

# *the* Behavior Therapist

## Contents

### Clinical Forum

*Kristine E. Rork and Cheryl B. McNeil*  
A Behavioral Model of School Consultation • 69

### Student Forum

*Jason C. Ong, Emerson Wickwire, Jr., Michael A. Southam-Gerow, Julie A. Schumacher, and Susan Orsillo*  
Developing Cognitive-Behavioral Treatments: A Primer for Early Career Psychologists • 73

### Lighter Side

*Elizabeth Moore*  
"Automatic Thoughts" • 77

### Obituary

*John R. Lutzker*  
Todd R. Risley, 1937–2007 • 78

### Book Review

*Reviewed by James D. Herbert*  
Forsyth, J. P., & Eifert, G. H. (2007). *The Mindfulness and Acceptance Workbook for Anxiety: A Guide to Breaking Free From Anxiety, Phobias, and Worry Using Acceptance and Commitment Therapy* • 79

### At ABCT

Welcome, New Members! • 81

### *Clinical Forum*

## A Behavioral Model of School Consultation

Kristine E. Rork and Cheryl B. McNeil,  
*West Virginia University*

In today's managed care environment, short-term, effective treatments must be used as often as possible. Utilization of a multiple-informant, multiple-setting intervention may be necessary to provide a child client with the most immediate and effective treatment possible. When treating children, concurrent intervention in the home and school environments may create timely decreases in child symptomatology. School interventions have shown success in helping to decrease symptoms when incorporated into the course of therapy, and have consistently demonstrated effectiveness in decreasing symptoms related to attention-deficit/hyperactivity disorder and attention problems (e.g., Chronis et al., 2001; Fabiano & Pelham, 2003; Waschbusch, Pelham, & Massetti, 2005), disruptive behavior (i.e., Hawken & Hess, 2006; Luiselli, Putnam, Handler, & Feinberg, 2005), bullying (i.e., Hirschstein & Frey, 2006), obesity (i.e., Spiegel & Foulk, 2006), adolescent depression (i.e., Possel, Baldus, Horn, Groen, & Hautzinger, 2005), and youth drug use (i.e., Botvin, Epstein, Baker, Diaz, & Ifill-Williams, 1997; LoSciuto, Freeman, Harrington, Altman, & Lanphear, 1997).

However, psychologists may find intervention within the school environment somewhat difficult. Research has shown that teachers may be hesitant to allow a psychologist into the classroom, and the teacher may refuse the school-based psychological consultation (Gonzalez, Nelson, Gutkin, & Shwery, 2004). Gutkin and Hickman (1990) surveyed school psychology consultants about their views of why teachers may be resistant to psychological consultation. The researchers found that consultants endorsed



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Published by the Association for Behavioral and Cognitive Therapies  
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(212) 647-1890/Fax: (212) 647-1865  
www.abct.org

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Subscription information: *the Behavior Therapist* is published in 8 issues per year. It is provided free to ABCT members. Nonmember subscriptions are available at \$40.00 per year (+\$32.00 airmail postage outside North America).

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- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
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nine factors they believed significantly related to teachers' resistance to school-based consultation. These factors included teacher factors (e.g., teaching efficacy, the teacher's perception of his or her own consultation skills, the teacher's perception of the psychologist's role, time available for consulting, and similarities between the teacher and the psychologist), psychologist qualities (e.g., the psychologist's problem-solving, interpersonal, and relationship skills), the principal's support for the consultation, and the opportunity for the teacher or school to reciprocate and provide consultation to the psychologist (Gutkin & Hickman). It is clear that school psychological consultants believed that the main difficulties in successful school consultation were due primarily to teacher qualities and psychologist skill deficits.

Several organizations and conferences have recognized the importance of effective consultation between teachers and psychologists. For example, at the 2002 Conference on the Future of School Psychology, several major professional school psychologist organizations collaborated to determine future directions of the profession. One of the main goals of this conference was to formulate a model of school consultation that would serve to "maximize the benefits to the children and schools" (Cummings et al., 2004). One of the main topics addressed was a call for increased in-school child and family services to promote mental health (integration) with community services (Cummings et al.). Additionally, the American Academy of Child and Adolescent Psychiatry (AACAP) developed practice parameters for psychiatric consultation to schools; the first recommendation was that "psychiatrists should understand how to initiate, develop, and maintain consultative relationships with schools" (AACAP, 2005). Further recommendations stressed the necessity that psychiatrists are sensitive to and knowledgeable about school procedures and the school environment, and that psychiatrists collaborate with school personnel to formulate and activate school-based prevention and intervention programs. The main focus of these recommendations was to encourage mental health professionals to consult with school personnel when treating child clients.

Although effective consultation between teachers and psychologists is important, it may be difficult to establish an alliance. Gonzalez and colleagues (2004) questioned teachers about variables they felt may promote or hinder effective consultation with school psychologists. In teach-

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ers' viewpoints, eight factors significantly related to effective school consultation, the largest contributor being characteristics of the school psychologist (endorsed by 36.8% of respondents). Additional factors, in order of the percentage of respondents who endorsed them, included the principal's support for consultation (5.4%), personal teaching efficacy (4.3%), teacher-psychologist similarity (3.5%), the teacher's classroom management/discipline efficacy (2.5%), time availability for consulting (1.7%), opportunity to reciprocate (1.6%),

and teacher consultation insight (1.4%; Gonzalez et al.). It is important to note that while several factors were viewed by both psychologists and teachers as being vital to effective school consultation, psychologists viewed the main difficulties impeding effective school consultation as primarily related to teacher qualities or psychologist skill deficits, while teachers viewed that the main difficulties were mostly related to school psychologist characteristics.

