Journal of Rational-Emotive & Cognitive-Behavior Therapy
Volume 18, Number 4, Winter 2000

EXPLORING COMPATIBILITIES BETWEEN ACCEPTANCE AND COMMITMENT THERAPY AND 12-STEP TREATMENT FOR SUBSTANCE ABUSE

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ABSTRACT: Behavioral science research has appeared to conflict with the 12-step treatment approach, which is the prevalent practice in the treatment of addictions in the United States. Compatibilities between 12-step and Acceptance and Commitment Therapy, a contextual behavioral treatment, are explored with the aim of reducing this friction and better serving consumers.

DISSEMINATING SUBSTANCE ABUSE TREATMENT ALTERNATIVES

A wide variety of treatments for substance abuse have been developed. The list of treatments that have been studied in controlled trials includes cognitive-behavioral and behavioral treatments for various types of addiction, such as behavior therapy for cocaine abuse (Higgins et al., 1993); relapse prevention (e.g., Carroll et al., 1994; Moser & Annis, 1996); cue exposure (e.g., Drummond & Gautier, 1994), motivational interviewing (Miller & Rollnick, 1991); aversion therapy (e.g.,

Preparation of this manuscript was supported in part by a grant from the National Institute of Mental Health, National Institute on Drug Abuse, #DA08634. Address correspondence to Kelly G. Wilson, Department of Psychology, Peabody 205, University of Mississippi, University, MS 38655; e-mail: kwilson@olemiss.edu.

Cannon & Baker, 1981); and social skills training (Chaney, 1989). And recently, results of Project Match suggest that 12-step facilitation may be as effective as motivational interviewing and cognitive-behavior therapy in the treatment of alcoholism (Project Match Research Group, 1997).

Although there are an extraordinary variety of treatment alternatives, mainstream substance abuse treatment remains quite uniform. The vast majority of providers continue to use a 12-step model of recovery (Roman & Blum, 1997). Why have cognitive-behavioral treatments not been adopted widely within the treatment community? Historically, there has been tremendous division between the 12-step-oriented treatment community and behavioral researchers. Much of the debate began around the issue of controlled drinking versus abstinence as a treatment goal (Sobell & Sobell, 1973, 1976, 1978). This controversy has polarized the behavioral and 12-step treatment advocates for nearly thirty years, resulting in an ongoing debate on appropriate treatment targets as well as a variety of other issues.

This uniformity of practice has implications for both providers and consumers. On the provider side of the equation, it is difficult to get therapists to provide a treatment that varies too dramatically from what they believe is the best approach. Data from treatment outcome studies suggest that allegiance to a particular treatment model affects outcome (e.g., Gaffan, Tsaousis, & Kemp-Wheeler, 1995). Even if we could get community-based providers to use behavioral treatments, we would be likely to see the same allegiance effects as are seen in clinical trials. Thus, the lack of fit of behavioral treatments to community practice presents a formidable barrier to their adoption.

On the consumer side of the equation, many individuals find the 12-step approach unacceptable, frequently citing the spiritual basis. If treatment providers are delivering a treatment that is unacceptable to the consumer, at best we should see decreased compliance with treatment. At worst, individuals suffering with substance abuse problems would simply avoid treatment altogether. In fact, given the known prevalence of substance abuse problems and the percentage seeking treatment, it may be deduced that the majority of individuals with substance abuse problems never seek any professional treatment.

The treatment of substance abuse with Acceptance and Commitment Therapy (ACT) will be discussed in this paper as an example of a behavioral treatment that may share some common ground with the 12-step tradition. ACT has been carried out in a variety of settings, with several different populations including hospitalized psychotic in-

dividuals (Bach, 2000), outpatient depressed clients (Zettle & Raines, 1989), a general clinical population in a managed care system (Strosahl, Hayes, Bergan, & Romano, 1998), and employees in a workplace stress study (Bond & Bunce, 2000). ACT is currently being examined for substance abusers in a clinical trial at the University of Nevada. We believe that ACT may be better matched to the existing practices, beliefs, and repertoires of substance abuse treatment providers than some previous behavioral treatments. It may present fewer barriers to adoption within the provider community and provide more alternatives for both providers and consumers. We will begin with a brief description of the experiential avoidance perspective, which provides a conceptual basis for ACT; describe ACT as practiced with substance abusers; explore compatibilities between ACT and 12-step treatment; and describe ways in which ACT may broaden available treatment for substance abuse.

EXPERIENTIAL AVOIDANCE: THE ROLE OF NEGATIVE COGNITION AND EMOTION IN BEHAVIOR PROBLEMS

Popular culture embraces the notion that positive emotions and cognitions cause good behavior and negative emotions and cognitions cause bad behavior. We expend enormous effort in our schools and workplaces teaching people to feel more confident, to have higher self-esteem, to be cheerful and optimistic. Negative thoughts and feelings, by contrast, are actively punished—unless they are extremely transient.

From childhood we are taught that we can and should control negative cognition and emotion. The little girl who cries out in the night is told that there is nothing to be afraid of. The little boy who cries on the playground is called a baby. Lonely adults who disclose that they do not believe anyone will ever love them will be told by friends that they ought not to think that, that it either is not true now or that it will not be true forever. It is as if feelings of fear and thoughts of rejection are as much the enemy as are frightening and rejecting circumstances. The underlying assumption is that one must feel courageous to act courageously and that one must believe that love is possible in order to find love. Thus, we learn to fight not only aversive circumstances, but also our own reactions to those circumstances.

