

the Behavior Therapist

Contents

From the Editor

Drew Anderson 1

Obituary

Cyril M. Franks and Janet L. Wolfe

Albert Ellis (1913–2007): Appreciation and Perspective
by Two Who Knew Him Well 3

Special Series: DISSEMINATION

Presented by the Couples Research and Therapy SIG

- William A. Aldridge II
Introduction 10
- Matthew R. Sanders
“Going to Scale”: Implementing a Population-Level
Parenting and Family Support Intervention 11
- Howard J. Markman, Tamara Williams, Lindsey Einhorn,
and Scott M. Stanley
The New Frontier in Relationship Education: Innovations
and Challenges in Dissemination 14
- Tera R. Hurt, Kameron J. Franklin, Steven R. H. Beach,
Velma McBride Murry, Gene H. Brody, Lily D. McNair,
and Frank D. Fincham
Dissemination of Couples’ Interventions Among African
American Populations: Experiences From ProSAAM 17
- William A. Aldridge II
Developing a Career in Applied Dissemination:
Reflections From a Graduate Student 19

CLASSIFIEDS 21

Plus . . .

- Call for Award Nominations/Student Awards Program 22
- Photo Gallery, 2007 Awards Ceremony 23
- Call for Nominations—the Next Candidates for ABCT Office 25
- ABCT Ambassadors: A New Program 26
- Call for Papers for the 42nd Annual Meeting *back page*

From the Editor

Drew Anderson, *SUNY, Albany*

Allow me to introduce myself. My name is Drew Anderson, and I am the new editor of *tBT*. I am extremely honored to serve as editor of *tBT*. ABCT has been my professional home since I began graduate school (I haven’t missed a conference since 1993), and it is an enormous part of my professional identity. I have served the organization in a number of ways; for example, I have been on the conference program committee almost every year since 1998, and I was also chair of the Obesity and Eating Disorders SIG from 2002 to 2005. This position is another wonderful way for me to give back to ABCT.

The mission statement of *tBT* notes that it is intended to be “a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.” I think these are absolutely critical functions, and they cannot be duplicated by any other ABCT publication. Because it is the only publication received by all members of ABCT, *tBT* must have a broad scope, and its previous editors have done a wonderful job of providing a venue to discuss a wide variety of topics of interest to all of our members. In particular, I want to acknowledge David Reitman, the outgoing editor of *tBT*. David did a great job as editor and he has made my transition to editor a smooth one. David assembled a great team of associate editors and, thankfully, several of them have agreed to stay on. With the addition of some new faces, we have an editorial team that I hope will continue to move *tBT* in the direction that David has taken it over the past 3 years.

This is an exciting time in the field of the cognitive and behavioral therapies, and I would like for *tBT* to be a vehicle to explore some of the current issues, debates, and news within both in the organization and the larger world.

tBT serves all its members, and so do I. I have an “open in-box” policy and I strongly encourage you to contact me with articles, news, ideas, complaints (and maybe even some praise). For details about the formal submission process, please review the Instructions for Authors box that appears in every issue of *tBT* (see p. 2).

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Editorial Assistant *Melissa Them*
Behavior Assessment . . . *Timothy R. Stickle*
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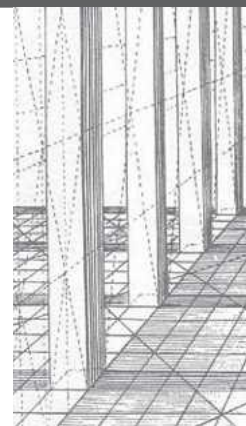
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*The Presidential Panels series springs from
ABCT's 40th annual meeting, during
which the past presidents of the organiza-
tion—some of CBT's most influential
thinkers—gathered to discuss issues facing
the field today and those they have faced
over the past 40 years.*



INSTRUCTIONS for AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a **Copyright Transfer Form** (a form is printed on p. 24 of this issue of *tBT*, or contact the ABCT central office): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Drew Anderson, at drewa@csc.albany.edu. Please include the phrase *tBT submission* in the subject line of your e-mail. Include the first author's e-mail address on the cover page of the manuscript attachment. By conventional mail, please send manuscripts to:

Drew A. Anderson, Ph.D.
SUNY-Albany
Dept. of Psychology/SS369
1400 Washington Ave.
Albany, NY 12222

Albert Ellis (1913–2007)

Appreciation and Perspective by Two Who Knew Him Well

Cyril M. Franks and Janet L. Wolfe

To fully appreciate Albert Ellis' contributions to therapy, it may be helpful to begin with a description of the general psychotherapy scene in the 1950s, when Ellis developed his REBT approach, as well as a brief history of British behavior therapy, where much of behavior therapy began.

In the mid-1950s worldwide, clinical psychology was a new and largely unrecognized discipline utilized by psychodynamically oriented psychologists engaged mostly in personality testing, intelligence testing, and vocational guidance. The prevailing therapy scenes in the U.S., Canada, and the U.K. alike were regrettably similar. All psychotherapy was unswervingly based on Freudian "truths." Everyday matters such as validity, accountability, data, outcome evaluation, and follow-up were regarded as either unnecessary or of no significance. Worse yet, only physicians were considered qualified to engage in this Freudian-based therapy; and for even behavioral psychologists, only research was acceptable.

Behaviorism, a precursor of behavior therapy, was formulated (and to some extent, popularized) in 1913 by the American psychologist J. B. Watson, who preached that there was only stimulus and response, with no such intervening variable as cognition. To the best of our knowledge no one has endorsed this position since Watson's behaviorism. Early behavior therapy in the U.K., on the other hand, rested largely upon the principles of Pavlovian conditioning, with acknowledgment of the then fashionable behavioral, *not* behaviorist, postulates of Clark Hull. Thus, British behavior therapy in the 1950s, and all behavior therapy to this day, is best regarded as behavioral, rather than behaviorist.

What may be described as the nearest approach to a breakthrough in behavior therapy occurred in 1958, when the South African physician Joseph Wolpe wrote his revolutionary book, *Psychotherapy by Reciprocal Inhibition*. Prior to 1958 most behavior therapy procedures had been tedious, time-consuming, and unsuitable for the relatively intact patients with whom

most traditional therapists worked. Around the same time, a small group of British psychologists and Ph.D. students at the University of London Institute of Psychiatry, under the leadership of Hans Eysenck and one of the present writers (CMF, who published his first book on conditioning techniques in clinical practice in 1956), began to explore a potentially viable, painstakingly data-based and testable alternative paradigm. This new data-based model was independently named behavior therapy by Hans Eysenck in the U.K. and by Arnold Lazarus in South Africa.

At first, this proposed new paradigm was totally rejected by virtually all mental health clinicians. Data accumulation remained a slow procedure and unappealing to most clinical practitioners, regardless of professional affiliation. Very gradually, however, behavior therapy became increasingly acceptable, especially to experimentally trained psychologists.

Cognition entered the scene when a small number of forward-looking clinicians, notably Arnold Lazarus, Cyril Franks, and Joseph Wolpe (the first three presidents of this Association), began to think and write about the unavoidable fact that behavior, conditioning, cognition, and affect were all vital components of all human activities. It was also around this same time that Albert Ellis, himself a practicing psychoanalyst from 1948 to 1953, became increasingly disenchanted with the prevailing clinical scene and searched for a viable alternative.

Significantly, the innovations of both Ellis and Lazarus stemmed exclusively from their remarkably creative minds rather than data, although it was data upon which the British founders of behavior therapy insisted. Even in those early days, Ellis—steeped and knowledgeable in certain aspects of philosophy, ancient history, and linguistic analysis—argued, along with most other logical positivists, that for cognitive statements to be meaningful, they must, at least in principle, be empirically verifiable as conceived. However, while both Ellis and Lazarus verbally acknowledged the importance of research, neither

had the inclination to accumulate and analyze data.

In the early days of behavior therapy—perhaps because of the dearth of research data—cognition was, regrettably, given short shrift by behavior therapy's still small number of practitioners. Furthermore, with the dubious advantage of hindsight's 20/20 vision, it was not until 2004 that the Association for Advancement of Behavior Therapy's name was changed to its present Association for Behavioral and Cognitive Therapies (ABCT).

Albert Ellis, an unusually knowledgeable and literate psychologist steeped in the writing of philosophers such as Epictetus, Spinoza, and numerous others, was able to create a seemingly clinically more effective, albeit not data-based, model of therapy. Ellis' first presentation of his new approach was at the American Psychological Association Annual Convention in 1956. At first called rational therapy, and later rational emotive behavior therapy (REBT), Ellis' model gradually expanded to incorporate behavior, conditioning, cognition, and affect. Over the years, eventually Ellis became one of the most widely known mental health practitioners and writers.

Little Albert

Albert Ellis grew up in the Bronx, the oldest of three children. All four grandparents were Jewish immigrants from Russia or Germany. Ellis described his mother as a fun-loving woman who spent much of her time playing mahjong and minimally attending to her children. His father, a traveling salesman, was on the road most of the time except for weekends. Ellis' parents divorced when he was 12. Very early on, Ellis decided that his mother was a "screwball" and he was determined not to take her too seriously. He took on the responsibility of caring for his siblings and, increasingly, Albert and his brother, Paul (with whom he remained close until Paul's death), learned to enjoy the freedom that parental "neglect" seemed to provide. During Ellis' half-dozen or so hospitalizations some distance from his Bronx home between the ages of 5 and 8 (for nephritis and a serious streptococcal infection), his parents did not often visit him.

In his teens, Ellis was a voracious reader, and his primary interest was philosophy. He devoured Epictetus, Marcus Aurelius, Spinoza, Wittgenstein, Bertrand Russell, and Schopenhauer and, according to a lifelong friend, held forth on his reading at a favorite spot in the Bronx Botanical Gardens,

attracting increasing numbers of intrigued friends and curious bystanders. This was also the place where he applied his then novel technique of desensitizing himself to rejection by approaching some 100 young women unknown to him; all but one (who later failed to show up for their date) turned him down! Another of his goals, Ellis reported, was to write Broadway musicals, a dream not realized; however, much later he managed to give expression to his musical bent by writing lyrics for dozens of “rational humorous songs” that became increasingly popular at his therapy training sessions.

Launching His Career

During the Depression years, with his father no longer able to contribute much to the household and his family financially strapped, Ellis made the decision to get a degree in business in order to help out with his family’s financial situation. After earning a B.A. in business from the City University of New York in 1934, he worked first in his own business in partnership with his brother, matching up trousers bought at garment auctions with financially limited customers’ still-useable suit jackets; then, later, as office manager for a novelty manufacturer, where he managed to do an entire day’s work in 4 hours. Ever enterprising, he struck a deal with his boss, who had offered him a raise, to provide him instead with afternoons off. This allowed him to pursue his dream of becoming a great novelist, which he decided to drop when his numerous full-length works were continually rejected.

Discovering that his skills lay in nonfiction writing, Ellis turned to writing on human sexuality, speculatively concluding after some time that disturbed relationships were really a product of disturbed persons, and that “if people were truly to be helped to live happily with each other, they first had better be shown how they could live peacefully with themselves.” This led him to seek a new career in psychology, in 1947 completing his Ph.D. in clinical psychology at Columbia University while beginning his own Freudian analysis. He started a part-time private practice in psychoanalysis and family and sex counseling, and, in the late 1940s, became Chief Psychologist of the New Jersey Department of Institutions and Agencies.