Given that interpersonal factors and skill levels may play a large part in the effec-

tiveness of school consultation, psychologists who are consulting within the school should keep in mind the basic therapeutic principles of rapport-building. These may include being able to “fit” their approach to the teacher, being confident and enthusiastic about their proposed intervention, being enthusiastic about the opportunity for school consultation, and ensuring that interventions are practical for the teacher to implement in the present school context without great expense (i.e., time and financial costs). Based on our experience in the schools, we developed a 10-step model of behavioral school consultation. The model is based upon behavioral reinforcement contingencies, and emphasizes establishment of rapport and provision of empathy.

### ***Put Yourself in the Shoes of the Teacher***

The best way to provide empathy and to establish appropriate rapport with a teacher is to put yourself in his or her shoes. Understand the demands placed upon the teacher, including class size, time pressure, and the necessity of having to manage the difficult behavior of one or two children in a classroom full of children who are generally well-behaved. Keep in mind that the teacher may feel threatened by having an outside person observe and recommend changes. Therefore, show the teacher that you respect her, particularly her time and expertise. Additionally, it is not only important to understand her situation, but also to convey your understanding to the teacher directly.

### ***Begin With Chit-Chat and Rapport Building***

Be approachable and friendly. This is an effective second step to building a positive relationship with a teacher. Engaging in small talk and discussing the ins and outs of the teacher’s experiences may not only help you begin to develop rapport, but may also provide you with valuable information about the child’s and teacher’s situations (individually and separately).

### ***Have the Teacher Describe His or Her Concerns to You***

Ask the teacher to describe his concerns about the child’s behavior to you first. This will allow him to “vent” about the problems that he has been having in terms of classroom behavior management. It also provides a great opportunity for you, as a consultant, to reflect his frustration and confirm the challenging nature of the problem. The teacher is more likely to feel heard

and valued if you are careful to avoid pushing your own views before the teacher has had a full opportunity to talk.

### ***Find Out What the Teacher Has Already Tried***

This is key to the therapeutic process. Knowing what the teacher has already attempted will allow you to determine what may or may not work in the current consultative process. Additionally, this may prove to be a wonderful opportunity to praise the teacher’s prior efforts, as well as her willingness, motivation, and dedication to create a positive environment for the child.

### ***Describe Your Own Experience(s)***

Tell the teacher about your background and experience with the presenting problem. Describe your expertise and the types of challenging children that you work with or have worked with in the past. For younger consultants, it is not wrong to admit that you have had limited experience, but it is extremely important to stress the knowledge and experiences that you have had (e.g., articles read, research conducted, clinical supervision received). This will help you, as a consultant, establish credibility with the teacher.

### ***Describe That Some Children Have Special Needs That Require a Unique Approach***

Explain to the teacher that what he is doing or has tried probably works well with 90% of the children in the classroom. However, the referred child has special needs that prevent him or her from responding well to traditional approaches. Therefore, a special approach is required to meet the unique needs of this child.

### ***Wait for the Teacher to Ask You for Strategies and Suggestions***

Rather than imposing your own ideas on the teacher when she may not yet be ready to welcome suggestions, wait for the teacher to ask you for advice on how to handle the difficult situation. This may take longer with certain teachers than others, but is imperative to the process of effective school consultation. It is important to note that this step may best be accomplished through ongoing discussions with the teacher, rather than waiting patiently for a return phone call. McNeil and Hembree-Kigin (in press) emphasized that only after establishing positive rapport and a positive working relationship with a teacher is the teacher likely to “buy in” to your approach.

### ***Present Your Program as Promising, but Acknowledge Limitations***

Show a great deal of enthusiasm when discussing your approach; enthusiasm is contagious! Be enthusiastic about the teacher’s willingness to give the program a chance. If necessary, describe the program as “an experiment” that the teacher is asked to try for a short period of time to see how it works. It is very important not to describe your program as a “miracle cure” or as a guarantee, because all approaches have limitations. It is best to be willing to acknowledge the potential limitations of your program, while at the same time encouraging the teacher by citing the prior research that has demonstrated efficacy.

### ***Importance of Coaching and Feedback***

Didactic training alone seldom works. Feedback and coaching usually are required to get teachers to use the program with integrity. We have found that shadowing the teacher during regular classroom activities or coaching using a bug-in-ear device may be distracting or threatening to teachers. However, we have had success with analog coaching, through which teachers are asked to pull out one to five children at a time from the classroom and therapists directly coach the teacher in behavior management skills with this small group of children. The primary aim of analog coaching is to instruct the teacher in classroom behavior management skills in a small group of children, which should then generalize to the entire classroom. We have also demonstrated success using delayed feedback (5-minute observation followed by 1-minute feedback period) and modeling skills for the teacher using her class. Teachers find these approaches to be effective, practical, and acceptable in that the consultation is collaborative and hands-on. The teacher and consultant receive immediate feedback from the children as to whether the new approaches are working.

### ***Tailor Your Consultation to Practical Concerns and Available Resources***

As noted previously, time and resource demands are a realistic concern when providing school intervention and consultation to a classroom teacher. Therefore, school interventions should be practically designed, based upon time and resource constraints. As McNeil and Hembree-Kigin (in press) noted, logistical issues such as setting up a time to conduct school observations and finding time to meet individually (or talk over the phone) with a teacher frequently

make school consultation difficult. These difficulties may not only be related to the teacher's time constraints, but also to those of the therapist (McNeil & Hembree-Kigin). Therefore, taking these considerations into account when conducting school consultations may decrease teacher reluctance and increase the potential for the intervention(s) to succeed.

