

# *the* Behavior Therapist

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**\* April is Election month at ABCT  
Look for your ballot in the mail!**

### ABCT PLANNING

## ABCT's 2007 Strategic Planning Retreat

*Ray DiGiuseppe, Past President*

*Anne Marie Albano, President*

*Mary Jane Eimer, Executive Director*

**A**BCT is a vibrant organization. The energy driving our organization is unending partly because our governing body changes to some degree each year. Presidents, treasurers, representatives, coordinators, and committee members rotate on and off the Board of Directors, providing a steady stream of new energy and new ideas. At the same time, our past presidents serve as the "senior statesmen and stateswomen," reminding us of our history and traditions, and keeping us focused on the mission of ABCT. Still, rotating the sitting Board members provides a structure that can be a sword that cuts both ways. Whereas yearly changes in the governance stimulate new energy and ideas, these changes could also result in the organization going off in different directions and into novel initiatives each year without continuing any one project long enough to reach its goals. To guard against a waffling Board, the leadership of ABCT holds a planning retreat, usually once every 3 years, to examine and update a strategic plan to guide the work of the organization. These strategic planning retreats began in the early 1980s. Newly elected and appointed members to the governance structure review the strategic plan when they take office to ensure that the organization follows a reasoned course and achieves its stated objectives.

The ABCT Board met for its 3-year planning retreat the weekend of May 31 to June 2, 2007, in Philadelphia (see text box on p. 47 for participants). In this article, we provide the highlights of this retreat and present the new strategic plan for the association. During the retreat, the Board

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All items published in *the Behavior Therapist*, including advertisements, are for the information of our readers, and publication does not imply endorsement by the Association.

# Archives

Nathan H. Azrin interviewed by John R. Lutzker  
Albert Bandura interviewed by Antonette Zeiss  
Aaron T. Beck interviewed by Philip C. Kendall  
Sidney Bijou interviewed by Steven C. Hayes  
John Paul Brady interviewed by Arthur M. Nezu  
Joseph Cautela interviewed by David H. Barlow  
Gerald C. Davison interviewed by David A. F. Haag  
Edward Dengrove interviewed by Christine M. Nezu  
Albert Ellis interviewed by Arthur Freeman  
Hans Eysenck interviewed by Philip C. Kendall  
Cyril M. Franks interviewed by G. Terence Wilson  
Steven C. Hayes interviewed by Victoria Follette  
Arnold A. Lazarus interviewed by G. Terence Wilson  
G. Alan Marlatt interviewed by Linda C. Sobell  
Donald Meichenbaum interviewed by Arthur Freeman  
Stanley Rachman interviewed by G. Terence Wilson  
Todd Risley interviewed by John Lutzker  
Andrew Salter interviewed by Gerald C. Davison  
Richard M. Suinn interviewed by Arthur M. Nezu  
Dorothy Susskind interviewed by Mary Jane Eimer  
Joseph Wolpe interviewed by Gerald C. Davison

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## 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 the January 2008 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. Submissions via e-mail are preferred and should be sent to the editor at [drewa@albany.edu](mailto:drewa@albany.edu). Please include the phrase *tBT submission* in the subject line of your e-mail. Include the first author's e-mail address on the cover page of the manuscript attachment. By conventional mail, please send manuscripts to:

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reviewed our association's mission and purposes, and added values and a vision statement. These revised documents appear in Table 1.

The following six topics of paramount importance drew the attention of the Board during the 2007 retreat:

1. What are we doing to maintain and serve our present members?
2. In what ways do we want ABCT to grow?
3. How should we accommodate the growth in the attendance at our annual convention?
4. What role should ABCT play in the dissemination of evidence-based treatments to other therapists and consumers?
5. How can we expand and improve our Web site to represent the public face of CBT and ABCT to various constituencies?
6. Should ABCT get into the business of offering credentialing to practitioners of CBT?

After 3 full days of discussion and planning, the Board set priorities to guide the presidents, representatives, coordinators, committees, and ABCT central office staff over the next 4 years. We decided that the Board would not have a strategic planning retreat in 3 years, the summer of 2010, so as not to conflict with the planned World Congress in Boston. Therefore, this current strategic plan will be in effect for 4 years.

The first priority for the Board was the completion of the ABCT Policies and Procedures manual that Jackie Persons initiated during her presidency and developed through the terms of Patti Resick, Gayle Beck, and Michael Otto. This policy manual outlines our governance structure, mission, and goals, and clearly states the responsibilities of the Board, the committees, and the professional staff.

The bulk of our time together was then spent in setting the course for evaluating and planning our priorities and initiatives. Initially, rank ordering the priorities of the

association proved a bit daunting. For example, we came to realize that the amount of attention that any priority receives can vary greatly within any given month or year, due to various competing priorities, and due to tasks and deadlines associated with set and standard activities of the association (e.g., holding elections, producing our publications, and bringing to fruition our convention program). Hence, progress in reaching a goal for any one priority may run an uneven course, as we recognized that committee chairs and our professional staff might experience some conflicts trying to achieve the outcomes of two priorities at the same time. Hence, in putting into practice what we preach, we decided as a Board to set a new policy whereby the Executive Committee will identify and define specific priorities, their associated tasks and sub-goals, and specific time frames for completion when a conflict arises. We are confident that this approach will allow us to identify potential conflicts in advance and/or manage any stall in progress in a reasonable and expedient manner.

The strategic priorities set for the association at the retreat included the following:

1. Continue to develop our Web site.
2. Facilitate a successful World Congress in July 2010 in collaboration with Boston University's Center for Anxiety and Related Disorders and the Boston University School of Social Work.
3. Serve and retain our current members and institute new member recruitment initiatives.
4. Disseminate evidence-based treatments.
5. Provide clinicians with desired continuing education events.

#### Web Site Development

In today's world, most people seek information through the Internet. The public face of every professional organization is its Web site. Our ability to serve our members, communicate our values, and promote CBT starts and often ends with our Web site.

Although we have made extensive renovations and improvements to our Web site in the past year, we recognize that continued and ongoing refinements are needed. To keep on top of the ever-evolving science and practice of CBT, the Board asks every committee to think about how they can contribute material to the Web site on a regular basis. In this way, the entire work of the association becomes available to our members and to the public via the Web. Our current Web Editor, Mitch Prinstein, is charged with finding novel and appealing ways to meet our mission, through new Web features such as creating a "Tip of the Week" column and similar pages to promote professional practice and training. A subgoal of the Web initiative is to become a vehicle for outreach and dissemination to immigrant populations in the U.S. and abroad, and to underserved countries with a strong interest in CBT. This will obviously require our Web material to be culturally sensitive and translated into languages other than English. To facilitate all of this work, the Web Editor has appointed Associate Editors Drs. Esteban Cardemil (Clark University), Kristina Gordon (University of Tennessee), and Bunmi Olatunji (Vanderbilt University) to develop content for the Web. Podcasting has become a common vehicle for receiving information. The Board is determined to make available educational materials, clinical demonstrations, research information, and other relevant information concerning CBT through podcasts. The Board instructed the Web Editor and the Director of Communications to investigate the software and technology needed for podcasting, to develop an editorial process to select programs for podcasting, and to understand the copyright and any other legal issues in using this form of media.

#### Facilitate a Successful World Congress With Boston University

Our association has entered into a cost-sharing partnership with Boston University's Center for Anxiety and Related Disorders and the School of Social Work to host the 2010 World Congress of

#### ABCT's 2007 Strategic Planning Retreat Participants

Ray DiGiuseppe, President; Michael W. Otto, Immediate Past President; Anne Marie Albano, 2006–2007 President-Elect; Bob Leahy, 2007–2008 President-Elect; Frank Andrasik, Secretary-Treasurer; George Ronan, Secretary-Treasurer Elect; Deb Hope, Jonathan Abramowitz, and Bob Klepac, Representatives-at-Large; Joann Wright, Academic and Professional Issues Coordinator Designate; Cheryl Carmin, Convention and Education Issues Coordinator; Mitchell Schare, Membership Issues Coordinator; Phil Kendall, Publications Committee Coordinator; David Barlow, Representative from the Past Presidents; Kevin Arnold, Ad Hoc Chair of the Committee on Specialization in Behavioral and Cognitive Therapies Within Various Professions; Mary Jane Eimer, Executive Director; Mary Ellen Brown, Director of Education and Meeting Services; and David Teisler, Director of Communications.

**TABLE 1. ABCT's Mission Statement, Nondiscrimination Policy, Purposes, Vision Statement, and Values**

**A. Mission Statement**

The Association for Behavioral and Cognitive Therapies is an interdisciplinary organization committed to the advancement of a scientific approach to the understanding and amelioration of problems of the human condition. These aims are achieved through the investigation and application of behavioral, cognitive, and other evidence-based principles to assessment, prevention, and treatment.

**B. Nondiscrimination Policy** (adopted in November 2006)

The Association for Behavioral and Cognitive Therapies is committed to a policy of equal opportunity in all of its activities, including employment. ABCT does not discriminate based on race, color, creed, religion, national, or ethnic origin, sex, sexual orientation, gender identity or expression, age, disability, or veteran status.

In addition, the Board requires that ABCT leaders and staff implement the ABCT policy on nondiscrimination as follows:

- ABCT will display our Statement of Nondiscrimination prominently on materials produced by the organization, including on our Web site, in correspondence, in our journals, and in other appropriate venues.
- ABCT will follow APA ethics. (This is in regard to how to handle the situation when scientific data at our conference or in our journals are misused to promote discrimination. The Board decided we did not need a separate policy because it is handled by the APA ethics statement.)
- ABCT will provide advertisers with information on our nondiscrimination policy and require statements from them on how they differ from our policy if they differ from our policy.
- The ABCT Awards and Recognition Committee will be asked to respond to the Ad Hoc Committee's request requiring that an individual's or entity's efforts in promoting equal opportunity, as appropriate within the mission of the organization, be considered as one of the criteria for all awards and honors bestowed by the organization. This criterion need not be the deciding factor, and it should be weighted as appropriate given the purpose of the award or honor.

Implementation of the policy is carried out variously, depending on medium.

**C. Purposes**

ABCT's proposed purposes are to:

- Encourage the development, study, and dissemination of scientific approaches to behavioral health.
- Promote the utilization, expansion, and dissemination of behavioral, cognitive, and other empirically derived practices.
- Facilitate professional development, interaction, and networking among members.

**D. Vision**

The application of science to the prevention and treatment of behavioral and emotional problems.

