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the Behavior Therapist

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ABCT's April 2009 Election for Officers Goes Electronic!

We are delighted to offer our members the opportunity to elect officers electronically this year. Please be sure that your email address is correct. You can only cast your vote if the email you use matches what ABCT has listed for you. All full members and new member professionals will receive an email when the voting portal is open.

President's Message

Unemployment Anxiety

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

Many of us have patients, family, or friends who are facing the dire circumstances of unemployment. In January 2009 598,000 new people were added to the ranks of the unemployed in the United States, for a total unemployment rate of 7.6% and a total of unemployed people reaching 11.6 million (http://stats.bls.gov/news.release/empsit.nr0.htm). Historically, the current rate is high and is likely to go higher—perhaps to 9% or 10%. Even though recessions eventually come to an end—and we hope that the current one will end this year—the experience of unemployment can take a severe toll on the individuals and their families who are affected.

Unemployment is associated with increased alcohol abuse and increased use of mental health services (Jin, Shah, & Svoboda, 1995). In a meta-analytic review of 104 studies, unemployment was associated with decreased mental health, life satisfaction, and subjective and objective physical well-being. Duration of unemployment also affects health indices (McKee-Ryan, Song, Wanberg, & Kinicki, 2005). Unemployment is related to increased risk for suicide (Preti, 2003). These data may not be surprising, but they do suggest that mental health professionals need to consider how they can adapt their approach to the specific problems of the unemployed. On a positive note, higher levels of resilience can decrease the negative impact of unemployment

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- 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 *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

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(Moorhouse & Caltabiano, 2007). The question addressed in this paper is how we can increase resilience for unemployed people.

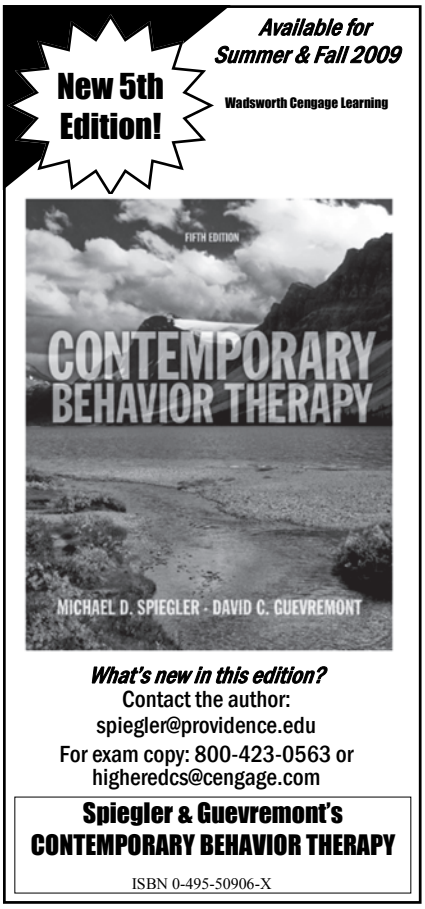
What are the problems associated with unemployment? Certainly, loss of income is a significant stressor for many, although there is a cushion for some with severance packages and unemployment insurance. Seldom, however, will these be sufficient as unemployment drags on. Yet, this loss of income is moderated by the perception of what the loss entails. We have found that some people have more difficulty readjusting their spending habits to stay within a reasonable budget. Thus, their unemployment may be complicated by increased consumer debt at exorbitant rates. Planning a budget and considering the elasticity of expenses is a good place to begin. Some individuals have used this period of unemployment to reassess what they "truly need" and, after they are reemployed, they benefit from this new awareness by more prudent spending and saving patterns. We can ask, "What can you learn about spending and saving that you can use in the future?"

Job loss often involves loss of daily structure, opportunities for feeling competent, social support, and status. Many unemployed individuals may find themselves listlessly going through their days, with lower levels of activity and a sense of aimlessness. Increased rumination often sets in, adding to the risk of depression. Bill was laid off and took an adaptive, behavioral activation approach to his situation. He structured each day with "searching for a job." This included making a list of possible contacts in his network of acquaintances and professional associates. He diligently contacted people in the network, telling them that he had been laid off and asking for potential leads. Of course, this was often frustrating, but he viewed searching for a job as a "numbers game"—"The more people I call, the closer I am getting to a job." He scheduled time to search the Internet, company websites, and other resources. In addition to his job search, he increased his exercise program, scheduling something on a daily basis. He also used the extra time available to help out at home, spend more time with his children, and to pursue recreational activities (such as golf). Eventually, Bill got a job and had mixed feelings about returning to work: "I will miss the free time I had."

Along with behavioral activation, many unemployed people can benefit from cognitive restructuring of their negative thoughts regarding their position. Self-criticism is often a consequence of unemployment. Identifying cognitive distortions, such as labeling ("I am a loser"), personalizing ("Why me?"), discounting the positives ("It doesn't matter that I am educated or a hard worker"), and all-or-nothing thinking ("I can't do anything right"), are good targets for evaluation. Hopelessness is often based on overestimating the importance of the current situation and relying on emotional reasoning to predict the future. For example, "I'm unemployed now, so I'll never get a job" can be countered by examining the evidence that unemployment rates rise and fall and the job market is continuously fluid. Normalizing the experience of unemployment—especially by looking at economic and structural factors (market trends, down-sizing)—can help dispel self-blame. For many, unemployment is associated with decreased status, a sense of humiliation and shame, and the perception that they may be ostracized. Again, cognitive therapists can help by employing the double-standard technique ("How would you feel about someone you know who has lost their job? Why would you be kinder to them than you are to yourself?"). Identifying other people who have been unemployed and who are now employed helps reduce the stigma and the sense of hopelessness associated with this issue. Another helpful question is to ask, "What evidence do you have that people think less of you because you have lost your job?" Or, to take it further, "Why should you care what they may think? Perhaps this is a time to find out who is a real friend."

Since unemployment is generally a temporary situation, we can consider increasing flexibility about time. For example, one man who had been out of work for 5 months had a sense of desperation about finding a new job. When I asked him, "Why not extend the period of time to look for a job? What is the urgency?" his anxiety decreased. It occurred to him that the period of time was arbitrary and, fortunately, he still had adequate resources to continue to pay his bills.

Finally, it is helpful for some unemployed people to view their time away from a job as an opportunity to develop new job skills. I have used the term "sabbatical" with some of my patients to help them recognize that they can profit from this time in terms of expanding their repertoire of skills that they can offer. This helps structure the day, provides opportunities to feel competent, and builds a sense of resilience that one can possibly come out of this in a better position to market one's abilities in an ever-changing world.



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Implementing Empirically Supported Treatments in Real-World Clinical Settings: Your Questions Answered!

Simon A. Rego, *Montefiore Medical Center,* David H. Barlow, *Boston University*, Barbara S. McCrady, *University of New Mexico*, Jacqueline B. Persons, *San Francisco Bay Area Center for Cognitive Therapy*, Thomas B. Hildebrandt, *Mount Sinai School of Medicine*, and R. Kathryn McHugh, *Boston University*

In November 2007, at the 41st Annual ABCT Convention in Philadelphia, I moderated a panel on implementing empirically supported treatments (ESTs) in real-world clinical settings. The panelists, all of whom were experts in their respective areas of research and practice, focused on four of the most frequently encountered psychological disorders in clinical practice: anxiety disorders (David H. Barlow, with assistance on this writeup from R. Kathryn McHugh), substance use disorders (Barbara S. McCrady), depressive disorders (Jacqueline B. Persons), and eating disorders (Thomas B. Hildebrandt). The panel presentation included a discussion on how treatment manuals could be modified for use outside of clinical research centers, how well ESTs "work" in real-world settings, misconceptions and misperceptions about how manuals are used, and practical suggestions on how to overcome obstacles in implementing ESTs in real-world clinical settings.

As the issue of implementing ESTs has been frequently discussed and debated on the ABCT list serve, I thought it would be informative to have our esteemed panelists respond to some of the most frequently encountered challenges that our own ABCT members faced in trying to achieve this task. As such, prior to the convention, I posted a message to the ABCT list serve (to which I highly recommend subscribing, for those who have not yet done so) informing the list members of this panel, and asking members to submit questions they had on this topic, to which panelists would respond at the end of the talk. While many people responded to my post, unfortunately, time did not allow for all of the questions to be addressed during the allotted time for the panel at the convention. Fortunately, however, all of the panelists agreed to continue their dialogue electronically after the convention, which I continued to moderate. As such, what follows is a summary of the "conversation" between our esteemed panelists on this important topic.

HOMEWORK

"Homework completion can be a really difficult issue for some clients, who are doing poorly at managing the current demands in their life already. The standard interventions of problem solving, scaling back the difficulty, exploring for cognitions (re, homework, etc.), are sometimes inadequate to get the client completing homework. What other ideas do the panelists have for severe homework completion problems?"

THOMAS B. HILDEBRANDT: I think that problems with homework completion, whether related to life circumstances (e.g., difficulties with home life, job stress), patient limitations (e.g., learning disability, comorbid ADHD), or patient resistance (e.g., mandated, legally or by family members, therapy), are common problems in delivering CBT to patients with eating disorders. Beyond those traditional interventions suggested in the question, I would also include limiting therapeutic contact. Waller et al. (2007) have an excellent discussion on how to use this strategy within the context of CBT for eating disorders. For example, they suggest that a therapist may elect to limit sessions to a 5-minute check-in if the patient is unable (e.g., due to life circumstances) or unwilling to complete homework assignments. The therapist would also regularly return to the importance of completing homework in addressing the patient's eating disorder and indicate that therapy may not be helpful if he or she is unable to use the homework assignments. In this model, the therapist is reinforcing the utility of homework through his or her behavior. In most cases, this type of intervention would follow attempts to increase compliance such as problem solving.

