

the Behavior Therapist

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President's Message

Financial Anxieties: Nine Steps for Coping With Your Worries

Robert L. Leahy, *American Institute for
Cognitive Therapy, New York*



Millions of people have experienced a wave of anxiety, rage, and feelings of hopelessness during this recent financial crisis. Many of our patients—and many of us, as well—have witnessed substantial losses in pension funds, devaluation of real-estate, foreclosures on homes, denial of credit, and loss of jobs. The financial crisis is world-wide, hitting countries outside of the United States even more severely. How can we use cognitive behavioral therapy to help ourselves and our patients cope with a real-life financial debacle?

I would suggest that there are nine steps that we can take to cope with this miserable problem (Leahy, 2005). By coping with a problem I do not imply that everything is wonderful and that there isn't reason for anxiety, anger—even rage. But the question to ask about coping with real problems is, "How long do you want to be unhappy about it?" and "How long do you want to worry about it?" Rather than add anxiety to injury, let's look at some coping strategies.

First, give yourself permission to say, "OUCH!!!" Yes, it does hurt. It is unfair. Validate the pain that this has caused you and recognize that you have every right to feel angry. Then ask yourself, "How long do you want to stay in the OUCH mode?"

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Awards & Recognition

ABCT Award Nominations Requested

David A. F. Haaga, *American University*, Chair, *ABCT Awards and Recognition Committee*

Do you know anyone who is good at what they do and deserves professional recognition? If so, please consider nominating this exemplary colleague for an ABCT award. A full list of the awards to be given this year, and instructions for making nominations, may be found on the ABCT website. To get to the awards page, click on "Current and Potential ABCT Members" and then "Awards" from the drop-down menu. Nominations in several major categories (Career/Lifetime Achievement, Distinguished Friend to Behavior Therapy, Outstanding Contribution by an Individual for Educational/Training Activities, Outstanding Training Program, Student Dissertation Awards) are due March 2, 2009, so now is the time to identify suitable candidates and write up your nominations.

There are several changes to the awards program this year. First, the generosity of friends and family of ABCT founding member Leonard Krasner has made it possible for us to offer an additional student dissertation award. Along with the Virginia A. Roswell Student Dissertation Award, we shall therefore give a Leonard Krasner Student Dissertation Award to honor Dr. Krasner's memory and his immense contributions to the field.

Second, colleagues, friends, and family of the late Neil Jacobson will honor his many contributions to clinical research by offering the Neil S. Jacobson Research Awards for Outstanding and Innovative Clinical Research. The deadline for proposals for these awards is May 1, and a committee separate from the ABCT Awards and Recognition committee will conduct the review. Please see the awards web page for the specifics on this exciting opportunity.

Third, we have simplified the process of nominating someone for the Career/Lifetime Achievement Award. It will no longer be necessary to submit three letters of support for such nominations. All that is required (again, see the web page for details) is one nomination letter, along with the nominee's CV. We will make the same change for the awards for Outstanding Contribution by an Individual for Clinical Activities and Outstanding Contribution by an Individual for Research Activities when these awards are next offered. The experience of the Awards Committee has been that additional letters are not needed in these categories, as the contributions in question are listed on the CV and usually well-known publicly. We will continue to request multiple letters in support of nominations for awards (e.g., Outstanding Mentor) dealing with activities that are less visible to the public.

Finally, there is a new Awards Committee this year (membership listed on the web page), comprised of savvy veterans with award-giving experience and a talented band of enthusiastic awards rookies. In my first year at the helm of this team, I am under pressure to fill some very large shoes. My predecessor, M. Joann Wright, Ph.D., set wise policies, established effective and efficient committee procedures, conducted memorable and moving awards ceremonies at each year's convention, and did it all with grace and good humor. Matching Joann's standard is beyond me, but as my students can attest I do have a couple of talents—cajoing people to write, and reminding them of deadlines.

So, one more time, please make one or more nominations, and do so by March 2, 2009. Please contact me with any questions at dhaaga@american.edu. ■

INSTRUCTIONS for AUTHORS

ABCT publishes *tBT* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy. ■ Feature articles that are approximately 16 double-spaced manuscript pages may be submitted. ■ Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred. ■ Feature articles and brief articles should be accompanied by a 75- to 100-word abstract. ■ Letters to the Editor may be used to respond to articles published in *tBT* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages. **Submissions must be accompanied by a Copyright Form** (a form is printed on p. 24 of the Jan. 2008 issue of *tBT*, or contact ABCT): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Submissions via e-mail are preferred and should be sent to the editor at drewa@albany.edu. Please include the phrase **tBT submission** in the subject line of your e-mail. Include the first author's e-mail address on the cover page of the manuscript attachment.

Second, if you are a worrier, think about what the costs and benefits are to you of worrying about the future. (Let's define "worry" as repetitive negative thoughts about future events that haven't happened.) How much time during the day is taken up with rumination and worry? Is it interfering with your life? What do you hope to gain from worry? Do you think that it will keep you from being surprised? Is it really working?

Third, use productive worry to take action and identify unproductive worry to discard useless thinking. Productive worry involves action steps that you can take in the next 24 hours that will really help you solve your problem. For example, you might diversify your investments, start keeping a budget, and reconsider major expenses. Unproductive worry involves "what-ifs" about which you have no control. Examples are, "What if the economy goes into a depression?"

Fourth, once you have identified unproductive worry, think about the advantages of accepting uncertainty (Dugas, Buhr, & Ladouceur, 2004). Many worriers continue their repetitive thinking to gain absolute uncertainty. There is no certainty in an uncertain world. Practice mindfulness meditation, stay in the moment, improve the moment, and let go of control.

Fifth, challenge some of your negative thinking. Some people view this as a "catastrophe." Think about how the present situation is really different from the 1930s and the Great Depression. In the 30's the market fell 89% and unemployment was 25%, whereas as of January 1, 2009, the Dow Jones Industrial Average fell for the prior year about 33% and unemployment is 6.7% (anticipated to go to about 9%) (National Bureau of Economic Research, 2009). In the 1930s (for much of the time) there was no unemployment insurance, no

FDIC, no Social Security, no food stamps, no safety net. Today, there are numerous federal and local programs that help cushion the loss of income. Average wealth and income were very low in the 1930s—but today, in America, total household wealth is about 52 trillion dollars. As bad as unemployment is, even if it were to go up to 9% it would reflect what the average unemployment rates were in Western Europe for most of the 1980s and 1990s (Cameron, 2001).

Sixth, we can normalize recessions as part of the nature of financial markets. For example, we had recessions (of various durations) starting in April 1960 (10 months), December 1969 (11 months), November 1973 (16 months), January 1980 (6 months), July 1981 (16 months), July 1990 (8 months), March 2001 (8 months), and, now 2008–2009 (National Bureau of Economic Research, 2009). Recessions come to an end. Think about getting ready with job skills and plans for recovering for the end of the recession. Plan for growth.

Seventh, try to distinguish your "needs" from your "preferences." What did you do before you had the money? What are some things that you can do for free? What do your children and partner really need from you? I have found that the current financial crisis has helped clarify for some patients what really matters. Indeed, liberating yourself from materialism can be the best way to enrich the life that you are living today. I suggest to my patients to begin each day by focusing on something that they can do for free—something that is valuable to you. This could be showing affection, experiencing appreciation, expressing gratitude, listening to music, praying, reading, exercising, or other "mundane" but truly wonderful experiences.

Eighth, stretch time to think about how you can build for the future. Many people are myopically focused on recent market trends. If history is any guide, most recessions are followed by 8 years of growth. If

this is the bottom, then we have a lot to look forward to.

Ninth, build a life portfolio. Positive psychology demonstrates that money can't buy you much happiness. A sense of flow and meaning in life can be found in clarifying your values—for example, try to aim for the virtues of integrity, courage, kindness, and compassion. Work at improving the loving-kindness in your relationships. Volunteer to help people who are less fortunate than yourself. If your life portfolio is greater than your financial portfolio, then you are highly diversified. And you are richer for it.

Keep in mind that you have every right to feel upset and every right to move beyond the situation to make your life better. It's your choice.

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Bridging the Knowledge-Practice Divide: Using Technology to Evaluate and Modify Behavioral Aspects of Chronic Pain in Children

Mark Connelly, *Children's Mercy Hospitals and Clinics, Kansas City, MO, and University of Missouri*

Pain that persists or recurs in the absence of ongoing organic pathology is a pervasive and increasing public health concern in the pediatric population. Approximately 1 out of every 4 children experiences a pain condition that continues for more than 3 months (Perquin et al., 2000), with as many as two thirds of these children developing significant physical, emotional, social, and academic impairments as a result (Konijnenberg et al., 2005). Prevalence of chronic pain conditions continues to increase at concerning rates in pediatrics, and children with these conditions often continue to have significant problems with pain and associated disability into adulthood (Brna, Dooley, Gordon, & Dewan, 2005; Harkness, Macfarlane, Silman, & McBeth, 2005). Further, the costs of medical care and lost productivity associated with chronic pain in children are estimated to total over \$400 billion (Sleed, Eccleston, Beecham, Knapp, & Jordan, 2005).

Effective treatments built on behavioral principles have been available for more than 20 years for the most common chronic pain disorder in children (chronic headache), and, more recently, behavioral treatments have been found effective for other common pediatric chronic pain problems (abdominal pain and musculoskeletal pain; Connelly, 2002; Connelly & Schanberg, 2006; Eccleston, Yorke, Morley, Williams, & Mastroiannopoulou, 2003; Huertas-Ceballos, Logan, Bennett, & Macarthur, 2008). Despite this progress, the gap between extant knowledge of behavioral strategies that work to improve chronic pain conditions in children and actual use of these approaches is remarkably wide. Evaluating whether technology can help address this gap to potentially offset a life of unnecessary impairment in children with pain disorders has been a focus of our research and will be briefly reviewed in this article.