**E. Values**

- We value inquiry based on the scientific method to understand and ameliorate human suffering.
- We encourage life-long professional learning and investigation.
- We promote clinical practice that is based on empirically supported assessments and interventions.
- We support the highest ethical standards in training, research, and practice.
- We seek collegial discourse and respectful debate from a range of diverse opinions within the field.
- We seek and respect diversity in our members and the communities we serve.
- We welcome the opinions and contributions of all disciplines and professions who seek to alleviate human suffering.
- We encourage members to serve as behavioral health resources to the community at large.

Behavioral and Cognitive Therapies. Organizing our annual conference is a major task. Our experience hosting the 2001 World Congress in Vancouver taught us that running two conferences in one year puts substantial strain on our small central office staff. To make the 2010 World Congress as successful as possible while ensuring that it does not interfere with other ABCT staff activities, the Board has partnered with our BU colleagues to share the efforts necessary to make a successful and brilliant World Congress event.

**Serve and Retain Our Current Members and Institute New Recruitment Initiatives**

ABCT exists to serve its members. The Board is committed to the membership and to finding new ways to improve our member services. To help achieve this goal, Membership Issues Coordinator Mitchell Schare, Membership Services Manager Lisa Yarde, and Executive Director Mary Jane Eimer will devise and conduct several surveys of people who failed to renew their memberships. Other surveys will assess your satisfaction with the association and what you want your governance to do for you as members. One such member-driven request will explore whether and how we may provide on-line access to professional/scientific journals (other than our own journals) to members who are in full-time clinical practice (a benefit that accompanies university faculty positions). Publications Coordinator Phil Kendall and Director of Communications David Teisler will investigate the potential of bundling more and diverse journals with our memberships.

The Membership Committee is also seeking ways to create incentives for members, such as membership cards and certificates. A new initiative stemming from the retreat is the ABCT Ambassador Program. In organizations or universities where more than one employee is a member of ABCT, one person will serve as our Ambassador to the organization. The Ambassador can answer basic questions about ABCT, recruit new members, and provide feedback to the governance of ABCT on our projects and initiatives.

Our Annual Convention represents a major benefit to our members, and the attendance has grown steadily in the last decade. Given the present size of the convention, we can choose from only a select number of hotels in the U.S. and Canada that are large enough to accommodate us in

one space. The Convention and Education Issues Committee and our Director of Education and Meeting Services, Mary Ellen Brown, work diligently throughout the year on all aspects of arranging and managing the Annual Convention. Venues for the Annual Convention must be booked several years in advance, and we already have our convention hotels booked through 2010. Looking toward 2011 and forward, our staff is investigating convention settings that offer the best space in either two adjacent hotels, a convention center, or a hotel that is adjacent to a convention center, such as the venue for this past convention in Philadelphia. Cost, accessibility, and space concerns are all given careful consideration when choosing a venue, and we take very seriously our members' feedback in this planning process.

### **Delivering to Clinicians What They Need and Want in Continuing Education Activities**

A core tenet of cognitive behavioral therapy is the scientific study of our principles and procedures, and the translation of scientific findings into clinical practice. As a large percentage of our members are practicing clinicians, the Board of Directors wants to ensure that science-based practice remains alive by providing for the needs of practitioners. This is especially important as studies continue to demonstrate the efficacy of cognitive behavioral therapy for the range of mental health problems. From the treatment of psychosis in adults to the alleviation of anxiety in children and adolescents, to novel iterations of CBT principles found in Acceptance and Commitment Therapy and approaches utilizing mindfulness and affect-regulation strategies, CBT continues to be advanced and meet the organization's mission of alleviating human suffering. It is critical to meet the needs of our members through ongoing continuing education efforts offered through our publications, Web site, and Annual Convention. The Board is also actively pursuing a needs and feasibility assessment for identifying other avenues of training, such as through regionally based workshops and distance learning methods.

### **Disseminate Evidence-Based Treatments**

ABCT now represents the best in empirically supported psychological treatments (ESTs). Many of the scientists who have developed and tested interventions come from the ranks of our members. Since we are now

a mature field, we are interested in disseminating these scientifically tested treatments to all health care providers. Dissemination of ESTs has been a strategic priority of the association for a number of years. Most of our attempts at dissemination have involved efforts to train mental health service providers through our CE activities. However, these efforts have not achieved the impact that we desire. Although the Board reaffirmed the priority of dissemination of ESTs, we identified several major tasks that we hope will have a greater impact on the number of therapists offering ESTs and the number of consumers receiving them.

At the same time that our treatments evolve and our CE activities expand, the priorities of outreach and training intersect with dissemination through our active efforts to recruit master's- and doctoral-level clinicians trained outside of traditional CBT programs and from the range of the mental health professions. To meet these converging priorities, we plan to conduct needs assessments that jointly assess what today's practicing clinician needs to know while also identifying key topic areas for our CE activities. With the Boston University School of Social Work as a cosponsor of the 2010 World Congress, we will actively conduct outreach to social workers to bring them to the World Congress. Social workers comprise one of the largest groups of clinicians serving the needs of individuals in the community, and traditionally, these practitioners are not trained in CBT. Hence, extending a welcome and expanding our training agenda to social workers will greatly enhance our dissemination efforts. In addition, the association will continue the initiative of offering specialized, targeted programming to psychiatrists during our Annual Conventions. Our overall goal is to engage other professional groups for all of our presentations and activities, with the ultimate goal of having CBT reach individuals in need.

Our first goal is to educate policymakers in local, state, and federal governments about our organization and CBT, to encourage evidence-based practice in government-supported community clinics and programs. We want to "create the pull" for dissemination, not just encourage the push. One avenue we are pursuing is to establish contact with State Commissioners of Mental Health. These individuals set the priorities for their state mental health initiatives while also controlling funding allocations for clinical services and continuing education for the service providers. Several

of our members have already been approached by such people and/or work at that level. Future columns in *tBT* will focus on these activities.

Next, we believe it is time for ABCT to develop its own task force to identify the core and active treatment principles involved in ESTs. Task forces of the Society of Clinical Psychology (APA Divisions 12) and the Society of Clinical Child and Adolescent Psychology (APA Divisions 53) have devised criteria and established lists of ESTs. Our Board recognizes that these organizations have done ground-breaking work in this area, and we are proud that many of our members are involved in these efforts. At this time, ABCT would like to take a different focus. Instead of evaluating a specific therapy manual or treatment, our task force would look at the principles of interventions from a broader level and examine what are the key components of effective treatment. To accomplish this, Michael Otto (ABCT President 2006–2007), will chair the Task Force on Empirically Supported Principles of Treatment. Representative-at-Large Bob Klepac will serve as liaison with APA Division 12 Task Force; President Anne Marie Albano will serve as liaison with APA Division 53 Task Force; and immediate Past President Ray DiGiuseppe will serve as liaison with SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). You will be hearing more about this task force in the future.

Another means of creating a pull to evidence-based practice is to offer certification in CBT. Several states and insurance companies have recognized the utility of evidence-based interventions for chronic mental health problems. Before they approve spending large sums of money on a treatment, they want assurance that the provider can deliver the treatment. Marsha Linehan has begun the creation of beta-tests to certify that practitioners have the knowledge and skills required to deliver DBT at the request of third-party payers. Presently, she has constructed two levels of certification. The first level assesses a practitioner's basic knowledge in behavioral and cognitive therapies. The second level involves the actual demonstration of clinical competency for all mental health professionals. Many areas of medicine already have such competence certifications that are required by third-party payers, and the mental health field seems behind other areas of health care in this model of provider certification.

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**TABLE 2. ABCT Priorities, Subpriorities, Strategies or Questions, People Responsible to Reach the Priority, and Measurable Outcome Adopted From the June 2007 Strategic Planning Retreat**

<b>Priority</b>	<b>Subpriority</b>	<b>Strategies or Question to be Resolved</b>	<b>Committee Responsible</b>	<b>Measurable Outcome</b>
<b>Service our current members</b>	1. Retain current members.	a) Provide an analysis of which members fail to renew their membership.	Membership Coordinator Mitch Schare, Lisa Yarde, Mary Jane Eimer	Retention of current membership
	2. Attract new members.	b) Ambassador Program. c) Development of surveys i) present member ii) members who have left d) Provide incentives for members i) membership cards ii) member certificates iii) provide more on-line professional journals to members e) Attempt to attract more members from Canada		
<b>Dissemination of ESPs with long-term goal of educating policymakers to encourage evidence-based practice, “create the pull” for dissemination</b>	1. Develop a list of ESPs (Empirically Supported Procedures)	a) Coordinate with lists developed by Divisions 12 and 53. b) Influence NREPP list. c) Create our own Task Force on Empirically Supported Principles of Treatment, to be chaired by Michael Otto.	Provide liaisons with other organizations listing evidence-based practices • Division 12 liaison: Bob Klepac • Division 53 liaison: Anne Marie Albano • NREPP: Ray DiGiuseppe	List of ESPs
	2. Consult with Marsha Linehan’s group on developing a test of basic CBT knowledge.	Explore others who may have developed these tests such as ADPCT (Anne Marie Albano & Phil Kendall will share their measures)	Task Force	Development of a test of CBT professional knowledge.
	3. Develop a plan and structure to conduct beta-test of credentialing for DBT/CBT		Task Force Chair	Possible creation of an independent organization to administer the test.
	4. Increase the election to APA organizational and divisional offices by people who share our values.	Monitor APA elections and inform members of who is running for office. (Creation of an APA Division of CBT was discussed but not considered necessary)	Committee on Professional Affairs. Sue Orsillo	Election of more people with our values to APA office
	5. Attempt to influence state Commissioners of Mental Health /Mental Hygiene to train clinicians in evidence-based interventions.	a) Make presentations to State Commissioners’ associations. b) Connect state agencies with members who can offer training on evidence-based interventions for specific problems.	Anne Marie Albano	Increase the number of therapists at state agencies receiving training in evidence-based interventions  Increase the number of therapists at state agencies offering evidence-based interventions to consumers.