Models of psychopathology also frequently accept the assumption

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

From an ACT perspective, negative cognition and emotion may, but need not, produce bad behavioral outcomes. Further, we believe that, at least under some circumstances, attempts to eliminate negative emotion and cognition may actually be pathogenic. We call attempts to reduce, eliminate, or decrease the probability of experiencing a variety of avoided private events including painful thoughts, emotions, memories, and bodily states, *experiential avoidance*. In doing so, ACT takes advantage of a growing body of literature that suggests that attempts to suppress or avoid negative private events may work to reduce those negative states over the short term, but may actually worsen outcomes over the long-term. Although evidence is not wholly uniform, there is considerable evidence in the experimental literature on thought suppression (Purdon, 1999, for recent review; cf., Pennebaker, 1997); in the coping literature among depressives (DeGenova, Patton, Jurich, & MacDermid, 1994; Bruder-Mattson & Hovanitz, 1990), survivors of child sexual abuse (Leitenberg, Greenwald, & Cado, 1992; Polusny & Follette, 1995); alcoholism (Moser & Annis, 1996; Cooper, Russell, Skinner, Frone, & Mudar, 1992), and recovery from traumatic events (Foa & Riggs, 1995) suggesting that avoidant means of coping predict poorer long-term outcomes. ACT focuses on the role of experiential avoidance in the exacerbation and maintenance of a number of psychological problems, including substance abuse (see Hayes, Wilson, Gifford, Follette, & Strosahl, 1996 for an extended discussion of experiential avoidance).

Substance abuse almost certainly emerges from a variety of causes. Most psychological models of substance abuse are sensitive to the role of private experience. Among the private experiences considered im-

portant in various theories are expectancy factors. These may pertain to self-efficacy and appraisal of situations, as well as to the pharmacological effects of drugs, cravings, aversive bodily states, and disagreeable emotions (Hester & Miller, 1989; Marlatt & Gordon, 1985; Meyer, 1986).

Some theorists have conceived substance abuse as a means of stress reduction (e.g., Powers, 1987). Others have examined the relationship between substance abuse and other psychological problems. For example, there is considerable evidence showing that substance abuse is frequent among those with affective and anxiety disorders and vice versa (e.g., Mirin, Weiss, & Michael, 1987; Pashko & Druley, 1987). Still other theorists have conceptualized substance abuse as a problematic coping strategy. It is maladaptive because "its use may change or allow negative emotions, which are cues that there are problems to be solved, to be ignored" (Chaney, 1989, p. 207). In other words, substance abuse can be conceived as a form of emotional avoidance that has the cost of making healthier coping responses less likely.

ACT FOR SUBSTANCE ABUSE

We will not fully describe the treatment techniques involved in ACT (see Hayes, Strosahl, & Wilson, 1999; Hayes & Wilson, 1994, for more extended description). Our goal is not to disseminate the treatment technology through this paper. Instead, we hope to provide sufficient description of the techniques and emotional tone of ACT to show how it may provide a better fit with existing practice.

ACT for substance abuse focuses on helping clients make psychological contact with the scope of their difficulties and to overcome cognitive and emotional barriers to stopping destructive drug use patterns. In this paper, we will highlight five main phases of the treatment of substance abuse from this theoretical and philosophical model:

1. *Creative Hopelessness*: Making contact with the scope of the problem and the effort expended to solve it
2. *Values Assessment*: Exploration of the client's personal values to direct and dignify the treatment
3. *Control as the Problem*: Identifying ineffective control strategies
4. *Defusing Language*: Making room for acceptance
5. *Applied Willingness*: Putting values into action

PHASE 1. CREATIVE HOPELESSNESS: ESTABLISHING THE SCOPE OF THE PROBLEM

This phase of treatment will vary according to the client's substance abuse history. For the purposes of this paper, we will describe the treatment of chronic, multi-problem substance abusers. The strategies can be as global as those described here, or as local as is appropriate for less severe problems. The initial stage of ACT for chronic substance abuse is devoted to exploring the breadth and depth of the client's difficulties and efforts to solve these difficulties.

We begin treatment by introducing the Comprehensive Substance Involvement Worksheet Part I.[1] The CSIW-I asks clients to recall and document their history of substance use and abuse, from their first recollected use up to their current use. The CSIW-I is divided into seven different drug categories. We ask clients to describe on the CSIW-I the approximate time period during which they used a particular substance, their pattern and quantity of use, the mode of administration, and times that patterns of use changed significantly. Clients are given both the instructions for the homework and forms on which to record their history. Many of our more chronic and severe clients comment that the CSIW-I is a difficult and daunting task. We completely agree with their assessment and acknowledge this in the instructions and in session.

The goal of the CSIW-I is twofold. First, the CSIW-I helps the therapist to understand the scope and severity of past and current substance use patterns. Upon the initial interview, clients will often volunteer some aspects of their substance involvement history and leave other aspects unmentioned. We often see clients with a 20-year history of serial substance use diagnoses. Many of the diagnoses are in full remission at the time of treatment; therefore, such clients do not report the old diagnoses as problems—and may not themselves think of old diagnoses as problems. However, a six-month history of cocaine abuse may be understood differently when seen in a client for whom this was a first and only substance involvement diagnosis as opposed to a client with a five-year long hallucinogen and marijuana diagnosis, followed by a five-year long amphetamine diagnosis, followed by a five-year long heroin diagnosis, followed by a five-year long alcohol diagnosis.