JACQUELINE B. PERSONS: A two-part strategy I find helpful in managing homework completion problems is to: (a) carefully look at the homework problem behavior and try to develop a formulation of the behavior and then, (b) use the formulation to get ideas for solving the problem. All of this should be done collaboratively with the patient. The formulation of the behavior consists of a hypothesis about what causes and maintains the behavior. If the homework-completion problem behavior is an example of a typical class of behaviors that is problematic for this client (e.g., agreeing to do things he or she doesn't really want to do and then asserting the desire to not do it in a passive way by being too busy to do it), then the patient and therapist may have already developed a formulation of that general class of problem behaviors that will help them understand this specific example (e.g., homework completion). The patient and therapist can then use the formulation of the behavior to guide efforts to solve the homework-completion problem behavior. For example, if the homework-completion problem is due to the patient's agreeing to do things he or she doesn't really want to do, then patient and therapist can work on the therapy homework assignment process to practice interactions in which the therapist recommends a homework assignment, the patient does a check of his feelings/wishes to see if he wants to do it/believes it would be helpful, and if not, asserts himself with the therapist to say that and ask for an alternative homework suggestion.

R. KATHRYN MCHUGH and DAVID H. BARLOW: In some cases, noncompliance with homework assignments may also be due to logistical factors, such as low functional literacy, which may be difficult for patients to disclose due to the associated stigma. Such basic deficits in the ability to complete homework assignments can be particularly challenging. Difficulty with reading and comprehending health information is not uncommon, and may be more prevalent in certain populations. Furthermore, the reading level of clinical materials may not only be high, but also may be substantially higher than clinicians realize (e.g., Greenfield, Sugarman, Nargiso, & Weiss, 2005). Thus, not only low functional literacy, but also lower reading levels may serve as an impediment to understanding and completing homework forms. As educational

attainment may not be a sufficient marker of literacy in some cases, assessment of patient reading level may be important to determine whether standard forms of homework are appropriate. A number of tests of reading ability are available, which range in cost and length. Commonly used cognitive batteries, such as the Woodcock Johnson and the Wechsler Adult Intelligence Scale, contain relevant reading subtests. Additionally, free resources for assessing reading level can be found at the National Institute for Literacy (http://www.nifl.gov).

If it is determined that there are limitations with regard to the patient's ability to read or disparities between the reading level of clinical materials and the patient's abilities, forms should be altered accordingly. For example, self-monitoring forms can be simplified and in some cases their use may need to be limited. The use of simple, clear language and formatting may also increase accuracy and adherence. For example, the use of check boxes may provide an alternative to a lengthier written format. Furthermore, use of memory aids in such circumstances may provide a partial substitute for the use of written forms. Use of small cards with relevant verbal or pictorial information (e.g., a coping statement, an alternative behavior) that can be stored in a wallet or pocket can serve as a reminder of homework assignments. In such cases, emphasis of concrete, measurable goals may be of particular importance.

INTENSIVE TREATMENT

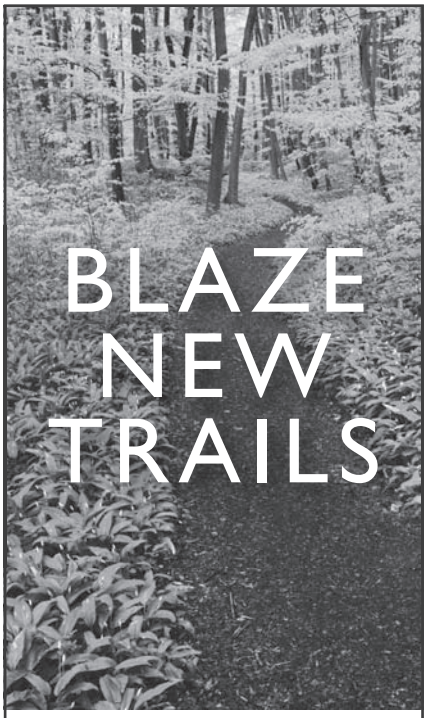
"One of the problems I have is doing intensive treatment, which so many clients need. I do not have the time to spend a few hours daily or even 1 hour daily with my client – and do not know of any insurance companies that will reimburse for this. How does the panel suggest I approach these cases?"

JACQUELINE B. PERSONS: Your question is a good one and I'll offer several answers. One is that if the patient in the clinician's judgment needs a treatment the clinician does not have the time or expertise to provide, then the clinician's job becomes educating the patient about his needs and helping him obtain the appropriate treatment. This might entail the patient making a trip out of town to one of the centers that provides this treatment (e.g., the Center for the Treatment and Study of Anxiety in Philadelphia, which offers intensive OCD treatment). The patient may offer many reasons why he or she can't do this, including cost. I suggest having a good discussion about the costs and whether the patient actually cannot afford it. This discussion may include questioning whether there is money and/or resources available for a problem like this that can be accessed by the patient, how severe/important the problem is for the patient, etc. I find patients often have the ability to save money for luxuries (e.g., vacations) but don't always consider how and why treatment of their condition might be a better way to spend that money.

If the patient wants to try modifying the intensive treatment to a less intensive one that the clinician could provide, the clinician might elect to provide this in certain circumstances—provided the clinician believes this modification of the treatment might work. In this situation, the clinician can modify the treatment to fit the setting and track the patient's progress to see if the patient is benefiting. If results are positive, treatment would continue. If the results are lacking, however, the clinician and patient would need to have an alternate plan, ideally specified in advance, to which they would turn (e.g., an out-of-town treatment, as described above).

An important piece of this plan would involve obtaining the patient's informed consent. Be sure to fully inform the client about the efficacy data, the modifications you are proposing, the rationale for the modifications, and the empirical approach, and make sure the patient agrees to these conditions. Many patients do not need to feel limited by what their insurance will or will not cover. By focusing on the clinical issues of what the patient needs and examining what resources he or she has or can draw on to get his or her needs met, patients often find that they do have other resources they can draw on. These discussions require therapist courage and clarity and confidence in our treatments.

R. KATHRYN MCHUGH and DAVID H. BARLOW: While it is always difficult to radically change schedules of care provision for busy clinicians, there are two important facts to consider: (a) intensive treatment, particularly for panic disorder with agoraphobia and OCD, is clearly empirically supported; and (b) it is often a great convenience to patients to have treatment structured this way. In fact, in our clinic it was because of repeated requests from patients, particularly parents of adolescents, who wondered if there were a way we could carry out treatment during a summer week or other condensed vacation pe-



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riod, that we initiated this service. Most of our patients were willing to self-pay for this service, but we have increasingly found little resistance by many third-party payers once they see the data and the fact that cost savings can sometimes accrue posttreatment. Thus, it may be time to consider how intensive treatment can be incorporated into monthly schedules (e.g., setting aside 1 week every 2 months for treatment). Since many of these patients are scheduled a month or more in advance, an unfilled week can often be filled well ahead of time. Many practitioners have found this kind of "niche" is good for marketing their practice and increases business overall.

THOMAS B. HILDEBRANDT: The issue of whether or not to conduct intensive treatments has economic, practical, and clinical implications. Unlike Jackie, David, and Kate's experience with panic disorder and OCD, intensive treatment (e.g., day treatment programs or even daily psychotherapy sessions) for eating disorders is less likely to be reimbursed and is currently without a strong empirical base to support it. Furthermore, the delivery of such intensive treatment is difficult in a standard psychotherapy practice, where adjusting your schedule to devote extensive time to an individual patient for a short period of time limits openings for new referrals, competes with time devoted to existing patients, and may require additional expertise outside that typically needed for traditional outpatient therapy (e.g., medical management in cases of anorexia nervosa or bulimia nervosa).

A second issue related to this question is whether the existing models (i.e., intensity levels practiced in empirical research) would be less effective than a more intense model for certain patients. For example, if this question were in reference to a patient with bulimia nervosa, it would be hard to argue without evidence of unsuccessful attempts, to begin with anything more than the twice per week for the first 2 weeks as recommended in the original treatment manual for bulimia nervosa. It is also unclear from the existing research exactly which clinical indicators would warrant a move to more intensive treatment. So this question about intensity of treatment really raises economic questions about reimbursement, practical questions about execution, and clinical questions about the utility of increased intensity of treatment. None of these are easily answered from the existing research on bulimia nervosa—and even less so with anorexia nervosa, where there is likely a greater need for more intense treatment due to the physical and psychiatric complications associated with the disorder. Despite these challenges, identifying economically viable and empirically sound intensive treatments for eating disorders would be a welcomed addition to the field.

BARBARA S. MCCRADY: This question is a big one in the substance use disorders (SUD) field. Unlike the eating disorders, intensity of treatment/level-of-care issues have been looked at rather carefully in the treatment of SUDs. Until the 1980s, inpatient treatment was the gold standard, and the widespread belief among clinicians in the alcohol/drug field was that patients with SUDs could not be treated on an ambulatory basis because, it was thought, they would drink or use drugs, and the treatment would not be intensive enough to "break through the denial" that was seen as central to SUDs. In fact, the "ideal" length of inpatient treatment was specified as well, typically being set at 28 to 30 days. Research over the past 25 years has generally proven these beliefs to be incorrect. Controlled studies have reported equivalent drinking outcomes over 2 years of follow-up for alcohol-dependent patients treated in inpatient versus intensive outpatient treatment settings. Some studies, however, have found greater attrition in ambulatory than inpatient settings. Unfortunately, controlled studies comparing weekly outpatient treatment to intensive outpatient programs are lacking. However, the American Society of Addiction Medicine (ASAM) has developed Patient Placement Criteria (PPC) that provide a research-based, clinically sensible guideline for determining the intensity of treatment a patient might need. Patients are rated along six dimensions to determine the level of care that is most appropriate to their current needs: acute intoxication/withdrawal potential, medical problems and complications, emotional/behavioral problems and complications, motivation to change, relapse potential, and characteristics of the social environment. Although the data aren't perfect, there are several studies that show better retention, and, sometimes, better outcomes for patients who receive treatment matched to PPC-determined level of care.