Table 2, continued

Priority	Subpriority	Strategies or Question to be Resolved	Committee Responsible	Measurable Outcome
<b>Deliver what clinicians want in CE Workshops.</b>	<b>Conduct major outreach to master's- and doctoral-level clinicians across disciplines as consumers of CE activities.</b>	<p>a) Survey to find out what is wanted and needed.</p> <p>b) Outreach to MSWs at World Congress can fall under this, or under membership</p> <p>c) Continue initiative to reach out to psychiatrists at the convention.</p> <p>d) Reach out to other professional groups for all of our presentations and activities.</p> <p>Some strategies discussed to meet this goal:</p> <ul style="list-style-type: none"> <li>• Advertise the fact that one can attend ticketed CE sessions without registering for entire convention</li> <li>• Develop and distribute a book/listing of most clinically relevant activities at convention</li> </ul>	Convention Membership	<p>Offer product and services that were deemed wanted and needed. Evaluate based on participation.</p> <p>Increase other professional groups' participation at Conventions, as practitioners of CBT, and members.</p>
<b>Continue Web site development</b>		<p>a) Every committee needs to look at the Web site and think about how they can contribute to it.</p> <p>b) Develop podcasting</p> <p>c) Tip of the week</p> <p>d) Promote training</p> <p>e) Translate information into Spanish</p>	<p>All Coordinators</p> <p>a) Academic and Professional issues</p> <p>b) Conventions and CE</p> <p>c) Publications</p> <p>d) Membership</p> <p>Web Editor, Director of Communications</p>	<p>Increase web content.</p> <p>Improve the public face of ABCT</p> <p>Increase the visits to the web site.</p>
<b>Facilitate a successful World Congress in 2010 without interfering with other staff activities.</b>		Outsource as much of the work as possible.	Just do it.	Putting together a high-quality program that has multidisciplinary appeal.
<b>Continue our policy of governance for the Board</b>	Finish Policies and Procedures for Convention and Education Issues		Ray DiGiuseppe, Art Freeman, Mary Jane Eimer, Anne Marie Albano	Policies and Procedures manual was completed by November 2007 Board meeting.



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GEISINGER

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Dr. Linehan approached our Board concerning ABCT becoming the home of such certification examinations. The Board does wish to explore developing a structure to conduct a beta-test of a basic knowledge credentialing test. The Board continued the discussion of this topic at our November meeting. Debate was intense on this topic and a final decision on how ABCT should proceed is still being examined. Two of the questions being considered by the Board are: Should we offer the clinical competency exam only in DBT? Once this exam is established, do we want to develop similar exams for other varieties of CBT? We are presently developing a plan and a structure to conduct a beta-test of credentialing for DBT/CBT and deciding how to proceed on the competency exams.

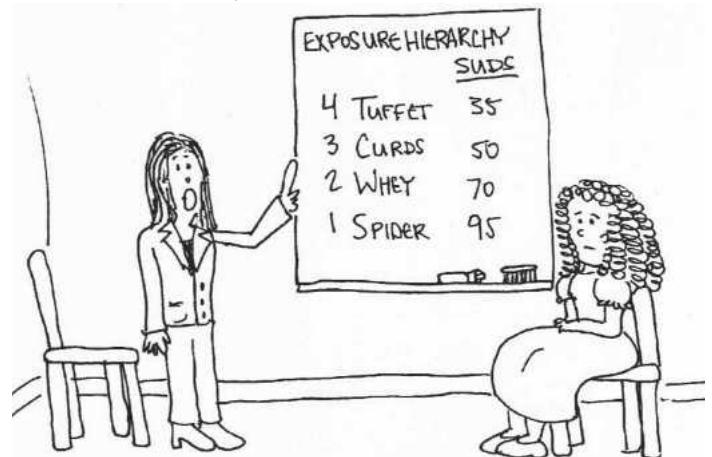
Another mechanism to disseminate ESTs would involve increasing the number of candidates to APA offices who share our values. To accomplish this, Sue Orsillo, Coordinator of Academic and Professional Issues, together with members of the Committee on Professional Issues, will monitor the APA elections and inform members of who is running for office. Another strategy we considered to influence APA was to create a division of CBT within the APA. Several members have proposed this for a number of years, arguing that a division would provide us with political power to disseminate our values with APA. After careful consideration and discussion, the Board decided against this strategy at the present time.

The Board will work on completing these priorities over the next 4 years. Remember, this is *your* association. Meeting these goals involves the collective efforts of our members who volunteer for positions and run for elected office, and our home office staff in New York City. We hope that some of you will join us in achieving these goals and become a member of one of the committees, run for office, and vote in the elections of our Board members. Please become active and help us make your organization successful. Any member of the Board, from the president all the way through to our editors and committee chairs, welcome your input and efforts. Together, we can work together to advance the science and practice of cognitive and behavioral therapy. ■

#### LIGHTER SIDE

### Exposure Hierarchy

Elizabeth Moore, *Mayo Clinic*



So now that you understand classical conditioning, we can begin working on your exposure hierarchy.



## Empathetic Jelly Beans: One Behavioral Intervention Begets Another

Megan M. Pinkston, Tara C. Carruth, and Kathleen J. Goggin, *University of Missouri–Kansas City*

Empathetic patient-provider communication is especially important in HIV disease management as it is positively associated with the behavior of medication adherence (Demmer, 2003; Murphy, Marelich, Hoffman, & Steers, 2004; Russell, Krantz, & Neville, 2004; Schneider, Kaplan, Greenfield, Li, & Wilson, 2004). Adherence to medications is imperative for appropriate HIV disease management (Levine et al., 2006; Moore et al., 2005); however, average adherence rates have been less than optimal. This is a serious problem as patients on earlier protease inhibitor (PI) based regimens need to be at or above 95% adherence in order to benefit from therapy and reduce the risk of developing resistance to the medications (Paterson et al., 2000; Shafer, Winters, Palmer, & Merigan, 1998). Most behavioral interventions for improving adherence have focused on changing the behaviors of patients. In this article we provide evidence to support the need for interventions that target providers' behaviors in order to ultimately affect the adherence behaviors of their patients.

### Background

As early as 1979, medication adherence was viewed as the most serious problem confronting medical practice (Dunbar & Stunkard, 1979). Lowered rates of adherence have been documented across a variety of conditions, including painful and sometimes life-threatening conditions such as hypertension (30% to 70%), epilepsy (50% to 65%), asthma (30% to 70%), and chronic obstructive pulmonary disease (19% to 47% and 46% to 69%) (Bailey et al., 1990; Bender, Milgrom, & Rand, 1997; Dolce et al., 1991; Hajjar & Kotchen, 2003; James, 1985; Leppik, 1991).

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Optimal adherence for an HIV-positive individual on a PI-based regimen translates into missing less than one dose per week for a patient on a twice-a-day pill regimen (Read, Mijch, & Fairley, 2003). In addition, highly active antiretroviral therapy (HAART) medication regimens are often very complex, requiring patients to take numerous pills, multiple times a day, with specific timing and food requirements (Chesney, 2000). Although newer, PI-boosted or nonnucleoside reverse transcriptase inhibitor (NNRTI) regimens are more

forgiving (ranging from > 54% to > 75% to 85%, respectively; Bangsberg, 2006; Maggiolo et al., 2005), several studies have reported less-than-optimal adherence rates among patients, ranging from 19% to 89% (Altice & Friedland, 1998; Bartlett, 2002; Halkitis, Parsons, Wolitski, & Remien, 2003; Sankar, Luborsky, Schuman, & Roberts, 2002; Singh, Squier, Sivek, & Wagener, 1996; Weidle et al., 1999).

The goal of treatment in HIV care is to suppress the number of viral copies of HIV as indicated in the plasma viral load. As

HIV worsens, CD4 cell counts decline and viral load increases. In order to have a decrease in viral load, an increase in CD4 cell count, and a lower rate of hospitalizations, one must have near perfect adherence (Paterson et al., 2000). Research has demonstrated that a nonadherent patient (i.e., self-report of taking less than 90% of prescribed medications) on HAART was 3.87 times more likely to die than an adherent patient on the same HAART regimen (de Olalla et al., 2002).

Of the categories identified as relating to adherence (i.e., patient factors, medication characteristics, interpersonal characteristics, and general medical care system; Chesney, 2000; Johnson et al., 2003; Remien, 1998; Remien et al., 2003), interventions that involve the role of the provider (i.e., interpersonal characteristics) in adherence are less in number than those that have solely focused on changing the patient's behaviors. Préau et al. (2004) suggested that adherence interventions should focus on optimizing the health-related quality of life of HIV-positive persons by improving the patient-provider relationship.

### The Patient-Provider Relationship

Terms such as *professionalism*, *integrity*, *humanism*, *compassion*, *empathy*, *respect*, and *altruism* have traditionally been used to characterize the role of a physician. Unfortunately, today these terms are more often used to describe characteristics of the physi-

cian that are disappearing in the face of modern technology. Considering the great stressors on physicians (i.e., threats of malpractice claims, reimbursement, reform and work overload) and with greater focus on the biomedical and technical aspects of science, it is not surprising that the physician-patient relationship may be in danger (Fredericks, Odiet, Miller, & Fredericks, 2006; Misch, 2002).

Despite the threats to the physician-patient relationship, research has demonstrated that physicians who develop an empathetic understanding can see their patients as humans and thus perceive their patient's demands and needs as more reasonable. As early as the 1970s, researchers demonstrated that the perception of physicians as warm and caring was related to greater adherence (Davis, 1978; Korsch & Negrete, 1972). Later these findings were replicated in HIV care (Becker, 1985; Friedland & Williams, 1999; Ingersoll & Heckman, 2005; Kennedy, Goggin, & Nollen, 2004; Lerner, Gulick, & Dubler, 1998; Mehta, Moore, & Graham, 1997; Préau et al., 2004; Russell et al., 2004; Schneider et al., 2004; Stall et al., 1996). Specifically, the aspects of the patient-provider relationship that influence adherence include the patient's perceptions of the provider's competence, affective tone of the relationship, trust, open communication, cooperation, and willingness to include the patient in treatment decisions (Stone et al., 1998). Given that the role of

the patient-provider relationship is a crucial component of the adherence behaviors of patients, we sought to develop a simple behavioral intervention to increase empathy in health care providers toward medication adherence. In order to allow providers to develop empathy for HIV medication adherence, we implemented interventions based on experiential learning.

Experiential learning has a long history in education, starting with Dewey (1938; 1997) and then expanded by Lewin (Cartwright, 1951), Schön (1983; 1991), and Kolb (1984). Experiential learning techniques provide individuals with opportunities to directly experience material as opposed to the traditional, more passive lecture-and-test approach (Thomas, 1993). For example, Henry-Tillman and colleagues (2002) demonstrated that after medical school students shadowed patients for a day, the students reported seeing their patients as people, not as numbers or diseases. Within the realm of psychotherapy, Hayes' Acceptance and Commitment Therapy encourages therapists to participate in experiential exercises so that they may appreciate the challenges that future patients may face in therapy (Hayes, Strosahl, & Wilson, 1999). We sought to employ such interventions in three different populations to increase the level of empathy toward HIV medication adherence. It is our ultimate goal that these interventions will later influence the future interventions of these health care providers with their own patients.

