

Chapter 2

Third-Wave Therapies for Children and Adolescents: Origins and Development

Overview

Originally, the need was recognized to expand and reconceptualize the then existing psychoanalytic and behavioral theories into an approach that would better address the processes of negative thinking and the profound impact that it seemed to have on problematic behavior and negative emotional experiences of adults. Where psychoanalytic approaches focused on the conscious and unconscious mental functioning of a person through the lens of childhood events, behavior therapies were only concerned with changing the person's behavior without considering its roots or cognitive content. With the advent cognitive therapy the importance of automatic negative thinking on the expression of problematic behavior was recognized. Gradually more focus was placed on the elimination of dysfunctional thoughts with the ultimate objective to change behavior, and Cognitive Behavioral Therapy (CBT) introduced the third generation of therapies. In this chapter, the development of CBT and the mindfulness-based and other approaches that were derived from its concepts will be discussed. It is outside of the current scope to discuss each psychotherapy in detail, therefore discussions will be brief and limited to a select few approaches that influenced the development of psychotherapy in general, and Mode Deactivation Therapy (MDT) specifically. Theorists and scholars are not always in agreement of which movements constitute the different generations of psychotherapy, but for the purpose of highlighting the progress in theory and practice in the last century or so, the advances will be discussed from psychoanalytic therapy as the “first wave,” behavior therapy as the second, cognitive therapy—including cognitive behavioral and derivative therapies—as the third.

First Wave: Psychoanalytic Therapy

Psychoanalytic theory is past-oriented, based on a disease model of pathology, and focus on the deficits of a person as a result of the influence of past early childhood experiences on current functioning. In essence, psychoanalytic therapy is a reconstruction of a client's past in the context of adult analysis. Psychoanalytic theory and therapy was developed by Sigmund Freud from the late nineteenth century, and has undergone many refinements since his work, coming to its height of prominence in the 1960s. Although its validity is now largely disputed and criticized, his examination of the development aspects of the personality produced valuable insights into the personality structure and how defense mechanisms are employed to balance the id and superego with the perceived construct of reality, whereby a healthy state of consciousness is maintained. Essentially, Freud laid the foundations of understanding the aspects of human thought and behavior that arise from our basic instincts and subconscious mind. From the foundations of early experiences, a person projects his or her unconscious impulses and conflicts. Therefore, in psychoanalytic psychotherapy a client is encouraged to reveal such issues with the aid of various techniques such as free association, behavioral observation, transference, and dream analysis. Freud believed that changes in personality were possible, but were questioning the practical merits of psychoanalysis to effect such a change (Ellis, Abrams, Abrams, Nussbaum, & Frey, 2009). He conceded that the process of psychoanalysis is a long and difficult one that requires sophisticated verbal, intellectual, and analytical skills of the therapist, with a real possibility to provoke anxiety and distress by the exploration of a client's past.

Despite Freud's inclination to emphasize the challenges that face the psychoanalytic approach, there are empirical evidences of the efficacy of psychodynamic therapy. In addition, clients appear to maintain therapeutic gains and continue to improve after treatment completion (Shedler, 2010). A meta-analysis study by De Maat, De Jonghe, Schoevers, and Dekker (2009) also concluded that long-term psychoanalytic therapy is effective in symptom reduction, as well as personality change, and although to a lesser extent it is significant in terms of quality of life and relapse prevention. However, it is clear that psychoanalytic therapy is a long journey that may not be suitable or effective for resistant and younger clients, and severe psychopathology. Freud agreed that it is a long and intricate process (2000, p. 67):

Psychoanalytic observation, reaching back into childhood from a later time, and contemporary observation of children combine to indicate to us still other regularly active sources of sexual excitation. The direct observation of children has the disadvantage of working upon data which are easily misunderstandable; psychoanalyses are made difficult by the fact that it can only reach its data, as well as its conclusions, after long detours. But by cooperation the two methods can attain a satisfactory degree of certainty in their findings.

Several techniques are used to explore those aspects of the self that are not fully known as they are manifested and influenced in the therapist–client relationship. The focus areas of exploration are (Shedler, 2010):

1. *Affect and expression of emotion*: The psychoanalytic therapist helps the client to describe unpleasant, contradictory, threatening, troubling, and repressed feelings to cultivate emotional insight.

2. *Attempts to avoid distressing thoughts and feelings*: Mechanisms of defense and resistance that are deliberately or inadvertently applied to avoid aspects of undesired experiences are focused on as avoidance is significantly related to negative feelings and problematic behavior. The client's affect and role in shaping events are examined directly and without compromise.
3. *Recurring themes and patterns*: A client may be unaware of, or aware but unable to manage painful or self-defeating recurring themes and patterns in their thoughts, feelings, self-concept, relationships, and life experiences. The psychoanalytic therapist guides the client to recognize and understand these.
4. *Past experience*: Our present experience is significantly affected by past events, especially early experiences of attachment figures. Therefore, the focus is on the past in relation to present problems and the client is encouraged to explore and understand the effects in order to free themselves from the bonds of the past.
5. *Interpersonal relations*: When object and attachment relationships are unsatisfying and do not meet emotional needs, psychological difficulties often arise. The client is assisted to establish adaptive personality and self-concept aspects to improve prosocial skills and attitudes.
6. *Therapy relationship*: The therapist–client relationship is considered vital in the psychoanalytic therapy process as problematic themes and patterns tend to emerge in some form in the therapeutic relationship. These aspects of transference and countertransference provide an opportunity to explore and analyze a client's interpersonal themes in vivo.
7. *Fantasy life*: Clients are encouraged to speak freely and engage in free association that provides a rich source of information of their thoughts, desires, fears, fantasies, dreams, and hopes, which signals their views of themselves, others, and the world, as well as aspects of experiential avoidance, and their interpretation of reality.