By 1953 Ellis had become increasingly disenchanted with Freudian practice and speculations, and began to set forth the principles of what he termed “rational therapy,” influenced by his readings in philosophy as well as Alfred Adler’s concept of an

“inferiority complex” and Karen Horney’s “tyranny of the shoulds.” He also adapted some of the treatment methods of behaviorist pioneers such as J. B. Watson and Mary Cover Jones to overcome his own public speaking anxiety. This behavioral emphasis remains a major element in his therapy approach.

The less-than-enthusiastic initial reception of Ellis’ novel ideas by many failed to extinguish his own enthusiasm: “Skinner was wrong,” he often explained. Indeed, Ellis passionately persisted, devoting the rest of his life to developing and teaching the approach that he fervently believed could help people to lead happier and healthier lives; and, over the past 30 years, his approach and that of many later cognitive behavior therapists has become increasingly popular, with some two-thirds of clinical psychologists now identifying themselves as using some form of cognitive behavior therapy. (As early as 1982, a survey of American and Canadian clinical and counseling psychologists rated Ellis as possibly having more influence on psychology than Sigmund Freud himself, topped only by Carl Rogers.) Over the decades, Ellis also garnered numerous awards, including the Humanist of the Year award from the American Humanist Association, and awards from ABCT, APA, and the American Counseling Association for distinguished contributions to psychotherapy.

Ellis’ first book for professionals, *Reason and Emotion in Psychotherapy*, appeared in 1962, just a few years before he joined the then-AABT. Subsequent REBT books and articles (the last written a few months before his death) include both professional and self-help books on a wide range of applications, including emotional education for children, addictions, marriage and family problems, workplace issues, overcoming procrastination, anxiety and anger management, assertiveness training, counseling religious clients, aging, and tolerance.

In his numerous books, articles, and lectures, Ellis relentlessly urged people to deal with reality in a rational way and get on with their lives and “have a ball” (without needlessly harming themselves or others). He challenged people to give up the three demands he saw as the root of emotional disturbance: I *must* always do well and be accepted; others *must* approve of me and treat me well; and the world *should* be comfortable and provide me with what I want. Ellis always insisted that there are no *shoulds* in life. But in this respect few would agree with him and neither do we.

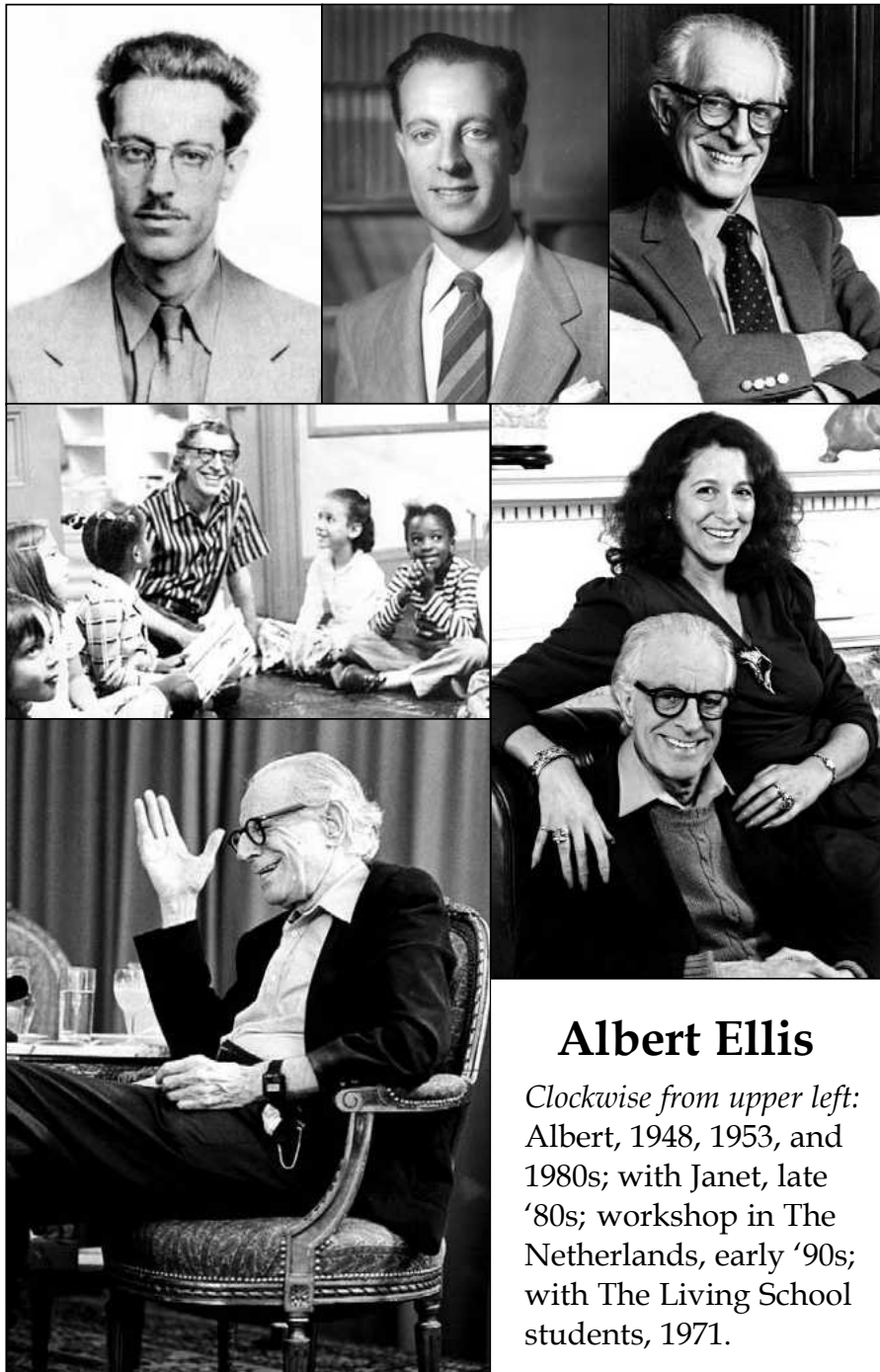
An early exponent of prevention and positive mental health, Ellis founded a school at his Institute in the early 1970s, where children aged 8 to 13 were taught self- and other-acceptance and how to cope with frustration, anger, and anxiety. Curricula based on this pioneering work have been expanded and used by numerous REBT practitioners worldwide. In the area of addictions, SMART Recovery—now one accepted alternative to Alcoholics Anonymous—is based on teaching people REBT as a means of reducing the emotional upset that often leads them to self-medicate through alcohol or drug abuse.

In 1959 Ellis founded the Institute for Rational Living, moving in 1965 to new headquarters in Manhattan and acquiring a charter in 1968 from the Board of Regents of New York State as one of this country’s first mental health facilities headed by psychologists rather than physicians. With Ellis putting most of his considerable income toward maintaining its operation, and with the loyalty of Janet Wolfe, its director for 37 years, the Institute grew from a four-person organization to a renowned training center with affiliates around the world.

Sexual Revolutionary

Even before he developed REBT, Ellis had become fascinated with sex (an interest, he facetiously asserted, that began at age 6 while “playing doctor with a schoolmate”). While completing his Ph.D., he began a private practice that increasingly attracted people with sex and relationship problems; he soon decided that even the most popular sex books of that time were “indefinite, vague, or inconclusive.” In an early (1953) essay, “Is the Vaginal Orgasm a Myth?” Ellis championed the then-novel notion that women have as much right to sexual satisfaction as men and that women who experienced primarily clitorally induced orgasms were neither necessarily “immature” nor “frigid” but normal and sexually healthy.

Ellis wrote some of the first widely read books that broke with the prevailing tradition of romance and sexual piety: *The Folklore of Sex* (1951), *The American Sexual Tragedy* (1954), and *Sex Without Guilt* (1958). On TV, radio, and in lectures—at a time when he was one of the few early voices advocating for sexual freedom—he made a case for sex education in the schools, guilt-free masturbation, premarital sex, and the nonpathologizing of homosexuality. In 1957, with other leading sexologists, Ellis founded the interdisciplinary Society for Scientific Study of Sex (SSSS), a group that



Albert Ellis

Clockwise from upper left:
 Albert, 1948, 1953, and
 1980s; with Janet, late
 '80s; workshop in The
 Netherlands, early '90s;
 with The Living School
 students, 1971.

is still going strong, later receiving the Society's award for Distinguished Scientific Achievement. In 1961 he edited the *Encyclopedia of Sexual Behavior*.

It was not until the early 70s that Violet Franks coined the then-denied and unbelievable term "nonsexist therapy." It took many years for the concept to become a meaningful part of the condition's armamentarium.

Ellis was an early feminist supporter. In his 1963 book, *The Intelligent Woman's Guide to Manhunting*, Ellis documented the pervasive sexism in American society, encouraging women to get involved in vital absorbing interests; to go for what they wanted in both the sexual and nonsexual areas of their lives; and to challenge their irrational beliefs that their entire worth and happiness rested on having a perfect face and body and getting a man at whatever cost.

Ellis' relationship with Janet Wolfe, his long-term partner, demonstrates his feminism in action. Wolfe became the Director of the Institute in 1965, freeing him from the everyday tasks of running an organization so that he could spend full time at his professional work, while she arranged meetings, wrote brochures, and performed the myriad tasks of supervising the staff and building. Not content to have her abilities relegated exclusively to administration, Ellis strongly encouraged Wolfe to enroll in New York University for a Ph.D. in clinical psychology so that she could become an equal professional partner and develop her own work, eventually leading to a rewarding career in which she became well-known in America, Europe, and Asia for her writing and workshops on women's assertiveness, self-empowerment, and relationship and sexual issues. Ellis always acknowledged her major role in helping build the Institute and expand REBT theory and practice. In 2002 Ellis and Wolfe parted on friendly terms, expressing mutual appreciation and respect for what they had meant and contributed to each other.

A "Gene for Efficiency"

Between 1956 and his death at 93, two months short of his 94th birthday, Albert Ellis' passion for his work, his energy, and his commitment to making the world a saner place and better place (from his perspective) continued almost unabated. In addition to writing or editing over 70 books and several hundred articles, for the greater part of his career he saw roughly 140 clients a week in individual or group therapy, and

streaked around the U.S. and abroad giving over 80 lectures and workshops a year, donating most of his income to the Institute while living very comfortably on the small salary he found adequate for his simple lifestyle.

At a roast of Ellis at an international REBT convention, in which participants were encouraged to make contributions with "no holds barred," Cyril Franks was invited by Ellis to conduct an Ellis roast. The proceedings began with Franks saying that Ellis is the founder of "self-plagiarism," asserting (quite correctly, Franks believes) that every book was more or less the same with only the subject matter different. "All of his books," Franks continued, "follow the same model with appropriate, but slightly different, contexts. Throughout all Ellis' books," Franks continued, "data are conspicuously absent (ignoring the fact that data is the hallmark of the new paradigm of behavioral science) and that most of Ellis' recommendations come out of Albert's remarkable clinical creativity and a few basic philosophers, primarily Epictetus." Franks went on to state that Ellis' prodigious output and numerous similar presentations could only be accounted for by the fact that Ellis was cloned and that there were actually *six* of him. Ellis loved this, and, quick as a flash, responded that "curiously enough, Cyril was also cloned, and the clones were destroyed, but, unfortunately, one defective clone survives."

