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Contents

Clinical Forum

Treating Obsessions With Competitive Memory Training: A Pilot Study

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Since the 1980s, in vivo exposure combined with response prevention (ERP) has been considered the psychological intervention of choice in the treatment of obsessive-compulsive disorder (OCD). Exposing patients to their feared stimuli while preventing them from performing neutralizing rituals not only reduces the compulsive behaviors of the patient, but also the frequency and emotional impact of accompanying obsessions (Emmelkamp, Van Oppen, & Van Balkom, 2002).

In OCD, "normal" cognitive intrusions, which are occasionally experienced by everybody, develop into pathological obsessions because OCD patients catastrophically misinterpret the personal meaning of these intrusive thoughts and, hence, become anxious (Salkovskis, 1985). Anxiousness and dysfunctional attempts to neutralize anxiety-provoking intrusions broaden the range of potentially dangerous stimuli and increase the number of intrusive thoughts (Rachman, 1997, 1998). While earlier cognitive interventions such as Meichenbaum's Self-Instruction Training (Emmelkamp et al., 1980) and Ellis' Rational Emotive Therapy (Emmelkamp & Beens, 1991; Emmelkamp, Visser, & Hoekstra, 1988) did not enhance the effectiveness of ERP, recent theorizing in OCD has stimulated the development of new cognitive interventions. These interventions have been ap-

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plied to OCD patients who present without overt compulsive behaviors. It has been estimated that between 9% (Foa & Kozak, 1995) and 25% (Freeston et al., 1997) of patients diagnosed with OCD experience obsessions only. The sole use of ERP with these patients has produced ambiguous results, compared to those in patients with both obsessions and compulsions (Craske, 1999; Stanley & Averill, 1998). Supplementing ERP with cognitive interventions was found to be beneficial for primarily obsessional patients (Freeston et al., 1997).

Moreover, although ERP is considered an effective treatment for OCD patients with manifest compulsions, only a minority of these patients achieves a nonsymptomatic status after treatment (Abramowitz, 1998). While several studies have shown that obsessive thinking in these patients reduced after ERP alone, it is suggested that adding cognitive interventions to ERP might further enhance its efficacy (Van Oppen et al., 1995).

While cognitive behavioral therapy in general is considered to be an effective intervention for a range of disorders, debate continues about the mechanisms involved in instigating change. According to Brewin (2006), cognitive therapy does not directly modify negative information in memory, but rather influences the relative retrievability of the different meanings of emotional concepts stored in memory. Strengthening positive representations that are in "retrieval competition" with dysfunctional negative representations is considered to be the common target of various cognitive and behavioral procedures.

Prior to Brewin's (2006) publication, but largely consistent with his suggestions, a series of cognitive behavioral interventions had been developed for patients who failed to develop a positive change in feelings, despite adequate changes in cognition after traditional Socratic challenging and behavioral testing of their dysfunctional thoughts. These interventions were based on Lang's concept of cognitive emotional networks (Lang, 1985, 1994) and were considered to be a modern, cognitive variant of counterconditioning. Assuming that the negative feeling state of these patients was directed by Lang's cognitive emotional networks, counterconditioning—or Competitive Memory Training (COMET)—aims to change these networks. According to Lang, cognitive emotional networks consist of cognitive representations of emotionally relevant stimuli, responses to these stimuli, and the (implicit and/or explicit) thoughts and interpretations about the relationship between both. Activation of an emotional network is a function of the number of matches between perceptions of the real world and the information already stored in long-term memory.