It follows that psychoanalytic therapy sessions are largely unstructured, without a predetermined agenda, and open-ended. The excessive long and costly nature of psychoanalytic therapy, together with the potential to harm a client by deeply intrusive explorations and an unrelenting focus on psychopathology as an illness that can increase internal conflict and instability, have caused sustained criticism over time. As an application of the principle of the cause and effect of human behavior, psychoanalytic theory arguably remains valuable in the sense that he explained the many features of behavior as the products of circumstances in the past experiences of an individual (Skinner, 1954). However, Freud's conception also "encouraged misinterpretation and misunderstanding" (p. 77) because of its complex and abstract nature that are thought to have obscured important details among the variables of which human behavior is a function. The most unfortunate effect of all, however, is the neglect of analysis of behavior as a telling manifestation of inner experiences, and the unquantifiable sense of psychoanalytic theory that largely ignores the dynamic nature of behavioral processes in a constant flux in favor of the notion of fixations on early stages of development. However, the conception of defense mechanisms that is at first a short-term solution to cope with distress and deprivation of emotional needs but are reinforced and firmly established through overutilization,

have remained valid and useful in the development of modern cognitive theories. In that sense, it is true that the past lives on in the presence. In other words, we view the present through the lens of past experience and therefore tend to distort the present reality by repeating and recreating aspects of our past.

Second Wave: Behavior Therapy

At this time, it is more than a century since Freud proposed the three-layered model of the human mind and science has not yet provided any evidence to support it. With the progress in neuroscience and the advent of cognitive psychology, however, a more complex view of nonconscious processes is possible. But first, behavior therapies were developed based on the need for an effective short-term therapy for anxiety, depression, and other emotional adjustments that veterans of the Second World War faced on their return home. Behavioral learning theory was the initial basis of the wave of behavior therapy, which was considered a revolutionary challenge to psychoanalytic therapy.

Behavior therapy is narrowly focused on changing a client's behavior by engaging in positive or socially reinforcing behavior. It is a structured approach that carefully monitors what a person is doing in order to identify opportunities for positive experiences. The focus is present-oriented on current causes of distress or maintenance of improvements. As such, it is problem-oriented and goal-directed with the only objective to change behavior, theory-based rather than individualized, and the therapist–client relationship follows a top-down strategy of information processing and knowledge sharing. Classical behavior therapy is a set of clinical procedures that are based on principles of learning that are systematically applied to achieve specific treatment goals that are measurable by focusing on the client's current behavior problems. The four main aspects of classical behavior therapy are:

1. *Exposure and desensitization*: In vivo desensitization involve a brief and graduated exposure to an accrual fear situation or event or a prolonged and intensive in vivo or imaginal exposure to anxiety-evoking stimuli without the opportunity to avoid it (flooding). In addition, Eye Movement Desensitization and Reprocessing (EMDR) applies rhythmic eye movements and other bilateral stimulation to manage fearful memories.
2. *Classical conditioning*: It is a type of learning that was originally described by Ivan Pavlov that occurs through interactions with the environment in an instinctive reflex instead of being mediated by thoughts, feelings, and emotions. By producing a conditioned response, fears and phobias can be managed and aversions stimulated by manipulating the environment.
3. *Operant conditioning*: It is also a learning process, but occurs through awards and punishments for behavior by an association between the behavior and its consequence. Its first proponent, behaviorist B. F. Skinner believed that external, observable causes of human behavior and the consequences directly associated

with it, explain behavior instead of thoughts, feelings, and emotions. Operant conditioning is commonly used in everyday life with the promise or possibility of rewards and punishment and is effectively a reaction to past consequences.

4. *Social learning*: It is a process of learning whereby others' behavior, attitudes, and outcomes of behaviors are observed and imitated or used as a model for appropriate or desired behavior. In this sense, there is a continuous reciprocal interaction between cognitive, behavioral, and environmental influences.

It is important to realize that behavior therapy is only designed to change behavior and not an underlying personal characteristic or trait (Miltenberger, 2012). As such, it is not concerned with the associated clinical condition, but only undesirable and observable behavioral excesses or deficits. There is a strong emphasis on current environmental events that are associated with the problematic behavior, and once these controlling events have been identified, they are altered to achieve a behavioral goal. Essentially, it is a self-regulatory process with the therapist acting as facilitator. But, even more importantly, there is a de-emphasis on the relevance of past events on current behavior, and therefore underlying causes are rejected. It is outside the scope of this book to engage with more detail of classical behavior therapies, but for now it suffices to note that the main limitations and criticisms of behavior therapy are that cognitive processes and experiences (and their correlation with behavior) are de-emphasized, relational factors are largely ignored, symptoms are treated rather than causes, and it does not provide a deeper insight into factors that may be contributing to internal distress and problematic behavior. It is considered by many scholars and practitioners to be standardized and mechanistic with the therapist applying control and manipulation to affect behavior change. As such, it lacks the promotion of internal growth and meaningful impact and an identification and understanding of the real problem that is required to achieve and maintain positive change and prevent relapse.

Third Wave: Cognitive Behavioral Therapies

The third-generation, or third wave, therapies developed from cognitive therapy in the 1960s when Aaron Beck recognized the importance of thinking patterns and unconscious mental processes in shaping and motivating behavior. Up to that time, cognitive processes were not afforded much prominence in psychotherapy. The limitations of not considering thought, feelings, beliefs, and interpretations that obviously played an important role to motivate behavior, caused dissatisfaction with the purely behavioral approach (Westbrook, Kennerley, & Kirk, 2011). In the 1970s, the recognition of the shortcomings of behavioral approaches lead to what has become known as the “cognitive revolution” whereby cognitive phenomena were brought into the theoretical and practical framework of modern psychotherapy methods.

Beyond classical CBT, there are many similarities, third-wave CBT therapists base themselves in empirical research, they acknowledge the important role of

behavior just as much if not more so than traditional CBT, most also continue to acknowledge the important role of cognitions (thinking). So what is different? Some of the main theoretical differences seem to be about control and emotional avoidance. The question became whether trying to control our thoughts and emotions is part of the solution or the problem. Up to recently the focus was only on the contents of thoughts rather than their context or the thinking process itself.

