Encyclopedia of PSYCHOTHERAPY

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Dr. Hersen has been the recipient of numerous grants from the National Institute of Mental Health, the Department of Education, the National Institute of Disabilities and Rehabilitation Research, and the March of Dimes Birth Defects Foundation. He is a diplomate of the American Board of Professional Psychology, Fellow of the American Psychological Association, Distinguished Practitioner and Member of the National Academy of Practice in Psychology, and recipient of the Distinguished Career Achievement Award in 1996 from the American Board of Medical Psychotherapists and Psychodiagnosticians. He has had full-time and part-time private practices.

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Dr. Sledge has had a long, distinguished career as an educator, and has functioned as an administrator of a variety of medical educational programs at Yale. In addition to his medical duties, he has been Master of one of the Yale undergraduate residential colleges, Calhoun College, for seven years, and is the chair of the Council of Masters.

Dr. Sledge has been active in the American Psychoanalytic Association and the American Psychiatric Association, primarily in the areas addressing education and psychotherapy. He is former chair of the American Psychiatric Association Committee on the Practice of Psychotherapy and a member of the Commission on the Practice of Psychotherapy by Psychiatrists. He is a member of the Group for Advancement of Psychiatry Committee on Therapy.

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Dr. Kay is the editor of 8 books and has published extensively on the topics of medical and psychiatric education, medical ethics, child psychiatry, psychoanalysis, psychotherapy, and psychosocial aspects of AIDS and of cardiac transplantation. He was designated as a 1994 Exemplary Psychiatrist by the National Alliance for the Mentally Ill and is the recipient of the 2001 APA-NIMH Seymore Vestermark Award for contributions to psychiatric education.

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Dr. Rounsaville has been a strong advocate for adopting psychotherapies shown to be effective in rigorous clinical trials. Dr. Rounsaville has also played a key role in clinical trials on the efficacy of a number of important treatments, including outpatient clonidine/naltrexone for opioid detoxification, naltrexone for treatment of alcohol dependence, cognitive–behavioral treatment for cocaine dependence, and disulfiram treatment for alcoholic cocaine abusers. He has contributed extensively to the psychiatric treatment research literature in over 200 journal articles and 4 books.

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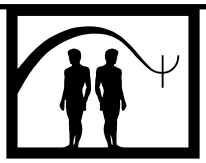
Dr. Tryon has published over 130 articles, has authored 1 book, and edited 2 others. He has presented over 115 papers at professional meetings. Dr. Tryon is on the editorial board of *Behavior Modification* and has served as reviewer for for over 30 journals and publishers. Seventy doctoral students have completed their dissertations under his direction.

EDITORIAL ADVISORY BOARD



Preface

When we began this project, it would have been beyond our most radical beliefs to think that we would be seeing a nation fraught with intense worry, anxiety, acute stress disorder, post-traumatic stress disorder, grief, and depression less than three years later. So now, as we put our finishing touches on this work, and following the terrorist incursions, we regrettably have been forced to see the graphic proof of the inherent value of psychotherapy. The critical contributions and the value of the psychotherapeutic arts have never been clearer to us than in the aftermath of the terrorist strikes. We say this with much humility, in that we would have preferred to continue to talk about the sometimes small theoretical differences in various psychotherapeutic applications, in what now seem to be needless polemics between such psychotherapeutic camps. Nonetheless, the original intent (which continues today in spite of world events) was to present a compilation of both the science and art of psychotherapy.

Psychotherapy has been a vital treatment in health care since development of the great innovative and technical approaches embodied by psychoanalysis and behaviorism at the beginning of the 20th century. In the course of its development, many questions have been raised about this treatment: What is psychotherapy? How does it work? Which forms are cost effective? Who can do it? How does it fit into a comprehensive approach to health care? What is its scientific basis? How does theory drive treatment? What is the role of complementary treatments such as pharmacotherapy in combination with psychotherapy?

The *Encyclopedia of Psychotherapy* strives to answer the aforementioned questions. It is a comprehensive reference to extant knowledge in the field and written in clear expository language so that it will be of value to professional and lay persons alike. Within its pages, this encyclopedia addresses over 200 topics by experts in psychotherapy. Topics were selected in order to give broad coverage of the field (albeit not exhaustive) so as to encompass the most contemporary schools and approaches that have clearly defined techniques, some form of systematic study, and measurement of outcomes. Eclectic and integrative approaches have also been considered. Additional topics that transcend all schools, such as the impact of culture and the importance of the therapeutic relationship, have also been included as well as discussion of the treatment for some specific disorders.

Psychotherapy is an extremely complicated process that is difficult to fully capture even in a work of large scope, such as this encyclopedia. The interplay between scientific confirmation of particular strategies and the actual implementation of a given therapeutic technique is not always isomorphic. Also, how theory drives practice and ultimately the empirical confirmation of such practice, is not always clear cut. Moreover, how cultural, financial, legislative, and forsensic issues act in confluence further complicate the intricacies of what we refer to as psychotherapy. However, it is these very intricacies and complexities which make psychotherapy such an interesting field to examine. In many ways, this work may raise more questions than it does provide answers, and that, perhaps, is the way it should be.