COMET is a stepwise cognitive-behavioral intervention based on this network theory of emotional representation. Basically, two variants of COMET protocols have been developed. One variant is aimed at changing the (felt) content of dysfunctional thoughts; the other is concerned with changing the attitude toward one's thoughts and thinking style. In the content variant, first the personal meaning and emotional theme of the dysfunctional emotional network are identified (e.g., intrusive thoughts about causing another person's death could mean that one is a "bad person"); next, a more functional but realistic alternative is formulated (e.g., "I am a good person"). Thereafter, this alternative is made more perceptible and retrievable for the patient by having him describe and imagine examples of positive situations in which these more functional alternatives were current (enhancing positive stimulus representations), by instructing him to (sub)vocalize positive self-statements in line with the imagination (enhancing positive meaning representations), and by asking him to accentuate and physically enact the positive images and statements by way a congruent posture and facial expression (stimulating positive response representations). Thus, several times a day the patient practices the strengthening of this competitive emotional network by imagining autobiographical situations in which he is, for instance, acting as a good and responsible adult, being helpful to others, or adequately performing responsible tasks. Implementation of these exercises is relatively straightforward, practiced in sets of no more than a couple of minutes each. The patient is simply asked to close his eyes and imagine himself being in the "positive situation." During these imaging practices, he sits with a straight back, strong shoulders, and a comforting facial expression, (sub)vocalizing, for example, "I am always there when I am needed." Then the exercise is stopped and the patient is asked whether he could experience at least "just a little bit of the positive feeling." If so, the exercise is repeated a couple of times. If not, the patient is helped to get a clearer image by giving him more guidance during his imagination, or by instructing him to be more expressive in his posture and facial expression. The patient is told that he has to become a "world champion in activating good images and feelings" by practicing 6 times a day for 5 minutes each time. Once a strong and competitive new emotional network has been formed, the patient imagines problematic situations (negative stimulus representations) from the old dysfunctional network, meanwhile assuming the positive posture and facial expression (positive response representations) and (sub)vocalizing the positive self-verbalizations (positive meaning representations) of the newly formed network. So, while activating obsessive thoughts about, for example, the death of his children, he keeps his "good person" posture and expression and keeps telling himself that he "is always there when he is needed." It is thought that in this way the old rigid dysfunctional emotional network is transformed into a more functional one. Although the procedure of COMET resembles that of systematic desensitization in several aspects, the supposed mechanisms behind this procedure are quite different.

An example of an "attitude variant" of COMET pertains to worry. In this protocol the patient learns to distance himself from his worrisome preoccupations by changing stimulus, response, and meaning representations. After explanation of the rationale ("Every person has the capacity to cling to issues of personal importance as well as to let go of things that have lost this personal importance—this protocol helps you to identify your capacities of letting go and to use these capacities in instances where you can't, but should let go"), a patient chooses his or her worry themes. Then, the patient learns, in a stepwise fashion, first to change the images of his worry themes ("zooming out" or "blurring" the picture as can be done with a camera, or picturing his worries on a stage and watching them from a distance like the audience in a theatre). Then, while imaging, he takes on an accepting or uninvolved posture and facial expression, (sub)vocalizing, for example, "These thoughts are boring, I won't allow them to interfere with my life," or other thoughts and attitudes that have previously been helpful in other situations where the patient could indeed take a distance or was able to let things go.

In their discussion on the mechanisms of exposure therapy, Foa and Kozak also refer to Lang's theory. They suggest a two-stage process. First, the automatic process of habituation reduces the patient's fear responses *within* exposure sessions. Second, the experience that fear is reduced automatically during exposure makes the patient less anxious at the beginning of the next ex-

posure session. This is referred to as fear reduction *between* exposure sessions. The combined action of fear reduction within sessions and between sessions is considered to be the working mechanism of exposure therapy (Foa & Kozak, 1986). One of the main differences between COMET and Foa and Kozak's account seems to pertain to the deliberateness of the therapeutic steps in COMET. Whereas for Foa and Kozak, both processes of fear reduction proceed automatically, patients in COMET should willfully and deliberately activate their positive as well as their negative beliefs and fears. In this respect, COMET resembles cognitive training in adjusting cognitive biases, as suggested by Mackintosh et al. (2006).

Until now, COMET protocols for several emotional problems have been developed and applied, among them self-esteem, worry, panic, and frustration (Korrelboom & ten Broeke, 2004). One of the COMET protocols pertains to the treatment of obsessions in OCD. This article describes the first empirical test of this COMET protocol for obsessions. It concerns an uncontrolled naturalistic study in a routine outpatient mental health setting.

Method

Patients

Patients were recruited from the Department of Anxiety Disorders of PsyQ, Parnassia, a large public mental health organization in the Netherlands. The study sample consisted of 17 outpatients with marked obsessions (a score greater than 7 on the obsessions subscale of the Y-BOCS) and a diagnosis of current OCD (*DSM-IV*; American Psychiatric Association, 1994), who had responded insufficiently after at least 7 sessions of regular outpatient treatment for OCD (i.e., "treatment-resistant" patients), consisting of ERP and pharmacotherapy, as recommended in the Dutch Multidisciplinary Guidelines for Anxiety Disorders (LSMR, 2003). On average, these patients had received 30 weeks (SD = 21 weeks) of therapy prior to the start of the current intervention. At the start of COMET, mean Y-BOCS scores were 23.47 and mean BDI scores were 16.43. These are in the same range as in several other clinical samples, with mean Y-BOCS and BDI scores of, respectively, 26.79 and 18.44 (Franklin et al., 2000), and 24.9 and 15.7 (Vogel, Stiles, & Götestam, 2004) at the start of therapy.