Violet and Cyril Franks, together with Arnold Lazarus, were members of the Albert Ellis Institute Board of Advisors for many years. One day Violet suggested that, when lecturing in London, Ellis visit the British Museum since it was only one block away from his hotel. Ellis' response, totally predictable, was "Who leaves the hotel?!" Cyril recalls an evening when he and Violet were having dinner at publisher Ursula Springer's house with Ellis and Wolfe also present. Albert was recovering from a recent operation, and about 9 P.M., he said, "I have to leave." Very sympathetically, the group nodded and said, "Of course, we understand, you must feel tired." "No," Ellis said, "not tired. I have to get a 20-page paper finished. I promised delivery by tomorrow morning, and I have 10 more pages to write" (which he did).

In similar vein, when Ellis was about to embark on a trip to northern India, Iris Fodor remarked how exciting it was that he could visit the Taj Mahal. Ellis replied, in his characteristically egotistic fashion, "I wouldn't visit the Taj Mahal unless they invited me to do a workshop there." "All this

fresh air might kill me" and "Scenery is scenery—if I want to see the world I can watch it on TV" captures the flavor of Ellis' unique personality well. Cyril recalls once asking Ellis which he would prefer: meeting the President of the United States or talking to a graduate student seeking to learn more about REBT. Predictably, and with no hesitation, Ellis chose the graduate student!

Ever-Evolving

Although the theory and practice of REBT were laid out in his 1963 work, *Reason and Emotion in Psychotherapy*, Ellis continued to expand his approach, writing many papers over the next 40 years. These included an expansion of his personality model and emphasis on the importance of forceful and energetic disputing in order to create meaningful change. Especially important was his elaboration of the concept of low frustration tolerance, or "discomfort disturbance," which he saw as a major factor in what he called "love-slobbism," self-pity, addiction, anger, anxiety, compulsivity, and other disorders.

Although Ellis felt that he had neither the time nor resources to maintain both his clinical work and teaching and also institute a research program, in the mid-70s he sponsored two think tanks to focus on areas of needed research related to REBT. Participants included Kanfer, Mahoney, Meichenbaum, Kendall, Hollon, and others, but, predictably, relatively little of substance came of it.

Porcupine or Teddy Bear?

Who was the person behind Ellis' at times prickly (as well as very funny) public persona? Ellis found the time to mentor many budding young professionals, often returning carefully critiqued manuscripts within the week. His feedback when supervising novice therapists was, according to their reports, the gentlest and most encouraging of any received from other supervisors, not to mention the most incisive. When colleagues came to him with problems, he did not hesitate to spend as much time as needed helping them sort things out; and when a close friend of Janet Wolfe needed care after his hospitalization for AIDS, Ellis immediately agreed to his staying in their apartment for as long as needed. These and other of his not-well-publicized acts of kindness caused Janet Wolfe to characterize him at his 90th birthday party as a "closet mensch."

Many attendees at Ellis' speaking engagements for professionals were quite in-

trigued by his ideas but somewhat put off by his repeated scatological expressions. Cyril once reminded Ellis about satiation and the advantage of using these words once or twice for effect but no more—all to no avail! Wolfe reports that when she urged him before one of his presentations not to use the word “s—t” or the *F* word, he “accommodated” her by switching to “turd.”

Janet Wolfe describes Ellis as one of the most playful and sometimes silly people she has ever known. At Institute staff parties, they improvised costumes and performed the “Dance of the Flowers” from the *Nutcracker Suite*. They raised two “kids”: birds named Reason and Emotion.

One of Ellis’ most unusual contributions to therapy was his use of humor, best epitomized by his numerous satirical rational songs set to popular tunes. These included “I Am Just a Love Slob”; “Whine, Whine, Whine”; “Glory Glory Hallelujah, People Love ‘Ya Till They Screw ‘Ya”; and “I Am Just a F—ing Baby.”

Albert Ellis could, at times, be cantankerous and difficult—especially when his busy schedule was interrupted by time delays or other glitches. When he barked, “Get me a new goddamn microphone!” he would say that he wasn’t angry, just being “definite.” Fortunately, after an outburst, he quickly returned to his usual unflappable demeanor while waiting for his turn to speak. Ellis could be aptly described as an iconoclast, a man who generally expressed his own perspective with minimal concern about people’s possible negative reactions to him.

Ellis, as noted, was particularly notorious for his salty language, yet aside from the fact that it made an impact on people (for better or worse), his pithy sayings—with or without four-letter words—were memorable and usually right on target. Many of his best one-liners were at his professional and public therapy demonstrations, especially at the Friday-night workshops he conducted at the Institute for almost 40 years.

In his Bronx-inflected speech, he would deliver zinging one-liners:

“All humans are out of their f—ing minds!”

“Blood is sicker than water.”

“Shouldhood leads to shithood.”

“Guilt = regret + shithood.”

Many of his idiosyncratic terms have become part of the REBT lexicon, including *awfulizing*, *catastrophizing*, *LFT*, *love-slobism*, *disturbance-about-disturbance*, and *mus-turbation*.

Practicing What He Preached

Perhaps nowhere is it more evident that Ellis had largely overcome his own LFT (low frustration tolerance) than in his disciplined management over the years of his insulin-dependent diabetes. He worked hard at staying as healthy as possible so that he could cram as many workshops and publications as he could into however many years he had left. Without ever complaining, he injected himself twice each day, measured his blood sugar regularly, and made six or more peanut butter sandwiches a day for 55 years so that he could maintain proper blood levels without having to interrupt his work for a meal, sometimes munching a sandwich on the platform at large professional meetings, usually with no explanation, leaving some people to view this simply as exhibitionist behavior.

Despite being sometimes mercilessly pilloried, especially in the 1960s and 1970s, Ellis rarely became angry with either his detractors or his imitators, and he never engaged in self-pity. He regularly espoused the importance of “work, work, work” for people to achieve their goals, and he spent every waking minute devoting himself to his teaching, writing, and therapy—even while still recovering from major surgery.

It should be very apparent by now that, throughout his long professional life, Ellis had few or no interests other than REBT. He was never seriously interested, or open to, any perspective other than his own.

During his last 1 ½ years, a series of medical problems resulted in Ellis going back and forth from hospital to rehabilitation center for all but the last 3 weeks of his life, when he returned to his apartment at the Institute. Debbie Joffe, an Australian hired as his assistant in 2002 and whom he subsequently married, was instrumental in maintaining the around-the-clock care that extended his life. Despite declining health, Ellis continued to write and to lecture, even giving a talk to a group of potential REBT students while still in intensive care. Sadly, after all Ellis had created and accomplished in his long life, his final years were marred by regrettable disputes with the Institute he founded. True to his beliefs, however, he did not whine about his situation and the considerable discomfort and inconvenience it entailed but continued to carry on with his life as best he could.

Albert Ellis was an outstanding role model of a gifted and productive dynamo who, despite old age, impaired hearing, illness, and misfortune, was able to keep going for over 93 years. He has possibly contributed more to the advancement of our new mental health paradigm and the now general acceptance of nonmedical mental health therapists than any other individual. For such reasons, due in no small part to his personality and his lifelong accomplishments, he has had a major impact worldwide. Albert Ellis was unique and, as clinicians and his friends, we are in his debt.

Cyril Franks is a Distinguished Professor Emeritus in the Graduate School of Rutgers University. A founding member and first president of AABT, now known as ABCT, he knew Albert Ellis for nearly 40 years.

Janet Wolfe lived with Albert Ellis from 1965 to 2002, and for 37 years served as the director of the Albert Ellis Institute. She has authored many chapters, articles, and books and lectures worldwide on REBT. She is currently in private practice and an Adjunct Professor at New York University.

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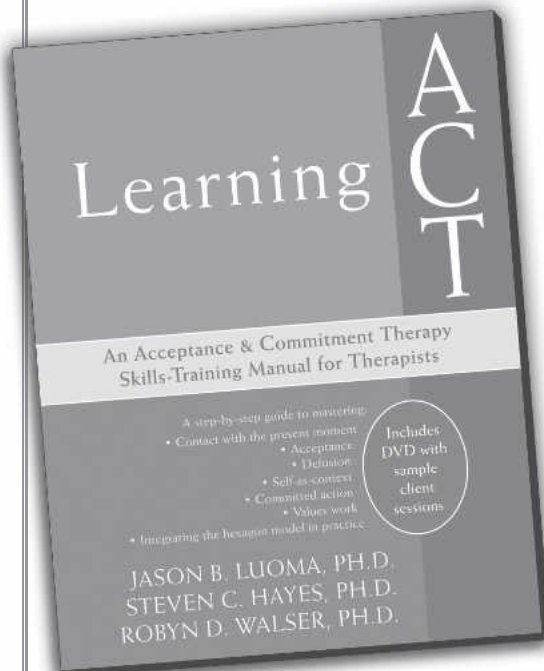
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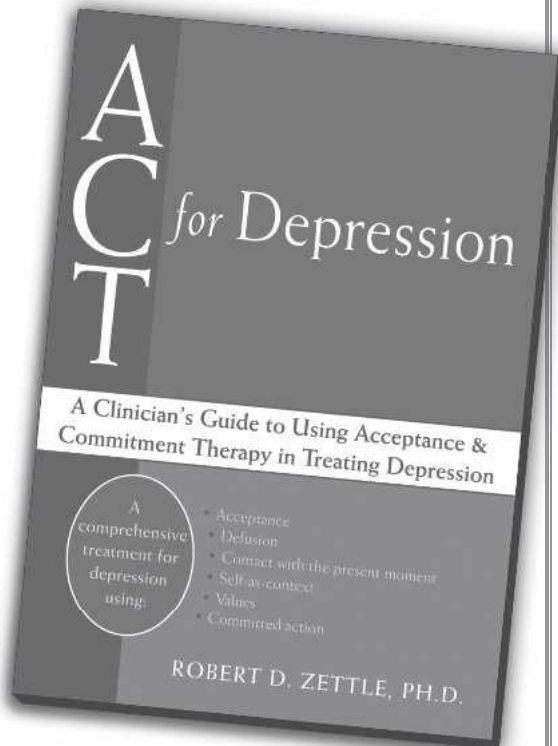
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Couples Research and Therapy SIG Presents Special Series on Dissemination

Introduction

William A. Aldridge II, *University of North Carolina at Chapel Hill, Student Co-President, Couples Research and Therapy SIG*

As we are all aware, the dissemination of empirically supported interventions has become a topic of high interest and much discussion within ABCT. The Couples Research and Therapy Special Interest Group (Couples SIG) has been no exception. In fact, last fall, the Couples SIG produced a special series of articles on the dissemination of empirically supported couple and family interventions for its semi-annual newsletter. Among the contributing authors were several leaders in the couple and parenting fields who have had significant experience, and success, in disseminating their own empirically developed programs. Considering the caliber of these authors and the quality of the entire series of articles, we wanted to share this series with ABCT at large.

What follows are the four articles originally published in the special dissemination issue of the Fall/Winter 2006 *Couples Research & Therapy Newsletter* (Volume 12, Issue 2), adapted for republication in this issue of *the Behavior Therapist*. The series begins with an article by Dr. Matthew R. Sanders, whose work in the development and dissemination of Triple P—Positive Parenting Program, a multilevel, evidence-based, cognitive-behavioral parenting program that is currently delivered through health practitioners in over 16 countries using a public health format, has become the gold-standard for the dissemination of empirically supported interventions. In his article, Dr. Sanders discusses the challenges and issues in taking an empirically sup-

ported intervention “to-scale” using a population-level public health format.