As the developer of Acceptance and Commitment Therapy (ACT), Prof. Steven C. Hayes of the University of Nevada explains:

Grounded in an empirical, principle-focused approach, the third wave of behavioral and cognitive therapy is particularly sensitive to the context and functions of psychological phenomena, not just their form, and thus tends to emphasize contextual and experiential change strategies in addition to more direct and didactic ones. These treatments tend to seek the construction of broad, flexible and effective repertoires over an eliminative approach to narrowly defined problems, and to emphasize the relevance of the issues they examine for clinicians as well as clients. The third wave reformulates and synthesizes previous generations of behavioral and cognitive therapy and carries them forward into questions, issues, and domains previously addressed primarily by other traditions, in hopes of improving both understanding and outcomes. (Hayes, 2004, p. 659)

The third generation, or third wave, of therapies are a loose affiliation of cognitive behavioral-based approaches that are not defined by any specific criteria and their inclusion are sometimes disputed by their developers. Well-known examples that are increasingly attracting empirical research and new applications are ACT, Dialectical Behavior Therapy (DBT), Schema Therapy, Mindfulness-based Cognitive Therapy (MBCT), and MDT. As psychoanalytic perspectives gave way to behavior therapies in an attempt to deal with psychological problems more quickly and directly, cognitive behavioral approaches again recognized that a significant piece of the behavioral puzzle would remain unaddressed if thinking patterns were ignored.

Cognitive Behavioral Therapy

CBT is a goal-directed, short-term treatment that is based on Dr. Aaron T. Beck's observations in the 1960s, and in which the therapist and client work collaboratively to resolve the client's problematic behaviors and emotions by solving problematic thinking. Its goal is to change patterns of clients' thinking and behavior that are the source of their difficulties. Beck recognized the significance of the link between thoughts and feelings and the fact that people are often not fully aware of these thoughts. Thus, he invented the term *automatic thoughts*, but theorized that people can be guided to become aware of and identify such thoughts. As behavioral techniques were employed as well, the approach became known as Cognitive Behavioral Therapy, or CBT. Since then, CBT has been applied to a growing variety of problems and has spawned many derivative approaches that are often referred to as third-generation, or third-wave, therapies.

CBT was originally conceptualized by exploring psychoanalytic concepts of depression when Dr. Beck found that depressed patients experienced streams of negative thoughts that seemed to arise spontaneously. These negative thoughts were oftentimes unrealistic views of themselves, others, and the world. By providing assistance to clients to become aware of and evaluate these thoughts, clients were able to think more realistically, and, as a result felt better emotionally and behaved more functionally. In 1964 Beck wrote two important papers in which he explained the link between thinking and depression in terms of idiosyncratic content and cognitive distortions of thoughts and how he related these concepts to theory and practice by way of the schema concept. Beck found that deviation from logical and realistic thinking forms a thematic content that can distinguish clinical groups and that a thought disorder may be common to all types of psychopathology. In particular, arbitrary inference, selective abstraction, overgeneralization, magnification, and minimization were identified as dysfunctional thinking processes (Beck, 1964a). He also argued that the disturbance seems to be secondary to the thinking disorder as the distorted ideas appeared immediately before arousal of the problematic affect, although there may also be a reciprocal interaction between the dysfunctional cognition and affect. Furthermore, it was concluded that idiosyncratic schemas underlie these irrational thought processes, whereby flexibility and an appropriate response to environmental stimuli is ultimately sacrificed. Beck defined schemas as “stereotyped or repetitive patterns of conceptualizing” that are regarded as “manifestations of cognitive organizations or structures” that are relatively enduring components of cognition (1964b, p. 562). In other words, a schema is a structure that is involved in the screening, coding, and evaluation of incoming stimuli. In essence, it presents the way that an individual interprets experiences meaningfully, adapts to external reality, and responds accordingly. Raw input data is molded into thoughts and feelings to act as motivators for behavior, but may not necessarily be effective or appropriate in the new circumstances. Schemas are not directly observable, but can be inferred by observing behavior and exploring thoughts and feelings. According to Beck (1964b):

The most striking characteristic of the schemas is their content. The content is generally in the form of a generalization and corresponds to the individual's attitudes, goals, values, and conceptions. The contents of the idiosyncratic schemas found in psychopathology are reflected in the typical chronic misconceptions, distorted attitudes, invalid premises, and unrealistic goals and expectations. (p. 563)

As such, the main objective of CBT is to identify the content of a client's schemas by an analysis of their ways of structuring and expressing experiences, from recurrent themes in thoughts, free associations, and ruminations, from thematic dream content, from direct questioning about attitudes, values, beliefs, and expectations, and, lastly, by psychological test instruments designed to measure fears and beliefs about themselves, others, and the world.

As the distortions in a person's thinking and judgment lead to psychological distress and dysfunctional behavior, those thoughts, assumptions, and beliefs that underlie problematic feelings and responses to events are identified and modified in CBT with the objective to eliminate maladaptive behavior and emotions. In fact, thoughts, feelings, and behaviors are continually interrelated in the context of core

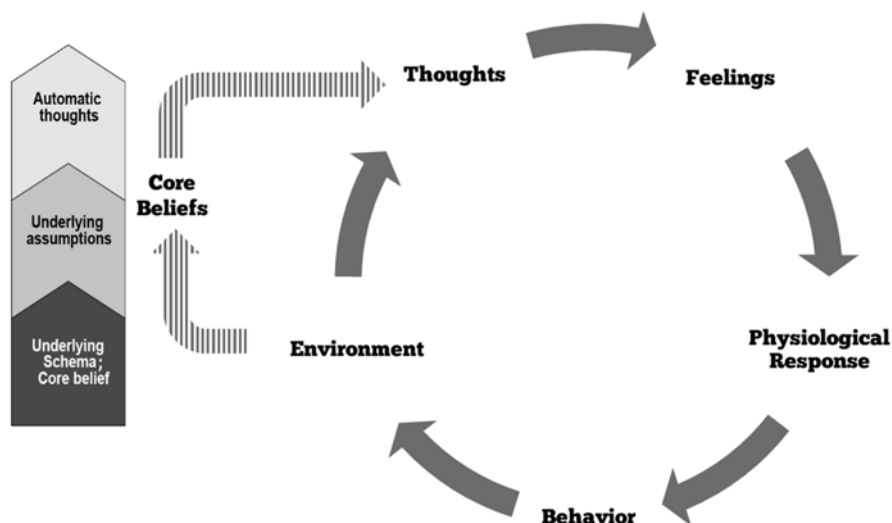


Fig. 2.1 Organization of beliefs, thoughts, and behavior

beliefs whereby cycles have an amplifying and perpetuating effect on symptoms while reinforcing existing core beliefs at the same time. The basic cognitive organization structure is illustrated in Fig. 2.1.