Patients were predominantly female (n = 11), of Western cultural background (n = 17), and with a relatively high education level (i.e., at least 13 years of education; n = 11). The mean age of the group was 33.1 years (SD = 10.4 years).

Instruments

The following assessments were conducted at baseline and posttreatment.

The Yale-Brown Obsessive Compulsive Scale–Dutch version (Y-BOCS; Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleishmann, et al., 1989). The Y-BOCS is a semistructured interview, designed to assess the severity of obsessive-compulsive symptoms. It yields a total score (Y-BOCS-tot) as well as two separate subscores: one for obsessions (Y-BOCS-obs) and one for compulsions (Y-BOCS-comp). The Y-BOCS is considered to be reliable and valid in assessing OCD symptomatology and is sensitive to treatment effects (Hiss, Foa, & Kozak, 1994). Y-BOCS ratings were made by the therapists themselves, so they were not independent. All therapists were trained in conducting Y-BOCS ratings.

The Beck Anxiety Inventory–Dutch version (BAI; Beck, Epstein, Brown, & Steer, 1988). The BAI is a 21-item self-administered questionnaire. Each item is scored on a 4-point Likert scale. The BAI is considered to be reliable and valid in measuring state anxiety (Osman et al., 1997).

The Beck Depression Inventory–Dutch translation (BDI; Beck et al., 1961). The BDI is a 21-item self-administered questionnaire, with a 4-point Likert scale for each item. The BDI has been demonstrated to be reliable (Bouman et al., 1985) and valid (Bouman, 1989) in measuring depression in Dutch populations.

Therapists

Patients were treated by four psychologists, all experienced in treating anxiety-disordered patients with CBT. All therapists had received two half days of training in conducting the COMET protocol. During the treatments, they were supervised by the first author for a total of 4 hours.

Procedure

All patients were informed by their therapists about the rationale, procedures, and treatment goal of COMET, and were asked to provide informed consent. After establishing the eligibility of each patient, the baseline assessments were conducted. The patients subsequently received 7 COMET sessions of 45 minutes each. Patients received COMET as an add-on to their ongoing routine therapy.

During the first session, all patients received a comprehensive treatment manual, in which the treatment rationale of COMET was emphasized (i.e., "Obsessions are nothing but strange thoughts which reveal nothing important about the person, his future, and the world he lives in"). To achieve this, the obsession and its personal meaning to the patient were determined. For instance: "Having intrusive thoughts about sexually abusing my child means that I am an immoral person." Next, a credible alternative description of the personality of the patient (or his world or his future) was formulated. For instance: "I am a person of high moral standards" (Session 1). Then, this alternative was elaborated in such a way that its meaning was not only intellectually *understood* by the patient but, in particular, more emotionally *felt* by him (Sessions 2 to 4). This was achieved by helping the patient to identify examples of himself being "a person of high moral standards" and by having him write down such examples during homework assignments.

In the next three steps, this process of "making the patient feel what he already knows" was intensified by having the patient (in therapy sessions and during homework) *imagine* these examples, meanwhile accompanying these imaginations by *(sub)vocalizing* adequate words and sentences ("I am honest and reliable") and compatible *posture and facial expressions*. It has been demonstrated that emotional experience and attitude can be influenced by manipulating writing, imaging, self-verbalizations, and posture and facial expression (Camras, Holland, & Patterson, 1993; Laird, 1974; Lang, 1985; Lange et al., 1998; Schnall & Laird, 2003; Segal, Gemar, & Williams, 1999). From a theoretical point of view, writing and imaging are considered to activate stimulus representations, while posture and facial expression are thought to be ways of triggering response representations. Finally, self-verbalizations are supposed to be examples of meaning representations.

In Sessions 5 and 6 and subsequent homework practices, the patient attempted to connect the newly achieved positive feeling state to his obsessions. This was realized by asking the patient to activate his obsession (stimulus representation of the dysfunctional network) while, at the same time, activating his incompatible response representation (facial expression and posture) and meaning representations (self-verbalizations) of the alternative, functional

Table 1. **Data of Completers on Symptomatology Before and After COMET for OCD**

	Pretreatment	Posttreatment	*t* value	*df*	Significance	Cohen's *d*
Y-BOCS-tot	23.47 (5.34)	15.60 (5.70)	6.24	14	.000	1.42
Y-BOCS-obs	12.80 (3.41)	8.33 (2.16)	7.75	14	.000	1.57
Y-BOCS-comp	10.67 (2.94)	7.27 (4.42)	3.34	14	.005	0.91
BAI	18.79 (5.42)	12.43 (5.05)	3.67	13	.003	1.21
BDI	16.43 (7.73)	10.36 (6.20)	3.50	13	.004	0.87

Note. Y-BOCS = Yale-Brown Obsessive-Compulsive Scale (tot = total score; obs = obsessions subscore; comp = compulsions subscore); BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory.