Dr. Sanders’s article is followed by an article written by Dr. Howard Markman and his colleagues at the University of Denver, who are well-known for their development and dissemination of the Prevention and Relationship Education Program (PREP), a relationship distress prevention and education program founded on broad-based behavioral couple principles and the only such intervention with long-term empirical reports. To date, the PREP team has trained over 12,000 individuals to become PREP instructors in 28 countries. In their article, Dr. Markman and his colleagues review current directions in the dissemination of couple interventions and make several recommendations for the future that have implications for the dissemination of empirically supported interventions at a broader level.

The third article in the series is written by Dr. Tera R. Hurt and her colleagues, who have developed and begun dissemination of the Program for Strong African American Marriages (ProSAAM), a relationship distress prevention and education program based on PREP that incorporates African American religious traditions and values. In their article, Dr. Hurt and her colleagues discuss their observations on the successful delivery of culturally sensitive variations of empirically grounded interventions for couples, with particular attention to religious/spiritual and ethnic issues. In doing so, Dr. Hurt and colleagues address the question of how we adapt our empiri-

cally supported interventions for use in culturally diverse contexts and communities.

The series ends with a contribution from me on how to develop a career in applied dissemination. As a graduate student interested in the dissemination of empirically supported interventions, I have been exploring this career trajectory for 3-plus years through conversations with some of the leaders in the couple and parenting fields, conversations with a variety of nonpsychology professionals, and actually learning and working in different public health and business environments. With the little guidance currently available to graduate students and young professionals on training for dissemination, I hope to provide some insight and direction based on my own experiences and learning.

In addition to learning from a number of rich perspectives on the dissemination of empirically supported interventions, through this series of articles I hope that you will begin to see the exciting work that members of the Couples SIG are doing and the ways in which we are advancing our field. If you are interested in the ideas and programs discussed in this series, I would like to invite you to consider joining the Couples SIG. Our group provides a great way to connect with the leaders in couple research and therapy while cultivating a family atmosphere.

Reference

Couples Research and Therapy SIG. (2006). Dissemination [Special issue]. *Couples Research & Therapy Newsletter*, 12(2).

Address correspondence to William A. Aldridge II, M.A., 238 Davie Hall, Psychology Department – UNC-CH, Chapel Hill, NC 27599-3270; e-mail: will_aldrige@unc.edu.

For more information about the Couples Research and Therapy SIG, visit the website at www.couplessig.net.

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“Going to Scale”: Implementing a Population-Level Parenting and Family Support Intervention

Matthew R. Sanders, *The University of Queensland*

As evidence accumulates, revealing that parenting interventions are effective in reducing a variety of child behavioral and emotional problems, there is increasing pressure on clinical researchers involved in program development and evaluation to disseminate these programs to the professional community so that the public may benefit. This paper shares the experiences of a small group of clinical researchers involved in the development of parenting and family interventions, specifically the Triple P–Positive Parenting Program at the University of Queensland, as we made the transition from being primarily concerned with efficacy trials that affect a relatively small number of families to a center that has now disseminated a population-level system of parenting support to 16 countries, trained over 20,000 practitioners, and has affected the lives of an estimated 3 million children and their families. The context for this transformation was the adoption of a public health framework to guide both program development and the dissemination challenge.

Why a Population Perspective Is Needed to Address the Adverse Effects of Poor Parenting

The case for adopting a public health approach to address parenting problems and to improve parenthood preparation is a compelling one. The strongest potentially modifiable risk factor contributing to the development of behavioral and emotional problems in children is the quality of parenting a child receives. Evidence from behavior genetics research and epidemiological, correlational, and experimental studies shows that parenting practices have a major influence on children's development (Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000). Parenting interventions derived from social-learning, functional analysis, and cognitive-behavioral principles are considered the interventions of choice for conduct problems in young children (McMahon & Kotler, 2004; Prinz & Jones, 2003; Sanders & Ralph, 2004; Taylor & Biglan, 1998). These programs

have also proven efficacious in prevention studies (Prinz & Dumas, 2004; Sanders, Markie-Dadds, Turner, & Ralph, 2004; Webster-Stratton, 1998). The positive effects of parenting interventions have been replicated many times and across different investigators, numerous countries, and a diverse range of client populations (Sanders, 1999).

Although there is clear evidence that parenting programs work, these programs are underutilized and have an insufficient impact on everyday practice. The majority of advisors that parents approach for guidance regarding children's development are potentially in a position to support parents but are not trained to use evidence-based parenting interventions or to use them effectively. Existing approaches to parent education simply do not reach enough parents to make any real difference and large numbers of children continue to develop significant behavioral and emotional problems that are likely preventable.

Rising to the Challenge to Implement a Public Health Approach

For a population approach to work, several important public health principles must be adhered to. There are seven specific principles:

1. Having evidence concerning the base prevalence rates of targeted child problems;
2. Having evidence concerning the base prevalence rates of risk and protective factors;
3. Having evidence that targeting such risk and protective factors reduces targeted child problems;
4. Having evidence that effective and culturally appropriate interventions are available for dissemination;
5. Having an effective system of training and dissemination;
6. Making the interventions widely available;
7. Tracking outcomes at a population level.

In addition, a strategy is needed to manage the sociopolitical environment that in-

evitably surrounds population-level interventions.

Evidence Concerning the Base Prevalence Rates of Targeted Problems

The success of a public health initiative depends on demonstrating that there are improved developmental and/or mental health outcomes in children whose parents have been exposed to the intervention. This means having knowledge of the base rates of behavioral and emotional problems in the target geographical catchments before the intervention begins. According to Australian epidemiological surveys, approximately 14% to 18% of children developed significant mental health problems (Sawyer et al., 2000). In addition, many parents are concerned about their children's behavior and development (Sanders et al., 2005; Sanders et al., 1999). Twenty-nine percent of parents reported their child had a behavioral or emotional problem in the previous 6 months and that they were concerned about both conduct problems and emotional problems (Sanders et al., 2005).

Knowledge of the Base Prevalence Rates of Risk and Protective Factors

Factors that place a child at risk of developing behavioral and emotional problems include exposure to a harsh, inconsistent parenting style; low parental self-efficacy in undertaking the tasks of raising children; mental health problems in parents, including depression and anxiety; high marital or partner conflict; and low levels of parenting support. Protective factors that reduce children's risk of developing problems include exposure to evidence-based parenting programs, access to professional support for children's emotional and behavioral problems, and having high levels of social and emotional support from significant others.

Evidence that Targeting Such Factors Reduces Targeted Family Problems

Parenting interventions have the potential to change important parenting and family-based risk and protective factors that contribute to children developing serious behavioral and emotional problems. A public health intervention targeting parenting should be considered for broader dissemination when there is sufficient, good-quality evidence that demonstrates that an intervention is effective.

The Triple P system of parenting interventions has a large number of well-controlled outcome studies that show the

intervention is effective in reducing early behavioral and emotional problems in children. Evidence showing that changing inappropriate or dysfunctional parenting practices improves children's mental health and well being comes from various clinical trials demonstrating that increasing positive parenting practices and reducing ineffective discipline practices produces better mental health outcomes in children than comparison conditions such as care as usual, no treatment, or waitlist control conditions (see www.triplep.net for a complete list of the Triple P evidence base).

Evidence That Effective and Culturally Appropriate Interventions Are Available

For an intervention to be usable as a public health strategy, it needs to be readily available for use by service providers serving geographical catchments or a population. This means having ready for use the appropriate materials and resources that are required for the intervention and having access to a professional training process that equips service providers to deliver the program with fidelity.

Every parent learns about how to parent in a specific cultural context. This context includes family composition and structure, availability of extended family, gender-based difference in roles, and exposure to traditions and mores. Cultural knowledge about parenting is acquired through exposure to other members of the culture, conversations with more experienced parents, modeling, and family-of-origin experiences.

There are also shared aspects of the parenting experience across diverse cultures. Parents in all cultures typically want their children to do well in life. Parents in diverse cultures experience similar developmental and behavioral problems as stressful and there are gender differences in parental responsibilities. Parenting practices vary within cultures and between cultures. A parent's culture also informs a parent's belief about what normal behavior is and what can be expected from children at different ages. It also informs about the kinds of responsibilities that are involved in being a parent, what behaviors are problem behaviors, and the kind of discipline to use in addressing problem behaviors.

One important area of research is developing parenting programs that are culturally relevant to the needs of indigenous parents. The poor health status of indigenous Australians in comparison to the wider Australian population has been well documented (Zubrick et al., 2005). On most in-

dices of health and well being, indigenous children and youth are extremely disadvantaged: they have higher rates of health risk behaviors, early school dropout, suicide, involvement with the juvenile justice system, family fragmentation and forced removal of children, and are overrepresented in abuse and neglect cases. According to the recent Western Australian Aboriginal Child Health Survey of almost 4,000 children aged 4 to 17 years, approximately 24% of indigenous children were reported by their parents to be at high risk of clinically significant emotional or behavioral difficulties, in comparison to 15% of nonindigenous children.

Making Interventions Widely Available

Unless an intervention reaches a sufficient number of parents it will not have a detectable impact on the rates of behavioral and emotional problems in children. To estimate population targets, in a large-scale population-level implementation of Triple P in Every Family, a project focusing on the transition to school, we estimated the number of parents that needed to attend either a group or parenting based on Triple P to achieve a 5%, 10%, or 15% reduction of child behavioral or emotional problems at a population level.

Calculations were performed using the population prevalence rate for behavioral and emotional problems, which indicated that 23% of children were in the clinical range for emotional and behavioral problems. From trial data, we estimated the number of children receiving the intervention who moved from the clinical to the nonclinical range in a universally offered delivery of Triple P. From this, we estimated the target parent participant rates needed to achieve a 5%, 10%, and 15% reduction in prevalence rates. (Visit the following link for more information: www.pfsc.uq.edu.au/everyfamily/technical.pdf.)

After determining the number of parents that need exposure, strategies are needed to ensure parents participate. One way of ensuring that parenting interventions can be accessed is by delivering the programs in a delivery format and context that is readily available to parents.

Another strategy is to develop stronger media and communication strategies. There is increasing evidence that the mass media can be effective in changing parenting practices (Sanders & Prinz, 2005). As part of a multilevel intervention strategy to decrease the prevalence of children's behavioral and emotional problems, the media

can play an important role in raising parents' awareness and willingness to attend a parenting program. Different media messages can be used to demystify what is involved in a parenting program by providing relevant, meaningful, and accurate information for parents. Media messages also provide opportunities for parent testimonials and to depict parents' experiences of receiving professional support.

Having an Effective System of Training and Dissemination

According to the Society for Prevention Research (2004), for a prevention program to be considered ready for broad dissemination, it must meet the criteria for both efficacy and effectiveness and, in addition, have the capacity to go to scale, have available clear cost information, and have available monitoring and evaluation tools for use by providers. It is also argued that a clear statement of factors that may affect sustainability of a program once it is implemented be available.