### Intervention

The intervention, also known as the "jelly bean trial," first involved the development of simulated HAART regimens by a Pharm.D. The pharmacist was careful to create realistic regimens that fit into three categories of difficulty. Six HAART regimens were developed: two easy, two moderate, and two difficult regimens based on the number of pills per day, dosing schedule, and side effects. Next, participants were randomized to one of the HAART regimens. Sample regimens are displayed in Table 1. Participants were asked to take the medications (i.e., jelly beans) for 2 weeks as prescribed (e.g., ranging from 1 jelly bean per day to 7 jelly beans per day, not including side effect medications) and to think of each week of the trial equating to 1 month of time. To aid with adherence, participants were encouraged to use alarms, beepers, and social support. During the trial, participants were provided with mock lab values and were asked for their impressions of the

TABLE 1. Mock Regimens

Level of Difficulty	Regimen
Easy	Atripla (3 medications in one pill) <ul style="list-style-type: none"> <li>• 1 tablet per day (preferably at bedtime)</li> <li>• take on empty stomach</li> <li>• central nervous system side effects such as vivid dreams, difficulty concentrating, sedation for first couple weeks of therapy</li> </ul>
Moderate	Kaletra 2 capsules two times daily Zerit 1 capsule 2 times daily Efavir 300 mg 1 tablet 2 times daily <ul style="list-style-type: none"> <li>• high triglycerides, high cholesterol risk with Kaletra</li> <li>• Peripheral neuropathy side effect with Zerit</li> </ul>
Difficult	Sustiva 600 mg 1 tablet per day Reyataz 150 mg 2 tablets one time per day with food Norvir 1 tablet per day with food and Reyataz Truvada 1 tablet per day Retrovir, (AZT) 300 mg 1 tablet every 12 hours <ul style="list-style-type: none"> <li>• possible side effects: diarrhea, belching, nausea</li> <li>• central nervous system side effects such as vivid dreams, difficulty concentrating, sedation for first couple weeks of therapy</li> </ul>

study at each meeting (i.e., preintervention, Week 1, and postintervention). At the end of the first week, a portion of participants were randomly informed that they would incur side effects commonly associated with their specific HAART regimen (e.g., diarrhea, cramping, nausea). Instructions for dealing with the side effects included adding a medication (i.e., additional jelly beans) to treat the side effect, changing individual dosing schedules, and/or changing a particular medication. Participants completed pre- and posttests inquiring about their beliefs about the intervention and how their views toward HIV medication adherence had changed as a result of the intervention. In addition, weekly sessions led by a facilitator allowed for discussion about side effects that participants were experiencing, tips for managing side effects, adherence barriers, and strategies for improving adherence. The discussions provided an opportunity for participants to learn basic information about HIV (e.g., meanings of viral load and CD4, common regimens, and side effects) and to imagine the challenging situations that HIV-infected individuals face. We employed this intervention first with health psychology graduate students and staff members of an HIV adherence grant and second with first-year medical students. More details about these participants are described next.

## Results

Our first intervention was a qualitative pilot study whereby health psychology graduate students ( $n = 21$ ) and staff members ( $n = 10$ ) of an HIV adherence program participated in the jelly bean trial. The majority of participants were female (85%) and Caucasian (79%), with an average age of 32 years ( $\pm 8.4$ ). Overall, despite their existing knowledge of HIV and the difficulty of the medication regimens, the students and staff were all amazed by the difficulty of taking the medications as prescribed. For instance, 84% of participants found that adherence was more difficult than anticipated. With regard to empathy, 71% of participants expressed an increase in empathy toward individuals with demanding medication regimens. For example, one participant reported, "As clinicians, we should be more understanding of how difficult adherence is for patients." Finally, participants expressed the need for health professionals to participate in experiential learning exercises, such as the jelly bean trial, to obtain greater awareness of the barriers that patients and clients face toward adherence. "I feel this

experience would benefit any person working [with] or assisting patients with adherence counseling. Participating in the jelly bean trial allows for greater understanding of the challenges and difficulties patients face." The full details of this study are currently under review for publication.

Our second intervention was a larger cohort-control, quantitative, pretest, posttest designed study employed with first-year medical students at two allopathic medical schools and one osteopathic medical school. The jelly bean trial was implemented in the same fashion as the pilot study whereby medical students were asked to take the jelly beans for 2 weeks as prescribed. Completers included 166 first-year medical school students (65 men and 101 women) aged 19 to 36 years ( $M = 23.3$ ).

Our preliminary analyses demonstrated that students' general level of empathy and HIV-related empathy increased significantly at the end of the intervention across all three schools. Further, students reported missing doses of medication for reasons similar to those of HIV-positive patients (e.g., simply forgot, away from home, busy with other things, etc.). Students also reported that they felt that they learned more in this intervention as compared to listening to a lecture and found the intervention to be simple and feasible. The results of this study are important as research has demonstrated that empathy declines by 75% as medical school students progress through medical school curriculums (Hojat et al., 2004). Further, there is growing recognition that medical education must prepare students to deal competently and compassionately with patients from all backgrounds and with multiple physical ailments (Turbes, Krebs, & Axtell, 2002). Additional analyses will look into what specific factors contributed to the students' level of empathy (e.g., gender, age, level of stress). To understand if this intervention will beget another successful intervention in the future, we plan to follow up with these students once on residency to determine how their level of empathy compares with others who did not participate in this intervention and to examine the adherence rates of their patients.

## Conclusions

At times, it can be very easy as a health care provider to assume that a patient/client needs to undergo an intervention to change a problem behavior. It can be difficult to acknowledge those things that we can change about ourselves. By challenging ourselves to identify what it would be like to walk for a

day in our patients' shoes, we may better understand the barriers that our patients face. With regard to medication adherence, and especially when our nation is faced with more chronic conditions in which patients must adhere to challenging medication regimens, developing empathy toward adherence barriers could influence your patient's adherence behaviors. As we found, our parsimonious intervention not only increased empathy across samples, but also, it was seen as feasible and effective by the participants.

Although the interventions described here specifically targeted HIV medication adherence, future applications could easily be modified to address adherence issues across a wide array of medical and mental health conditions. For instance, clinicians who work with patients/clients with schizophrenia might benefit from participation in the *Hearing Voices: A Simulation to Increase Empathy and Understanding* workshop developed by Pat Deegan, which guides participants through a day of living with auditory hallucinations. Within the realms of health psychology, clinicians might improve their understanding of the barriers that patients/clients may face in completing the daily food/exercise/stress diaries that are often prescribed. Experiential learning techniques like those described here offer great promise in narrowing the gap between clinicians' and patients' experience.

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## STUDENT FORUM

# Actively Assessing Fit When Applying to Ph.D. Programs in Clinical/Counseling Psychology: The Applicant's Perspective

Elizabeth K. Reynolds, Marsha N. Sargeant, Mary E. Rooney, Ty Tashiro, and C. W. Lejuez, *University of Maryland, College Park*

Applying to graduate school in clinical/counseling psychology can be a challenging experience.<sup>1</sup> The process is competitive, with the median acceptance rate around 10% (Norcross, Kohout, & Wicherski, 2005) and rates as low as 1% at the most competitive schools. With such low acceptance rates, applicants may be so concerned about maximizing their chances for gaining admission that they lose sight of what they are looking for in a program. Although publications such as the American Psychological Association's *Graduate Study in Psychology* (APA, 2005) and the *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology* (Sayette, Mayne, & Norcross, 2004) present a wealth of information about programs in general, there are few resources for students that provide specific and pragmatic guidance for evaluating how available programs fit with their training goals and interests. This article

aims to fill this gap by providing practical guidance for assessing fit with potential graduate programs from the applicant's perspective across several key areas: the mentor, the training/program orientation, and the balance between research and clinical experience. Although it is important to acknowledge that personal and other miscellaneous issues (e.g., location, typical duration of program, and funding issues) inevitably affect one's preference for where to apply, our focus here is limited to aspects of fit based on academic criteria.

### Three Domains of Fit to Assess, From the Applicant's Perspective

#### *The Mentor*

The mentor is a pivotal figure in the training of a graduate student in clinical/counseling psychology. Many undergraduate students are accustomed to educational

models in which contact with a faculty member is limited to the classroom and possibly research meetings in a larger group setting. Graduate school often differs from the undergraduate model in that the relationship is a mentorship educational model defined by collaboration and mutual exchange, with more intensive individual contact, and with the mentor often serving as the key collaborator in the student's professional development and progression into the field of psychology. Accordingly, active consideration of several mentor-related factors is crucial.

The first factor to consider is whether the mentor is conducting research and/or clinical work in an area of interest to the student. To help in this determination, it is beneficial for the applicant to develop some understanding of the type of research and clinical work he or she would like to pursue in graduate school (and beyond). Although a student may be able to expand upon a mentor's existing areas of interest, the general scope of interest should match the student's to allow for appropriate support and guidance. Additionally, an applicant should attempt to gain some sense of the mentor's goals and vision and how these fit with the student's goals and working style. For example, does this mentor publish a small number of extremely high-quality publications, increasing knowledge in line with a very specific question? Or is the mentor involved in multiple projects—working with investigators from other institutions and having a more broad scope of influence but with a more subtle connection across their work? Does the mentor work exclusively on basic psychopathology research questions? Are clinical activities also part of the research?

The applicant also should consider the advisor's mentorship style, including level

<sup>1</sup> To increase the scope of this manuscript we address issues relevant to both clinical and counseling psychology more broadly. Because many issues related to selection apply equally well to both types of programs, the two are only differentiated as key differences warrant. Although both clinical and counseling programs are addressed, we elected to focus on Ph.D. programs rather than Psy.D. programs. While selection issues related to Psy.D. programs are important, it is beyond the scope of this paper, which focuses on a mentorship model (smaller classes selected to work with a particular faculty member rather than a larger nonmentor assigned class). In addition, this manuscript applies primarily to programs that admit students to work with a particular faculty member rather than those that admit a class of students who are later paired with a faculty mentor.

of supervision (i.e., hands-on versus more room for independence), frequency and focus on feedback (e.g., opportunities for corrective feedback, explicit notice of positives), and approach (i.e., direct and to the point versus a more gentle touch). Other specific considerations include: availability for meetings, accessibility via email for more time-sensitive questions, level of involvement in the development of more independent projects such as thesis and dissertation, working relationship with the program and other faculty, and the larger zeitgeist of their laboratory (i.e., is the laboratory a smaller community with very close contact to the mentor or are there opportunities for midlevel supervision from post-doctoral fellows or even research faculty with possibly less direct contact with the mentor?). The above questions are not meant to suggest quality of a mentor in general, but are aimed more toward a specific fit with an applicant's strengths, weaknesses, and goals. For example, an individual who prefers a structured style may have difficulty adjusting to a hands-off approach in a mentor; but the same hands-off approach may work extremely well for someone who places a premium on intellectual freedom.