[1] The Comprehensive Substance Involvement Worksheets I and II, as well as all other forms mentioned in this paper, are available from the senior author.

The CSIW-I is not merely an assessment. It is also an active component of the treatment. The second purpose of the CSIW-I is to bring clients into contact with their entire history of substance involvement. Some have never considered their use in this comprehensive and step-by-step fashion. Clients often report being surprised by the scope and duration of their struggles once they have taken the time to carefully document this history.

Following the completion of the CSIW-I, we administer the CSIW-II. The CSIW-II examines specific life domains in which substance involvement may have caused problems. Using the client's homework, the therapist and the client explore the consequences of using drugs and alcohol. We ask about financial, emotional, physical, social, and familial costs, among others. As with CSIW-I, the goal is to bring both the client and the therapist into close contact with any costs of drug use.

We rarely see clients with serious substance abuse problems that have not engaged in a wide variety of attempts to change their patterns of drug use. Clients may have tried to lessen drug use or to stop using particularly problematic substances; changed to less harmful substances; changed to less harmful modes of administration; gone to inpatient treatment, outpatient treatment, and detoxification; gone to one or many 12-step, religious, or secular self-help groups; or tried getting therapy to resolve emotional or relationship problems. If these individuals have come into treatment with us, then in some sense all of these attempts have fallen short of the outcomes for which they were intended.

It can be extraordinarily difficult to stop a long substance abuse career. The difficulties are multifold. Withdrawing from many drugs can be physically quite uncomfortable. In addition to physical discomfort, there may be serious psychological distress. Some of this psychological distress is directly associated with abstinence. So, for example, the client may be obsessed with thoughts of using and plagued with concerns about relapse. Other psychological problems such as anxiety and depression may be seen. It has been suggested that in addition to clients who medicate dysphoric states that are the direct result of excessive drug use, others may be medicating pre-existing psychological problems (Mirin et al., 1987).

Finally, substance abusers often precipitate difficulties in their lives as result of using drugs. One client treated by the first author (KGW) had introduced her teenage daughter to intravenous drug use. These difficulties become all the more painful as the medicating effects of the

substances subside. Unless one is willing to experience a fair amount of distress, it is can be nearly impossible to stop. Despite Herculean efforts, many substance abusers get stuck and stay stuck.

We are careful in ACT to do the CSIW I and II in a sensitive and nonjudgmental way. The exploration of the client's substance abuse history is never done to punish or belittle the client. Because the mores and norms of Western culture oppose substance abuse, particularly drug addiction, we assume that if judging or punishing were likely to help clients with their drug problem, it already would have, since that is precisely the treatment that the culture provides.

Welcoming Hopelessness into Therapy

Doing and hearing such a history can be heart wrenching. There is a temptation for both therapists and clients to move quickly through this phase of treatment and onto the next. This is particularly true if the substance abuse history has involved significant disruption in the client's life. Instead of rushing away from the negative affect and cognitions that are generated by the CSIW I and II, the ACT therapist goes further yet:

Therapist: I can see how hard you have struggled, and your great sense of what has been lost. I wonder if you ever feel hopeless?
Client: Sometimes, sure, but I keep trying. I try to be optimistic.
Therapist: I can see that from what you have told me. And from the history we have taken, I can see that at times in your life, it seemed as though you were going to succeed.
Client: Yes.
Therapist: But I wonder whether, at some very deep level, you have the sense that no matter how hard you try, no matter how many times you try, over the long run, you won't win. I wonder, even when you feel like you are winning the war, if there isn't a deep down sense that it won't last—a sense of hopelessness? And how hard have you tried to make that sense of hopelessness go away?
Client: Hard.
Therapist: And what if there is something very right about that sense of hopelessness?
Client: Are you saying I am hopeless?
Therapist: No, not that *you* are hopeless, but that *something* is hopeless. What if your sense of hopelessness is accurate? And,

> what if that sense of hopelessness you have been trying to get rid of is in fact a great asset?

Somewhat surprisingly, we have not had clients get up and leave a session when we address creative hopelessness. In fact, clients report feeling affirmed and intrigued. They feel affirmed, since their own sense of their situation is accurate. They feel intrigued because hopelessness is usually associated with giving up. Instead, the ACT therapist appears encouraged by finding this sense of hopelessness. The client, and in fact the culture, have an agenda that says once I get rid of the "bad" thoughts and emotions (hopelessness, sadness), and get more of the "good" thoughts and emotions (self-confidence, optimism), then I will be able to live my life more effectively. It is precisely this feel-good-to-live-well agenda that we consider hopeless.