Here, an external event acts as a trigger to activate the underlying schema or core belief based on underlying assumptions that the interpretation is real, logical, and meaningful. Automatic thoughts are constantly generated, much outside our conscious awareness. Yet, they have a powerful impact on our conscious thinking, feelings, and physiological responses that are all designed to test reality and respond appropriately, but in the context of severe or chronic distress, it is common to lose the ability and balance of objective examination when coping defenses kick in to meet emotional needs (Beck, 2011). Again, it is not the intention to provide a detailed account of the theory and practice of CBT here, but rather to principles, differences, and issues that were important in the development of MDT as a different perspective on the management of problematic core beliefs. Westbrook et al. (2011) summarized the basic principles of CBT as follows (p. 8):

- The *cognitive principle* involves interpretations of events, but not the events themselves, which are a crucial distinction in CBT.
- The *behavioral principle* emphasizes that what we do has a powerful influence on our thoughts and emotions.
- In the continuum principle mental health problems are best conceptualized as exaggerations or avoidance of normal processes.
- In CBT the focus is strongly on the *here-and-now principle* as it is usually considered to be more fruitful to focus on current processes instead of past experiences.

- In the *interacting systems principle* problems are viewed as interactions between thoughts, emotions, physiology, and behavior, physiology, and the environment in which the person operates.
- CBT is based on the *empirical principle* whereby an evidence base is established for the theory and practice.

Now we will briefly consider the important stages of CBT treatment. There are many variations in methodology and applications, but according to Turk and Flor (2013), the “traditional” CBT methodology has six basic phases, namely (1) assessment, (2) reconceptualization, (3) skills acquisition, (4) skills consolidation and application training, (5) generalization and maintenance, and (6) posttreatment assessment follow-up.

1. The *assessment* stage involves interviews with patients and their families that are supplemented by a series of psychological self-report test instruments to identify the degree and nature of the psychological impairment, including the automatic thoughts or irrational beliefs that underlie it. The most appropriate course of action is determined.
2. *Reconceptualization* involves the disputation and challenging of automatic negative thoughts and irrational beliefs. Clients are asked to provide evidence attesting to the truth or falseness of their beliefs, to consider whether they are logical or not, and contemplate the functionality of new alternative beliefs. CBT holds that irrational beliefs are inconsistent with reality, therefore illogical, and yield negative results. By developing and considering functional alternative beliefs cognitive restructuring takes place.
3. In the *skills acquisition* phase, behavioral activation is enabled as the client is guided to improve social and cognitive skills in order to execute the cognitive restructuring. Skill use is an important mechanism of change that contributes to positive treatment outcomes. Examples of skills are communication, time management and planning, awareness, motivation, and prosocial behavior.
4. In the *skills consolidation and application training* step, clients are given homework to help reinforce the skills that they have acquired in the previous stage. Homework is reviewed at each following session, and serves to provide feedback on progress and the practical application of the different tools, skills, and techniques. The quality and quantity of homework is considered an important predictor of treatment outcome.
5. *Generalization and maintenance* is conducted by discussing the future and ensuring that clients are well equipped to cope after treatment completion.
6. In *posttreatment assessment follow-up* clients are monitored and evaluated to determine how effectively they continue to apply CBT skills and techniques in their everyday lives and day-to-day functioning.

Already, in the brief discussion of the important principles and practices of standard CBT, several points worth noting stand out. In general there are two main criticisms. Firstly, CBT provides a model of cognitive restructuring and learning, but takes minimal consideration of early development and the effect that past experiences

have on psychological and personality structures. However, a person's temperamental characteristics and beliefs that form the essence of his personality have a profound effect on his interaction and attachment with others, especially in the home. The repetition over time of early patterns of interaction anchors perceptions, thoughts, feelings, beliefs, values, attitudes, and behavior that are constantly reciprocally influenced by anticipated or actual responses from others. Secondly, the fact that beliefs and cognitions are treated as irrational can be deeply invalidating and negatively affect aspects that are essential change agents, including self-concept, therapeutic alliance, cooperation, and commitment. These concerns were the basic impetuses for most of the third-generation therapies that followed.

The effectiveness of CBT has been well established for adults with a variety of psychological conditions. Although adolescents with internalized disorders such as depression achieve symptom improvement with CBT, changes were often found to be relatively small and temporary, especially when compared to third-generation therapies that utilize acceptance, mindfulness, and family system principles (Ruiz, 2012; Swart & Apsche, 2014). The effectiveness of CBT for adolescents with conduct disorders and other populations who are considered as difficult-to-treat has not been well documented. Although the third-generation therapies that followed CBT are by some still considered to lack an adequate empirical base (Öst, 2008), evidence is quickly mounting that these approaches are fast achieving empirically supported status, adding considerable value and treatment possibilities for patient groups that had received little specific attention in the past (Kahl, Winter, & Schweiger, 2012). Arguably, one possible reason is that the CBT approach appears to view reality through rose-tinted lenses. When a patient has problems with, or negative views of his reality, it is immediately ascertained that his beliefs are irrational, his interpretations are faulty, and that he is by inference "bad," "deficient," and "wrong," which can seem like a privileged and presumptuous point of reference. Conceivably, these are exactly the beliefs that may have caused the client's problems in the first place. For the sake of illustration, consider the thought experiment of Nozick (1989) about a Holocaust survivor:

A proponent of maximizing our own happiness might recommend we ignore these negative portions of reality and focus our attention selectively only upon the positive. Sometimes that might be appropriate; a person in a Nazi extermination camp might focus eventually upon memories of Mozart's music in order to escape the horrors around him. But if this were his preoccupation from the beginning, smiling constantly in fond memory of the music, that reaction would be bizarre. Then he would be disconnected from important features of his world, not giving them emotional attention commensurate with the evil they inflict. (pp. 118–119)

By focusing on what could be uplifting in different circumstances, one's attention is diverted from the way things are, while this very diversion can be considered equivalent to psychological or experiential avoidance, which not only prevents or blocks resilience and other positive adaptive coping mechanisms, but is strongly associated with many forms of psychopathology. Potentially, this approach can create very negative responses from clients, especially adolescents with a history and present experiences of abuse and deprivation. By "keeping it real" newer third-wave therapies share a different approach to "reality," by validating rather than disputing the

client's beliefs and experiences, and cultivating a sense of awareness and acceptance with clients rather than avoidance of the truth. For the purpose of providing a brief overview and “feel” for third-generation therapies that were developed after CBT, four approaches are selected based on their level of research and empirical status, establishment in practice, and relevance to the development of MDT. In addition to MDT, the following three approaches are very briefly highlighted, in no particular order: ACT, DBT, and Schema Therapy.

