internal states associated with emotion dysregulation (Stiglmayr et al., 2001), which contributes to self-harm and comorbid dissociative disorders (Korzekwa et al., 2009).

Emotion-Driven Behaviors

Barlow and colleagues (Campbell-Sills & Barlow, 2007; Barlow et al., 2011) describe emotion-driven behaviors as counterproductive responses to emotion-driven action tendencies, which typically are contextually inappropriate and inadvertently *increase* the emotions patients are trying to avoid. For example, patients with BPD often experience self-harm urges in response to (and in an effort to avoid or escape) distressing emotions such as shame or anger (Linehan, 1993a). Through negative reinforcement, many emotion-driven behaviors are strengthened because they initially reduce the intensity of emotional pain. For example, deliberate self-harm results in immediate relief of emotional distress (Chapman et al., 2006). Consequently, emotion-driven behaviors tend to increase, interrupting opportunities for new learning that could help challenge inaccurate beliefs about behaviors, emotions, and personal resilience, and lead to improved coping. Moreover, emotion-driven behaviors have neurophysiological correlates that make them particularly difficult to treat because of powerful intrinsic reward systems (Siegle et al., 2007). Targeting these response mechanisms and teaching skills to supplant them can reduce patients' avoidance behaviors and enhance coping (Barlow et al., 2011; Linehan, 1993a).

Cognitive Misappraisals

Cognitive misappraisals involve distortions in thinking and include overgeneralizing, all-or-none thinking, personalizing, and mind reading, among others (see J. S. Beck, 2011; Burns, 1999). Unlike schemas, cognitive misappraisals are specific distortions related to situational events, though distortions often are activated by schemas. For example, if a patient's schemas include beliefs that she is unlovable and others are critical and rejecting, automatic thoughts such as *Sue never wants to spend time with me* or *I must have done something wrong* could result from a friend declining a lunch invitation. These cognitive misappraisals strengthen negative core beliefs and can lead to withdrawal or avoidance behaviors, perpetuating a self-reinforcing cycle of emotional pain, experiential avoidance, and impaired functioning (A. T. Beck et al., 1979; S. C. Hayes et al., 2012).

Understanding the cognitive misappraisals associated with specific problems can elucidate potential thinking errors for individual patients. Aaron Beck (1976) observed associations between the content of cognitive misappraisals and different disorders, such as the link among themes of loss, negative expectations, and depression. Distorted mental images and negative appraisals

of body image contribute to body dysmorphic disorder symptoms (Neziroglu et al., 2008). Bipolar patients often have multiple and contradictory interpretations of mood state fluctuations and how they affect functioning and behavior, which may potentiate and maintain symptoms (Kelly et al., 2011). Similarly, threat monitoring and negative interpretation of symptoms in PTSD disrupt healthy processing of trauma (Wells & Sembi, 2004).

Cognitive misappraisals involving overestimation of threat are characteristic of anxiety disorders (A. T. Beck et al., 1985; Tolin et al., 2003). For example, catastrophic misappraisals of bodily sensations are related to panic disorder (D. M. Clark, 1986), whereas health anxiety concerns involve negative appraisals of bodily changes and sensations related to future dangerous consequences (Warwick & Salkovskis, 1990). Individuals with social anxiety hold negative self-images, along with appraisals that these distorted images accurately reflect how they appear and are evaluated by others (D. M. Clark & Wells, 1995; Rapee & Heimberg, 1997). Prominent features of social anxiety symptoms include cognitive misappraisals of perceived social danger and threat, negative evaluations of social performance, and predictions of consequences of negative evaluation by others.

Attentional Focus

Attentional bias with hypervigilance toward threat is well established as a mechanism underlying anxiety disorders (Barlow, 2002). Attentional bias involves fixed attention on threat-related stimuli and is part of the cognitive attentional syndrome (Wells, 2009), which consists of a pattern of responses to negative thoughts and beliefs (rather than flexibility in responding to them) that includes fixed attention, worry, rumination, and unhelpful self-regulatory strategies. Ingram (1990) posited that self-focused attention (SFA) combined with attention regulation deficits contributes to psychopathology. For example, individuals with high SFA demonstrate poor problem solving (Woodruff-Borden et al., 2001) and are prone to anxiety and depression (Muraven, 2005). SFA correlates strongly with negative affect (Mor & Winquist, 2002), and negative SFA fuels depressive rumination and mood deterioration in depression (Nolen-Hoeksema, 1991). Models of social anxiety implicate SFA in generating and maintaining anxiety and prohibiting processing of corrective information that could challenge social fears (D. M. Clark & Wells, 1995; Rapee & Heimberg, 1997), and targeting SFA shows promising results in treating social anxiety disorder (Schreiber et al., 2013).

As with cognitive misappraisals, patients likely will focus attention on specific concerns. Panic disorder and health anxiety are associated with elevated vigilance for bodily changes and sensations (Deacon & Abramowitz, 2008), which also has been demonstrated in hypochondriasis, GAD, and medical utilization and safety-seeking behaviors related to health concerns (Olatunji et al., 2007). Attention to and vigilance toward threats in the environment that may indicate negative evaluation by others contribute to social anxiety (Rapee & Heimberg, 1997), and both internal and external attentional focus may be related to social anxiety (Schultz & Heimberg, 2008). Similarly, self-focused and selective attention to negative mental imagery and distorted body image are defining features of body dysmorphic disorder, along with comparisons to the appearance of others (Neziroglu et al., 2008).

Attributional Bias

Attribution theory describes how individuals explain their own and others' behavior (Jones et al., 1971). Causal attributions play a key role in motivation and emotion, especially within the context of perceived causes of success and failure (Weiner, 1985). Attributional style may contribute to exacerbation of both depressive and hypomanic symptoms in bipolar individuals when combined with negative and positive life events, respectively (Mansell et al., 2011). Maladaptive attributions often arise in response to feelings of guilt and shame (Tangney & Dearing, 2002), which may link with vulnerability mechanisms, such as emotion regulation deficits (Linehan, 1993a) or negative schemas (Young et al., 2003). The propensity to experience shame has been tied to numerous psychological problems, including anxiety, depression, PTSD, eating disorders, obsessive-compulsiveness, psychoticism, and addictions (for reviews, see Stuewig et al., 2010; and Van Vliet, 2009). Reducing shame and internalizing attributions (e.g., self-criticism) can lead to increased empathy and distress tolerance via compassion-focused interventions that activate social affiliative and soothing neural systems (Gilbert & Irons, 2005).

Internalizing

Self-blame, self-criticism, and other self-attacking behaviors accompanying feelings of guilt and shame are associated with numerous psychological

problems (Tangney & Dearing, 2002). Shame frequently accompanies PTSD (Cloitre et al., 2005; Lee et al., 2001), especially in the context of nonsupportive or blaming responses by caregivers (Fletcher, 2011), and may play a key etiological role in PTSD following interpersonal trauma (La Bash & Papa, 2013). Memories of shaming experiences that become central to self-identity play an important role in paranoia and depression, the latter of which is mediated by self-criticism (Pinto-Gouveia et al., 2013). The potency of self-blame—and its importance as a treatment target—may be seen in both its dampening effect on genetic risk factors and its potentiating effect on environmental variables in ADHD (Nikolas et al., 2012).

Internalizing attributions in response to shame are associated with emotion dysregulation and poor self-concept in BPD (Rüsch et al., 2007). Shame can predict BPD symptoms via the pathways of anger rumination and anger (Peters et al., 2013) and may contribute to depression, dissociation, and complex PTSD in trauma survivors (Fletcher, 2011). Individuals who explain personal trauma with self-blaming attributions experience shame, which activates negative schemas, exacerbates symptoms, and contributes to their avoidance of seeking treatment (Lee et al., 2001). Self-directed anger associated with shame has been linked with fear of negative evaluation and social anxiety (A. T. Beck et al., 1985; Gilbert et al., 1994), and self-loathing has been linked with obesity and eating disorders (Edman et al., 2011; Fairchild & Cooper, 2010).

Externalizing

Judging and blaming others is a maladaptive coping style that is associated with emotional and behavioral problems in both clinical and nonclinical populations (Tangney & Dearing, 2002). As with internalizing attributions, externalizing attributions may be a response to feeling shamed (Van Vliet, 2009) and can generate behavioral problems such as school bullying (Ahmed & Braithwaite, 2004). When individuals respond to shame by judging or blaming others, they may be more prone to anger, hostility, and aggression (Bennett et al., 2005), implicating externalization of blame as an important treatment target across a range of problems. For example, externalization of blame was shown to mediate significant positive correlations between shame and aggression (both physical and verbal) among independent samples of college students, adolescents, jail inmates, and at-risk youth (Stuewig et al., 2010).

Repetitive Negative Thinking

Repetitive negative thinking, such as worry and rumination, involves problematic thinking styles rather than content. This TDM also includes post-event processing, with the content of thoughts being relevant to perceived failure in social and interpersonal contexts (D. M. Clark & Wells, 1995). Worry is focused on future-oriented repetitive thinking, while rumination involves repetitive patterns of thinking about past events. Although worry and rumination share similar features, they are distinct and distinguishable constructs (Nolen-Hoeksema et al., 2008). Associations recently have been demonstrated between repetitive negative thinking and metacognitions, cognitive avoidance, and thought control strategies (McEvoy et al., 2013). The Repetitive Thinking Questionnaire (RTQ; McEvoy et al., 2010) can assess repetitive negative thinking across anxiety and depressive disorders (Mahoney et al., 2012).

Worry

Worry is a hallmark feature of GAD and has been studied in relation to multiple mechanisms involved in maintaining psychological symptoms. The avoidance model of worry (Borkovec et al., 2004) posits that worry serves the functions of avoiding perceived threats, solving problems, and distracting from emotionally distressing thoughts, images, or sensations. The intolerance of uncertainty model of GAD frames worry as an attempt to avoid uncertainty; intolerance of uncertainty, along with negative problem orientation, positive beliefs about worry, and cognitive avoidance, contribute to worrying (Dugas et al., 2005). The metacognitive model of GAD (Wells, 1995, 1999) includes both positive beliefs (e.g., *Worry is useful*) and negative beliefs (e.g., *Worry is uncontrollable and dangerous*) about worry, and frequency of metaworry appears to be a defining feature of GAD (Wells, 2005). Negative metacognitive beliefs about worry lead to maladaptive responses that maintain worry, such as avoidance, reassurance seeking, and thought control strategies (Wells, 2005).

The Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990) commonly is used to assess the tendency to engage in excessive worry. The Why Worry – 2 (WW-2; see Hebert et al., 2014) can predict worry severity and assess beliefs that worry facilitates problem solving, enhances motivation, prevents negative emotion, prevents negative outcomes, and is a positive personality trait that may facilitate problem solving and protect against negative emotions in the

wake of negative events (Hebert et al., 2014). Assessing the perceived functions of worry is an important aspect of TDM hypothesis development.

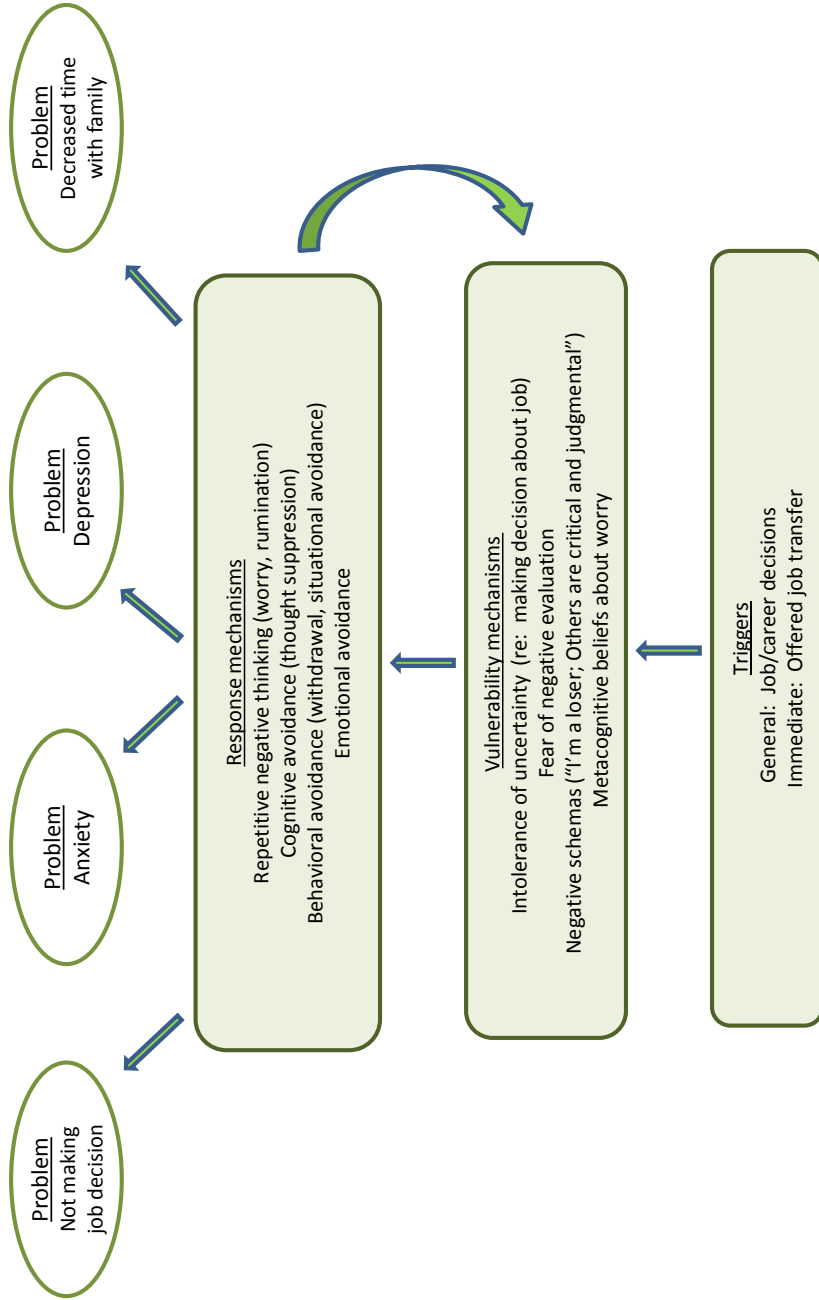
Rumination

Nolen-Hoeksema (1991) proposed that individuals who respond to depression by repetitively focusing on their symptoms and the possible causes and consequences of those symptoms without making plans or taking steps to alleviate distress (i.e., ruminating) will experience prolonged and more severe depression. Rumination has been linked to symptoms of depression, anxiety, and eating disorders in undergraduates (Aldao & Nolen-Hoeksema, 2010), and it negatively impacts problem solving, goal-directed behavior, and social support (Nolen-Hoeksema et al., 2008). The transdiagnostic nature of rumination is highlighted by the numerous problems in which it appears: anxiety disorders, depression, PTSD, insomnia, eating disorders, hypochondriasis, alcohol abuse, self-harm, bipolar disorder, and psychosis (for reviews, see Ehring & Watkins, 2008, and Olatunji et al., 2013). Rumination and negative emotions interact in BPD to contribute to emotion dysregulation and experiential avoidance (see Baer et al., 2012, for a review), and rumination interacts with negative cognitive styles to predict duration of depressive symptoms (Nolen-Hoeksema et al., 2008). Rumination mediates the concurrent association between depressive and anxiety symptoms in adolescents, and in adults it mediates both predicted increases in anxiety based on existing depression and predicted increases in depression based on existing anxiety (McLaughlin & Nolen-Hoeksema, 2011). It also mediates the relationship between concern over mistakes (perfectionism) and PTSD (Egan et al., 2013) and acts as both a mediator and moderator of intolerance of uncertainty in depression and anxiety (Liao & Wei, 2011). Rumination can be assessed with the Response Styles Questionnaire (RSQ; Nolen-Hoeksema, 1991).

Post-event Processing

Post-event processing (D. M. Clark & Wells, 1995) involves cognitive reviews of social performance and interpersonal interactions, including previous events in which individuals perceive social failure. It has been studied as one of three transdiagnostic mechanisms within repetitive negative thinking, which has been linked to anxiety, depression, anger, shame, and general distress (McEvoy et al., 2010).

Developing Tom's TDM Formulation



Tom's TDM Formulation Worksheet

Name: Tom

Date: 1/25/13

Identified problems

- Feeling "in a funk," "down and stuck," mild depressive symptoms*
- Feeling "stuck on worry thoughts" about decision making, "worries too much," anxiety symptoms*
- Difficulty making a decision about job transfer*
- Withdrawing from family and concerned about negative impact on family*

Hypothesized mechanisms (from the TDM Hypotheses Worksheet)

- Intolerance of uncertainty*
- Fear of negative evaluation*
- Negative self-schema*
- Metacognitive beliefs about worry*
- Repetitive negative thinking (worry, rumination)*
- Experiential avoidance: cognitive (thought suppression), behavioral (withdrawal and situational avoidance), and emotional*

Narrative or diagrams of how the mechanisms fit together and explain patient problems

Trigger: Offered job transfer → Vulnerability mechanisms (A–D):

- A. Uncertainty about decision/intolerance of uncertainty*
- B. Concerns about disappointing others/fear of negative evaluation*
- C. Negative schemas about self and others*
- D. Metacognitive beliefs about worry → Response mechanisms:*

Repetitive negative thinking: worry and "replaying" previous discussion with father → Feels more "stuck" → Tries not to think about decision because he feels worse (cognitive and emotional avoidance) → Avoids people (wife, kids, conversations with coworkers) → Feels down, discouraged, anxious → Repetitive loop with vulnerability mechanisms (A–D) continues

Factors that could worsen problems or impede treatment

Time pressure to make decision and let boss know

Patient strengths and resources that could support and facilitate treatment

- Very pleasant and likable*
- Supportive spouse, has social supports, "many blessings"*
- Motivated to make changes*
- Excellent rapport, participates in session*

PART 3

Planning Treatment

clinician can select from many other elements within ESTs and other methods currently available in order to achieve identified goals. The elegance of the transdiagnostic road map lies in its specificity to each patient based on the TDM formulation.

To help clinicians choose among the ever-increasing number of treatment options, we offer a unique categorization system that identifies the functional properties of interventions and allows therapists to consider their utility in meeting individualized TDM change goals and achieving patients' desired outcomes. We divide the interventions into four categories: those that increase patients' understanding of their problems and motivation to engage in treatment; those that facilitate individuals' ability to step back from their problems; core strategies for change derived from evidence-based treatment protocols; and approaches that help patients develop and improve a range of skills to resolve specific problems.

Functional Categorization of Interventions

Interventions that enhance understanding and motivation

- Psychoeducation
- Conversations about ambivalence and motivation to change
- Cost-benefit analysis
- Identifying values

Interventions that facilitate stepping back from the problem

- Problem deconstruction and analysis
- Self-monitoring
- Mindfulness
- Detached mindfulness
- Acceptance and validation
- Cognitive defusion

*contd.**Core strategies for change*

- Behavioral activation
- Behavioral contingencies
- Cognitive restructuring
- Schema change
- Behavioral experiments
- Attention training techniques
- Situational attention retraining
- Postponement strategies
- Exposure (behavioral, cognitive, emotional, and interoceptive)
- Compassionate mind training and imagery rescripting
- Distress tolerance skills
- Emotion regulation skills
- Interpersonal effectiveness skills

Adjunctive skills training for specific problems

- Breathing retraining
- Progressive muscle relaxation
- Applied relaxation
- Guided imagery
- Anger management
- Problem solving
- Organization and planning
- Time management
- Sleep management
- Strategies for eating problems
- Strategies for body-focused repetitive behaviors

Most of the interventions listed can target multiple TDMs. Therapists may choose among them based on which mechanisms are being targeted, how those mechanisms manifest in the individual patient, the patient's strengths and limitations, and how mechanisms must change to achieve global outcome goals. To help guide the selection process, we have developed a structured Progress Note (available in the appendix and in downloadable format at <http://www.newharbinger.com/28951>), which allows therapists to track interventions for each session and patient responses to them relative to treatment goals.

Interventions That Enhance Understanding and Motivation

The interventions discussed in this section may be used throughout treatment to enhance individuals' understanding of their problems and motivation to change ineffective behaviors and engage in clinical interventions.

Psychoeducation

Education about the nature and treatment of patients' problems has been a long-standing cornerstone in evidence-based therapies (e.g., A. T. Beck et al., 1979; Foa et al., 2007; Linehan, 1993a), including recent transdiagnostic protocols (Barlow et al., 2011; Norton, 2012) and paradigms (Leahy et al., 2011). Psychoeducation allows patients to assume an active and collaborative role in therapy by helping them understand their presenting symptoms, the context in which problems develop, and the rationale underlying treatment. It is hard to imagine anyone engaging in a process that requires effort and commitment to change without understanding what is expected and why. If patients ultimately are to become self-sufficient with the skills we teach them—practicing between sessions and implementing strategies well beyond termination—they must fully comprehend the nature, consequences, and mechanisms of action of their problems.

Psychoeducation also teaches patients that the problems plaguing them are often learned or have neurophysiological underpinnings (i.e., vulnerability mechanisms). In this way, we can reduce negative self-perceptions and feelings of shame while also introducing TDMs and educating patients about how mechanisms can be targeted and treated. In addition to providing an answer

to “Why me?” we can help patients see how many response mechanisms are understandable ways of coping with vulnerabilities, yet contribute to a vicious cycle that exacerbates those vulnerabilities and intensifies suffering. In so doing, we teach patients the importance of learning how to think differently about their vulnerabilities and develop alternative ways of responding to them.