What do these findings mean for the individual practitioner? First, most insurance that covers treatment for SUDs will cover different levels of care, and arguing for more intensive treatment based on the PPC is usually received well. In fact, some states now use the ASAM PPC as their primary criterion for supporting level of care for publically funded treatment as well. Thus, solo practitioners should be considering their patients' needs in light of the PPC.

Second, it is unlikely that a solo practitioner could provide the intensity (9 to 20 hours) or kinds of services someone might need if they qualified for intensive outpatient treatment (a structured environment, observation and medical support for detoxification, etc.). My suggestion, then, is to consider referring the patient who needs more intensive SUD treatment to a local intensive outpatient (IOP) or partial hospital treatment program (PHP) that specifically treats persons with SUDs. These programs may be offered during the day or evening, making them easier for people who work or who have child care responsibilities during the day. It should be noted, however, that virtually all these programs draw upon a 12-step framework as their program model. If the practitioner has been working from a CBT treatment model with a focus on abstinence, this is probably not a problem, as CBT provides skills that can be complementary to the social support and spiritual components of AA. Given the strong evidence that now supports the efficacy of 12-step facilitation treatment and AA involvement as contributing to positive outcomes, the CBT practitioner may need to learn new skills to integrate their ongoing CBT treatment with what the patients learns/experiences in another treatment setting. However, if the CBT practitioner has been working with a patient from a harm reduction or moderation training model, the patient will receive a very different kind of message in a more intensive treatment setting. In this case, the practitioner may be in a real dilemma, for which there really aren't clear solutions. Here, I would suggest that either the goals would need to shift toward abstinence to take advantage of the larger treatment system or the practitioner would need to independently provide more intensive treatment, which may not be covered by insurance because the goals would not be consonant with the level-of-care needs.

RESISTANCE FROM COLLEAGUES

"One issue that I have struggled with in implementing empirically supported treatments in real-world settings is resistance on the part of nonacademic clinicians to implement the treatment according to the protocol. The resistance is often displayed as

negative labeling and expectations about the protocol (e.g., 'Now we have to do the boring research protocol!' and 'Researchers don't have any idea about what really works!'). Hearing from the panel about how to overcome such resistance would be helpful."

R. KATHRYN MCHUGH and DAVID H. BARLOW: Research in the dissemination of innovations suggests that perceptions about an innovation are critically important to rates of adoption (see Rogers, 2003). Likewise, negative perceptions about ESTs are a major barrier to successful dissemination. Examination of dissemination science and early successful efforts to disseminate ESTs provides potential strategies for addressing this barrier (McHugh & Barlow, in preparation). Addressing resistance may be best undertaken by building evidence for the benefits of ESTs within the system and emphasizing communication among clinicians. Identifying potential advocates within the system to champion the adoption of ESTs may be a good strategy both to build initial support and to maintain use of protocols over time. Promotion efforts may attempt to dispel myths and also to publicize utilization of treatments within the system. This can be facilitated through examination of the specific concerns or perceptions that are held among clinicians within each setting. Thus, promotion efforts can be specifically targeted and problem-solving can be undertaken.

Furthermore, gathering evidence within the system demonstrating the advantages of ESTs can provide powerful evidence to counter negative perceptions. Early utilization can be built through offering incentives (if possible), or by targeting clinicians who may be most open to trying new interventions. Peer communication about the benefits of the treatment can be complemented by the gathering of outcome data to demonstrate positive outcomes. Communication among members within a system is often more powerful than encouragement from outside of the system, and if leaders within a setting adopt a treatment, others may be more likely to follow suit (see Rogers, 2003).

Another important consideration is to emphasize the utilization of treatments that are a good fit for the clinical system's needs. Ensuring the fit of treatment structure, intensity, and target to the needs of those served by the system may facilitate willingness to adopt. It should be noted that the balance between flexible use and strict adherence to ESTs provides a particular challenge for both clinicians and researchers and remains largely unexplored. Some recent efforts to develop more flexible modular approaches (e.g. Chorpita, 2007) may be a beneficial starting point for someone more hesitant to adopt treatment protocols. Building support within a system can be a long process and attitudes are often slow to change, but demonstrating the advantages of ESTs through developing advocates, increasing communication within clinics, and publicizing efforts and outcome advantages may facilitate changes in attitudes and increase willingness to use treatments. Such efforts in combination with large-scale efforts to increase collaboration between researchers and clinicians will be important to shifting beliefs about the nature and effectiveness of ESTs.

JACQUELINE B. PERSONS: In order to answer this question I will have to rework it a bit, as I am lucky enough to work in a system (a small private practice—not an accident!) where there is no resistance to ESTs! I am most likely to experience resistance to ESTs from clinicians outside my group. I do

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try to think carefully about how to interact with these clinicians in a way that might bring them one step down the road of increased interest in and acceptance of ESTs, and would suggest that some of the strategies from motivational interviewing can be helpful here. One such strategy is called "asking for permission." Shortly after 9/11, I attended a meeting of a local psychological association to hear a talk about critical incident stress debriefing, which I had been learning about and was disturbed to find was non-evidence-based (in fact, some data indicated the procedure was harmful!) and yet widely touted and disseminated. I chose a careful moment during the meeting to volunteer that I had been reading the evidence on the procedure and would be happy to summarize it for the group if that would be of interest. I was amazed and pleased to find that the psychologists there actually did want more information and were quite receptive to my providing a brief review of the evidence there. Later they asked to print a brief literature review on the topic that I had written with two UC Berkeley graduate students (Tai Katzenstein and Barbara Stuart), in their newsletter!

THOMAS B. HILDEBRANDT: I believe that this is a core issue we face in the dissemination and implementation process. One way in which I've dealt with this issue while training and supervising community therapists is by starting with the assumption that they are probably doing many things correctly and competently. The amount of change necessary to achieve some reasonable degree of protocol integrity is not substantial in many cases, even when the individual's training or theoretical orientation is inconsistent with some aspect of the protocol. Reinforcing strengths goes a long way towards increasing incorporation of protocol elements. That being said, without training, monitoring, and feedback on fidelity, I think it unreasonable to assume that a therapist would implement a full protocol-based intervention on their own. I find that therapists really won't embrace a protocol-based treatment until they have had the opportunity to deliver it under some degree of regular supervision and with some success. Otherwise, there is little motivation for them to change their existing approach and/or little sense of therapeutic self-efficacy with the treatment protocol. The absence of either can lead to resistance of even the idea of protocol-based psychotherapy.

In addition, as Dave and Kate mentioned, another issue I run into with this approach is the lack of data on how much protocol adherence matters to treatment outcome. A majority of RCTs have a rather high degree of protocol adherence, although this is rarely examined as a predictor of treatment outcome (Perepletchikova, Treat, & Kazdin, 2007). There is probably not enough variability in therapist adherence among these studies to have true predictive power as therapists who either had a large degree of difficulty with executing the protocol or were resistant to delivering the protocol are unlikely to have been therapists in the study. To study this question, the research design would actually need therapists who did very poorly at adhering to the treatment protocol. Without data such as these, therapists who question the utility of protocol adherence have some validity to their concern.

BARBARA S. MCCRADY: I would unpack this question into three pieces: (a) acceptance of ESTs; (b) adherence to EST protocols, and (c) skill in the delivery of ESTs. Acceptance of ESTs has not come readily to the substance use disorders (SUD) treatment field. Historically, there was a sharp split between EST research and the kind of treatment that was delivered in community substance use disorders treatment programs. There was a similar split between individual practitioners who adopted a 12-step-oriented ("drug counseling") approach and those that adopted CBT as their primary modality. Probably the most interesting development in the past 15 years has been the increasing evidence base for 12-step and drug counseling from both Project MATCH (Project MATCH Research Group, 1997) and the Cocaine Collaborative Study (Crits-Christoph et al., 1999), which suggests that practitioners can work from more than one perspective and still be delivering an EST.

As has been mentioned by the other panelists, there are few data on adherence, and the information that does exist does not lend support to the importance of adherence. For example, in a randomized clinical trial of community-based addictions counselors, Morgenstern et al. (2001) found comparable outcomes for counselors who were trained to use the Project MATCH CBT manual and then either followed the manual or integrated what they learned about CBT into their own clinical style. Skill in the delivery of ESTs seems to be the most important key in the SUD field. Multiple studies have found that clinician empathy (e.g., Miller, Benefield, & Tonigan, 1993) and clinician ability to deliver treatment in a consistent and structured manner (REF) account for substantial amounts of variance in outcomes, and some data suggest that, at least with motivational interviewing, delivering treatment consistent with the "spirit" of motivational interviewing is most critical to success. Training clinicians clearly requires supervised practice with feedback over time (Miller, Yahne, & Moyers, 2004).

So, what does all this mean when we want to "convince" clinicians of the importance of adhering to EST protocols for treating SUDs? My colleagues in this discussion have made several good suggestions that I won't repeat. Echoing Tom, I would agree that joining with the clinician and focusing on how the EST can add to and complement their current knowledge base is important and consistent with the data in our field. I also emphasize that we have more than one EST for SUDs, and that what seems to be important is delivering that EST in a consistent and structured manner, using good general clinical skills.