The *Encyclopedia of Psychotherapy* is designed to serve the needs of a multi-faceted audience. As a reference work, we see it being used by students and professionals from counseling and clinical psychology, psychiatry, psychiatric nursing, and social work. Certainly, other disciplines will make reference to it as well. But the encyclopedia will also be of use to interested lay individuals seeking information about this burgeoning field. Topics are arranged alphabetically. As appropriate, a good many of the entries have case

descriptions to illustrate the specifics of theory and technique. The topics addressed span clinical, theoretical, cultural, historical, and administrative and policy issues, as well as the matters of schools and specific patient conditions. Most importantly, a comprehensive user friendly Index is provided.

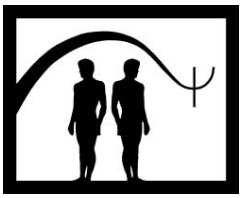
Early on it was apparent that a project of this magnitude would require associate editors and an advisory board to ensure broad coverage of issues and topics. The inclusion of these colleagues has added immeasurably to the fruition of this work. The associate editors (Alan M. Gross, Ph.D, Jerald Kay, M.D., Bruce J. Rounsaville, M.D., Warren W. Tryon, Ph.D.) were chosen in order to represent the cross-fertilization between the medical and the psychological, adult and child, theoretical and pragmatic, research and practice, and behavioral and non-behavioral. Similarly, the 18 advisory board members (both M.D.s and Ph.D.s) were selected because of their broad range of interests and expertise in all aspects of the psychotherapeutic endeavor.

The iterative process began with a large list of topics selected by the two editors-in-chief, which was then refined by the associate editors and the advisory board members. Excellent suggestions for authors were made and the solicitation process began. When received by Academic Press, each entry was evaluated by an appropriate associate editor, revised to the editor's specifications, and then sent on to one of the two editors-in-chief for approval and/or further modification. All entries were reviewed on the basis of accuracy, completeness, clarity, brevity, and the absence of polemics. The resulting *Encyclopedia of Psychotherapy* is a product of complete collaboration between the two editors-in-chief, and hence the order of editorship is alphabetical.

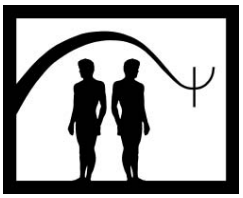
We are grateful to the many individuals who helped make the *Encyclopedia of Psychotherapy* possible. Thank you to the four associate editors who performed in an exemplary fashion. Thank you also to our 18 members of the advisory board for their wise counsel and excellent suggestions. Thanks also to our contributors who took time out from their busy schedules to become part of our project, sharing their expertise as well as articulating their views on where this field stands. We thank Alex Duncan, Angelina Marchand, and Angelina Basile for their research efforts. We appreciate Carole Londeree's technical assistance. We thank all at Academic Press who were involved in the production effort, especially the acquisitions editor, George Zimmar, and the coordinator of the *Encyclopedia,* Anya Kozorez, for helping us to conceptualize this work and overcome obstacles to see it through to publication.

We dedicate this work to our colleagues who work on a daily basis to relieve the suffering of their clients.

Michel Hersen
William Sledge



Contents of Volume 1



Contents of Volume 2

Note: Pages of Volume 2 have prefix 'b' (b1, b2, …**)**

Acceptance and Commitment Therapy

Kirk Strosahl

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GLOSSARY

cognitive fusion The act of perceiving private experiences such as thoughts and feelings from the perspective structured by the private event itself rather than the perspective of an observer of that event as a process. Reducing fusion is a key target of meditation, mindfulness, and deliteralization interventions in ACT.

cultural change agenda The culturally sanctioned model most clients bring into therapy holds that the goal is to gain control of and eliminate negative personal content. This agenda for changing from an unhealthy person with "issues" to a healthy person without "issues" has the paradoxical effect of increasing suffering.

literality The capacity of representational thought and language to take on literal meaning and for the derived stimulus functions of referents to dominate over other sources of behavior. An example is "anticipatory panic attacks," which result from simply imagining being in a panic associated situation, such as a mall or elevator, and then taking those thoughts literally.

relational frame theory (RFT) A post-Skinnerian account of the structural and functional properties of human language and thought that is based in contextual behaviorism. RFT views language and thought as relational behavior that is controlled by learning factors.

Acceptance and commitment therapy (ACT) is a contextually based cognitive behavioral treatment. The ACT model holds that culturally supported attempts to control and eliminate unpleasant private experiences (i.e., negative emotions, thoughts, memories) result in personal suffering, behavior disorders, and a lack of vital and purposeful living. ACT attempts to teach clients to accept, rather than control or eliminate, private experiences that are not amenable to first order change. Acceptance is accomplished through teaching the client to see these private experiences as conditioned verbal responses, rather than literal truth. ACT emphasizes that the client approach, rather than avoid, valued life goals, even though pursuing such goals may stimulate "uncomfortable" private experiences.