Background

Although mechanisms underlying development of chronic pain in children remain unclear, the role of learning and behavior has long been recognized and is routinely discussed in the extant literature (P. A. McGrath & Hillier, 2003). For example, at the physiological level, sensitization of nociceptive neurons throughout the peripheral and central pain processing system and resultant lowered pain thresholds is a feature common across many chronic pain conditions in children (Fitzgerald & Howard, 2003). Such sensitization appears to be in essence a learned (conditioned) response to repeated patterns of complex biochemical and soft tissue alterations in the context of physiological stress (with a continual pain stimulus itself being one source of stress; Dufton et al., 2008; Hermann, Hohmeister, Demirakça, Zohsel, & Flor, 2006). Thus, identifying stressors through self-monitoring and substituting new patterns of behavioral and cognitive responses is an underlying feature of psychological treatment approaches to chronic pain in children and has documented efficacy (P. J. McGrath, Dick, & Unruh, 2003). In addition, how children with chronic pain respond to and express their pain perception is also a process of social learning and operant conditioning. Parents may model helpful or unhelpful methods of expressing or coping with their own pain complaints that, in turn, children manifest (Palermo & Chambers, 2005). Parents or others in a child's social environment also may respond to children in ways that positively reinforce (e.g., through increased attention) or negatively reinforce (e.g., through removal of undesired roles or responsibilities) pain behaviors or functional impairment (Claar, Simons, & Logan, 2008). Consequently, forms of pain expression and strategies for pain coping can become overlearned and entrenched as habits. Behavioral treatments

that seek to extinguish unhelpful patterns of pain expression and coping through changing aspects of the child's social context are therefore often used in the treatment of chronic pediatric pain and have documented efficacy.

Thus, over the past two decades of research into pediatric pain, it has rarely been debated that behavioral assessment and treatment have a place when working clinically with children with chronic pain disorders. The vast majority of these children, however, will never be seen by a behaviorally trained practitioner. Reasons include barriers to access (e.g., geographic restrictions, insurance restrictions, time restrictions, etc.), barriers in knowledge (e.g., limited awareness of the efficacy of these approaches in physician colleagues or parents of children with chronic pain), and barriers to effectively disseminating these interventions for routine use in clinical practice. One approach to addressing some of these barriers is developing behavioral approaches to assessment and treatment that are more readily accessible to children. Given that more than 75% of American children currently have home computer access, and more than 50% of children use the Internet to obtain health information (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005), computer-based approaches to behavioral pain assessment and management seem to have great potential in reaching those children that could most benefit.

Technology Tools for Behavioral Assessment and Intervention in Children With Chronic Pain

Increasingly, information technology is being harnessed to address some of the challenges in pediatric health-care delivery. Studies have started to demonstrate that using technology-based behavioral self-management tools to complement the medical care of certain health conditions may in fact be more appealing to children than more traditional approaches and may result in greater engagement (Chan et al., 2007). Further, there is a significant positive association between level of behavioral health risk factors in children and their willingness to use technology for health promotion (Tercyak, Abraham, Graham, Wilson, & Walker, in press). Randomized controlled trials on behavioral interventions for other pediatric populations delivered via the Internet or CD-ROM have shown positive outcomes for encopresis (Ritterband et al., 2003), eating behavior (Doyle et al., 2008; Williamson et al., 2006), asthma (Bussey-

Smith & Rossen, 2007), cystic fibrosis (Davis, Quittner, Stack, & Yang, 2004), and preventative health behaviors (Buller et al., 2008; Christakis, Zimmerman, Rivara, & Ebel, 2006). Our own research group has focused on two primary areas for using technology to behaviorally evaluate and treat chronic pain in children that are subsequently reviewed in more detail: electronic methods of pain tracking and computer-based self-management interventions.

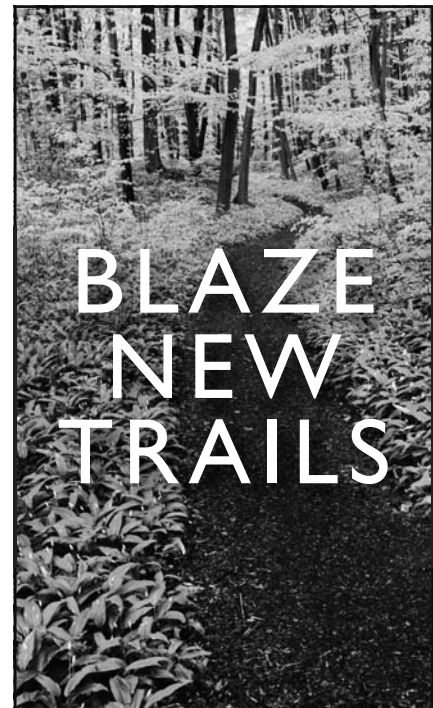
With respect to computer-based pain interventions, we have developed a CD-ROM (now Web-based) self-management program for pediatric chronic headache founded primarily on behavioral principles for pediatric pain management (Connelly & Rapoff, 2002; Connelly, Rapoff, Thompson, & Connelly, 2006). The initial program incorporated four primary content "modules" comprising 4 to 6 lessons each in the following areas: behavioral model of headaches and self-monitoring of headache triggers; relaxation training (i.e., progressive muscle relaxation, relaxed breathing, guided imagery and autogenic training); skills training in cognitive strategies for headache management (e.g., problem-solving related to headache triggers, thought reframing to modify aversive emotions related to stressful situations); and joint parent/child training in behavioral strategies for reducing headache-related disability (e.g., pacing of activities, lifestyle factor modification, and changing parent/caregiver behaviors that may reinforce headache occurrence or disability). The content is fully narrated and presented in developmentally appropriate language, along with graphics, music, exercises, and password games to engage children in the content and motivate adherence. This initial program was designed to be self-directed by young children (ages 7 to 12) and their parents. The program was intended as an adjunct to medication, with the goal of equipping children and parents early on with behavioral skills that could be used to reduce and potentially preempt headaches and related disability into the future.

Pilot study data of the computer-based self-management training from a small randomized trial were quite positive (Connelly, 2005; Connelly et al., 2006). Thirty-seven children participated in the pilot trial and were randomly assigned to control versus treatment condition. Control participants continued to take headache medications as prescribed by their neurologist and did not receive any other intervention. Treatment participants completed lessons in each of the modules of the program on their home

computers over the course of 4 weeks in addition to continuing to take headache medications as prescribed by their neurologist. Quality of life, treatment satisfaction, and headache outcomes were assessed via questionnaires and daily headache logs up to 3 months following the completion of the CD-ROM program. Results demonstrated superior immediate posttreatment and follow-up results on headache frequency, duration, and intensity for the group receiving the CD-ROM program, and user receptivity data were very positive. Those receiving the CD-ROM program were more than twice as likely to be clinically significantly improved up to 3-months follow-up relative to children in the control condition (Number Needed to Treat = 2.38). Children in the CD-ROM condition also had significantly improved health-related quality of life by 3-month follow-up, whereas quality-of-life changes in the control condition were not significant (Connelly & Rapoff, 2006). Based on these promising preliminary data, our group is currently doing several additional projects involving development, testing, and dissemination of Web-based behavioral self-management interventions for different pediatric pain conditions and age groups.

With respect to electronic methods of pain tracking, we have evaluated the feasibility and utility of electronic experience sampling methodology using personal digital assistants (PDAs) and Web-enabled cell phones. One goal of this research has been to increase the ease by which the behavioral antecedents and consequences of pain occurrences in children are assessed and organized into a clinically useful format. With the advent of wireless technology, these data can be transmitted in real-time to an electronic database from mobile devices that can then be accessed by clinicians (or patients) in summary reports to aid in assessment. The data could then be used to guide individually tailored behavioral self-management interventions for those who would most benefit.

In one recently completed preliminary study in this area, 22 children, aged 8 to 18, with a chronic primary headache disorder, completed daily headache reports on a wireless-enabled PDA in which they entered information about potential headache triggers three times daily for 2 weeks (Connelly, Miller, Bickel, & Gerry, 2008). Weather patterns also were tracked in real-time as part of this study to determine if weather variables such as humidity or barometric pressure were predictive of a child's headache onset. Compliance data sup-



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ported the feasibility of this approach (e.g., children completed on average 87.3% of the 42 assessment points per child), and individual level data showed clinically relevant variation in which subset of variables (e.g., weather patterns, stressful events, dietary factors, and sleep changes) were significantly predictive of headache onset and intensity. Thus, this technology may have the capacity to help, in real-time, identify key headache antecedents for a given child so as to facilitate more targeted interventions and reduce the need for unnecessary treatments or office visits.

In another small-scale study, we used a similar methodology to assess social context factors that could also inform self-management interventions. In this study, 9 children with chronic pain from polyarticular arthritis answered questions on a Palm device thrice daily for 14 days about their pain and pain-related interference in mood, academics, social functioning, and physical activities while their primary caregivers also independently completed electronic logs on how they responded to their child's pain complaints (Connelly, Anthony, Schanberg, & Gil, 2007). Multilevel models were used for analyses and showed that after controlling for baseline disease severity and level of pain intensity at the given assessment point, parent "solicitous" responses (that negatively or positively reinforce pain expression) significantly predicted the level of total activity reductions and the extent of specific reductions in social, physical, and school activities. Based on these initial studies, we are now conducting larger scale studies in an effort to merge pain tracking data with tailored behavioral pain interventions for specific pediatric pain populations.