Conversations About Ambivalence and Motivation to Change

Most experienced clinicians will attest to the importance of evaluating patients’ commitment to change before moving forward with treatment. It is easy for novice and senior clinicians alike to develop a formulation and treatment plan and excitedly begin therapy before ensuring that the patient is equally motivated to put the plan into action. We recommend taking sufficient time to discuss any hesitation, concerns, or ambivalence that may arise, not only about motivation to change but also about what will be involved when making those changes.

It is beyond the scope of this book to discuss the many processes involved in using a motivational interviewing style of communication with patients to help enhance their motivation and commitment to change, as described by Miller and Rollnick (2012). We encourage you to familiarize yourself with this important work, which can help you engage in collaborative conversations exploring patients’ motivations for and commitment to active change. Taking a motivational interviewing stance involves developing a working alliance, clarifying direction of change, identifying and enhancing the patient’s own motivation for change, and developing a plan for change. The therapist does so by creating an atmosphere of partnership, acceptance, and compassion, while simultaneously evoking patients’ wisdom, strengths, and resources to bring forth their motivation to change (Miller & Rollnick, 2012).

Like many of the interventions discussed in this chapter, guided discovery and Socratic questioning are core strategies used throughout CBT and other evidence-based therapies. We mention them here because they play an integral role in enhancing motivation and commitment to change. Overholser (2011) nicely summarizes these core CBT processes and their role in facilitating autonomy and independent decision making, versus therapists telling or directing patients to take actions (e.g., engaging in certain interventions). Clinicians can benefit from honing their skills in using guided discovery and Socratic questioning throughout treatment to help patients clarify problems and

objectives, identify TDM change and global outcome goals, and engage in interventions to facilitate forward progress.

Cost-Benefit Analysis

Looking at costs and benefits is a benchmark strategy to help resolve ambivalence about decisions, behaviors, or beliefs. Linehan (1993b) has patients evaluate the pros and cons of continuing to engage in self-harm and other target behaviors as a means of reducing distress and facilitating more effective coping. Most of us think through advantages and disadvantages of options before committing to important decisions, and this strategy is used in CBT when patients are deciding to embark upon treatment, make behavioral changes, or embrace alternative cognitive constructs, such as deciding that the disadvantages of perfectionism far outweigh any advantage (Burns, 1999). Writing down the costs and benefits of maintaining current beliefs and behaviors or taking steps toward change creates a concrete list of discussion points to enhance patients' motivation for change. This technique can help individuals decide whether to begin therapy and may be used at any point during treatment if patients are hesitant to move forward. One author (JD) routinely uses a cost-benefit analysis worksheet with patients before beginning exposure-based interventions, even when patients report that they are in agreement with the treatment plan. Fleshing out hesitations about facing problems, changing behaviors, or learning to tolerate discomfort while identifying the many advantages to trying interventions can help patients get off to a good start and fully engage in therapy, a process that often is uncomfortable, anxiety provoking, or otherwise challenging.

Identifying Values

“Valued living,” a key change mechanism in ACT, defines values in behavioral terms that can be measured with the Valued Living Questionnaire (VLQ; Wilson et al., 2010). Identifying values helps individuals clarify how they want to live across multiple life domains (e.g., relationships, work) and how they want to behave on an ongoing basis (S. C. Hayes et al., 2012). Values exercises can facilitate engagement in exposure and other challenging interventions (Meuret, Twohig, et al., 2012) and can help patients become more willing to relinquish ineffective coping behaviors and develop new skills (Linehan, 1993a). We routinely use values exercises to help patients address problems and

decisions in their daily lives, such as whether to forgo working overtime to attend a child's birthday party, or whether to tolerate distress and ask a friend to lunch because they value a life that is connected to others and not restricted by anxiety. Discussing how TDMs impede movement toward identified values, and how pursuing those values may reduce suffering and help individuals achieve a more desirable and fulfilling life, often can be quite effective in helping patients relinquish long-held TDMs.

Interventions That Facilitate Stepping Back from the Problem

Patients often feel consumed by their difficulties, which can add to emotional distress and misconceptions that decrease their ability to engage in treatment. The interventions discussed in this section help patients step back from their problems to understand them differently and participate more effectively in therapy. Many of these also act as springboards for change.

Problem Deconstruction and Analysis

A number of techniques may be used to deconstruct problems and facilitate patients' ability to step back from them, thereby acting as catalysts for other interventions. For example, thought records help patients identify negative automatic thoughts underlying functional difficulties, a necessary step toward correcting those thoughts and developing healthier cognitive and behavioral alternatives (e.g., J. S. Beck, 2011; Persons, 2008). Similarly, McCullough's situational analysis (2000) can help chronically depressed patients correct negative (depressogenic) beliefs and identify alternative strategies for achieving desired outcomes and building self-esteem. Our Problem Deconstruction Log allows patients to identify the affective, behavioral, cognitive, and physiological components of problems to better understand the mechanisms underlying them.

Functional analysis stems from B. F. Skinner's contextual behaviorism (1953) and is a fundamental strategy used throughout treatment for deconstructing problematic behaviors to assess their function in obtaining some desired outcome for the patient. After the therapist provides psychoeducation about functional analysis, therapist and patient discuss and agree upon the

specific behaviors that will be analyzed by looking at their antecedents and consequences. It also is used to explore the function of specific thoughts, emotions, and behaviors that arise throughout therapy and may be causing interruptions in treatment or in the patient's life. Linehan (1993a) developed behavioral chain analysis to help patients identify opportunities to use skills as alternatives to ineffective coping behaviors. Functional analytical psychotherapy (Kohlenberg & Tsai, 1991) utilizes functional analysis to understand patients' interactions with the therapist in order to generate hypotheses about similar behaviors occurring outside therapy that may explain interpersonal problems. While functional analysis targets response mechanisms such as behavioral avoidance and emotion-driven behaviors, it also is effective in identifying a functional context for vulnerability mechanisms such as perfectionism and intolerance of uncertainty, and in highlighting how patients' private experiences (e.g., emotions and thoughts) can maintain problems.

Self-Monitoring

Self-monitoring involves deliberate attention to an aspect of one's behavior, and increases patients' awareness of thoughts, feelings, behaviors, and other key aspects of presenting problems. Self-monitoring provides data to increase patients' and therapists' understanding of problems and guide treatment decisions (Persons, 2008). It "is considered essential to the personal scientist model of cognitive-behavioral therapy" (Craske & Barlow, 2008, p. 24) in that it facilitates collaborative empiricism and enhances patients' sense of agency (Cohen et al., 2013). Both disorder-specific protocols (e.g., Foa et al., 2007) and universal protocols (e.g., Barlow et al., 2011) incorporate self-monitoring interventions early in treatment to track symptoms, effectiveness of interventions, and overall progress. Having patients monitor treatment targets (e.g., mood, worry thoughts, self-criticism, social withdrawal) has widespread value, ranging from heightening awareness of ineffective coping to cueing problem solving and enhancing self-regulation (e.g., Frank, 2005; Linehan, 1993a).

When patients track identified components of problems, they assume a third-person perspective that helps them step back from their problems while also increasing their awareness of the treatment targets they are trying to change. Standardized symptom measures and protocol-based monitoring forms that identify and track specific components of problems are available, and we also encourage therapists to be creative in tailoring self-monitoring to patient needs. For example, the lead author (RIF) developed a self-monitoring tool that allows for a subjective definition of "distress" based on the patient's

presenting problems. Thus, one person might track distress by monitoring his experience of mood swings and trauma flashbacks, whereas another might track the aggregate effect of different elements of panic attacks and associated alcohol consumption.

Mindfulness

Mindfulness involves learning how to control the focus of attention, which can increase individuals' awareness of and ability to step back from their problems, engage in their present reality, and enhance coping. Mindfulness can interrupt emotion-driven behaviors and cognitive misappraisals (Lynch et al., 2006) and mitigate the detrimental effects of unavoidable distressing experiences on mental health (Bergomi et al., 2013). Mindfulness is central to many therapies, including mindfulness-based cognitive therapy (Segal et al., 2002), mindfulness-based stress reduction (Kabat-Zinn, 1990), DBT (Linehan, 1993a), and ACT (S. C. Hayes et al., 2012). Mindfulness-based interventions have demonstrated efficacy in treating both psychological and physical problems (Baer, 2003), implicating mindfulness in self-regulation and self-management; emotional, cognitive, and behavioral flexibility; values clarification; and the ability to tolerate and benefit from exposure (Shapiro et al., 2006).

Kabat-Zinn (1994) defined mindfulness as “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally” (p. 4). Linehan (1993b) deconstructed the practice of mindfulness into “what” skills (observe, describe, participate) and “how” skills (nonjudgmental, one thing in the moment, effective) to help patients find the dialectical synthesis of emotional experiencing and logical reasoning: “wise mind.” Different aspects of mindfulness (observing, describing, acting with awareness, not judging, not reacting) can be assessed via the Five Facet Mindfulness Questionnaire (Baer et al., 2006). Mindfulness exercises may include grounding in current reality to target trauma-related mechanisms, noticing and letting go of self-critical thoughts to reduce negative schemas, or increasing emotional awareness to counter avoidance, among many others.

We encourage patients to practice and incorporate mindfulness skills as they move through daily living: simply paying attention while driving or walking down the street; fully immersing themselves in folding laundry; or observing and describing tastes, textures, and other sensations while eating an apple. Although conceptually simplistic, mindfulness is typically difficult to master—for therapists and patients alike. However, it is a core component of numerous interventions and, with practice, it can facilitate lasting behavioral change.

Detached Mindfulness

Detached mindfulness techniques (Wells & Matthews, 1994) help individuals develop meta-awareness of thoughts and beliefs so they can disengage from them, allowing patients to either appraise those thoughts and beliefs differently or respond more effectively. These interventions help patients learn to take a metacognitive perspective that interrupts repetitive negative thinking, such as worry and rumination. Further, patients learn to take the observer perspective, which helps them develop a new way to relate to their thoughts and beliefs—one that increases flexibility regarding thinking styles and fosters a new view of the significance and importance of cognitions. Detached mindfulness techniques, described in detail by Wells (2009), include exercises such as the use of imagery and metaphor to facilitate changes in metacognition and learning.

Acceptance and Validation

Acceptance reflects the ability to simply be in the present moment, with whatever is there, without resistance or judgment (Kabat-Zinn, 1994). Before individuals can even think about changing behaviors, they must first accept the problematic nature of those behaviors (Prochaska & DiClemente, 1984). Validation—recognizing patients’ experiences, corroborating their authenticity, and framing their dysfunctional nature in the context of past learning and current stressors—is a core strategy for increasing acceptance in DBT (Linehan, 1993a). Validation can stabilize patients’ sense of self, reduce emotional arousal, enhance learning, and increase motivation to change (Lynch et al., 2006). Acceptance is viewed as a necessary precursor of behavioral change and problem solving (Linehan, 1993a). Validating patients’ experience of their problems (e.g., “I can’t imagine not being anxious, given your learning history” or “Anyone would be anxious in that situation”) can convey empathy and understanding, reduce self-criticism, and increase motivation and participation in therapy (Linehan, 1993a). This is particularly salient for chronic conditions such as bipolar illness or catastrophic injury, where treatment focuses on adaptation, improved functioning, and enhanced quality of life.

Cognitive Defusion

Cognitive defusion is an intervention within ACT (S. C. Hayes et al., 2012) that targets cognitive avoidance (including worry), cognitive misappraisals (e.g.,

negative predictions, cognitive distortions), and negative attributions (e.g., self-criticism), among other TDMs. Defusion helps patients step back from their thoughts rather than being consumed by or acting on them. It helps patients distance from thoughts via labeling (e.g., “There’s another one of those self-critical thoughts”) or observing (e.g., “I’m having the thought that I don’t want to go to work because I think I can’t cope with facing my boss”). In DBT patients learn how to disengage from distressing thoughts and feelings in the service of regulating emotions and managing distress (Linehan, 1993b). Defusion can be a useful stepping-stone to other interventions, such as exposure and cognitive restructuring (e.g., “It’s just your mind having flashbacks of the trauma. When we do exposure, those will gradually decrease, and you’ll be able to take the memories off the shelf at will rather than always having them come crashing down on you.”).

It is important to provide psychoeducation about the power of thoughts, the ineffectiveness of trying to suppress them, and the benefit of learning ways to disengage from them. Helping patients assess whether problematic thoughts facilitate or impede achievement of goals often can highlight the thoughts’ disruptive nature. Cognitive defusion may be used to target rigid rules, judgments, past- and future-oriented thoughts, and (erroneous) core beliefs that impede values-based action (S. C. Hayes et al., 2012). Many exercises and metaphors are available for noticing thoughts, examining their function, and disengaging from them in order to reduce subjective distress and move toward valued living. For example, imagining problematic thoughts as leaves floating down in a gentle breeze without having them interrupt a pleasant stroll could help a patient disengage from worry thoughts that impede her ability to chaperone her son’s class trip. Other defusion exercises have patients say or sing problematic thoughts out loud, focusing on the sound of a thought (versus its meaning) as a way to reduce its significance and dysfunctional impact. Another useful strategy involves writing a thought on a flash card and having patients compare looking at the card at arm’s length versus directly in front of their eyes to notice the difference between having a thought (being able to read it at arm’s length) and being consumed by the thought (being unable to focus their eyes and decipher the letters).

Core Strategies for Change

Numerous interventions have been developed that target both vulnerability and response mechanisms to facilitate change in multiple dimensions of patients’ lives. Many of these come from ESTs for specific disorders that subsequently have been shown to be effective across a range of problems.

Behavioral Activation

Behavioral activation is based on theories that depression results from a lack of positive reinforcement and environmental rewards, which occurs when individuals avoid certain situations (Ferster, 1973; Lewinsohn, 1974). It targets behavioral avoidance by scheduling activities that increase motor activity, a sense of achievement and mastery, and pleasurable experiences to elicit positive reinforcement and reduce negative affect (Martell et al., 2010). Behavioral activation also provides information to refute negative self-schemas (A. T. Beck et al., 1979).

Activity scheduling (A. T. Beck et al., 1979; J. S. Beck, 2011) begins with psychoeducation about the relation between behavioral inactivity and depression, followed by collaborative identification of activities that will increase overall motor output and begin improving mood. For example, we might help a patient develop a plan for doing a load of laundry so she can have clean clothes to wear and begin to feel better about herself. Therapist and patient work together to schedule and evaluate additional activities that can build a sense of achievement and mastery, increasing self-efficacy and helping the patient continue or resume functioning (e.g., cleaning the house, purchasing groceries, returning to work). Activities that increase a sense of pleasure (e.g., going to a movie, meeting a friend for lunch) also are scheduled and balanced with mastery activities. Helping patients identify avoidance behaviors and understand their role in fueling depressed mood, along with the importance of sustaining activity levels and positive reinforcement, is an important factor in relapse prevention (Martell et al., 2010). We recommend including life tasks that could create more problems if not addressed (e.g., scheduling a dental appointment, calling the credit bureau), which can be initiated in session if patients are unable to complete them alone. Adding values-based activities, such as volunteering for a charity or exercising to improve health, can increase the benefits of behavioral activation (S. C. Hayes et al., 2012).

Behavioral Contingencies

Behavioral contingencies, which are based on the premise that learning is heavily influenced by the consequences of our behavior, are integral to CBT and DBT. Ideally, the consequence should directly follow the behavior to effectively increase or decrease the probability of the behavior reoccurring. For example, clinicians often neglect to follow up on homework assignments, and then they wonder why patients stop completing them! Contingency

management refers to attempts by the therapist (and patient) to support effective behaviors and extinguish ineffective behaviors both in and out of session, and includes reinforcement, extinction, shaping, and punishment. For example, DBT therapists often limit a session to a painstakingly detailed chain analysis of cutting following an incident of such self-harm, preventing discussion of other topics (Linehan, 1993a). However, ineffective behavior may be inadvertently rewarded, such as when therapists increase phone contact during crises or become more attentive to patients who stop talking in session. If this is not addressed, the therapist may feel overextended, which can compromise the therapeutic alliance and potentially jeopardize treatment. Limiting the therapist's availability to brief phone coaching and crisis management, shaping non-crisis contact with the therapist, and quietly waiting for patients to reengage in dialogue are examples of contingency management strategies to reduce ineffective responses, enhance coping, and facilitate interpersonal effectiveness (Linehan, 1993a).

Behavioral contingencies are highly effective in targeting behavioral and emotional avoidance. Contingency procedures must be explained to patients prior to using them and are most effective when implemented in a transparent, nonjudgmental, and collaborative manner. We encourage you to be creative in developing contingencies with patients, such as rewarding themselves with an ice cream or small gift after completing a homework exercise, or planning a fun activity following completion of a feared task to decrease procrastination (e.g., going to a movie after asking the boss for a raise).

Cognitive Restructuring

Cognitive therapy is based on the theory that perceptions of situations, rather than situations themselves, can influence how people feel (A. T. Beck, 1964). Specific situations can trigger automatic thoughts that often are distorted and activated by underlying schemas, and these cognitive appraisals give rise to negative emotional states and problematic behaviors. Beck's cognitive therapy of depression (A. T. Beck et al., 1979) utilizes a Daily Record of Dysfunctional Thoughts to log automatic thoughts that become the focus of cognitive techniques aimed at identifying and responding to cognitive distortions. Variations of this worksheet currently are used in clinical practice to record automatic thoughts in the service of developing effective cognitive and behavioral responses that target mood problems and cognitive misappraisals. Strategies to correct cognitive misappraisals include identifying distortions in thinking, exploring evidence supporting and not supporting cognitions,

considering alternative explanations, and examining whether cognitions are helpful in improving mood, interpersonal relations, and functioning (J. S. Beck, 2011; Burns, 1999; Persons et al., 2001).

Cognitive restructuring helps patients identify and evaluate their thinking so they can develop more balanced, effective, and adaptive responses. It aims to increase awareness of, test, and change maladaptive beliefs. These interventions are a mainstay within CBT and are used to correct misappraisals that contribute to specific symptoms across a range of problems (e.g., fears of bodily sensations or judgment by others, overestimation of threat appraisals and likelihood of negative outcomes, distortions related to traumatic events or body image). Cognitive restructuring also challenges underlying assumptions, such as *If I don't do everything perfectly, no one will like me* and *I should excel at everything I try to do*. Maladaptive beliefs are viewed as vulnerabilities that, when activated, can contribute to how individuals interpret their experiences. For example, if a patient experiences heightened anxiety related to the activation of beliefs about threat and inability to tolerate uncertainty and responds by using escape and avoidance behaviors, cognitive restructuring can engage her in discussions about her overestimations of threat and underestimations of her ability to tolerate distress when these constructs are activated.

Metacognitive therapy also incorporates cognitive restructuring, though its purpose is not to change the content of thoughts or schemas, but rather to modify patients' beliefs about their thoughts and emotions (i.e., metacognition; Wells, 2009). Metacognitive strategies include core CBT techniques such as Socratic questioning, examining evidence, and identifying cognitive distortions, which seek to weaken metacognitions (e.g., positive and negative beliefs about worry and rumination and the function of those behaviors; positive beliefs about threat monitoring; beliefs that intrusive thoughts are important and need to be controlled). Thus, cognitive restructuring may be used to address multiple levels of thoughts, including developing more balanced and effective responses to automatic thoughts, challenging underlying assumptions, changing or modifying schemas, and changing or modifying metacognitive beliefs.

Schema Change

Cognitive models view underlying constructs such as schemas as being central to understanding problematic thinking, behaviors, and emotions. Schema change methods are used to restructure maladaptive core beliefs about self, others, the world, and the future (e.g., *I'm unlovable*, *Others are critical*, *The world is dangerous*, and *The future is bleak*) and include interventions such as

historical tests of schemas (Young et al., 2003), continuum methods that shed light on the dichotomous nature of schemas (Padesky, 1994), core beliefs worksheets to examine evidence supporting and not supporting beliefs (J. S. Beck, 2011), and positive data logs to record evidence in support of positive or balanced schemas (Padesky, 1994). Expressive writing techniques, like having a patient write narratives of past invalidating experiences as she engages in treatment of PTSD and examining how those accounts vary over the course of therapy, may also be helpful. Narrative therapy has been shown to influence self-identity (Singer, 2004) and improve psychological and physical health (Pennebaker, 2010).

Young and colleagues (2003) developed schema therapy to target chronic psychological difficulties associated with long-lasting interpersonal problems (e.g., personality disorders). Their model includes identification of the most common schemas, which they refer to as “life traps.” These schemas are developed during childhood and activated in different situations. Once agreement is reached about which schema to target, the patient monitors its activation in various situations and relationships in order to develop more effective responses to triggers.

Behavioral Experiments

Behavioral experiments complement cognitive restructuring interventions as a strategy to assess the validity of patients’ beliefs. Beliefs are tested by gathering evidence to discredit maladaptive beliefs and support new, more adaptive ones through experiential learning and practice (Bennett-Levy et al., 2004). Behavioral experiments provide observational data in real time to target cognitions at the levels of automatic thoughts, assumptions, core beliefs, schemas, and metacognitions.

Behavioral experiments may be planned to either test hypotheses (e.g., *If I get lost and ask for directions, no one will help me*) or make new discoveries (e.g., *I actually am really resilient and resourceful!*). They may be implemented in real-life situations or via role-plays and typically include trying new behaviors, observing behaviors, or surveying others to gather information. Behavioral experiments require careful planning and specificity about the cognitions and beliefs being targeted and how they will be tested. Potential safety-seeking behaviors are identified so they can be relinquished during behavioral experiments to ensure that new learning is not disrupted by reliance on subtle avoidance strategies. For example, if a patient tests the belief that she cannot handle anxiety when she is the focus of attention by designing an experiment to sing

out loud while walking down the street, she will not benefit from testing her belief if she sings so softly that no one can hear her. Given the transdiagnostic application of behavioral experiments to inform case formulations and test maladaptive beliefs, they are a core strategy that may be used to identify, test, modify, and change problematic beliefs across multiple problems and disorders (Bennett-Levy et al., 2004).