I. THEORETICAL BASES OF ACT

Acceptance and commitment therapy is unique among the cognitive behavioral therapies in that it is theoretically derived from relational frame theory (RFT). RFT is a post-Skinnerian behavior analytic account of the functional properties of human language and thought, developed by Steven Hayes and other behavior analytic researchers around the world. Hayes and colleagues conducted two decades of basic research to validate the core principles of RFT before introducing the ACT therapy model. As we shall see, many ACT interventions are based in RFT principles and are designed to influence the contextual and functional characteristics

of language and thought. There are several principles of RFT that are directly relevant to both the development of human suffering and psychopathology, as well as clinical interventions.

First, it is not functionally useful to separate the functions of human language and thought from the contextual field in which the human organism operates. These processes are learned, reinforced, and reciprocally governed in the same fashion as any other learned human behavior. In RFT, language and thought are a special form of relational behaviors that enable the human organism to relate events bidirectionally and in combination, whereas direct experience is only unidirectional. For example, learning that a ball is called "ball" enables the human to look for and orient toward the ball when later hearing "ball." This simple process is apparently absent in nonhumans, but occurs in human infants by about 14 months.

A second critical RFT principle is that the context or "field" of language and thought involves both externally and internally generated verbal relations. The external context is the verbal community, consisting of verbally transmitted cultural practices (i.e., the language called "English" is what you will speak), social influence and consequence (i.e., you need to justify with the correct set of words why you hit someone, otherwise you get punished), and interpersonal influence (i.e., if you don't give a good reason why you hit Johnny, you will get a spanking). The development of a culturally compliant human organism is dependent on this process. The main vehicle of cultural transmission is the process of language acquisition and refinement. Eventually, language is experienced covertly in the form of thinking. The internal context is the relationship between the thought and the thinker. Humans have the ability to "receive" thoughts, weigh their merits (using other thoughts) and produce an action justified in terms of the second set of thoughts. The complexity of this constantly evolving set of relationships, combined with a constant reciprocal interaction with the verbal community, requires that humans engage in hundreds of thousands of language and thought transactions daily, much of them beneath the level of conscious awareness. The result is that humans become so dependent on these symbolic processes that they cease to recognize them for what they are: arbitrarily derived relations between verbal stimuli. When this occurs, the dominance of language and thought can become so excessive that the organism ceases to adapt to the demands of the environment and, instead, is controlled by symbolic representations of the environment. In ACT, this is referred to as the hegemony of language.

A third key principle of RFT is that there are distinct functional properties of language and thought that explain not only the tremendous evolutionary advantage of human thought, but also its "dark side." The bidirectionality of human language enables humans to produce pain simply by remembering past pain or anticipating it in the future. For that reason, humans cannot regulate their psychological discomfort by escaping aversive situations, and instead begin to attempt to avoid or modify emotions. Thus, emotional avoidance is built into human language. Many unique forms of human behavior (e.g., humans are the only species known to commit suicide), seem to be a side effect of this process.

Relational behavior in turn enables rule-governed behavior: the generation of verbal formula to use in guiding human action. Unlike contingency governed actions, which are shaped systematically through direct trial and error (e.g., learning to ride a bicycle), rule-governed behaviors are developed through the verbal specification of contingencies, rather than through direct contact with them. This form of learning greatly expands the potential for learning important rules without having to make direct contact with the contingencies specified by those rules.

There are many different types of rule-governed classes that have clinical significance. Augmentation involves a rule that changes motivation, typically by relating some immediate situation with a verbally constructed set of future contingencies. For example, a young college student might be highly motivated to study by having images of getting a high-paying job several years hence (i.e., a motivative augmental). Getting an "A" on an important exam is reinforcing because of the augmenting effect of the future contingencies. The consequence is the persistence of studying behavior. Pliance is a more basic form of rule-governed behavior. "Plys" are rules that influence the person to behave in culturally sanctioned ways. Telling a crying child, "Be a good boy now and stop crying," is in effect saying to please the parents by stopping the act of crying. The child may stop crying, even though significant physical discomfort is present. Tracking is another common form of rule following that involves establishing a relationship between a rule and a set of nonarbitrary contingencies. A track might involve responding to a weather report that calls for record cold temperatures by securing a heavier coat, because past history has established a relationship between the

temperature outside and the type of clothing that produces warmth.

Because of the general utility of rules, a pervasive consequence for rule-governed behavior is sense making. It appears that humans are highly motivated to organize derived relations within an overarching framework that helps them "make sense" of these relationships. Independent of whether the relationships are factually correct, humans will create this type of conceptual order. In ACT, this is referred to as the "context of reason giving."

The ACT account of human pathology applies RFT principles to the larger rule-governed context of human behavior. First, RFT research has established that, for all their evolutionary utility, rule-governed behaviors are extremely resistant to the mitigating effects of direct experience. At the same time, these change-resistant features are hidden in the very structure of language and thought. A brief clinical example will highlight how basic RFT principles directly convert into clinical dysfunction:

> A woman who was sexually abused as a child reports persistent problems with extreme fearfulness when engaging in any kind of intimate behavior with a new boyfriend. She reports having the same kinds of experiences she remembers having when she was being sexually victimized (based on a "frame of coordination" between the two events). She reports being unable to trust her male friend even though there is evidence that he is different than her abusive father (a "transformation of functions" through that frame of coordination). She has been taught that the key to a fulfilling life is to form a positive intimate relationship, and has continued dating so as not to disappoint her mother (pliance). She is frustrated and angry with herself because she believes she is "defective" due to her childhood abuse history. The proof of this is healthy people are able to trust others in intimate relationships and she cannot (sense making). She has decided to stop dating because she believes her fear, mistrust, and disappointment will just get worse (augmentation). She wonders what she ever did to deserve being abused.