In addition to style, it is also important to be aware of a mentor's expectations for students to spend their time participating in the execution of already existing larger-scale projects as compared to spending their time dedicated to developing new research ideas. Both have their strengths, with the former approach more likely to provide access to excellent resources as well as structure and support within a team atmosphere, while the latter approach is more likely to provide flexibility and room for individual creativity within the context of a self-driven project. On the negative side, the former approach may involve a more narrow focus, with longer hours dedicated to a single project, less time to explore new ideas, and less opportunity to develop a project from start to finish; the latter approach may involve fewer resources and more modest data, with little opportunity to learn how to conduct a large-scale study. Although an ideal situation likely includes some combination of the two approaches, many laboratories have clearly established cultures, often beginning with the views of the mentor. These views should be taken very seriously by potential applicants when considering what their research experience may be like.

One final consideration involves the primary mentor's policy on access to other potential mentors. Although students

typically have one primary mentor, it is increasingly common to have secondary advisors or co-advisors in some graduate programs. There are potential advantages of having the freedom to work with more than one mentor, including increased breadth of training, possibilities for bridging concepts or methods across subfields, and being better prepared for future careers or grants focused on multidisciplinary research. Those students interested in multidisciplinary training should try and gain some sense of how common it is for students to work with more than one mentor, how open a particular mentor is to having a student work with other faculty, and if there are preexisting mechanisms that encourage cross-disciplinary work. For example, one university offers a minor in a cross-disciplinary field called an "Interpersonal Relationships Minor." Completing this minor entails completing coursework across various departments (e.g., Institute of Child Development, Psychology, Family Social Science) and creates natural opportunities for students to begin research on interpersonal relationships with secondary advisors.

Given these issues, it is important to consider how one may gather such information. At the beginning of the process, start with department and faculty websites that detail past and current research projects and interests. In addition, word of mouth from current supervisors and undergraduate mentors is helpful to evaluate how research and/or clinical activities fit with an applicant's interests. Another strategy to identify current and past scholarly activities includes the use of directed literature searches; useful options include PsycInfo and PsycArticles. Furthermore, CRISP (Computer Retrieval of Information on Scientific Projects), a searchable database of federally funded biomedical research projects conducted at universities, hospitals, and other research institutions, is available publicly. This web-based database, maintained by the Office of Extramural Research at the National Institutes of Health, includes projects funded by NIH, SAMHSA, HRSA, FDA, CDCP, AHRQ, and OASH. The applicant can use this database to identify both active and past grant activity.

These databases, in addition to information provided by the program's website, can help answer some questions, but as the process evolves, and certainly if an interview is granted, there is no substitute for asking questions. It should be noted that these questions should not be asked in a manner that can be interpreted as evaluative of the mentor's commitment to his or her students

or quality of work, but instead, to simply attain an honest assessment of the faculty member's mentorship style. Indeed, more general questions are appropriate at the interview and prior to receiving an offer for admission; more detailed and directed questions are more appropriate after an acceptance is granted. It is important to note that current graduate students at different stages in the program are an invaluable resource for understanding the reality of working with a particular mentor. Once an offer is made, well-developed and specific questions are key at this final stage of the application process, as information gathering will provide you with a final opportunity to assess mentor fit.

As a note of caution, mentors often accept an extremely small number of students and may not accept any in a given year. To determine whether or not a potential mentor is in a position to take on students in the coming year, it is appropriate to send a brief e-mail message on this subject to the professor. It is not necessary to be discouraged if the professor does not reply; he or she may take note of the application without necessarily returning the e-mail. Regardless, sending another e-mail is not needed or appropriate, with the possible exception of a brief e-mail at the time the application is submitted.

### *Training and Program Orientation*

A frequently asked question concerning the type of training one receives in a graduate program concerns the difference between clinical and counseling psychology programs. Both clinical and counseling Ph.D. programs allow one to become licensed as a practicing psychologist, but the foci of these two subareas are generally different. Clinical psychology tends to focus on clinically diagnostic psychopathology and matching treatment plans based on diagnostic category and/or functional impairments (Scotti, Morris, McNeil, & Hawkins, 1996). Although there may be a slightly greater focus on research across clinical programs, there are many counseling programs with a rigorous research component to complement the focus on therapy training. Clinical programs are almost exclusively housed in departments of psychology and provide students more training in psychopathology and biological bases of pathology. According to the 2003 survey of new doctorate recipients by the American Psychological Association (Wicherski & Kohout, 2005), new clinical psychology graduates were twice as likely to be em-

ployed in hospitals, medical schools, and independent practice compared to those receiving counseling degrees. Counseling psychology programs generally focus on vocational concerns, multicultural issues, outpatient work, developmental issues, prevention, and positive aspects of human functioning. Most counseling programs are located in schools of education (although several programs are housed in psychology departments), train students in working with less severe presenting problems, and generally place students interested in applied work in college counseling centers, schools, and private practice. The 2003 survey of new psychology doctorates indicated that counseling psychology graduates were more likely to be employed in human services-related positions (Wicherski & Kohout, 2005).

Once the applicant has settled on clinical or counseling, theoretical orientation of the particular program becomes an important consideration, as it will guide the majority of training and experience. Although some programs will consider themselves eclectic in nature, most programs are guided by a theoretical orientation that ties together faculty research and clinical activities. Although some accounts chronicle as many as 400 types of therapy (Nuttall, 2002), most training programs in clinical/counseling psychology utilize some combination of five major theoretical orientations: psychodynamic/psychoanalytic, applied behavioral analysis/radical behavioral, family systems/systems, existential/phenomenological/humanistic, and cognitive/cognitive-behavioral (Norcross et al., 1998). Each orientation provides a distinct explanation of the causes of psychological disorders and their appropriate treatments. Attending a program that identifies itself as primarily emphasizing one theoretical approach does not necessarily preclude access to training and experiences in other orientations, but it does clearly identify the prevailing approach(es) that will pervade one's course work and clinical training (and possibly research experience, depending on how well the scientist and practitioner aspects of the program genuinely are integrated).

An applicant should have a clear understanding of the different orientations and of his or her desired area of training. Although a program may state that it offers multiple orientations, the applicant should be certain that he or she will receive adequate training in the desired orientation. Alternatively, if the applicant desires an eclectic approach, then he or she should be certain that a specialized program will allow sufficient expo-

sure to a variety of orientations. Of course it is important to have an open mind and take advantage of opportunities from a new orientation that may be provided in graduate school, but it makes little sense and could cause unnecessary strife to attend a program that does not offer the depth of training in a desired orientation.

### ***Balance Between Research and Clinical Work***

Finding a balance between research and clinical experience that matches a student's needs is an extremely important factor when assessing fit. The balance has to match with the long-term career goals of the applicant. If the applicant wants a career in academia or research, he or she would benefit most from a research-oriented program. If the applicant wants a more clinically oriented career, he or she would not likely be satisfied in a program in which research drives one's training. Finding this balance is also an issue in determining if a counseling or clinical program is the right choice for an individual (covered in more detail above). Beyond this choice, however, this balance has even greater implications for one's decisions regarding other types of programs. For example, if a student is purely interested in clinical work, a Psy.D. or M.S.W. program may be more appropriate. Conversely, if an applicant has no interest in clinical phenomena whatsoever, then an experimental psychopathology or even another type of applied program, such as social or experimental, may be the best fit. Finding a fit for the applicant with the balance between research and clinical work will ensure that the student leaves a program with skills that they desire.

Taking into account the points above, it is useful to consider emphasis of training without mistakenly assuming that an applicant must choose only research or therapy-based experience. Most Ph.D. programs adhere to the scientist-practitioner model of clinical/counseling psychology, which demands an active integration of research and practice, highlighting the importance of research in informing clinical practice; a graduate of this model is capable of functioning as an investigator and as a practitioner. Despite most programs adhering to the scientist-practitioner model of training, they still vary in the degree to which they place a premium on research experience and clinical skills training. The *Insider's Guide* provides useful ratings for comparing this balance among various programs (Sayette

et al., 2004). For example, in clinical science programs it is typical for a student to accrue about 500 to 1,000 hours working face to face with clients, whereas in more practitioner-focused programs, students often spend 2,000 hours working with clients. On the other hand, those in clinical science programs will likely participate in a variety of research projects at one time and publish numerous articles during graduate school, whereas those in more practitioner-focused programs may have few expectations and opportunities for publishing during graduate school. This balance is critical because if one has interests in academia, developing a strong program of research while in graduate school is integral to success on the job market. Conversely, diverse clinical experience and expertise with certain types of treatments are important to being competitive in applied careers. A solid clinical or counseling psychologist should be well trained across the entire spectrum of the scientist-practitioner model, but it makes little sense to "suffer" through a program that heavily weighs one end of the spectrum if the applicant's interests fall on the other end.

When gathering information about the program's research or clinical practice emphasis, a student should study the program's mission statement carefully, or if a mission statement is not available then an applicant can consult the educational emphasis and goals section of the program's website. This section of the website usually states the philosophy and goals of the program and tells the reader if the program uses the scientist-practitioner model of training and if they are APA-accredited. This section of the website is also likely to provide more specific information about academies to which the program belongs. For example, membership in the Academy of Psychological Clinical Science underscores a commitment to taking an empirical approach to evaluating the validity and utility of testable hypotheses and to advancing knowledge by this method. These programs will likely place a strong emphasis on research and will uphold the clinical science model, in which an empirical approach to research and clinical practice is imperative.

When attempting to understand the level of emphasis placed on clinical work, an applicant can also research the clinical experiences available at a program including: sequence of training (in-house to out-of-house), number of practicum hours required, availability of externships, and internship placement. Of note, at the end of clinical or counseling psychology doctoral programs, students apply to 1-year intern-

ship programs that entail devoting most of their time to psychotherapy for 1 full year. It is important for applicants to consider questions such as how many students match on national match day, how many students get their first choice, and the quality of training at the internship sites where the students match (this information is included with the APA full disclosure data required on the program's website). Also useful is finding out whether any of the research being conducted involves clinical work (e.g., opportunities to be a therapist within the context of research studies). The interview is a good time to gather more general answers from students and faculty, with more detailed and specific questions possibly held until the decision-making period after offers are made.

### Case Studies

#### Case 1

After graduating with a B.A. in psychology, Jonathan accepted a position as a full-time research assistant with a 2-year commitment. In his first year in the position he prepared for the graduate school application process by taking both the general GRE and the psychology subject test. He then started thinking about what he wanted from his graduate school experience. He knew he was interested in pursuing a career in research but was undecided whether he wanted to be in academia. He also knew he was interested in addictions research and clinical experience and wanted an emphasis on cognitive-behavioral orientation. Jonathan did not have any location restrictions, and therefore started his application process by conducting a general web search of programs; he spent time reading program websites and researching the work of potential mentors. He conducted multiple literature searches with PsycInfo using potential mentors as the search criteria as well as looking for research conducted on addiction, being careful that researchers he identified were housed in departments of psychology (clinical or counseling programs) or able to mentor clinical or counseling psychology students if their primary appointments were in another program (e.g., experimental or social psychology) or an affiliated medical school or VA hospital. He was also fortunate to be currently working in a field related to addiction so he was able to seek advice from his current supervisors, who recommended programs and mentors with whom they thought he would receive excellent training in the field of ad-

diction. Jonathan narrowed his list down to 12 schools.