PROTOCOLS VS. PRINCIPLES

"I would like to hear the panelists' thoughts on empirically supported **principles** ***versus empirically supported*** **protocols**, ***and whether it might be easier to train therapists in detecting and targeting important principles over learning particular manuals."***

R. KATHRYN MCHUGH and DAVID H. BARLOW: The large number of available empirically supported treatment protocols presents a significant barrier to the effective training of clinicians and the greater dissemination of evidence-based mental health care. This is particularly problematic for the emotional disorders, where many treatments are available for individual mood and anxiety disorders. To receive training in a battery of treatments involves significant time and resources, and even selecting the treatments in which to pursue training may be a difficult process. To address this problem, there has been a recent shift to developing more "user-friendly" treatments by focusing on the identification of intervention principles, rather than protocols. One application of this has been the development of a unified protocol for emotional disorders (Allen, McHugh, & Barlow, 2007). This approach is supported by evidence for common vulnerabilities across disorders (e.g., Barlow, 2002) and high rates of comorbidity and

symptom/feature overlap (e.g., Brown et al., 1998). Furthermore, cognitive-behavioral treatments for discrete anxiety and mood disorders utilize similar principles, which can be adopted for use in a transdiagnostic model. The development of more user-friendly approaches is particularly beneficial because of the reduction in training burden and may also facilitate greater applicability of skills across a range of disorders.

BARBARA S. MCCRADY: In addition to Kate and Dave's very nice response to this question, I would like to add that the substance use disorders (SUD) field has a plethora of treatment manuals published through commercial publishers, with SAMHSA, NIAAA, and NIDA also playing an important role. For example, NIDA and NIAAA have published treatment manuals from a number of single-site and multisite clinical trials that they have funded, SAMHSA has published their Treatment Improvement Series and also established NREPP—the National Registry of Evidence-Based Programs and Practices (http://www.nrepp.samhsa.gov). Thus, as with mood and anxiety disorders, there is an overwhelming wealth of information available.

In response to the proliferation of EST manuals, when Larry Beutler was president of Division 12 of APA, he established a task force on empirically supported principles and treatments. Several of us in the SUD field participated in the task force and developed a set of cross-cutting principles that we saw as underpinning the SUD literature. These were published in a book edited by Larry Beutler and Louis Castonguay (2005), and in shorter versions in the *Journal of Clinical Psychology* (cf. Haaga, McCrady, & Lebow, 2006). In brief, we recommended: (a) structured, well-organized, goal-directed treatment that involved the client actively in the treatment; (b) providers who are knowledgeable about the treatment of SUDs, rather than generalist clinicians; (c) a focus on accurate empathy; (d) a systematic and continuous focus on enhancing and maintaining motivation to change; (e) matching level and intensity of care to the severity of the individual's problems; (f) attention to co-occurring disorders and other life problems; (g) a systematic focus on individual cognitive, affective, and behavioral coping skills; and (h) a systematic focus on the social environment. Despite the strong empirical base underlying each of these eight principles, there is no empirical literature to date that has examined whether these principles are the correct ones underpinning effective SUD treatment, and whether there are multiple effective roads to achieving these principles. In essence, the focus on principles versus protocols implies that we understand the mechanisms underlying successful change. If this were true, then it would matter less what techniques a clinician used, than whether the techniques were effective in impacting the underlying mechanisms of change. The current focus on mechanisms of change research (e.g., Kazdin & Nock, 2003) may yield an empirically informed approach to training clinicians in principles for the effective treatment of different client problems.

THOMAS B. HILDEBRANDT: Newer approaches to CBT training have moved away from treatment manuals to more modular or integrated treatments as suggested by my colleagues. CBT for eating disorders has undergone a similar evolution, and the newest version (CBT-Enhanced) is a modular form of CBT (Fairburn, 2008). In my experience with training community therapists in CBT-E for eating disorders, the modular format has much more appeal. It reinforces the clinical flexibility often desired by community therapists, is more easily adapted to different types of treatment settings and cultures, and ultimately yields more therapist implementation of CBT in psychotherapy sessions. I have found that the presumed "all-or-nothing" assumption of strict protocol adherence to a therapy manual is met with much resistance and opposition, which ultimately interferes with the desired training goals of increased use of CBT in practice. As Barbara highlights, mechanisms of change research is a priority not only for improving treatment outcomes, but also for guiding our decisions based on CBT training in graduate schools (e.g., MSW, MFT, PsyD, etc.) and in dissemination efforts to postgraduate community clinicians.

As recent survey results by Weissman et al. (2006) suggest, training in most graduate schools fails to adequately train and supervise therapists in empirically supported treatments and is more likely to train and supervise students in non-ESTs. These sobering results suggest that without a massive paradigm shift in training at this level, most therapists we target to use CBT will have more expertise and experience in non-CBT interventions. Developing training modalities that address this reality are essential as we are just beginning to understand the difficulties to EST dissemination. What would be of great help to our field is for increased funding opportunities to study therapist training, as it has received negligible attention in the empirical literature. The National Institutes of Health have long funded training grants that have focused on developing scientists. Given their new direction and priorities for dissemination, training grants designed to study therapist acquisition of empirically supported treatments may have an equal value, particularly if individuals who graduate from the training grant may also act as agents of dissemination.

BARBARA S. MCCRADY: A footnote in response to Tom's very useful summary: There is an excellent article on therapist training in motivational interviewing for substance use disorders (cf. Miller et al., 2004), and one of my colleagues here at the University of New Mexico (Theresa Moyers) has a new RO1 from NIAAA to conduct additional research on effective elements of therapist training. The published study (Miller et al.) found that structured feedback over time, based on review of taped therapy sessions, was critical to skill mastery after an initial period of training.

THOMAS B. HILDEBRANDT: This is a good sign and sounds like a great study. One interesting area for Theresa Moyers to examine might be that of "therapist drift"—or posttraining deviation from motivational interviewing in psychotherapy. I think this is something that I witness quite often, and may be a bit normative in the context of unsupervised psychotherapy. I am curious as to how to prevent this drift from occuring, especially since ongoing supervision models are very costly alternatives.

BARBARA S. MCCRADY: In response to your question, based on Bill Miller's earlier findings (Miller et al., 2004), the training associated with Theresa's new grant includes periodic review of tapes over time exactly because the earlier findings suggested that one-shot training without reinforced practice does not lead to much retention (and therefore therapist drift). The current grant is looking at two models of motivational interviewing training in terms of the kind of behaviors therapists learn to reinforce/shape the motivational interviewing sessions.

JACQUELINE B. PERSONS: In response to the question of whether to train therapists to understand and use principles or protocols, my own leaning is in the direction of principles, and I have elaborated on

this notion in my writings about the use of a case formulation to guide treatment. The case formulation is a hypothesis about the idiographic mechanisms that cause and maintain an individual's symptoms and problems, and it can help the therapist develop a treatment plan and pursue it consistently over time. More recently, I've expanded my ideas about the use of a formulation in treatment to include having the therapist use regular progress and outcome monitoring at every session, in order to evaluate the effectiveness of the treatment being provided to that patient and also test the accuracy of the case formulation. In so doing, the therapist is using an idiographic empirical approach with each case. Reliance on a case formulation allows the therapist to incorporate into his view of the case *all* of the patient's symptoms and problems and *all* of the therapies that patient is receiving, rather than simply (as in most protocol approaches to treatment) treating a single disorder and without attending to other therapies the patient may be receiving. Advantages of this strategy include its flexibility, attention to multiple comorbidities and other complexities of individual cases, use of empirical methods (like progress monitoring of each case), and conceptual elegance. A weakness is the limited empirical support for the use of formulation-driven CBT. More studies on the treatment utility of an individualized case formulation are needed. Nevertheless, when using a formulation to guide treatment for an individual case, the therapist can evaluate the utility of the method for the case at hand by collecting data to monitor the patient's progress in treatment and to test the formulation's mechanism hypotheses.

Conclusions

While the debate appears to be over as to whether psychosocial treatments exist that "work" for psychiatric disorders, their dissemination and implementation in real-world clinical settings remains a challenge. There appear to be several reasons for this, including: (a) ongoing misperceptions about the nature of efficacy studies (e.g., do these subjects represent real-world patients?), (b) clinician concerns and misconceptions about adopting empirically supported treatment manuals (e.g., will therapists' ability to be creative and autonomous and make clinical decisions be abandoned?), and (c) practical, administrative difficulties in implementing treatment manuals in non-research-based clinics (e.g., how to select the right treatment in the face of comorbidity; how to get reimbursed for longer or more frequent sessions). Fortunately, researchers and clinicians are now beginning to address these issues, both empirically and practically, allowing the field as a whole to gain insight into how to overcome obstacles in implementing empirically supported treatments in real-world clinical settings. I wish to thank all of the panelists for their time and effort in this project, which is yet another step in facing this challenge.

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Match as Match Can: An Insider's Look at the APPIC Clearinghouse

Glen J. Veed, Judith A. Jordan, Christopher Campbell, Amanda Kras, Verónica Chávez, and Elaine K. Martin, *University of Nebraska, Lincoln*

It happens! More than 700 times a year *it* happens. *It* happens to applicants of all calibers, with a variety of experiences, from a wide range of theoretical orientations, in assorted areas (i.e., Clinical, Counseling, School). Graduate students from behavioral and cognitive-behavioral-oriented programs, such as the readers of *the Behavior Therapist*, might feel they are immune from *it* because of their evidence-based training and scientist-practitioner background, but it happens to them, too. I came from such a program, and it happened to me. I failed to match with a predoctoral internship through APPIC's computer matching program. I then participated in the APPIC's Clearinghouse with the 743 other individuals who, just like me, did not match. The purpose of this article is to provide the next generation of unmatched graduate students with a description of the process, helpful hints, and reassurance that you can successfully survive the Clearinghouse. These hints are drawn only from my own experiences and the experiences of those who helped me through the process. Others' experiences may differ, but I hope that our thoughts are helpful nonetheless.

To begin, I should provide a few background details. I applied for internship as a 4th-year graduate student in a clinical psychology program that has one of the highest match rates in the country. I do not attribute my not matching to a lack of quality training or a lack of any specific qualifications. I may not be the perfect applicant, but I did have 1,500 clinical and assessment hours, over 30 integrated assessment reports, more than a dozen research presentations at major conferences, and three articles undergoing review. My interests lie primarily in working with children and adolescents. I applied to 14 internships, interviewed at 7 of them, and ranked all of them. My story, however, really begins after all of this on Friday, February 22: Match Day.