Attention Modification

Attention-focusing exercises allow patients to see how their focus of attention (e.g., bodily sensations, health concerns, negative self-images, environmental threats) can influence their thinking styles, beliefs, and feelings. These interventions also teach patients how to shift their attention.

Attention Training Techniques

Attention training techniques (Papageorgiou & Wells, 1998; Wells, 1997, 2000) are an integral component of metacognitive therapy and may be used as an effective stand-alone intervention in the treatment of mood and anxiety disorders (Wells, 2009). They were designed to change attentional styles and increase metacognitive flexibility. According to Wells, “The metacognitive model assumes that the control of attention in psychological disorder becomes inflexible as attention is bound up with perseverative, self-focused, worry-based processing and monitoring for threat. The redirection of attention away from such activity should provide a means of interrupting the CAS [cognitive attentional syndrome] and of strengthening metacognitive plans for controlling cognition (improving flexible executive control)” (2009, p. 56).

Toward this end, patients are taught to selectively attend to particular sounds while not attending to competing ones, to shift attention between sounds, and then to attend to multiple sounds simultaneously. It is important to assess motivation and ensure that patients understand the rationale for these exercises to reduce the risk of using them as a form of emotional or cognitive avoidance. The goal is to increase awareness of the focus of attention and learn to strengthen control over it.

Situational Attention Retraining

Situational attention retraining is used in metacognitive therapy to help patients shift attention in a way that allows them to process information that

is incompatible with maladaptive or distorted beliefs, or to shift away from monitoring for external threats (Wells, 2009). Clark and Wells's model of social phobia (1995) posits that patients with social anxiety engage in self-monitoring and self-focused observations with attention on negative thoughts, self-images, and internal cues. To address self-focused attention, patients engage in behavioral experiments to test beliefs and make observations as they practice shifting focus toward their external environment. They compare anxiety levels and beliefs about how they appear and perform when practicing external attention focusing versus engaging in self-focused attention, self-monitoring, and safety behaviors. Exercises that shift attention away from the internal and toward an external focus allow patients with social anxiety to discover that their anxiety lessens, which correlates with modifying beliefs about how they appear and perform (D. M. Clark, 2001).

Given that attentional bias toward threat may be a risk factor in PTSD (Aupperle et al., 2012), attention retraining can help patients with PTSD notice when they are engaging in external threat monitoring and selectively focusing attention on possible dangers. This provides a stepping-stone to assessing current situations in more balanced and effective ways, which is a key aspect of corrective learning (Foa et al., 2007). Attention training exercises to reduce bodily scrutiny have been shown to be effective in reducing hypochondriasis (Papageorgiou & Wells, 1998), and various attention-focusing exercises are useful in helping patients with health anxiety shift attention away from bodily concerns (Taylor & Asmundson, 2004). Thus, interventions aimed at modifying and changing attentional focus play an integral role in interrupting hypervigilance for threat and repetitive negative thinking, and by improving flexible executive control (Wells, 2009).

Postponement Strategies

Postponement strategies help patients refrain from engaging in immediate responses to internal or external triggers (e.g., reactive anger, escape behaviors, impulsivity), creating an opportunity to practice more effective responses learned in treatment. Postponement often is integrated into behavioral experiments, such as postponing worry to test beliefs about the uncontrollability of worry. Rumination or attending to and engaging in negative thoughts can be delayed until a later, designated time, which strengthens flexibility in how patients observe and change their responses to thoughts. The goal is not to suppress negative or anxiety-provoking thoughts, but to notice them and allow

them to arise and be present while at the same time disengaging from immediate responses of repetitive negative thinking.

Originally conceptualized as a stimulus control strategy, scheduling worry times can weaken associations between worry and external and internal stimuli (Borkovec et al., 1983). Patients are taught to identify specific worries, set specific places and times for daily worries, practice postponing worry as it is triggered throughout the day by refocusing attention on the immediate environment, and then use scheduled worry times to engage in worry. Postponement and scheduled worry or rumination times limit when and where those behaviors occur, modify and change beliefs about their usefulness, and allow patients to develop a sense of control over their responses and thinking styles when stimuli trigger the urge to engage in them.

Exposure

Exposure-based interventions target avoidance responses. Avoidance strengthens erroneous beliefs that situations, thoughts, feelings, and sensations are threatening and dangerous; that exposure to them might result in overwhelming feelings of distress or anxiety; and that the individual may not be capable of coping with the threat or discomfort. Exposure-based interventions aim to change responses to triggers of fear and discomfort by having the individual intentionally face such triggers without engaging in escape and avoidance behaviors.

Long-standing proposed mechanisms of change in exposure-based interventions have included habituation—decreasing conditioned fear by repeated and prolonged exposure to feared stimuli (Mowrer, 1960)—and emotional processing theory, in which corrective learning involves nonfear structures replacing or competing with original fear structures (Foa & Kozak, 1986). More recently, inhibitory learning (and its subsequent retrieval) has been highlighted as the key mechanism of change in exposure (Craske et al., 2008). Specifically, original associations learned during fear conditioning are not erased; rather, secondary learning about the associations develops. Exposures are designed to violate expectancies regarding feared outcomes (Craske et al., 2008; Craske et al., 2012), and strategies for optimizing inhibitory learning are emphasized, including promoting development of competing nonthreat associations and retrieval of those associations over time and across contexts (Abramowitz & Arch, 2013). Exposure sessions continue until expectancies have been violated.

Exposures can target behavioral avoidance of situations, cognitive avoidance of distressing thoughts, emotional avoidance of painful affective

experiences, or somatic avoidance of feared physiological (interoceptive) sensations. Exposure-based interventions may be conducted in vivo or by using imagery of the feared situation when real-life exposures are not possible (e.g., trauma experiences) or when patients are preparing for in vivo practices (e.g., imagining driving on the highway to generate sensory and emotional experiences prior to actually trying to do so). Traditionally, exposures are conducted through graded practices with response prevention of avoidance or escape behaviors, using a rank-ordered hierarchy of feared cues. Since violation of expectancies rather than fear reduction is the crucial change mechanism in inhibitory learning, exposures at varying levels of distress and across relevant contexts are targeted. Like behavioral experiments, exposure-based interventions provide disconfirming evidence for overestimations of threat or beliefs regarding inability to cope with or tolerate uncomfortable emotional states, thereby facilitating new learning.

Emotional exposure includes mindfulness of affective experiences to draw attention to the ebb and flow of emotions and challenge beliefs that negative emotions are interminable and intolerable (Linehan, 1993a). Emotional exposure often is used to increase tolerance of painful feelings such as shame, guilt, and anxiety and reduce patients' tendency to escape situations that evoke them. Incorporating ACT interventions (acceptance, defusion, values-based action), both alone and in conjunction with exposure, can be instrumental in reducing fear-based symptoms (Meuret, Twohig, et al., 2012).

Compassionate Mind Training and Imagery Rescripting

Compassionate mind training was developed for individuals experiencing high degrees of shame and self-criticism, which tend to co-occur and are present in many disorders (Gilbert & Irons, 2005). It posits that regulatory disruptions among neurophysiological systems of drive and achievement, threat assessment and safety seeking, and affiliation and soothing contribute to chronic shame and self-attacking behaviors. While these interventions are often used to treat trauma-related problems (e.g., PTSD following abuse, social anxiety following bullying), they are helpful in targeting negative self-schemas and attributional biases across problems. Shame and self-criticism appear transdiagnostically and have been linked to depressive rumination (Cheung et al., 2004), poor adjustment following sexual abuse (Feiring et al., 2002), diminished efficacy of cognitive interventions (Lee, 2005), and relapse in patients

recovered from depressed (Teasdale & Cox, 2001). Compassionate mind training has proven effective in reducing depression, anxiety, self-criticism, shame, inferiority, and submissive behavior (Gilbert & Proctor, 2006) and is the core strategy of compassion-focused therapy (Gilbert, 2010).

Compassion-focused therapy includes many interventions that help patients achieve balance among competing neurophysiological systems in order to experience self-compassion and increase their ability to self-soothe. Imagery can potentiate affective responses via activation of neural structures involved in emotion, perception, and autobiographical memory (Holmes & Matthews, 2010) and is used extensively in compassion-focused therapy to build self-compassion and self-validation as well as rescript outcomes to engender a sense of competence, safety, and control.

The two-chair technique (Greenberg, 1979) is used in compassion-focused therapy to help patients disengage from loathing and attacking different aspects of themselves and to facilitate self-compassion. For example, the therapist might gesture to an empty chair and ask an adult patient struggling with shame and self-criticism related to PTSD to imagine himself as a little boy sitting in session with them in present time. The therapist then might ask the patient how he sees that child and what he might say to him. When viewing themselves this way, patients often are more willing to relinquish self-attacking thoughts and behaviors.

Skillful creativity can be a key stepping-stone in developing self-compassion and helping individuals be kind to themselves. For example, children's books depicting loving and compassionate relationships may be read with patients; mantras or affirmations may be developed for daily practice that reflect themes such as "I matter" and "I am lovable"; objects within the therapist's office may be transformed into compassionate talismans that patients can recall during imagery; and patients can carry photographs of themselves as children to help them develop loving, kind, and compassionate self-schemas.

In imagery rescripting (Hackmann, 1998), patients focus on the negative content of intrusive images and memories and imagine alternative, positive outcomes that have been identified and practiced with the therapist. Imagery rescripting as either a stand-alone intervention (Brewin et al., 2009) or part of other treatments (Brewin, 2006) has been shown to be effective in providing symptom reduction in bipolar depression, hypomania, and PTSD. It is gaining increasing support as a transdiagnostic intervention for PTSD (Hackmann, 2011), social phobia (Wild & Clark, 2011), depression (Wheatley & Hackmann, 2011), eating disorders (Cooper, 2011), and personality disorders (Arntz, 2011).

Distress Tolerance Skills

Distress tolerance skills comprise a core module in DBT and were developed to help patients survive crises and accept reality as it is in the moment (Linehan, 1993b). These skills include most well-known stress management and relaxation techniques, such as progressive muscle relaxation, breathing retraining, self-soothing, and distraction. “Radical acceptance,” which refers to the ability to completely accept reality as it is in the current moment, is a key strategy within this module and is viewed as the path “to turn suffering that cannot be tolerated into pain that can be tolerated” (Linehan, 1993b, p. 102). Distinctions between willingness and willfulness are emphasized to help patients turn their minds toward acceptance, which is essential for effective problem solving. Patients also are taught biofeedback principles about how physiological changes accompanying shifts in body position and temperature trigger neurochemical changes that regulate emotions, which underlie interventions like half smiling, opening one’s hands to symbolize letting go, and briefly plunging one’s face into a bowl of ice water. Distress tolerance skills are effective in addressing multiple mechanisms, such as arousal and emotion regulation deficits, intolerance of uncertainty, and perfectionism. Once distress is lowered, patients can learn alternative coping strategies to replace escape and avoidance behaviors.

Emotion Regulation Skills

Emotion regulation is another DBT skills module. It was developed to help patients understand the critical functions of emotions, identify and label them, and reduce emotional reactivity (Linehan, 1993b). Some of the interventions are based on exposure principles to target emotional and behavioral avoidance, such as mindfulness of current emotional experiences (staying with the emotions until they dissipate) and engaging in behaviors that oppose action urges to flee unpleasant emotional states. Another strategy is creating positive emotional experiences, such as engaging in activities that evoke emotions opposite to those that are distressing (e.g., watching a funny movie to combat depression, learning to ski to target fear of heights). Cognitive interventions such as fact-checking address many of the cognitive misappraisals accompanying emotion dysregulation and help identify emotional responses that are justified based on the reality of surrounding circumstances (which are difficult to distinguish for individuals experiencing pervasive invalidation). Other emotion regulation skills involve improving sleep, nutrition, and exercise patterns to reduce physiological vulnerabilities to emotional reactivity.

Interpersonal Effectiveness Skills

Interpersonal effectiveness skills include assertiveness training and problem-solving techniques. Linehan (1993b) developed these skills to help patients with chronic interpersonal problems assess their expectations and goals in various situations and communicate more effectively with others about their needs, desires, and limits. However, many patients struggle with interpersonal communication and speaking up for themselves, regardless of presenting problem. These skills help individuals attend to relationships and find balance between others' expectations and their own needs. Some skills help patients articulate desired relationship outcomes, while others modulate the impact of emotional reactivity and maintain the individual's self-respect. Patients are taught how to listen to others, ask others to start or stop a behavior by using assertive scripts, identify goals for a particular conversation, recognize aversive interpersonal strategies they may engage in, and deal with conflict.

Adjunctive Skills Training for Specific Problems

In addition to the core change strategies, numerous interventions facilitate the development of skills to help with specific problems. We recommend using in-office training and practice, role-plays, and behavioral rehearsals to help patients master these skills and many of the other interventions described herein.

Physical Tension and Stress

A number of interventions help lower emotional arousal and reduce the physical tension that often accompanies stress.

Breathing Retraining

Breathing retraining is used to reduce stress and modulate emotional arousal. When patients release muscle tension and slow their breathing, the parasympathetic nervous system is activated, which helps them experience a more relaxed state by lowering their heart rate and blood pressure. Breathing retraining may be combined with mindfulness practices to help individuals let go of distressing thoughts and regulate emotions (Linehan, 1993b).

Breathing interventions are based on the principle that when the body experiences stress, muscles tense and air intake is restricted, creating a feeling of suffocation that frequently leads to hyperventilation. The resulting cascade of physiological changes related to reduced carbon dioxide in the blood (a condition referred to as hypocapnia) includes impaired nerve conduction, tingling sensations, tachycardia, and light-headedness or dizziness. This is particularly problematic for patients prone to panic, who are hypervigilant about respiration, heart rate, and other somatic experiences and tend to fall into a vicious cycle of increased hyperventilation and intensification of panic symptoms (see Meuret, Wolitzky-Taylor, et al., 2012, for a review). The capnometry-assisted respiratory training protocol (Meuret et al., 2010) targets panic-related hypocapnia by employing a portable feedback device to teach patients to control the rate and depth of breathing, which normalizes carbon dioxide levels and thus reduces hyperventilation. Findings show that these corrections mediated changes in symptom appraisal and perceived control and were associated with changes in panic symptom severity (Meuret et al., 2010).

Progressive Muscle Relaxation

Progressive muscle relaxation is based on the theory that many negative emotional states and psychosomatic conditions result from neuromuscular hypertension (E. Jacobson, 1938). It can be a core treatment component for some anxiety symptoms and has been found useful in reducing symptomatic distress in multiple psychological conditions (see Conrad & Roth, 2007, for a review). Progressive muscle relaxation is part of a standardized relaxation training program (D. A. Bernstein et al., 2000) that involves intentionally tensing and relaxing the muscles within various muscle groups throughout the body (e.g., legs, arms, torso) in a structured sequence. Patients are coached to tense individual muscles within each group for approximately seven to ten seconds as they inhale, followed by releasing them for about fifteen to twenty seconds as they exhale. Over time, patients learn to notice and differentiate states of tension and relaxation and can recall the sensations without tensing and releasing muscles. The goal is to achieve voluntary relaxation states throughout the body in order to reduce emotional arousal and distress across situations.

Applied Relaxation

Applied relaxation (Borkovec & Costello, 1993) involves learning skills to notice early signs of anxiety and respond with relaxation before the cycle

of anxiety becomes entrenched. It has been used as a treatment component for GAD and has been shown to be equivalent to cognitive therapy for treating GAD (Siev & Chambless, 2007). It incorporates psychoeducation about anxiety, exercises to enhance early detection of anxiety cues (e.g., clenched jaw, stiff neck), and relaxation skills. Relaxation training includes breathing retraining exercises, progressive muscle relaxation, and cue-controlled relaxation. Cue-controlled relaxation pairs words such as “relaxing” with physical and emotional feelings of relaxation following progressive muscle relaxation—for example, using the word “relaxing” when exhaling—so that future invocation of cue words in distressing situations will facilitate relaxation and reduce emotional and physiological arousal. Mindfulness-based body scans (Segal et al., 2002) are incorporated to increase nonjudgmental awareness of tension, helping patients release muscle tension throughout the day. Recently, it was hypothesized that applied relaxation may lead to clinical improvement via mindfulness, decentering, and acceptance (Hayes-Skelton et al., 2012).

Guided Imagery

Another intervention that facilitates reduction in emotional and physiological arousal is guided visualization of thoughts and images to elicit a feeling of safety and soothing. Imagery has been shown to be more effective than verbal, language-based processing in evoking emotions (Holmes & Mathews, 2010), and negative imagery is associated with a multitude of psychological problems (Hackmann & Holmes, 2004). Incorporating imagery into CBT can target multiple mechanisms and potentiate positive behavioral change (Hackmann et al., 2011). Imagery in the service of stress reduction utilizes meaningful, patient-specific scenarios rich in emotional, sensory, cognitive, and environmental detail to facilitate relaxation and self-soothing. For example, a therapist might help someone who enjoys the ocean visualize lying on a warm beach while imagining the sounds of the water lapping against the shore, the warmth of the sun on her face and the sand under her body, the salty smell of the ocean, and the cool breeze washing over her. Audio recordings of imagery exercises may be used to facilitate recall outside session.

Anger Management Problems

CBT protocols for anger management problems include psychoeducation about the anger cycle, stress management techniques (e.g., interventions

targeting physical tension), cognitive restructuring, and assertiveness training (e.g., Reilly et al., 2002). Other models also include imaginal exposure of anger-inducing situations with coping rehearsal, training in problem solving, and motivational interviewing (Fuller et al., 2010). ACT-based strategies for managing anger emphasize mindfulness practices to facilitate acceptance of anger (versus attempts to control or suppress it), cognitive defusion to help patients increase tolerance of anger and alter how they respond to it, and identification of values and strategies for committed action to help them create a more desirable life (Eifert et al., 2006).

Problem Solving

Problem-solving therapy focuses on enhancing the ability to cope with life stressors and overcoming barriers to effective problem solving, such as cognitive overload under stress, limited emotion regulation skills, biased cognitive processing, limited motivation, and ineffective problem-solving styles (Nezu et al., 2013). Two problem-solving dimensions, problem orientation and problem-solving style (D’Zurilla et al., 2002), underpin this treatment, which presents strategies designed to enhance positive problem-solving orientation and rational problem solving, decrease negative problem-solving orientation, and minimize avoidant or impulsive problem solving (Nezu et al., 2013). Problem-solving therapy is an empirically supported and flexible approach that can be a primary or adjunctive treatment, with its efficacy demonstrated across multiple physical and emotional problems, including depression (Nezu et al., 2013). Many patients can benefit from interventions that improve problem solving. J. S. Beck (2011) uses a problem-solving worksheet to guide patients in identifying problems, revealing automatic thoughts and beliefs related to each problem, developing effective responses, and generating possible solutions.

Improving problem-solving skills is a core intervention in the treatment of ADHD, helping patients accurately identify problems, consider all possible solutions and likely outcomes of each option, choose the best solution based on potential outcomes, and break down tasks into manageable steps (Safren et al., 2005). Using tangible and external aids (e.g., writing things down) facilitates problem solving by decreasing reliance on working memory when completing these problem-solving steps (Barkley, 2010).

Attentional, Organizational, and Hyperactivity Problems

Interventions that were developed for adults with ADHD target neurophysiological vulnerabilities such as impairments in inhibition, self-control, and executive functioning (Barkley, 2010; Solanto, 2011). Patients with ADHD generally benefit from learning strategies that facilitate self-regulation of emotions and impulsivity and enhance recognition of and attention to the consequences of choices. ADHD protocols also include skills to improve self-control, such as increasing awareness of and resisting impulses, and learning to delay immediate gratification in the service of long-term benefits. Compensatory strategies for neuropsychiatric impairments in attention, inhibition, and impulsivity are instrumental in improving patient functioning (Safren et al., 2005). These include stimulus control strategies to manage distractibility (e.g., reduce distracting noises, increase background noise) and enhance problem solving, organizing, planning, and time management skills.

Organization and Planning

Problems with organization and planning reflect core executive functioning deficits in ADHD (Solanto, 2011), though patients seeking treatment for other problems (e.g., bipolar depression) may experience similar difficulties. Building skills in organization and planning involves many strategies that are individualized to patients' needs and center around teaching them to develop external means of remembering rather than relying on their internal memory. For example, learning to use a single calendar and notebook to help remember appointments, activities, and tasks, with organizational systems that include color coding and clearly labeled file folders for distinguishing and quickly accessing information, is highly effective (Solanto, 2011). Other strategies include prioritizing tasks, developing systems for keeping track of items (e.g., always hang keys on the same wall hook), deconstructing large tasks into more manageable steps, working for shorter periods of time, and taking planned breaks to help maintain focus. Many patients may benefit from learning organizational and planning skills, especially if deficits in these areas impact other problems and overall functioning, including the ability to complete therapy homework.

Time Management

Time management is another primary executive functioning problem in ADHD (Solanto, 2011), though many patients can benefit from time management strategies, such as recording how long tasks take to make more realistic predictions about their capabilities and improve scheduling. Similarly, using timers or setting alarms to help cue remembering can help keep patients on task, and having regular check-ins with the therapist for feedback and coaching can facilitate ongoing practice between sessions to help patients master skills and incorporate them into daily routines.