Overlaps Between Creative Hopelessness and the 12-Step Tradition

Although we would be unlikely to use the words "powerless" or "unmanageable" while doing ACT, there is certainly overlap between creative hopelessness and the first step of AA's 12 steps. The first step in the AA program is "We admitted we were powerless over alcohol—that our lives had become unmanageable"(Alcoholics Anonymous, 1976, p. 59). The sort of writing done in the CSIW I and II is consistent with writing that might be done by a member of AA working on the first step with an AA sponsor. Doing the CSIW-II is also consistent with, though not identical to, AA's fourth step: "Made a fearless and searching moral inventory of ourselves" (Alcoholics Anonymous, 1976, p. 59). Again, we would probably not use AA's language of morality, since that language often carries connotations of good and evil. ACT tends to focus on workable and unworkable rather than good and bad. Finally, an open discussion of the results of the CSIW-II with the therapist is consistent with parts of the fifth step of AA: "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs" (Alcoholics Anonymous, 1976, p. 59).

PHASE 2. VALUES ASSESSMENT: GIVING THERAPY A DIRECTION

Engagement in emotionally difficult material in ACT differs from some emotionally-focused approaches in that there is no interest in

confronting pain for its own sake. Although ACT may be painful, that pain is always in the service of the client's chosen values. It is to the issue of values then that the therapy now turns. In ACT, the client's values both direct and dignify the treatment.

Once a sense of the client's struggle has been firmly established, treatment targets must be determined. The metaphor of a person attempting to cross a swamp in the dark can be applied to ACT values work. Values provide a rope that can be stretched from one end of the swamp to the other. The rope provides a guide for successful navigation. However, in the metaphor and in the client's life, having a guide rope does not mean that you can get to the other side of the swamp without crossing, or that the crossing will be less uncomfortable or treacherous.

To begin the discussion of values, clients are asked to complete the Values Assessment Packet, which prompts them to consider various life domains (e.g., family relations, social relations, employment/training, physical health). In the homework assignment, clients are asked to identify a direction they would want to take in these domains in a world where they could choose a direction. Particularly with chronic and severe cases, as with the CSIW I AND II, this can be a difficult assignment.

Clients often begin writing about particular goals they would like to achieve. If they do, the therapist helps the client to identify the underlying value. Unlike goals, values have the capacity to direct behavior over extended periods of time, and they are relatively impervious to the achievement of particular goals or particular timelines. We often use travel metaphors to illustrate this point. If living life in a valued direction were travel, values would be like traveling in a specific direction. One could always, for example, go further east. Goals are more like places along the way that let you know that you are headed in the right direction. Traveling east from Los Angeles, if you arrived in Dallas, you would know that you had been headed east. Particular goals may or may not be achievable; however, one may nearly always move in the direction of the underlying value. If a parent has lost custody of a child, there are often ways to be a loving parent, even if regaining custody is impossible.

Overlap Between Values Assessment and the 12-Step Tradition

Many early forms of behavior therapy for substance abuse focused rather narrowly on reductions in destructive substance involvement. A

reduction in drug abuse may be worthwhile in itself. Both ACT and AA are interested in reduced substance involvement; however, both target directly a broader range of the substance abuser's behavior than simple elimination or reduction of substance use. In ACT we focus on values, and substance involvement becomes a target of treatment to the extent that it keeps clients from effectively living their values. Similarly, only one of AA's steps, the first, even mentions the word alcohol. The remaining steps involve careful self-examination (steps four & five), repairing past wrongs perpetrated against individuals and institutions (steps eight & nine), engaging in an ongoing program of self examination and making amends when wrong (step 10), prayer and meditation (step 11), and helping others without compensation (step 12). Though formally different than the values assessment phase of ACT, these steps focus on the ways in which people can bring their lives into alignment with their values.

PHASE 3. CONTROL AS THE PROBLEM— IDENTIFYING DESTRUCTIVE CONTROL STRATEGIES

In the Creative Hopelessness phase of treatment, we made contact with the client's sense of hopelessness. Sometimes this sense of hopelessness becomes even more acute as the clients' values are explicitly discussed. We now attempt to reveal *what* is hopeless. From an ACT perspective, attempts at exercising conscious purposeful control have generalized from areas where conscious purposeful control works to areas in which it does not. We use a variety of metaphors and experiential exercises to help the client notice where control is effective and where it is ineffective.

There are many life domains in which conscious purposeful control works quite well—most areas, in fact. If a person wants to clean the house, get a college degree, or repair a car, making and executing a plan is an effective strategy. In a number of areas, however, planful action is ineffective and sometimes counterproductive. Emotion can be one such domain. Contrary to the opinions espoused in some current new-age self-help books, people cannot simply *choose* to be happy. Physiological responses can be similarly unresponsive to planful control. For the substance abuser, drug cravings or conditioned responses to drug relevant stimuli cannot be turned off and on by an act of will.

These responses were not established by choice, and they are not eliminated in that way.

Likewise, some thinking is not well managed by control strategies. The Jelly Donut exercise illustrates the point. The client is told: "Do not think of a jelly donut. Do not think of the way the frosting tastes on your lips. Do not think about the way that first bit of jelly tastes as it hits your tongue." Our clients, and probably the reader, have difficulty following such instructions, since the instruction makes present the event that is to be put out of mind. Clients have often tried various strategies in order to keep their minds off drugs as well as a variety of other matters that inevitably emerge when they have attempted to stop, such as thoughts about whether they will be able to stay clean over any length of time, memories of enjoyable drug experiences, and painful thoughts of transgressions done while using or done in order to obtain drugs. While attempts at suppressing thoughts may be efficacious over the short term, there is an emerging body of experimental and clinical data that suggests that attempts to suppress unpleasant cognitions, emotions, and physical sensations may increase those experiences over the long term (see Hayes et al., 1996, for review).