For behavioral clinicians who currently see children with chronic pain, the use of electronic self-monitoring for pain antecedents and consequences might be considered as an adjunct to treatment, particularly given data on superior validity and adherence relative to the paper-based self-monitoring that often gets used by behavioral clinicians (Palermo, Valenzuela, & Stork, 2004). Tracking programs for mobile devices are available for certain pediatric pain populations (Stinson et al., 2006; Stinson et al., 2008), or basic programs that require only minimal computer knowledge can be self-developed using available free software (Weiss, Beal, Lucy, & MacDermid, 2004).

Summary and Conclusions

Behavioral evaluation and treatment have been well established as helpful components to managing children with chronic pain, but only a minimal subset of children receive treatment—primarily because of issues of accessibility. Computer technology may have the potential to aid in making these important approaches more broadly utilized, more individually tailored, and more cost-effective. Clearly, the technology tools studied by our group, as well as others, are not, nor likely ever will be, a panacea for pediatric pain conditions. Much more research is needed to determine the extent to which patient characteristics may modify the utility and efficacy of certain technologies such as Internet health interventions. Further, technology has not always been found to produce more superior outcomes or likeability than other cost-effective approaches to health interventions such as print media (e.g., Marks et al., 2006). Nevertheless, information technology has the capacity to help a far greater proportion of children that are challenged with chronic pain conditions than is currently possible with conventional clinic-based behavioral evaluation and treatment approaches. Future work will likely be directed at developing and testing increasingly "personalized" health interventions in pediatrics through technology like "Web 2.0 systems" that incorporate ongoing user data to tailor interventions (Timpka et al., 2008). Exciting and innovative research in technological tools for behavioral interventions likely will continue to blossom over the next decade and beyond to help address the growing public health concern of chronic pain and other health conditions in children and adolescents.

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It Doesn't Feel Good: The Biggest Obstacle to Condom Use Among College Students

James W. Sturges, J. Morgan Sims, Kareem Omar, Riye Balian, Cynthia Angell, and Julie Davenport, *California State Polytechnic University, Pomona*, and Scott C. Roesch, *San Diego State University*

According to the Centers for Disease Control and Prevention (CDC), about 13% of new annual HIV/AIDS diagnoses occur among youth aged 13 to 24 (CDC, 2008). Preventing HIV transmission should involve "well-targeted behavioral interventions that require commitment and sustained resources" (Kalichman, 2008, p. 334). An important component of prevention efforts is enhancing motivation (Fisher & Fisher, 1992; Fisher, Fisher, Williams, & Malloy, 1994; Kalichman, Picciano, & Roffman, 2008). In this regard, a combination of raising self-efficacy to use condoms and increasing perceived vulnerability to HIV has yielded the highest levels of protection motivation (see Rogers & Prentice-Dunn, 1997) and intentions to use condoms (Witte, 1992; Yzer, Fisher, Bakker, Siero, & Misovich, 1998). For example, threat appeals appear to be a valid method of HIV prevention, including among Latinos (e.g., Albarracin, Albarracin, & Durantini, 2008), who make up an important segment of the population in the present investigations. However, threat appeals should be combined with feasible and effective coping strategies (Rogers & Prentice-Dunn, 1997; Sturges & Rogers, 1996; Witte, 1992), and should take into account the listeners' readiness for change (Prochaska, Redding, Harlow, Rossi, & Velicer, 1994; Prochaska, Velicer, et al., 1994).

Sexually active youth may hesitate to use condoms based on perceived norms, communication with partners, or practical difficulties. In protection motivation theory, perceived drawbacks of following recommendations may affect self-efficacy as well as the "response costs" of engaging in recommended behaviors. Partner attitudes, for example, have been found to be very important for Caucasian and African American college women (Soet, Dilorio, & Dudley, 1997). Interestingly, however, in at least one study, response costs did not affect college women's intentions to practice safe sex (Raleigh, 2003). Also of interest is that Soet

and colleagues (1997) found differences across race for the impact of self-efficacy (it was more important for Caucasians than African Americans, but they did not include Latino and Asian American participants).

STUDY 1

We surveyed students at a large public university, measuring perceived vulnerability to HIV, response-efficacy (effectiveness) of condoms, and self-efficacy to use condoms. We also measured response costs, stage of change related to condom use, intentions to use condoms, and self-reported sexual risk behavior.

Statement of Purpose

The purpose of Study 1 was to explore the role of efficacy, vulnerability, and response costs across Asian American, Latino, and Caucasian young adults. We were also interested in how response costs and stage of change variables related to intentions to use condoms and self-reported sexual risk behavior.

Hypotheses

We predicted that higher levels of vulnerability, response efficacy, self-efficacy, and stage of change, but lower levels of perceived response costs would be associated with higher levels of intentions to use condoms, and less risky behavior, to be evaluated via regression analysis.

Study 1 Method

A group of 127 undergraduates in many different academic majors at our university completed a survey regarding their HIV knowledge (using an adaptation of the measure validated in Kelly, St. Lawrence, Hood, & Brasfield, 1989) and risk. There were 64 men and 63 women in the sample, which included 38% of Asian or Pacific Islander origin, 28% Caucasians, 21% Latinos (most of whom were Mexican American), 11% who endorsed "other," and 2% who did not

indicate their ethnicity. Ninety-five percent of the participants were single. Ages ranged from 18 to 40, with a median of 19.5 years (mean age 21.0, $SD = 3.2$ years). Ninety-three percent said their sexual behavior was exclusively directed toward the opposite sex. Forty-six percent said they were "not in a primary or serious relationship," 45% said they were "in a primary or serious relationship of less than 6 months," and 9% reported being "in a primary or serious relationship for more than 6 months." Only 28.6% of all participants reported having ever been tested for HIV; 44% of those in a relationship had been tested and 36% of their partners had been; fewer than 18% of participants in a relationship of more than 6 months had tested themselves and partner after being monogamous for 6 months (to allow seroconversion from previous sexual activity). However, only 4 participants reported having more than one partner in the last 30 days.

Using questionnaire items with 9-point Likert scales of agreement, which ranged from *strongly disagree* (1) to *strongly agree* (9), a three-item Vulnerability scale was developed for this study that was comprised of the items stating that the participant was vulnerable to contracting HIV, somewhat at risk, or could possibly get HIV given current behavior. Cronbach's alpha was .70.

Four self-efficacy (whether participants felt confident that they could use condoms) and the two response efficacy items (condoms are effective in preventing HIV, and a reverse-scored statement that condoms are not that useful in stopping it) were combined to form an Efficacy variable (Cronbach's alpha = .69)

Perceived response costs of and barriers to condom use were queried with seven items written for this study that asked whether condom use might create a hassle, suspicion, interpersonal difficulties, or reduce pleasure. The scale had a Cronbach's alpha of .80.

Dependent Measures

Readiness for change. Participants were asked to indicate level of agreement on 9-point Likert scales with statements that "I see no reason to change my behavior patterns regarding condom use at this time," "I have given serious thought to taking steps toward improving and practicing behaviors that will reduce my risk of HIV," "I have made some unsuccessful attempts to change risky sexual behaviors in the past, but I intend to try again," "I have already taken steps to reduce my risk of getting

HIV,” and “I have made changes that reduce my risk of getting HIV and I have stuck with them for more than 6 months now.” Participants’ stage of change was coded based on the strongest statement with which they indicated agreement or strong agreement. This is a well-validated “categorical staging algorithm” (Grimley, Riley, Bellis, & Prochaska, 1993, p. 459).

Intentions with primary partners. Two statements regarding intentions to use condoms with primary partners in the next 6 months, written for this study, had an r of .69 (participants selected answers from 9-point Likert scales of agreement to the item, “I intend to use condoms with intercourse in the next 6 months with my PRIMARY partner,” and the reverse-scored item, “I have no plans to use condoms with my PRIMARY partner”). In past studies, intentions have been consistently related to condom use (Kalichman, 2007).

Intentions with casual partners. The two intention items regarding casual partners written for the study had an r of .79 (“If I have intercourse with any CASUAL sex partners in the next 6 months, I intend to use condoms,” and the reverse-scored item, “If I have intercourse with any CASUAL sex partners in the next 6 months, I have no intentions of using condoms”).

Self-reported behavior. Participants were queried regarding the number of times in the past 30 days that they had engaged in sexual intercourse (vaginal or anal), and how many times they had used a condom during intercourse (using fill-in-the-blank questions).

Study 1 Results

HIV-related knowledge was high (12.8 correct answers out of 15). Participants disagreed ($X = 3.9$, $SD = 1.8$) that they were vulnerable to HIV. They even disagreed with an item stating that they were “somewhat at risk” ($X = 4.0$; $SD = 2.1$). Participants acknowledged having intercourse without a condom on an average of 2.2 times ($SD = 5.3$) in the last 30 days. Even when perceived vulnerability was examined among only those who acknowledged having intercourse without a condom in the last 30 days, they still did not agree that they were at risk ($X = 4.3$, $SD = 1.6$; the same results were obtained when this was limited to only those in a current relationship). Participants in a current rela-

tionship had intercourse without a condom an average of 4.0 times ($SD = 6.6$).

Perceptions of risk did not vary by ethnic group. Forty-two percent of the participants had intercourse in the past month, and of those, 62% failed to use condoms at least once. Self-efficacy and response-efficacy ratings were moderate (X s = 6.6–6.9, SD s = 1.1–1.9) and did not differ across ethnic groups, $F(2, 106) = .46$ ($p = .633$) and $F(2, 105) = 1.92$ ($p = .152$), respectively. Perceived response costs averaged 3.0–3.1 (SD s from 1.1 to 1.4) and did not vary by ethnic group, $F(2, 105) = .012$ ($p = .99$). Men reported higher response costs of using condoms ($X = 3.3$, $SD = 1.3$) than did women ($X = 2.7$, $SD = 1.3$), $t(123) = 2.52$ ($p = .013$).