Sleep Problems

Many patients experience sleep problems, which may stem from primary insomnia or from mood, anxiety, and other disorders. Treatment of sleep problems targets mechanisms of conditioned arousal (i.e., stimuli that signal sleep, such as the bed, bedroom, or nighttime, having become associated with insomnia), safety-seeking behaviors that contribute to an attentional focus and hypervigilance about sleep (e.g., symptom monitoring, clock watching), and dysfunctional beliefs about sleep. In addition to cognitive restructuring and behavioral experiments to address beliefs about “normal” sleep and negative consequences related to lack of sleep, other behavioral strategies are available to target maladaptive coping responses. These interventions help patients associate sleep stimuli with sleep and interrupt conditioning with other stimuli. Sleep restriction (restricting the amount of time spent in bed nightly to the average amount of nightly sleep, based on data obtained from logging sleep patterns) is used to increase sleep efficiency. Stimulus control strategies (limiting behaviors and conditions that could interrupt sleep and following a strict sleep regimen) are used to build conditioning of bedtime stimuli with sleep. Sleep hygiene strategies can help create healthy habits that may improve sleep, such as restricting certain activities (e.g., use of electronics) prior to bedtime and limiting use of the bedroom to sleeping and sexual activity. Many of the relaxation practices described earlier are incorporated to help reduce somatic and cognitive arousal, which may interfere with sleep. For detailed information about interventions to treat sleep disorders, see Morin and Espie (2012) and Perlis and colleagues (2011).

Problems Involving Eating Behaviors

Some patients experience problems involving bingeing, purging, and restricting intake of food, even if they do not present with a primary eating disorder. Due to the potential health risks associated with these problems (e.g., starvation, electrolyte imbalance), therapists must evaluate patients for medical intervention and seek consultation and referral as necessary. Traditional CBT interventions include cognitive restructuring of misconceptions about food and body weight; self-monitoring of food intake (e.g., what the patient eats, when and where food is consumed, situations and feelings surrounding eating); logging problematic thoughts and behaviors related to eating (e.g., urges to binge, misappraisals of food intake, vomiting, and laxative use); and preventing escape behaviors such as bingeing and purging (Fairburn, 2008). CBT strategies (J. S. Beck, 2007) are equally effective in helping overweight patients increase awareness of problematic thoughts and behaviors and learn skills to successfully implement healthy weight loss plans. ACT-based protocols (Sandoz et al., 2010) emphasize identification of patient values, interventions such as cognitive defusion to help patients step back from their problems, and increasing patients' psychological flexibility so that they can replace problematic eating behaviors with committed action that will move them toward the life they want.

Problems with Body-Focused Repetitive Behaviors

Strategies aimed at reducing and managing body-focused repetitive behaviors, such as trichotillomania and pathological skin picking, encompass a range of interventions targeting core mechanisms hypothesized to contribute to these problem behaviors. Detailed self-monitoring of the behavior and its antecedents and consequences increases awareness of problem components and provides information to guide the selection and timing of interventions. Habit reversal training (Azrin & Nunn, 1973) includes awareness training, competing response training (e.g., responses that are incompatible with picking or pulling, such as fist clenching), and social support. A comprehensive model for behavioral treatment of trichotillomania (Mansueto et al., 1999) identifies problems and interventions across sensory, cognitive, affective, motoric, and situational domains. Many interventions can target mechanisms within these domains, including cognitive restructuring, emotion and arousal regulation

strategies, and stimulus control (e.g., covering mirrors, removing tweezers), among others. Specific interventions to provide sensory substitutes (e.g., toys to fidget with, textured objects) and block automatic motor responses (e.g., wearing gloves or rubber fingertips, changing positioning of hands during routine activities) are among many available options that can be individualized to fit the patient's needs. In addition, studies indicate that incorporating acceptance-based strategies from ACT (Flessner et al., 2008) and emotion regulation strategies from DBT (Keuthen et al., 2012) can be beneficial in treating problems with body-focused repetitive behaviors.

Other Interventions

While we have attempted to cover most well-known interventions, we recognize that there are countless techniques—well beyond the limits of space and scope of this book—that can help people resolve problems, reduce suffering, and improve their lives. Diagnosis-specific treatments (e.g., Linehan, 1993a), universal or transdiagnostic protocols (e.g., Barlow et al., 2011), and treatments targeting specific vulnerability mechanisms, such as perfectionism (Egan et al., in press) can help direct clinicians toward interventions proven most effective in targeting components of presenting problems. We encourage therapists to collaborate with their patients to find the most appropriate and effective interventions based on the TDM formulation, and to be creative in tailoring techniques to meet individual needs.

APPENDIX

Road Map Worksheets

Feel free to reproduce the worksheets in this appendix for use in your practice. They are also available in standard, 8½ x 11 format; visit <http://www.newharbinger.com/28951> to download them. Instructions for download can be found on the very last page of this book.

Problem Deconstruction Log

Name: _____ Date: _____

Problematic situation: Please specify who, what, when, and where.

Thoughts: What were you thinking at the time? Any images?

Emotions: What emotions did you feel at the time?

Physical sensations: Did you notice anything in your body?

Behaviors: What did you do?

Observations: Please indicate anything that stands out for you.

TDM Hypotheses Worksheet

Name: _____ Date: _____

Diagnostic considerations (based on intake forms, interview, initial measures)

Observations (by therapist, patient, family or others)

Hypothesized mechanisms based on specific examples of presenting problems (from Problem Deconstruction Logs, thought records, chain analyses, intake data, etc.)

Mechanism measures (to confirm, disconfirm, or further understand components of TDM hypotheses)

TDM Formulation Worksheet

Name: _____ Date: _____

Identified problems

Hypothesized mechanisms (from the TDM Hypotheses Worksheet)

Narrative or diagrams of how the mechanisms fit together and explain patient problems

Factors that could worsen problems or impede treatment

Patient strengths and resources that could support and facilitate treatment

Treatment Goals Worksheet

Name: _____ Date: _____

Global outcome goals and markers of change (What will life look like if treatment is successful?)

Mechanism change goals and markers of change (What needs to change?)

Motivation and readiness for change (Where is the patient on the continuum of readiness for change? Be sure to address concerns about general changes *and* concerns about mechanism changes.)

Prioritization of global outcome and mechanism change goals (e.g., life-threatening and other immediate concerns, facilitating treatment of other problems, patient preferences, etc.)

Progress Note

Patient name: _____ Date: _____ Session #: _____

Others present: No Yes Who: _____

Measures and scores:

CPT (billing) Code and service description:

Mental status (mood, affect, thinking, judgment, appearance):

Within normal limits Note any comments or changes:

Emergent or important events:

Homework follow-up:

Focus of session: Treatment goals and mechanisms targeted

Interventions Used or Reviewed in Session

Enhance understanding and motivation for change

- Psychoeducation
- Conversation about ambivalence and motivation to change
- Cost-benefit analysis
- Identifying values
- Other: _____

Core strategies for change

- Behavioral activation
- Behavioral contingencies
- Cognitive restructuring
- Schema change
- Behavioral experiments
- Attention training techniques
- Situational attention retraining
- Postponement strategies
- Exposure (behavioral, cognitive, emotional, and interoceptive)
- Compassionate mind training and imagery rescripting
- Distress tolerance skills
- Emotion regulation skills
- Interpersonal effectiveness skills
- Other: _____

Facilitate stepping back from problems

- Problem deconstruction and analysis
- Self-monitoring
- Mindfulness
- Detached mindfulness
- Acceptance and validation
- Cognitive defusion
- Other: _____

Skill development

- Breathing retraining
- Progressive muscle relaxation
- Applied relaxation
- Guided imagery
- Anger management
- Problem solving
- Organization and planning
- Time management
- Sleep management
- Strategies for eating problems
- Strategies for body-focused repetitive behaviors
- Other: _____

Discuss or follow up on adjunctive treatment components

- Medication and medication compliance
- Coordination with other providers
- Support groups or educational groups
- Other: _____

Indicate any changes to the TDM formulation or treatment plan:

Homework plan:

Next session (date/day/time): _____

Therapist signature: _____ Date: _____

References

- Abramowitz, J. S. (2009). *Getting Over OCD*. New York: Guilford.
- Abramowitz, J. S., & Arch, J. J. (2013). Strategies for improving long-term outcomes in cognitive behavioral therapy for obsessive-compulsive disorder: Insights from learning theory. *Cognitive and Behavioral Practice, 21*, 20-31.
- Abramowitz, J. S., Tolin, D. F., & Street, G. P. (2001). Paradoxical effects of thought suppression. *Clinical Psychology Review, 21*, 683–703.
- Abramowitz, J. S., Whiteside, S., Kalsy, S. A., et al. (2003). Thought control strategies in obsessive-compulsive disorder. *Behaviour Research and Therapy, 41*, 529–540.
- Addis, M. E., Wade, W. A., & Hatgis, C. (1999). Barriers to dissemination of evidence-based practices: Addressing practitioners' concerns about manual-based psychotherapies. *Clinical Psychology: Science and Practice, 6*, 430–441.
- Ahmed, E., & Braithwaite, V. (2004). "What, me ashamed?" Shame management and school bullying. *Journal of Research in Crime and Delinquency, 41*, 269–294.
- Aldao, A., & Nolen-Hoeksema, S. (2010). Specificity of cognitive emotion regulation strategies: A transdiagnostic examination. *Behaviour Research and Therapy, 48*, 974–983.
- Alloy, L. B., Abramson, L. Y., Walshaw, P. D., et al. (2006). Cognitive vulnerability to unipolar and bipolar mood disorders. *Journal of Social and Clinical Psychology, 25*, 726–754.
- Alloy, L. B., & Riskind, J. H. (Eds.). (2006). *Cognitive vulnerability to emotional disorders*. Mahwah, NJ: Lawrence Erlbaum.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA.
- American Psychological Association. (2010). American Psychological Association ethical principles of psychologists and code of conduct including 2010 amendments. Retrieved October 20, 2012, from <http://www.apa.org/ethics/code/index.aspx>.

- Anestis, M. D., Fink, E. L., Smith, A. R., et al. (2011). Eating disorders. In A. Bernstein, M. J. Zvolensky, & A. A. Vujanovic (Eds.), *Distress tolerance*. New York: Guilford.
- Anestis, M. D., Knorr, A. C., Tull, M. T., et al. (2013). The importance of high distress tolerance in the relationship between nonsuicidal self-injury and suicide potential. *Suicide and Life-Threatening Behavior*, *43*, 663–675.
- Antony, M. M., Ledley, D. R., & Heimberg, R. G. (2005). *Improving outcomes and preventing relapse in cognitive-behavioral therapy*. New York: Guilford.
- Antony, M. M., Orsillo, S. M., & Roemer, L. (2001). *Practitioner's guide to empirically based measures of anxiety*. New York: Springer.
- Arntz, A. (2011). Imagery rescripting for personality disorders. *Cognitive and Behavioral Practice*, *18*, 466–481.
- Aupperle, R. L., Melrose, A. J., Stein, M. B., et al. (2012). Executive function and PTSD. *Neuropharmacology*, *62*, 686–694.
- Azrin, N. H., & Nunn, R. G. (1973). Habit reversal. *Behaviour Research and Therapy*, *11*, 619–628.
- Baer, R. A. (2003). Mindfulness training as a clinical intervention. *Clinical Psychology: Science and Practice*, *10*, 125–143.
- Baer, R. A., Peters, J. R., Eisenlohr-Moul, T. A., et al. (2012). Emotion-related cognitive processes in borderline personality disorder. *Clinical Psychology Review*, *32*, 359–369.
- Baer, R. A., Smith, G. T., Hopkins, J., et al. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment*, *13*, 27–45.
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, M., & Goldman, C. (1995). Expanding the contextual analysis of clinical problems. *Cognitive and Behavioral Practice*, *2*, 119–141.
- Baptista, M. N., Magna, L. A., McKay, D., et al. (2011). Assessment of obsessive beliefs: Comparing individuals with obsessive-compulsive disorder to a medical sample. *Journal of Behavior Therapy and Experimental Psychiatry*, *42*, 1–5.
- Bardone-Cone, A. M., Wonderlich, S. A., Frost, R. O., et al. (2007). Perfectionism and eating disorders. *Clinical Psychology Review*, *27*, 384–405.
- Barkley, R. A. (1997). Behavioral inhibition, sustained attention, and executive functioning: Constructing a unifying theory of ADHD. *Psychological Bulletin*, *121*, 65–94.
- Barkley, R. A. (2010). *Taking charge of adult ADHD*. New York: Guilford.
- Barlow, D. H. (2000). Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory. *American Psychologist*, *55*, 1247–1263.
- Barlow, D. H. (2002). *Anxiety and its disorders* (2nd ed.). New York: Guilford.
- Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders. *Behavior Therapy*, *35*, 205–230.
- Barlow, D. H., Farchione, T. J., Fairholme, C. P., et al. (2011). *Unified protocol for transdiagnostic treatment of emotional disorders*. New York: Oxford University Press.
- Barlow, D. H., Levitt, J. T., & Bufka, L. F. (1999). The dissemination of empirically supported treatments. *Behaviour Research and Therapy*, *37*, 147–162.

- Beck, A. T. (1964). Thinking and depression: II. Theory and therapy. *Archives of General Psychiatry*, *10*, 561–571.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.
- Beck, A. T., Emery, G., & Greenberg, R. L. (1985). *Anxiety disorders and phobias*. New York: Basic Books.
- Beck, A. T., Freeman, A., & Davis, D. D. (2006). *Cognitive therapy of personality disorders* (2nd ed.). New York: Guilford.
- Beck, A. T., Rush, A. J., Shaw, B. F., et al. (1979). *Cognitive therapy of depression*. New York: Guilford.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory* (2nd ed). (BDI-II). San Antonio, TX: Psychological Corporation.
- Beck, J. G., Gudmundsdottir, B., Palyo, S. A., et al. (2006). Rebound effects following deliberate thought suppression: Does PTSD make a difference? *Behavior Therapy*, *37*, 170–180.
- Beck, J. S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York: Guilford.
- Beck, J. S. (2007). *The Beck diet solution*. Birmingham, AL: Oxmoor House.
- Beesdo-Baum, K., Jenjahn, E., Hofler, M., et al. (2012). Avoidance, safety behavior, and reassurance seeking in generalized anxiety disorder. *Depression and Anxiety*, *29*, 948–957.
- Beevers, C. G. (2005). Cognitive vulnerability to depression. *Clinical Psychology Review*, *25*, 975–1002.
- Behar, E., DiMarco, I. D., Hekler, E. B., et al. (2009). Current theoretical models of generalized anxiety disorder (GAD). *Journal of Anxiety Disorders*, *3*, 1011–1023.
- Beidas, R. S., Benjamin, C. L., Puleo, C. M., et al. (2010). Flexible applications of the Coping Cat program for anxious youth. *Cognitive and Behavioral Practice*, *17*, 142–153.
- Beidas, R. S., & Kendall, P. C. (2010). Training therapists in evidence-based practice. *Clinical Psychology: Science and Practice*, *17*, 1–30.
- Bell, A. C., & D’Zurilla, T. J. (2009). Problem-solving therapy for depression. *Clinical Psychology Review*, *29*, 348–353.
- Bennett, D. S., Sullivan, M. W., & Lewis, M. (2005). Young children’s adjustment as a function of maltreatment, shame, and anger. *Child Maltreatment*, *10*, 311–323.
- Bennett-Levy, J., Butler, G., Fennell, M., et al. (Eds.). (2004). *Oxford guide to behavioural experiments in cognitive therapy*. New York: Oxford University Press.
- Bentley, K. H., Gallagher, M. W., Boswell, J. F., et al. (2013). The interactive contributions of perceived control and anxiety sensitivity in panic disorder: A triple vulnerabilities perspective. *Journal of Psychopathology and Behavioral Assessment*, *35*, 57–64.
- Bergomi, C., Ströhle, G., Michalak, J., et al. (2013). Facing the dreaded: Does mindfulness facilitate coping with distressing experiences? A moderator analysis. *Cognitive Behaviour Therapy*, *42*, 21–30.
- Bernstein, A., Zvolensky, M. J., Vujanovic, A. A., et al. (2009). Integrating anxiety sensitivity, distress tolerance, and discomfort intolerance. *Behavior Therapy*, *40*, 291–301.

- Bernstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New directions in progressive relaxation training*. Westport, CT: Praeger.
- Bernstein, E. M., & Putnam, F. W. (1986). Development, validity, and reliability of a dissociation scale. *Journal of Nervous and Mental Disease*, *174*, 727–735.
- Boelen, P. A., & Reijntjes, A. (2009). Intolerance of uncertainty and social anxiety. *Journal of Anxiety Disorders*, *3*, 130–135.
- Bohart, A. C., Elliott, R., Greenberg, L. S., et al. (2002). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work*. New York: Oxford University Press.
- Bond, F. W., Hayes, S. C., Baer, R. A., et al. (2011). Preliminary psychometric properties of the Acceptance and Action Questionnaire – II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy*, *42*, 676–688.
- Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice*, *16*, 252–260.
- Borkovec, T. D., Alcaine, O. M., & Behar, E. (2004). Avoidance theory of worry and generalized anxiety disorder. In R. G. Heimberg, C. L. Turk, & D. S. Mennin (Eds.), *Generalized anxiety disorder*. New York: Guilford.
- Borkovec, T. D., & Costello, E. (1993). Efficacy of applied relaxation and cognitive-behavioral therapy in the treatment of generalized anxiety disorder. *Journal of Consulting and Clinical Psychology*, *61*, 611–619.
- Borkovec, T. D., & Roemer, L. (1995). Perceived functions of worry among generalized anxiety disorder subjects. *Journal of Behavior Therapy and Experimental Psychiatry*, *26*, 25–30.
- Borkovec, T. D., Wilkinson, L., Folensbee, R., et al. (1983). Stimulus control applications to the treatment of worry. *Behaviour Research and Therapy*, *21*, 247–251.
- Bourne, C., Mackay, C. E., & Holmes, E. A. (2013). The neural basis of flashback information. *Psychological Medicine*, *43*, 1521–1532.
- Brewin, C. R. (2006). Understanding cognitive behaviour therapy: A retrieval competition account. *Behaviour Research and Therapy*, *44*, 765–784.
- Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of post-traumatic stress disorder. *Psychological Review*, *103*, 670–686.
- Brewin, C. R., Gregory, J. D., Lipton, M., et al. (2010). Intrusive images in psychological disorders. *Psychological Review*, *117*, 210–232.
- Brewin, C. R., Wheatley, J., Patel, T., et al. (2009). Imagery rescripting as a brief stand-alone treatment for depressed patients with intrusive memories. *Behaviour Research and Therapy*, *47*, 569–576.
- Briere, J. (2001). *Detailed Assessment of Posttraumatic Stress (DAPS)*. Odessa, FL: Psychological Assessment Resources.
- Briere, J. (2011). *Trauma Symptom Inventory – 2: Professional manual*. Odessa, FL: Psychological Assessment Resources.
- Brockmeyer, T., Bents, H., Holtforth, M. G., et al. (2012). Specific emotion regulation impairments in major depression and anorexia nervosa. *Psychiatry Research*, *200*, 550–553.

- Brockmeyer, T., Holtforth, M. G., Pfeiffer, N., et al. (2012). Mood regulation expectancies and emotion avoidance in depression vulnerability. *Personality and Individual Differences*, *53*, 351–354.
- Brown, T. A., & Naragon-Gainey, K. (2013). Evaluation of the unique and specific contributions of dimensions of the triple vulnerability model to the prediction of DSM-IV anxiety and mood disorder constructs. *Behavior Therapy*, *44*, 277–292.
- Brown, T. A., White, K., Forsyth, J., et al. (2004). The structure of perceived emotional control: Psychometric properties of a revised Anxiety Control Questionnaire. *Behavior Therapy*, *35*, 75–99.
- Bryant, R. A. (2010). The complexity of complex PTSD. *American Journal of Psychiatry*, *167*, 879–881.
- Buhr, K., & Dugas, M. J. (2006). Investigating the construct validity of intolerance of uncertainty and its unique relationship to worry. *Journal of Anxiety Disorders*, *20*, 222–236.
- Burns, D. D. (1999). *The feeling good handbook*. New York: Plume.
- Campbell-Sills, L., & Barlow, D. H. (2007). Incorporating emotion regulation in conceptualizations and treatments of anxiety and mood disorders. In J. J. Gross (Ed.), *Handbook of emotion regulation*. New York: Guilford.
- Campbell-Sills, L., Barlow, D. H., Brown, T. A., et al. (2006). Effects of suppression and acceptance on emotional responses of individuals with anxiety and mood disorders. *Behaviour Research and Therapy*, *44*, 1251–1263.
- Carleton, R. N., Collimore, K. C., & Asmundson, G. J. G. (2007). Social anxiety and fear of negative evaluation: Construct validity of the BFNE-II. *Journal of Anxiety Disorders*, *21*, 131–141.
- Carleton, R. N., Mulvogue, M. K., Thibodeau, M. A., et al. (2012). Increasingly certain about uncertainty: Intolerance of uncertainty across anxiety and depression. *Journal of Anxiety Disorders*, *26*, 468–479.
- Carleton, R. N., Norton, P. J., & Asmundson, G. J. G. (2007). Fearing the unknown: A short version of the Intolerance of Uncertainty Scale. *Journal of Anxiety Disorders*, *21*, 105–117.
- Carleton, R. N., Park, I., & Asmundson, G. J. G. (2006). The Illness/Injury Sensitivity Index. *Depression and Anxiety*, *23*, 340–346.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685–716.
- Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy*, *44*, 371–394.
- Cheung, M. S. P., Gilbert, P., & Irons, C. (2004). An exploration of shame, social rank, and rumination in relation to depression. *Personality and Individual Differences*, *36*, 1143–1153.
- Chorpita, B. F. (2007). *Modular cognitive-behavioral therapy for childhood anxiety disorders*. New York: Guilford.
- Chorpita, B. F., & Barlow, D. H. (1998). The development of anxiety: The role of control in the early environment. *Psychological Bulletin*, *124*, 3–21.