The process of changing professionals' consulting practices involves a complex interaction between the quality of the intervention, the skills training and the practitioner's post-training environment. The approach to disseminate a program following empirical validation is underpinned by two complementary perspectives:

Self-regulation: Dissemination activities are based on a self-regulatory approach to promoting professional behavior change. To promote practitioner self-efficacy, program content and processes are introduced through active skills training with a focus on self-directed learning, personal goal-setting for skill development, self-evaluation, and problem solving.

Ecological context: The second perspective is a systems-contextual approach that aims to support practitioners' program use in their workplace. As professional change is optimized when managers, administrators, supervisors, and colleagues support the adoption of the innovation and when adequate supervision and support are available (Henggeler, Melton, Brondino, Sherer, & Hanley, 1997), the work environment is also targeted in our dissemination activities. We propose that an effective dissemination process not only must adequately train practitioners in the content and processes of an intervention, but also must engage participating organizations to ensure that program adoption is supported.

Tracking Outcomes at a Population Level

Evidence concerning the impact of a public health intervention goes well beyond attention to individual well-being and is concerned with the well-being of entire populations. It assesses whether the public health intervention reduced the prevalence rates of indicators of dysfunction and increased well-being of the target problem. To achieve that, some form of population-level auditing or survey of parents is needed to assess whether parental concerns about children's behavioral and emotional problems have decreased, whether there has been an increase in parents' use of positive parenting methods, and a decrease in dysfunctional parenting practices. Changes in parent participation rates in parenting programs and access to formal and informal support should also have changed.

In comparison with efficacy and effectiveness trials, the measurement processes for a population trial are more complicated and less well developed by the field. The Every Family measurement procedure involved multiple domains and constructs that targeted population indices of penetration and impact, assessment of practitioners, and evaluation of cost considerations. A random-dialing telephone survey of caregivers in households with children ages 4 to 7 years conducted prior to the intervention and then again after 2 years of exposure to the intervention in each of 20 census collection districts in Brisbane, Sydney, and Melbourne was used to assess the impact of media and informational exposure to Triple P, parent involvement in parenting consultation and support (generally and also specifically through Triple P), parenting practices, parental confidence and stress, and reports of child adjustment.

Managing the Sociopolitical Environment

There are many important lessons we have learned from over a decade of experience disseminating a large-scale, multidisciplinary, population-level parenting and family support intervention in diverse cultural contexts. Most clinical researchers have little experience in dealing with the day-to-day intricacies of managing a clinical service. The successful dissemination of a program requires working knowledge of the immediate challenges that confront service providers. Workplace issues such as securing funding for service delivery, having employment policies and practices that support the implementation of a program, and providing line management and supervision support to staff are all challenges that

need to be addressed if a program is to be effectively implemented.

Many tasks that we encountered were not immediately addressable via our training as clinical researchers and interventionists. These challenges required a lot of on-the-job learning. Some examples of these tasks include: (a) how to present evidence from clinical trials to politicians, policy advisors, economists, the media, agency managers, and consumers in a way that promotes understanding without distorting or embellishing the message; (b) how to work collaboratively with the media so that the power of the media can be harnessed constructively to support and initiative rather than to simply dramatize the problem or be a critic of an initiative; (c) how to develop a viable business model to support a dissemination process so it can become self-sustaining; (d) how to constructively deal with misinformation and criticism of a program without becoming defensive; (e) how to accurately estimate the cost of a program from the perspective of a government, agency, individual service provider, and consumer.

In conclusion, parenting interventions are among the most powerful and cost-effective tools available to improve children's health and well being. Good parenting should be the centerpiece of population-level efforts to prevent major mental health, social, and educational problems in children and young people. Evidence-based parenting programs need to be much more widely available if they are to achieve their potential and reduce the prevalence of serious behavioral and emotional problems in children. To rise to the challenge of successfully disseminating parenting and other programs that work, clinical researchers need to become more focused on the end users' interests, preferences, and organizational constraints. Perspective taking will ensure that evidence-based programs are designed from the beginning so they have a better ecological fit to the delivery context and therefore are more likely to be used and sustained over time. At the same time, interventions such as Triple P have sought to be responsive to field-based evidence, feedback, and experience in using a program so that the system of intervention continues to evolve and remain data responsive.

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Address correspondence to Matthew R. Sanders, Ph.D., Director, Parenting and Family Support Centre, School of Psychology, The University of Queensland, Brisbane, QLD 4072, Australia
e-mail: matts@psy.uq.edu.au

The New Frontier in Relationship Education: Innovations and Challenges in Dissemination

Howard J. Markman, Tamara Williams, Lindsey Einhorn, and Scott M. Stanley,
University of Denver

As we approach the 44th anniversary of the assassination of President John F. Kennedy, we imagine that just about all of our readers over 50 remember where they were when they heard JFK was killed. What many do not remember is that the last piece of legislation he signed was the Community Mental Health Centers Act. This innovative and far-reaching plan called, in part, for making research-based mental health services, including preventive interventions, available to everyone. Kennedy was especially interested in reaching underserved people in community settings close to home. Not surprisingly, these ambitious goals were not achieved (see Bloom, 1977, and Heller & Monahan, 1977, for the fascinating story). Today, however, Kennedy's dream actually has the potential to be realized in the couples field. Specifically, in the U.S., one aspect of the reauthorization of welfare reform in 2006 is the growth of state-, federal-, and community-level efforts to reach thousands of couples with relationship and marriage education—the first time that such efforts have been attempted on such a large scale as a matter of public policy, at least in the U.S. (Horn, 2003; Ooms, 1998).

How this happened is a very long story, with many twists and turns. However, the field has followed a synergistic model of research, intervention, dissemination, and social policy consistent with one we had proposed many years ago related to making research-based programs available to all couples planning marriage and beyond (e.g., Markman, Jamieson, & Floyd, 1983). In brief, the model involves the confluence

of various key factors: (a) a large-scale social problem (marital distress and divorce); (b) advances in basic couples research; (c) the development and evaluation of research-based couples interventions in university-based and community settings; (d) growing access to institutions that reach a large number of couples at key transition points; and (e) policymakers being willing to consider the implications of a society having difficulty reaching their own aspirations for stable and healthy marriages and families.

In the rest of this paper we discuss the opportunities for disseminating research-based marriage education curricula in a variety of settings in the community. We will draw on our dissemination work with variations of the Prevention and Relationship Enhancement Program (PREP; Markman, Stanley, Blumberg, Jenkins, & Whaley, 2004) in a wide range of settings, highlighting some of what we believe are important lessons learned. We conclude by highlighting some of the major challenges facing us as we and others ramp up dissemination efforts.

Before turning to broader issues, we wish to observe what all of us in the couples field know, or should know, well: There is a vast amount to be learned about relationships, about marriage, and about the most effective ways to intervene to help more couples. As we have noted, "We know enough to take action but we need to take action to know more" (Stanley, 2001). That is not a bad motto for scientist-practitioners. Our research team does not believe that we, or others, have any lock on the most effective educational or therapeutic methods

and content. We certainly have our ideas and our reasons for them, but our confidence lies far more in our commitment to empiricism than in fixed content. We believe that regular refinement and improvement of strategies based on current, sound, and basic intervention research is the essence of the scientist-practitioner model.

The Current Context

Despite the alarmingly high rates of divorce and marital distress and the associated negative effects on couples, children, companies, and society, one statewide, large, random survey shows that less than 20% of divorced adults sought help for relationship problems, with most of the help being provided by clergy and not mental health professionals or couples' therapists (Johnson et al., 2002). Moreover, and until recently, few large-scale dissemination efforts have been mounted to help couples increase chances for a successful marriage, despite the availability of evidence-based prevention programs (e.g., Hahlweg & Markman, 1988; Halford, Sanders, & Behrens, 2001; Markman et al., 2004). However, a new era has begun where policymakers are recognizing that such efforts may benefit diverse couples on a large scale.

There are a variety of initiatives under way at federal and state government levels to enact policies and programs that might help couples who choose marriage to have healthy marriages. In early 2006, the Administration for Children and Families (ACF) put out requests for proposals for a large range of community-based, preventive education services designed to help partners make good choices about mates in the first place and teach partners skills and principles to keep a happy relationship happy (for a review of prevention curricula for couples, see Halford, Markman, Kline, & Stanley, 2003).

ACF has now funded a range of efforts designed to teach couples skills associated with having a healthy marriage as well as to

promote responsible fatherhood, including: marriage education for couples where one of the partners is incarcerated; technical assistance about adapting intervention models to make them culturally appropriate; the development of innovative methods for reaching individuals long before they have made relationship choices that put them at risk; promoting responsible fatherhood, in part, by adding to the mix of existing approaches and strategies that recognize that father involvement is strongly related to involvement with the mother in healthy, committed relationships; and the funding of demonstration projects for implementing and evaluating post-adoption services designed to help these high-risk families. Common to most of the funded projects are the requirements that couples be the primary recipients of services, that services be supported by evidence from research, and that agencies coordinate with local domestic violence resources. For more details on these (and others) ACF grants, go to: <http://www.acf.hhs.gov/healthymarriage>.

Dissemination Model: The Messenger Matters

Consistent with prevention science (Coie et al., 1993; Markman et al., 1983) and dissemination (Markman et al., 2004), we have focused on gaining access to institutions that serve couples naturally in the community at key transition points and reaching policymakers that regulate services provided by these institutions. For example, because 75% of first marriages take place in religious settings, we have worked closely with religious organizations; premarital prevention services are overwhelmingly provided in this context in the U.S. (Stanley, Amato, Johnson, & Markman, 2006). Another example is our work with the U.S. Army, wherein the Chief of Chaplains has instituted PREP training as part of the curriculum for all chaplains. Our prior research, as well as preliminary, smaller-scale research in that context (Stanley, Allen, Markman, et al., 2005), has led to a large, random trial of these services in the U.S. Army, funded by National Institute of Child Health and Human Development.

The core of our dissemination model is that "the messenger matters." Focusing on training individuals who are members of the increasingly diverse communities to whom we are disseminating our work has proven critical in the success of such efforts. Delivery of a curriculum such as PREP depends far less on any specific type of knowl-

edge or participation in formal training programs or having degrees (such as in mental health counseling or therapy) than it depends on instructors who are trained specifically in the PREP model, understand the content, and who are engaging and enthusiastic teachers of the content and skills. From the standpoint of organizations desiring to provide marriage education to couples, such people are more available and cost-efficient than skilled therapists. In addition, we focus on organizations recruiting and training instructors who know the situation of the couples they serve and are known to the couples. This increases the quality of the alliance between the instructors and couples and, we believe, increases positive outcomes. The growing emphasis on government efforts at reaching diverse cultural groups confirms the importance of training community-based trainers to provide services. Finally, as part of our ongoing efforts to refine our methods, we have learned to seek and gather a great deal of feedback from those we desire to serve, listening carefully to providers and recipients of services about what works.

Current Dissemination Efforts

Most of the early work with preventive education was conducted with premarital, middle-class White couples (Markman, Floyd, Stanley, & Storaasli, 1988). Based on promising results and the needs in various communities, variations of PREP (which in this context denotes more specifically our curriculum work that is built based on empiricism than on fixed content) are now being used and/or tested in the army, as noted above, prison systems (Einhorn et al., 2007), foster care and adoption services, first-offender programs for youth, refugee resettlement programs, high schools, and transition to parenthood services in the form of Pam Jordan's Becoming Parents Program—used along with other curricula, such as John Gottman's, in a large federal trial (Building Strong Families). We are currently expending a great effort to develop curricula for low-income couples as part of our involvement in another large, federal trial (Supporting Healthy Marriage; Stanley, Markman, et al., 2006). We are likewise exploring ways to expand relationship services to workers through their companies and offering weekend Love Your Relationship workshops to successful people whose relationships need a jump start. (Markman, Myrick, & Pregulman, 2006). Our group is involved with many other activities, including innovative marriage/rela-

tionship education models for reaching African American couples, headed up by Steven Beach at the University of Georgia and a college community-based model headed up by Frank Fincham and Kay Pasley at Florida State.