When a person encounters negative personal content such as in the sexual abuse vignette, culturally transmitted, verbally based responses are activated that determine both the outcome to be achieved and the processes needed to achieve it. Basic social programming suggests that "health" is measured by the absence of negative psychological content. In western culture, psychopathology and suffering are viewed as deviations from a natural state of psychological health. When confronted with negative personal experience, the socially sanctioned response is directly analogous to the process used to handle challenges in the external world. Specifically, first one identifies the cause of the problem, then employs strategies designed to eliminate the cause and, through the causal chain, the problem itself.

In contrast, the ACT approach holds that suffering and dysfunction arise from following these culturally sanctioned, but ineffective, rules for coping with distressing experiences. Paradoxically, the use of control and elimination strategies leads to greater suffering and an apparent loss of control of the symptoms to be eliminated. In ACT, this is termed the "rule of mental events." Specifically, the less one is willing to have a problematic private experience, the more one gets of it. There is significant research to support this core feature of human experience. For example, the thought suppression literature demonstrates that suppression and control strategies produce an upsurge in unwanted thoughts, and increased distress. Ironically, the strategies that have produced so much success for the human species in the external world are the cause of suffering and psychopathology when applied to events "between the ears." The reasonable, normal, sensible things people do to address suffering in fact generates suffering. In ACT, this is referrred to as the problem of unhealthy normality. Clients do not present for treatment because they are "broken," but because they are trapped in an unworkable culturally supported change agenda.

The cultural change agenda is supported by basic rule-governed behaviors that normally are not within the awareness of the client. In ACT, these core dysfunctional responses are described in the FEAR model of suffering:

Fusion: This is the tendency of humans to merge with the content of their private experiences, leading to the problem of literality. Literality means that the distinction has been lost between symbolic activity and the event that acts as its referent. In the example above, the woman is fusing historically learned physical and emotional symptoms (from the original trauma) with a conceptually similar current event (intimate relations with her boyfriend) and attributing her reactions to the current event. She has fused the emotional and physical properties of a distant event with a minimally similar current event. Hence, her verbal formulation suggests she has trust issues, whereas the core issue is her fusion with historically conditioned responses.

Evaluation: This is the tendency of humans to categorize and attribute qualities to referents, as though they are primary properties of the referents. An example of major evaluative themes in psychopathology and human suffering are "good-bad," "right-wrong," or "fair-unfair." Through the process of fusion, evaluations become inseparable from the events they are intended to qualify. In the example above, the woman states she is defective, as if defective was a primary property at the level of being. In truth, she is a woman who is having the self-evaluative thought called, "I am defective." She indicates that healthy people do not have these issues, a form of good-bad attribution. She wonders what she did to deserve the abuse, essentially imbuing life with some independent property of fairness.

Avoidance: Due to the impact of bidirectionality and rule-governed behavior, humans are inclined to avoid the situational or representational "triggers" for unpleasant consequences. Paradoxically, this type of experiential avoidance may stimulate feared or unwanted private experiences such as thoughts, feelings, memories, or bodily sensations. There is a significant empirical literature demonstrating the unhealthy effects of experiential avoidance, even in nonpsychiatric samples. It is implicated as a primary mechanism in numerous mental and chemical dependency disorders. Experiential avoidance is almost always predicated on the mistaken belief that, by avoiding participation in challenging life events, one will not have to experience the uncomfortable private experiences associated with participation. In the example above, the woman indicates she has decided to stop dating, rather than experience continued fear, mistrust, and relationship failure. Paradoxically, it is precisely by withdrawing from the "field of play" that her childhood trauma exerts its maximum negative influence over her life. Each day spent not participating lends credence to her notion that she is "defective," elevates her anticipatory fear response about accidentally meeting a soul mate, and deprives her of the opportunity to practice being intimate while being afraid.

Reason Giving: This is the tendency to present reasons that explain the cause of particular forms of private experience and/or behavior. In essence, the cultural context of language and thought teaches humans to give socially sanctioned reasons for behavior, especially behavior that is out of the perceived cultural norm. The most common reason-giving strategy is a two-step process: First, describe a set of historical influences that hypothetically explain a predisposing private experience such as a negative thought, feeling, memory, or physical sensation: Second, describe the predisposing private experience as a cause of the resulting behavior. In the example above, the woman presents her problem as being linked historically to her sexual abuse. The sexual abuse is used to explain her fear experiences during intimacy. She then justifies her lack of intimacy behavior by setting her private experiences in opposition to the desired outcome (i.e., one cannot be intimate while being afraid; fear causes the loss of intimacy). In the end, she has "justified" why intimacy is impossible and why she is entitled to cease efforts in that area.