- Clark, D. A. (2009). Cognitive behavioral therapy for anxiety and depression: Possibilities and limitations of a transdiagnostic perspective. *Cognitive Behaviour Therapy*, 38, 29–34.
- Clark, D. M. (1986). A cognitive approach to panic. *Behaviour Research and Therapy*, 24, 461–470.
- Clark, D. M. (2001). A cognitive perspective on social phobia. In W. R. Crozier & L. E. Alden (Eds.), *Research and interventions relating to the self and shyness*. West Sussex, UK: Wiley.
- Clark, D. M., & Wells, A. (1995). The cognitive model of social phobia. In R. G. Heimberg, M. R. Liebowitz, D. A. Hope, et al. (Eds.), *Social phobia*. New York: Guilford.
- Clay, R. A. (2010). More than one way to measure. *Monitor on Psychology*, 41, 30–31.
- Clen, S. L., Mennin, D. S., & Fresco, D. M. (2011). Major depressive disorder. In A. Bernstein, M. J. Zvolensky, & A. A. Vujanovic (Eds.), *Distress tolerance*. New York: Guilford.
- Cloitre, M., Miranda, R., Stovall-McClough, K. C., et al. (2005). Beyond PTSD: Emotion regulation and interpersonal problems as predictors of functional impairment in survivors of childhood abuse. *Behavior Therapy*, 36, 119–134.
- Cohen, J. S., Edmunds, J. M., Brodman, D. M., et al. (2013). Using self-monitoring. *Cognitive and Behavioral Practice*, 20, 419–428.
- Collimore, K. C., Asmundson, G. J. G., Taylor, S., et al. (2009). Socially related fears following exposure to trauma. *Journal of Anxiety Disorders*, 23, 240–246.
- Conrad, A., & Roth, W. T. (2007). Muscle relaxation therapy for anxiety disorders. *Journal of Anxiety Disorders*, 21, 243–264.
- Cooper, M. J. (2011). Working with imagery to modify core beliefs in people with eating disorders. *Cognitive and Behavioral Practice*, 18, 454–465.
- Corcoran, K., & Fischer, J. (2013a). *Measures for clinical practice and research: Volume 1. Couples, family, and children*. New York: Oxford University Press.
- Corcoran, K., & Fischer, J. (2013b). *Measures for clinical practice and research: Volume 2. Adults*. New York: Oxford University Press.
- Craske, M. G. (2012). Transdiagnostic treatment for anxiety and depression. *Depression and Anxiety*, 29, 749–753.
- Craske, M. G., & Barlow, D. H. (2008). Panic disorder and agoraphobia. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (4th ed.). New York: Guilford.
- Craske, M. G., Kircanski, K., Zelikowsky, M., et al. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy*, 46, 5–27.
- Craske, M. G., Liao, B., Brown, L., et al. (2012). Role of inhibition in exposure therapy. *Journal of Experimental Psychopathology*, 3, 322–345.
- Crowell S. E., Beauchaine, T. P., Gatzke-Kopp, L., et al. (2006). Autonomic correlates of attention-deficit/hyperactivity disorder and oppositional defiant disorder in preschool children. *Journal of Abnormal Psychology*, 115, 174–178.
- Crowell, S. E., Beauchaine, T. P., McCauley, E., et al. (2005). Psychological, physiological, and serotonergic correlates of parasuicidal behavior among adolescent girls. *Development and Psychopathology*, 17, 1105–1127.

- Dattilio, F. M., Edwards, D. J. A., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: Toward a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy, 47*, 427–441.
- Dattilio, F. M., & Hanna, M. (2012). Collaboration in cognitive-behavioral therapy. *Journal of Clinical Psychology, 68*, 146–158.
- Davidson, J., Martinez, K. A., & Thomas, C. (2006). Validation of a new measure of functioning and satisfaction for use in outpatient clinical practice. Paper presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, Chicago, IL.
- Deacon, B. J., & Abramowitz, J. S. (2006). Anxiety sensitivity and its dimensions across the anxiety disorders. *Journal of Anxiety Disorders, 20*, 837–857.
- Deacon, B. J., & Abramowitz, J. S. (2008). Is hypochondriasis related to OCD, panic disorder, or both? *Journal of Cognitive Psychotherapy, 22*, 115–127.
- DeJong, P., & Berg, I. K. (2008). *Interviewing for solutions* (3rd ed.). Belmont, CA: Brooks/Cole.
- Derogatis, L. (1977). *SCL-90-R: Administration, scoring, and procedures manual*. Baltimore, MD: Clinical Psychometric Research.
- DeShazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York: Norton.
- Diamond, L. M., & Aspinwall, L. G. (2003). Emotion regulation across the life span. *Motivation and Emotion, 27*, 125–156.
- Dickson, K. S., Ciesla, J. A., & Reilly, L. C. (2012). Rumination, worry, cognitive avoidance, and behavioral avoidance: Examination of temporal effects. *Behavior Therapy, 43*, 629–640.
- Dugas, M. J., Buhr, K., & Ladouceur, R. (2004). The role of intolerance of uncertainty in etiology and maintenance. In R. G. Heimberg, C. L. Turk, & D. S. Mennin (Eds.), *Generalized anxiety disorder*. New York: Guilford.
- Dugas, M. J., Gagnon, F., Ladouceur, R., et al. (1998). Generalized anxiety disorder: A preliminary test of a conceptual model. *Behaviour Research and Therapy, 3*, 215–226.
- Dugas, M. J., Marchand, A., & Ladouceur, R. (2005). Further validation of a cognitive-behavioral model of generalized anxiety disorder. *Journal of Anxiety Disorders, 19*, 329–343.
- Duncan, B. L., & Miller, S. D. (2008). *The Outcome and Session Rating Scales: The revised administration and scoring manual, including the Child Outcome Rating Scale*. Chicago: Institute for the Study of Therapeutic Change.
- Dunkley, D., Blankstein, K., Masheb, R., et al. (2006). Personal standards and evaluative concerns dimensions of “clinical” perfectionism. *Behaviour Research and Therapy, 44*, 63–84.
- D’Zurilla, T. J., Nezu, A. M., & Maydeu-Olivares, A. (2002). *Manual for the Social Problem-Solving Inventory* (Rev. ed). (SPSI-R). North Tonawanda, NY: Multi-Health Systems.
- Edman, J. L., Yates, A., Aruguete, M., et al. (2011). The impact of self-loathing on disordered eating attitudes among obese females. *North American Journal of Psychology, 13*, 539–548.

- Egan, S. J., Hattaway, M., & Kane, R. T. (2013). The relationship between perfectionism and rumination in post traumatic stress disorder. *Behavioural and Cognitive Psychotherapy*, *42*, 211-233.
- Egan, S. J., Wade, T. D., Shafran, R., et al. (in press). *Cognitive behavioral treatment of perfectionism*. New York: Guilford.
- Egan, S. J., Wade, T. D., & Shafran, R. (2011). Perfectionism as a transdiagnostic process. *Clinical Psychology Review*, *31*, 203-212.
- Egan, S. J., Wade, T. D., & Shafran, R. (2012). The transdiagnostic process of perfectionism. *Revista de Psicopatología y Psicología Clínica*, *17*, 279-294.
- Ehlers, A., & Breuer, P. (1992). Increased cardiac awareness in panic disorder. *Journal of Abnormal Psychology*, *101*, 371-382.
- Ehlers, A., & Clark, D. M. (2000). Cognitive factors involved in the onset and maintenance of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*, 319-345.
- Ehring, T., & Watkins, E. (2008). Repetitive negative thinking as a transdiagnostic process. *International Journal of Cognitive Therapy*, *1*, 192-205.
- Eifert, G. H., McKay, M., & Forsyth, J. P. (2006). *ACT on life not on anger*. Oakland, CA: New Harbinger.
- Eysenck, M. W., Derakshan, N., Santos, R., et al. (2007). Anxiety and cognitive performance: Attentional control theory. *Emotion*, *7*, 336-353.
- Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. New York: Guilford.
- Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive-behaviour therapy for eating disorders. *Behaviour Research and Therapy*, *41*, 509-528.
- Fairchild, H., & Cooper, M. (2010). A multidimensional measure of core beliefs related to eating disorders. *Eating Behaviors*, *11*, 239-246.
- Feiring, C., Taska, L., & Lewis, M. (2002). Adjustment following sexual abuse discovery: The role of shame and attributional style. *Developmental Psychology*, *38*, 79-92.
- Fergus, T. A., & Wu, K. D. (2010). Do symptoms of generalized anxiety and obsessive-compulsive disorder share cognitive processes? *Cognitive Therapy Research*, *34*, 168-176.
- Fergus, T. A., & Wu, K. D. (2011). Searching for specificity between cognitive vulnerabilities and mood and anxiety symptoms. *Journal of Psychopathology and Behavioral Assessment*, *33*, 446-458.
- Ferster, C. B. (1973). A functional analysis of depression. *American Psychologist*, *28*, 857-870.
- Flessner, C. A., Busch, A. M., Heideman, P. W., et al. (2008). Acceptance-enhanced behavior therapy (AEBT) for trichotillomania and chronic skin picking. *Behavior Modification*, *32*, 579-594.
- Fletcher, K. E. (2011). Understanding and assessing traumatic responses of guilt, shame, and anger among children, adolescents, and young adults. *Journal of Child and Adolescent Trauma*, *4*, 339-360.
- Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Therapist guide*. New York: Oxford University Press.

- Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear. *Psychological Bulletin*, 99, 20–35.
- Foa, E. B., Yadin, E., & Lichner, T. K. (2012). *Exposure and response (ritual) prevention for obsessive-compulsive disorder: Therapist guide*. New York: Oxford University Press.
- Forster, P. L., Frank, R. I., & Daly, M. C. (2008). Out of the abyss: Building positive emotions and self-esteem in bipolar depression. Paper presented at the annual meeting and scientific program of the Northern California Psychiatric Society, Monterey, CA.
- Frank, E. (2005). *Treating bipolar disorder*. New York: Guilford.
- Frisch, M. B. (1994). *Quality of Life Inventory manual and treatment guide*. Minneapolis, MN: NCS Pearson and Pearson Assessments.
- Frost, R. O., Glossner, K., & Maxner, S. (2010). Social anxiety disorder and its relationship to perfectionism. In S. Hofmann & P. M. Dibartolo (Eds.), *Social anxiety* (2nd ed.). San Diego, CA: Elsevier.
- Frost, R. O., Marten, P., Lahart, C., et al. (1990). The dimensions of perfectionism. *Cognitive Therapy and Research*, 14, 449–468.
- Frost, R. O., Novara, C., & Rhéaume, J. (2002). Perfectionism in obsessive compulsive disorder. In R. O. Frost & G. Steketee (Eds.), *Cognitive approaches to obsessions and compulsions*. Amsterdam: Elsevier.
- Fuller, J. R., DiGiuseppe, R., O'Leary, S., et al. (2010). An open trial of a comprehensive anger treatment program on an outpatient sample. *Behavioural and Cognitive Psychotherapy*, 38, 485–490.
- Gehrman, P., Findley, J., & Perlis, M. (2012). Insomnia I: Etiology and conceptualization. In C. M. Morin & C. A. Espie (Eds.), *The Oxford handbook of sleep and sleep disorders*. New York: Oxford University Press.
- Gentes, E. L., & Ruscio, A. M. (2011). A meta-analysis of the relation of intolerance of uncertainty to symptoms of generalized anxiety disorder, major depressive disorder, and obsessive-compulsive disorder. *Clinical Psychology Review*, 31, 923–933.
- Gilbert, P. (2005). Compassion and cruelty: A biopsychosocial approach. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research, and use in psychotherapy*. London: Brunner-Routledge.
- Gilbert, P. (2010). *Compassion focused therapy*. London: Routledge
- Gilbert, P., & Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory*, 12, 507–516.
- Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion*. London: Brunner-Routledge.
- Gilbert, P., Pehl, J., & Allan, S. (1994). The phenomenology of shame and guilt. *British Journal of Medical Psychology*, 67, 23–36.
- Gilbert, P., & Proctor, S. (2006). Compassionate mind training for people with high shame and self-criticism. *Clinical Psychology and Psychotherapy*, 13, 353–379.
- Giorgio, J. M., Sanflippo, J., Kleiman, E., et al. (2010). An experiential avoidance conceptualization of rumination. *Behaviour Research and Therapy*, 48, 1021–1031.

- Goodwin, F. K., & Jamison, K. R. (2007). *Manic-depressive illness*. New York: Oxford University Press.
- Gotlib, I. H., & Joormann, J. (2010). Cognition and depression. *Annual Review of Clinical Psychology*, 6, 285–312.
- Grabe, H., Rainermann, S., Spitzer, C., et al. (2000). The relationship between dimensions of alexithymia and dissociation. *Psychotherapy and Psychosomatics*, 69, 128–131.
- Gratz, K. L., & Tull, M. T. (2011). Borderline personality disorder. In A. Bernstein, M. J. Zvolensky, & A. A. Vujanovic (Eds.), *Distress tolerance*. New York: Guilford.
- Greenberg, L. S. (1979). Resolving splits: Use of the two-chair technique. *Psychotherapy: Theory, Research, and Practice*, 16, 316–324.
- Greenberg, L. S. (2002). *Emotion-focused therapy*. Washington, DC: American Psychological Association.
- Gregory, J. D., Brewin, C. R., Mansell, W., et al. (2010). Intrusive memories and images in bipolar disorder. *Behaviour Research and Therapy*, 48, 698–703.
- Grenier, S., Barrette, A., & Ladouceur, R. (2005). Intolerance of uncertainty and intolerance of ambiguity. *Personality and Individual Differences*, 39, 593–600.
- Grisham, J. R., Brown, T. A., Savage, C. R., et al. (2007). Neuropsychological impairment associated with compulsive hoarding. *Behaviour Research and Therapy*, 45, 1471–1483.
- Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology*, 2, 271–299.
- Gross, J. J., & Thompson, R. A. (2007). Emotion regulation: Conceptual foundations. In J. J. Gross (Ed.), *Handbook of emotion regulation*. New York: Guilford.
- Hackmann, A. (1998). Working with images in clinical psychology. In A. S. Bellack & M. Hersen (Eds.), *Comprehensive clinical psychology*, (Vol. 6). New York: Elsevier.
- Hackmann, A. (2011). Imagery rescripting in posttraumatic stress disorder. *Cognitive and Behavioral Practice*, 18, 424–432.
- Hackmann, A., Bennett-Levy, J., & Holmes, E. A. (2011). *Oxford guide to imagery in cognitive therapy*. New York: Oxford University Press.
- Hackmann, A., & Holmes, E. A. (2004). Reflecting on imagery. *Memory*, 12, 389–402.
- Harned, M. S., Korslund, K. E., Foa, E. B., et al. (2012). Treating PTSD in suicidal and self-injuring women with borderline personality disorder. *Behaviour Research and Therapy*, 50, 381–386.
- Hart, T. A., Mora, D. B., Palyo, S. A., et al. (2008). Development and examination of the Social Appearance Anxiety Scale. *Assessment*, 15, 48–59.
- Harvey, A. G., Murray, G., Chandler, R. A., et al. (2011). Sleep disturbance as transdiagnostic. *Clinical Psychology Review*, 31, 225–235.
- Harvey, A. G., Watkins, E. R., Mansell, W., et al. (2004). *Cognitive behavioural processes across psychological disorders*. Oxford: Oxford University Press.
- Hayes, A. M., Beevers, C., Feldman, G., et al. (2005). Avoidance and emotional processing as predictors of symptom change and positive growth in an integrative therapy for depression. *International Journal of Behavioral Medicine*, 13, 111–122.

- Hayes, A. M., Feldman, G. C., Beevers, C. G., et al. (2007). Discontinuities and cognitive changes in an exposure-based cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 75*, 409–421.
- Hayes, S. C. (1994). Content, context, and the types of psychological acceptance. In S. C. Hayes, N. S. Jacobson, V. M. Folette, et al. (Eds.), *Acceptance and change*. Reno, NV: Context Press.
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy* (2nd ed.). New York: Guilford.
- Hayes, S. C., Wilson, K. G., Gifford, E. V., et al. (1996). Emotional avoidance and behavioral disorders. *Journal of Consulting and Clinical Psychology, 64*, 1152–1168.
- Hayes-Skelton, S. A., Usmani, A., Lee, J. K., et al. (2012). A fresh look at potential mechanisms of change in applied relaxation for generalized anxiety disorder. *Cognitive and Behavioral Practice, 19*, 451–462.
- Haynes, S. N. (1992). *Models of causality in psychopathology*. New York: Macmillan.
- Haynes, S. N., O'Brien, W. H., Keawe'aimoku, J., et al. (2012). Concepts of causality in psychopathology. *Journal of Unified Psychotherapy and Clinical Science, 1*, 87–103.
- Hebert, E. A., Dugas, M. J., Tulloch, T. G., et al. (2014). Positive beliefs about worry: A psychometric evaluation of the Why Worry – II. *Personality and Individual Differences, 56*, 3–8.
- Herpertz, S. C., Dietrich, T. M., Wenning, B., et al. (2001). Evidence of abnormal amygdala functioning in borderline personality disorder. *Biological Psychiatry, 50*, 292–298.
- Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts. *Journal of Personality and Social Psychology, 60*, 456–470.
- Hewitt, P. L., & Flett, G. L. (2002). Perfectionism and Stress Processes in Psychopathology. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism*. Washington, DC: American Psychological Association.
- Hill, C. E., & Knox, S. (2002). Self-disclosure. In J. C. Norcross (Ed.), *Psychotherapy relationships that work*. New York: Oxford University Press.
- Hirschfeld, R., Williams, J. B. W., Spitzer, R. L., et al. (2000). Development and validation of a screening instrument for bipolar spectrum disorder: The Mood Disorder Questionnaire. *American Journal of Psychiatry, 157*, 1873–1875.
- Holmes, E. A., & Mathews, A. (2010). Mental imagery in emotion and emotional disorders. *Clinical Psychology Review, 30*, 349–362.
- Hong, J. J., Beckner, V., Persons, J. B., et al. (2011). Session Assignment and Feedback Form – v.10 (SAFF). Oakland, CA. Available at http://www.sfbacct.com/images/stories/session_assignment_and_feedback_form_v11-2.pdf.
- Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work*. New York: Oxford University Press.
- Ingram, R. E. (1990). Self-focused attention in clinical disorders. *Psychological Bulletin, 109*, 156–176.
- Insel, T. (2013). Director's blog: Transforming diagnosis [Blog post, April 29, 2013]. Retrieved from <http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml>.

- Jacobson, E. (1938). *Progressive relaxation* (2nd ed.). Chicago: Chicago University Press.
- Jacobson, N. S., Martell, C. R., & Dimidjian, S. (2001). Behavioral activation treatment for depression. *Clinical Psychology: Science and Practice*, 8, 255–270.
- Jones, E. E., Kanouse, D. E., Kelley, H. H., et al. (Eds.). (1971). *Attribution: Perceiving the causes of behavior*. Morristown, NJ: General Learning Press.
- Julien, D., O'Connor, K. P., Aardema, F., et al. (2006). The specificity of belief domains in obsessive-compulsive subtypes. *Personality and Individual Differences*, 41, 1205–1216.
- Kabat-Zinn, J. (1990). *Full catastrophe living*. New York: Delacorte.
- Kabat-Zinn, J. (1994). *Wherever you go, there you are*. New York: Hyperion.
- Kelly, R. E., Mansell, W., Wood, A. M., et al. (2011). Extreme positive and negative appraisals of activated states interact to discriminate bipolar disorder from unipolar depression and non-clinical controls. *Journal of Affective Disorders*, 134, 438–443.
- Kendall, P. C., & Beidas, R. (2007). Smoothing the trail for dissemination of evidence-based practices for youth. *Professional Psychology: Research and Practice*, 38, 13–20.
- Kendall, P. C., Chu, B., Gifford, A., et al. (1998). Breathing life into a manual. *Cognitive and Behavioral Practice*, 5, 177–198.
- Kendall, P. C., Gosch, E., Furr, J., et al. (2008). Flexibility within fidelity. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47, 987–993.
- Keough, M. E., Riccardi, C. J., Timpano, K. R., et al. (2010). Anxiety symptomatology: The association with distress tolerance and anxiety sensitivity. *Behavior Therapy*, 41, 567–574.
- Keough, M. E., Timpano, K. R., Riccardi, C. J., et al. (2010). Suppressing the white bears interacts with anxiety sensitivity to predict mood and anxiety symptoms. *Personality and Individual Differences*, 49, 408–413.
- Kessler, R. C., Chiu, W. T., Demler, O., et al. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 617–627.
- Keuthen, N. J., Rothbaum, B. O., Fama, J., et al. (2012). DBT-enhanced cognitive-behavioral treatment for trichotillomania. *Journal of Behavioral Addictions*, 1, 1–9.
- Kim, S., Yu, B. H., Lee, D. S., et al. (2012). Ruminative response in clinical patients with major depressive disorder, bipolar disorder, and anxiety disorders. *Journal of Affective Disorders*, 136, e77–e81.
- Kimble, M. O., Riggs, D. S., & Keane, T. M. (1998). Cognitive behavioural treatment for complicated cases of post-traumatic stress disorder. In N. Tarrier, A. Wells, & G. Haddock (Eds.), *Treating complex cases: The cognitive behavioral approach*. New York: Wiley.
- Klein, D. F. (1993). False suffocation alarms, spontaneous panics, and related conditions. *Archives of General Psychiatry*, 50, 306–317.
- Koerner, K. (2012). *Doing dialectical behavior therapy*. New York: Guilford.
- Koerner, K., Dimeff, L. A., & Swenson, C. R. (2007). Adopt or adapt: Fidelity matters. In L. A. Dimeff & K. Koerner (Eds.), *Dialectical behavior therapy in clinical practice*. New York: Guilford.