Friday

I had gone to sleep Thursday night with nervous thoughts, wondering which of seven new cities I might be living in next year. I knew I would be receiving the first of two e-mails early in the morning, so I had planned on waking up every hour, starting at 5:00 A.M., to check my e-mail. 5:00 A.M. … nothing. 6:00 A.M. … nothing. 7:00 A.M. … an e-mail! I half-groggily, half-excitedly clicked. Looking back, I question whether I even read the e-mail the first time my eyes passed over it. I forced myself to relook and saw one phrase, "We regret to inform you that you did not match to a position." I stared at this phrase (helpfully sectioned off from the rest of the e-mail by those kind folks at APPIC), trying to decipher what it meant. If its meaning seems obvious to you, it is because this phrase did not decimate 9 months of planning and preparation. I reread it. I reread the rest of the e-mail to make sure the body agreed with this sentence. I reread it again. It wasn't until 7:20 A.M. that I finally stopped rereading the e-mail and stood up from my desk. Every reaction that you can think of—scream, cry, hit things, denial, quit psychology, etc.—I wanted to do all at once.

My first phone call was to my fiancée. My next few calls were to fellow internship applicants to make sure they had matched (and to see if they had somehow received my e-mail by mistake). I did not call my parents, and I did not call my adviser. I did, however, forward my adviser the e-mail with a note saying, "I think we will need to meet to discuss options"—understatement of the year. For 2 hours in my apartment, I called and e-mailed, but mostly paced, in a vaguely dissociated state. The first useful thing I decided to do was go to work. I was miserable at home and some part of my brain remembered that returning to normal routines is a good thing after a tragedy. Over the course of the day I did several things that helped ease my mind, and by the end of the day I was committed to attempting the Clearinghouse on Monday. I found the following points particularly helpful.

Meet With Advisers

One of the most important, initial tasks on Friday, once you have passably worked through the emotional turmoil, is to meet with your adviser. Your adviser is someone who can, hopefully, offer support and understanding during this difficult time (odds are he or she is experiencing, on a smaller scale, many of the same reactions that you are). Even if he or she cannot provide you with all of the support you need, your adviser does possess the knowledge and experience to help you carefully consider your options. As advisers differ in their level of experience with the match process, I recommend consulting with at least two. Multiple perspectives will be useful. In addition, you may find it reassuring to have multiple respected psychologists expressing how shocked they are that you did not match and how great a candidate you are. I think my day was completely turned around when I spoke with one of my letter-writers and he exclaimed, "I told them you walked on water, what the #@&% else do they want?!?!"

Consider Your Options

Most of your Friday is likely to be focused on one important question: What do I do next? During your meetings with your advisers, and in consultation with colleagues and loved ones, you should consider the paths available to you. The APPIC Clearinghouse is obviously the only way to obtain an internship for the next year, but there are many other possibilities. Another year of graduate school and practicum may offer the opportunity to increase clinical and assessment hours, make progress on/finish your dissertation, or publish. In addition, some programs may allow their students to take a year without classes or responsibilities so that students can be with loved ones, work (yes, you can actually make money!), or even take the EPPP. Of course, waiting a year also carries with it the uncertainty of another match process.

One thing that is important to consider when making this decision is the reason(s) that you did not match. Your first response will almost certainly be that you did not match because you are an unqualified hack who never belonged in this business in the first place and you will never achieve your deepest hopes and dreams. Challenge these negative, automatic thoughts! Be frank and ask your advisers. One way to do this is to

ask if they have any suggestions on what you could improve if you took a year and applied again. Even if you do not intend to wait, knowing your weaknesses will help you to become a better Clearinghouse applicant. That said, do not spend all of your time obsessing over this point because the inscrutable methods of the computer match do result in very good applicants not matching.

You will need to focus all of your energy on giving your best performance to the Clearinghouse, so make up your mind by the end of Friday. Remember, the Clearinghouse is nonbinding (at least until you accept an internship), so you can back out at any time if you change your mind. There are a lot of significant (and negative!) existential questions you will want to ask yourself in this process. *Is this a sign that I was never meant to be a psychologist? Are my plans for the next year completely ruined? Does my partner/adviser/mother still love me even if I didn't match?* Work, talk to peers, consult with faculty, or whatever you need to do to distract yourself from questions like these and maintain a positive perspective during this process. To be clear, I am recommending avoidance here, as next week there will be plenty of time to think about these things.

Social Support

As we would tell any of our clients facing a significant stressor, maintaining strong social support is a key to surviving the Clearinghouse process. In actuality, many of the tips I can offer boil down to nothing more than "practice what you preach!" Unmatched applicants may be tempted to isolate and avoid contact with graduate student colleagues. I did exactly the opposite. On Friday, I did not hide the fact that I had not matched; I e-mailed my friends, consulted with numerous colleagues, and even spoke about what happened to first-year students I barely knew! For me, this level of disclosure demystified and destigmatized not matching and I became someone who my classmates could rally around to help out of a bad situation. Your internship applicant cohorts will want to celebrate. Join them. You do have a reason to celebrate after all; many of your peers have finished the process! You will need the support, so seek it out early. It is for these reasons that you have built and maintained relationships with the others in your graduate program for so long. It is time to take advantage of those relationships.

The Weekend

I had survived Friday and went to sleep knowing I was going to give the Clearinghouse a shot. I woke up Saturday, feeling refreshed, depressed, and ready to work. Applications for the Clearinghouse consist of a 10-page document that contains at least your vita and an optional cover letter. I had to slim my vita, and I wrote about three different cover letters to be sent to different types of sites (in my case, child clinical, pediatric psychology, and generalist programs). Between fielding calls from people worried about me, I attempted to learn everything about every internship site that existed. Below are several things I did over the weekend that were most helpful to me on Monday.

Clearinghouse Application

It goes without saying that you will spend much of the weekend working on your vita and cover letters for your application. Obviously you will send these documents to your adviser for his/her feedback, but I would say you should go one step further—send them to everyone you can. For instance, I had my fellow internship cohort, several faculty I knew, my parents, and my fiancée all reviewing my application. My parents (neither of whom do anything at all related to psychology) offered perhaps the best advice I received by encouraging me to make my cover letter as eye-catching (in terms of content, not style!) as possible so that internship coordinators who receive literally hundreds of applications can quickly identify me as an excellent candidate.

Broaden Your Search

You have not done enough research into internships sites to be prepared for the Clearinghouse. Part of this is because none of the sites you ranked and only 15% of the other sites you initially researched will be on the Clearinghouse vacancy list. These are statistical realities (APPIC, 2008). During the Clearinghouse, you will need to know very quickly which sites to apply to. This is a daunting task, and it requires you to be explicit about what you are willing to consider. For myself, I asked if getting a site with certain (less desirable) features would be better for me than spending another year in graduate school. Some features about sites to consider: Are you willing/able to move anywhere on the continent (including Hawaii, but who wouldn't live there for a year!)? Are there any experiences you must have on internship (I insisted on some form of experience with children or adolescents)? Are you willing to consider non-APA accredited internships? There are about twice as many nonaccredited sites on the Clearinghouse list as there are accredited ones, but be careful about what your graduate program and future licensure board(s) require for your internship—consult your Director of Clinical Training first. Don't lose hope about there not being any great internship sites on the list. Just as fantastic applicants can be mistreated by the matching algorithm, so too can fantastic sites. You can expect that at least one or two of these sites will appear on the Clearinghouse list.

Your Team

Despite the intense desire to isolate, seeking out assistance from other people will be extremely helpful in the Clearinghouse process. I recommend getting a team together of fellow graduate students who will help you on Monday. These should be people with whom you can work easily, especially under stress, and they should be willing to give up at least half of their Monday. You may want to bribe them with such things as food, eternal gratitude, and stats help. Over the weekend, compile this team and get them organized and ready for Monday. Decide where to meet and formulate a plan about what you want each of them to do, with specific instructions. In my case, I actually had other graduate students mailing applications from my e-mail address in order to save time. You definitely want well-prepared people doing that! You will also want to prepare your team for the madness that will occur at 10:00 A.M. The list of open sites is likely to be at least 30 pages long, and your team can help you sort, research, and apply in the shortest amount of time possible. There are few things as formidable in this world as a room containing 4 to 10 highly motivated and intelligent graduate students; having that kind of resource on your side will allow you to tackle anything that the Clearinghouse gives you.

Start Networking

Networking will be a crucial part of the process, and the more people who know that you are looking for sites, the more people available who can recommend you or let you know should an opening arise. I spent a fair amount of my time over the weekend e-mailing every person I could think of to inform them that I would be in the Clearinghouse and asking them to let me know if they knew of any good openings. I

e-mailed graduate students on internship, friends, family, and the entire faculty of my program. Your faculty advisers will have many friends across the country, and I cannot state strongly enough how important it is to be tapped into their networks when Monday rolls around.

In the end, have everything ready and get a good night's sleep in preparation for Monday. Despite my advice to not do this, you will spend much of the weekend contemplating if this is the right decision for you, and this is natural (and exactly what I did). Before you go to sleep on Sunday, however, make sure you recommit yourself to your decision and be ready to hit the ground sprinting on Monday.

Monday

Monday morning I woke up, ran to the store, bought doughnuts, and was in the basement of the psychology building until well after the sun had set. When the 10:00 A.M. bell rang, my team was a flurry of activity, all somewhat choreographed by me. The adrenaline rush of having a team to manage and applications to send completely drove from my mind, until early evening, the self-pity and self-doubt that I had been fighting off all weekend. Being in the psychology building also helped because I was frequently visited by my faculty advisers who were always supportive and interested in the process (I don't think my program has ever seen anything quite like what we put together that morning). By lunch time, I had applied to more places than I had originally applied to, and I was able to be fairly selective in those Clearinghouse sites to which I applied.