Reason giving is a pervasive issue in human dysfunction for many reasons, but two are worth noting. First, not only do humans have extremely limited access to the vast multitude of influences that shape their learning history, but also there is no convincing evidence that private events "cause" behavior. The client's story is an arbitrary set of internally consistent, culturally shaped and sanctioned reasons that probably bears little resemblance to a complete historical analysis. Second, most forms of therapy are rooted in the verbal community and consequently a premium is placed on giving "good" reasons for being distressed and dysfunctional. Not only is the abused woman giving an inaccurate account of her learning history (focusing on the sexual abuse and ignoring a multitude of other learning factors), proposing an unlikely cause–effect relationship (her fear "causes" her to stop being intimate), but very likely will have this "story" tacitly endorsed by the therapist.

II. DESCRIPTION OF ACT TREATMENT

ACT seeks to accomplish several major results. The first is to help the client use direct experience, instead of rule following, to discover more effective responses to the challenges of being alive. The second is to discover that control and elimination strategies are the cause of suffering, not the cure for suffering. The third is to realize that acceptance and willingness are viable alternatives to struggle, control, and elimination. The fourth is to understand that acceptance is made possible by learning to detach from the rule-governing effects of language and thought. The fifth is to realize that the basic, unchanging self as consciousness is a place from which acceptance and committed action can occur. The final result is the understanding that

the road to vitality, purpose, and meaning is a journey consisting of choosing valued actions that are performed in the service of valued life ends. In ACT, the response to the life-limiting effects of FEAR is:

Accept
Choose
Take action

To many clients, the notion of turning around and embracing feared memories, hidden insecurities, perceived shortcomings, and negative personal history is frightening. The grip of self-limiting, rule-governed responses is so complete that clients cannot even see the system they are trapped in. Most clients know they are suffering, but are completely immersed in the private logic of their verbal conditioning. To attack this basic problem, ACT tries to engender a healthy skepticism about the role of language and thought in managing negative personal content. Ironically, therapy is an enterprise that occurs within the context of the verbal community. To attempt to undermine dysfunctional rule-governed behaviors through the use of verbal concepts such as "belief," "understanding," and "insight" is analogous to fighting a small fire with a can of gasoline. The ACT therapist must use words, images, metaphors, and experiential exercises in ways that undermine the client's confidence in the utility of language and thought. This must occur without ACT concepts being coopted into the client's system of "understanding." It is not unusual for an ACT therapist to say such things as, "If this makes sense, then that's not it" or "Don't believe a word I'm saying." By attacking the hegemony of language and thought through the nonliteral use of verbal concepts, the therapist is fighting fire with fire. The trick is to avoid being burned.

ACT can be separated into basic thematic components that often occur in a somewhat predictable sequence. However, it is important to understand that the relative prominence of different themes drives both the focus and strategies of therapy. It is frequently unnecessary to expose a client to all the stages of ACT. Some clients already have applied experience with acceptance and mindfulness strategies and may readily employ them when supplied with the proper framework. However, the same client might struggle mightily with committed, valued actions. With this type of client, more focus would be placed on values clarification, distinguishing life processes from life outcomes and so forth. For present purposes, we shall describe the core themes as "stages," because there is a sort of logic to how human suffering unfolds and, consequently, to how ACT might unfold.

A. First Thematic Stage: Creative Hopelessness

The goal of creative hopelessness is to help the client determine that the cultural change agenda is unworkable. The change agenda the client typically brings into therapy is to determine the cause of suffering and then to eliminate the cause, so the problem will dissipate. This typically converts into a cause and effect statement: "If I had more confidence in myself, I wouldn't be so anxious in new social situations." The goal of therapy is to provide me with more confidence, so my anxiety will go away. The notion of "workability" is central to ACT. Generally, clients have tried these commonsense change strategies repeatedly, even in the face of repeated disconfirming experience (the more you try to get confidence, the less confident you are). The client's rule following has all but eliminated the corrective effects of direct experience. The client tries the same strategies over and over again, even though direct experience suggests these strategies are doomed to fail. In ACT, the therapist is likely to ask, "Which are you going to believe here? Your mind or your experience?" Often, the clinical goal of this stage is simply to get the client to stop using strategies that are not workable. At the same time, the therapist is attempting to create a readiness to see the problem in a larger context.

B. Second Thematic Stage: Control Is the Problem, Not the Solution

In this thematic module, the client is exposed to the unworkable, paradoxical nature of control and elimination strategies and their natural offshoot, experiential avoidance. The client is exposed via metaphor, story, and experiential exercise to an essential feature of control and elimination strategies: The more one attempts to control undesirable content, the more undesirable content occurs. The rule of mental events, described earlier, is a cornerstone of this stage. In this stage, the negative effects of experiential avoidance are drawn out for the client. Generally, this involves determining what situations and/or experiences the client is avoiding in the service of controlling negative experiences. Next, the client will evaluate whether the avoidance is "paying off" in terms of promoting positive psychological events or reducing

negative ones. For example, the sexually abused woman might be asked to gauge whether avoiding dating has increased or decreased her sense of mistrust of men, increased or decreased her sense of relationship failure, and so on. Generally, the concept of "willingness" will be introduced, as an alternative to control, elimination, and avoidance. Willingness is the choice to have unpleasant private content at the level of awareness, but without evaluation or struggle. Often, clients will be asked to maintain a "willingness-suffering-workability" diary that lets them collect data on the relationship between levels of willingness, intensity of suffering, and perceived workability of their lives.