- Koerner, N., & Dugas, M. J. (2006). A cognitive model of generalized anxiety disorder: The role of intolerance of uncertainty. In G. C. L. Davey & A. Wells (Eds.), *Worry and its psychological disorders*. Sussex, UK: Wiley.
- Koerner, N., & Dugas, M. J. (2008). An investigation of appraisals in individuals vulnerable to excessive worry: The role of intolerance of uncertainty. *Cognitive Therapy and Research*, 32, 619–638.
- Kohlenberg, R. J., & Tsai, M. (1991). *Functional analytic psychotherapy*. New York: Plenum Press.
- Korzekwa, M. I., Dell, P. F., Links, P. S., et al. (2009). Dissociation in borderline personality disorder. *Journal of Trauma and Dissociation*, 10, 346–367.
- Kumpula, M. J., Orcutt, H. K., Bardeen, J. R., et al. (2011). Peritraumatic dissociation and experiential avoidance as prospective predictors of posttraumatic stress symptoms. *Journal of Abnormal Psychology*, 120, 617–627.
- Kuyken, W., Padesky, C. A., & Dudley, R. (2009). *Collaborative case conceptualization*. New York: Guilford.
- La Bash, H., & Papa, A. (2013). Shame and PTSD symptoms. *Psychological Trauma: Theory, Research, Practice, and Policy*, DOI: 10.1037/a0032637.
- Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington, DC: American Psychological Association.
- Lambert, M. J., & Barley, D. E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J. C. Norcross (Ed.), *Psychotherapy relationships that work*. New York: Oxford University Press.
- Lambert, M. J., Harmon, C., Slade, K., et al. (2005). Providing feedback to psychotherapists on their patients' progress. *Journal of Clinical Psychology*, 61, 165–174.
- Leahy, R. L., Tirsch, D., & Napolitano, L. A. (2011). *Emotion regulation in psychotherapy*. New York: Guilford.
- Lee, D. A. (2005). The perfect nurturer: A model to develop a compassionate mind within the context of cognitive therapy. In P. Gilbert (Ed.), *Compassion*. London: Brunner-Routledge.
- Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events. *British Journal of Medical Psychology*, 74, 451–466.
- Levenson, J. C., Nusslock, R., & Frank, E. (2013). Life events, sleep disturbance, and mania. *Clinical Psychology: Science and Practice*, 20, 195–210.
- Levinson, C. A., Rodebaugh, T. L., White, E. K., et al. (2013). Social appearance anxiety, perfectionism, and fear of negative evaluation: Distinct or shared risk factors for social anxiety and eating disorders? *Appetite*, 67, 125–133.
- Lewinsohn, P. M. (1974). A behavioral approach to depression. In R. J. Friedman & M. Katz (Eds.), *The psychology of depression*. Oxford: Wiley.
- Ley, R. (1985). Blood, breath, and fears: A hyperventilation theory of panic attacks and agoraphobia. *Clinical Psychology Review*, 5, 271–285.
- Leyro, T. M., Zvolensky, M. J., & Bernstein, A. (2010). Distress tolerance and psychopathological symptoms and disorders. *Psychological Bulletin*, 136, 576–600.

- Liao, K. Y., & Wei, M. (2011). Intolerance of uncertainty, depression, and anxiety: The moderating and mediating roles of rumination. *Journal of Clinical Psychology, 67*, 1220–1239.
- Linehan, M. M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.
- Linehan, M. M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford.
- Linehan, M. M., Bohus, M., & Lynch, T. R. (2007). Dialectical behavior therapy for pervasive emotion dysregulation. In J. J. Gross (Ed.), *Handbook of emotion regulation*. New York: Guilford.
- Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Sydney, AU: Psychology Foundation.
- Lunsford-Avery, J. R., & Mittal, V. A. (2013). Sleep dysfunction prior to the onset of schizophrenia. *Clinical Psychology: Science and Practice, 20*, 291–320.
- Lynch, T. R., Chapman, A. L., Rosenthal, M. Z., et al. (2006). Mechanisms of change in dialectical behavior therapy. *Journal of Clinical Psychology, 62*, 459–480.
- Macatee, R. J., Capron, D. W., & Schmidt, N. B., et al. (2013). An examination of low distress tolerance and life stressors as factors underlying obsessions. *Journal of Psychiatric Research, 47*, 1462–1468.
- Magee, J. C., Harden, K. P., & Teachman, B. A. (2012). Psychopathology and thought suppression. *Clinical Psychology Review, 32*, 189–201.
- Mahoney, A. E. J., & McEvoy, P. M. (2012). A transdiagnostic examination of intolerance of uncertainty across anxiety and depressive disorders. *Cognitive Behaviour Therapy, 41*, 212–222.
- Mahoney, A. E. J., McEvoy, P. M., & Moulds, M. L. (2012). Psychometric properties of the Repetitive Thinking Questionnaire in a clinical sample. *Journal of Anxiety Disorders, 26*, 359–367.
- Malta, L. S. (2012). Allostasis: The emperor of all (trauma-related) maladies. *Clinical Psychology: Science and Practice, 19*, 241–259.
- Mansell, W., Harvey, A., Watkins, E., et al. (2009). Conceptual foundations of the transdiagnostic approach to CBT. *Journal of Cognitive Psychotherapy, 23*, 6–19.
- Mansell, W., Paszek, G., Seal, K., et al. (2011). Extreme appraisals of internal states in bipolar disorder. *Cognitive Therapy and Research, 35*, 87–97.
- Manser, R., Cooper, M., & Trefusis, J. (2012). Beliefs about emotions as a metacognitive construct. *Clinical Psychology and Psychotherapy, 19*, 235–246.
- Mansueto, C. S., Golomb, R. G., Thomas, A. M., et al. (1999). A comprehensive model for behavioral treatment of trichotillomania. *Cognitive and Behavioral Practice, 6*, 23–43.
- Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2010). *Behavioral activation for depression: A clinician's guide*. New York: Guilford.
- Matthews, A., & MacLeod, C. (2005). Cognitive vulnerability to emotional disorders. *Annual Review of Clinical Psychology, 1*, 167–195.
- Maydeu-Olivares, A., & D’Zurilla, T. J. (1996). A factor-analytic study of the social problem solving inventory. *Cognitive Therapy and Research, 20*, 115–133.

- Mazzucchelli, T. G., & Sanders, M. R. (2010). Facilitating practitioner flexibility within an empirically supported intervention: Lessons from a system of parenting support. *Clinical Psychology: Science and Practice, 17*, 238–252.
- McCullough, J. P. (2000). *Treatment for chronic depression: Cognitive behavioral analysis system of psychotherapy (CBASP)*. New York: Guilford.
- McEvoy, P. M., & Mahoney, A. E. J. (2011). Achieving certainty about the structure of intolerance of uncertainty in a treatment-seeking sample with anxiety and depression. *Journal of Anxiety Disorders, 25*, 112–122.
- McEvoy, P. M., & Mahoney, A. E. J. (2012). To be sure, to be sure: Intolerance of uncertainty mediates symptoms of various anxiety disorders and depression. *Behavior Therapy, 43*, 533–545.
- McEvoy, P. M., Mahoney, A. E. J., & Moulds, M. (2010). Are worry, rumination, and post-event processing one and the same? Development of the Repetitive Negative Thinking Questionnaire. *Journal of Anxiety Disorders, 24*, 509–519.
- McEvoy, P. M., Moulds, M. L., & Mahoney, A. E. J. (2013). Mechanisms driving pre- and post-stressor repetitive negative thinking. *Journal of Behavior Therapy and Experimental Psychiatry, 44*, 84–93.
- McHugh, R. K., & Otto, M. W. (2012). Refining the measurement of distress intolerance. *Behavior Therapy, 43*, 641–651.
- McHugh, R. K., Reynolds, E. K., Leyro, T. M., et al. (2013). An examination of the association of distress intolerance and emotion regulation with avoidance. *Cognitive Therapy and Research, 37*, 363–367.
- McKay, M., Fanning, P., & Zurita Ona, P. (2011). *Mind and emotions*. Oakland, CA: New Harbinger.
- McLaughlin, K. A., & Nolen-Hoeksema, S. (2011). Rumination as a transdiagnostic factor in depression and anxiety. *Behaviour Research and Therapy, 49*, 186–193.
- Medley, A. N., Capron, D. W., Korte, K. J., et al. (2013). Anxiety sensitivity: A potential vulnerability factor for compulsive hoarding. *Cognitive Behaviour Therapy, 42*, 45–55.
- Meeten, F., Dash, S. R., Scarlet, A. L. S., et al. (2012). Investigating the effect of intolerance of uncertainty on catastrophic worrying and mood. *Behaviour Research and Therapy, 50*, 690–698.
- Metcalf, L. (2007). *The miracle question*. Bethel, CT: Crown House.
- Meuret, A. E., Rosenfield, D., Seidel, A., et al. (2010). Respiratory and cognitive mediators of treatment change in panic disorder. *Journal of Consulting and Clinical Psychology, 78*, 691–704.
- Meuret, A. E., Twohig, M. P., Rosenfield, D., et al. (2012). Brief acceptance and commitment therapy and exposure for panic disorder. *Cognitive and Behavioral Practice, 19*, 606–618.
- Meuret, A. E., Wolitzky-Taylor, K. B., Twohig, M. P., et al. (2012). Coping skills and exposure therapy in panic disorder and agoraphobia. *Behavior Therapy, 43*, 271–284.
- Meyer, T. J., Miller, M. L., Metzger, R. L., et al. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy, 28*, 487–495.

- Miklowitz, D. J., & Johnson, S. L. (2006). The psychopathology and treatment of bipolar disorder. *Annual Review of Clinical Psychology, 2*, 199–235.
- Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing* (3rd ed.). New York: Guilford.
- Mitchell, M. A., Riccardi, C. J., Keough, M. E., et al. (2013). Understanding the associations among anxiety sensitivity, distress tolerance, and discomfort intolerance. *Journal of Anxiety Disorders, 27*, 147–154.
- Moeller, F. G., Barratt, E. S., Dougherty, D. M., et al. (2001). Psychiatric aspects of impulsivity. *American Journal of Psychiatry, 158*, 1783–1793.
- Mor, N., & Winquist, J. (2002). Self-focused attention and negative affect. *Psychological Bulletin, 128*, 638–662.
- Morin, C. M., & Espie, C. A. (2012). *The Oxford handbook of sleep and sleep disorders*. New York: Oxford University Press.
- Morris, A. S., Silk, J. S., Steinberg, L., et al. (2007). The role of the family context in the development of emotion regulation. *Social Development, 16*, 361–388.
- Mowrer, O. A. (1960). *Learning theory and behavior*. New York: Wiley.
- Munsey, C. (2010). Treatment guidelines are coming. *Monitor on Psychology, 41*, 30–31.
- Muraven, M. (2005). Self-focused attention and the self-regulation of attention. *Journal of Social and Clinical Psychology, 24*, 382–400.
- Myers, S. G., & Wells, A. (2005). Obsessive-compulsive symptoms: The contribution of metacognitions and responsibility. *Journal of Anxiety Disorders, 19*, 806–817.
- Naragon-Gainey, K. (2010). Meta-analysis of the relations of anxiety sensitivity to the depressive and anxiety disorders. *Psychological Bulletin, 136*, 128–150.
- Neziroglu, F., Khemlani-Patel, S., & Veale, D. (2008). Social learning theory and cognitive behavioral models of body dysmorphic disorder. *Body Image, 5*, 28–38.
- Nezu, A. M., & Nezu, C. M. (1995). Clinical decision making in everyday practice. *Cognitive and Behavioral Practice, 2*, 5–25.
- Nezu, A. M., Nezu, C. M., & D’Zurilla, T. J. (2013). *Problem-solving therapy: A treatment manual*. New York: Springer.
- Nezu, A. M., Nezu, C. M., & Lombardo, E. (2004). *Cognitive-behavioral case formulation and treatment design*. New York: Springer.
- Nezu, A. M., Ronan, G. F., Meadows, E. A., et al. (2000). *Practitioner’s guide to empirically based measures of depression*. New York: Springer.
- Nigg, J. T. (2000). On inhibition/disinhibition in developmental psychopathology. *Psychological Bulletin, 126*, 220–246.
- Nikolas, M., Klump, K. L., & Burt, S. A. (2012). Youth appraisals of inter-parental conflict and genetic and environmental contributions to attention-deficit hyperactivity disorder. *Journal of Abnormal Child Psychology, 40*, 543–554.
- Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology, 100*, 569–582.
- Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking rumination. *Perspectives on Psychological Science, 3*, 400–424.

- Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, et al. (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.
- Norton, P. J. (2012). *Group cognitive-behavioral therapy of anxiety*. New York: Guilford.
- Obsessive Compulsive Cognitions Working Group. (1997). Cognitive assessment of obsessive-compulsive disorder. *Behaviour Research and Therapy*, 35, 667–681.
- Obsessive Compulsive Cognitions Working Group. (2005). Psychometric validation of the Obsessive Belief Questionnaire and Interpretation of Intrusions Inventory: Part 2. Factor analyses and testing of a brief version. *Behaviour Research and Therapy*, 43, 1527–1542.
- Olatunji, B. O., Deacon, B. J., Abramowitz, J. S., et al. (2007). Body vigilance in nonclinical and anxiety disorder samples. *Behavior Therapy*, 38, 392–401.
- Olatunji, B. O., Naragon-Gainey, K., & Wolitzky-Taylor, K. B. (2013). Specificity of rumination in anxiety and depression. *Clinical Psychology: Science and Practice*, 20, 225–257.
- Overholser, J. C. (2011). Collaborative empiricism, guided discovery, and the Socratic method: Core processes for effective cognitive therapy. *Clinical Psychology: Science and Practice*, 18, 62–66.
- Padesky, C. A. (1994). Schema change processes in cognitive therapy. *Clinical Psychology and Psychotherapy*, 1, 267–278.
- Papageorgiou, C., & Wells, A. (1998). Effects of attention training on hypochondriasis. *Psychological Medicine*, 29, 193–200.
- Pennebaker, J. W. (2010). Expressive writing in a clinical setting. *Independent Practitioner*, 30, 23–25.
- Perlis, M., Aloia, M., & Kuhn, B. (Eds.). (2011). *Behavioral treatments for sleep disorders*. London: Elsevier.
- Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach*. New York: Norton.
- Persons, J. B. (2008). *The case formulation approach to cognitive-behavior therapy*. New York: Guilford.
- Persons, J. B., Beckner, V. L., & Tompkins, M. A. (2013). Testing case formulation hypotheses in psychotherapy. *Cognitive and Behavioral Practice*, 20, 399–409.
- Persons, J. B., & Davidson, J. (2010). Cognitive-behavioral case formulation. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (3rd ed.). New York: Guilford.
- Persons, J. B., Davidson, J., & Tompkins, M. A. (2001). *Essential components of cognitive-behavior therapy for depression*. Washington, DC: American Psychological Association.
- Persons, J. B., Roberts, N. A., Zalecki, C. A., et al. (2006). Naturalistic outcome of case formulation–driven cognitive-behavior therapy for anxious depressed outpatients. *Behaviour Research and Therapy*, 44, 1041–1051.
- Peters, J. R., Geiger, P. J., Smart, L. M., et al. (2013). Shame and borderline personality features: The potential mediating role of anger and anger rumination. *Personality Disorders: Theory, Research, and Treatment*, PMID: 23834517.
- Pinto-Gouveia, J., Castilho, P., Matos, M., et al. (2013). Centrality of shame memories and psychopathology. *Clinical Psychology: Science and Practice*, 20, 323–334.

- Prochaska, J., & DiClemente, C. (1984). *The transtheoretical approach*. Homewood, IL: Dow Jones-Irwin.
- Purdon, C. (1999). Thought suppression and psychopathology. *Behaviour Research and Therapy*, 37, 1029–1054.
- Quraishi, S., & Frangou, S. (2002). Neuropsychology of bipolar disorder. *Journal of Affective Disorders*, 72, 209–226.
- Rachman, S. J. (1993). Obsessions, responsibility, and guilt. *Behaviour Research and Therapy*, 31, 149–154.
- Rachman, S. J., Radomsky, A. S., & Shafran, R. (2008). Safety behaviour: A reconsideration. *Behaviour Research and Therapy*, 46, 163–173.
- Rachman, S. J., Thordarson, D. S., Shafran, R., et al. (1995). Perceived responsibility: Structure and significance. *Behaviour Research and Therapy*, 33, 779–784.
- Ramnerö, J., & Törneke, N. (2008). *The ABCs of human behavior: Behavioral principles for the practicing clinician*. Oakland, CA: New Harbinger
- Rampacher, F., Lennertz, L., Vogely, A., et al. (2010). Evidence for specific cognitive deficits in visual information processing in patients with OCD compared to patients with unipolar depression. *Progress in Neuropsychopharmacology and Biological Psychiatry*, 34, 984–991.
- Rapee, R. M., & Heimberg, R. G. (1997). A cognitive-behavioral model of anxiety in social phobia. *Behaviour Research and Therapy*, 35, 741–756.
- Reardon, J. M., & Williams, N. L. (2007). The specificity of cognitive vulnerabilities to emotional disorders: Anxiety sensitivity, looming vulnerability, and explanatory style. *Journal of Anxiety Disorders*, 21, 625–643.
- Reilly, P. M., Shopshire, M. S., Durazzo, T. C., et al. (2002). *Anger management for substance abuse and mental health clients*. Rockville, MD: US Department of Health and Human Services.
- Reiss, S. (1991). Expectancy model of fear, anxiety, and panic. *Clinical Psychology Review*, 11, 141–153.
- Reiss, S., & McNally, R. J. (1985). Expectancy model of fear. In S. Reiss & R. R. Bootzin (Eds.), *Theoretical issues in behavior therapy*. San Diego, CA: Academic Press.
- Reiss, S., Peterson, R. A., Gursky, D. M., et al. (1986). Anxiety sensitivity, anxiety frequency, and the prediction of fearfulness. *Behaviour Research and Therapy*, 24, 1–8.
- Resick, P. A., & Schnicke, M. K. (1996). *Cognitive processing therapy for rape victims*. London: Sage Publications.
- Richards, J. M., Daughters, S. B., Bornovalova, M. A., et al. (2011). Substance use disorders. In A. Bernstein, M. J. Zvolensky, & A. A. Vujanovic (Eds.), *Distress tolerance*. New York: Guilford.
- Riley, C., Lee, M., Cooper, Z., et al. (2007). A randomized controlled trial of cognitive-behaviour therapy for clinical perfectionism. *Behaviour Research and Therapy*, 45, 2221–2231.

- Rizvi, S. L., & Harned, M. S. (2013). Increasing treatment efficiency and effectiveness: Rethinking approaches to assessing and treating comorbid disorders. *Clinical Psychology: Science and Practice*, *20*, 285–290.
- Robichaud, M. (2013). Cognitive behavior therapy targeting intolerance of uncertainty. *Cognitive and Behavioral Practice*, *20*, 251–263.
- Robichaud, M., & Dugas, M. J. (2005). Negative problem orientation: Part I. Psychometric properties of a new measure. *Behaviour Research and Therapy*, *43*, 391–401.
- Rodebaugh, T. L., Weeks, J. W., Gordon, E. A., et al. (2012). The longitudinal relationship between fear of positive evaluation and fear of negative evaluation. *Anxiety, Stress, and Coping*, *25*, 167–182.
- Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.
- Rosenthal, M. Z., Cheavens, J. S., Lynch, T. R., et al. (2006). Thought suppression mediates the relationship between negative mood and PTSD in sexually assaulted women. *Journal of Traumatic Stress*, *19*, 741–745.
- Rottenberg, J., Wilhelm, F. H., Gross, J. J., et al. (2002). Respiratory sinus arrhythmia as a predictor of outcome in major depressive disorder. *Journal of Affective Disorders*, *71*, 265–272.
- Rüsch, N., Lieb, K., Göttler, I., et al. (2007). Shame and implicit self-concept in women with borderline personality disorder. *American Journal of Psychiatry*, *164*, 500–508.
- Safren, S. A., Sprich, S., Perlman, C. A., et al. (2005). *Mastering your adult ADHD*. New York: Oxford University Press.
- Salavert, J., Gasol, M., Vieta, E., et al. (2011). Fronto-limbic dysfunction in borderline personality disorder. *Journal of Affective Disorders*, *131*, 260–267.
- Salkovskis, P. M. (1991). The importance of behavior in the maintenance of anxiety and panic. *Behavioural Psychotherapy*, *19*, 6–19.
- Salkovskis, P. M., Shafran, R., Rachman, S. J., et al. (1999). Multiple pathways to inflated responsibility beliefs in obsessional problems. *Behaviour Research and Therapy*, *37*, 1055–1072.
- Salkovskis, P. M., Wroe, A. L., Gledhill, A. et al. (2000). Responsibility attitudes and interpretations are characteristic of obsessive compulsive disorder. *Behaviour Research and Therapy*, *38*, 347–372.
- Sandoz, E. K., Wilson, K. G., & DuFrene, T. (2010). *Acceptance and commitment therapy for eating disorders*. Oakland, CA: New Harbinger.
- Schmidt, N. B., Buckner, J. D., & Keough, M. E. (2007). Anxiety sensitivity as a prospective predictor of alcohol use disorders. *Behavior Modification*, *31*, 202–219.
- Schmidt, N. B., Eggleston, A. M., Woolaway-Bickel, K., et al. (2007). Anxiety sensitivity amelioration training (ASAT). *Journal of Anxiety Disorders*, *21*, 302–319.
- Schmidt, N. B., Mitchell, M. A., Keough, M. E., et al. (2011). Distress tolerance in anxiety and its disorders. In A. Bernstein, M. J. Zvolensky, & A. A. Vujanovic (Eds.), *Distress tolerance*. New York: Guilford.
- Schmidt, N. B., Richey, J. A., Cromer, K. R., et al. (2007). Discomfort intolerance: Evaluation of a potential risk factor for anxiety psychopathology. *Behavior Therapy*, *38*, 247–255.