In the summer before the applications were due, he sent formal e-mails to potential mentors inquiring whether they were likely to take students for the following academic year. He worked diligently on his personal statement, making sure to tailor it to each school and mentor. Jonathan received interviews from 6 schools. Before attending the interviews he spent time researching in detail the programs and the mentors with whom he was applying to work and became well versed in each program and current and past work of his potential mentors. Jonathan also prepared a list of questions for the potential mentor that focused on the mentor's future research directions, opportunities for clinical training in addiction, required courses, potential funding sources, and placements of previous graduates. He also wanted to get a sense of how well his personality and working style fit with the mentor and current students in the program.

As Jonathan progressed through the interview process he became more and more aware of what he wanted from a program. He received offers from two programs, leaving him with a fortunate decision. Jonathan weighed the pros and cons of the two schools by considering the three areas of fit. He felt comfortable with both mentors and received positive feedback from the current students about their availability. Both mentors were conducting research in addiction: one at more of a basic process level and the other utilizing a more translational framework with more explicit integration of clinical application. Both programs emphasized a cognitive-behavioral orientation. In terms of balance between research and clinical work, one program seemed to emphasize research training while the other program had more of a balance, with professors and students conducting research on treatment development and evaluation. Although he believed that both programs would provide good research training in addiction, he chose the program that had more of a balance between research and clinical work. Ultimately, he accepted the offer because the program offered an externship at a substance abuse treatment center and the mentor was conducting research on substance abuse treatment development. His choice was guided by one of his original desires of a program: receiving research and extensive clinical training in addiction.

#### Case 2

Cory wanted to attend a program that offered a balance between research and clinical work. Her primary interest was finding a program with a mentor who conducted research in anxiety, specialized in treatment outcome research, and was highly involved in clinical supervision. She applied to several schools, received interviews, and ultimately was granted admission to one program. The program and mentor from which she received the offer were both very research oriented. She learned on the interview that the clinic was not especially active, with some students suggesting that the clinical training at the program was deemphasized. Thus, she had to decide whether she would attend a program that did not meet her desire for a balance between research and clinical work or to turn down the offer and apply again the following year. Cory had heard that it was not uncommon for students to apply to and enter a program with a good name, even if the emphasis did not fit their own. Often students overemphasized an interest stated by the program to appear more attractive to the program. Luckily, she had also heard that these students were rarely happy and usually frustrated that they were spending much of their time on aspects of training that they personally prioritized less and, worse, were not getting the type of training that had driven their interest in a career in psychology in the first place. After much thought and consideration she decided that she would be unsatisfied with a program that did not fit with her desire for an equal balance between research and clinical work. She decided to turn down the offer and reapply the following year, starting earlier with a focus on fit and only applying to schools that genuinely met her multiple training needs, combined with efforts to gain additional experience targeted to her goals to make her more appealing to programs that better fit her goals and interests.

### Conclusion

A successful graduate training experience begins with a well-researched and well-conceived application process. Students who are able to make the most of their graduate experiences are often those who entered their programs with a thorough understanding of how their interests fit with the program characteristics. Therefore, when a student decides to apply to graduate school in clinical/counseling psychology, he or she should develop a list of desired qualities of the graduate school and



their long-term career goals. This list should include items related to the three essential topics listed above: the mentor, balance between research and clinical experience, and training/program orientation. This list can then be used to continually assess fit throughout the various time points of the application process—from the initial appraisal of programs, through the completion of applications, to interviewing, and finally, in making the final decision of where to attend. This may seem counterintuitive and more difficult than simply looking at rankings, such as in *U.S. News and World Report*, and applying only to the top schools or only applying to schools that have reputable undergraduate programs. A school that is ranked highly by *U.S. News and World Report* may be an excellent program overall, but does not necessarily have a mentor, orientation, and balance between research and clinical work that fits well with the applicant. The focus of the application process should be about finding a school that has both an appropriate mentor and program.

In the early stages of the application process, the road to acceptance in a clinical/counseling psychology program may appear overwhelming. Although having some sense of these issues before applying is important, one need not feel panicked about not having all of the answers about what one's personal preference is in all of these domains. The process of assessing fit can begin broadly and gradually become more specific. In the early stages it is expected that the applicant will have general

criteria by which he or she defines fit. Specifically, when an applicant is choosing which schools to apply to, it is fine to be more general about the criteria of fit. Indeed, applicants do not necessarily know the nuances of theoretical orientations or even the specific area of research, but doing one's best to get a general sense of these issues prior to applying is well worth the homework and introspection. When one is less than certain about what is wanted from a graduate school experience, choosing a school that offers many diverse training opportunities is probably a good decision rule. For example, if one is uncertain about whether a career in clinical work or research is the desired career path, choosing a program with both strong research faculty and rich psychotherapy opportunities allows one to decide after sampling from these various experiences. Of course, choosing to wait a year or two and get more experience is another good way to address the problem of "not knowing" what one wants to do. In the end, applicants armed with a cohesive plan and an arsenal of knowledge will not only find the challenges conquerable, but will come to see that they have approached the process in a way that will have long-term benefits.

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## Find-a-Therapist

### How to Find-a-Therapist

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

Members frequently post requests for therapist referrals on the ABCT listserve. Although this yields results, utilizing the Find-a-Therapist directory service may be a more comprehensive and expedient method. We frequently revise this service to ensure it meets your needs. Be sure to log on to the ABCT home page regularly to view additions and new features.

- Step 1** Go directly to the ABCT home page at: [www.abct.org](http://www.abct.org)
- Step 2** Click on the "Find a Therapist" link in the right-hand navigation bar
- Step 3** Type in your desired variables and click on "search."

Presto! Results will appear immediately in a randomized order. Remember, the Find-a-Therapist directory is available to both members and the public. Therefore, members can refer clients to the directory to perform their own searches. The ABCT makes frequent changes to improve this on-line service based upon direct feedback from the membership. Please submit your ideas and suggestions to [km@sfbacct.com](mailto:km@sfbacct.com).

To list your practice in the Find-a-Therapist directory, or to add Practice Particulars to your listing in the referral directory, select MEMBER LOG-IN on the ABCT home page. Log in, and select FIND-A-THERAPIST DIRECTORY AND REFERRAL SERVICE, "join now." Once your request is processed, you can log on to the member's home page at any time to make edits and ensure your information remains up to date.

*Timely Tip:* Check your listing every 3 to 6 months.

## Milton L. Kleinman, 93

Milton Leopold Kleinman of New Brunswick, NJ, and Woodstock, NY, a pioneering clinical psychologist whose influence shaped the practice of psychology in New Jersey and beyond, died after a short illness on Thursday, November 15, 2007, at the age of 93. Dr. Kleinman's achievements in the field of psychology span over 50 years. During his distinguished career Dr. Kleinman was both an educator and innovator in clinical psychology and continued to work and study into his 90s. He served on numerous boards, was the president of the NJ Academy of Psychology, founded and chaired the Continuing Education Committee of the Academy of Psychology, was recognized as Psychologist of the Year by the New Jersey Psychological Association, and was honored for his outstanding lifetime of clinical service by the American Psychological Association.

Shaped by his memories of the Great Depression, Dr. Kleinman was an innovator who remained committed to the ideas of public service throughout his long career. Accepted to the inaugural class of Brooklyn College, Dr. Kleinman completed his bachelor's degree in 1938. Dr. Kleinman served overseas in World War II, rising to the rank of master sergeant and helping to establish a U.S. Army medical facility in Recife, Brazil.

After receiving his Ph.D. from NYU in 1952, Dr. Kleinman joined the staff of the New Jersey State Diagnostic Center in Menlo Park, NJ. Not happy with the clinical outcomes of the insight-oriented therapy developed by Freud and as taught by

Harry Stack Sullivan, he attended the conference at which Dr. Joseph Wolpe first presented in the United States the principles and techniques of behavior therapy that he had developed in South Africa. This led Dr. Kleinman to become New Jersey's first behavior therapist and to his 1972 establishment of the Center for Behavior Therapy. He continued to innovate and practice behavior therapy into his 90s.

Dr. Kleinman was an early leader in the development of standards and credentials for psychologists and therapists. While still a doctoral candidate he worked to develop the first standards for psychological practice in New York State and he later spearheaded the drive that led to New Jersey adopting a statute requiring licensure of psychological therapists. A leading expert in psychological evaluation, Dr. Kleinman collaborated with Rutgers University to help to evaluate the initial candidates for the U.S. Peace Corps volunteers. High among Dr. Kleinman's priorities was professional education. As chair of the Education Committee of the NJ Academy of Psychology for two decades from the late 1960s, Dr. Kleinman developed one of the first statewide programs of continuing education for clinicians in the country. He also helped to establish the Graduate School of Applied and Professional Psychology at Rutgers University, where he later supervised many graduate students. Recognizing the profound psychological impact of cleft palate and other craniofacial anomalies, Kleinman helped to establish the Cleft Palate team, a holistic approach to managing craniofacial anomalies, at Saint Peter's University Hospital in New Brunswick in

the mid-1960s, where he remained a driving force on the team for 25 years. After suffering a heart attack in the mid-1970s, Dr. Kleinman developed a seminar for couples coping with the stress of one partner having a heart attack. Dr. Kleinman published scholarly articles on topics ranging from psychological testing to psychogenic deafness, from the management of cleft palate to novel behavior therapeutic techniques.

Dr. Kleinman served as a director on the Board of the New Jersey Academy of Psychology. He was a pioneer in the integration of the technique of Eye Movement Desensitization and Reprocessing (EMDR) into behavior therapy. Dr. Kleinman was a consultant to the New Jersey State Division of Disability Determinations and for 25 years consulted to the Cleft Palate Team at Saint Peter's University Hospital. His work on the cleft palate team was reflected in his article "Cleft Palate: A Psychologist's View" published in 1982 in *Seminars in Speech, Language and Hearing*.

As a young man, Dr. Kleinman trained with a portrait photographer in Brooklyn, NY, and built his own cameras. Photography became a lifelong hobby, and he continued taking pictures into his 90s.

Dr. Kleinman is survived by his wife of 60 years, Gertrude M. Kleinman of New Brunswick, 5 children, 11 grandchildren, and 3 great-grandchildren, as well as 2 sisters, Helen Schaum of Brooklyn, NY, and Lillian Bloch of Riverdale, NY.