Acceptance and Commitment Therapy

ACT is rooted in the framework of Relation Frame Theory (RFT) and was developed by Steven C. Hayes, Kelly G. Wilson, and Kirk Strosahl in the late 1980s by combining the core strategies of acceptance and mindfulness to affect behavior change by way of psychological flexibility. Psychological flexibility is defined as “the ability to contact the present moment more fully as a conscious human being, and to either change or persist when doing so serves valued ends” (Hayes, Strosahl, Bunting, Twohig, & Wilson, 2004, p. 5). ACT has proven effective in treating a wide range of psychological problems, including depression, anxiety, PTSD, and substance abuse, among others. It is a functional contextual approach, in other words, the ability to predict and influence psychological experiences—thoughts, feelings, and behaviors—by managing variables in their context. ACT is not considered to be a manualized treatment protocol, but techniques and exercises are created and individualized as the need arises (Harris, 2006). A state of mindfulness is viewed as the primary method to achieve acceptance, and is, as such, divided into four skill subsets, namely acceptance, cognitive defusion, contact with the present moment, and observing self. Therefore, instead of focusing on the elimination or reduction of symptoms, as is the case in CBT, the aim is to transform the client's understanding and relationship with difficult thoughts and feelings, so that they are viewed and accepted as a natural part of life. Although it is not an explicit goal to reduce symptoms, it is nevertheless achieved as a byproduct in the ACT process, because to view symptoms as a “disease,” permanent, and harmful often cause the problem in the first place, and exacerbates it afterwards. By recognizing that psychological suffering is not “abnormal,” that the assumption of a healthy environment, lifestyle, and social context cannot always hold true, ACT accepts suffering as a natural human process. According to ACT, cognitions, as the universal “private language,” creates psychological suffering for everyone through the process of experiential avoidance. However, as mentioned elsewhere, virtually every psychological problem “begins [and is sustained] as an attempt to avoid or get rid of unwanted thoughts and feelings such as boredom, loneliness, anxiety, depression, and so on” (Harris, 2006, p. 4).

Instead of considering, as is the general approach of CBT, that problem areas such as automatic negative thoughts or dysfunctional beliefs can be isolated and modified in a larger system that comprises inherent personality characteristics, an interpretation of all previous experiences, and the personal environment, ACT views

clients as a whole in their historical and situational context. In other words, as Hayes, Strosahl, and Wilson (1999) explained:

Rather than trying to change the form of private experience, ACT therapists attempt to change the functions of private experiences by manipulating the context in which some forms of activity (e.g., thoughts and feelings) are usually related to other forms (e.g., overt behaviors). (p. 24)

Therefore, it becomes important in ACT treatment to explore the context of the client's psychological struggles in order to direct change, which is determined by his or her values—another core focus point of the ACT methodology. In ACT, values are defined as the desired qualities that we are able to choose and control to drive our ongoing actions (see Fig. 2.2, adapted from Hayes, Luoma, Bond, Masuda, and Lillis 2006).

Where CBT is more narrowly and determinedly focused on identifying, targeting, and eliminating dysfunctional cognitions and behaviors, ACT is more broadly interested in the second-order effect of changing the functions and contexts of behavior that is equally suitable for the treatment of children and adolescents in a family system context. Finally, Gaudiano (2011) concludes that ACT is not an entirely new treatment approach intended to replace CBT, but an extension of behavioral and cognitive roots with sufficient distinctive theoretical and procedural elements to differentiate it from CBT. This distinction is particularly important from the perspective of continuing debates to integrate therapy approaches for the sake of cost-effectiveness and theoretical integrity. Although this is an important topic, it is one that falls outside of the current scope.

Dialectical Behavior Therapy

DBT was developed by Dr. Marsha Linehan in the 1970s as a modification of traditional CBT after a series of failed attempts to treat chronically suicidal patients with CBT (Dimeff & Linehan, 2001). Afterwards, DBT evolved into a treatment of patients diagnosed with Borderline Personality Disorder (BPD) and coexisting problems such as depression, Bipolar Disorder, PTSD, anxiety, eating disorders, suicidal behavior, and substance abuse. More recently, DBT has also been applied successfully to suicidal adolescents (Rathus & Miller, 2002). In recognizing some of the difficulties to treat chronically depressed patients with, including procedures that the patient experienced as invalidating, and lack of attention to teaching and strengthening new skills and creating an environment that is conducive to their use. Therefore, dialectical thinking patterns and acceptance were applied to replace rigid and dichotomous thinking that are found in CBT. According to Dimeff and Linehan (2001), DBT serves the following five main functions (p. 10):

1. Enhances behavioral capabilities
2. Improve motivations to change by modifying inhibitions and reinforcement contingencies