Gender¹, ethnicity, self-efficacy, response-efficacy, vulnerability, Efficacy \times Vulnerability, and response costs were regressed onto (a) proportion of intercourse without a condom, (b) intentions with casual partners, (c) intentions with primary partners, and (d) stage of change. The only significant predictors are described below.

Proportion of Intercourse Without a Condom

There was a significant overall effect on self-reported recent unsafe sex: $R^2 = .368$, $F(7, 34) = 2.83$ ($p = .02$). Efficacy \times Vulnerability (multiplied to create an interaction term for use as a predictor in linear regression; Aiken & West, 1991) was a significant predictor: Beta = -1.99 ($p = .038$). This interaction term, as expected, predicted less unsafe sex. When Efficacy and Vulnerability levels were both high, less unsafe sex had occurred. Ethnicity, limited to the three major ethnic groups, was also a significant predictor: Beta = $.352$ ($p = .035$). Latinos had a significantly ($p < .05$) higher proportion of unsafe sex (69%) than Asian Americans (23%), and Caucasians (55%). Results were nonsignificant in a separate regression analysis examining the interaction effects of ethnicity and Efficacy ($p < .064$) and ethnicity and Vulnerability ($p < .338$) on proportion of intercourse without a condom.

Intentions

There was a significant overall effect on intentions with primary partners: $R^2 = .237$, $F(7, 55) = 2.44$ ($p = .03$). The only significant predictor was response costs:

Beta = $-.296$ ($p = .035$). The higher the response costs, the lower the intentions.

There was a significant overall effect on intentions with casual partners: $R^2 = .174$, $F(7, 106) = 3.19$ ($p = .004$). Response costs were significant, Beta = $-.222$ ($p = .045$). As response costs increased, intended condom use decreased, as expected. Ethnicity was also significant: Beta = $.215$ ($p = .018$). Average casual-partner intentions were higher for Latinos ($X = 8.2$, $SD = 1.4$) than Asian Americans ($X = 7.5$, $SD = 1.8$), and were higher for Caucasians ($X = 8.1$, $SD = 1.3$) than Asian Americans ($p < .05$).

Stage of Change

There was a significant overall effect on stage of change: $R^2 = .217$, $F(7, 111) = 4.40$ ($p = .001$). Self-efficacy was a significant predictor: Beta = $.523$ ($p = .001$). Ethnicity was also a significant predictor: Beta = $.170$ ($p = .048$), but the ethnic group differences were not significant in the follow-up regressions ($p > .05$).

Study 1 Discussion

Only a combination of vulnerability and efficacy variables in high levels was associated with lower proportions of recent unsafe sex. This illustrates the importance in HIV prevention of addressing perceptions of low vulnerability to HIV in combination with beliefs in the capacity to relatively easily increase safety by using condoms. Higher self-efficacy was strongly associated with more advanced stages of change. It makes sense that feeling efficacious about using condoms was associated with having taken successful steps toward doing so. Latinos had more unprotected intercourse than Caucasians and Asian Americans, but ironically Latinos and Caucasians reported higher levels of intentions to use condoms than did Asian Americans. Exploration of the reasons for different patterns in self-reported past behavior and intended future behavior are warranted, and could be due to specific biases such as socially desirable responding regarding future behavior.

The only significant predictor of intentions to use condoms (less) in the future was response costs. Men perceived higher response costs of condom use than did the women. Men in our study more than women viewed condoms as a hassle, offensive to partners, or likely to reduce sexual pleasure.

¹Gender was coded as men = 1, women = 2. Ethnicity coded as API = 1, African American = 2, Caucasian = 3, Native American = 4, Other = 5, Latino = 6.

STUDY 2

It was clear from Study 1 that although protection motivation could be enhanced in a predictable manner, the response costs of using condoms could make intended use less likely and were important among college students. We wanted to study possible response costs of condom use in an experimental fashion to better evaluate the effects of likely barriers to use. We thus created and administered vignettes that operationalized four previously established barriers to condom use, those of the Condom Barriers Scale (CBS; St. Lawrence et al., 1999). The CBS uses 5-point Likert scales of agreement with 29 face-valid items pertaining to its four factors. In previous studies the four internally consistent factors have been retained and have been shown to relate to recent condom use (Calsyn, Doyle, Hatch-Mailllette, & Song, 2006).

Statement of Purpose

The purpose of Study 2 was to study the relative effects of four barriers to condom use for men and women, in a within-subject design comparing intention ratings following each of four vignettes.

Hypotheses

It was predicted that the Effect on Sexual Experience vignette would result in significantly lower intentions than the other vignettes for the male participants, who are anatomically most likely to have sensation affected, followed by access to condoms, partner-related issues, and motivation/involvement/commitment (these factors are discussed in more detail below). Because of the possibly greater needs for communication and assertiveness by women to ensure condom use by their male partners, it was predicted that the partner-related issues would result in significantly lower intentions than the other vignettes among female participants, followed by motivation/involvement/commitment, followed by effect on sexual experience, followed by access to condoms. Comparisons across vignettes were conducted with repeated-measure ANOVAs and follow-up comparisons.

Study 2 Method

The four established factors were condom access, partner-related issues, effect on sexual experience, and "motivation." They incorporated communication barriers and some of the physical difficulties of condoms. Condom access may be a particularly important variable among youth (Empelen &

Kok, 2008). The Motivation scale included forgetting to use condoms, not wanting to put one on a partner, "I never catch anything," "I use another method," "I feel less involved or committed," and "Most of the time neither of us has a condom available." Because the CBS was written for women, we developed a parallel men's version (as did Calsyn et al., 2006) so that we could administer the CBS to men and women, in an Asian-American, Latino, and Caucasian sample of varied socioeconomic status.

A group of 332 undergraduates in many different academic majors at our university were recruited to participate in exchange for extra credit (49% women and 51% men). The sample included 40.1% identifying themselves as primarily Asian or Pacific Islander, 27.6% as Caucasian, 23.1% as Latino, and 1.9% as African-American. Ages ranged from 18 to 57, with a median age of 22 (mean age 23.0, $SD = 5.1$ years). Only 6 participants (1.8%) acknowledged having current or previous same-sex partners. In terms of socioeconomic status, median parent income was \$60,000 annually ($SD = \$49,200$), with a mean of 2.9 years of college for at least one parent ($SD = 2.3$). Their families had on average 3.1 children ($SD = 1.6$).

All participants read four vignettes derived from the CBS factors, completed 10-point Likert ratings of agreement with six items regarding intentions to use condoms in each of those situations, the CBS, and a one-page demographic questionnaire. In order to develop the (heterosexual) men's version of the CBS, items were changed as necessary such that the partner was referred to with the feminine pronoun rather than the masculine (e.g., "If I suggested using a condom she might end the relationship"). Item 2, "I don't want to put a condom on my partner," was changed to "I don't want my partner to put a condom on me." Item 14, "... he might be turned off or lose his erection/hard on," was changed to "... she might be turned off or lose her lubrication/slipperiness." Item 23, "It's up to the man to provide a condom," became "It's up to the woman to provide the condom."

The four vignettes that all participants read were based on high-loading items from their related CBS subscales. This was the Access Difficulty vignette:

You and your partner are planning to be intimate later in the evening. You want to purchase condoms, but you are concerned about the cost, where to buy them, and how to get there. You are also

embarrassed about being seen buying condoms. You wonder whether this is your responsibility.

This was the Partner Reactions vignette:

You and your partner are planning to be intimate later in the evening. You want to use a condom, but are afraid of discussing it with your partner. You worry that your partner might think you are untrusting, might take it as an insult, and might even get angry. You wonder whether it is worth an argument.

This was the Effects on Experience vignette:

You and your partner are planning to be intimate later in the evening. You want to use a condom, but have some concerns. You and your current partner were discussing this recently and believe that condoms reduce sensation and feel unnatural. You wonder whether it is worth these problems.

This was the Involvement/Commitment vignette:

You and your partner are planning to be intimate later in the evening. You want to use a condom, but have some concerns. You and your current partner were discussing this recently and believe that condoms make people feel less involved and committed to the relationship. You wonder whether it is worth these problems.

Study 2 Results

Condom Barriers Scale Results

A principal components factor analysis with varimax rotation was performed on the women's and men's scales. Factors were retained if their eigen-values exceeded 1.

For both women and men, a similar set of four factors to St. Lawrence and colleagues' (1999) each explained more than approximately 5% of the variance. The internal consistency of the subscales as measured by Cronbach alphas within genders was moderate to high, .68–.93, for the CBS and subscales, other than the group of four items that emerged for men as the Motivation subscale (.54). The alphas on the Intention scales ranged from .86 to .92.

Women. A repeated measures ANOVA found differences in women's mean item scores on the original CBS subscales, $F(3, 157) = 240.02$ ($p < .001$). The highest scores (most agreement with problems

listed) were on the Experience subscale, which was significantly higher than the Access subscale ($p = .001$), which in turn was higher than the Motivation and Partner subscales ($p = .001$).

Men. A repeated measures ANOVA found differences in men's mean item ratings across the men's CBS subscales derived from the factor analysis on this sample, $F(2, 155) = 287.71$ ($p < .001$). In paired sample t -tests, the highest level of agreement was given to Experience as a barrier, followed by Partner barriers, followed by Access barriers, followed by Motivation barriers ($p < .001$).

Vignette Results

Women. There were significant differences in women's intentions to use condoms following the different vignettes, $F(3, 159) = 10.23$ ($p < .001$). Follow-up paired t -test comparisons found that Intentions following the Effect on Experience vignette were significantly lower than those following the Involvement/Commitment vignette ($p < .001$). Involvement/Commitment scores were significantly lower than Partner Reaction scores ($p = .011$).