Overall, there are several issues to keep in mind when serving as a psychological consultant to the school system. Out of all such issues, conveying respect for the teacher's experience, training, and unique skills, and being enthusiastic about the proposed approach (and willing to note the limitations), may be the most important skills to keep in mind. Through use of these skills, a psychological consultant may be able to form an important and long-lasting relationship with a teacher, and therefore be able to accomplish the most important goal of all: to improve the child's overall functioning and future outlook.

### References

- American Academy of Child and Adolescent Psychiatry. (2005). Practice parameter for psychiatric consultation to schools. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 1068-1083.
- Botvin, G., Epstein, J., Baker, E., Diaz, T., & Iffill-Williams, M. (1997). School-based drug abuse prevention with inner-city minority youth. *Journal of Child and Adolescent Substance Abuse*, 6(1), 5-19.
- Chronis, A. M., Fabiano, G. A., Gnagy, E., Wymbs, B., Burrows-MacLean, L., & Pelham, W. E. (2001). Comprehensive, sustained behavioral and pharmacological treatment for ADHD: A case study. *Cognitive and Behavioral Practice*, 8, 346-359.
- Cummings, J. A., Harrison, P. L., Dawson, M. M., Short, R. J., Gorin, S., & Palomares, R. S. (2004). The 2002 Conference on the Future of School Psychology: Implications for consultation, intervention, and prevention services. *Journal of Educational and Psychological Consultation*, 15 (3 & 4), 239-256.
- Fabiano, G. A., & Pelham, W. E. (2003). Improving the effectiveness of behavioral classroom interventions for ADHD: A case study. *Journal of Emotional and Behavioral Disorders*, 11, 122-128.
- Gonzalez, J. E., Nelson, J. R., Gutkin, T. B., & Shwery, C. S. (2004). Teacher resistance to school-based consultation with school psychologists: A survey of teacher perceptions. *Journal of Emotional and Behavioral Disorders*, 12, 30-37.
- Gutkin, T. B., & Hickman, J. A. (1990). The relationship of consultant, consultee, and organizational characteristics to consultee resistance to school-based consultation: An empirical analysis. *Journal of Educational and Psychological Consultation*, 1(2), 111-122.
- Hawken, L. S., & Hess, R. S. (2006). Special section: Changing practice, changing schools. *School Psychology Quarterly*, 21, 91-111.
- Hirschstein, M., & Frey, K. S. (2006). Promoting behavior and beliefs that reduce bullying: The Steps to Respect Program. In S. R. Jimerson & M. Furling (Eds.), *Handbook of school violence and school safety: From research to practice* (pp. 309-323). Mahwah, NJ: Lawrence Erlbaum.
- LoSciuto, L., Freeman, M., Harrington, M., Altman, B., & Lanphear, A. (1997). An outcome of the Woodrock Youth Development Project. *Journal of Early Adolescence*, 17, 51-56.
- Luiselli, J. K., Putnam, F., Handler, M. W., & Feinberg, A. B. (2005). Whole-school positive behavior support: Effects on student discipline problems and academic performance. *Educational Psychology*, 25, 183-198.
- McNeil, C. B., & Hembree-Kigin, T. (in press). *Parent-Child Interaction Therapy* (2nd ed.). New York: Springer.
- Possel, P., Baldus, C., Horn, A. B., Groen, G., & Hautzinger, M. (2005). Influence of general self-efficacy on the effects of a school-based universal primary prevention program of depressive symptoms in adolescents: A randomized and controlled follow-up study. *Journal of Child Psychology and Psychiatry*, 46, 982-994.
- Spiegel, S. A., & Foulk, D. (2006). Reducing overweight through a multidisciplinary school-based intervention. *Obesity Research*, 14, 88-96.
- Waschbusch, D. A., Pelham, W. E., & Massetti, G. (2005). The behavior education support and treatment (BEST) school intervention program: Pilot project data examining school-wide, targeted-school, and targeted-home approaches. *Journal of Attention Disorders*, 9, 313-322.

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## Student Forum

# Developing Cognitive-Behavioral Treatments: A Primer for Early Career Psychologists

Jason C. Ong, *Stanford University Medical Center*, Emerson Wickwire, Jr., *Johns Hopkins University School of Medicine*, Michael A. Southam-Gerow, *Virginia Commonwealth University*, Julie A. Schumacher, *University of Mississippi Medical Center*, and Susan Orsillo, *Suffolk University*

It is important to ensure that the best available treatments reach those who are in need of services. Despite the empirical support for many cognitive-behavioral therapies (CBT), continued work is needed to develop novel treatments as new findings about a particular disorder are unveiled or technological advances allow for

innovative approaches. However, guidance is scarce regarding the process of translating a new treatment idea into a program of research designed to evaluate this treatment—especially in contrast to the extensive literature guiding the later stages of efficacy testing. As a result, procedures within the earliest stages of treatment de-

velopment are often unfamiliar to young investigators, including students and early career psychologists (ECP). This is unfortunate given that these young investigators are prime candidates for conducting treatment development work. ECPs are often seeking to establish a research niche but have little or no funding to support an independent program of research. However, they can bring a fresh perspective, are usually eager to collect data, and many would welcome the opportunity to direct a small-scale project that could lead to a program of research.

We believe that treatment development is a vital, exciting, and largely underappreciated area within clinical research. The purpose of this paper is to bring attention to the process of conducting treatment development research, with particular emphasis on those issues relevant to graduate students and ECPs. First, we describe the characteristics of treatment development

research and review the most common approaches to conducting these studies. Next, we offer ideas and strategies for helping students and ECPs to conduct treatment development research with an eye toward career development, early career funding, and dissemination of results. It is hoped that this paper will encourage ECPs to adopt a programmatic approach to clinical research with specific considerations for treatment development.