For the individual attempting to recover from a serious substance abuse problem, ineffective control strategies are usually focused on what the abuser sees as the cognitive, emotional, and physical barriers to getting and staying clean and sober. Substance abusers imagine that if they could eliminate cravings and urges to use, could reduce negative emotional states that would be eased by using, could eliminate thoughts of using, could eliminate painful memories about things they have done or that have been done to them, they could finally stop using and get on with their lives. In ACT, we attempt to make psychologically present the futility of these attempts at control—the hopelessness of these strategies. If an individual can make experiential contact with this hopelessness, the possibility of new responses to these barriers to sobriety are opened up.

In fact, the substance abuser has the ultimate technology for controlling thoughts and feelings. Heroin, for example, taken in a sufficient dosage will temporarily solve all cognitive, emotional, and physical problems. Although heroin is extremely useful in gaining control over one's cognitive and emotional states, it can have severe consequences for effective living.

Overlaps Between Control as the Problem and the 12-Step Tradition

The Serenity Prayer, which is used to open AA meetings, acknowledges a difference between control usefully and unusefully applied: "God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." ACT is more specific than AA as to where control can be usefully applied.

There is some discussion in the AA literature of the use of alcohol to manage unpleasant cognitive and emotional states. In a letter to someone who had recently relapsed, Bill Wilson (Alcoholics Anonymous, 1967), co-founder of Alcoholics Anonymous, stated:

> I believe that when we were active alcoholics we drank mostly to kill pain of one kind or another—physical, emotional or psychic. Of course, everyone has a cracking point, and I suppose you reached yours—hence the resort once more to the bottle. If I were you, I wouldn't heap devastating blame on myself for this; on the other hand, the experience should redouble your conviction that alcohol has no permanent value as a pain killer. (p. 291)

Although, as above, there is some reference to problematic control of private events, most discussion of ineffective control is focused on attempts to control drinking (Alcoholics Anonymous, 1976):

> We are unable, at certain times, to bring into our consciousness with sufficient force the memory of the suffering and humiliation of even a week or a month ago. We are without defense against the first drink. . . . There is a complete failure of the kind of defense that keeps one from putting his hand on a hot stove. (p. 24)

From an ACT perspective, drinking/not drinking falls within the province of overt behavior—a domain in which planful control is rightly applied. However, in order to be able to gain control over drinking, one needs to be willing to have urges and craving, thoughts about using, doubts about one's ability to maintain sobriety, thoughts about sobriety not being worth the effort, memories of wrongs done and wrongs experienced. The ACT solution to these painful psychological and physical states is mindful acceptance. The next phase of therapy explores methods used to facilitate a posture of radical acceptance in the service of a valued life.

PHASE 4. DEFUSING LANGUAGE: MAKING ROOM FOR ACCEPTANCE

If control of these avoided private events is the problem, what is the alternative? ACT offers the possibility of acceptance as an alternative to control. ACT is careful to distinguish acceptance from tolerating or wanting. Acceptance is sometimes compared to the experience of a picnic blanket, accepting the leaves and rain that inevitably fall upon it. The blanket does not "want" the leaves or "tolerate" them. The blanket does not resist, attract, or otherwise attempt to control the leaves. Acceptance could be conceived as a willingness to be a container for thoughts, emotions, memories, and other experiences without attempting to control, titrate, or change them in any way.

The Problem with Language

A major barrier to acceptance of avoided private events is the dominance of the verbally-established psychological functions of cognition, emotion, and physical reactivity. ACT is based upon a contextual behavioral view of language (Hayes & Wilson, 1993; Wilson & Blackledge, 2000; Hayes et al., 1999; Wilson & Hayes, 2000). In brief, words come to have some of the psychological functions of their referents. To the extent this occurs, behavioral regulation is dominated by verbally established contingencies at the expense of directly experienced contingencies.

Cognition plays a key role in this analysis, since even physical and emotional states contain a verbal component. Physiological responses are not merely physiological responses. "Anxiety" for example is in a verbal category of "bad" arousal, whereas sexual arousal is in a category of "good" arousal. Similarly, emotions such as sadness are "bad" and happiness is "good." There is considerable evidence within the experimental literature showing that animals will avoid aversive events, as well as events that precede those aversives (that is, classically conditioned stimuli). However, there is no evidence that animals avoid their own reactions to aversive events (see Wilson & Blackledge, 2000, for an elaborated analysis). Presumably, reactions to aversives give the organism some adaptive advantage. Reactions are unlikely to become aversive through classical conditioning, since they follow, rather than precede the aversive event.

However, when reactions participate in verbal relations they may become equivalent to the aversive events to which the individual is

reacting. Thus, for example, we avoid thoughts of the death of a loved one just as we would avoid the actual death of a loved one. For the substance abuser, thoughts of inevitable failure may be responded to in the same way as the fact of inevitable failure. If one is certain to fail, trying makes little sense. Who could, or should, accept the fact of inevitable failure? The substance abuser, however, is not experiencing the fact of inevitable failure. That would involve experiencing a future that has not yet occurred. What needs to be accepted is not the fact of failure, rather the thought of failure—and, of course, all of the emotional responses that come along with thoughts of failure.