The family requests that in lieu of flowers, donations should be made to the Dr. Milton L. Kleinman Scholarship Fund of the Brooklyn College Foundation, 2900 Bedford Ave., Brooklyn, NY 11210. ■

*This article was originally published in the Woodstock Times.*

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## Minutes of the Annual Meeting of Members

Saturday, November 17, 2007 • Philadelphia Marriott

### Call to Order

President DiGiuseppe welcomed members to the 41st Annual Meeting of Members and called the meeting to order at 12:07 P.M. Written notice of the meeting had been sent to all members in August.

### Minutes

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

M/S/U: The November 18, 2006, minutes were unanimously accepted as distributed.

### Service to the Organization

President DiGiuseppe thanked the Board members for their hard work this year. He especially thanked Frank Andrasik, who, as Treasurer, made the Association's finances transparent and understandable; he thanked Deb Hope, outgoing Representative-at-Large, who made great contributions to the Board, always stressing process in trying to reach decisions; Stephanie Felgoise, Nominations and Elections Committee Chair, for her work in attracting such strong candidates as are now coming into leadership positions; George Ronan, who led all others in recruiting new members; Christine Maguth Nezu for her leadership of the International Associates Committee; David Reitman for his successful tenure as Editor of *the Behavior Therapist*; Cheryl Carmin, Convention and Education Issues Coordinator, who has been responsible for the remarkable increase in both quality and attendance of the annual convention; Dean McKay, who put together this year's great program.

President DiGiuseppe thanked the Associate Editors of *the Behavior Therapist*: Timothy R. Stickle, Associate Editor, Behavioral Assessment; Andrea M. Chronis, Associate Editor, Book Reviews; John P. Forsyth, Associate Editor, Clinical Forum; Brian P. Marx, Associate Editor, Dialogues; Drew Anderson, Associate Editor, Public Health Issues; Mark R. Dadds, Associate Editor, International Scene; Kelly G. Wilson, Associate Editor,

Lighter Side; Ethan S. Long, Associate Editor, Professional & Legislative Issues; David J. Hansen, Associate Editor, Research-Practice Links; Gayle Y. Iwamasa, Associate Editor, Research-Training Links; Jeffrey M. Lohr, Associate Editor, Science Forum; Andrea Seidner Burling, Associate Editor, Special Interest Groups; Megan M. Kelly, Associate Editor, Student Forum; David Penn, Associate Editor, Institutional Settings; Tamara Penix Sbraga, Associate Editor, Institutional Settings; James A. Carter, Associate Editor, Technology Update; and Clint Field, Associate Editor, Clinical Training Update. President DiGiuseppe also thanked Editorial Assistant Kyle Boerke.

President DiGiuseppe thanked the members of the 2007 Program Committee. They are Dean McKay, Chair; Sandra Pimentel, Associate Program Chair; Wesley D. Allan, Drew A. Anderson, Karla Anhalt, David C. Atkins, Sonja V. Batten, Carolyn Black Becker, Debora J. Bell, Jennifer Block-Lerner, Michele Boivin, Joaquin Borrego, Carolyn E. Brodbeck, Elissa J. Brown, Steven E. Bruce, Andrea Seidner Burling, Annmarie Cano, Cheryl N. Carmin, Corinne Cather, Alexander L. Chapman, Brian Chu, Mari L. Clements, Rebecca J. Cobb, Marlene J. Cohen, Dennis R. Combs, James V. Cordova, Lisa W. Coyne, Ronda L. Dearing, Thilo Deckersbach, Patricia Marten DiBartolo, David DiLillo, Linda A. Dimeff, Brian D. Doss, Laura E. Dreer, Greg Dubord, Jill T. Ehrenreich, Frank D. Fincham, Martin E. Franklin, Sharon Elizabeth Morgillo Freeman, Wendy S. Freeman, David M. Fresco, Alan Fruzzetti, Richard Gallagher, Scott T. Gaynor, Kristina Coop Gordon, Laurie A. Greco, Amie E. Grills Taquechel, Lindsay Ham, Melanie Harned, Trevor A. Hart, Aude I. Henin, Joseph A. Himle, Flora Hoodin, Debra A. Hope, Jennifer L. Hudson, Sue C. Jacobs, Emily Johnson, Matthew D. Johnson, Maria Karkla, Shalonda Kelly, Robert S. Kern, John W. Klocek, Brett R. Kuhn, Jennifer Langhinrichsen-Rohling, Robert H. LaRue, Jaslean J. LaTaillade, Jean-Philippe Laurenceau, Erika Lawrence, Steven R. Lawyer, Penny A. Leisring, Patricia J. Long,

Jennifer Lundgren, David Martin, Dean McKay, Gerald F. McKeegan, Robert J. McMahan, Daniel McNeil, John R. McQuaid, Elizabeth A. Meadows, Terri Messman-Moore, Catherine Michas, Lynn Miller, Candice Monson, Todd M. Moore, Tracy L. Morris, Douglas Nangle, Amy E. Naugle, Tara M. Neavins, Larissa N. Niec, Bunmi O. Olatunji, Holly K. Orcutt, Conall O'Cleirigh, Carolyn M. Pepper, Michael R. Petronko, Melissa Polusny, Sheila A. M. Rauch, Jennifer P. Read, David Reitman, Melisa Rempfer, Deborah L. Rhatigan, Shireen L. Rizvi, Melisa J. Robichaud, Dana Rofey, Ronald Rogge, Kelly J. Rohan, George F. Ronan, Frederick Rotgers, Kristalyn Salters-Pedneault, Steven L. Sayers, Julie A. Schumacher, Kathleen J. Sexton-Radek, Tamara Goldman Sher, Jillian C. Shepherd, Sandra T. Sigmon, Daniel W. Smith, Jasper A. J. Smits, Jennifer Snyder, William D. Spaulding, Amy E. Street, Gregory Stuart, Maureen A. Sullivan, Daniel J. Taylor, Mark D. Terjesen, Kimberli R. H. Treadwell, George C. Tremblay, Matthew Tull, Cynthia L. Turk, David P. Valentiner, Robyn D. Walser, Robert L. Weiss, Amy E. Wenzel, Mark A. Whisman, Kamila S. White, Maureen L. Whittal, Brenda K. Wiederhold, Nathan L. Williams, Carrie L. Winterowd, Deborah C. Wise, Katie A. Witkiewicz, Claudia Zayfert, and Michael J. Zvolensky.

President DiGiuseppe thanked the Local Arrangements Committee for an outstanding job in making us all feel very welcome to the "City of Brotherly Love": Amy Wenzel, Local Arrangements Committee Chair; Randy Fingerhut, Associate Local Arrangements Committee Chair; and the 26 members of their committee: Sarah Anghelone, Leah Behl, Sunil Bhar, LeeAnn Cardaciotto, Jennifer Connor, Marjie Crozier, Amy Cunningham, Kelly Foran, Evan Forman, Allison Fox, Dara Friedman-Wheeler, Rachel Gerstein, Brianna Mann, Katie McGrath, Maggee Messing, Elizabeth Mintzer Nolan, Chad Morrow, Elizabeth Musewicz, Dimitri Perivoliotis, Ayelet Meron Ruscio, Deena Sadiky, Rachel Salbo, Shannon Stirman, Donna Sudak, Rolando Vega, and David Zembroski.

President DiGiuseppe then asked the Coordinators to give the attendees some sense of what their respective committees have accomplished over the past year and what they will be doing in 2008.

*continued on next page*

## Coordinator Reports

### *Academic and Professional Issues*

Coordinator Sue Orsillo noted that Jennifer Block Lerner and the members of the Academic Training Committee continue to secure both graduate and undergraduate syllabi, which are being posted on the Web site under the Educators and Trainers section. The Academic Training Committee is also investigating the feasibility of producing on-line directories of CBT-oriented internship and postdoctoral programs. She remarked that the Awards and Recognition Committee did a fine job at this year's Awards Ceremony, where the Association honored Steven C. Hayes with ABCT's Lifetime Achievement Award; Thomas D. Borkovec with the Outstanding Researcher Award; the Ph.D. Program in Combined Clinical and School Psychology (Mitchell L. Schare, Director of Training) at Hofstra University with ABCT's Outstanding Training Program; Art Dykstra, CEO of Trinity Services, as the Distinguished Friend to Behavior Therapy; and Mitchell L. Schare for Outstanding Service to ABCT. Dr. Orsillo encouraged all members to submit names for the 2008 nominations. Details and applications are available on our Web site. She also announced that Laura Allen was the winner of the 7th Annual Virginia Roswell Dissertation Award, Jasper Antonius Josephus Smits received the President's New Researcher Award, and Katharina Kircanski, Alyson K. Zalta, and Heather J. Risser received the Elsie Ramos First Author Student Poster Awards. She also acknowledged the ADAA Travel Award winners—R. Nicholas Carleton, Justin W. Weeks, and Charles Taylor—who selected ABCT as the convention of choice as their prize. Dr. Orsillo thanked Christine Maguth Nezu for the work she had done chairing the International Associates Committee and serving as ABCT's liaison to the World Congress Committee, noting the success of the 2007 World Congress in Barcelona. She said that WCBCT 2010 will be in Boston. Kevin Del Ben will be the new Chair of the Professional Issues Committee and brings much expertise to the position. Steve Bruce, Chair of the Committee on Research Facilitation, has been keeping tabs on exciting new research-based findings and funneling them to the Web, and is developing a Web-based survey. Kevin Arnold serves as liaison to the Council of Specialties and has been working with APA on competencies. His ad hoc committee, Specialization in Behavioral and Cognitive

Therapies Within Various Professions, is now a permanent committee reporting to Dr. Orsillo as Coordinator of Academic and Professional Issues.

### *Convention and Education Issues*

Coordinator Cheryl Carmin noted this was her last year as Coordinator and expressed her gratitude to Mary Ellen Brown and Tonya Childers. She said that she couldn't have done her job without them. She said that the preliminary count for convention attendance was 3,533 and that we had met our room-block commitment. She noted that submissions had increased, and that the huge number of submissions had forced a lower acceptance rate. She said that she was well aware of the problems in the electronic submission process and that Dean McKay and staff had done a marvelous job in spite of that.

### *Membership Issues*

Coordinator Mitchell Schare reported that membership is healthy with more than 4,700 members, which is near a record high. He noted that nominations remains a task for the Leadership and Elections Committee (formerly known as the Nominations and Elections Committee), but they've also been charged with growing governance and finding new ways to get more people involved in volunteer activities within the organization. He said that we're developing new membership cards that will serve as reinforcers and will include such information as members' ID numbers as well as important dates. He noted that there's a strong correlation between attendance at a meeting and the subsequent year's membership numbers; our convention growth, therefore, is a portent of good things. He said that the Ambassador program is being developed: the program entails having one or more members of ABCT at as many institutions as possible. The ambassador will serve as a two-way conduit of information between ABCT and the members—and potential members—at that institution as well as serving as mentors for new members' early organizational activity.