### Characteristics of Treatment Development Research

#### *What Is Treatment Development Research?*

In the broadest sense, treatment development research consists of those activities related to gathering initial evidence for a new treatment program or approach. In many ways, it is the first step in translating basic psychological science (e.g., laboratory-based experimental findings) or clinical observations into clinical practice. Taking the results from a hypothesis-generating study (e.g., a cross-sectional study identifying a risk factor) and developing a hypothesis-testing study (e.g., experimental design with a priori hypothesis), these activities can provide initial testing of a new theory or a hypothesized mechanism of treatment. The subsequent results can be used to determine if further, more rigorous, testing of the new treatment approach is warranted.

#### *What Research Strategies Are Used for Treatment Development?*

Whether the idea for a new treatment stems from a clinical observation, a new theory, or previous research findings, a general strategy is to begin with one or more small-scale pilot studies. Each pilot study should address a specific research question and thus have clearly specified aims. These aims are typically guided by the need to develop and refine a new or adapted intervention and to establish the safety of the intervention. Additional treatment development objectives include evaluating feasibility and acceptability of a novel treatment approach, developing the treatment protocol, and identifying appropriate measures of adherence, compliance, and outcomes. Treatment development activities frequently involve an iterative process of pilot testing, revising, refining, and collecting more data. These endeavors can be very time intensive but allow freedom for investigators to combine creativity and innovation with experimental methods.

Currently, there is no gold-standard methodology for conducting treatment development studies, nor is there agreement on the progression of a specific set of studies. Instead, the specific aims should guide decisions regarding research design, and many investigators have creatively applied sound scientific methods to the examination of a theory or testing of a hypothesis. Depending on the specific research question and available evidence in the literature, the range of research designs might include open-label (i.e., uncontrolled) studies, single-case designs, qualitative designs, or mixed-methods approaches. If there is no available evidence to support a new approach, a first step might begin with a single case design using the new treatment approach on a few patients. Or if some preliminary evidence exists or a treatment manual has been developed, then an open-label study using a small sample might be considered. Another aspect of treatment development includes exploring a hypothesized mechanism of behavior change to provide evidence for the “active ingredients” of the intervention. In this instance, a multiple-baseline design could be used to systematically examine how one or more variables change with treatment. Finally, qualitative data can be collected (either within the aforementioned designs or separately) to evaluate issues related to treatment acceptability and compliance or to modify the intervention to better suit the needs of the target population.

#### *What Approaches to Treatment Development Are Used by Models of Clinical Research?*

Treatment development represents the first step in the continuum of clinical research. Therefore, it is necessary to consider the entire program of research that might emerge from this work. In general, the progression of clinical research should include: (a) development and early testing of the intervention, (b) testing of the efficacy of the intervention, (c) testing of the effectiveness of the intervention, and (d) transporting and/or disseminating the intervention to the appropriate end user. Below, we review some notable clinical research models with a focus on how each model approaches the treatment development phase.

*Stage model.* The stage model of behavioral therapies (Rounsaville, Carroll, & Onken, 2001) is one of the most well-known models of clinical research within the CBT domain. The stage model follows the clinical trial phases for drug develop-

ment advocated by the Food and Drug Administration (FDA), making adjustments for special issues encountered in behavioral research. Rounsaville and colleagues (2001) define three stages of research, each with specific objectives that mirror the FDA clinical trial phases. During Stage I, the treatment development stage, the goal is to systematically develop the elements necessary for testing the efficacy of the treatment. Rounsaville et al. (2001) recommend sequencing this stage into two substages. Stage Ia activities include development of a treatment manual, conducting focus groups to provide feedback about feasibility and acceptability, and selecting and testing appropriate measures for adherence and outcomes. Stage Ib activities include pilot testing to obtain initial treatment effects and detect contraindications of the treatment as well as training of therapist. Often, a small-scale RCT design is employed, although the use of a control group is not specifically required. By the end of Stage I, all elements of the treatment should be developed and a protocol should be in place for efficacy testing in the next stage.

Stage II focuses on evaluating treatment efficacy using an RCT design, which is considered the gold-standard design for evaluating efficacy. If the data from the RCT supports the efficacy of the treatment, then the treatment moves into Stage III testing. During Stage III, the research questions shift to consider treatment effectiveness, generalizability, and transferability. Other issues typically evaluated during Stage III include implementation, cost-effectiveness, and marketing. Overall, the stage model emphasizes evaluating efficacy with an RCT, with the treatment development stage serving as preparation for the Stage II study and issues involving implementation and dissemination addressed following the efficacy study.

*Portfolio model.* In contrast to the linear approach of the stage model, the portfolio model employs a multimethod approach to address the broad range of questions that arise within the continuum of clinical research (Kazdin, 2001). Questions relevant to this model include: (a) Is this treatment better than no treatment? (b) How does the treatment work? (c) For whom does the treatment work? (d) What contextual factors influence treatment outcome? (e) To what extent are treatment effects generalizable? The portfolio approach advocates theory development, encouraging diverse approaches to the early stages of treatment development work. For example, methods

such as single-case designs, quasi-experiments, and case studies are encouraged during the treatment development phase and provide more methodological latitude than the stage model. Moreover, it is argued that the stage model is too linear, and its pilot work too demanding for behavioral researchers with limited resources (Kazdin, 2001).

*Mixture model.* Similar to Kazdin's portfolio model, Clark (2004) has proposed a multimethod strategy for treatment development based on the interplay of psychological theories, phenomenological observations, and experimental testing. Developed within a cognitive psychology framework, this approach includes: (a) clinical interviews and psychology paradigms to identify core cognitive abnormalities, (b) a theoretical explanation of the abnormality, (c) experimental tests of the maintaining factors, and (d) developing treatments aimed at these targets. In addition, treatment development work continues until a pre-to-post treatment effect size of at least 1.0 is obtained. Only then is an efficacy trial (i.e., RCT) conducted (Clark, 2004).