Assuming that certain cognitive, emotional and physical states are barriers to recovery, most cognitive and behavioral treatments attempt to reduce or eliminate them. Exposure procedures are used to reduce or eliminate urges, cravings, and associated physiological arousal in the presence of drug cues. Cognitive therapies engage in disputation and cognitive restructuring in order to eliminate irrational negative cognitions and supplant them with rational thinking. In ACT, instead of attacking the form of problematic private events, we attempt to alter the function of these events.

In a technical sense, various cognitive and emotional states come to have a very narrow range of psychological functions. This is a state of affairs akin to what has been labeled functional fixedness in the cognitive psychology literature. We become fixed on certain ways of interacting with events and this fixedness can markedly narrow our range of responses. In some instances, we may be unable to solve a problem if the solution requires us to use some object in an uncharacteristic way, such as using a brick as a measuring device (Solso, 1979). Langer (1989) provides an exercise that illustrates the ways in which preconceived notions about events may impact our reactions. She suggested the following experiment:

> Moisten your mouth with the your saliva—the back of your teeth, the tip of your tongue, and so on. It should feel pleasant. Now spit some saliva into a clean glass. Finally, sip a bit of this liquid back into your mouth. (p. 23)

Langer commented that because we all learned as children that spitting is disgusting, we are repelled. Similarly, very early on we learned that certain ideas, emotions, and sensations are bad and ought to be avoided. And so we avoid them, sometimes even when the consequences are grave. In ACT we attempt to alter highly routinized responses to negative thoughts, emotions, and bodily states.

Distinguishing between self-as-context from self-as-content makes radical acceptance possible. It is easier to accept that one *has* something bad, than to accept that one *is* something bad. One by-product of language is that we become identified with the content of consciousness. The very structure of speech conspires to reinforce this identification. We do not say "I have anxiety." We say "I am anxious." We do not say "Being a father is one of my roles." We say "I am a father." We do not say "I have a strong body." We say "I am strong." If identification with such a self-concept is strong, disruption can make adjustment quite difficult. When careers end, when a child dies, when health is lost, people are sometimes said to undergo a crisis of identity. Substance abusers may become identified with thoughts such as "I can't stand these cravings," "I can't stay clean, I get too depressed," or "I'll never do anything right in my life." To the extent that these thoughts are responded to in terms of their literal meaning, rather than as thoughts, recovery can be difficult. To the extent that they lose the distinction between those thoughts (self-as-content) and the self that has those thoughts (self-as-context), recovery can be difficult.

Some meditative exercises are used in ACT in order to help clients experience a sense of themselves independent of their roles, thoughts, emotions and bodily states (see Observer Exercise, Hayes et al., 1999, pp. 193–196). We also use metaphors, such as the Furniture in the House, in which the person is the house and the person's thoughts, emotions, and bodily states are the furniture. The furniture is not, and can never be, the house. The furniture is the content of the house. Whether the furniture is thought to be good or bad, says nothing about the value of the house.

In addition, we adopt language conventions in treatment. ACT therapists will ask their clients to be mindful of thoughts and feelings by labeling them as such. Rather than fusing with the content of the private experience, we ask that clients distinguish themselves from the content by using the prefix, "I am having the thought that . . ." or "I'm feeling. . . ." So instead of saying "I'll never be able to stay clean," the client is asked to say "I'm having the thought that I will never stay clean." Adopting this language convention is awkward. By its very awkwardness though, the convention disrupts a well-established pattern of responses to avoided content. When one uses such a convention, it makes it quite clear that there is an "I," a thought about some event, and the actual event as experienced, and that these three are not identical.

ACT and Spirituality

Historically, the behavior therapy movement has not had a comfortable relationship with spirituality. Sometimes it has simply been ignored. At other times, it has been treated as standing in opposition to science. In the development of ACT, we have persistently explored a naturalistic analysis of topics such as spirituality and transcendence (Hayes, 1984; Hayes et al., 1999; Hayes & Wilson, 1993; Wilson, 1991). When children are taught to answer questions such as "What do you see?," "Where did you go?," "What did you eat?," they eventually learn to answer from a unique perspective—their own. Through various exercises, clients are assisted in experiencing a sense that the "I" that is in therapy is the same "I" that went to the first grade forty years ago; that vacationed at Yellowstone Park last summer; that once thought that there was a real Santa Claus; and that felt sad when mom died. This "I" does not fit well into the matter-spirit distinction embraced by our dualistic society.

Material objects are typically thought of as occupying space and having location and duration. "I" as we experience it, however, has been wherever we have been. In the abstract, we know that "I" has duration and that it came into existence when we did and will go when we go. However, we have no experience of "I" coming into being or leaving. We cannot recall being where it has not been, recall a time when it was not, or say precisely what space it occupies. This is the you that transcends an ever-changing set of thoughts, emotions, bodily states, and conceptual selves that come and go over time. Interestingly, this sense of self, that has thought everything we thought, been everywhere we have been, and felt everything we have felt, is itself entirely stable once it comes into existence. We have never experienced a thought, memory, image, emotion, or bodily sensation that caused this sense of "I" to cease existence.