- Schmidt, N. B., Richey, J. A., & Fitzpatrick, K. K. (2006). Discomfort intolerance: Development of a construct and measure relevant to panic disorder. *Journal of Anxiety Disorders, 20*, 263–280.
- Schreiber, F., Heimlich, C., Schweitzer, C., et al. (2013). Cognitive therapy for social anxiety disorder: The impact of the “self-focused attention and safety behaviours experiment” on the course of treatment. *Behavioural and Cognitive Psychotherapy*, DOI: <http://dx.doi.org/10.1017/S1352465813000672>.
- Schultz, L. T., & Heimberg, R. G. (2008). Attentional focus in social anxiety disorder: Potential for interactive processes. *Clinical Psychology Review, 28*, 1206–1221.
- Searson, R., Mansell, W., Lowens, I., et al. (2012). Think effectively about mood swings (TEAMS): A case series of cognitive-behavioural therapy for bipolar disorders. *Journal of Behavior Therapy and Experimental Psychiatry, 43*, 770–779.
- Segal, Z. V., Williams, M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression*. New York: Guilford.
- Shafran, R., Cooper, Z., & Fairburn, C. G. (2002). Clinical perfectionism: A cognitive-behavioural analysis. *Behaviour Research and Therapy, 40*, 773–791.
- Shafran, R., Egan, S., & Wade, T. (2010). *Overcoming perfectionism*. London: Robinson.
- Shafran, R., & Rachman, S. (2004). Thought-action fusion: A review. *Journal of Behavior Therapy and Experimental Psychiatry, 35*, 87–107.
- Shafran, R., Thordarson, D. S., & Rachman, S. (1996). Thought-action fusion in obsessive compulsive disorder. *Journal of Anxiety Disorders, 10*, 379–391.
- Shapiro, S. L., Carlson, L. E., Astin, J. A., et al. (2006). Mechanisms of mindfulness. *Journal of Clinical Psychology, 62*, 373–386.
- Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure. *Journal of Consulting and Clinical Psychology, 78*, 298–311.
- Shipherd, J. C., & Salters-Pedneault, K. (2008). Attention, memory, intrusive thoughts, and acceptance in PTSD. *Cognitive and Behavioral Practice, 15*, 349–363.
- Siegle, G. J., Ghinassi, F., & Thase, M. E. (2007). Neurobehavioral therapies in the 21st century. *Cognitive Therapy and Research, 31*, 235–262.
- Siev, J., & Chambless, D. L. (2007). Specificity of treatment effects: Cognitive therapy and relaxation for generalized anxiety disorders. *Journal of Consulting and Clinical Psychology, 75*, 513–522.
- Simons, J. S., & Gaher, R. M. (2005). The Distress Tolerance Scale: Development and validation of a self-report measure. *Motivation and Emotion, 29*, 83–102.
- Singer, J. A. (2004). Narrative identity and meaning making across the lifespan. *Journal of Personality, 72*, 437–460.
- Skinner, B. F. (1953). *Science and human behavior*. New York: Free Press.
- Smits, J. A. J., Berry, A. C., Tart, C. D., et al. (2008). The efficacy of cognitive-behavioral interventions for reducing anxiety sensitivity. *Behaviour Research and Therapy, 46*, 1047–1054.

- Snorrason, I., Belleau, E. L., & Woods, D. W. (2012). How related are hair pulling disorder (trichotillomania) and skin picking disorder? *Clinical Psychology Review, 32*, 618–629.
- Solanto, M. V. (2011). *Cognitive-behavioral therapy for adult ADHD: Targeting executive dysfunction*. New York: Guilford.
- Steele, A., Waite, S., Egan, S. J., et al. (2013). Psycho-education and group cognitive-behavioural therapy for clinical perfectionism. *Behavioural and Cognitive Psychotherapy, 41*, 129–143.
- Steil, R., & Ehlers, A. (2000). Dysfunctional meaning of posttraumatic intrusions in chronic PTSD. *Behaviour Research and Therapy, 38*, 537–558.
- Stewart, S. H., & Kushner, M. G. (2001). Introduction to the special issue on “anxiety sensitivity and addictive behaviors.” *Addictive Behavior, 26*, 775–785.
- Stiglmayr, C. E., Shapiro, D. A., Stieglitz, R. D., et al. (2001). Experience of aversive tension and dissociation in female patients with borderline personality disorder. *Journal of Psychiatric Research, 35*, 111–118.
- Storch, E. A., Rasmussen, S. A., Price, L. H., et al. (2010). Development and psychometric evaluation of the Yale-Brown Obsessive-Compulsive Scale (2nd ed). *Psychological Assessment, 22*, 223–232.
- Stott, R., Mansell, W., Salkovskis, P., et al. (2010). *Oxford guide to metaphors in CBT*. Oxford: Oxford University Press.
- Stuewig, J., Tangney, J. P., Heigel, C., et al. (2010). Shaming, blaming, and maiming: Functional links among the moral emotions, externalization of blame, and aggression. *Journal of Research in Personality, 44*, 91–102.
- Suveg, C., Morelen, D., Brewer, G. A., et al. (2010). The emotion dysregulation model of anxiety. *Journal of Anxiety Disorders, 24*, 924–930.
- Swann, A. C., Dougherty, D. M., Pazzaglia, P. J., et al. (2005). Increased impulsivity associated with severity of suicide attempt history in patients with bipolar disorder. *American Journal of Psychiatry, 162*, 1680–1687.
- Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York: Guilford.
- Taylor, S., & Asmundson, G. J. G. (2004). *Treating health anxiety: A cognitive-behavioral approach*. New York: Guilford.
- Taylor, S., & Rachman, S. J. (1991). Fear of sadness. *Journal of Anxiety Disorders, 5*, 375–381.
- Taylor, S., Zvolensky, M. J., Cox, B. J., et al. (2007). Robust dimensions of anxiety sensitivity: Development and initial validation of the Anxiety Sensitivity Index – 3. *Psychological Assessment, 19*, 176–188.
- Teasdale, J. D., & Cox, S. G. (2001). Dysphoria: Self-devaluative and affective components in recovered depressed patients and never depressed controls. *Psychological Medicine, 31*, 1311–1316.
- Tee, J., & Kazantzis, N. (2011). Collaborative empiricism in cognitive therapy. *Clinical Psychology: Science and Practice, 18*, 47–61.
- Thayer, J. F., Friedman, B. H., & Borkovec, T. D. (1996). Autonomic characteristics of generalized anxiety disorder and worry. *Biological Psychiatry, 39*, 255–266.

- Tolin, D. F., Woods, C. M., & Abramowitz, J. S. (2003). Relationship between obsessive beliefs and obsessive-compulsive symptoms. *Cognitive Therapy and Research, 27*, 657–669.
- Tolin, D. F., Worhunsky, P., & Maltby, N. (2006). Are “obsessive” beliefs specific to OCD? A comparison across anxiety disorders. *Behaviour Research and Therapy, 44*, 469–480.
- Trafton, J. A., & Gifford, E. V. (2011). Biological bases of distress tolerance. In A. Bernstein, M. J. Zvolensky, & A. A. Vujanovic (Eds.), *Distress tolerance*. New York: Guilford.
- Treanor, M., Erisman, S. M., Salters-Pedneault, K., et al. (2011). Acceptance-based behavioral therapy for GAD. *Depression and Anxiety, 28*, 127–136.
- Turk, C. L., Heimberg, R. G., Luterek, J. A., et al. (2005). Emotion dysregulation in generalized anxiety disorder. *Cognitive Therapy and Research, 29*, 89–106.
- Utschig, A. C., Presnell, K., Madeley, M. C., et al. (2010). An investigation of the relationship of fear of negative evaluation and bulimic psychopathology. *Eating Behaviors, 11*, 231–238.
- Van der Heiden, C. Melchior, K., Muris, P. E. H. M., et al. (2010). A hierarchical model for the relationships between general and specific vulnerability factors and symptom levels of generalized anxiety disorder. *Journal of Anxiety Disorders, 24*, 284–289.
- Van Vliet, J. (2009). The role of attributions in the process of overcoming shame. *Psychology and Psychotherapy, 82*, 137–152.
- Vujanovic, A. A., Bernstein, A., & Litz, B. T. (2011). Traumatic stress. In A. Bernstein, M. J. Zvolensky, & A. A. Vujanovic (Eds.), *Distress tolerance*. New York: Guilford.
- Vujanovic, A. A., Bonn-Miller, M. O., Potter, C. M., et al. (2011). An evaluation of the relation between distress tolerance and posttraumatic stress within a trauma-exposed sample. *Journal of Psychopathology and Behavioral Assessment, 33*, 129–135.
- Warwick, H. M. C., & Salkovskis, P. M. (1990). Hypochondriasis. *Behaviour Research and Therapy, 28*, 105–117.
- Watkins, E. R. (2008). Constructive and unconstructive repetitive thought. *Psychological Bulletin, 134*, 163–206.
- Weeks, J. W., Heimberg, R. G., & Rodebaugh, T. L. (2008). The Fear of Positive Evaluation Scale: Assessing a proposed cognitive component of social anxiety. *Journal of Anxiety Disorders, 22*, 44–55.
- Weeks, J. W., Heimberg, R. G., Rodebaugh, T. L., et al. (2012). Psychometric evaluation of the Fear of Positive Evaluation Scale in patients with social anxiety disorder. *Psychological Assessment, 24*, 301–312.
- Weeks, J. W., Jakatdar, T. A., & Heimberg, R. G. (2010). Comparing and contrasting fears of positive and negative evaluation as facets of social anxiety. *Journal of Social and Clinical Psychology, 29*, 68–94.
- Wegner, D. M., Schneider, D. J., Carter, S. R., et al. (1987). Paradoxical effects of thought suppression. *Journal of Personality and Social Psychology, 53*, 5–13.
- Wegner, D. M., & Zanakos, S. (1994). Chronic thought suppression. *Journal of Personality, 62*, 615–640.

- Weiner, B. (1985). An attributional theory of achievement motivation and emotion. *Psychological Review*, 92, 548–573.
- Wells, A. (1995). Meta-cognition and worry: A cognitive model of generalized anxiety disorder. *Behavior Modification*, 23, 526–555.
- Wells, A. (1997). *Cognitive therapy of anxiety disorders*. New York: Wiley.
- Wells, A. (2000). *Emotional disorders and metacognition*. New York: Wiley.
- Wells, A. (2005). The metacognitive model of GAD: Assessment of meta-worry and relationship with DSM-IV generalized anxiety disorder. *Cognitive Therapy and Research*, 29, 107–121.
- Wells, A. (2009). *Metacognitive therapy for anxiety and depression*. New York: Guilford.
- Wells, A., & Cartwright-Hatton, S. (2004). A short form of the Metacognitions Questionnaire: Properties of the MCQ-30. *Behaviour Research and Therapy*, 42, 385–396.
- Wells, A., & Davies, M. I. (1994). The Thought Control Questionnaire: A measure of individual differences in the control of unwanted thoughts. *Behaviour Research and Therapy*, 32, 871–878.
- Wells, A., & Matthews, G. (1994). *Attention and emotion*. Hove, UK: Lawrence Erlbaum.
- Wells, A., & Sembi, S. (2004). Metacognitive therapy for PTSD. *Journal of Behavior Therapy and Experimental Psychiatry* 35, 307–318.
- Wenzlaff, R. M., & Wegner, D. M. (2000). Thought suppression. *Annual Review of Psychology*, 51, 59–91.
- Wheatley, J., & Hackmann, A. (2011). Using imagery rescripting to treat major depression. *Cognitive and Behavioral Practice*, 18, 444–453.
- Wheaton, M. G., Berman, N. C., Franklin, J. C., et al. (2010). Health anxiety: Latent structure and associations with anxiety-related psychological processes in a student sample. *Journal of Psychopathology and Behavioral Assessment*, 32, 565–574.
- White, K. S., Brown, T. A., Somers, T. J., et al. (2006). Avoidance behavior in panic disorder: The moderating influence of perceived control. *Behaviour Research and Therapy*, 44, 147–157.
- Wild, J., & Clark, D. M. (2011). Imagery rescripting of early traumatic memories in social phobia. *Cognitive and Behavioral Practice*, 18, 433–443.
- Wild, J., Hackmann, A., & Clark, D. M. (2007). When the present visits the past: Updating traumatic memories in social phobia. *Journal of Behavior Therapy and Experimental Psychiatry*, 38, 386–401.
- Wilhelm, S., & Steketee, G. S. (2000). *Cognitive therapy for obsessive-compulsive disorder: A guide for professionals*. Oakland, CA: New Harbinger.
- Williams, K. E., Chambless, D. L., & Ahrens, A. H. (1997). Are emotions frightening? An extension of the fear of fear concept. *Behaviour Research and Therapy*, 35, 239–248.
- Wilson, K. G., Sandoz, E. K., Kitchens, J., et al. (2010). The Valued Living Questionnaire: Defining and measuring valued action within a behavioral framework. *Psychological Record*, 60, 249–272.

- Woodruff-Borden, J., Brothers, A. J., & Lister, S. C. (2001). Self-focused attention: Commonalities across psychopathologies and predictors. *Behavioural and Cognitive Psychotherapy, 29*, 169–178.
- Yeragani, V. K., Pohl, R., Berger, R., et al. (1993). Decreased heart rate variability in panic disorder patients. *Psychiatry Research, 46*, 89–103.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy*. New York: Guilford.
- Zayfert, C., DeViva, J. C., & Hofmann, S. G. (2005). Comorbid PTSD and social phobia in a treatment-seeking population. *Journal of Nervous and Mental Disease, 193*, 90–101.

Rochelle I. Frank, PhD, is a clinical psychologist in Oakland, CA, where she maintains a private practice providing psychotherapy, professional consultation, supervision, and training workshops. She is also an assistant clinical professor in the clinical science program at the University of California, Berkeley. Frank has over twenty-five years of clinical experience in outpatient, inpatient, and residential settings, and specializes in the treatment of severe mood disorders, borderline personality disorder, and trauma and dissociative disorders. She is past president of the Alameda County Psychological Association, and served on the faculty of the University of California, San Francisco, School of Medicine and several Bay Area clinical psychology graduate programs. Previously, she was a clinical director with the San Francisco Department of Public Health, where she contributed to the development and implementation of behavioral health care policies, procedures, and training curricula throughout county mental health programs.

Joan Davidson, PhD, is co-director and founding partner of the San Francisco Bay Area Center for Cognitive Therapy and assistant clinical professor in the clinical science program at the University of California, Berkeley. For over twenty years she has worked as a cognitive behavioral clinician specializing in the treatment of adults with mood and anxiety disorders. In addition, she teaches, writes, and provides clinical consultation and supervision to students and licensed professionals. Davidson is Founding Fellow of the Academy of Cognitive Therapy and an Academy of Cognitive Therapy Certified Trainer/Consultant. She is the author of *Daring to Challenge OCD: Overcome Your Fear of Treatment and Take Control of Your Life using Exposure and Response Prevention* (New Harbinger, 2014) and coauthor of *The Essential Components of Cognitive-Behavior Therapy for Depression* (American Psychological Association, 2001) and videotape series of the same name.

Foreword writer **Jacqueline B. Persons, PhD**, is director of the Cognitive Behavior Therapy and Science Center and a clinical professor in the department of psychology at the University of California, Berkeley. Persons is the author of three books, including *The Case Formulation Approach to Cognitive-Behavior Therapy* and *Cognitive Therapy in Practice: A Case Formulation Approach*. She is past president of the Association for Behavioral and Cognitive Therapies and the Society for a Science of Clinical Psychology.

Index

A

- acceptance, 136, 147, 151, 183
- acceptance and commitment therapy (ACT), 9
- acceptance-based interventions, 25, 34
- action stage of change, 122
- activity scheduling, 138
- ADHD (attention deficit hyperactivity disorder), 16, 17, 43, 151, 152, 153
- adjunctive skills training, 129, 148–155
- Affective Control Scale (ACS), 39
- agoraphobia, 125–126
- alcohol abuse, 172, 173
- ambiguity, intolerance of, 25
- American Psychological Association, 5
- anger management problems, 150–151
- anxiety: avoidance/escape behaviors and, 34; executive functioning deficits and, 17; fear of sensations related to, 24; intolerance of uncertainty and, 25–26; perceived control and, 25
- Anxiety Control Questionnaire – Revised (ACQ-R), 25
- anxiety sensitivity (AS), 24
- Anxiety Sensitivity Index – 3 (ASI-3), 24
- applied relaxation, 149–150
- apps, therapy-based, 64, 178
- arousal regulation deficits, 16–17
- assertiveness training, 148
- assessment, 69–91; behavioral chain analysis for, 79–84; deconstructing patient problems for, 78–90; diagnostic considerations in, 72–73; initial impressions in, 70–71; mechanism measures for, 90–91; observations used in, 73–78; Problem Deconstruction Log for, 84–90, 198; of readiness for change, 121–123; standardized measures for, 71–72
- attention deficit hyperactivity disorder. *See* ADHD
- attention modification, 142–143
- attention training techniques, 142
- attentional bias, 41
- attentional focus, 41–42
- attribution theory, 42
- attributional bias, 42–43; externalizing attributions, 43; internalizing attributions, 42–43

avoidance behaviors, 34–36, 138

B

Beck, Aaron, 8, 22, 40, 56, 115

Beck Depression Inventory – 2 (BDI-2), 71

behavioral activation, 138

behavioral avoidance, 36, 138

behavioral chain analysis, 79–84;
dialogue illustrating, 82–84;
mechanism hypotheses generated
from, 98–100; origin and development
of, 134; worksheet example, 81

behavioral contingencies, 138–139

behavioral experiments, 141–142, 171

behaviors: avoidance and escape, 34–36;
body-focused repetitive, 154–155;
eating, 154; emotion-driven, 40;
observation of, 74–75; therapy-
interfering, 124

beliefs: maladaptive, 140; metacognitive,
22–23; pervasive, 21–23

benchmarks of change, 116

bipolar spectrum conditions, 18, 95, 162

body-focused repetitive behaviors,
154–155

BPD (borderline personality disorder),
17, 18, 39, 95

breathing retraining, 148–149

Brief Fear of Negative Evaluation Scale
– 2 (BFNE-2), 28

Burns Anxiety Inventory (BAI), 71

C

case formulation: clinical function of,
3–4; individualizing treatment
through, 6–7; limitations of existing
models of, 4; transdiagnostic road map
to, 10

categorical diagnosis, 72

categories of interventions, 128–129

chain analysis. *See* behavioral chain
analysis

change: assessing readiness for, 121–123;
core strategies for, 137–148;
establishing benchmarks of, 116; goals
for mechanism, 120–121; motivation
to, 131; stages of, 122–123

children's books, 146, 177

classical conditioning, 20

clients. *See* patients

clinical interviews, 73

Clinical Perfectionism Questionnaire
(CPQ), 27

cognitive avoidance, 37–38

cognitive behavioral therapy (CBT), 9,
115

cognitive defusion, 136–137

cognitive distortions, 170

cognitive misappraisals, 40–41

cognitive restructuring, 139–140

collaborative empiricism, 48–49

comorbidity, psychiatric, 5

compassionate mind training, 145–146

compassion-focused therapy, 146

compulsions, 35–36

conditioning: operant, 20–21;
respondent (classical), 20

consultation and training, 65–66

contemplation stage of change, 122

contingency management, 138–139

control: perceived, 24–25; thought, 37

cost-benefit analysis, 132

creativity, skillful, 47, 50, 63–65, 146,
177–178

cue-controlled relaxation, 150

D

Daily Record of Dysfunctional
Thoughts, 139

data collection: mechanism measures
for, 90–91; standardized measures for,

- 71–72; TDM Hypotheses Worksheet for, 70, 199. *See also* assessment
- deconstructing patient problems, 78–90; behavioral chain analysis for, 79–84; Problem Deconstruction Log for, 84–90, 198
- defusion, cognitive, 136–137
- depression: cognitive therapy of, 139; facilitating the treatment of, 125; information-processing biases and, 18
- Depression Anxiety Stress Scales (DASS), 71
- destabilizing treatments, 125
- detached mindfulness, 136
- Detailed Assessment of Posttraumatic Stress (DAPS), 72
- diagnosis-specific treatments, 155
- Diagnostic and Statistical Manual of Mental Disorders*, 7
- diagnostic considerations: assessment process and, 72–73; TDM formulation and, 94–95
- dialectical behavior therapy (DBT), 9
- diary cards, 183
- differential diagnosis, 72, 94
- direct observation, 75
- discomfort intolerance, 32
- disinhibition, 16
- dissociation, 39
- Dissociative Experiences Scale (DES), 39
- Distress Intolerance Index (DII), 31
- distress tolerance (DT), 30, 31–32
- Distress Tolerance Scale (DTS), 31
- distress tolerance skills, 126, 147
- E**
- easy-to-treat problems, 126
- eating behavior problems, 154
- education: ongoing training and, 65–66; psychoeducation as, 130–131
- emotion regulation deficits, 18–19
- emotion regulation skills, 147
- emotional avoidance, 38–39
- emotional exposure, 145
- emotional hyperarousal, 16
- emotional processing theory, 144
- emotion-driven behaviors, 40
- empirically supported treatments (ESTs): contemporary proliferation of, 3; flexible delivery of, 5–6; limitations of, 5
- errors, therapist, 60–62
- escape behaviors, 34–36
- evaluation, fear of, 27–28
- executive functioning deficits, 17
- experiential avoidance (EA), 33–40; avoidance and escape strategies, 34–36; behavioral (situational) avoidance, 36; cognitive avoidance, 37–38; definition of, 33; emotional avoidance, 38–39; emotion-driven behaviors, 40; interoceptive (somatic) avoidance, 38; transdiagnostic processes and, 8
- exposure hierarchies, 183
- exposure-based treatments, 35, 39, 95, 125, 144–145
- expressive writing techniques, 141
- externalizing attributions, 43
- F**
- family observations, 77–78
- fear: of anxiety-related sensations, 24; of evaluation, 27–28
- fear of negative evaluation (FNE), 28, 164, 170
- fear of positive evaluation (FPE), 28
- feedback, responding to, 186–190
- Five Facet Mindfulness Questionnaire, 135
- flexibility within fidelity, 5–6, 62–63
- forms. *See* worksheets