*Deployment model.* Given that psychological treatments are delivered in a variety of settings, including private clinics, hospitals, schools, and communities, the deployment-focused model (e.g., Weisz, 2000; Weisz, Southam-Gerow, Gordis, & Connor-Smith, 2003) addresses the rising concern that the research clinic might not be the optimal "laboratory" to test the treatment if the ultimate context of treatment delivery is not considered. This model also advocates a multimethod approach but is unique in that the context of treatment delivery is considered throughout the treatment development and testing phases. For example, aspects of routine clinical practice (e.g., patient no-shows, comorbidities, therapist skill level) that other treatment development models seek to eliminate or to control are actually used and tested as part of the treatment development process. This model also argues for moving beyond a client-symptom focus of outcome measures and including measures of how provider, agency, and service system variables impact treatment outcome, which could yield important insights regarding the effectiveness of the treatment in its intended setting (see also Schoenwald & Hoagwood, 2001; Southam-Gerow, Ringeisen, & Sherrill, 2006). Addressing these questions at the treatment development stage can aid in the design and preparation of future efficacy and effectiveness studies.

*Dissemination/implementation model.* Southam-Gerow, Hourigan, and Allin (in press) have outlined a clinical research model that elaborates on issues relevant to large-scale dissemination and implementation. Similar to other models, the early stage of treatment development involves single-case designs or open trial studies to establish safety and preliminary effects of a new treatment, followed by efficacy studies, wherein the outcomes of the treatment are tested in controlled settings compared to some control group, and then effectiveness studies, wherein the treatment is tested in less-controlled contexts (e.g., practice or school-based settings) and cost-effectiveness is often examined. Rather than wide-scale dissemination as the next step, the dissemination/implementation model suggests that the next step should be transportability studies, wherein the processes involved in deploying the treatment in a community setting are examined (e.g., Chorpita & Nakamura, 2004; Fixsen, Naom, Blasé, Friedman, & Wallace, 2005; Schoenwald & Hoagwood, 2001). The primary outcome of transportability research is an implementation intervention, an elaboration of the methods, and procedures needed for treatment adoption in new settings. The final step in the model is the dissemination stage, focusing on how to disseminate the treatment and the implementation strategies, with the key outcome being widespread adoption. In this way, a third intervention, the dissemination intervention, is tested. This intervention consists of procedures and methods that encourage adoption of both the treatment and the implementation procedures that appear needed. Given the complexity of clinical research, aspects of treatment development are likely to occur throughout all steps, making the overall process more iterative and recursive than linear in nature.

### Considerations and Strategies for Early Career Psychologists

Given its foundational role in clinical research, it is surprising how little attention graduate training programs give to methodological issues related to treatment development. Typically, courses on research methodology focus on teaching the fundamentals of experimental design, which is used to test efficacy and effectiveness. The processes of treatment development rarely receive the same emphasis. In addition, there are relatively few role models in the field who are available to train students in treatment development. It is more common

to find faculty members in psychology departments who conduct cross-sectional studies, validation studies, or laboratory-based studies than those involved in treatment development work. Even for the highly motivated student or ECP, there are few guidelines in the literature on how to conduct treatment development research in psychology. As a result, young researchers who are capable of generating new ideas and have an interest in developing a psychological treatment might subsequently abandon their initiative. Alternatively, junior investigators not well-trained in the processes of initiating and advancing treatments in their earliest stages might prematurely attempt to conduct an efficacy study without the requisite treatment development work. Although young investigators might only be at the formative stages of a program of research with little or no funding, treatment development activities can provide an excellent opportunity to begin carving out a niche and establishing expertise in a particular area. Following a sequential approach will maximize scientific integrity as well as the likelihood of progressing beyond treatment development.

### Career Development

From a career trajectory standpoint, students and ECPs can first become involved in treatment development activities during their training years. For those seeking an academic career, it is valuable to identify a mentor who is familiar with treatment development work and appreciates the continuum of clinical research activities. A senior mentor can provide guidance on issues related to the feasibility of conducting a project, suggestions for funding, and recommendations on study design. Moreover, students can develop small-scale projects within the context of a larger laboratory or as an independent project in a smaller laboratory. For example, a master's thesis might examine the psychometric properties of a questionnaire on adherence or a dissertation might utilize focus groups to examine issues related to acceptability and feasibility of a new protocol. A postdoctoral fellowship might be spent constructing a treatment manual and testing it using an "open label" or wait-list design. These activities can result in valuable pilot data to present during job talks, to help establish a program of research for a junior faculty position, or to serve as the basis for future grant applications.

### *Funding Treatment Development Studies*

Unfortunately, resources for supporting the programmatic development of new CBT treatments are relatively sparse, especially when compared to the pharmaceutical support for drug development. Furthermore, the “glamour” of efficacy trials sometimes overshadows the importance of developing a solid empirical foundation through appropriate treatment development research. However, these challenges should not deter ECPs from conducting high-quality treatment development projects. As mentioned earlier, it is important to identify a mentor who can provide guidance and potentially support the resources necessary to conduct a small-scale study. It should be noted that many treatment development activities can be conducted with relatively small budgets. For example, single-case designs or case studies might serve as a starting point for testing a particular hypothesis about a mechanism of change or a new approach based upon clinical observation. This could be completed in a clinic, with little or no external funding. Open-label or uncontrolled studies could be conducted with focus groups to evaluate patient acceptability and to obtain feedback necessary to improve the intervention. Cross-sectional studies can be conducted to validate questionnaires within a new population or to guide selection of existing questionnaires. Students who are considering these treatment development projects could apply for dissertation awards, departmental funding, or foundation awards to support these projects.