While some might think such efforts by us and many others in this field outstrip the available empirical information, we believe that such a view disregards three relevant facts:

1. Researchers cannot ask society to wait for decades of more research; when society decides to act, researchers act on what they know or choose to be irrelevant.
2. While we certainly all desire to have much more knowledge, there is considerable empirical knowledge in our field that can inform all such efforts.
3. The burgeoning opportunities for service development and dissemination of the present moment provide a landscape upon which research can make advances on an unprecedented scale. There is a wave to catch, and the wave may not be here 10 years from now.

As described elsewhere (Markman, Stanely, Jenkins, Petrella, & Wadsworth, in press), early versions of PREP focused more on communication and conflict management (Markman & Floyd, 1980; Stanley, Blumberg, & Markman, 1999), fueled by a host of studies demonstrating that patterns of negative interaction are associated with marital functioning and long-term risk (e.g., Birchler, Weiss, & Vincent, 1975; Clements, Stanley, & Markman, 2004; Gottman & Krokoff, 1989; Karney & Bradbury, 1995). Some of the newer generation of preventive education programs developed in the past 15 years, such as the current version of PREP, retain a strong emphasis on communication and the management of conflict and negative emotions but include considerable emphasis on themes such as commitment, friendship and positive connection, and forgiveness.

One example of how we are evaluating our dissemination efforts involves a study in which we trained clergy in the PREP approach. Upon completion of the main research portion of the study, we tracked every 6 months the extent to which the clergy were continuing to use the program. The initial report on dissemination (Markman et al., 2004) focused on clergy in 22 religious organizations (ROs). We found, for example, that these clergy, in the first 5 years after training, had served 1,121 couples with part or all of the curriculum in

which they were trained (728 premarital, 393 marital). Here we provide the findings for 12 of 22 ROs over the next 4 years. These clergy served an additional 659 (413 premarital, 246 marital) couples. Of these services, 64% were full PREP and 36% parts of the PREP program. When using parts of the PREP program, the most common aspects of the program used were the speaker-listener technique (83%), information about destructive communication patterns (66%), problem solving (62%), forgiveness (57%), and constructive expression of negative emotions (57%).

Clearly, there is interest and follow-through in such community-based efforts, though it is also clear that such preventive services are largely unavailable to couples who are not religiously involved (Stanley et al., 2006)—a situation that current federal and state efforts may go a long way toward addressing.

Challenges and Questions as We Move Forward

Below we list some of the areas of exploration that are crucial as we attempt to make relationship and marriage education available to all couples in the U.S. (and in other countries) who desire healthy lives in love and marriage (see Markman et al., in press, for an elaboration):

- assessing preventive effects with relevant control groups;
- matching services to couple needs and dynamics as we expand to increasingly culturally diverse populations and settings (e.g., Halford, O'Donnell, & Lizzio, 2006; Stanley, Pearson, & Kline, 2005);
- getting couples and individuals to seek services and creative ways the field is developing alternative service-delivery methods, such as self-directed programs and telephone interventions;
- determining if relationship education services can benefit couples when given only to individuals;
- making sure that couples are receiving education as opposed to therapy.

One big failure of the Community Mental Health Center Act of 1963 was that it increased therapy services but not prevention services. That is, service providers were trained as therapists, and so they did what they were trained to do (Snow & Newton, 1976). We want to make sure we do not repeat this mistake and make sure that we develop new training programs for marriage education service providers

Like many said about the 60s, we live in interesting times in early 2000s. In John Kennedy's inauguration speech in 1961, he challenged the country to "go to the moon," and he followed up with significant funding to make this goal a reality. At a recent meeting in Washington, a well-connected person said to a group of esteemed academics that the color of money right now is marriage, and he was encouraging the group to incorporate questions about healthy marriages in their research. What he meant was that there will be an infusion of funding into our science because this is how things work: major new funds are quickly available when those in government choose to accomplish a new, far-reaching goal. So much of the growth of physics and engineering came not because the government wanted to fund those things for their own right, but because the government (and our country) decided to go somewhere—to the moon. We believe that this is the moon-shot for our field. Many believe we do not have the knowledge to go for a "marital moon shot." But that is not how many advances actually occur. Instead, a goal is set and scientists feel the pressure to go out and learn what is needed to reach the goal. As we conclude this brief journey through one of the new frontiers in the couples field, dissemination efforts, it is worth considering what you can do to contribute to shaping and exploring the new frontier.

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Dissemination of Couples' Interventions Among African American Populations: Experiences From ProSAAM

Tera R. Hurt, Kameron J. Franklin, Steven R. H. Beach, Velma McBride Murry, and Gene H. Brody, *University of Georgia*, Lily D. McNair, *Spelman College*, and Frank D. Fincham, *Florida State University*

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Address correspondence to Howard Markman, Ph.D., Department of Psychology, University of Denver, Frontier Hall, 2155 S. Race St., Denver, CO 80208; e-mail: hmarkman@du.edu.

In this article, we discuss successful delivery of culturally sensitive variations of empirically grounded strategies for relationship enhancement and divorce prevention. This discussion focuses on the importance of religious traditions in culturally sensitive marriage enrichment services. In particular, we highlight our ongoing investigation of the Program for Strong African American Marriages (ProSAAM) and share some of our experiences in disseminating ProSAAM to communities in northeast Georgia.

As intervention providers continue to explore ways to enhance their programs, a direct focus on dissemination issues is of critical importance. Clearly, access to prevention programs and marital therapy differs across regions of the country and among ethnic groups (Stanley, Amato, Johnson, & Markman, in press). Dissemination is particularly important for African Americans, who are underserved by typical means of health care delivery. Rural African American families tend to be skeptical of the benefits to be derived from mental health services; therefore, they are not likely to advocate for these services in their communities (Brody, Stoneman, Flor, 1996; Murry & Brody, 2004). Reasons for this reluctance include mistrust of medical researchers, contextual factors such as a lack of transportation or means to pay for services, and culturally irrelevant programs (Murry, Kotchick, et al., 2004). African Americans also have the highest therapy dropout rate of all ethnic groups (Sue, Zane, & Young, 1994). For these reasons, establishing trust and offering programs that take into consideration the racial, socioeconomic, and regional characteristics of the populations they serve are critical to effective program delivery.

Among African American couples, religiosity and church involvement predict relationship quality (Brody & Flor, 1996; Taylor, Mattis, & Chatters, 1999), suggesting that this population is more likely to respond favorably to relationship enhancement programs if those programs encour-

age couples to draw upon their religious practices. Historically, religious participation has been an important survival strategy for African Americans. During enslavement, a strong religious orientation served as a framework for preserving family values and overcoming staggering experiences of injustice in a dehumanizing environment. This legacy of spirituality and religious involvement has been passed down through generations, remaining a consistent part of the fabric of African American culture over time, location, and context (Taylor, Chatters, & Levin, 2004). For many African Americans, cultivating a relationship with God remains the ultimate source of inspiration and guidance (McAdoo, 1983; Taylor & Chatters, 1991). For this reason, religiosity plays a significant role in predicting family outcomes in African American populations.

Several key research concepts helped us to incorporate religious elements into a culturally sensitive intervention designed to minimize the effects of discrimination on African American couples. First, we noted the link between prayer and dealing with adversities such as health problems (Dunn & Horgas, 2000; Ellison, 1998). Second, we examined the growing body of research on religious forms of coping and the potential for religiously based coping to facilitate adjustment and well-being (Ellison, 1991) and to reduce depression (Williams, Larson, Buckler, Heckman, & Pyle, 1991). Third, we reviewed studies that integrated religious practice with standard practices in psychotherapy (Tan, 1987) and marriage enrichment (Stanley et al., 2001). Finally, because experiences with discrimination are emotionally disruptive to African Americans (Murry, Brown, & Brody, 2001), we focused on materials that explicitly help spouses support one another in responding to discrimination.

Our incorporation of religious material and prayer into ProSAAM was one means of creating a culturally sensitive vehicle for relationship enhancement that would be familiar and appealing to the participants

while keeping the program consistent with established intervention guidelines. In addition, emphasizing programs that really work and that have a strong skill-based component is a good way to connect with African American communities. We based ProSAAM on the Prevention and Relationship Enhancement Program (PREP), allowing us to discuss with community leaders the strong empirical foundation that PREP brings to relationship enhancement. ProSAAM also explicitly incorporates African American religious traditions and values, allowing couples who wish to learn relationship skills in the context of their religious beliefs and prayer the opportunity to do so.

Our experiences with church officials and other African American community leaders raised important issues to be considered in effectively disseminating programs among African Americans. Our ongoing ProSAAM trial began with a focus group that included 12 African American husbands and fiancés. Some of the group's discussions focused on personal preferences for the program's structure, whereas others underscored the value of the church as a recruitment source and the pastor's endorsement as an incentive for couples to take part in the program. As one focus group member said, "You've got to work with the churches. The churches are key. That's where it all begins for most married people, ya' know, in the church. That's where we not only begin our marriages, but it's where we come to learn more about how to stay married and be husbands and wives." Another group member noted, "You're going to need someone to endorse the program because marriages are so personal. . . . Bottom line, it's a real incentive to us if the pastor endorses it."

The focus group thus gave us a strong and consistent message that we should have community pastors evaluate the program and endorse it from the pulpit before we offered it to congregation members. We revised the program and our recruitment plans in response to the group's suggestions and the community's needs. Consequently, we formulated ways in which to work more closely with African American church leaders. We developed a packet of materials designed to introduce ProSAAM to pastors and pulpit associates. This helped us to connect with over 100 churches, and we developed partnerships with many of these congregations. One particularly successful means of developing partnerships was a reception for area pastors that we called "An Evening of PRAISE"—prayer, recruitment,

advertisement, information, sponsorship, and endorsement, the six ways in which we asked pastors to support ProSAAM. The reception featured a catered meal and a presentation that introduced the church officials and their spouses to ProSAAM. After the presentation, we answered questions, took suggestions for ways to improve the program, and met with each church official individually to discuss the formation of partnerships with them and their congregations. The reception's success was grounded in the opportunity it gave us to make clear to the clergy that we valued their input and desired their feedback. The pastors, many of whom knew each another, appreciated the opportunity to socialize while learning about an exciting program that used prayer and skills to enhance marriages. After establishing partnerships with clergy, we were often invited, and sometimes requested to attend, church meetings, Bible studies, worship services, and other church events to meet, network with, and inform congregations about ProSAAM and recruit couples into the program.

Pastoral endorsements proved critical to recruitment, which skyrocketed after we obtained the pastors' approval. Couples, particularly husbands and fiancés who were initially skeptical about participating, were willing and even excited about taking part in the program if their pastor had endorsed it. After completing the program, a 40-year-old man said,

"It really helped broaden my listening skills and it gave me useful information on how to keep an argument from escalating. I would suggest that all African-American couples, especially men, take part in ProSAAM. I think it would be particularly beneficial to couples who are engaged. It could teach them how to start off with good listening skills and how to give noncritical advice. The program not only helps you be a better husband, it also helps you be a better father and a better man in general."