Dr. Schare said that the Membership Committee was undertaking outreach in an effort to retain members and especially to facilitate the membership category upgrades from student to new professional and from new professional to full member. We're also reaching out to psychiatry, especially through training in psychiatric internship programs. The Committee on Clinical Directory and Referral Issues continues to

try to make on-line referral service, Find-a-Therapist, more useful. He indicated that they are aiming to have members use the clinical directory or Find-a-Therapist feature more often and rely less on the listserv in finding referrals. We'll be launching the new "Featured Clinician" in 2008 in which one of our pioneering clinical members will be spotlighted on the Web. Problems that some of us experienced in the initial launching of ABCT's listserv, when we moved its hosting function from UCLA to ABCT, are essentially resolved, with Laura Dreer, List Serve Committee Chair, and central staff members Lisa Yarde and David Teisler providing oversight and problem-solving functions as new issues occur. Dr. Schare is impressed with the way membership is embracing the listserv, discussing issues of substance.

Dr. Schare reported that there are two new Special Interest Groups in formation. He suggested that our SIGs can have more impact on our convention programming by sending their CVs and area(s) of expertise to the program chair each year to serve on the Program Committee as reviewers. He reported that this year's elections resulted in our choosing Bob Leahy as the 2007-2008 President Elect and Stefan Hofmann serving as 2007-2010 Representative-at-Large and Board liaison to Academic and Professional Issues. He then thanked all his committee members, committee chairs, and the many members of the association we all serve.

### *Publications*

Coordinator Phil Kendall reported that *Behavior Therapy* has seen a meteoric rise in its impact ratings that began under Editor Dave Haaga and is continuing under Rick Heimberg's tenure. Stefan Hofmann, Editor of *Cognitive and Behavioral Practice*, will be turning over the journal to Maureen Whittal, who will begin receiving all new submissions in January. Both journals are now available electronically via Elsevier's ScienceDirect portal, and all members have access to all issues back to the beginning of time. Drew Anderson takes over from David Reitman as Editor of *the Behavior Therapist*. He announced that past issues (from 2005 to the present) of *the Behavior Therapist* are now available on our Web site as PDFs.

Dr. Kendall noted that all future Archives and Clinical Grand Rounds sessions will be recorded for DVD format. We are adding three new Clinical Grand Rounds from this year's convention and the

five presidential panels captured at last year's convention are completed. The Public Education and Media Dissemination Committee, headed up Bryce McLeod, continues to revise fact sheets to ensure that they are current—many are already posted on our Web site. Mitch Prinstein is assembling a crew to assist him in his efforts as Web Editor, with the goal of making the Web site more accessible to ABCT's various constituencies and to expand the content. In general, Dr. Kendall said that the committee had completed 8 of the 10 priorities it set for itself, with two others ongoing and a tenth in process. He noted that publications are doing well, on schedule, and serving as a great revenue stream for the association.

### Executive Director's Report

Mary Jane Eimer, ABCT's Executive Director, exclaimed that it has been a "wow year," highlighted by the incredible involvement of the leadership. We're nearing completion of the process begun over 5 years ago in which we fully delineate all our policies and procedures. Having met over the summer in support of what the leadership calls a very successful strategic planning retreat, she stressed that she observes great synergy between leadership and staff and that both leadership and staff concur.

Ms. Eimer thanked Stephanie Schwartz, ABCT's Managing Editor, for the consistently good work she does as an editor and for the creative designs that grace so much of our work. She thanked Patience Newman, our Web Master, who also did much of the work on the program book and the corresponding Web pages. She welcomed Ann Sullivan, the new Administrative Secretary, who started just one month before the convention and is still standing in spite of everyone's best efforts to overwhelm her. She thanked Lisa Yarde, Membership Services Manager, for all her work on the database and her immense efforts in support of registration and membership renewal. Ms. Eimer thanked Tonya Childers, who serves as our Convention Registrar and Exhibits Manager and is considered one of the great multitaskers of the world. She said that David Teisler, Director of Communications, protects the Association with his great negotiation skills and work on the Web. And she congratulated Mary Ellen Brown, Director of Education and Meeting Services, on what is shaping up to be another record-breaking convention running virtually flawlessly. Thank you, all.

### Finance Committee Report

Secretary-Treasurer Frank Andrasik said that one of his goals has been to make the Association's finances clear and understandable to all.

Dr. Andrasik noted that the Finance Committee's charges include overseeing annual financial condition, monitoring fiscal projections, ensuring funds are available for achieving specified goals over single- and multiple-year spans; making recommendations regarding personnel and capital equipment; and ensuring reserve funds are invested prudently (and George Ronan spearheaded efforts to revise the policy this year). To accomplish all this, ABCT has a committee that consists of a Secretary-Treasurer elected by the membership (Frank Andrasik); two hand-selected members (Pat Friman and George Ronan); plus that year's President-Elect (Anne Marie Albano).

Dr. Andrasik explained the scope of the Finance Committee's work, which includes over 400 budget lines. He explained that the committee meets in the off-season, between meetings of the Board, and that they communicate frequently during the year and our ably served by the central office staff, "primarily what we like to refer to as the 'Big 3,' plus our bookkeeper, Damaris Williams."

Dr. Andrasik related ABCT's financial picture as follows: Over the last 22 years, we have been in the black 19 of them, and 2007 will be no exception. Our income over expenses has ranged from -7.5% (2000) to +23.1% (1988). Of those three down years, one of them was due to the purchase of headquarters, which we now own outright. For the 2007 Budget Year, which runs November of 2006 through October of 2007, we are estimating a healthy income over expense. Our financial foundation is built on three pillars:  $\approx 37\%$  Convention;  $\approx 30\%$  Membership; and  $\approx 27\%$  Publications; the remaining  $\approx 6\%$  is comprised of miscellaneous sources (prompting Dr. Andrasik to say, "Thank you for paying dues, subscribing to publications, and supporting our annual meeting!")

The financial state of ABCT is fiscally responsible and sound. We routinely pass yearly independent audits and we follow accepted accounting principles (GAAP). We are compliant with all state and federal regulations. And, unlike federal governments, we cannot commit to projects without having the funding. Our budgets are transparent and we track staff time and task

allocation. There are no corporate scandals here!

Our "Rainy Day Fund" includes a Restricted Reserve, which has been running about 1/4 to 1/3 of operating expenses. Our immediate goal is to have at least 50% of operating expenses; and our long-term goal is to have 100% of operating expenses. The current amount is \$750,000. There are also other set-asides, including a technology enhancement fund, a fund for our office overhaul; and a fund for our triannual retreat.

Dr. Andrasik thanked the membership for entrusting the Association's finances to his and his committee's care for the last three years. He thanked George Ronan and Pat Friman for their yeomen efforts over the years. Pat is rotating off and George Ronan has been elected as your new Secretary-Treasurer. Dr. Andrasik finished by stating that he believes he is leaving financial matters in excellent hands with Dr. Ronan.

### President's Report

Ray DiGiuseppe made some final remarks as President. He commented that it had been a busy and benchmark year for the association. We have broken membership and convention attendance records. We had a productive strategic planning retreat, the details of which will appear in *tBT* (see p. 45). The leadership has completed the ABCT Policies and Procedures and we are well on the path to some very important initiatives for our field. He thanked the members for the opportunity they gave him to serve as the President of ABCT this year.

### New Appointments

President DiGiuseppe announced the members joining leadership in 2007. Art Freeman will serve as Convention and Education Issues Coordinator from 2007-2010; Sandra Pimentel will be the Program Chair in 2008 in Orlando; Lata McGinn will be Program Chair in 2009 in New York City; Steve Hayes will serve as International Associates Committee Chair from 2007-2010; Craig Marker will be the 2006-2009 AMASS Committee Chair; Kristene Doyle will serve as 2007-2010 Leadership and Elections Committee Chair; Drew Anderson will be serving as *tBT* Editor for Volumes 31-33 during the 2008 through 2010 calendar years; Brian Chu will serve as Media Production Committee Chair from 2007-2009; Mitchell Prinstein will serve as Web Editor from 2007-2010; Bryce McLeod will serve as Public Education and Media Dissemination Chair from 2007-2009; Judith Favell will serve as

a Finance Committee Member from 2007-2010; and Frank Andrasik will serve as a Finance Committee Member in 2007-2008. President DiGiuseppe expressed the Association's heartfelt thanks for volunteering and your anticipated great service.

#### Transition of Leadership

President DiGiuseppe announced the transition of officers: Bob Leahy, 2007-2008 President-Elect; Stefan Hofmann,

Representative-at-Large and Board Liaison to Academic and Professional Issues; George Ronan, Secretary-Treasurer; and Anne Marie Albano, who, as of this moment, is now your President.

#### Adjournment

There being no additional business, the meeting was adjourned at 1:10 P.M. Eastern Standard Time. ■

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.



Call  
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President's New Researcher

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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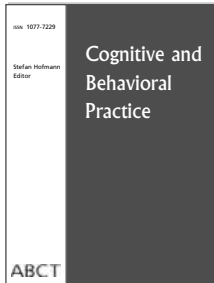
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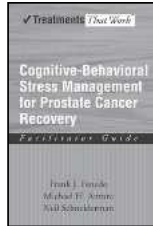
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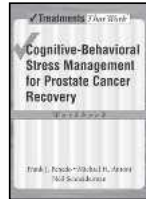
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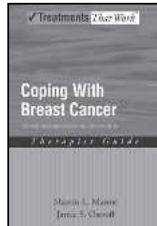
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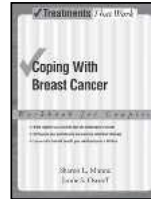
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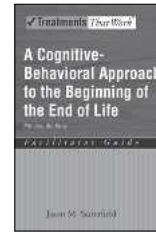
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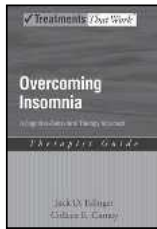
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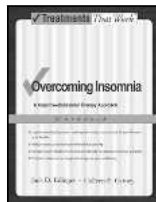
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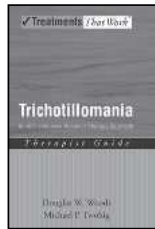
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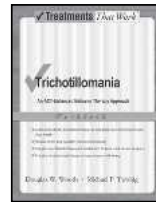
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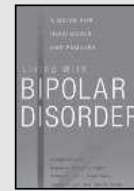


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