Table 2. **Data of Intention to Treat on Symptomatology Before and After COMET for OCD**

	Pretreatment	Posttreatment	*t* value	*df*	Significance	Cohen's *d*
Y-BOCS-tot	22.24 (6.13)	15.29 (5.44)	5.44	16	.000	1.20
Y-BOCS-obs	12.53 (3.29)	8.59 (2.15)	6.35	16	.000	1.42
Y-BOCS-comp	9.71 (3.97)	6.71 (4.51)	3.21	16	.005	0.71
BAI	19.69 (8.93)	14.13 (9.58)	3.46	15	.003	0.60
BDI	17.06 (8.51)	11.75 (8.09)	3.29	15	.005	0.64

Note. Y-BOCS = Yale-Brown Obsessive-Compulsive Scale (tot = total score; obs = obsessions subscore; comp = compulsions subscore); BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory.

network. It is thought that the patient could then *experience* that his obsession is "nothing more than a strange thought, revealing nothing important about the patient, his future, or the world he lives in."

In the last part of COMET (Sessions 6 and 7), the patient learned to distance himself from his obsession. Again, he was asked to activate his (now, supposedly, emotionally weakened) obsessive thought. Again, he had to activate incompatible motor and meaning responses. This time the alternative motor responses were "looking bored" or "looking amused" or "surprised," assuming a physical posture congruent with this feeling state and, at the same time, (sub)vocalizing "bored," "amused," or "surprised" words and sentences. Also the patient was asked, if possible, to change the image of his obsessions by "placing it at a distance in his mind (zooming out) or by making the picture of it less focused (blurring)."

Results

Of the 17 participating patients, 15 patients completed all seven COMET sessions. Both dropouts were female and they were slightly younger than the completers (23.5 versus 34.4 years). Also, dropouts had received less ERP therapy before COMET started (mean: 14 weeks versus 32 weeks), were more depressive (mean BDI: 21.50 versus 16.40), more anxious (mean BAI: 26.00 versus 18.79), and less obsessive-compulsive (mean YBOCS-tot: 13.00 versus 23.47) at the start of COMET. As far as significance can mean anything in this situation, the only significant difference was found on the Y-BOCS-tot. As no follow-up data could be obtained from the treatment dropouts, pre- to posttreatment patients' changes were primarily analyzed in the treatment completers (see Table 1). However, we also did an intention-to-treat analysis by substituting the pretreatment scores of the two dropouts as their posttreatment scores (see Table 2).

As summarized in Table 1, all measures showed significant reductions of symptomatology from baseline to follow-up. These reductions would remain significant after Bonferroni correction for multiple testing. Effect sizes (Cohen's *d*: Cohen, 1988) were large (> .80) for all anxiety measures as well as for depression. In the intention-to-treat analysis (Table 2), all results remained significant, while effect sizes for compulsions,

general anxiety, and depression decreased from large to moderate (between .40 and .80), but stayed large for obsessions and OCD.

To estimate the number of patients that showed a clinically significant improvement, we followed the procedure of Jacobson and Truax (1991). In accordance with Steketee, Frost, and Bogert (1996) and Vogel et al. (2004), we calculated the percentage of patients that fell within the nonpatient range by having a posttreatment Y-BOCS-tot < 16 (47%) as well as the percentage of patients with an Reliable Change Index (RCI) based on the Y-BOCS test-retest reliability of .79 (53%). Patients who had both an RCI and a posttreatment score on Y-BOCS-tot within the normal range were considered to have realized a clinically significant improvement during COMET (27%).

Discussion

This pilot study represents the first empirical investigation of COMET as an adjunct to ongoing routine treatment in OCD patients, specifically aimed at obsessive symptomatology. The results suggest that COMET may be effective in reducing both obsessive-compulsive symptoms and co-occurring depressive and anxiety symptoms in this population. In addition, the procedures used in COMET could be transferred relatively easily to therapists and were well accepted by the patients. These results are in line with findings from other preliminary studies in which variants of the COMET procedures were tested in other clinical conditions. In three uncontrolled studies (Olij et al., 2006; Peeters, Korrelboom, Voermans, & Huijbrechts, 2005; Van der Gaag, personal communication), patients with various psychiatric disorders (i.e., panic disorder, depression, eating disorder, PTSD, schizophrenia, and personality disorder) reacted positively to variants of COMET for treating low self-esteem, auditory hallucinations, and panic.