Men. There were significant differences in men's intentions to use condoms across the vignettes, $F(3, 153) = 5.27$, $p = .002$. Paired t -test follow-up comparisons indicated that there were the lowest Intentions to use condoms in the Effect on Experience and Involvement/Commitment conditions, which each resulted in lower intentions than the both Partner Reactions and Access Difficulty conditions ($p < .008$).

Study 2 Discussion

Men's intentions were, as expected, affected more by the perceived effects of condoms on sexual experience than by other concerns, and they considered this the biggest drawback of condoms, followed by access barriers, followed by concerns about partner reactions. Similarly, their scores on CBS items reflected this pattern. In a follow-up analysis of an item asking participants to rank the scenarios, however, participants chose the access barrier scenario as least likely to involve condom use (a reasonable assumption if intercourse occurs, given that the access barrier might have precluded condom availability).

Contrary to our expectations, women were similar to men in reporting the biggest drawback of condoms to be the effect on sexual experience. This reduced women's intentions to use condoms. It was followed by (a) problems with access and availability

of condoms, (b) effects on involvement and commitment, and (c) concerns about partner's reactions to condom use, respectively.

Unfortunately, it is not clear from CBS item wording (or our vignette wording) whether negative effects on sexual experience should be interpreted to include negative effects on partners' sexual experiences. Items that say that condoms do not feel good, rub and cause irritation, or change the orgasm fail to specify whether these effects are happening to the woman herself. In order to try to get at this issue, we looked specifically at the correlation between Item 14, "If I suggested my partner use a condom he might be turned off or lose his erection/hard on" (a Partner barrier item), and the Sensation subscale for female participants. The correlation was $r = .442$ ($p < .001$). For comparison, consider the Sensation subscale correlation with Partner barriers in general, $r = .354$ ($p < .001$). It appears that whereas women in our study denied that worries about partner reactions influence their choices not to use condoms, their concerns about the effect of the condom on the partner's sexual experience is very important. It is not clear how condoms are perceived by women to affect their own sexual experience apart from the effect on men's sexual experience. Future research should include items that are self-directed (e.g., "I might lose my arousal").

U.S. women do not consider themselves powerless in condom choices. Cabral, Pulley, Artz, Brill, and Macaluso (1998) interviewed 441 women in public health clinics and found only 5% felt they had no control of condom use. However, worries about losing the relationship was associated with inconsistent condom use and failure to ask for condom use when they desired them. This may point to specific high-risk situations for women, especially in combination with the perception that men will not enjoy sex as much if using condoms, or beliefs about involvement and commitment that may result in reduced intentions to use condoms. This may suggest that prevention efforts with college students should continue to include social norms information supporting the idea that condom use is typical and expected of men, and that sex with condoms is potentially even more enjoyable because there is less to worry about from pregnancy, STDs, and HIV. Relatedly, changing men's perceptions regarding the drawbacks of using condoms may increase the likelihood of condom use, especially among Latinos, who reported having more unsafe sex, and Asian Americans, who reported lower levels of intentions to use con-

doms in future casual sexual encounters. In clinical practice, discussion of safe sex should elicit the drawbacks of condom use as perceived by the client, the ambivalence resulting from that, and goals for future behavior, as is often done in motivational interviewing.

We have to consider the possibility that the relatively lesser importance of partner reactions in this sample may be due to higher self-efficacy among college women than women without any college education, some degree of negative reaction to implications in the measures that they would be swayed by partner-pressures, or artifacts of paper-and-pencil measures and social desirability.

Limitations of this study included the fact that the order of the vignettes was not randomized (the order was Access, Partner, Experience, and Involvement/Commitment). Although there is not reason to believe that an order effect occurred, we cannot rule out that possibility. Additionally, the rather artificial nature of presenting vignettes and the reliance on metacognition to induce perceived response costs causes concern about the generalizability of the findings to real situations. It is also possible that because the vignettes mention "your current partner," they are less generalizable to more casual encounters. However, the vast majority of our students report being monogamous, albeit sometimes serially so when they move to a different relationship. These monogamous relationships may themselves serve to discourage condom use, sometimes justifiably so, as does the use of other birth control strategies within these relationships. When asked why they did not use condoms during intercourse, 6 of our participants mentioned both monogamy and other birth control, 6 others alluded to other birth control but not monogamy, and 9 others monogamy but not other birth control.

In a large study of naturally occurring obstacles to condom use, Murphy, Stein, Schlenger, Maibach, and the NIMH Multisite HIV Prevention Trial Group (2001) found that a model that combined the situational context (type of partner, whether drinking, reason for sex), and level of difficulty (talking about safe sex, convincing a partner who hates condoms, sex when both prefer not to use condoms, and leaving the situation if unsafe) best predicted condom self-efficacy. Expectations that individuals have regarding the effects of alcohol on their sexual behavior may be particularly relevant to the college population (Abbey, Parkhill, Buck, & Saenz,

2007). Because these issues are so important, it is crucial to continue to explore a variety of environmental factors that interfere with intentions to use condoms or keep intentions from being translated into action. Research that involves daily diaries and personal digital assistants to document and study mental processes associated with safe versus risky practices may be especially promising for health promotion in general.

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The NIMH Professional Coalition for Research Progress 2008 Report

Steven E. Bruce, *University of Missouri, St. Louis, ABCT Committee on Research Agenda*

The National Institute of Mental Health (NIMH) held its fourth annual Professional Coalition for Research Progress (The Coalition) Meeting on April 18, 2008, in Washington, DC. The major themes of the meeting included the state of NIMH as well as specific discussion regarding hot-topic areas including PTSD, autism, and schizophrenia. The meeting allowed participants the opportunity to (a) hear about exciting and new mental health research; (b) discuss important information on changes in the field; (c) network with colleagues and discuss issues relevant to stakeholders; and (d) interact with and express their views directly to the NIMH Director, Dr. Thomas Insel, and senior-level staff. Participants included approximately 25 representatives from professional organizations with an interest in NIMH research as well as NIMH staff (program officers, scientific review administrators, etc). Thus, the goal of the meeting was to allow the scientific community to provide comment on the following topics:

The State of NIMH

Dr. Insel opened with an update on current NIMH research priorities and directions. In a brief review, Dr. Insel discussed recent genome-wide association studies in mental disorders as well as recent findings from brain imaging studies across a variety of mental illnesses to underscore NIMH's position for the following statements:

1. Mental disorders are brain disorders.
2. Mental disorders are developmental disorders.
3. Mental disorders result from complex genetic risk plus experiential factors.
4. Current treatments for psychological disorders may be necessary but not sufficient for recovery.

In his presentation, Dr. Insel stated that while genomic studies will likely not yield a diagnostic test, identify a cause, or develop specific gene therapies for mental disorders,

these genetic studies can identify risk and reveal mechanisms for disease. Thus, genomic research can point to new targets for prevention and treatment. Dr. Insel also noted that today's current treatments for some mental disorders are not as beneficial as they clearly need to be. Current treatments help too few people get better and very few get well. Using schizophrenia as an example, Dr. Insel noted the high rate of discontinuation of antipsychotics (74%) for individuals and the limited access of psychosocial treatments. Additionally, he noted high rates of relapse and medical comorbidity for individuals with bipolar disorder, as well as few proven psychiatric or behavioral approaches for individuals with autism. Thus, one major goal of NIMH is to optimize care in real-world settings.

Given these findings, Dr. Insel emphasized that investing in the science of mental health disorders has never been more urgent. Unfortunately, with the current budget crisis, the projected NIMH budget for 2009 is expected to be only .1% higher than 2008. This, in essence, is a decline in the NIMH budget given the annual rise in inflation, which will be the fifth year in a row the NIMH budget has declined after controlling for yearly inflation. Thus, Dr. Insel reported that it is likely that the NIMH success rate for principal investigators will be lower than previous years, with a possibility that the total success rate will be below 15% for the first time in many years.

With the fiscal realities as they are, Dr. Insel again emphasized the major objectives of NIMH's overall strategic plan. Grant applications examining these objectives are likely to get more consideration as the Institute becomes more stringent with the allocation of grant dollars. The major objectives of the NIMH strategic plan are:

Objective 1: Promote discovery in the brain and behavioral sciences to fuel research on the causes of mental disorders (i.e., genes to circuits to behavior).

Objective 2: Chart mental illness trajectories to determine when, where, and how to intervene (e.g., biomarkers).

Objective 3: Develop new and better interventions for mental disorders that incorporate the diverse needs and circumstances of people with mental illness (i.e., personalized medicine, more accessibility to care).

Objective 4: Strengthen the public health impact of NIMH-supported research (e.g., measure success as an Institute by how investments in research alter clinical practice).

PTSD and Traumatic Stress: Public Health and Disasters, War and Trauma

Dr. Robert Ursano, Director for the Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences (USUHS), discussed recent findings related to soldiers returning from Iraq and Afghanistan as well as studies examining PTSD symptoms in individuals exposed to Hurricane Katrina. Specifically, Dr. Ursano discussed being able to define the "structure of trauma," which would allow for helpful interventions to be administered at different points of the trauma. The presentation focused on three responses to trauma: disaster risk behaviors, disaster mental health, and distress and the importance of public health care for the population after disaster.

Disaster behaviors. Dr. Ursano said that it is important to understand behavioral responses to disaster. After the trauma, there is often a "honeymoon effect" that takes place that brings communities together. However, this period is often short-lived and is followed by a period of anger and disbelief when communities ask questions related to why the disaster happened and how it could have been avoided. Dr. Ursano also noted that communities affected by disaster may not be localized to the geographic location where the disaster occurs. For example, Dr. Ursano stated that the psychological effects from Hurricane Katrina do not just affect the New Orleans area, but have a large ripple effect throughout the country as many residents have moved all over the country after the disaster.