That being said, this was not a fun process. The first internship filling was posted 66 minutes after opening. The majority of the sites I applied to never even responded to my initial e-mail. By the early evening I was out of sites to apply to and had little motivation left to do anything, least of all think about what to do next. The numbers say that approximately 24% of applicants who find a match through the Clearinghouse do so on Monday, and I was one of the other 76%. I held on to the hope that I would be among the 50% that match in the first week, but I knew that about 44% of those unmatched on Match Day remain unmatched. While those two numbers loomed, my team disbanded, and I was left alone with nothing left to do but wait (and speak to my parents who had been calling me every 3 hours since Friday). Monday night may have been the worst night of the process. Here are a few tips that may help you become one of the 24% that does match on Monday!

Inform Faculty and Advisers

Networking is one of the most important tools you have during the Clearinghouse process—take full advantage of it. Inform your advisers of all the sites you have applied to and see if they know anyone at those sites who they might contact on your behalf. Sites are looking for anything to help them weed through the hundreds of applications they receive. If a recommendation from an old colleague accomplishes that for your application, so much the better.

Call Internship Sites

One thing I regret not doing more of is calling sites to make sure they received my materials. Some advice I received from another successful Clearinghouse intern was to call the sites in which you are most interested. This way the site knows that you are truly interested in them, and they may give you valuable information. Of course, you should also be prepared for limited information—if they even answer the phone. It is a hectic time for them too! Regardless, it is vitally important that you be reachable not only by phone, but also via e-mail constantly in case sites ask for more information or change their application requirements.

The Rest of the Week

Here are some tips on how to handle the rest of the first week and beyond. Don't forget, only 50% of those who find a match through the Clearinghouse do so in the first week!

Phone Interviews

Once you've sent the initial barrage of applications, begin thinking about how you want to handle phone interviews when they come. You will need to be prepared at a moment's notice because you will probably not be able to reschedule them. Sites probably do not expect you to know everything there is to know about them. They know they are in the Clearinghouse and how it works. Prepare in advance a list of crucial things that you will want to know from each site (e.g., hours, rotations, theoretical orientation, benefits). Much of your material/knowledge from regular internship interviews will be of use here. However, time may be limited, so prioritize and try to take away the most important information from each interview.

Offers

You will likely not be able to predict in advance how many offers you will be receiving, so plan for getting more than one. APPIC guidelines suggest that when sites make an offer, they do not require you to decide immediately. Further, APPIC *suggests* that sites give you at least 4 hours to make a decision after an offer has been made. While 4 hours may seem like a very short time, the truth is that sites do not have to do either of these things! If they make you an offer, no matter how certain you are, ask them for time to think the offer over. Remember, once they make you the offer, they cannot take it back; the ball is in your court! If you are given some time to make a decision, make a realistic estimate about your chances with other sites, call the ones that you are most interested in, and let them know you are considering another offer, and ask them when they will be making offers and where you fall in their rankings. In the end, use your best problem solving, and do not look back on your decision.

Resume Normal Life

When you feel ready, it will be time to resume doing all the things you were doing the week before Match Day. This will mean seeing clients and working at practicums, research, and classes. For each, you should make an informed decision about whether you are ready to return. Do not under any condition see clients on Monday! You cannot afford to give them your undivided attention, and you probably aren't in a satisfactory mental state yourself. As the week goes on, you can take longer breaks between checking your e-mail—though I still kept my cell phone on and with me at all times. No matter what happens with the Clearinghouse or what decisions you make, remember that you are still a normal graduate student for the next 3 months with the same expertise, skill, and expectations you had before Friday. You were good at your job before and you still are!

Consider Your Options Again

As the week wears on, if you can maintain a positive or, at least, a realistic perspective, you will likely have a better idea of how things are going. Do you have several promising sites that you know are still considering applications? Have you not heard back from any sites at all? If nothing else, by

the end of the Clearinghouse process, many unknowns have now been made known, and you can make a more informed judgment about what to do next. What would another year of graduate school look like? Have you learned of anything in your application that you could improve by next year? Whatever you do, practice what you preach and use solid cognitive restructuring, emotional awareness, social support, and behavioral activation to make the best of the situation.

My Success Story

In the end, it was networking that made my Clearinghouse process a success. I awoke on Tuesday, not quite sure how to proceed. Over the day, I ended up calling several of the sites to which I had applied to ask about their process. Some were helpful (in the sense that they told me they had filled their position) and some were not (not answering their phones). But later Tuesday afternoon a site that had a previous history with my program called to schedule an interview. At the time, I still had some other sites I was wondering about, but by the time the interview came on Wednesday, I was down to almost none. The interview went very well, and they made me an offer on the spot, giving me until Thursday morning to decide. Conversations followed with my family, advisers, and fiancée, which involved many a "bird in the hand" or "glass half full" or "make lemons from lemonade" analogy. Despite the site not being in the exact area of my interest (rehabilitation psychology vs. child/adolescent), they were willing to make accommodations for my interests and training. The atmosphere of the site fit my experience and preference perfectly, and the answer was fairly obvious. I made my final decision at 5:00 P.M. Wednesday and haven't looked back.

In the end, I found a very good, APA-accredited site that will provide me with excellent training and (also important) the ability to graduate in 2009 rather than 2010! Social support, my advisers, and practicing the cognitive restructuring we so regularly preach were the keys to my success in the Clearinghouse and would have resulted in success for me regardless of the outcome. I truly believe that whatever happens can turn out for the best if you take care to approach it from the correct perspective.

So whether you experience the Clearinghouse firsthand, advise a student or friend who does, or just better appreciate the struggles of those who do, I hope my advice has been helpful. For me, this process has been the final step in taking the lemon of not matching and making it into the lemonade of passing on what I learned to others. Good luck!

Reference

APPIC. (2008, February 25). *2008 APPIC Match Statistics: Match Report from the APPIC Board of Directors.* Retrieved February 3, 2009, from http://www.appic.org/match/5_2_2_1_10_match_about_statistics_general_2008.html

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The authors wish to thank David Hansen, Ph.D., and Mary Fran Flood, Ph.D., for their extensive help with the editing and preparation of this article as well as their support throughout the Clearinghouse and internship processes.

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Book Reviews

Sherman, M. D., & Sherman, D. M. (2005). *Finding My Way: A Teen's Guide to Living With a Parent Who Has Experienced Trauma.* Edina, MN: Beaver's Pond Press.

Sherman, M. D., & Sherman, D. M. (2006). *I'm Not Alone: A Teen's Guide to Living With a Parent Who Has a Mental Illness.* Edina, MN: Beaver's Pond Press.

Reviewed by Patricia A. Bach and Michael Vernale, *Illinois Institute of Technology*

The mother and daughter team of Michelle and DeAnne Sherman have combined their respective experience as clinical psychologist and teacher of teens in composing a pair of self-help books (available at http://www.seedsofhopebooks.com) for teenagers whose parents are experiencing mental health problems. The more recent, *I'm Not Alone: A Teen's Guide to Living With a Parent Who Has a Mental Illness*, focuses on schizophrenia, bipolar disorder, depression, and addictions. *Finding My Way: A Teen's Guide to Living With a Parent Who Has Experienced Trauma,* while emphasizing PTSD, also briefly addresses addictions, depression, and anxiety. Adolescents may need outside resources to help them cope with a parent's mental illness, yet the stigma of mental illness leaves many reluctant to discuss or ask questions about their parent's mental illness (Tussing & Valentine, 2001). Self-help books are, therefore, a natural for teens. They have the advantages of being inexpensive, readily available, and don't require asking questions or disclosing information (Green & Malouff, 2007) that may be embarrassing to an ashamed and confused teenager.

Sherman and Sherman do a good job of providing psychoeducation, normalizing teens' reactions to a parent's mental illness, describing and facilitating identification of a variety of positive coping skills, encouraging social support and helping the reader identify persons with whom they might communicate, understanding what the parent is experiencing and how to be helpful to one's parent with a mental health problem, and describing additional resources. All of this is written in a tone that offers support and hope to the reader.

Part I of each volume begins by addressing the question, "Why should I read this book?" and space is provided for the reader to write down responses to questions about their recent experiences with their parents. The authors then, and repeatedly, emphasize that the reader is not alone in their experience, pointing out that there are many teens in similar situations and that the reader is not as alone as she might feel. In

Finding My Way, Sherman and Sherman provide easy-to-understand information about the causes, symptoms, and course of PTSD. They provide short vignettes of parents with PTSD and describe the teenagers' bewilderment, anger, sadness, confusion and other reactions to their parent's behavior. The authors also describe reactions to trauma including social anxiety, panic attacks, depression, and substance abuse. *I'm Not Alone* is organized in a similar fashion with information about schizophrenia, bipolar disorder, and depression followed by a section on substance abuse co-occurring with mental illness. Readers are invited to describe their parent's behavior and their reactions to that behavior. The authors attempt to explain why persons with mental illness behave as they do (including turning to drugs or alcohol). Importantly, there is also a short section on what to do if a parent is suicidal, including the toll-free phone number of a national suicide hotline. Part I concludes with descriptions of different treatment options (e.g., therapy, support groups, medication, family therapy) for the parent and for family members. Brief personal accounts, poems, and writing from teens are scattered throughout Parts I and II, adding a warm personal touch to the information provided.