We believe that this transcendent sense of self has parallels in virtually every great religious and spiritual tradition, and further, that this sense of self is susceptible to naturalistic analyses (Hayes, 1984; Hayes et al., 1999; Hayes & Wilson, 1993; Wilson, 1991). Individuals we have trained in ACT have commented on the overlap between this sense of self and Eastern traditions such as Buddhism, to the mystical aspects of Judaism, Christianity, Islam, and also to some Native American spiritual sensibilities. When a client can make experiential contact with this transcendent sense of self, the vicissitudes of daily life become less formidable.

Overlaps Between Defusing Language and the 12-Step Tradition

The overlaps between defusing language and the 12-step tradition are less clear than the overlaps in other domains. The 12-step tradition does not speak directly to the problem of language in the same ways that it speaks directly to the place of hopelessness, to problematic control, and to the possibility of acceptance as a radical alternative. However, there are a number of aspects of AA that may functionally attack the literal meaning of language. For example, AA embraces a number of paradoxes. Members are told they must "surrender to win." They are told that out of utter defeat come purposeful lives. AA also is playful with some of the culture's most sacred cows. For example, AA members may mock thinking and planning as all-powerful means to achieving a good life, saying things like "My best thinking got me to AA," or "If you want to give God a good laugh, tell him your plans." Members are taught to laugh at their own mistakes and to not take themselves too seriously. Members are encouraged to talk openly about avoided content, including urges, relapses, depression, anxiety, and anger. When openness to these topics is reinforced in the social-verbal context of meetings, generalization to non-meeting contexts may follow.

The 12-step tradition, like ACT, heartily endorses acceptance as an alternative to unproductive control. In an oft quotes passage, one of the stories in the back of *Alcoholics Anonymous* (1976) suggests:

> And acceptance is the answer to *all* my problems today. When I am disturbed, it is because I find some person, place, thing, or situation unacceptable to me, and I can find no serenity until I accept that person, place, thing, or situation as being exactly what it is supposed to be at that moment. . . . Until I could accept my alcoholism, I could not stay sober; unless I accept life completely on life's terms, I cannot be happy. (p. 449)

In this passage, we find that AA recognizes the paradox that acceptance is a necessary condition for change (cf., Linehan, 1993).

AA describes its approach as spiritual, rather than religious. Throughout the history of the AA there has been an essential wariness of organized religion (Kurtz, 1979). The spirituality described in the AA basic text was certainly heavily influenced by Christian sensibilities. It was, after all, written in a dominantly Christian cultural context. However, even in the earliest days of AA there were dissidents within AA that

forced openness in the language used to describe what defined spirituality. AA has always, at its core, remained faithful "to unconventional spirituality" (Kurtz, 1999, p. 67). The approach to spirituality described in ACT is not at all outside the bounds of what might be acceptable within AA.

PHASE 5. APPLIED WILLINGNESS: PUTTING VALUES INTO ACTION

ACT is a thoroughly behavioral treatment—both theoretically and in its ultimate aim. ACT is not aimed at making people feel better feelings and think better thoughts. ACT is aimed at helping people live better lives—where "better" is always gauged by the extent to which people are living lives that are consistent with their values. If we have executed the initial stages of treatment adequately, we will have put in place the foundation upon which applied willingness becomes possible.

Over the course of treatment, at the most difficult points, we have looked back to the values assessment to dignify the difficulties of treatment. Now, we return to it in earnest. The balance of the therapy involves work we call Goals, Barriers and Actions (Hayes et al., 1999). We ask clients to choose a particular valued life domain from their homework. We ask clients to generate some particular short- and long-term goals that would let them know if they were headed in the direction of a given value.

As an example, consider a case treated by the first author. This man had been divorced as result of a serious and persistent substance abuse problem. He had irregularly visited his daughter, who was three at the time of the divorce, during the six years since the divorce. The man had stopped using any intoxicating substances, but had difficulties re-establishing a relationship with his daughter (who lived in another city). He went through cycles of having a reasonable level of contact, followed by very little contact. During the periods of little contact he would feel increasingly depressed and guilty. Eventually, he would become sufficiently distressed and would re-engage with his daughter, beginning yet another cycle.

The client's value was to be a good father to his daughter. For this client, fatherhood was a particularly sensitive domain. His own father had left when he was three years of age and had been mostly absent through his childhood. Through an experiential exercise, the client

was asked to imagine himself as a small child, and further, to imagine his father coming into the room. He was asked to imagine seeing that child (himself) from his father's eyes, and then to see his father from the eyes of that child. Finally he was directed, from the perspective of the child, to ask his father for what he needed. After the exercise, the needs of the child were explored. As it turned out, the main thing the child wished for was to know that his father cared about him. Much of the childhood disappointment was centered in small things like the absence of birthday cards or telephone calls. The client wondered whether his father had ever thought of him at all, and said that it would have meant a lot just to know.

Five important things emerged from this experience. First, it was reasonable to imagine that it might mean something to his daughter to know that he cared about her and thought about her. Second, he was avoiding contact with his daughter in order to manage his own emotional discomfort connected to his history of failure in the marriage and as a father, and probably also his emotional pain with respect to his own father. Third, management of short-term emotional pain using avoidance would, over the long term, cost him a relationship with his daughter—just as certainly as his relationship with his own father had been lost. This client's sadness about his relationship with his own father was instrumental in directing this client towards his value. When asked whether there were anything he would ask of his father right at that moment, if it were possible, he said that he just would like to know if he had meant anything to his father. Still, 30 years after the abandonment, the question remained: Does my father love me? The fifth, and most important thing to emerge form this session was a commitment. The client was clear that, at least for him, there was no such thing as too late to express love for a child. He made a commitment to move towards being a father to his daughter, again and again and again, no matter how many times he had to recommit to action in service of that value.

