

Acceptance-Based Treatment for Smoking Cessation

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This pilot study applied a theoretically derived model of acceptance-based treatment process to smoking cessation, and compared it to a pharmacological treatment based on a medical dependence model. Seventy-six nicotine-dependent smokers were randomly assigned to one of two treatments: Nicotine Replacement Treatment (NRT), or a smoking-focused version of Acceptance and Commitment Therapy (ACT). There were no differences between conditions at posttreatment; however, participants

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in the ACT condition had better long-term smoking outcomes at 1-year follow-up. As predicted by the acceptance process model, ACT outcomes at 1 year were mediated by improvements in acceptance-related skills. Withdrawal symptoms and negative affect neither differed between conditions nor predicted outcomes. Results were consistent with the functional acceptance-based treatment model.

The 1960s and 1970s were the golden age of behavior therapy development for smoking cessation. Multiple new technologies based on behavioral models resulted in notable improvements in outcomes (Shiffman, 1993a). Since that time, however, the development of new behavioral therapies has slowed (Niaura & Abrams, 2002; Shiffman, 1993a). According to Shiffman (1993a), this reduction may be attributed to a shift in focus from behavioral smoking cessation treatments that are based on unitary specified mechanisms of change to multicomponent, atheoretical grab-bag approaches incorporating any technologies believed to offer help.

While applying combinations of helpful treatments seems justifiable given the severe consequences of smoking, atheoretical treatment packages can obscure clarity about critical mechanisms of change (Shiffman, 1993a). Clarity about the processes responsible for treatment effects leads to better understanding of disorders and existing treatments, and leads to the development of new, more powerful therapies (Follette, 1995; Kazdin, 2001). Recently, a number of investigators have called for a return to theory-driven treatment development based on behavioral mechanisms of action (Niaura & Abrams, 2002; Rounsaville, Carroll, & Onken, 2001).

The present study is an investigation of a new treatment for smoking based on a specific behavioral theory of change. The treatment was designed for smokers whose smoking is maintained by efforts to avoid or modify aversive internal experiences such as negative affect and other withdrawal symptoms. It is a basic behavioral principle that avoiding aversive stimuli can provide negative reinforcement for maladaptive behavior. For example, the alcoholic who drinks to avoid or regulate negative affect reaps immediate benefits from drinking (Conger, 1956; Marlatt & Gordon, 1985).

Evidence suggests that the negative reinforcement available through avoidance is an important component of nicotine dependence (Shiffman, 1993b). Negative affect and the negative reinforcement produced by reductions in negative affect are potent predictors of smoking and smoking relapse (Brandon, 1994; Brandon, Tiffany, Obremski, & Baker, 1990). Negative affect is strongly associated with smoking in epidemiological studies (Anda et al., 1990; Cinciripini, Hecht, Henningfield, Manley, & Kramer, 1997), appears to predict treatment failure (Hall, Munoz, Reus, & Sees, 1993; Hall et al., 1996), and has powerful psychophysiological interactions with nicotine and nicotine withdrawal (Newhouse & Piasecki, 2000; Pomerleau & Pomerleau, 1984). In a recent study of 632 smokers (Kenford et al., 2002), postquit negative affect was the strongest predictor of relapse, above physiological dependence symptoms and history of drug exposure. Smoking may be maintained

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