While Part I focuses on psychoeducation about mental illness, Part II speaks directly to the teen. In our opinion, two of the most valuable aspects of the books are normalizing the feelings and experiences of the teenager with a mentally ill parent, and making clear that they did not cause their parent's problems. The reader is offered the opportunity to write about his feelings and experiences with his parent and to explore questions he'd like to ask his parent or another adult. The authors then describe several coping skills with examples and provide an opportunity for the reader to identify the coping skills that might best suit and be most helpful to him. Social support is addressed next, with discussion of the benefits of sharing with others and exercises for identifying social supports in the teen's milieu, and advice and exercises on how to discuss their parents' problems with others, including peers. We enjoyed the next chapter on supporting one's parent, as it offers the reader the opportunity to explore how he might offer support and comfort in a situation where feeling helpless is common. The authors provide an opportunity to explore how one might feel proud of their parent and might also miss and grieve over "the way things used to be" before the onset of the illness. *I'm Not Alone* includes an additional chapter in Section II on strategies for managing crisis situations, such as when a parent behaves violently or bizarrely or needs to be hospitalized.

Part III begins with a summary of lessons learned throughout the book and with an opportunity for the reader to identify what she has learned about herself. There is then a chapter on frequently asked questions about PTSD or mental illness, and a glossary of mental health terms and definitions that might be unfamiliar to the average teenager. Both volumes conclude with a list of resources for adults and children, including books and websites. One of us (MV) reviewed several of the listed websites and found that they offered the promised content and were aimed at the appropriate audience.

While both books have a similar organization and we have described them together, there are some differences. We both found *I'm Not Alone* the better of the two books. As the more recent of the two books, we speculate that the authors improved on the earlier *Finding My Way*. The vignettes in the latter were at times vague on describing teens' reactions to parents with PTSD. In addition, females were underrepresented as examples of both teenagers and parents. By focusing exclusively on feelings the teen might have in response to a parent's problems, both books fail to address the possibility that teens might be engaging in maladaptive behavior. We also felt that it might have been useful for the authors to further describe the possible benefits of journaling/completing the exercises in the book. However, these minor shortcomings are mitigated by the many strengths described above. In sum, we think these books are likely to be useful for teens to read on their own or to read as an adjunct to therapy. They are likely to provide the teen with useful knowledge about mental illness, to identify ways of coping, to offer reassurance that the teen did not cause her parent's problems and that she is not alone, and, most of all, to offer hope.

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Special Interest Groups

Minutes of the Annual Meeting of Members

Saturday, November 15, 2008, Orlando, Florida

Call to Order

President Albano welcomed members to the 42nd Annual Meeting of Members and called the meeting to order at 12 noon. Written notice of the meeting had been sent all members in August.

Minutes

Secretary-Treasurer Ronan asked for any comments or corrections to the minutes from last year's meeting; hearing none, he asked for a motion to accept.

M/S/U: Minutes of the November 17, 2007, Annual Meeting of Members were unanimously accepted as distributed.

Service to the Organization

President Albano noted that ABCT is blessed with an incredible staff who are the backbone of the organization, holding down the fort while looking toward the future. Members don't know what goes into putting together the conference, keeping the publications, list serve, the web, and membership functioning smoothly. We thank Mary Jane Eimer, Mary Ellen Brown, David Teisler, Stephanie Schwartz, Tonya Childers, Lisa Yarde, Keith Alger, and Damaris Williams. They stay with us in spite of us.

President Albano thanked the members of the Board for their hard work on behalf of the organization. Many projects have advanced under their leadership. She especially thanked Jonathan Abramowitz, who is rotating off after 3 years as Representative-at-Large and the Board liaison to Membership Issues, and Ray DiGiuseppe, rotating off as Immediate Past President.

President Albano said a special thank-you to Past Presidents Steve Hollon and Michael Otto, who spent untold hours reviewing practice guidelines generated by the American Psychiatric Association. Dr. Hollon reviewed the guidelines on depression and Dr. Otto reviewed guidelines on bipolar disorder in adults. She remarked how pleased she is that APA has continued to keep ABCT on their list of essential reviewers.

President Albano thanked our outgoing committee chairs Susan M. Orsillo, Academic and Professional Issues Coordinator, who completely energized the entire set of committees reporting to her; Steven E. Bruce, Committee on Research Facilitation Chair, who began great work on the website, offering lots of new resources; M. Joann Wright, Committee on Awards and Recognition Chair, for fabulous choices that represent us well; John Klocek, Continuing Education Issues Committee Chair, for getting the CE calendar off the ground; Trevor Hart, Special Interest Groups Committee Chair, who energized the base of the organizations; Kristen Sorroco, Membership Committee Chair, who kept 5,000 members happy, and Stefan G. Hofmann, Editor, *Cognitive and Behavioral Practice*, Volumes 12-15, who oversaw the transition to electronics and managed a journal very near to her heart.

President Albano thanked the outgoing members of the Membership Issues Committees: Trevor Hart for his wonderful job as the Chair of the Special Interest Groups Committee—the program has expanded to over 40 SIGs under his leadership; and Kristen Sorocco for her role in expanding our membership and coordinating terrific seminars to New Member Professionals during the annual convention as Chair of the Membership Committee.

President Albano also thanked the outgoing members of Convention and Education Issues, including Joseph Scardapane, Committee on Institutes Chair, Patricia M. Averill, Committee on Master Clinician Seminars Chair, and noted her great friend and colleague, and the woman who put this show together, Sandra S. Pimentel, 2008 Program Chair.

President Albano also thanked the members of the Program Committee for their time and dedication they offered to help put together a program of this quality and complexity. She thanked those who helped review program submissions:

Anne Marie Albano, Wesley D. Allan, Drew A. Anderson, David C. Atkins, Sonja V. Batten, Carolyn Black Becker, Kathryn Bell, Debora J. Bell, Jennifer Block-Lerner, Michele Boivin, Carolyn E. Brodbeck, Elissa J. Brown, Steven E. Bruce, Annmarie Cano, Cheryl N. Carmin, Corinne Cather, Alexander L. Chapman, Brian C. Chu, Mari L. Clements, Rebecca J. Cobb, Marlene J. Cohen, Dennis R. Combs, Jonathan S. Comer, Jill S. Compton, James V. Cordova, Ronda L. Dearing, Thilo Deckersbach, Patricia Marten DiBartolo, David DiLillo, Brian D. Doss, Laura E. Dreer, Greg Dubord, Jill T. Ehrenreich, Frank D. Fincham, Marie A. Franklin, Sharon Elizabeth Morgillo Freeman, David M. Fresco, Patti A. Timmons Fritz, Richard Gallagher, Scott T. Gaynor, Kim L. Gratz, Laurie A. Greco, Amie E. Grills-Taquechel, Lindsay S. Ham, Melanie Harned, Trevor A. Hart, Flora Hoodin, Jennifer L. Hudson, Sue C. Jacobs, Emily Thomas Johnson, Matthew D. Johnson, Maria Karekla, Shalonda Kelly, Robert S. Kern, Muniya S. Khanna, Brett R. Kuhn, Jennifer Langhinrichsen-Rohling, Robert H. LaRue, Jean-Philippe Laurenceau, Erika Lawrence, Penny A. Leisring, Patricia J. Long, Jennifer D. Lundgren, Dean R. McKay, Robert J. McMahon, Daniel W. McNeil, John R. McQuaid, Elizabeth A. Meadows, Catherine R. Michas, Lynn D. Miller, Todd M. Moore, Douglas W. Nangle, Amy E. Naugle, Tara M. Neavins, Larissa N. Niec, Conall M. O'Cleirigh, Bunmi O. Olatunji, Holly K. Orcutt, David W. Pantalone, Michael R. Petronko, Sandra S. Pimentel, Sheila A. M. Rauch, Jennifer P. Read, Simon A. Rego, Dana L. Rofey, Ronald D. Rogge, Kelly J. Rohan, George F. Ronan, Kristalyn Salters-Pedneault, Steven L. Sayers, Kathleen J. Sexton-Radek, Tamara Goldman Sher, Jillian C. Shipherd, Sandra T. Sigmon, Jasper A. J. Smits, Jennifer A. Snyder, Amy E. Street, Gregory L. Stuart, Kimberli R. H. Treadwell, Matthew T. Tull, Cynthia L. Turk, Robert L. Weiss, Amy E. Wenzel, Mark A. Whisman, Kamila S. White, Pamela S. Wiegartz, Nathan L. Williams, Claudia Zayfert, and Michael J. Zvolensky.

President Albano thanked the Local Arrangements Committee, including its Chairperson, Deborah C. Beidel, and all the committee members: Jeff Bedwell, Pam Brown, Stacey Dunn, Beth Hammons, Sharon Hayes, Vidya Kamath, Katy Lacefield, Teri Marino, Melissa Middleton, Charles Negy, Diana Orem, Joe Raiker, Kim Renk, Dustin Sarver, Samantha Scott, Scott Sutterby, Theresa Trombly, Betsy Wack, and Rachel Wolfe.

President Albano asked the Coordinators to give the membership an idea of the issues confronting the Association and our efforts to deal with them.

Coordinator Reports

Academic and Professional Issues

Coordinator Sue Orsillo reported that 99% of her work is generated from her committees and the Executive Director. She noted that her committees are putting lots of material up on the website. Jennifer Block-Lerner's Committee on Academic Training continues to expand the graduate and undergraduate syllabi available on the web; and they are developing a directory to link those of our members who have already provided training to the medical community with physicians and others in allied health professions. They are also working to develop a mentorship directory. Joann Wright, as you've no doubt seen, did a great job as Awards and Recognition Committee Chair these last 3 years. Under her direction, a subcommittee developed policies on named awards; and another subcommittee is working on developing a Self-Help Book Award program to further our priority of disseminating CBT to the public. Steve Bruce has done a great job expanding the material available to researchers on the website as well as writing for *tBT* in his role as Chair of the Research Facilitation Committee; Amy Wenzel, Committee on Professional Issues Chair and her committee members, continue to develop a program to showcase our members' treatment manuals and to provide commentary on other existing manuals; and committee members are exploring innovative ways to expand opportunities for clinicians to be get the most out of ABCT; Steve Hayes is at the helm of International Associates Committee and coordinating with the WCBCT slated for Boston in 2010; and Kevin Arnold remains our point person on the Committee on Specialization in Behavioral and Cognitive Therapies Within Various Professions.