In their interactions with us, pastors often expressed their excitement about the program and noted as they pledged their support that strong churches begin with strong families. Many of those whose churches had been affected by weak or broken marital bonds said that they wanted to strengthen marriage within the African American community and were enthusiastic about the role of prayer in building better marriages. Pastors who wanted to offer their congregations a marriage ministry or a culture-specific enrichment alternative wel-

comed ProSAAM as an effective step toward their goals.

Our experiences thus far have led us to identify particular steps in our efforts to disseminate ProSAAM to the African American community. The first step is to identify and solicit input from community stakeholders and local leaders. A good example of a stakeholder is a pastor whom the community perceives as energetic, progressive, and willing to embrace new approaches. With this pastor's endorsement, couples may be inspired to participate in an initial program. Their participation becomes the start of the second wave. As the first couples who take part in the program report positive experiences, their grass-roots endorsement combines with advertising to prompt other couples to enroll in the program as well. As the program becomes more widely accepted and trusted, initially reluctant couples may decide to participate. This snowball effect suggests that widespread dissemination will likely proceed in stages.

In summary, as efficacious programs become increasingly available, it will be important to create culturally sensitive approaches that allow them to be disseminated to the people who need them most. Our experience with African American couples suggests that religion plays an important role in effective dissemination of programs to this population. It is therefore important to work effectively with pastors and church leaders to receive their approval, generate enthusiasm for the program, and ultimately gain their endorsement. The desire for efficacious approaches to strengthening marriages, particularly skill-based programs, is very strong in the communities in which we have been working (see also Karney, Garvan, & Thomas, 2003; Stanley & Trathen, 1994). For behaviorally oriented marital researchers who are able to master the necessary community interaction and dissemination skills, programs like ProSAAM are likely to be quite well accepted and very helpful in African American community development.

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Address correspondence to Tera R. Hurt, Ph.D., Center for Family Research West, University of Georgia, Boyd Graduate Studies Research Center, Fifth Floor, Athens, GA 30602; e-mail: terah@uga.edu.

Developing a Career in Applied Dissemination: Reflections From a Graduate Student

William A. Aldridge II, *University of North Carolina at Chapel Hill*

Dissemination is rapidly becoming one of the more important dimensions of our professional evolution as applied researchers and practitioners of evidence-based psychology. Effectiveness research, evaluating treatment outcomes and dissemination strategies in real-world settings, is becoming more common and should be a major focal point for our field in the near future. The actual practice of disseminating empirically supported interventions and knowledge in the real world—becoming a dissemination practitioner—is a more daunting and complex task at this point. However, carving out an entire or significant portion of a career for this pursuit will likely bring many unique and exciting challenges, experiences, and rewards. Over the past 3-plus years, I have been exploring this professional track through conversations with some of the leaders of our field, conversations with a variety of nonpsychology professionals (e.g., business

executives, management consultants, lawyers, and religious leaders), and actually learning and working in different public health and business environments. What follows are the top five lessons I have learned for young professionals interested in developing a career in applied dissemination.

1. Become the Best Scientist-Practitioner You Can Be

One of the most important tasks we have in entering the public and private sectors with our programs and skills is to maintain and further differentiate our training and reputations among the leading psychologists in the world. As a member of ABCT and your ABCT SIG, you've already got a lot going for you! Continuing to develop both in the science and practice of clinical psychology and as a member of ABCT and your ABCT SIG should be a top priority.

What sorts of activities does this translate into for a graduate student? Well, more of what you're probably already doing. First, a core task is to seek to not only understand behavior in a variety of contexts and stages of development but also to contribute new knowledge to the field. The good thing is that most of the programs and research labs in which ABCT graduate students are involved push this hard, so it won't take a lot of extra effort to create these opportunities.

Second, seek out opportunities to work in a variety of contexts. This can be trickier for graduate students, who are often limited to the clinical training activities provided by graduate programs. However, diverse training experiences will not only be resourceful when leading programs in communities and organizations, but also simply as a credibility issue. When the leader of your first client community or organization asks if you've done this before, you should be able to say, "Yes, a number of times!"

Finally, become a more active graduate student member of ABCT and your ABCT SIG. Whether you enjoy it or not, a career in applied dissemination will result in your becoming very visible in a variety of professional contexts. As a graduate student, one place to start is within ABCT and your ABCT SIG. By helping out with administrative or governmental activities, you will

get to know and interact with many wonderful professionals. A great side benefit is that they will also get to know you! In finding ways to get involved, persistence can really pay off. Contact your ABCT SIG president or graduate student president for more information or ideas about how you can contribute.

2. Decide What You Want Out of a Career

This is probably one of the most personally important, and tough, decisions to make. Becoming a dissemination practitioner will likely bring a number of novel experiences and demands that can be very different from a traditional scientist's or practitioner's career. In a sense, this can boil down to a personality issue.

Among the demands that a career heavy in applied dissemination is likely to present are an increased amount of professional risk, an increased demand for adaptation to different people and contexts, a large amount of time and travel, and a broad skill-set for interpersonal interaction. Considering that we all are trained in the last of these dimensions, that one should be an asset for us! However, risk, adaptation, time, and travel are not things to take lightly. If you're the type of person that can tolerate a certain amount of risk (if you're like me, figuring out how to market and disseminate empirically supported programs is likely something at which you'll fail many times before you succeed), enjoys and is good at relating to many types of people in diverse contexts, likes to travel, and can commit unknown quantities of time to ambiguous tasks, then you may find the job a good fit!

While the demands are high, the rewards can be equal for a successful career in applied dissemination. These may include the ability to connect with and positively affect the lives of a vast number of people; the flexibility to apply your training in new and creative ways; the chance to work with some of the top leaders in a variety of communities, organizations, and professions; and the opportunity to achieve a good level of financial stability. Nothing is guaranteed, but there is a lot to be gained!

A full-time career in applied dissemination might mean that traditional academic and clinical activities take a secondary role in your career. However, you should not give up your connections to research and evidence-based clinical work (or those that are advancing these fields). Responsible and successful dissemination will require an ongoing association with the leading research

and best practices in our field; this is and will continue to be our greatest value-adding asset in developing best practices for dissemination.

3. Network

"Networking" can be a dirty word in some circles, so let me start by clarifying that I want to emphasize the intrinsic motivation to build collaborative relationships—not the extrinsic motivation to use people for professional gain. Networking is an essential task for aspiring dissemination practitioners because venturing into applied dissemination means stepping into the worlds of social, business, and government organizations. Ask leaders in those worlds about how to become successful and sooner rather than later you will hear the familiar phrase, "It's not what you know, it's who you know."

Developing collaborative professional relationships is not always the easiest thing to do, especially as a graduate student. If you're at least somewhat normal, you'll probably find yourself asking, "Why would a social/business/government leader talk to me?" or "How would I even begin to get access to social/business/government leaders?" Well, if you haven't already figured this out from your relationships with your mentors, most leaders love working with young people who have valuable ideas and pursuits; it's their way of giving back and helping to shape the future.

Getting access can be the trickier part. Most of the time, this comes down to a simple decision to introduce yourself. Figuring out how to introduce yourself in an effective and succinct way can be a valuable networking skill. Sometimes, however, gaining access may take a little more confidence, persistence, and, again, tolerance for failure. Have you ever knowingly watched someone get into an exclusive club or access a restricted area without membership? If you have, you probably noticed that somehow they were able to look as if they belonged. That's the type of confidence that's sometimes required—the old behavioral technique of "fake it 'til you make it." Additionally, if you saw that person before, you might have noticed they were thrown out of a number of other clubs before they got access to one; that's where persistence and tolerance for failure comes in. The great thing is that if you can build a relationship with even one person, referrals usually follow.

Networking is not something to do simply among social, business, and govern-

ment crowds, but an activity that should start within ABCT and your ABCT SIG. By networking within these professional groups, you can develop a number of collaborative relationships that will be of great benefit now and as you begin a career in applied dissemination. Odds are that you will also find others that are interested in applied dissemination (faculty members, professionals, or graduate students). At minimum, you will have access to people with whom to share and exchange ideas. At most, it could lay the foundation for a future joint project! If you're looking for a place to start, talk to me. ABCT and the ABCT SIGs are where those who make everything happen in our field meet. The benefits of creating a home base there are immeasurable.

4. Think, Talk, Listen, and Don't Be Afraid to Ask for Help

So you develop a few collaborative relationships: What's next? Let's discuss a few cognitive-behavioral skills.

First, take the time to think creatively yet rationally. Applied dissemination is a large, complex, and rather amorphous task to undertake. Because dissemination is, in many ways, still unexplored territory, there is no one right or wrong way to go about business. The good news is that many of the same problem-solving skills we use as good researchers and therapists will be effective in tackling the project. Additionally, just because you do not have a background in business or public health does not mean that you can't come up with effective dissemination ideas. Be creative and think outside the box; challenge traditional ways and imagine yourself as somewhat of an entrepreneur.

Second, communicate your ideas to your colleagues and those both within and outside of psychology that have had success in marketing and disseminating ideas and services. Refining your communication skills within the collaborative relationships you've built is a highly valuable use of time. I have found that talking about my ideas with members of my ABCT SIG is very different from talking about my ideas with nonpsychology professionals. Most of the time, nonpsychology professionals have trouble grasping the ideas I'm pitching because of the language I use. This is challenging me to learn different professional languages and values and be able to communicate in a way that is easily understandable in a variety of contexts.

Third, take time to be an active listener. No one gets anywhere with his or her first set of ideas. In fact, most creative problem solvers go through many permutations before they find something that initially works. Then that idea is refined over time to provide more efficiency and effectiveness. Listening to feedback from others on your ideas is the best way to find out what is good and what is not so good about your ideas. Furthermore, listening gives you a chance to take in the ideas of others and increase the likelihood that, together, a solution will be found.

Finally, don't be afraid to ask for help. In a documentary interview conducted about a decade ago, Donald Keough, then President of Coca-Cola, was asked what differentiates those who become successful from those who do not. He responded, "What separates those who achieve from those who do not is in direct proportion to one's ability to ask others for help" (Saperston & Jones, 2003). As clinicians, we reinforce our clients' decisions to seek assistance when facing a setback or uphill struggle. We should use our own good advice!

5. Get Experience

What do I mean by "get experience"? Well, both you and I know that, as graduate students, we are not in a position to lead a dissemination project. But there are ways to get experiences that will be relevant to a future career in applied dissemination. Here are a few ideas.

Try to find a treatment outcome study with which to be involved. Not only does this provide research and clinical experience, but many of these projects are run like small businesses in local communities. Figuring out how to market the study to potential participants, coordinate treatment services, and develop relationships with people in the community maps well onto applied dissemination activities.

If you can, take one or two classes outside of the psychology department. Many universities not only allow this, but encourage it. Some will even pick up the tab for an extra class in another field of study! This can be a great opportunity to learn the fundamentals of public health, business, government, law, or any other professional field related to dissemination. Furthermore, a class like this will allow you to continue developing relationships with people outside psychology. They also look great on your transcript.