Disaster mental health. Dr. Ursano discussed that having a strong and responsive mental health infrastructure is important at all times and not only in times of disaster. He reviewed the literature demonstrating the escalation of psychological disorders following disasters, including PTSD and de-

pression; as well as an increase in cognitive behavioral symptoms such as insomnia, irritability, and an increase in health risk behaviors such as alcohol consumption and smoking.

Public health. Dr. Ursano emphasized that there are significant public health concerns during and immediately following a disaster, as access to medical care and other mental health services decrease in time of disaster (while the number of individuals needing treatment exponentially increases). Thus, this limited access to care greatly influences who receives treatment. He also noted that displacement and the mobility of individuals after disaster make it difficult for mental health practitioners to provide continuous treatment to individuals, further increasing the problem of the continuum of care following a disaster.

Upon completion of the presentation on PTSD, Dr. Insel also discussed the coordinated efforts from the NIMH and the DOD to assist in increasing funds available for research into PTSD (in light of both the budget realities of NIMH as well as the increasing number of combat soldiers returning with PTSD).

Autism

Dr. Susan E. Swedo, Chief of Pediatrics and Developmental Neuropsychiatry Branch at NIMH, discussed recent advances and discussed potential future studies for the treatment of autistic spectrum disorders (ASD). She indicated that they are continuing to examine both genetic and environmental triggers to the development of autism. Specifically, they are focusing on the exposure of a very high fever during a specific developmental window as a possible contributor to the development of autism. She also stated that they are narrowing their focus to the onset date between 12 and 18 months, as research is showing that it appears that most children diagnosed with autism began to have associated symptoms during this time period.

Dr. Swedo discussed the urgent need to conduct studies to examine the environmental factors that may play a role in the development or exacerbation of ASD. In order for these studies to occur, Dr. Swedo noted that several clinical factors need to be addressed, including: developing a standardized definition of autism and related disorders; collecting incidence data from populations with disparate risk factors; systematic evaluation of anecdotal case reports; randomized controlled trials of novel therapeutics (i.e., reliable, valid, develop-

mentally appropriate, and change-sensitive outcome measures); and identification of clinically meaningful subtypes of ASD (i.e., onset and clinical presentation, associated symptoms and clinical course, medical and behavioral comorbidities, sensitive and specific biological/behavioral markers).

Finally, Dr. Swedo discussed future studies of autism that include the examination of the role of anxiety in young children with ASD, examining the role of oxytocin in social cognition, and identification of potential environmental triggers of autism. Additionally, delineation of medical and behavioral abnormalities in ASD with a focus on identifying treatment targets, identification of biomarkers of treatment response, and collaboration with basic neuroscientists to take "bedside findings" to the bench.

Prodrome of Schizophrenia: New Opportunities for Early Detection and Intervention

Dr. Robert Heinssen, the Acting Deputy Director of the NIMH Division of Services and Intervention Research, discussed recent advances into the understanding of schizophrenia, including research examining ways in which schizophrenia can be detected earlier to enable more effective treatments. He stated that the 2-year period preceding the onset of the first psychotic episode is usually marked by an increasing symptomatic presentation and functional deterioration, including cognitive impairments, behavioral disturbances, and anxiety, depression, hostility. Dr. Heinssen noted that this 2-year period preceding psychosis onset is a critical interval for studying neurobiological processes associated with emerging psychotic symptoms and disorganization. Research examining neuronal volume reduction, reduced cortical connectivity in prefrontal and temporal lobe regions, and altered cortical plasticity could be done to examine if there are changes during this prodromal period. With specific assessments (i.e., use of the Structured Interview for Prodromal Syndrome [SIPS]) utilizing drug use history, genetic risk, social impairment, Dr. Heinssen reported that it is now possible to predict the onset of initial psychosis with 81% accuracy.

In a discussion of future directions, Dr. Heinssen discussed the need for studies to confirm that the prediction algorithm with positive predictive power greater than 80% can be replicated. Additionally, examination of clinical risk factors, neurocognition, and biomarkers of schizophrenia continue

to be a research priority. Moreover, Dr. Heinssen emphasized the need for studies examining mechanisms accounting for psychosis onset such as neural, hormonal, and cognitive pathways, as well as exogenous triggers (trauma, substance abuse, etc.). Finally, studies looking at alternatives to antipsychotic therapy are needed, including research examining lithium, Omega-3 fatty acids, and Glycine in the treatment of schizophrenia as well as research examining cognitive and behavioral exercises to strengthen residual adaptive capacity.

Of note, following Dr. Heinssen's presentation, Dr. Insel asked about the advances in CBT to treat individuals with schizophrenia. He stated that the outcome data showing quality-of-life improvements were extraordinarily impressive and asked why there has not been more publicity in this area. He also questioned why the NIMH is not funding more studies examining the effects of CBT on symptom reduction and quality-of-life improvement in individuals with schizophrenia. Dr. Insel instructed his staff to begin to put together a call for such research proposals.

Discussion

During the course of the meeting, coalition members had the opportunity to direct questions and comments to Dr. Insel, senior NIMH staff, and presenters about any topic of concern. Of note, in response to a question if NIH will form relationships with pharmaceutical and biotech companies to promote the development of new medications, Dr. Insel emphasized that drug development is not NIH's focus and that it is left to the pharmaceutical companies to have a drug development pipeline in place. He further stated that other treatments, such as CBT, must still be funded given the efficacy of CBT across numerous mental disorders. At the conclusion of the meeting, Dr. Insel summarized the major points discussed and thanked coalition members for providing helpful feedback and expertise. Additional information regarding this meeting is available on the NIMH website at: www.nimh.nih.gov/health/outreach/coalition/coalition-summary-4-18-08.pdf

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David Miklowitz's Family-Focused Therapy Featured in *The New York Times*

Felice Reddy and David DiLillo, *University of Nebraska*

David J. Miklowitz, Ph.D., professor of psychology and psychiatry at the University of Colorado and ABCT member, was featured in a *New York Times* article entitled "Clinic Treats Mental Illness by Enlisting the Family" (Hartocollis, 2008). The article offers an inside look into Dr. Miklowitz's Family-Focused Therapy (FFT) for the treatment of bipolar depression, as being implemented in the Family Center for Bipolar Disorder at Manhattan's Beth Israel Clinic.

Dr. Miklowitz developed FFT to address family issues, particularly communication and problem solving, in the context of bipolar disorder. FFT helps patients and relatives develop a shared understanding of environmental factors that may increase vulnerability to mood episodes and address barriers to medication adherence. In FFT, family members of the client are not targeted for treatment (as they are in family therapy), but rather are included as part of a comprehensive approach to managing the patient's illness. Family members are viewed as being especially useful in recognizing potential triggers for the person with the diagnosis. Adrian and Helen are two clients of the clinic who gave permission to be highlighted in the article. During sessions, the patients and their family members processed past manic or depressive episodes and worked together to brainstorm the risk factors and warning signs. Dr. Igor Galynker, the clinic's cofounder, explained to the *Times* reporter that family members are in the best position to catch the early warning signs of a manic or depressive episode because they know the person very well; he said it can even be as "subtle as a change in lipstick shade."

A unique feature of the article is that the reporter, Anemona Hartocollis, sat in on actual therapy sessions with families in order to gain an inside view of the novel treatment. This allowed her to observe the process of transforming bipolar disorder from a baffling and isolating enemy into a common foe, which can be approached with the help of loved ones. Hartocollis gives detailed descriptions of Adrian's and Helen's

personal experiences with mania and depression and the ways in which their family members can offer support. For example, during Adrian's therapy session, his sister describes how difficult it has been for the family to help him through his severe highs and lows. His siblings and girlfriend discuss the emotions they had when he impulsively flew across the country to self-deliver an email, or when he had the desire to jump from their New York rooftop. However, the article notes that FFT has vastly increased Adrian's recovery time from his most recent manic phase. He and his siblings report that with FFT he has returned to a level of improved functioning and regained his self-esteem within 3 months, a process that took him 2 years without FFT. During Helen's therapy, she discusses the fact that math and numbers are triggers for her, describing the movie *Swordfish* as an example, and then explains how her mania quickly swirls into a debilitating depression. During session the idea is generated that her brother could be a person to incorporate into her daily life, while her husband is at work, to help make sure she stays safe.

Dr. Galynker and his patients at the FFT clinic at the Beth Israel Medical Center agreed to open the therapy sessions to the reporter in an effort to reduce the stigma that surrounds mental illness and prevents many people from confiding in their loved ones. One of the stated goals of the article is to increase public knowledge about the symptoms of the disease, its hereditary nature, and the fact that there is support available for families affected by bipolar disorder.

Recent research supports the use of FFT with bipolar patients. Dr. Miklowitz is quoted in the article affirming that FFT combined with medication consistently results in quicker recoveries and longer intervals of wellness, in comparison with other therapies. He goes on to say that in addition to less frequent relapses, "functioning improves, including relationship and family functioning." Indeed, a recent large-scale randomized controlled trial published in the *Archives of General Psychiatry* (Miklowitz et al., 2007) supports the use of psychother-

apy in general, and FFT in particular, in conjunction with medication for bipolar disorder. In the study, 293 participants from 15 clinics were assigned to one of three long-term intensive psychotherapy treatments (FFT, Interpersonal and Social Rhythm Therapy, or CBT) or to a short-term collaborative care protocol. The results indicated that FFT as well as the other psychotherapies were related to delayed relapses, reduced symptom severity, and improved relationship and family functioning, when compared with collaborative care treatment. In a second study, Miklowitz and his team found that FFT in combination with pharmacotherapy was especially effective in managing bipolar depressive symptoms among adolescents over a 2-year period (Miklowitz et al., 2008). These studies indicate that FFT in combination with medication offers an innovative and promising approach to the management and treatment of bipolar disorder. The full text of the article can be accessed at: www.nytimes.com.