As a first pilot study in OCD, this study clearly has limitations. These include the small sample size, absence of a (preferably randomized) comparison condition, as well as the lack of a long-term follow-up and adequate control of the therapeutic procedures. In addition, COMET was provided as an adjunct to the patients' ongoing routine therapy. Therefore, the positive results found in this study cannot be attributed unequivocally to COMET per se. Nevertheless, patients had received their routine therapy for an average of about 6 months prior to the start of COMET, but still exhibited symptom levels for OCD and depression that were comparable to baseline levels found in other studies in OCD patients (e.g., Foa et al., 2005; Vogel et al., 2004). Hence, whereas patients were still symptomatic after their routine therapy, the addition of COMET resulted in substantial reductions of their symptoms in a short period of time, and with effect sizes comparable to that of other studies in OCD (e.g., Foa et al., 2005; Van Balkom et al., 1994; Vogel et al., 2004). Based on the therapists' clinical impression, longer duration of COMET might have been even more beneficial for some patients, as might have a more deliberate tuning of COMET with ERP.

To summarize, COMET may be an effective (adjunctive) intervention for OCD. The promising results found in the current study merit further investigation of this intervention in a well-defined population, using a better controlled design, sufficiently large samples, and a sufficiently long follow-up period.

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Student Forum

Selecting a Theoretical Orientation: Tips and Interdisciplinary Considerations

Eric L. Sullivan, *Suffolk University*

Many students of clinical psychology, as part of their professional development, select a theoretical orientation from which to conceptualize, research, and treat psychopathology. Theoretical orientation is a useful heuristic that guides psychopathology conceptualization and treatment, making it faster and more efficient. An orientation provides a prepackaged explanation of clinical problems and, usually, a method for changing them. Choosing an orientation, however, can be a daunting task, as there are many from which to select and compelling reasons to select any number of them. A nonexhaustive list of theoretical orientations and therapies includes behaviorism, cognitive therapy, cognitive behavioral therapy (CBT), humanism, psychodynamic therapies, gestalt therapy, existential therapy, and many more. In addition, many recent theorists and practitioners have elected to maintain an eclectic treatment approach, applying a variety of therapeutic technologies from across orientations and/or adopting their principles as part of a larger pastiche orientation.

Despite the oppressive number of possibilities from which to choose, there are steps that students can take to facilitate the selection process. These appear at the end of this article. In addition, students should consider the theories and research findings of the various nonclinical fields within psychology as well as that of other disciplines. Fusing interdisciplinary knowledge with the theory, research, and practice of clinical psychology can augment, broaden, and deepen the student's understanding and treatment of psychopathology. This idea receives discussion in this article, using the theory of cognitive development as an example of how students might enhance their understanding of clinical phenomena. But first, it is important to consider the reason for selecting a theoretical orientation in the first place.

Why Select an Orientation?

During practicum and internship, many students often struggle with conceptualizing clinical problems and selecting treatments to address them. Many feel overwhelmed by the multitude of possible theoretical models and treatment packages from which to select. In this author's experience, treating clients in practicum raised many doubts and concerns. The questions, "Have I selected the *right* treatment to effectively address this individual's problems?" or even "Am I doing the client any good at all?" often arose. Working within a theoretical orientation (such as CBT) can ease such concerns by offering a framework within which to understand client problems and a host of treatments that effectively address them. By adopting an orientation, the emerging clinician does not have to flounder with "reinventing the wheel." When using empirically supported treatments and theories, students can increase the likelihood that their case conceptualizations are accurate and their treatments effective because the wisdom and experience of a community of professionals and a large body of empirical support (in the case of CBT) predicates them.

Identifying with a theoretical orientation also provides an opportunity to enter a professional community, which most readers of this newsletter have done by joining ABCT. Professional organizations can provide support for students through e-mail listserves and conferences. Listserves and conferences are important and useful venues for students to explore and learn from the experience, wisdom, and scientific research of professionals. In such forums, professionals and students can exchange and evaluate ideas. These forums are also useful for networking with influential psychologists to build contacts and make friends. Conferences provide opportunities for students to hear, firsthand, the philosophy and science of the various treatments and concepts within an orientation.