C. Third Thematic Stage: Defusing Cognitive Fusion

The Latin root of fusion means to "pour together." As discussed earlier, clients suffer when they pour together direct experience, representations of direct experience, thoughts, feelings, and so forth. They become lost in the maze of private events, such that it becomes difficult to separate what is real from what is being represented. The goal of this stage is to help the client detach from the literal meaning of private experiences and instead to see private experiences as separate from the basic self. This goal is critical because it is very difficult for clients to accept the most provocative, negative forms of private experience without the ability to see private experiences from the perspective of an observer. ACT employs a wide variety of "deliteralization" strategies in this stage. Deliteralization strategies generally seek to reveal the functional and/or representational properties of language, stripped of their concealment in the system of language. This allows the client to see thoughts as thoughts, feelings as feelings, reasons as reasons, evaluations as evaluations, and so forth. The result is that the client is able to defuse fusion. This might involve showing how easily behavior can be programmed through simple, obvious augmentation strategies. Alternatively, the client might be asked to produce multiple, different autobiographies or to say the word "milk" over and over again until the word "goes away" and a gutteral, chopping sound is all that is experienced. Throughout this stage, clients are exposed to the FEAR algorithim, as it is expressed through cognitive fusion. A host of metaphors, stories, and experiential exercises are typically employed to attack the literal attachment to cognition, emotion, memory, and other private representations of experience.

D. Fourth Thematic Stage: Self as Content, Self as Context

Acceptance is most likely to occur when there is an unassailable point from which to observe and make room for distressing private content. Similar to various forms of meditation, ACT seeks to help the client locate a sense of self that is larger than the experience of the products of brain behavior. This is done in the service of making willingness and various forms of acceptance less emotionally hazardous for the client. In ACT, there are three types of self: (1) Self as conceptualized content is analogous to a "self concept." It is the verbally evaluated summary statement of characteristics and attributes (i.e., I have always hated fighting). This form of self is quite rigid and is frequently a problem in therapy. Many clients will vigorously defend their "self concept," as if their life depended on it, even when the content of the self-concept is negative; (2) Self as ongoing process reflects the ability to report current mood states, thoughts, verbal analyses, and other products of direct experience. This form of self is necessary for psychological health. It is the vehicle for experiencing what is to be experienced in the "here and now." Avoidance of this form of self tends to produce the most basic and severe forms of psychopathology; (3) Self as context is the most basic sense of self that is possible. It is awareness and consciousness itself. There are no limits or boundaries to basic consciousness. It contains everything within it. It is immutable and, unlike other forms of self, never changes in character. It is the context in which all private events take on reference. Whatever their form or content, the client's struggles are acted out on the stage of consciousness itself. Yet, the integrity of consciousness is not at issue. If accessed, this space puts the client in a position where private experiences can be observed, without struggle. In ACT, this is referred to as the "you that you call you." Learning to make contact with this form of self is a skill that can be learned with practice. Consequently, ACT employs a wide diversity of mindfulness, awareness, and meditation exercises to develop this connection.

E. Fifth Thematic Stage: Willingness as a Chosen Action

Given the conditioned, rule-governed nature of private experience, little direct control can be exerted over the instantaneous reactions triggered by various stimulus events. In a previously described stage of ACT, willingness is used to describe a nonjudgmental

awareness of disturbing private content. However, there is a more basic form of willingness that is central to ACT. Willingness the action is the choice to enter into valued life activities, with certain knowledge that feared, private responses will be stimulated. These "monsters" generally are associated with the control, elimination, and avoidance behaviors that have previously trapped the client. This form of willingness is a qualitative act, driven by choice, rather than by persuasion or reason.

Choice is a core concept in ACT. It is an action taken with reasons, but not for reasons. It is a form of volunteerism, or voting with one's feet. This is the resting potential of any client; the ability to transcend learning, history, and logic and simply take an action that can produce vitality, meaning, and purpose. A variety of ACT exercises teach the client that willingness is both a chosen action and almost invariably involves making room for feared experiences. Choosing willingness is made more difficult when cognitive fusion is extreme and the sense of self as context is weak. Thus, willingness and choice generally become therapeutic foci when cognitive defusion and self-identification strategies have had some degree of success. In the sexual abuse example, the willingness question might be, "Would you be willing to continue dating in the service of your dreams of developing intimacy, knowing that you will have to make room for mistrust, conditioned fear responses, and self critical thoughts?"