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Book Review

Hopko, D. R., & Lejuez, C. W. (2007). *A Cancer Patient's Guide to Overcoming Depression and Anxiety*.

Oakland, CA: New Harbinger.

Reviewed by Lisa M. Thornton and Barbara L. Andersen, *Ohio State University*

A diagnosis of cancer can be devastating. Patients may be overwhelmed with the necessities of the diagnosis, such as choosing physicians, making treatment decisions, coping with side effects of treatment, navigating financial strain, and managing the disruption to the family. With all these stressors, emotional difficulties such as anxiety and depression are likely. In fact, data suggest 30% to 50% of patients studied meet criteria for mood or anxiety disorders (Burgess et al., 2005; Derogatis et al., 1983), with depression being the most common (van't Spijker, Trijsburg, & Duivenvoorden, 1997).

Unfortunately, depression and anxiety often go unrecognized and untreated. Patients and medical staff may trivialize such emotional reactions as normal. For example, among 112 women with major depression undergoing cancer treatment, Ell et al. (2005) found that few were being treated: only 12% were receiving antidepressants and only 5% were receiving psychological therapy. Excepting the most obvious (e.g., suicidal ideation; Oquendo et al., 2004), psychopathology symptoms may be trivialized as a "normal" reaction by patients and medical staff, and/or they may be recognized but interpreted as due only to impaired physical status (Evans et al., 2005). Indeed, studies show that oncologists and nurses detect depressive symptoms in only a third of the patients who have them and then underestimate their severity (McDonald et al., 1999; Newell, Sanson-Fisher, Girgis, & Bonaventura, 1998).

In ideal conditions, patients would receive psychological intervention designed with cancer patients in mind. In fact, such treatments have been designed and are, in general, efficacious (Andersen, 1992; Meyer & Mark, 1995; Osborn, Demoncada, & Feuerstein, 2006). Although patients may find memoirs or other sources of advice in bookstores, empirically supported techniques are not widely available. Thus, it is significant that Hopko and Lejuez have

published a self-help book based on empirically supported treatments for people coping with anxiety and depression after a cancer diagnosis.

A Cancer Patient's Guide to Overcoming Depression and Anxiety is a sensible collection of intervention strategies that have been used in empirically supported psychological treatments for medically ill people. Hopko and Lejuez have selected strategies that are straightforward and likely to be accessible and useful for most consumers. After educating the reader about cancer, cancer treatments, depression, anxiety, and avoidant coping, this book guides patients through a self-directed program of behaviorally oriented treatment. The main thrust of the treatment is behavioral activation, but other useful strategies are described: problem solving, interpersonal assertiveness training, strategies for specific physical symptoms, and relaxation (progressive muscle relaxation, mindfulness, and self-hypnosis). This treatment was successfully piloted in an individual therapy setting by Hopko and colleagues (2008). There were clinically significant improvements for all 18 patients who completed the program and patients were highly satisfied with the treatment. The authors have not tested the efficacy of the intervention when self-administered.

While the intervention presented in this book has not been tested in a randomized clinical trial, evidence suggests that it would be efficacious. First, each of the strategies has been shown to be efficacious in other settings. Behavioral activation for depression, for example, was as effective as cognitive behavioral therapy in a recent clinical trial (Dimidjian et al., 2006). Relaxation in its various forms is frequently used in the treatment of distress for patients with medical illness and as a component of treatment for anxiety disorders (Andersen, 1992; Manzoni, Pagnini, Castelnuovo, & Molinari, 2008). It can reduce anxiety and may treat physiologic manifestations of anxiety and reduce symptomatology (e.g.,

chemotherapy nausea/vomiting, fatigue, sleep problems; Luebbert, Dahme, & Hasenbring, 2001). In our clinical trial of a group psychological intervention for breast cancer patients, relaxation was taught, and frequency of relaxation use correlated with the reductions in distress and reductions in physical symptoms/signs of illness (Andersen, Shelby, & Golden-Kreutz, 2007). Second, a recent review of self-help strategies for depression suggests that many of the components included in *A Cancer Patient's Guide* are effective when self-administered. Reviewing the small numbers of randomized trials of self-help strategies, Morgan and Jorm (2008) concluded that evidence is suggestive (but not conclusive) for the effectiveness of bibliotherapy, relaxation, and positive activity scheduling in reducing depressive symptoms.

The book's opening chapter begins with a clear description of cancer disease processes and basic information about the most common treatments: surgery, radiation, and chemotherapy. Information about depression and anxiety follows, including information about pathological forms of these states. Education alone can be an effective distress-reducer (Scheier et al., 2005). It can help alleviate unnecessary fears, increase a sense of control, and, most importantly, normalize patients' emotional reactions to their situation. Hopko and Lejuez present the information in a sympathetic, no-nonsense style that may appeal to readers. Some readers—who are, no doubt, overwhelmed and already inundated with information about cancer and treatments—may find these early chapters to be overly academic or burdensome. Patients who are struggling with depression may lack the necessary concentration or motivation required to persevere through 4 weeks of education prior to the introduction of active distress-reduction strategies. However, the information would likely be valuable for those who utilize it.

A significant strength of this book is contained in the fourth chapter, a focus on avoidance as a detrimental coping strategy. Our data suggest that use of avoidance coping strategies was likely among patients who reported high levels of stress after a diagnosis of recurrent breast cancer (Yang, Brothers, & Andersen, 2008). More important, use of avoidance strategies significantly predicted poorer quality of life for all patients. Although less commonly used than approach coping, avoidance should be discouraged for all patients. Hopko and Lejuez describe avoidance strategies and explain their dangers and then proceed to pre-

sent a series of approach-oriented strategies in the subsequent chapters.

Behavioral interventions make up the majority of the workbook, with behavioral activation receiving the greatest emphasis. Hopko and Lejuez present each intervention in a user-friendly, methodic way. First, each chapter begins with an estimate of the amount of time patients can expect to spend on the intervention. For example, Chapters 1 through 4 are projected to take 1 week each, while 10 weeks are recommended for Chapter 5, "Behavioral Activation Treatment for Cancer," and 1 week each for coping with treatment side effects, problem solving, improving sleep, assertiveness training, and relaxation strategies. Second, within each intervention, an understandable and thorough rationale is presented. Third, patients are guided through a logical progression via worksheets and clear behavioral recommendations. For example, during the behavioral activation phase, patients begin by tracking activities for 1 week (a worksheet is provided). Additional exercises help patients identify environmental contingencies maintaining their depression/anxiety and setting life goals. The authors then guide patients to use these worksheets to set specific behavioral goals to improve mood. Similar progressions are offered throughout the workbook.

An additional strength of this book is the provision of relapse prevention strategies in the final chapter. Relapse prevention is frequently given little attention in self-help material, but we know from psychotherapy clinical trials that relapse is common with depression, and attention to maintaining change could significantly reduce relapse (Jarrett et al., 2001). In our RCT, patients were encouraged to use therapy techniques during a maintenance phase of treatment, and those who did so continued to benefit from the strategies (Andersen et al., 2007). Patients are encouraged to monitor their mood and return to the techniques learned from the workbook frequently.

One caution associated with this book is its proposed breadth relative to the treatments offered. In Chapter 3, "Recognizing Anxiety," the authors describe anxiety in the general sense and its relationship to cancer. They further provide brief descriptions of six common anxiety disorders, noting the ways in which symptoms may manifest in patients with cancer. What is omitted, however, is information about the expected effectiveness of the intervention strategies contained in this book for patients with

pathological anxiety. As noted above, components of the treatment overlap with those for clinical depression and for cancer-related stress and distress. It is likely that the treatments will reduce feelings of anxiety for most patients, especially considering that psychological interventions for cancer patients have larger effects on anxiety than on depression (Meyer & Mark, 1995; Osborn et al., 2006). However, for the minority of patients who have an anxiety disorder independent of their cancer, this book may not be especially helpful. Primary components of effective behavioral intervention for anxiety disorders, such as interoceptive exposure for panic disorder or exposure and response prevention for obsessive-compulsive disorder, are not included. Further, there is a section near the end of the book where the authors present a helpful summary of effective treatments for depression, suggested for patients whose symptoms have not remitted. However, anxiety disorders are not referenced. Thus, patients are not made aware of the available effective treatments for anxiety disorders. Perhaps a foreword indicating which patients are most likely to benefit from the treatment would be a useful addition to a future edition.

Overall, this appears to be an exceedingly useful book for cancer patients coping with emotional distress. It is the first widely available collection of empirically supported distress-reduction techniques for patients with cancer. It would be a useful adjunct to individual or group treatment of distress in cancer patients, and—although research is needed to evaluate its effectiveness as a stand-alone treatment—it is likely to be quite helpful for the patient coping with the emotional side of cancer.

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Web Corner

Link Your Website to ABCT!

Mitch Prinstein, *University of North Carolina, Chapel Hill, ABCT Web Editor*

Introducing ABCT's new website—now on-line! We revised the website to meet several goals. First, we were interested in expanding the website to make it more accessible to at least three audiences: the general public; health care professionals who want to learn about CBT; and current and prospective members. Second, we wanted to make the many resources and opportunities provided by ABCT more transparent to its current and potential members. Achieving this goal meant some changes to the structure and navigation of the website.