An additional benefit of selecting a theoretical orientation is that it promotes consistency in research and clinical practice. This is useful for two reasons. First, it allows one to hone one's understanding of psychopathology and clinical skills to a finer degree. An orientation narrows the focus of conceptualization and treatment, which

provides more time to practice skills and evaluate theoretical conceptions. The example of sports illustrates this notion. That is, one may elect to play many sports or to focus on one sport. The more one elects to participate in multiple sports, the less likely he or she will be able to become expert at any one due to limitations in time and energy. By contrast, electing to focus on one sport allows a person to devote more time and energy to honing his or her abilities in that sport. If a basketball player practices foul shots daily, the amount of foul shots the player successfully makes will increase steadily. The same is true for clinical practice and research. For example, the more one practices thought monitoring (a component of cognitive therapy), the more effective one will become in skillfully leading clients in building awareness of automatic thoughts, identifying emotions linked to those thoughts, and eliciting alternative thoughts.

Second, the conceptual and clinical consistency that accompanies selecting a theoretical orientation also provides an anchor for exploring outside perspectives and ideas. When evaluating outside perspectives, these perspectives can be considered in contrast to a deep understanding of the theoretical framework within which one identifies. While contrasting ideas does not necessitate such an approach, it is useful from a practical standpoint: It prevents the confusion and bewilderment that could result from considering multiple orientations without a point of reference. It focuses exploration to make evaluating other ideas easier. Thus, while some may consider selecting a theoretical orientation confining, it may actually provide a platform from which one may explore other ideas and disciplines.

Selecting a theoretical orientation within which to ground conceptualization and treatment of psychopathology provides multiple benefits. Once one selects a theoretical orientation, however, it is easy to lose sight of the diversity of ideas and insight that nonclinical psychology research and disciplines outside of psychology (e.g., medicine) have to offer. In the following section, the theory of cognitive development serves as an example of how other branches of psychology (and outside disciplines) can augment understanding and treatment of psychopathology. Most readers of *the Behavior Therapist* have adopted a CBT orientation, which tends to emphasize the present and often deemphasizes development and experience. (However, this perspective does not discount their impor-

tance.) The theory and research of cognitive development can complement CBT conceptualizations by offering insight into the development of psychopathology.

Interdisciplinary Considerations in Selecting Theoretical Orientation

Richardson's (1998) classification system of cognitive development theories provides a useful framework within which to categorize conceptualizations of clinical issues. In Richardson's model, there are four basic schools of cognitive development: nativism, associationism, constructivism, and sociocognitive. These same divisions also underlie some theoretical differences between cognitive-behaviorists. These divisions are not independent, but rather, represent domains of theoretical emphasis or levels of analysis. Many clinical problems have biopsychosocial elements. Nonetheless, understanding these divisions will broaden student understanding of clinical phenomena and personal orientation and improve their ability to understand and change problems.

Nativism

Nativists explain cognitive development through genetic and biological factors. This perspective can also extend to behavior (e.g., skills, abilities, etc.). Nativism in its most extreme form would involve identifying genetic, inborn causes for every cognitive process and behavior. Most nativists, however, are not so extreme, emphasizing inborn and genetic causes to varying degrees. Noam Chomsky is a contemporary example of a nativist. According to his theory of language development (1980), humans are born with the ability to speak, including an innate understanding of grammar, which shapes one's acquisition and use of language.

In CBT, nativists view psychopathology in a similar vein. Nativist CBT therapists seek inherited or biological deficits. Some disorders have known biological underpinnings (such as schizophrenia and bipolar disorder). Therapists working with such clients might "work around" these inherited deficits by emphasizing existing skills, teaching skills through psychoeducation, and restructuring problematic cognition. One such approach is psychiatric rehabilitation (Pratt, Gill, Barrett, & Roberts, 2002).

Many psychiatrists also conceptualize clinical problems from a nativist perspective. They consider the acquired or genetic biological underpinnings of psychopathology and treat them by altering chemical and other physiology. Interventions may include restoring neurotransmitter concentration balance via prescription medicine, changing the electric behavior of the nervous system via electroconvulsive therapy, or altering physical structures via psychosurgery. Recently, the nativist perspective has surged in popularity via mass media marketing of psychotropic drugs.

Associationism

Acquisition of information about the world and reinforcement of behavior via interaction with the environment forms the underpinnings of associationist explanations of cognition and behavior. Learning, in its simplest form, is the acquisition of associations, or connections between objects and events or behavior and its consequences. Classical (Pavlovian) and operant conditioning are two of the main processes through which people learn. B. F. Skinner is among the most famous of the behaviorists (i.e., associationists). Behavior therapy emerged, in large part, because of his work. He theorized and empirically demonstrated that contingencies in one's environment shape one's behavior (i.e., operant conditioning; Skinner, 1953). While not denying the existence of cognition (Skinner often spoke of "verbal behavior"), associationism traditionally has not emphasized cognition due to the inability to observe it.