For those seeking government funding, it might be advantageous to follow the stage model, given that it was developed to serve as a guide to facilitate federal funding for treatment development work (Kazdin, 2001; Rounsaville et al., 2001). The National Institutes of Health (NIH) offers clinical trial planning grants (e.g., R34) that are designated for treatment development studies. Other funding sources from the NIH, such as predoctoral (F31) and postdoctoral (F32, T32) fellowships, frequently include a small budget that could be used to support small-scale treatment development research. For junior faculty, mechanisms such as career development awards or seed grants could be used to design projects relevant to treatment development research, such as evaluating protocol issues, feasibility and acceptability of the control condition, or determining an appropriate randomization procedure. Regardless of the source of funding, an important outcome is

to gather preliminary data to guide future proposals.

### *Presenting and Publishing Treatment Development Studies*

Disseminating research findings is an important part of the scientific process as well as a central component of academic career advancement. One way to disseminate these findings is to present them at local and national conferences. These functions provide an outlet to inform others about ongoing work and to network with colleagues who are conducting treatment development studies. These presentations can enhance one’s curriculum vitae and ECPs can use these meetings to exchange ideas about methodology, measures, and recruitment strategies. Another outlet for disseminating this type of work is via peer-reviewed publications. While the findings from treatment development studies are frequently not within the scope of the most competitive journals, these studies are increasingly recognized as essential components of treatment research and important contributions to the treatment literature.

One note of caution is that many reviewers are not accustomed to evaluating treatment development studies. As a result, some reviewers might apply evaluative criteria typically associated with efficacy studies when critiquing treatment development studies. To help address these concerns, it is important to be extremely clear about the aims of the study and the context in which the study was conducted. For example, if the study aims were to evaluate the acceptability and feasibility of the new treatment, the structure of the manuscript should reflect this by featuring the findings on acceptability and feasibility. If appropriate, references to the treatment development approach (e.g., stage model, deployment model) should be used to help guide the reviewer. Indeed, we strongly suggest that students and ECPs adopt one of the models of treatment development outlined above and identify this in the manuscript.

While treatment development research can be exciting and very rewarding, it is essential that investigators acknowledge the limitations of their findings so that readers who are not familiar with differences between treatment development work and efficacy trials do not adopt these treatments into clinical practice. We recommend that authors clearly state that their study represents an early stage of testing that does not demonstrate sufficient evidence to adopt the treatment in clinical practice until fur-

ther testing using a more rigorous designs is conducted. We also recommend that authors discuss future directions or provide indications as to how this pilot study will inform future research. Again, describing the study within the framework of a clinical research model could aid in writing the discussion.

### **Conclusions**

The objective of this paper was to provide students and ECPs with a primer for issues to consider when conducting treatment development research. By explaining the key characteristics of treatment development research and providing specific ideas and suggestions for students and ECPs, we hope that readers will come away with a more sophisticated approach to clinical research. We also hope that the issues illuminated in this paper might serve as a call to the field to improve training in this area.

One area of improvement involves graduate training on research methods. Currently, most graduate courses or seminars on research methods discuss efficacy and effectiveness studies but spend little or no time discussing the process of treatment development. This bias might lead junior investigators to favor using known RCT designs, even though the lack of preliminary evidence suggests that treatment development studies should be conducted. Providing training to young investigators about the issues discussed in this paper can help prevent unnecessary expenditure of valuable time and money.

A second area for improvement involves modifying journal author instructions and reviewer instructions to recognize the importance of pilot studies and small-scale studies using nonexperimental designs that fall within the realm of treatment development. We propose that investigators of treatment development studies bear the burden of accurately describing the context, scope, and limitations of their research and its implications. At the same time, journal reviewers should bear the burden of reviewing studies with an open mind toward research design and evaluate manuscripts based on criteria appropriate to the type of research conducted (e.g., treatment development). In fact, Wilkinson and the Task Force on Statistical Inferences (1999) specifically warned researchers (i.e., reviewers) against favoring particular designs or certain forms of research. Hopefully, the growing body of treatment development literature will help educate peer reviewers



about the merits of treatment development work.

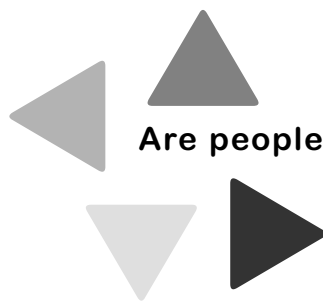
In the current environment of psychological science and practice, evidence-based treatments are the gold standard. If CBT practitioners are committed to advocating these treatments, then resources should be mobilized to facilitate the treatment development process. The overall quality of new cognitive-behavioral treatments could be enhanced by supporting young investigators who are well-trained in the entire scope of clinical research, from treatment development to dissemination.