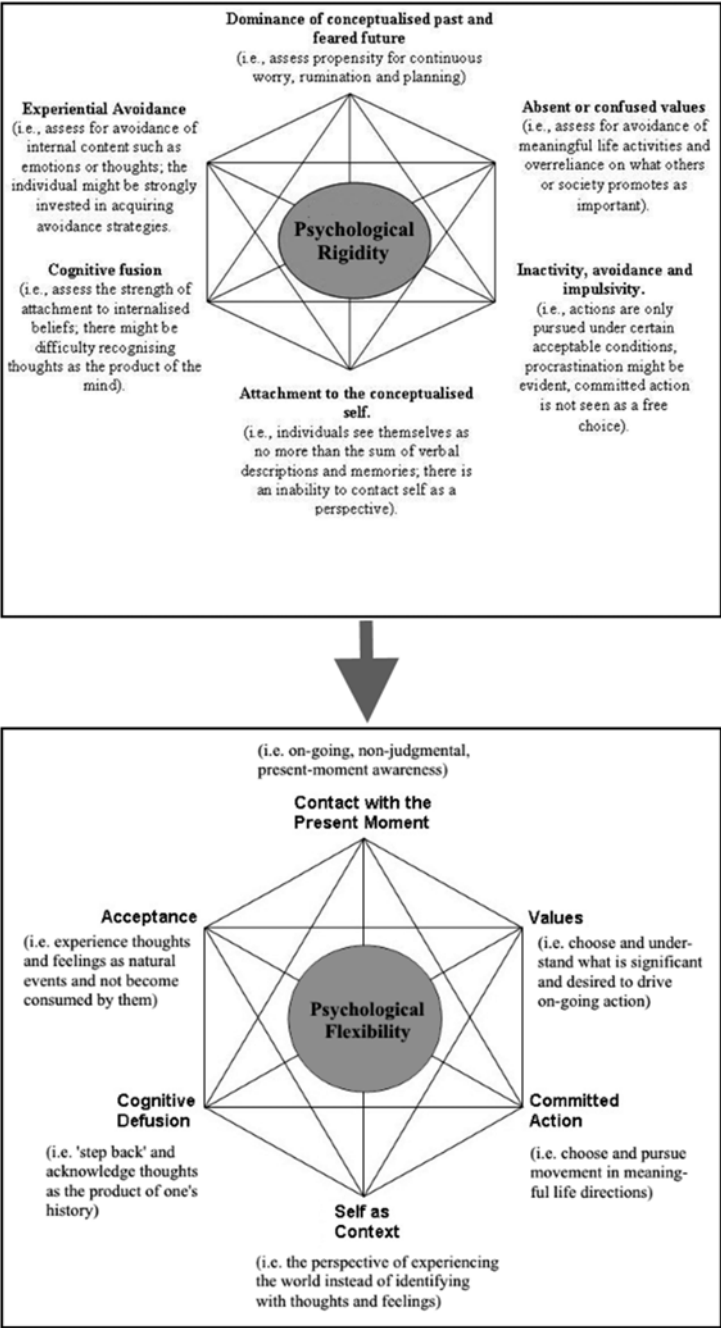


Fig. 2.2 ACT core processes

Table 2.1 Levels of validation in DBT

Level	Validation practices
Accurate reflection	Paraphrase what an adolescent says; communicate that you accurately understand what the adolescent has said
Mindreading	Communicate that you understand the adolescent's private experiences or that which is unsaid. Articulate private experiences of the adolescent based on your knowledge of him or her
Observing and listening	Use nonverbal and paralinguistic cues to indicate interest. Communicate that you wish to know the adolescent's emotions, thoughts, and behaviors
Validating in terms of causes	Make sense of behavior based on the adolescent's learning history or biology. Describe how a behavior is effective for short-term but not long-term goals
Validating in terms of the present	Search for and reflect the wisdom and truth in the adolescent's behavior by saying things such as "Of course you feel this way! Anyone would feel the same in your situation"
Radical genuineness	Act natural, like a real person, rather than a "therapist." Communicate belief and confidence in the adolescent

Source: Salsman and Arthur (2012)

3. Assures that new capabilities generalize to the natural environment
4. Structure the treatment environment in ways essential to support client and therapist capabilities, and
5. Enhances therapist capabilities and motivation to treat clients effectively

These functions are delivered through individual psychotherapy, group skills training, and other modes of consultation. As alluded to earlier, DBT is based on principles of radical acceptance and validation of clients' capabilities and functioning together with a dialectical approach to accept the status quo and motivate change. Several levels and techniques of validation are applied to cultivate trust and confidence in the client (see Table 2.1).

In addition, the skills required to affect these positive changes are identified, exercised, and monitored. DBT treatment utilizes three principal stages with corresponding skills development, namely (1) to stabilize the client and achieve improved behavioral control, especially pertaining to life-threatening, treatment-interfering, and quality-of-life interfering behaviors, (2) to cultivate non-traumatic emotional experiencing, (3) to maintain progress and reduce ongoing problems, and (4) to resolve a sense of incompleteness and find satisfaction and joy.

Throughout the process, it is important that the therapist continuously juxtapositions acceptance and change techniques to find the appropriate balance to optimize progress quickly and efficiently as possible. In support, DBT systematically teaches those skill sets that are associated with the client's problems. For example, with suicidal adolescents, these are: emotional regulation, mindfulness, interpersonal effectiveness, distress tolerance, and "walking the middle path" (Salsman & Arthur, 2012). Walking the middle path is a DBT skills training exercise to help clients balance the ideas of acceptance and change by acknowledging all experiences as

well as change as real and natural (Christensen, Riddoch, & Huber, 2009). As such, these skills are designed and implemented to enable clients to manage specific problems.

Research has established that DBT is a superior treatment when compared to treatment-as-usual (TAU) protocols, especially in terms of treatment adherence, decline in incidents of life-threatening and treatment-interfering behaviors, fewer inpatient psychiatric days per client, and global and social functioning. Furthermore, improvements were “largely maintained” during a one-year posttreatment follow-up period (Dimeff & Linehan, 2001, p. 12). Lastly, it is perhaps appropriate to note here that Marsha Linehan does not consider DBT to be part of the third-wave movement, but, instead, views DBT as a form of traditional CBT that includes acceptance strategies (David & Hofmann, 2013). Nevertheless, as a derivative of CBT that embraces acceptance and mindfulness as core concepts, and an important input in the conceptualization of MDT, DBT is included here.

Schema Therapy

Although Schema Therapy is not commonly included as a third-wave therapy approach, it is included here as it has a cognitive behavioral base and elements that influenced the development of MDT. Schema Therapy is an integrative psychotherapy approach that was developed in the early 1990s by Jeffrey Young that combine cognitive, behavioral, psychodynamic object relations, and existential/humanistic approaches to treat personality disorders and other difficult-to-treat conditions (Young, Klosko, & Weishaar, 2006). The main theoretical concept in Schema Therapy is early maladaptive schemas, coping styles, modes, and basic emotional needs. Young defines schemas as “broad, pervasive themes regarding oneself and one’s relationship with others, developed during childhood and elaborated throughout one’s lifetime, and dysfunctional to a significant degree” (McGinn & Young, 1996, p. 188). In Schema Therapy, 18 early maladaptive schemas are divided into five broad developmental categories of schema domains, namely

1. *Disconnection and rejection*, which includes abandonment/instability, mistrust/abuse, emotional deprivation, defectiveness/shame, and social isolation/alienation, and is associated a family origin that is detached, cold, rejecting, unpredictable, and abusive and does not meet emotional needs of nurturing, safety, acceptance, and stability.
2. *Impaired autonomy and performance*, which includes dependence/incompetence, vulnerability to harm or illness, enmeshment/undeveloped self, and failure, and is typical of a family origin that has lack of boundaries, undermining confidence and overprotective, thereby interfering with the child’s ability to function independently.
3. *Impaired limits*, includes entitlement/grandiosity, and insufficient self-control/self-discipline, which is typically cultivated by a family environment that lacks discipline, is overindulgent, and values superiority, and develops a deficiency in internal limits, lack of regard for others, and poor long-term goal orientation.