F. Sixth Thematic Stage: Values, Goals, and Committed Action

Although ACT is heavily focused on dismantling ineffective rule-governed behaviors, this process is important only to the extent that it results in the client living a more vital, purposeful life. This can only be achieved through committed actions that are in pursuit of valued life outcomes. Often clients have lost sight of their dreams, because of the pernicious effects of control and avoidance behaviors. They have slipped into a haze where it is difficult to imagine a life much different from the one they are living. ACT attempts to "jump start" the process of committed action by helping the client define core life values, associated goals and develop specific committed actions. A basic ACT intervention is called, "What do you want your life to stand for?" This involves having the client imagine that he or she has died and is listening to eulogies from different significant others at the funeral. The question to be answered is, "What do you want to be remembered for, by those you leave behind?"

There are many nuances involved in developing committed action. One is helping the client differentiate between values as process rather than values as outcomes. To this end, ACT employs a variety of exercises that emphasize committed action as a journey, rather than a destination. A basic ACT principle is, "Goals are the process by which the process becomes the goal." Vitality is produced by seeking, rather than by reaching valued outcomes. Further, some values cannot be "achieved," only enacted on a continuing chosen basis. An example is the value of being a loving spouse. One never "reaches" love; there is always more love to experience. Similarly, a loving act often occurs when the feeling of love is missing. A second issue is that, in the name of seeking vitality, the client may have to jettison a well-practiced story that rationalizes why vitality and meaning are impossible to attain. Frequently, this story involves traumatic personal history and the need to remain dysfunctional to prove that a transgression occurred. The client may have to let go of the sense of trauma, shame, and blame in order to pursue vitality. In ACT, this form of forgiveness is construed to mean, "Giving oneself the grace that came before the transgression." A common ACT question is, "Who would be made right, or who would have to be let off the hook of blame, if you committed yourself to living a valued life?"

III. EMPIRICAL STUDIES OF ACT

ACT is a relative newcomer to the family of cognitive-behavioral treatments and therefore does not have a highly developed empirical literature at this point. However, the initial empirical results have been positive. There have been two controlled studies looking at the relative efficacy of ACT and cognitive therapy with depressed patients. In one controlled study, ACT produced significantly greater reductions in depression than cognitive therapy. A second controlled study with depressed patients showed the two treatments to have equal efficacy. However, analysis of depressive thinking process measures suggested that ACT had a significantly greater impact in reducing the believability of depressive thoughts. A recent study examined the effect of providing a psychoeducational intervention or ACT with a randomly assigned group of hospitalized patients with schizophrenia. The interventions were designed to target the disturbing effects of visual and auditory hallucinations. Results were intriguing: ACT

patients reported a greater self-reported frequency of hallucinations, but rated the hallucinations as less distressing than the psychoeducational intervention patients. In contrast, the patients undergoing psychoeducational treatment reported significantly fewer hallucinations, but significantly more distress associated with the hallucinations. ACT interventions have also been shown to have a significant effect with such diverse problems as chronic pain, occupational stress, and high medical utilization.

ACT is one of the few cognitive-behavioral treatments to undergo a field-based clinical effectiveness study. Strosahl and colleagues developed an ACT training package for a group of masters' level therapists in an outpatient HMO mental health system. Compared with a control group of therapists who did not receive the training, ACT therapists produced greater clinical benefits as reported by patients, had less referrals for psychiatric medicines, and were more likely to complete cases earlier with the mutual consent of the client. In an uncontrolled clinical effectiveness study, Strosahl found that chronically depressed personality-disordered patients treated in the ACT model reported significant reductions in depression and an increased rate of achieving important personal goals. There are several large clinical trials underway examining the effectiveness of ACT with severe drug addiction, tobacco cessation, and social phobia. Hopefully, results of these and future studies will help delineate the clinical effectiveness of ACT, as well as describe the process mechanisms that underpin the treatment.

IV. SUMMARY

Acceptance and commitment therapy is one of the new generation of cognitive and behavioral therapies that utilizes acceptance and mindfulness strategies, in addition to first-order change strategies. The emphasis on acceptance strategies may be attributed to the growing recognition that first-order change is not always possible, or even desirable. There are many aspects of human experience that cannot be directly altered through psychotherapy or any other type of change effort. As we have discussed, the human nervous system works by addition, not by subtraction. Rule-governed responses never really disappear, they are simply placed in a different relational frame under the dominance of new rule-governed behaviors. When ACT is successful, clients understand that there is no need to shun undesirable personal history, temperament, spontaneous emotions, thoughts, and so forth. These are unique and healthy human qualities. Indeed, the human organism is perfectly made to experience each of these qualities, and therein lies the potential for vitality, purpose, and meaning.

See Also the Following Articles

Avoidance Training ■ Language in Psychotherapy ■ Relational Psychoanalysis

Further Reading

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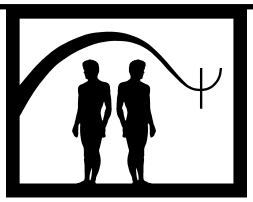

Addictions in Special Populations: Treatment

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GLOSSARY

cultural competence The belief that treatment providers should recognize and respect other cultural groups and be able to effectively work with them in a clinical setting.

special populations People with special treatment needs related to age, gender, ethnic background, or health status that are underserved by alcohol and drug treatment resources.

