Abstract - Dealing with the problems of substance abuse requires both an appreciation of clinical reality and an understanding of basic psychosocial principles. Each of the conference presentations of theory and research, most of them nonapplied in nature, created a welcome and rare occasion for experimental and clinical psychologists (and hybrids) to reflect together on the applied implications of some basic research and on the research implications of some applied professional activities. Among the issues found especially noteworthy by this discussant were the following: the return of cognition and rational decision making as legitimate and critical foci in behavior therapy, the role of exposure to aversive events in reducing their fearfulness, the advantages of not working doggedly to achieve goals that are better approached with a nonachievement attitude, the possibility that the difficulty in altering pathological behavior derives from the properties of human language, appreciation of individual differences in psychotherapy outcome research, the importance of considering the meaning that therapeutic ministrations can have for certain patients, and the need to reexamine the utility of patients’ expressing their concerns.

The philosophical notion that experimentalists and clinicians have much to say to each other is the mother’s milk of the scientist-practitioner model of training in applied psychology. Most recently articulated in the report of the Gainesville Conference (Belar & Perry, 1992) and elaborated upon in some recent work of my own (Davison & Lazarus, 1994, 1995), this model of training, practice, and scholarship was enlivened by the conference from which this Special Section arose. Although most of my comments are organized around individual articles, I intend for many observations to be general in nature, consonant with the role that Borkovec and I were assigned.

DANIEL WEGNER

With respect to the two-stage process postulated by Wegner, I would suggest that the ironic effects of suppression may have more conscious aspects than he proposes. Specifically, if I am trying not to think about a white bear by distracting myself with objects around me that are not white bears, I am necessarily making judgments with reference to that which I am not supposed to think about. "There’s a table. Fine, I’ll focus on that because it is not a white bear. Ah, there’s a turnip. I’ll focus now on that non-white-bear entity." Such distraction would seem to be at least as conscious as unconscious (out of verbalized awareness).

It may also be the case that the injunction to not think about a white bear elicits performance anxiety, a core feature of Masters and Johnson’s classic work on sexual dysfunction (1966, 1970). Making a goal salient, indeed, making a performance a goal per se, can generate excessive concern about its attainment. A host of human actions are putatively performed more readily if their performance is not an explicit task. "I’m going to have a good time tonight" is often the self-statement of a person who, like some men with erectile disorder, is adopting an achievement-oriented attitude. Yet, not caring about the goal is the better way to achieve it. A central feature of relaxation training has long been the seemingly paradoxical directive of not getting more relaxed, but rather, just to follow the instructions to tense and relax the muscles, allowing oneself to feel whatever happens (Goldfried & Davison, 1994). Via such a nonfocused set, it seems that relaxation-induced anxiety (Heide & Borkovec, 1984) can be minimized.

A final comment on Wegner’s article relates to a theme that arose throughout the conference, namely, the time-honored tradition of encouraging patients to expose themselves to what they would otherwise avoid or escape from. To the extent that some problems of substance abuse arise from or are exacerbated by unwarranted anxieties, confronting events so that the anxiety can extinguish is a promising strategy that cuts across many theoretical perspectives.

BARUCH FISCHHOFF AND JULIE DOWNS

Fischhoff and Downs highlight a basic issue in psychopathology and intervention, namely, the extent to which (conscious) rational cognition plays an operative role in how troubled people can become better. Based on a negative evaluation of the benefits from analytic and client-centered therapies, behavior therapy totally rejected insight therapy in the 1950s and early 1960s, turning away from cognition and embracing conditioning theories that eschewed appeal to the role of thought (e.g., Eysenck, 1960; Wolpe, 1958; Wolpe, Salter, & Reyna, 1964). Indeed, behavior therapy was often referred to as “conditioning therapy.” An early correction to what many people came to perceive as an overreaction against cognition was London’s 1964 book, which contained the first cognitive account of Wolpe’s systematic desensitization (Wolpe, 1958) and, in general, a set of conceptual proposals about what London termed “action therapy” that went far beyond the boundary conditions of the so-called conditioning therapies. Other cognitive efforts followed (e.g., Bandura, 1969; Goldstein, Heller, & Sechrest, 1966; Mischel, 1968), in some respects recapitulating the clinical-cognitive theorizing of the 1950s in the pathbreaking work of Kelly (1955) and Rotter (1954).