4. *Other-directedness*, includes subjugation, self-sacrifice, and approval-seeking/recognition-seeking, which is rooted in a family dynamics of conditional acceptance and approval, and children learn to focus excessively on the desires, feelings, and responses of others at the expense of their own in order to feel approved and avoid retaliation.
5. *Overvigilance and inhibition* includes negativity/pessimism, emotional inhibition, unrelenting standards/hypercriticalness and punitiveness, which comes from a family background that is demanding and punitive, and children tend to suppress spontaneous feelings to meet rigid rules and expectations about behavior and performance.

The presence of maladaptive schemas is primarily measured with the Young Schema Questionnaire—Short Form (see Chap. 6: FMDT Assessment Process for structural information). The 18 maladaptive schemas are rated with 90 questions in the YSQ-S3, which were found to be generally associated with interpersonal problems due to maladaptive coping (Thimm, 2013), and has a valid factor structure and good internal consistency when used with adults and adolescents (Martin & Young, 2010). According to the theory of Schema Therapy, early maladaptive schemas develop when a child's core emotional needs are consistently not met. These are safety, predictability, love, nurturing, and attention, acceptance and praise, empathy, guidance and protection, and validation of feelings and needs. The specific maladaptive schemas are then expressed as a coping style of behavior—broadly speaking, surrender, avoidance, or overcompensation responses—in the context of cultural influences and innate temperament. Some of these styles include aggression, dependence, impulsivity, dependence, and withdrawal. Those schemas and coping responses that are active at any time for an individual determines their predominant state, or schema mode, in a particular situation or context. Accordingly, Schema Therapy first assesses clients in terms of their natural maladaptive schemas, which is linked to presenting problems and life history. Then, after identification of the dysfunctional schemas and coping styles, change is facilitated through emphatic confrontation and reality-testing (Young et al., 2006). This treatment phase consists of four basic stages, namely cognitive restructuring, experiential exercises, therapy relationship, and behavioral pattern breaking. In the cognitive restructuring stage of treatment, emphatic confrontation means that “the therapist empathizes with the reasons for patients having the beliefs that they do—namely, that their beliefs are based on their early childhood experiences—while simultaneously confronting the fact that their beliefs are inaccurate and lead to unhealthy life patterns that patients must change in order to improve” (p. 92). Practical experiential exercises involving the use of guided imagery are conducted to vent anger and grief and to empower the client. In the change process, Schema Therapy also focuses on the therapeutic relationship to provide limited parenting when maladaptive schemas and coping styles arise in sessions. Finally, depending on the specific maladaptive schemas and coping styles that were identified in the assessment stage, individualized behavioral and interpersonal change goals are assigned and rehearsed in sessions to break dysfunctional behavioral patterns.

Relative to CBT, the typical Schema Therapy program is longer—the assessment stage can take 2 or 3 months, and the change phase a year or more, but often 3 years for pervasive personality disorders—it is more integrative, conceptually and procedurally, utilizes psychoanalytic techniques by trying to understand where beliefs and schemas come from, and more individualized and less structured, which enables a closer therapeutic relationship. Schemas are trait-related and modes state-related, and Schema Therapy works with both, but typically focus more specifically on schemas. Cognitive therapy suggests that schemas play a vital role in the maintenance of chronic problems, and therefore Schema Therapy is an important pathway to treat schema-based personality and other chronic problems in individual cases and groups, for adults and adolescents, that has demonstrated clinically effective outcomes (Bamelis, Evers, Spinhoven, & Arntz, 2014; Masley, Gillanders, Simpson, & Taylor, 2012).

Mode Deactivation Therapy

As an entire later chapter is devoted to the theoretical framework and foundations of MDT, only an overview is presented here in the context of its development from the perspective of other third-generation approaches. A more detailed theoretical perspective is provided in a following chapter (Chap. 4: Theoretical Framework and Comparison). The most basic premise of MDT is that maladaptive modes that present as state phenomena in problematic internalized and externalized behavior are caused by dysfunctional core beliefs. These beliefs are viewed—and approached—as valid and reasonable remnants of distressful past experiences.

The MDT assessment process—utilizing the client typology survey, Fear Assessment, and Compound Core Beliefs Questionnaire, or CCBQ—is designed to identify dysfunctional beliefs and pair it with avoidance and exaggerated behavior, while establishing a strong therapeutic rapport to support cooperation and commitment (the MDT assessment process is described in detail in Chap. 6). The collaborative MDT case conceptualization process engages the adolescent and family to develop a treatment planning blueprint by further elucidating beliefs and behavior dynamics in the collective family system, where beliefs, values, and attitudes are shared or conflicting among family members (the MDT case conceptualization process is covered in Chap. 8). From early on in the MDT process, mindfulness techniques are utilized to cultivate an open and nonjudgmental awareness of the self in the present moment, which is proposed to contribute to a detachment between problematic thoughts and feelings on the one hand, and self-identity in the context of views about others and the world, on the other.

The Validation–Clarification–Redirection (VCR) process step is unique to MDT and represents the crux of the treatment change process. Here, the “grain of truth” in the client’s attitudes, values, and beliefs is discovered, which is an important part of the validation and acceptance approach. All responses and information are clarified in order to ensure a common understanding and agreement between therapist,

adolescent, and family members. Thereafter, cognitive redirection is applied by using the principle of cognitive continuum to progressively move the client along to employ functional alternative beliefs, or FABs. The VCR process is not aimed at eliminating or changing the content of individual and family beliefs, but rather to change their context (the VCR process is explained in Chap. 9).

Controlled and comparative research studies have provided evidence that MDT is effective and superior compared to traditional CBT and TAU protocols in treating adolescents with serious behavioral problems and other complex coexisting problems, together with their families (Swart & Apsche, 2014; also see Chap. 5: FMDT Empirical Status). Currently, efforts are underway to continue the development of MDT with the objective to proliferate its use, broaden the application in terms of diversity of cultures, populations, settings, and mental health problems, refinement of theory, and a deeper use of ego-transcendence principles and techniques.