I. INTRODUCTION

The origin of the term "special population" can be attributed to several U.S. government agencies involved in health and human services in the mid-1970s. The term is reserved for groups whose need for substance abuse treatment programs has been underserved. The purpose was to identify subgroups in order to help with planning and evaluating the national treatment system for alcohol and drug problems. The goal was to provide funding for specialty programs, or to ensure that mainstream programs were structured to provide appropriate treatment services. Special population groups are most often defined in terms of age, race/ethnicity, gender, and health status. This article focuses on the treatment of addictive behavior in racial/ethnic minorities and women. These groups present unique treatment issues such as pregnancy and culture-specific beliefs and attitudes regarding substance use. In addition members of minority groups report higher rates of substance abuse problems than do whites, and the number of women entering treatment for substance abuse problems has increased in the past two decades.

II. RACIAL/ETHNIC MINORITIES

A. Description of Treatment

Ethnic and racial diversity is increasing in the United States, and according to the 1991–1993 National Household Survey on Drug Abuse members of various ethnic minorities report higher rates of substance use and related problems than do Whites. Although a need for treatment services exists, special populations often encounter barriers to obtaining treatment for alcohol and drug problems. The Office for Substance Abuse Prevention includes the following common barriers to treatment:

- *Cultural barriers:* Many programs lack staff who share the cultural background of those being treated. In addition, staff may lack sensitivity and/or training regarding the cultural beliefs and practices of their clientele. Language barriers also may exist.

• *Funding:* Many members of minority groups lack insurance or personal funds to pay for treatment.
• *Availability:* Waiting lists are common at affordable programs.
• *Child care:* Often not available at treatment sites. Some people may fear losing custody of their children if they seek treatment for an alcohol or drug problem.

These factors make it less likely that minorities will enter mainstream treatment programs. Of those who do enter treatment, the outcome data are mixed with some studies showing minority patients to have treatment outcomes equal to those for Whites, and other studies showing that minority patients have poorer outcomes and are less likely to complete treatment.

The high rates of substance use problems among many ethnic and racial minorities, combined with the barriers encountered by these individuals in mainstream treatment programs, raise the issue of whether or not to develop culturally sensitive treatment programs. Typically, these programs employ staff from varied cultural backgrounds and/or provide training to staff members in cultural issues. Culturally sensitive treatment programs may improve access to treatment for some individuals, but there are few scientific studies that examine or support their ability to produce improved outcomes. Therefore, the benefits of such programs are not yet thoroughly understood. Moreover, there is often considerable heterogeneity within specific ethnic or racial groups. Major sources of such heterogeneity include

• *Subgroups within a major ethnic group:* For example, there are approximately 300 different American Indian tribes. Many of these have their own unique culture and have developed specific norms regarding substance use, help-seeking behavior, and healing. Similarly, Hispanics who are Cuban American, Central American, Puerto Rican, and Mexican American have different attitudes toward substance use and treatment for substance-related problems.
• *Personal characteristics:* Members of the same minority group vary on several dimensions that have implications for treatment outcome. Included here are socioeconomic status, education level, and employment status.
• *Acculturation:* Members of the same minority group may differ in terms of their acculturation or assimilation to the majority culture.

It is unlikely that a single treatment approach could be developed that would suffice in addressing such variability. Alternatively, it would not be realistic nor cost effective to develop separate programs for each distinct subgroup. This is not to say that the development and cross-cultural validation of such programs be discontinued. However, while these programs are being developed and evaluated, it seems reasonable to utilize existing approaches that have been demonstrated to have relative efficacy with other populations of substance abusers. Such treatment approaches include, but are not limited to, brief motivational interventions, cognitive-behavioral approaches, behavioral couples therapy, and the community reinforcement plus vouchers approach.

1. Brief Motivational Interventions

Brief interventions (e.g., motivational enhancement therapy, guided self-change) have been shown to be as effective as long-term inpatient treatment for alcohol problems. Core elements of these interventions include objective feedback regarding the nature and severity of the problem, acceptance of personal responsibility for change, providing a menu of change strategies, and an empathic therapist style.

2. Cognitive-Behavioral Approaches

A set of strategies including social skills training, behavioral self-control training, relapse prevention, and cognitive therapy. Core elements often include assertiveness training, coping with high-risk alcohol and drug use situations, managing urges and cravings, managing thoughts about drinking and drug use, problem-solving training, drink and drug refusal skills, and managing negative thinking and negative moods.

3. Behavioral Couples Therapy

This approach aims to improve communication and conflict resolution skills to help achieve and maintain abstinence. It assumes that family members can reward abstinence and that alcohol and drug abusers with healthier relationships have a lower risk of relapse. According to Timothy O'Farrell and William Fals-Stewart a core element of this approach is the daily sobriety contract in which the patient expresses his or her intention not to drink or use drugs on a given day, and the spouse provides support for efforts to remain abstinent.

4. Community Reinforcement Plus Vouchers Approach

This approach includes a number of skills-training components similar to those mentioned earlier. It also includes prompt reinforcement for drug abstinence by