The theory and research described by Fischhoff and Downs, in seeming isolation from applied work, may already have shown its relevance in the cognitive behavior therapy for alcoholism reported by the Sobells (Sobell & Sobell, 1993). Their approach to controlled drinking for many problem drinkers assumes that people have more potential control over their excessive drinking than they typically believe and that heightened awareness of the costs of drinking to excess as well as of the benefits of abstaining or cutting down can be...
of material help. Termed guided self-change, this outpatient approach emphasizes personal responsibility and control. Patients are discouraged from viewing themselves as the victims of an addictive disease; rather, they are encouraged to see themselves as basically healthy people who have been making unwise, often self-destructive choices about how to deal with life's inevitable stresses. The Sobells assume, as do Fischhoff and other decision theorists, that conscious, logical analysis and problem solving can help people live better—an assumption that is at odds with many other theoretical perspectives, from the classical and even more contemporary psychoanalytic to the noncognitive behavioral approaches.

In the Sobells' approach, the therapist is empathic and supportive while he or she makes salient to the problem drinker the negatives that the person may not have been attending to. For example, most problem drinkers do not calculate how expensive it is to drink to excess (costs of drinking at home can easily run to more than $2,000 a year, and the costs can be double or triple that for drinking in a bar or restaurant) or how much weight gain is attributable to alcohol. They also seldom consider how seemingly minor behavioral changes can help them drink less (e.g., that they could go home by a different route that does not take them by a bar they have been going to habitually). Sometimes getting the person to delay 20 min before taking a second or third drink can help him or her reflect on the costs versus the benefits of drinking to excess. Outcome data lend support to the effectiveness of this approach in helping problem drinkers moderate their intake and otherwise improve their lives (Sobell & Sobell, 1993).

Relevant also to Fischhoff and Downs's article and supportive of the view that such research has something to offer the clinician is the decades-old research in social problem solving (D'Zurilla & Goldfried, 1971; Nezu, 1986). Sometimes just being able to conceptualize the chaos of one's life in terms of inadequate, ineffective methods of dealing with life's inevitable problems can have a calming and reassuring effect (Haaga & Davison, 1991).

A cautionary note is in order for any theorizing that is based on analogue laboratory research. The emotional conditions under which people make personally and clinically relevant decisions are typically quite different from those prevailing in the lab. When one has to decide, for example, whether to use a condom, one is experiencing heightened sexual arousal, and a moment's introspection reveals that the context for such a decision is not what characterizes the laboratory research reported by investigators like Fischhoff. This is not an insurmountable problem; one of my own students, Natalie Masson, is applying the theory of reasoned action (Fishbein & Ajzen, 1975) to decision making on engaging in safer sex, endeavoring to uncover the nature of such rational weighing of alternatives under conditions closer to the actual decision situation than are generally found in basic cognitive research.

JAMES PENNEBEAKER

Psychoanalytic therapists have argued for about 100 years that troubled patients need to talk at length about their problems. Behavior therapists have set themselves against this belief (culturally prevalent in Western society) by downplaying, even ridiculing, the potential benefits of expressing one's concerns verbally. Pennebaker's programmatic research demonstrates the shortsightedness of this tack and requires open-minded reexamination of the question. His data are too consistent and too strong to ignore.

STEVEN HAYES AND ELIZABETH GIFFORD

This article reminds us that behavior analysts can and do study complex human experience, and not just overt behavior, however complex. Hayes and Gifford argue that the avoidance of negative experiences (thoughts, feelings, etc.) can be pathogenic. Also disadvantageous to people is the avoidance of active coping that can follow from experiential avoidance. This tendency, they suggest, is relevant to substance abuse, the notion being that psychoactive drugs are often employed to enhance the avoidance of negative thoughts and feelings.

Of particular interest to those who believe that the integration of theories of psychotherapy is a feasible and desirable effort, experiential avoidance is related to the Gestalt therapy-oriented work of Greenberg and Safran (1989). The essence of that approach is that getting in touch with denied or suppressed feelings and thoughts is essential to therapeutic change. Hayes and Gifford's argument, however, is that experiential avoidance is virtually built into human language and therefore is inherently difficult to change, leading to the conclusion that pathological conditions are extremely resistant to alteration. Compounding the problem, they argue further, is the ubiquity of rule-governed behavior, which entails the construction of general classes of phenomena that reduce the person's sensitivity to changing circumstances. Given how difficult it is to alter dysfunctional behavior in deep and lasting ways—particularly behaviors associated with substance abuse—Hayes and Gifford's data, theorizing, and extrapolations should be attended to with as much care as the widespread assumption that physical addiction accounts for most of the recalcitrance of substance abuse to therapeutic change efforts.