### References

- Chorpita B. F., & Nakamura, B. J. (2004). Four considerations for dissemination of intervention innovations. *Clinical Psychology: Science & Practice, 11*, 364-367.
- Clark, D. M. (2004). Developing new treatments: On the interplay between theories, experimental science and clinical innovation. *Behaviour Research and Therapy, 42*, 1089-1104.
- Fixsen, D. L., Naoom, S. F., Blasé, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis De la Parte Florida Mental Health Institute, The National Implementation Research Network.
- Kazdin, A. E. (2001). Progression of therapy research and clinical application of treatment require better understanding of the change process. *Clinical Psychology: Science and Practice, 8*, 143-151.
- Rounsaville, B. J., Carroll, K. M., & Onken, L. S. (2001). A stage model of behavioral therapies research: Getting started and moving on from stage I. *Clinical Psychology: Science and Practice, 8*, 133-142.
- Schoenwald, S. K., & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when. *Psychiatric Services, 52*, 1190-1197.
- Southam-Gerow, M. A., Ringeisen, H. L., & Sherrill, J. T. (2006). Introduction to Special Issue: Integrating interventions and services research: Progress and prospects. *Clinical Psychology: Science and Practice, 13*, 1-8.
- Southam-Gerow, M. A., Hourigan, S. E., & Allin, R. B. (in press). Adapting evidence-based treatments for youth in partnership with mental health stakeholders. *Behavior Modification*.
- Weisz, J. R. (2000). Lab-clinic differences and what we can do about them: I. The clinic-based treatment development model. *Clinical Child Psychology Newsletter, 15*, 1-3, 10.
- Weisz, J. R., Southam-Gerow, M. A., Gordis, E. B., & Connor-Smith, J. K. (2003). Primary and secondary control enhancement training for youth depression: Applying the deployment-focused model of treatment development and testing. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based treatments for children and adolescents* (pp. 165-183). New York: Guilford.
- Wilkinson, L., and Task Force on Statistical Inference, APA Board of Scientific Affairs. (1999). Statistical methods in psychology journals: Guidelines and explanations. *American Psychologist, 54*, 594-604.

*Preparation of this article was supported in part by a National Center for Complimentary and Alternative Medicine Grant K23 AT003678 awarded to the first author and a National Institute of Mental Health Grant K23 MH69421 awarded to the third author.*

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### Lighter Side

## Automatic Thoughts

Elizabeth Moore, *Mayo Clinic*



*OK, so now we need to delve deeper and work on your core beliefs. . . . I'm afraid you're not going to like this. . . .*



## Obituary

# Todd R. Risley

1937–2007

John R. Lutzker, *Emory University School of Medicine*

Todd R. Risley, a pioneer of applied behavior analysis and President of AABT (1976–77), died in Palmer, Alaska, on November 2, 2007. He was born in Alaska on September 8, 1937; thus, Todd was only 70 years old when he died. He was a giant of the field literally and figuratively. He was a visionary who developed and explored some of the earliest applications of behavior analysis and was one of the field's greatest thinkers. His passion for science and the applications of behavior analysis never abated. As AABT's Managing Editor, Todd facilitated a significant change for the organization in the late 1970s, moving its journals from an academic publisher that was not doing well for *Behavior Therapy*, thus instituting ABCT as the journal's publisher.

He credited some of his vigor and appreciation for the importance of change to his early days in the rugged territory of Alaska where his father was a homesteader and railroad worker. In his early years, the family homestead on what is now Risley Mountain had neither indoor plumbing nor electricity. This contributed to Todd's belief that technology was very useful and should be explored, which, in turn, contributed to his belief that social technology, what he later called the "social dance" between parents and children, was equally important.

Todd received his B.A. from San Diego State College and his M.S. and Ph.D. from the University of Washington, a hotbed of experimental child psychology where a number of young faculty and brilliant graduate students were creating the field of applied behavior analysis. The faculty included Donald Baer, Sidney Bijou, and Jay Birnbrauer, and two postdocs, Ivar Lovaas and Montrose Wolf. Todd became especially close with Mont Wolf, who was examining the role of social attention on the behavior of preschool children. They, along with H. L. Mees, worked with a 2 1/2-year-old child with autism, Dickey, who became the most important case study and is still the most famous child in the applied behavior analytic literature. Their work with

Dickey was the first successful application of behavior analysis to change the behavior of a child with autism. Dickey had cataracts and had to learn to wear glasses. He was also aggressive, without language or social skills, and self-injurious. Using shaping and the first human experimental use of timeout from positive reinforcement, Wolf, Risley, and Mees were very successful in teaching Dickey to wear glasses, end self-injury, and learn language and social skills. Todd remained in contact with Dickey well into Dickey's adult life. Thus, the methods of applied behavior analysis were born in the mid-1960s at the University of Washington, with much of the leadership exerted by a graduate student, Todd Risley.

Todd held long academic stints at the University of Kansas Department of Human Development and Family Life (23 years) and the University of Alaska, Anchorage. Kansas was and still is one of the major homes of the field. Shortly after returning to his native Alaska, Todd was asked by the governor to take a short term as the state's Director of Mental Health and Developmental Disabilities. This post, though frustrating to Todd because of the bureaucracy, allowed him to apply his principles and precepts at the broadest societal level. In doing so, he moved most of the ambulatory residents of the state hospitals to community-based programs.

Exploring a variety of applications became Todd's mission. In addition to mental health, developmental disabilities, and autism, Todd's work extended to nursing homes, police departments, and work with Indian nations, neighborhoods, and what he called "living environments." This included work in infant and toddler centers, exploring how environmental arrangements affected and could be changed for the better for young children.

He felt that his most significant work, with Betty Hart, was the study of language in the homes of middle-class and low socioeconomic status (SES) families. The 40-year effort was depicted in a 1995 Pulitzer Prize-nominated book, *Meaningful Differ-*

*ences in the Everyday Lives of Young American Children*. The outcome of this longitudinal effort was clear—that the more parents talk to their children, the better the social and academic outcomes for those children. The gap between low SES and middle-class families starts large and grows larger over time, with middle-class families talking more and expanding the vocabularies of their children far more than low-SES families. The consequent differences in social and academic achievement mirror the differences in talking such that the gains by middle-class children far outweigh those in low SES children. Todd dedicated the remaining years of his career to delivering the message to parents, "Talk, talk, and talk some more to your children." His other motto, "Do good and take data," pervaded his approach to applied research. His career embodied this credo.