The client set small goals in the beginning. The first was a commitment to *some* regular contact, no matter how brief. The key aspect of the commitment was consistency. The actions taken to facilitate living the goal was to gather a dozen generic "missing you" greetings cards. In each card the client wrote a simple sentence like: "Hi sweetie. I just wanted you to know that I love you and was thinking of you today." He addressed all of the envelopes and put stamps on them and set them up in his kitchen. His commitment was that every three weeks he

would send one of these cards. If he had more to say, he would write more, send a picture, make a phone call in addition, but at a bare minimum, he would put the card in the mail and let his daughter know that he cared about her.

Barriers to this contact were numerous. Contact with his daughter was painful. He could not speak to her without being aware that, through his own doing, he could not spend much time with her. He had doubts about his own worth. He wondered if she would not be better off without him in her life at all. The question he had to ask himself again and again was whether he would make his daughter go without a father in order to manage his own sadness, self-doubt, and guilt.

Overlap Between Applied Willingness and the 12-Step Tradition

Like ACT, AA is interested in broad life reorientation, rather than being narrowly focused on the elimination of drinking. For example, in *Living Sober* (Alcoholics Anonymous, 1975) in a section entitled "Getting Active":

> Simply trying to avoid the drink (or not think of one), all by itself, doesn't seem to be enough. The more we think about the drink we are trying to keep away from, the more it occupies our mind. . . . Just *not drinking* is a negative and sterile thing. To *stay* stopped we found we need to put in place a positive program of action. We've found we had to learn to *live* sober. (p. 13)

This chapter goes on to describe a variety of areas including physical health, recreation, community service, and education as areas of living in which the recovering person might usefully "get active."

Applied willingness as practiced in ACT is also consistent with steps eight, nine and ten of AA: eight, "Made a list of all persons we had harmed, and became entirely willing to make amends to them all"; nine, "Made direct amends to such people wherever possible, except when to do so would injure them or others"; and ten, "Continued to take personal inventory and when we were wrong promptly admitted it." As in the ACT values work, AA advises righting areas of living that have been damaged during a substance abuse career and also in pursuing new directions in broad areas of life-functioning.

BROADENING SUBSTANCE ABUSE TREATMENT ALTERNATIVES

In order to create treatments that can and will be disseminated, we need to attend not only to what is likely to be effective, but also what will fit with the preferences of both providers and consumers. As suggested by Table 1, ACT may provide more acceptable treatment options for both providers and consumers.

In the area of substance abuse treatment, on the one hand, we have a population of providers who are largely adherents of the 12-step model or work within a treatment setting that follows that model. On the other hand, we have a group of consumers who may or may not be open to a 12-step orientation. ACT could provide a palatable solution given an array of possible configurations of provider and consumer preferences. If the provider and consumer are both open to a 12-step approach, aspects of ACT may usefully complement treatment (upper left quadrant). If the provider has a 12-step orientation, but the consumer is not open to that orientation, ACT can give the provider a

Table 1

Fitting ACT to Therapist and Client Preferences

		Client Orientation	
		Open to 12-Step	**Not Open to 12-Step**
Therapist Orientation	**12-Step Oriented**	ACT can be integrated with a 12-Step treatment approach	ACT can allow the therapist to pursue strategies not identical with 12-step, but not incompatible
	Not 12-Step Oriented	Therapist can engage in ACT treatment strategies that can facilitate client's 12-Step recovery without explicitly engaging in discussions of 12-Step recovery	ACT can be practiced from an approach that does not introduce any explicit 12-Step agenda

treatment strategy that may be more palatable to clients, yet still consistent with their own perspective (upper right quadrant). If the provider is behaviorally oriented and the consumer is interested in participating in 12-step groups, ACT provides a behaviorally based treatment strategy that need not conflict with the client's 12-step activities occurring outside treatment (lower left quadrant). If both the consumer and the provider are not open to 12-step participation, or 12 step treatment, ACT can be delivered with a thoroughgoing behavioral rationale and with an openness to harm reduction rather than abstinence as a treatment goal (lower right quadrant).

CONCLUSION

Rice, Kelman, and Miller (1991) estimate 5.2 million persons between the ages of 18 and 64 currently meet clinical criterion for drug abuse or dependence. Another estimates 10.5 million U.S. adults display symptoms of alcohol dependence, with 7.2 million more abusing alcohol (Department of Health and Human Services, 1990). The resulting losses are enormous in both financial and human terms. The differences that exist between behavioral scientists and 12-step-oriented providers ought not blind us to the fact that we have a shared goal in addressing this enormous public health problem. Although some differences may never be overcome, others may be less intractable than they seem at first glance. We have attempted to describe some convergences between ACT and the most commonly practiced substance abuse treatment model. The interaction of behavioral and 12-step approaches has been adversarial for thirty years. Resolution seems no less near than when the debate began. Perhaps it is time to resign the debate and explore ways to join forces.

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