WILLIAM SWANN

Swann's research encourages us to adopt a sophisticated approach when dealing with people with low self-esteem. A simple approach might involve encouraging them with pep talks, reassurances that they are really better than they think they are. What is omitted from these simplistic assumptions is that, over time, people build up a self-system and a set of expectations about their social environment that provides predictability and control—and they are motivated to preserve this even if it means resisting efforts to help them feel better about themselves. Our analytic colleagues term this secondary gain. Therapists in particular must beware the unintended negative effect of using their
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special positions of influence to heap positive reinforcers on patients who do not see themselves as worthy of them. The negatively reinforcing properties of most drugs suggest that abusers self-medicate in order to escape from negative states of mind and feeling. One source of such negatives may ironically be the people who care about the abuser and convey that caring via noncontingent positive regard.

Clinical anecdotes punctuated some of the discussion throughout the conference. Though not probative, clinical experiences are illustrative and heuristic. One of my own contributions related to a female patient I saw in the mid-1960s, when I was very much a novice in independent clinical work. Among her many anxiety-related problems was an acute social sensitivity that was bound up with a very negative image of herself as an individual undeserving of positive attention. In the middle of an initial relaxation induction that appeared to be going smoothly, she began to sob. My inquiry led to her saying that the effects of my words were very positive, and for that very reason, she felt bad and sad. She indicated tearfully that she did not deserve to feel this good and did not deserve the empathic attention that I was giving her. It took several sessions, as a result, to bring her to the point of accepting the positive and reassuring ministration that is inherent to effective relaxation training. Therapeutic strategies and tactics have meaning to patients, and behavior therapists have tended to overlook this fact (Wachtel, 1977).

THOMAS PIASECKI, SUSAN KENFORD, STEVENS SMITH, MICHAEL FIORE, AND TIMOTHY BAKER

One of the striking findings of Baker and his associates is that the most critical withdrawal symptoms—those that predict relapse after cessation from smoking—are affective, not physical. Attention to the negative affect associated with smoking cessation for some smokers is critical if one is to reduce the chances of relapse. The importance of negative affect would seem to warrant greater care in helping ex-smokers (and other ex-addicts) deal with the aversive emotional sequelae of refraining from using addicting substances and of no longer experiencing the negatively or positively reinforcing consequences of drugs. As Mark Twain is reputed to have said, "Quitting smoking is easy—I’ve done it hundreds of times." If, for example, sleeping problems are part of the cessation picture, helping abstainers enjoy more restful sleep ought to enhance the chances of maintenance. Successful self-quitters are probably people who have developed on their own some strategies for dealing with problematic affect following cessation. "Don’t mess with me—I haven’t had a cigarette for a week" is a time-honored way that quitters have discovered to give themselves some leeway in social intercourse as they learn to deal with life’s challenges (and banalities) without their accustomated drugs.

A methodological feature of this article that is noteworthy, especially for that vast majority of us who conduct group research, is the systematic examination of individual variability. Consideration only of averages, with variance regarded more as a hindrance to statistically significant between-group differences than as potentially important information, is replaced in this research by a single-subject focus that hearkens back to Hayes’s operant research. This is a welcome development. Indeed, one often hears complaints from practicing clinicians that comparative therapy research lacks relevance for their own work because it focuses on group averages more than it does on individual subjects or patients, a problem I have recently discussed (Davison & Lazarus, 1994, 1995).

CLOSING COMMENT

These days one hears the call for more interdisciplinary research. The encouragement of such research at Pennsylvania State, as described by Borkovec, is to be found at my own institution as well. In one sense, psychology is interdisciplinary sui generis, and clinical psychology seems especially so. My old friend and mentor, Perry London, helped me in graduate school in 1963 to appreciate the power and appeal of clinical psychology as a specialization when he called it "a bastard discipline." Sometimes doubtful parentage can be an advantage. The thinking of psychologists across the spectrum of our diverse field has always reflected a blend of many formally separate disciplines, from chemistry and biology to sociology and anthropology. There has always been a strong presence of the humanistic as well, even though many psychologists are uncomfortable with that inevitable connection. This Special Section suggests that continued collaboration is advisable in the effort to understand better the etiology, maintenance, and alteration of substance abuse as well as other complex human phenomena.

What happened during these two days in May 1996 in Bethesda, Maryland, can be easily replicated within each of our own departments. Sometimes it has seemed to me that the best informed people in psychology and related departments are the students, for we usually require that they take courses from faculty outside of their own areas of specialization. Moreover, most master’s and doctoral committees have to include at least one faculty member outside of the student’s area. This conference afforded each of the participants the privilege of learning more about the research of other investigators as it might bear on our own scholarship in ways hitherto unexamined. Similar sharing and collaborative possibilities are available to each of us within our own departments and schools. Everyone’s perspective and research will be the richer for this.

REFERENCES