Many past CBT therapies emphasized the conceptualization of cognitions and behaviors as learned associations formed via interaction between the individual and his or her environment. In these conceptualizations, psychopathology arises through reinforcement of problematic thoughts and behaviors. Early behavior therapists used reinforcement principles to shape adaptive behaviors or change old, maladaptive ones. In its simplest form, psychiatric hospitals have used token economies to shape the behavior of patients by reinforcing desirable behavior with reward and ignoring or punishing undesirable behavior. Behavior therapists also utilize psychoeducation about behavior and strive to create and reinforce new, adaptive behaviors, such as coping skills (see Wilson, 1995, for a review of behavior therapy). Current third-wave behavior therapies, such as Acceptance and Commitment Therapy, also emphasize action, for example, citing the role of experiential avoidance in problem formation and maintenance (Hayes, Strosahl, & Wilson, 1999). These therapies use behavioral exercises to reshape experience and alter client perspectives.

Associationism extends to an explanation of cognition as well. In part, cognitive schemas are simply a collection of learned associations. The study of schemas is the main content of theory and research in the associationist cognitive development literature. This model does not allow for meaning making to originate within the individual, however.

Constructivism

Constructivists strike a balance between the nativist and associationist perspectives. They propose that individuals genetically inherit core cognitive abilities or structures. These abilities and structures are necessary for cognitive development. Using these structures and abilities, individuals both make meaning of their environment and are shaped by it. People also possess the ability to make novel cognitive constructions. The most famous of the constructivist cognitive development theorists is Jean Piaget.

Many CBT theories and therapies fit most easily into this model. Contemporary theorists view the individual as an active agent of meaning making and change. In support of this model, consider that the way one individual makes sense of events often differs from the manner in which others make sense of those same events. Different events have different meanings for different people. These dissimilarities in processing events arise from a number of sources, including biology, learning, and individual differences. This perspective, therefore, also makes room for environmental shaping. CBT practiced from this perspective takes individual differences in cognition into account and uses cognitive and environmental realities unique to the individual to formulate alternative perspectives that are less harmful to mood. Traditional cognitive therapy takes this approach by seeking to change depressed mood by correcting faulty information processing and distorted thinking (Beck, 1967; Burns, 1980). This often involves assimilation and accommodation of information into existing, individual cognitive associative networks (i.e., schemas). Schema therapy, for example, aims to change maladaptive schemas that have developed because of environmental shaping and personal construction (Young, Klosko, & Weishaar, 2003). At the same time, a constructivist might additionally work to modify maladaptive behaviors or build adaptive ones (e.g., coping skills).

Sociocognitive

This perspective of cognitive development emphasizes the role of society in shaping individual cognition. Vygotsky and other social constructivists argue that, unlike Piaget and pure constructivists, individuals do not simply act upon their world. Rather, larger social networks inculcate that individual with that society's worldview and knowledge. While the child acts upon its environment, making meaning of it, the knowledge learned by that child is reciprocally shaped by that child's social context. This occurs in a way that is congruent with that society's worldview. This view is similar to associationism and behaviorism in its emphasis on environmental influence on behavior, but different in that it speculates about the shaping influence of a particular society's worldview.

In its simplest form, social constructivist psychotherapy would equate to clinics and hospitals shaping behavior, playing on the strength of institutions to shape their members. It could also take the form of a directive therapist who makes suggestions and offers direction to clients. As a social representative of moral authority, a priest, reverend, or spiritual leader could offer guidance to a client seeking help. Considered by many as authorities on the values of a given society, they would be well suited to offer ethical advice and guidance and promote that society's values. *Walden Two* (Skinner, 1976) illustrates the potential of applying theories of operant conditioning in shaping the members of society to create a modern utopia.

Tips for Selecting an Orientation

In addition to considering the theory and research of other fields of psychology and disciplines, here are some general tips for selecting a theoretical orientation.

Supplement Your Reading About Therapies and Theoretical Systems With Supervision From Mentors and Seasoned Researchers and Clinicians

From their experience and knowledge, they can offer a hindsight view of the successes and pitfalls that accompany selecting and utilizing the approaches of theoretical orientations. Similarly, seek opportunities to observe the founders of an approach in action. Read classic case studies. Watch recordings of the founders practicing their therapies. When possible, attend conferences like ABCT for a more interactive experience. At ABCT conferences, one can observe leading CBT figures in action, ask them questions, and seek their advice.