Frost Multidimensional Perfectionism Scale (FMPS), 27
functional analysis, 79, 133–134
functioning, diminished, 124–125
Functioning and Satisfaction Inventory (FSI), 72

G

generalized anxiety disorder (GAD):
 intolerance of uncertainty and, 26;
 negative problem orientation and, 29;
 perceived control and, 25; worry related to, 38, 44
global outcome goals, 113, 114–119;
 benchmarks of change for, 116;
 discussing with patients, 115–116;
 miracle question and, 116–117;
 monitoring progress toward, 180–181;
 narrowing the focus of, 117–119;
 working toward, 160–161
goals for treatment, 113–126;
 achievement of, 192–194; discussing with patients, 115–116; example of working with, 118–119; exploring non-achievement of, 183–185; global outcome goals, 113, 114–119; importance of defining, 113–114; mechanism change goals, 113, 114, 120–121; prioritizing, 123–126, 164–165; Treatment Goals Worksheet, 113, 201
guided discovery, 131–132, 169
guided imagery, 150

H

habit reversal training, 154
habituation, 144
hair pulling, 19, 154, 172–173
homework reviews, 183
hypochondriasis, 143

I

illness/injury sensitivity, 30
Illness/Injury Sensitivity Index – Revised (ISI-R), 30
imagery, 64, 146, 150
imagery rescripting, 146
implementing treatment, 159–178;
 global outcome goals in, 160–161;
 mapping the road ahead in, 163–171;
 mechanism change goals in, 161–163;
 patient motivation addressed in, 174–177; people vs. problems in, 171–174; skillful creativity in, 177–178;
 steps in process of, 159–160
impulsivity, 16
in vivo observations, 78
individualizing treatment, 6–7
inflated responsibility beliefs, 29–30
information processing deficits, 17–18
informed consent, 49–55
inhibitory anxiety, 26
inhibitory control deficits, 16–17
inhibitory learning, 144
initial impressions, 70–71
injury/illness sensitivity, 30
internalizing attributions, 42–43
interoceptive avoidance, 38
interpersonal effectiveness skills, 148
interventions, 127–155; acceptance and validation, 136; anger management, 150–151; applied relaxation, 149–150; attention modification, 142–143; behavioral activation, 138; behavioral contingencies, 138–139; behavioral experiments, 141–142; body-focused repetitive behavior, 154–155; breathing retraining, 148–149; categorization of, 128–129; cognitive defusion, 136–137; cognitive restructuring, 139–140; compassionate mind training, 145–146; cost-benefit analysis, 132; detached mindfulness,

- 136; distress tolerance skills, 147; eating behavior, 154; emotion regulation skills, 147; exposure-based, 144–146; functional analysis, 133–134; guided discovery, 131–132; guided imagery, 150; imagery rescripting, 146; interpersonal effectiveness skills, 148; mindfulness, 135; motivational interviewing, 131; organization and planning, 152; postponement strategies, 143–144; problem deconstruction, 133; problem-solving, 151; progressive muscle relaxation, 149; psychoeducation, 130–131; schema change, 140–141; selecting for TDMs, 127–128, 130; self-monitoring, 134–135; skills training, 147, 148–155; sleep problem, 153; Socratic questioning, 131–132; time management, 153; values identification, 132–133
- intolerance of ambiguity (IA), 25
- intolerance of uncertainty (IU), 25–26
- Intolerance of Uncertainty Scale – 12 (IUS-12), 26
- L**
- learned responses, 19–21; modeling, 21; operant conditioning, 20–21; respondent (classical) conditioning, 20
- life-threatening crises, 123
- M**
- maintenance stage of change, 122–123
- maladaptive beliefs, 140
- mechanism assessment tools, 90–91
- mechanism change goals, 113, 114, 120; markers for achieving, 120–121; measures for tracking, 182–183; monitoring progress toward, 181–183; targeting in treatment, 161–163
- mechanism hypotheses, 97–106; chain analysis for generating, 98–100; insights provided by, 162; PDL for generating, 101–104
- memory biases, 17–18
- Metacognitions Questionnaire – 30 (MCQ-30), 37
- metacognitive beliefs, 22–23
- metacognitive therapy, 140
- metaphors, 64
- mindfulness, 135, 150
- miracle question, 116–117
- modeling, 21
- monitoring: progress, 179, 180–186; self-, 134–135
- Mood Disorder Questionnaire (MDQ), 71
- motivation: addressing in patients, 117, 174–177; interventions that enhance, 128, 130–133
- motivational interviewing, 131, 195
- multidimensional construct, 30–32
- Multidimensional Perfectionism Scale (MPS), 27
- N**
- narrative therapy, 141
- negative problem orientation (NPO), 28–29
- Negative Problem Orientation Questionnaire (NPOQ), 28
- negative reinforcement, 21
- negative schemas, 22, 170
- negative thinking. *See* repetitive negative thinking
- neurophysiological predispositions, 15–19; arousal regulation deficits, 16–17; emotion regulation deficits, 18–19; executive functioning deficits, 17; information processing deficits, 17–18; inhibitory control deficits, 16–17; sleep regulation deficits, 19

O

observations, 73–78; behavioral, 74–75; data comparative, 76–77; direct, 75; in vivo, 78; patient and family, 77–78; TDM formulation and, 95–97

Obsessive Beliefs Questionnaire – 44 (OBQ-44), 23, 26, 27, 29

OCD (obsessive-compulsive disorder): inflated responsibility and, 29; information processing deficits and, 17; intolerance of uncertainty and, 26; metacognitive beliefs and, 23; overestimation of threat and, 29; perfectionism and, 26–27; thought control and, 37

OCD Analysis Worksheet, 79

ongoing consultation/training, 65–66

operant conditioning, 20–21

organization/planning skills, 152

Outcome and Session Rating Scales, 187

outcome goals. *See* global outcome goals

overestimation of threat, 29–30

P

panic attacks, 16, 20

patients: assessment of, 69–91; deconstructing problems of, 78–90; exploring non-achievement of goals with, 183–185; goals for treatment defined by, 115–116; introducing TDM formulation to, 94–109; motivation addressed in, 174–177; observations made by, 77; referral options for, 194–195; responding to feedback from, 186–190; termination of treatment with, 192–196; treating as people vs. problems, 171–174; values and preferences of, 126

PDL. *See* Problem Deconstruction Log

peer consultation, 65, 66

Penn State Worry Questionnaire (PSWQ), 44

perceived control, 24–25

perfectionism, 26–27

pervasive beliefs, 21–23; metacognitive beliefs, 22–23; negative schemas, 22

photographs, childhood, 146, 177

physical tension and stress. *See* stress

planning treatment: developing treatment goals, 113–126; selecting interventions, 127–155; steps in process of, 159–160; transdiagnostic road map to, 10–12

positive data logs, 141, 182, 183

positive reinforcement, 21

post-event processing, 45

postponement strategies, 143–144

post-traumatic stress disorder. *See* PTSD

precontemplation stage of change, 122

preparation stage of change, 122

problem deconstruction, 133

Problem Deconstruction Log (PDL), 84–90, 198; collaboratively reviewing, 87–90; example of completed, 86; mechanism hypotheses generated from, 101–104; using as intervention, 133

problem identification, 70–72

problem orientation, 28

problem-solving therapy, 29, 151

progress monitoring, 179, 180–186; global outcome goals and, 180–181; mechanism change goals and, 181–183; non-achievement of goals and, 183–185; refining TDMs based on, 185–186; TDM tracking tools for, 182–183

Progress Note template, 130, 183, 202–204

progressive muscle relaxation, 149

prospective anxiety, 26

psychiatric comorbidity, 5

psychoeducation, 130–131

PTSD (post-traumatic stress disorder):

- attention retraining for, 143;
- dissociation related to, 39; emotion regulation deficits and, 18–19;
- exposure-based treatments for, 95;
- information processing deficits and, 18

punishment, 21

Q

Quality of Life Inventory (QOLI), 72

quality of life issues, 72, 124

R

radical acceptance, 147

randomized controlled trials, 5

readiness for change, 121–123

reassurance seeking, 35

referral options, 194–195

relationship ruptures, 60–62

relaxation training, 149–150

repetitive negative thinking, 8, 44–45;

metacognitions about, 170–171;

post-event processing as, 45;

rumination as, 45; worry as, 44–45

Repetitive Thinking Questionnaire (RTQ), 44

respiratory control mechanisms, 16

respondent conditioning, 20

response mechanisms, 33–45;

attentional focus, 41–42; attributional

bias, 42–43; cognitive misappraisals,

40–41; experiential avoidance, 33–40;

repetitive negative thinking, 44–45;

summary listing of, 14

Response Styles Questionnaire (RSQ), 45

Responsibility Appraisal Questionnaire (RAQ), 29

Responsibility Attitude Scale (RAS), 29

rumination, 45

S

safety-seeking behaviors, 35

scheduled worry, 144

scheduling activities, 138

schema therapy, 141

schemas: activation of negative, 22;

methods for changing, 140–141

self-attacking behaviors, 8, 42–43

self-disclosure by therapists, 58–60

self-focused attention (SFA), 8, 41, 143

self-harm, 5, 39, 40

self-monitoring, 134–135

Session Assignment and Feedback

Form, 187

shame, feelings of, 43

situational analysis, 133

situational attention retraining, 142–143

situational avoidance, 36

skillful creativity, 47, 50, 63–65, 146, 177–178

skills: anger management, 150–151;

developing for specific problems,

148–155; distress tolerance, 126, 147;

emotion regulation, 147; interpersonal

effectiveness, 148; organization and

planning, 152; problem solving, 151;

stress management, 148–150; time

management, 153

skin picking, 19, 79, 154, 172, 173

sleep problems, 153

sleep regulation, 19

social anxiety disorder, 28, 41

Social Problem-Solving Inventory

– Revised (SPSI-R), 28

Socratic questioning, 131–132, 169, 195

somatic avoidance, 38

specific cognitive constructs, 23–30;

anxiety sensitivity, 24; fear of

evaluation, 27–28; illness/injury

sensitivity, 30; inflated responsibility

beliefs, 29–30; intolerance of

uncertainty, 25–26; negative problem

orientation, 28–29; perceived control, 24–25; perfectionism, 26–27; threat estimation, 29–30
stages of change, 122–123
standardized measures, 71–72
stepping back from problems, 128, 133–137
stimulus control strategies, 153
stress: applied relaxation for, 149–150; breathing retraining for, 148–149; guided imagery for, 150; progressive muscle relaxation for, 149
suicidal patients, 123
suppression, thought, 37–38
Symptom Checklist – 90 – Revised (SCL-90-R), 71

T

TDM formulation. *See* transdiagnostic mechanism (TDM) formulation
TDM Formulation Worksheet, 93, 108, 200
TDM Hypotheses Worksheet, 70, 199
termination of treatment, 192–196; achievement of therapy goals and, 192–194; referral options related to, 194–195
therapeutic alliance, 55–62; being real in, 56–58; essential role of, 56; repairing ruptures in, 60–62; therapist self-disclosure and, 58–60; three components of, 55
therapy-based apps, 64, 178
therapy-interfering behaviors, 124
thinking: control/suppression of, 37–38; repetitive negative, 8, 44–45
thought control, 37
Thought Control Questionnaire (TCQ), 37
thought records, 133, 139, 170, 183
thought suppression, 37–38
thought-action fusion (TAF), 23

threat estimation, 29–30
time management, 153
training and consultation, 65–66
transdiagnostic mechanism (TDM)
 formulation, 93–110; chain analysis for, 98–100; diagnostic impressions and, 94–95; diagram illustrating, 105–106; factors to consider in, 109–110; introducing to patients, 94–109; mechanism hypotheses in, 97–106; observational data and, 95–97; PDL used for, 101–104; problem examples used in, 97–106; refining in therapy, 185–186; TDM Formulation Worksheet for, 93, 108, 200; tying the pieces together in, 106–109
transdiagnostic mechanisms (TDMs):
 definition of, 10; identification of, 10–11; intervention selection for, 127–128, 130; response mechanisms, 14, 33–45; summary listing of, 14; vulnerability mechanisms, 14, 15–32
transdiagnostic models, 8–10
transdiagnostic processes, 8
transdiagnostic road map: contemporary interest in, 7–8; core principles of, 47–66; process for developing, 7–12; treatment planning and, 10–12; value in using, 196; worksheets based on, 197–204
Trauma Symptom Inventory – 2 (TSI-2), 39, 72
treatment: achieving the goals of, 192–194; assessing patients for, 69–91; developing goals for, 113–126; flexible delivery of, 5–6; implementation of, 159–178; individualized approach to, 6–7; mapping the road ahead in, 163–171; of people vs. problems, 171–174; selecting interventions for, 127–155; targeting new problems in,

190–191; TDM formulation for, 93–110; termination of, 192–196; transdiagnostic models of, 8–10
 Treatment Goals Worksheet, 113, 201
 treatment planning. *See* planning
 treatment
 trichotillomania, 19, 154, 172
 triple vulnerability model, 20
 two-chair technique, 146
 two-factor theory, 20

U

uncertainty, intolerance of, 25–26
 understanding, enhancing, 128, 130–133

V

validation, 136
 Valued Living Questionnaire (VLQ), 132
 values: actions based on, 126, 138; identification of, 132–133, 170
 vulnerability mechanisms, 15–32; learned responses, 19–21;

multidimensional construct, 30–32;
 neurophysiological predispositions, 15–19; pervasive beliefs, 21–23;
 specific cognitive constructs, 23–30;
 summary listing of, 14

W

White Bear Suppression Inventory (WBSI), 37
 Why Worry – 2 (WW-2) measure, 44
 willingness, 147
 worksheets, 12, 197–204; Problem Deconstruction Log, 84–90, 198; Progress Note, 130, 183, 202–204; TDM Formulation Worksheet, 93, 200; TDM Hypotheses Worksheet, 70, 199; Treatment Goals Worksheet, 113, 201
 worry, 38, 44–45, 144

Y

Yale-Brown Obsessive-Compulsive Scale – 2 (Y-BOCS-2), 71

Register your **new harbinger** titles for additional benefits!

When you register your **new harbinger** title—purchased in any format, from any source—you get access to benefits like the following:

- Downloadable accessories like printable worksheets and extra content
- Instructional videos and audio files
- Information about updates, corrections, and new editions

Not every title has accessories, but we're adding new material all the time.

Access free accessories in 3 easy steps:

1. Sign in at NewHarbinger.com (or **register** to create an account).
2. Click on **register a book**. Search for your title and click the **register** button when it appears.
3. Click on the **book cover or title** to go to its details page. Click on **accessories** to view and access files.

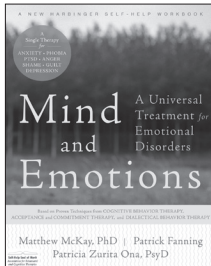
That's all there is to it!

If you need help, visit:

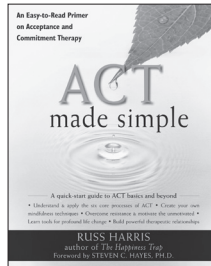
NewHarbinger.com/accessories



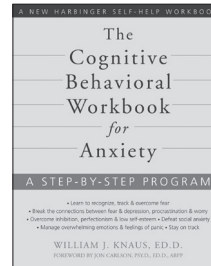
MORE BOOKS from NEW HARBINGER PUBLICATIONS



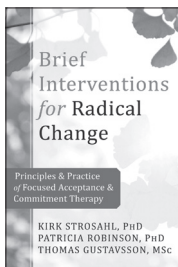
MIND & EMOTIONS
A Universal Treatment for
Emotional Disorders
ISBN: 978-1608820153 / US \$21.95
Also available as an e-book



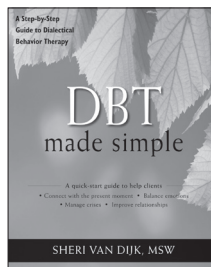
ACT MADE SIMPLE
An Easy-To-Read Primer on
Acceptance & Commitment
Therapy
ISBN: 978-1572247055 / US \$39.95
Also available as an e-book



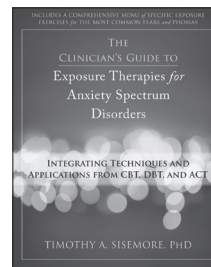
**THE COGNITIVE
BEHAVIORAL WORKBOOK
FOR ANXIETY,
SECOND EDITION**
A Step-By-Step Program
ISBN: 978-1626250154 / US \$24.95
Also available as an e-book



**BRIEF INTERVENTIONS
FOR RADICAL CHANGE**
Principles and Practice of
Focused Acceptance &
Commitment Therapy
ISBN: 978-1608823451 / US \$49.95
Also available as an e-book



DBT MADE SIMPLE
A Step-by-Step Guide to
Dialectical Behavior Therapy
ISBN: 978-1608821648 / US \$39.95
Also available as an e-book



**THE CLINICIAN'S GUIDE
TO EXPOSURE
THERAPIES FOR ANXIETY
SPECTRUM DISORDERS**
Integrating Techniques &
Applications from CBT,
DBT & ACT
ISBN: 978-1608821525 / US \$49.95
Also available as an e-book



newharbingerpublications
1-800-748-6273 / newharbinger.com



Like us on Facebook



Follow us on Twitter
@newharbinger.com

(VISA, MC, AMEX / prices subject to change without notice)



Don't miss out on new books in the subjects that interest you.
Sign up for our **Book Alerts** at newharbinger.com/bookalerts

Sign up to receive QUICK TIPS for Therapists—
fast and free solutions to common client situations mental health professionals encounter.
Written by New Harbinger authors, some of the most prominent names in psychology today,
Quick Tips for Therapists are short, helpful emails that will help enhance your client sessions.

Sign up online at newharbinger.com/quicktips

→ The Essential Guide to Transdiagnostic Treatment Planning

Clinical research over the last few decades has given rise to a greater understanding of the psychological mechanisms that underlie many emotional and behavioral disorders. Evidence now suggests that transdiagnostic approaches—rather than protocols that focus on a singular diagnosis—can greatly improve treatment outcomes. If you are interested in treating patients with symptoms that span different diagnostic categories, or are struggling to keep up with the growing number of disorder-based protocols, this book is an extremely important addition to your professional library.

This breakthrough guide provides a compass for navigating both simple and complex cases to arrive at a more effective, individualized type of treatment planning—one that is tailored to your client's specific needs. This transdiagnostic approach focuses on the mechanisms that underlie client symptoms. It offers a departure from traditional treatments relying on DSM categorization and provides mental health professionals with essential tools for treating a broad range of client problems. Finally, it builds on existing case formulation approaches by bridging research on psychological mechanisms with practical steps for assessment and treatment.

“Amid today’s flood of books and cacophony of webinars and podcasts, Frank and Davidson’s sage advice stands out in this unique text on transdiagnostic road maps. This book is well written with clinical acumen and a solid link to the empirical literature on comorbidity. It should be required reading for all students, clinicians, and researchers in the field. I highly recommend it!”

—FRANK M. DATTILIO, PhD, ABPP, Harvard Medical School, Boston, MA

ROCHELLE I. FRANK, PhD, is a clinical psychologist who specializes in the treatment of severe mood disorders, borderline personality disorder, and trauma and dissociative disorders. She is assistant clinical professor in the clinical science program at the University of California, Berkeley.

JOAN DAVIDSON, PhD, is codirector and founding partner of the San Francisco Bay Area Center for Cognitive Therapy and assistant clinical professor in the clinical science program at the University of California, Berkeley. She specializes in the treatment of adults with mood and anxiety disorders.

Foreword writer **JACQUELINE B. PERSONS, PhD**, is director of the Cognitive Behavior Therapy and Science Center and clinical professor in the department of psychology at the University of California, Berkeley.



new harbinger publications
www.newharbinger.com