Third, we wanted to increase ABCT's presence as an international leader in the dissemination of information on behavioral and cognitive therapies. Towards this aim, we developed a structure that would accommodate a growing list of articles, resources, videos, and educational materials as it develops. Our work on this aim does not end with the addition of web content, however. This is where we can use your help!

In an effort to increase the presence of the ABCT site on the web, we are asking all members with their own websites (practice or faculty sites, for instance) to please include a link to the ABCT home page: <http://www.abct.org>. We hope that the information on-line will be a helpful resource that can link your web visitors to articles on CBT, expectations for treatment, course syllabi, slides, videos, etc. Your link to the

ABCT website also will help increase web traffic in a way that can help ABCT's position within a Google search on behavioral and cognitive therapies. This is an essential next step in disseminating information to the audiences who might benefit from ABCT's resources.

In this Web Corner series, we will highlight ongoing developments to the website and direct your attention to recent additions. Stay tuned for more information. In the meantime, we hope you enjoy the new ABCT website. The site always remains a work in progress, and suggestions for revisions or additions always are welcome.

Last, I once again would like to offer tremendous gratitude to David Teisler, M. J. Eimer, Stephanie Schwartz, and Webmaster Leonid Shiriaev for their work on the website, as well as our Web Committee: Esteban Cardemil (Associate Editor), Kristi Gordon (Associate Editor), Bunmi Olatunji (Associate Editor), and John Guerry. ABCT's new website is due to the extraordinary efforts of this terrific team.

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Classified

ASSISTANT OR ASSOCIATE PROFESSOR (RESEARCH). The Department of Medicine at Rhode Island Hospital, one of the affiliated hospitals of The Warren Alpert School of Medicine at Brown University, seeks a research faculty member on or before July 1, 2009. This is a renewable, non-tenure track position. The successful candidate must qualify for a faculty position at the rank of Assistant or Associate Professor (Research). Associate Professor level candidate should have a national reputation and scholarly achievements.

Applicants must have a doctoral degree in psychology, sociology, social work or equivalent with research experience and interest in women's health, correctional health, international health, cancer screening, pain medicine, substance abuse, mental health, and/or HIV disease. Primary responsibilities include the applicant is expected to develop an independent funded research program and participate in Brown's funded research program working with multidisciplinary group of investigators whose adult and adolescent studies include behavioral interventions, health services research, international research, community-based research, and work with incarcerated populations.

Please send CV and letter of interest to: Peter Friedmann, MD, MPH, Rhode Island Hospital, Division of General Internal Medicine Research, 593 Eddy St.-Plain St. Bldg., Providence, RI 02903. Review of applicants will begin immediately and continue until the search is successfully concluded. Rhode Island Hospital is an EEO/AA employer and actively solicits applications from minorities and women.

And don't forget ABCT's on-line . . .

JOB BANK

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<http://jobbank.abct.org>

Preparing to Submit an Abstract

ABCT will once again be using the Scholar One abstract submission system. The step-by-step instructions are easily accessed from the ABCT home page. As you ready materials please keep in mind:

- **Presentation type:** Please see “Understanding the ABCT Convention” (right-hand column) for descriptions of the various presentation types.

For Symposia please have 1 or 2 Chairs, only 1 Discussant, and a minimum of 3 and a maximum of 5 papers.

For Panel Discussions and Clinical Roundtables please have 1 moderator and between 3 and 5 panelists.

- **Title:** Be succinct.

- **Authors/Presenters:** Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their ABCT category. Possibilities are M – current member; NM – lapsed member or nonmember; SM – student member; SNM – student nonmember; or NP – new professional.

- **Affiliations:** The system requires that you enter affiliations before entering authors. This allows you to enter an affiliation one time for multiple authors. **DO NOT LIST DEPARTMENTS.** In the following step you will be asked to attach affiliations with appropriate authors.

- **Key Words:** Be as specific as possible. These are used as search criteria by interested attendees. Do not list *behavior therapy*, *cognitive therapy*, or *cognitive behavior therapy*.

- **Goals:** For Symposia, Panel Discussions, and Clinical Round Tables, write 3 statements of no more than 125 characters each, describing the goals of the event. Sample statements are: “Described a variety of dissemination strategies pertaining to the treatment of insomnia”; “Presented data on novel direction in the dissemination of mindfulness-based clinical interventions”; “Highlighted and discussed the effects of OEF/OIF deployment on functioning in military couples and families.

- **Overall:** Ask a colleague to proof your abstract. A second set of eyes often catches inconsistencies or typos.

Understanding the ABCT Convention

The ABCT Annual Convention is designed for practitioners, students, scholars, and scientists. All of the ABCT members involved in making the convention have as their central goals the provision of opportunities to meet the needs of the diverse audiences interested in the behavioral and cognitive therapies. Attendees have varying disciplines, varying levels of experience, varying theoretical CBT orientations, as well as special clinical concerns. As important are the opportunities to meet people with similar interests for social as well as professional networking.

Some presentations each year will offer the chance to see and hear what is new and exciting in behavioral and cognitive work from our dynamic and vibrant presenters. Other presentations will address the clinical-scientific issues of how we develop empirical support for our work.

The Convention consists of General Sessions and Ticketed Events. There are between 150 and 200 general sessions each year competing for your attention.

GENERAL SESSIONS

Symposia. Presentations of data, usually investigating efficacy of treatment protocol or particular research. Symposia are either 60 minutes or 90 minutes in length. They have one or two Chairs, one Discussant and between three and five papers.

Panel Discussions and Clinical Round Tables. Discussions (sometimes debates) by informed individuals on a current important topic. These are organized by a Moderator and have between three and six Panelists who bring differing experience and attitudes to the subject matter.

Membership Panel Discussion. Organized by representatives of the Membership Committees, these events generally have a particular emphasis on training or career development.

Special Sessions. These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years our Internship Overview and Postdoctoral Overview have been helping people find their educational path.

Clinical Grand Rounds. Master-level clini-

cians give simulated live demonstrations of therapy. Clients are generally portrayed by graduate students studying with the presenter and specializing in the problem area to be treated.

Poster Sessions. One-on-one discussions between researchers who display graphic representations of the results of their studies, and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,200 and 1,400 posters are presented each year.

Special Interest Group Meetings. More than thirty SIGs meet each year to renew relationships, accomplish business, such as electing officers, and often offering presentations. SIG talks are not peer-reviewed by the Association.

TICKETED EVENTS

In addition to a 250-word description, several goals, and recommended readings, these listings include a level of experience to guide attendees.

Workshops. Covering concerns of the practitioner/educator/researcher, these remain an anchor of the Convention. These are offered on Friday and Saturday, are 3 hours long, and are generally limited to sixty attendees.

Master Clinician Seminars. The most skilled clinicians explain their methods and show videos of sessions. These are offered throughout the Convention, are 2 hours long, and are generally limited to 40 to 45 attendees.

Advanced Methodology and Statistics Seminars. Designed to enhance researchers' abilities, there is generally one offered on Thursday and one offered on Sunday morning. They are 4 hours long and limited to 40 attendees.

Institutes. Leaders and topics for Institutes are taken from previous ABCT workshop presentations which need a longer format. They are offered as 7-hour or 5-hour session on Thursday, and are generally limited to 40 attendees.

Clinical Intervention Training. One and two-day events emphasizing the “how-to” of clinical intervention. The extended length, either 7 hours or 14 hours, allows for exceptional interaction.

Call for Papers

UNIVERSAL PROCESSES

Mediating Roles in Vulnerability and Treatment

Lata K. McGinn, Ph.D., Program Chair

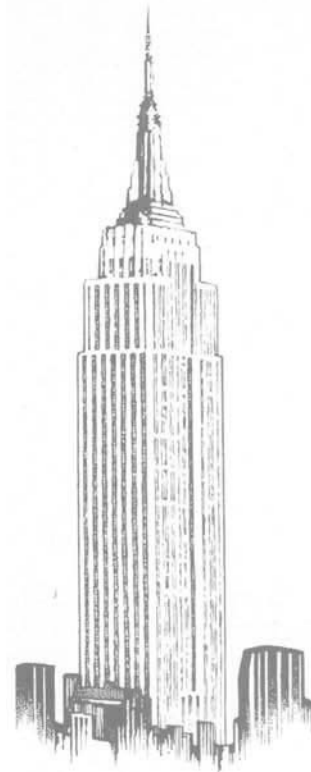
Submissions may be in the form of symposia, round tables, panel discussions, and posters. Discussants will be encouraged to integrate processes implicated in the development, maintenance, and treatment of psychopathology across theoretical models.

Information for submitting abstracts can be found on ABCT's website, www.abct.org, or on p. 47 of this issue of tBT.

**SUBMISSION
DEADLINE:
March 2, 2009**

Cognitive behavioral models stress the impact of various processes on the development, maintenance, and treatment of psychopathology. Recent advances in methodology have facilitated the growth of studies attempting to test cognitive and behavioral processes and their mediating role in vulnerability and treatment. An emerging body of evidence appears to support the mediating impact of various processes in the development and maintenance (vulnerability) and reduction of psychopathology (mechanisms of change). Moving beyond a categorical nosology, there is also a growing interest in identifying common processes that play a role in the vulnerability and treatment across diagnostic categories.

The theme of the 43rd Annual Convention will be on identifying the various cognitive and behavioral processes that have been implicated in the development of vulnerability and treatment of psychopathology, particularly across diagnostic categories and models. We welcome submissions that focus on identifying universal processes across diagnostic areas and cognitive behavioral models. Submissions that highlight models developed to identify common processes across diagnostic disorders and innovative methods and designs for examining development of vulnerability and mechanisms of change are especially encouraged and will receive special consideration.



43rd ANNUAL CONVENTION

November 19–22, 2009
New York City



the Behavior Therapist

Association for Behavioral and Cognitive Therapies
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