Beyond the Third Wave

Now that we have briefly reviewed the development of psychotherapy in the last century by way of a selected few approaches, the question is where is it likely to head next? It has become clear that major impetuses has been, and remains, (1) cost-effectiveness in terms of brevity, specificity, broad applications, and efficiency of outcome changes and durability, (2) theoretical integrity in terms of a distinctive and qualifiable framework, (3) evidence based on scientific research that is independent, falsifiable, and valid, and (4) an increase in the importance of diagnostic classifications and pharmacological management. For various reasons, “niche” and difficult-to-treat conditions, especially for children, adolescents, and families, and underdeveloped communities, have not yet received proportional attention in primary and applied research. However, what is already clear with the rapid advances in neuroscience, genome sequencing, and technology that psychotherapy approaches will have to increasingly incorporate these findings and capabilities into their theory and practice. Furthermore, psychotherapy will continue to adapt to reduce the burden of mental illness by a multifaceted approach that includes a portfolio of models of delivery such as video and voice over IP and smartphone apps, multidisciplinary collaborations, and the integration of prevention and treatment. Kazdin and Blasé (2011) argued that the traditional one-to-one face-to-face meetings between a client and therapist are not sustainable given the increasing rates of mental illness, diversity in populations, and affordability of health care.

But, practical measures aside: What is likely to constitute the fourth wave of cognitive behavioral psychology? As mentioned, the third-wave therapies mostly integrate mindfulness and acceptance techniques with behavioral and cognitive change theory, and although traditional Zen wisdom is increasingly incorporated, the methods stop short of the concepts of liberation and awakening as embodied in Buddhist practices. It is possible that the fourth wave will embody more nondualism traditions, although in a “secular” and scientific approach. In this sense “secular”

refers to a nonreligious, this-worldly perspective (Batchelor, 2012), and nondualism to the non-difference of the absolute and relative, the object and subject, the self and the world. Today, the behaviorist view remains largely an intellectual understanding, which can act as a strong barrier to progress from awareness to more abstract concepts such as the non-self, the absolute truth, or the ultimate reality. Perhaps, in therapy today, thinking and interaction remains too reverent, linear, and amiable to allow the meaningful changes that are required in a process of awakening. To a large extent already, third-wave therapies deconstruct the clients' concepts of their self through the challenge of thoughts and feelings that define their identities, but it is arguably not sufficient to change the paradigm.

Lastly, approaching awareness and awakening from a behavioral point of view is part of the larger convergence between science and consciousness being explored in our time, which also brings systems theory (individual problems result from a larger dysfunctional system), the concepts of chaos (deterministic nonlinear dynamic processes), and complexity science (self-organization and emergence) into the future realm of psychotherapy. All three concepts are associated with an understanding of complex systems in which an individual, or an individual's identified cognitions and problems, cannot be understood by purely studying the larger system's parts independently. Therefore, it is predicted that psychotherapy will, in part, become much more complex on a scientific level as it cross-interchange ideas and data with neuroscience and complex computational systems, but, also, uncomplicated as transcendence uncomplicates the human mind and its relation with the self and the world.

Conclusions

After the tremendous amount of work that was done by Freud in psychoanalytic theory to understand and structure the human mind, the focus shifted more towards treating symptoms and syndromes that are observable in the present moment. Their development and root causes became less important, and it can be argued that psychotherapy became similar to a Band-Aid solution; convenient and versatile, which is not necessarily a bad thing as it attempts to solve the most imminent and damaging problem. The subsequent cognitive revolution continued in much the same way, but utilized processes of thoughts and feelings to change behavioral symptoms. Still, the emphasis was on the present moment and only concerned with observable changes. With traditional cognitive behavioral approaches, problematic beliefs, thoughts, and feelings were disputed and challenged, in the hope that changes will occur. But, in many circles, the invalidation of a client's beliefs in the context of his past experiences was viewed as a shortcoming that alienated the client from the therapist and therapeutic process, and did not contribute anything positive to an idiosyncratic self-concept that was often weak, dysfunctional, or unrealistic. As a result, many claimed that traditional cognitive behavioral therapies were not

effective for adolescents, distressed families, and populations that are considered difficult-to-treat, such as personality disorders, complex comorbidity, and childhood-related chronic conditions.

Many newer third-wave therapies arose from these perceived deficiencies and failures. In many cases the basic cognitive theory was only slightly adapted, but procedural elements and philosophical approaches were changed to increase the appeal to clients. Mostly, acceptance and validation replaced the attitude of disputation, and the concept of mindfulness was added to cultivate awareness of the present moment to offset the tendency to ruminate and self-identify with unpleasant thoughts and feelings. However, for the most part, therapy remained a relatively brief, present-focused, one-on-one, face-to-face affair that does not seem to have adequate access to family and community systems, especially those that are disadvantaged in some way, distressed, marginalized, underdeveloped, or of lower socioeconomic status. Family-based MDT, as one of the most recent third-wave approaches, employ much of the same principles and techniques, such as mindfulness, acceptance, and schema mode theory, but also incorporates a psychoanalytic component to affect a more stable and durable change, and has moved strongly towards a family systems approach. The main objective of MDT is to “keep it real” with clients while transcending to a level where the self-identity is deconstructed to manifest differently in the world.

Key Points

1. The advancement of psychotherapy started more than a century ago with Freud’s psychoanalysis, linking irrational drives with the structure of personality.
2. Interest in specifically targeting behavior started with behavior modification in 1911 and became prominent after WW2; behavior is viewed as the result of learning, and conditioning is used to counter it.
3. The cognitive revolution, which started in the 1950s, culminated in CBT that has become the gold standard of psychotherapy, disputing dysfunctional beliefs in order to change problematic behavior.
4. Noting several shortcomings of CBT (e.g., client resistance, ineffectiveness with complex conditions), third-generation therapies such as ACT, DBT, Schema Therapy, and MDT evolved.
5. Generally, the third-wave therapies apply cognitive theory, acceptance, and mindfulness, but in varying degrees and with procedural differences.
6. MDT can be considered a third-wave approach that combines a unique treatment change process—VCR—with elements from ACT, DBT, and mindfulness, and has proven superior to treat adolescents and their distressed families.

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