Finally, if you are particularly ambitious and can find the time during a vacation or a summer, try working with a community organization, business firm, or government agency. This can be both a great way to test out the lifestyle and an invaluable source of real-world experience. Knowing and working with the people to which you want to disseminate empirically supported programs will give you a distinct advantage later in your career. In addition, if you want to begin your career with an established professional firm, many require that you

have previous experience in a formal organizational setting.

In closing, keep in mind that, as graduate students, we have a lot of responsibilities: classes, practicum, dissertations, teaching, and the research in our labs. All that, plus we hope to have a social or family life and find the time to do our laundry. This is why I have listed "get experience" last—our major responsibilities and priorities should be taken care of first. In addition, experience can always be gained after graduate school; pursuing experience while in school only helps to get an early leg up!

Reference

Saperston, E. (Producer/Director) & Jones, P. (Producer). (2003). *The journey* [Motion Picture]. United States: Journey Productions.

Will Aldridge is currently a fifth year graduate student working in Dr. Donald Baucom's Couples Studies Lab at UNC-Chapel Hill.

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Address correspondence to William A. Aldridge II, M.A., 238 Davie Hall, Psychology Department – UNC-CH, Chapel Hill, NC 27599-3270; e-mail: will_alldridge@unc.edu.

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A 2-YEAR POSTDOCTORAL FELLOWSHIP IN ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS will be available beginning July 1, 2008 at the Yale Child Study Center Anxiety Disorders Specialty Clinic of the Yale University School of Medicine. The fellowship will offer training in clinical services and administration with an opportunity to develop clinical research in anxiety disorders in children and adolescents. Fellows have the opportunity to be heavily involved in the development of an Anxiety Disorders Program for clinical, training, and research in a medical academic setting, involving an interdisciplinary approach to treatment. The ideal candidate will have a combination of clinical and research interests in cognitive-behavioral treatments in general and in anxiety disorders in particular.

Qualifications include a doctoral degree in Psychology or related field and training and experience in both clinical and research applications of cognitive-behavioral approaches to treatment of anxiety in children and adolescents in clinical and/or educational settings. The stipend is \$37,000 plus benefits. Deadline for application materials is February 15, 2008.

Write to: Diane B. Findley, Ph.D., Director, OPC, Yale Child Study Center, 230 S. Frontage Road, New Haven, CT 06520. The Yale University School of Medicine is a nondiscriminatory/affirmative action employer.

POSTDOCTORAL CLINICAL AND RESEARCH FELLOWSHIPS AT THE CENTER FOR ANXIETY AND RELATED DISORDERS (CARD) AT BOSTON UNIVERSITY. We are seeking a number of postdoctoral fellows with expertise in cognitive-behavior therapy to join a team providing novel and empirically-based treatments for anxiety, mood, and substance use disorders. These clinical and clinical research postdoctoral positions are dependent on final funding decisions for NIMH and NIDA treatment and assessment grants (PIs: Drs. Tim Brown and Michael Otto). Supervisors are senior CARD staff. For some positions, duties also include treatment of non-pro-

tocol patients in the clinic. When hired at the postdoctoral fellow level, opportunities for non-tenure track Assistant Professor appointments to the research faculty may be available following completion of one to two postdoctoral fellowship years. The start date for the position is negotiable, and the salary is \$37,000 annually pending final funding decisions. Boston University is an Affirmative Action/Equal Opportunity Employer. Applications can be initiated by sending a CV, three letters of reference, and a statement of interest to Bonnie Brown by e-mail (bonnieb@bu.edu; subject heading "postdoctoral research applicant") or regular mail: CARD, 648 Beacon St, 6th floor, Boston MA, 02215.

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2008

STUDENT AWARDS PROGRAM

President's New Researcher Award

ABCT's President, Anne Marie Albano, Ph.D., invites submissions for the 30th 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 basic research 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 Anne Marie Albano, Ph.D.; Raymond DiGiuseppe, Ph.D., ABCT's Immediate Past-President; and Robert Leahy, the ABCT President-Elect. Submissions must be received by August 13, 2008, 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.

Virginia A. Roswell Student Dissertation Award

This award will be given to a student based on his or her doctoral dissertation proposal. The research should be relevant to behavior therapy. Accompanying this honor will be a \$1,000 award to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligible candidates for this award should be student members who have already had their dissertation proposal approved and are investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor should complete the nomination. Please complete an on-line nomination by visiting www.abct.org, and completing the appropriate application forms. Then, e-mail the completed forms to ABCTAwards@gmail.com. Also, mail a hard copy of your submission to ABCT, Virginia A. Roswell Dissertation Award, 305 Seventh Ave., New York, NY 10001.

Elsie Ramos Memorial Student Poster Awards

These awards will be given to three student poster presenters (student first authors only), member or nonmember, at ABCT's 42nd Annual Convention in Orlando. The winners will each receive a 2009 ABCT Student Membership, a 1-year subscription to an ABCT journal of their choice, and a complimentary general registration at ABCT's 2009 Annual Convention. To be eligible, students must complete the submission for this year's ABCT convention by **March 3, 2008**. The proposal must then pass ABCT's peer review process. ABCT's Awards and Recognition Committee will judge all student posters.

Awards
will be
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2007 Awards Ceremony * ABCT's Annual Convention, November 16, 2007

Top row, left to right: Art Dykstra (CEO, Trinity Services), Distinguished Friend to Behavior Therapy; Ray DiGiuseppe, President; M. Joann Wright, Awards & Recognition Committee Chair; Mitchell Schare, Outstanding Service to ABCT and Outstanding Training Program (Director of Hofstra's Ph.D. Program in Combined Clinical and School Psychology). Bottom row, left to right: Katharina Kircanski, Elsie Ramos Poster Award; Laura Allen, Virginia Roswell Dissertation Award; Alyson K. Zalta and Heather J. Risser, Elsie Ramos Poster Award; Jasper A. J. Smits, President's New Researcher; Steven C. Hayes, Lifetime Achievement Award



Jasper A. J. Smits (center), President's New Researcher, with M. Joann Wright and Raymond DiGiuseppe



Left to right: Lily McNair, Awards Committee, with Elsie Ramos Poster Award winners Alyson K. Zalta, Katharina Kircanski, and Heather J. Risser



Thomas Borkovec accepting the Outstanding Researcher Award, with President Raymond DiGiuseppe



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Mitchell Schare, Outstanding Service to ABCT and Outstanding Training Program



Steven C. Hayes, Lifetime Achievement

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NOMINATE

The Next Candidates for ABCT Office

I nominate *the following individuals
for the positions indicated:*

PRESIDENT-ELECT (2009–2010)

REPRESENTATIVE-AT-LARGE (2008–2011)

NAME (printed)

SIGNATURE (required)

Every nomination counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2008, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Contact the Nominations and Elections Chair for more information about serving ABCT or to get more information on the positions.

Please complete, sign, and send this nomination form to Kristene Doyle, Ph.D., Nominations & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.

position descriptions

President-Elect

The person elected as President-Elect (2009–2010) will serve as President (2010–2011) and Past President (2011–2012) and on the Board of Directors for 3 years. The Board meets once a year the Thursday of the convention and conducts monthly conference calls the other 11 months of the year.

The President-Elect works closely with the President on all executive matters. In the President's absence at any meeting except the Board meeting during the annual convention, the President-Elect presides. In case of absence, disability, or resignation of the President, the President-Elect will perform the duties of the President.

The President presides at, schedules, and prepares the agendas of meetings of the Board, the annual meeting of the Association, and any special meetings that may be called. The President may make nominations for approval by the Board for any appointive position which must be filled except as otherwise stated. The President of ABCT is responsible in all matters, stated or implied, that are related to the welfare, stature and proper operation of the Association.

Representative-at-Large

This individual serves as liaison to an ABCT Coordinator, working to review, develop, and/or maintain activities that service and support the members of ABCT in that respective area of the governing structure and serving as the "big picture" person to assist the coordinator in knowing who to keep informed of activities that have an effect on other areas of the governing structure.

The Representative-at-Large should be familiar with the ABCT mission statement, bylaws, and the most recent strategic long-range planning report, and is expected to attend the annual fall Board of Directors meeting and monthly conference calls; maintain contact with the coordinator, and to serve as a facilitator if required to move projects and/or activities along; encourage members' involvement in ABCT and encourage prospective members to join; and attend the annual convention, including all relevant meetings (i.e., with your coordinator and committee chairs).

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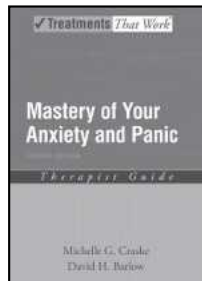
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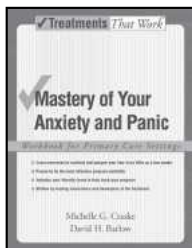
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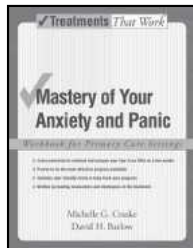
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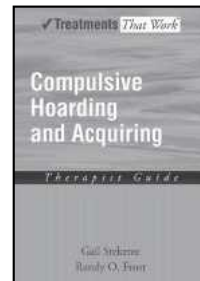
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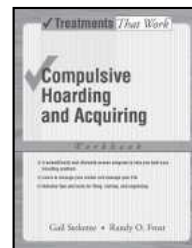
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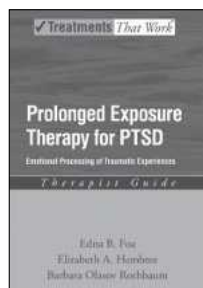
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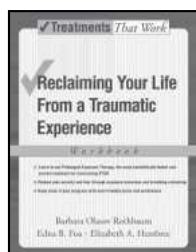
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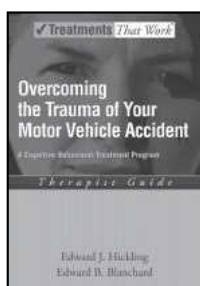
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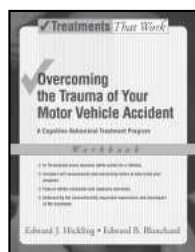
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There is widespread and growing interest in the development and implementation of evidence-based psychotherapies. As evidence has accumulated supporting the efficacy of cognitive and behavioral therapies, policymakers and practitioners seek to disseminate and deliver CBT to an ever-expanding array of clinical populations.

The theme of the 42nd Annual ABCT Convention recognizes the pivotal role of CBT in the delivery of mental health care. The convention will emphasize the role of researchers and practitioners in developing and continuously enhancing theoretical knowledge of psychopathology across the lifespan, developing efficacious forms of CBT, and advancing these treatments into clinical practice.

The meeting will focus on the dissemination of CBT to the range of populations, problems, and systems. We welcome submissions for research symposia, clinical sessions, and workshops focused on the application of CBT across stages of development, diagnostic areas, and organizational systems of care. Submissions that highlight models of dissemination, methods for evaluating and maximizing CBT training and skill transfer, and collaborative arrangements between research and service settings are especially encouraged and will receive special consideration.

Submissions may be in the form of symposia, round tables, panel discussions, and posters.

Discussants will be encouraged to integrate efficacy, effectiveness, and dissemination research.

*Information, including deadlines for submitting abstracts, can be found after January 1, 2008, on ABCT's web site, www.abct.org, or in the February issue of *tBT*.*

Sandra Pimentel, Ph.D., Program Chair



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