Convention and Education Issues

Coordinator Art Freeman noted that members complain that there's too much to do here. What a wonderful problem. He noted that there were 2,528 preregistered for the convention, and 420 have registered on-site to date. He complimented Sandy Pimentel on putting together a great, BIG program; he thanked Cheryl Carmin for having left him with great committees, noting, "I'm standing on the shoulders of giants." He said he is looking forward to the next 2 years in New York and San Francisco. "I'll see you there."

Membership Issues

Coordinator Mitchell Schare noted that we are ahead of last year—4,882 members compared to 4,734—so we're growing, especially our student members, although our full membership rolls are flat. We need to encourage students to become full members and we need to get members into leadership. To help this, we recently rolled out the Ambassador program to encourage faster and greater participation among our newer members. He thanked Joaquin Borrego, Chair of the Student Membership Committee, who just completed a student survey to better understand and serve our student members; Kristen Sorocco, Chair of Membership Committee, just as we are enjoying a tremendous growth spurt; Kristene Doyle, Chair of Leadership and Nominations, who is looking at ways to increase participation in our governance and did a fabulous job coordinating a "meet and greet" of current and past leadership for attendees' at the Friday-night Welcoming Cocktail Party; Trevor Hart, Chair of the SIG Leaders Committee, who was essential to our expanding SIG program; Jerry Tarlow, who heads up the Clinical Directory and Referral Services Committee that just launched the new Featured Clinician and continues to make our Find-a-Therapist directory more user friendly; and Laura Dreer, Chair of the List Serve Committee, which becomes a more and more useful activity daily. He urged the membership to nominate colleagues for the 2009 election and that members will have the opportunity to cast their votes electronically.

Publications

Coordinator Philip Kendall reported that Publications were in great hands: Mitch Prinstein heard the Board of Directors and is making their ideas a reality on the web; Rick Heimberg continues to set the pace for manuscript flow, handing more manuscripts, and well, than in two decades; he'll be leaving *Behavior Therapy* in the capable hands of Tom Ollendick, who begins accepting submissions come January; Maureen Whittal recently took over the reins at *Cognitive and Behavioral Practice* and is working hard to maintain the fastest turnaround for manuscripts and a climbing impact rating; *tBT* remains in the capable hands of Drew Anderson; Brian Chu and Ellen Flannery-Schroeder are working to develop and expand both the number of offerings and the vehicles that deliver them; Elizabeth Gosch is coordinating our application to Med Line and actively rewriting policy on journal authors and reviewers covering conflict of interest, consort statements, and more; Bryce McLeod is heading up a task force to review how we publish the journals; and David Teisler, at the Central Office, makes it happen.

Executive Director's Report

Mary Jane Eimer, ABCT's Executive Director, noted that the Board of Directors finalized the Policies and Procedures last year, and this year they are tackling a Board Assessment Procedures to evaluate its own performance. She thanked the leadership, who spend untold hours in your service. She said that communication among committees is horizontal and vertical, probably the best it has ever been. She noted that ABCT is partnering with Boston University Center for Anxiety and Related Disorders and Boston University School of Social Work to host the World Congress of Behavioral and Cognitive Therapies in Boston, June 2-5, 2010. She said that we're about to say "uncle" because of the difficulties we've encountered with our association management software, and will likely change suppliers for next year, which, she hopes, will make the renewal and registration process so much easier for members, attendees, and staff. She thanked Tonya Childers, our Registrar and Exhibits Manager; Lisa Yarde, our Membership Services Manager; Keith Alger, Administrative Secretary and our newest member of the team who is handling the list serve, and is likely the initial voice you hear when you call; Damaris Williams, who has brought great consistency and an even keel to our bookkeeping slot; Stephanie Schwartz, our efficient Managing Editor who also brings tremendous design talents to many of the products you see; plus Mary Ellen Brown and David Teisler, who always have the Association's best interest at heart and who are consummate professionals and who make coming to work a pleasure. She also thanked Anita Nazario and Colleen McIntyre, two freelancers we hired who pitched in to help make this year's convention run smoothly.

Secretary-Treasurer's Report

Secretary-Treasurer George Ronan recounted ABCT's tremendous long-term success, stating, "The Association has had a tremendous influence" on health care, noting that the typical person on the street is likely to have heard of CBT; and that's not an accident. He acknowledged all the hard work that has gone into developing our website and was quite positive regarding its

influence on disseminating CBT to the public. Given the major impact ABCT has had in fostering CBT around the world, he suggested that we consider instituting a program for both members and patients who have benefited to either gift or endow funds to the Association.

Secretary-Treasurer George Ronan reminded the membership that the Finance Committee oversees the fiscal health of ABCT; monitors income, expenses, and projections; ensures funds are available for achieving specified goals; makes recommendations regarding personnel; ensures reserve funds are invested prudently; evaluates financial considerations related to ownership of permanent headquarters. He noted that the committee is comprised of the Financial Secretary plus two hand-selected members, Judy Favell and Frank Andrasik (the latter to be replaced by Mike Petronko next year), and the President-Elect, currently Bob Leahy. The scope of the work includes reviewing all budget lines and meeting in November and each spring, with additional frequent communication with Damaris Williams, ABCT's bookkeeper, and M. J. Eimer, Executive Director.

He reported that revenues come from three main sources: 42% convention ($739,349); 26% dues and other fees ($446,736), 27% publications ($464,884), plus 5% from other sources ($93,367). For the year just ending, we project an income of $1,590,733 against expenses of $1,481,386, for net income after expenses of $109,347. In addition, ABCT has earmarked funds to several projects, including funds for the 2010 World Congress, Capital Expenditures for replacing our headquarter's air-conditioning unit and office renovation, Technology Enhancement Funds, and for the 2011 Strategic Planning Retreat. He discussed the Association's long-term investments, indicating that 62% were in equities; 38% were in bonds; and 8% was in cash. He noted that the Association's long-term investments are down 26%, which is not unusual in this global economic downturn. The Finance Committee is exploring options for selecting a financial consultant to help manage long-term investments.

He concluded his report noting that ABCT is fiscally sound; we consistently pass yearly independent audits; we follow accepted accounting principles; we are compliant with all state and federal regulations; our budget is completely transparent; we track staff time and task allocation. He concluded by remarking that he is cautiously optimistic during this recession and sees no need for Congressional Bailout.

President's Report

Anne Marie Albano recounted that "1985 was my first year year at ABCT, and I couldn't be happier than to have been able to serve this organization that has been so important for me for the last 20 years." She again thanked all the members of the governance and staff for working together so effectively.

New Appointments

President Albano announced the following members would be serving the Associaton in leadership capacities in 2008 and, for most, beyond:

M. Joann Wright: Academic and Professional Issues Coordinator (2008–2011)

Lata McGinn: Program Chair, New York City (2009)

Jan Mohlman: Local Arrangements Chair (2009)

Hilary Vidair: Membership Committee Chair (2008–2011)

Colleen Carney: Special Interest Groups Committee Chair (2008–2011)

Michael Petronko: Finance Committee Member (2008–2011)

David Haaga: Awards and Recognition Committee Chair (2008–2011)

Patricia Averill: Committee on Institutes Chair (2008–2011)

Joseph Scardapane: Committee on Master Clinician Seminars Chair (2008–2011)

Transition of Officers

President Albano announced the transition of officers: Frank Andrasik will serve as 2008-2009 President-Elect; Cheryl Carmin joins the Board as Representative-at-Large and liaison to Membership Issues; and Bob Leahy becomes, once I hand over this gavel, your President.

Adjournment: There being no further business, the meeting was adjourned at 1:04 P.M. Eastern Standard Time.

Call

***for* PAPERS**

President's New Researcher

Submissions must be received by August 13, 2009, and must include four copies of both the paper and the author's vita. Send submissions to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.

ABCT's President, Robert L. Leahy, Ph.D., invites submissions for the 31st Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of $500. Submissions will be accepted on any topic relevant to behavior therapy, but submissions consistent with the conference theme emphasizing universal processes across cognitive behavioral models that have been implicated in the development of vulnerability and treatment of psychopathology are particularly encouraged. Eligible papers must (a) be authored by an individual with five years or less posttraining experience (e.g., post-Ph.D. or postresidency); and (b) have been published in the last two years or currently be in press. Submissions can consist of one's own or any eligible candidate's paper. Papers will be judged by a review committee consisting of Robert L. Leahy, Ph.D.; Anne Marie Albano, Ph.D., ABCT's Immediate Past-President; and Frank Andrasik, the ABCT President-Elect.

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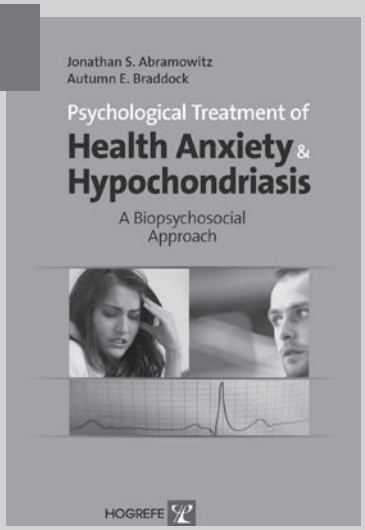

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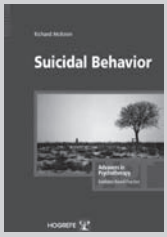

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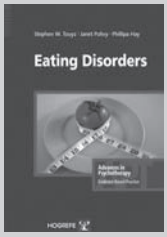

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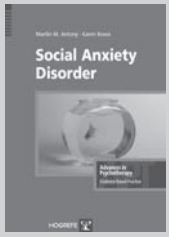

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