Integrate theory and research from other fields of psychology and professional disciplines (e.g., medicine) into your search. It will improve the breadth and scope of your understanding of cognition and behavior, as well as improve your ability to predict and change them. While this article presents the schools of cognitive development and their application to CBT, many ideas from other branches of psychology are useful as well. Other disciplines and schools can broaden your understanding of the world. Remain open to the body of knowledge, experience, and wisdom that other disciplines and perspectives can offer.

Consider Your Personal Strengths, Weaknesses, Predilections, and Values When Selecting an Orientation

Does a certain orientation more naturally fit your strengths and way of thinking? Go with what feels right. Much like selecting a career, it will be easier to adopt an approach or perspective that fits with your existing values, proclivities, and strengths. It will facilitate research and understanding, as well as increase clinical effectiveness. Similarly, consider also the theoretical inclination, experiences, and abilities of the faculty and mentors in your program. Benefit from their knowledge and experience. They can offer more of a bird's-eye view of the development and implementation of theories and practices than is possible with a student's limited experience and knowledge.

Consider the Findings of Scientific Research

Empirical inquiry provides the most objective forum in which to test ideas. While proclivity and values are useful guides and can serve as strengths, they can also serve as biases that cloud one's view. While an approach may feel natural or easy, it may not necessarily be effective in addressing clinical problems. Knowing that scientific studies support one's research program or clinical work offers additional confidence in the utility of one's professional activities.

Outside of the empirical literature, it is also useful to think as a scientist in one's daily professional activity. When you have selected an orientation, use practical methods and personal reflection to test its worth. Can you use the theories and research of your orientation to understand a wide range of behavior? Can you use the theory and research of your orientation to understand behavior? If not, why? This will also sharpen your ability to conceptualize cases. Be open to change. If new scientific findings conflict with theoretical aspects of your orientation, it may be an indication that the perspective is limited and can improve. Perhaps you could even research the anomaly to enhance scientific knowledge in the area.

Selecting and exploring an orientation can be an exciting experience. One can explore a large body of philosophy, ideas, and techniques, within both the entire discipline of psychology and others. Approaching the selection process in this manner can keep the search interesting, as well as provide the benefits of both selecting a theoretical orientation and considering diverse perspectives and wisdom. Have fun with the process and best wishes!

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Katherine Martinez, *Committee on Clinical Directory and Referral Issues*

One of the first questions a potential client may ask is, "Do you take my insurance?" ABCT's expanded Find-a-Therapist Practice Particulars can resolve this and many other questions asked by clients and referral sources. Giving your valuable time to talk on the phone with a potential client can become burdensome when you realize midway through the call that the client has insurance that you do not take, or requests an evening appointment on days you do not work. To prevent this problem, try using the Practice Particulars option in the Find-a-Therapist directory to specify such important details as:

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Letter to the Editor

In "Convention, Tradition, and the New Wave: Assessing Clinician Identity in Behavior Therapy," Storaasli, Kraushaar, Wilson, and Emrick (2007) compared endorsements of various interventions by therapists who utilize Acceptance and Commitment Therapy (ACT), by therapists who utilize CBT, and by psychology students. The authors found that although there was some overlap, there was a clear difference between ACT therapists and CBT therapists.

One theoretical difference between ACT and CBT therapists is that CBT therapists challenge dysfunctional cognitions, while ACT therapists accept dysfunctional cognitions but encourage patients to pursue their valued goals in spite of conflicting dysfunctional cognitions.

But asking patients to behave in ways that conflict with a cognition indirectly suggests that the cognition is dysfunctional. So I would argue that ACT challenges dysfunctional cognitions indirectly and gently, while CBT challenges dysfunctional cognitions directly and forcefully.

As a CBT therapist, I once gave a workshop with a psychodynamic therapist in which we explained how each of us would treat specific patients. At one point I said that I would tell a patient, "Go home and tell your husband ——." My psychodynamic colleague responded that she would ask the patient, "I wonder why you don't go home and tell your husband —— ?" So maybe the most important difference between therapists of various orientations is in how directly we challenge dysfunctional cognitions.

Reference

Storaasli, R. D., Kraushaar, B., Wilson, K. G., & Emrick, C. (2007). Convention, tradition, and the new wave: Assessing clinician identity in behavior therapy. *the Behavior Therapist, 30*, 149-155.

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ERRATUM

The January issue of *tBT* (Vol. 31, p. 23) incorrectly identified the winner of the 2007 President's New Researcher Award as "Japster A. J. Smits." The correct spelling is Jasper A. J. Smits. We apologize for this error.

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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 basis 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.

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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 presented at ABCT's convention November 13–16, Orlando

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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.

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