Todd Risley died in his favorite chair in his home on Risley Mountain from which there were "huge" views. "Huge views" establishes a perfect metaphor for Todd's life. He saw what too many professionals do not see, the biggest of pictures and how to achieve significant change. Like Alaska's constantly changing weather, Todd believed that the field and our methodologies must always change.

Todd Risley was a hero to so many of us in the field. We prompted him and cajoled him to give us direction and advice, and he was generous in his responses. He is already sorely missed. He is survived by his beloved wife, Cheryl, and his son, Todd Michael.

## Reference

- Hart, B., & Risley, T. R. (1995). *Meaningful differences in the everyday experience of young American children*. Baltimore: Paul H. Brookes. ■



## Book Review

Forsyth, J. P., & Eifert, G. H. (2007). *The Mindfulness and Acceptance Workbook for Anxiety: A Guide to Breaking Free From Anxiety, Phobias, and Worry Using Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger. 267 pages; \$21.95

Reviewed by James D. Herbert, *Drexel University*

The past decade has witnessed a veritable explosion in interest in mindfulness and acceptance-based models of behavior therapy. The degree to which these developments represent an incremental evolution of the status quo or a revolutionary shift in the field has recently become a point of considerable contention. Of the various mindfulness and acceptance-based models, acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999) has generated the most controversy, and the most research. Whatever one's stance on the question of how ACT and its sister approaches are situated with respect to traditional cognitive behavior therapy, there is no doubt that these approaches are having an impact. In the case of ACT, there has been a dramatic increase in scientific publications, professional conference presentations, training workshops, and most recently, self-help books.

Since its original incarnation in the 1980s, ACT has been especially concerned with the problem of pathological anxiety. John Forsyth and Georg Eifert have been at the forefront of the application of the ACT approach to problems of anxiety, and their book for practitioners on the subject currently stands as the principal work on ACT for anxiety (Eifert & Forsyth, 2005). It is in this context that they introduce the current work as a user-friendly self-help guide designed for anyone suffering from problems of anxiety.

This book has many outstanding qualities. Perhaps most importantly, it presents the ACT model in a highly accessible, user-friendly format. This is no easy task, as the model is often counterintuitive, confusing, and difficult to grasp, even for experienced clinicians. New Harbinger Publications has taken the lead in producing self-help books

that translate complex ideas into highly accessible language, and this book continues that tradition.

Forsyth and Eifert eschew detailed discussion of the specific anxiety disorders as demarcated by the official psychiatric nomenclature in favor of a more general discussion of the psychological factors that underlie the various manifestations of pathological anxiety. They highlight the paradoxical effects of efforts to exert direct control over anxiety, and the dangers of such efforts. Defusion, or achieving psychological distance from one's distressing experience, along with nonjudgmental acceptance of that experience, are discussed at length. Metaphors, thought experiments, and hypothetical case examples are frequently used to illustrate key concepts. Exercises are suggested throughout to acquire and master key skills.

One of the most useful features of the book is the accompanying CD, which contains printable PDF versions of forms to be used with various exercises, as well as nine guided meditation exercises. The latter, which range from less than 3 minutes to more than 15 minutes in duration, are very well done, and are themselves worth the price of the book. Each of these meditations is linked to a particular section of the book, although they can also be used as stand-alone exercises.

Like any self-help book, the current work is not without its problems. Chief among these is the fact that the ideas are presented more or less simultaneously, rather than in a more sequential format. That is, most of the key components of the model, from highlighting the paradox of experiential control, to fostering defusion, acceptance, mindfulness skills, and values clarification, are presented early on, and then reintroduced and elaborated several times throughout the book. For example, the issue of values clarification is first introduced briefly in Chapter 1, and then revisited every few chapters throughout the remainder of the book. It is quite possible that many readers will find this format useful. It may reinforce interrelated ideas without unnecessary elaboration on conceptual details that may not be relevant. On the other hand, the format also sometimes gives the feel of an unfocused jumping from topic to topic. A greater danger is that such an approach risks being perceived by some readers as dismissive of the seriousness of their distress. One of the most challenging aspects of the ACT model to grasp is that it cannot be reduced to a simple message of "pull-yourself-up-by-your-bootstraps." ACT

is not a simple matter of accepting one's distress and getting on with life; if it were that simple there would be no need for book-length treatments. A more linear—perhaps even more patient—presentation of the model would first firmly establish, using the patient's own experience as a guide, the futility of experiential control before broaching the idea of acceptance. And when acceptance is introduced, care would be taken to emphasize that it represents a skill that is neither straightforward nor easy to realize. By presenting these concepts more or less simultaneously, some readers may not be sufficiently prepared, and may perceive the model as overly simplistic or as dismissive of their pain.

As a behavior therapy with conceptual roots in the experimental analysis of behavior, ACT is fully committed to empirical testing of its theory and techniques. Forsyth and Eifert frequently note this scientific basis, and cite key works from the scientific and professional literatures. At times, however, they overstate the research support for key ACT principles and outcomes. For example, there have only been a handful of trials of ACT with anxiety disorders, even if one includes closely related approaches, and most of these have been relatively modest in size and scope. In addition, these trials do not yet demonstrate conclusively that factors specific to ACT are driving improvement, although the findings to date are quite promising in this regard. Although encouraging, it is therefore premature to present ACT as an unequivocally well-supported intervention for anxiety disorders, as Forsyth and Eifert imply. Likewise, there is a strong antimedication bias running throughout the book. Like many scientifically oriented psychologists, the authors are understandably concerned about the overuse of anxiolytic and antidepressant medications for mood and anxiety disorders, especially when equally (and perhaps more) effective psychosocial treatments are available. Nevertheless, a scientific perspective requires that one not simply dismiss out of hand the substantial literature on the efficacy of medications for at least some individuals with severe anxiety disorders. Contra the implications of the book, there is nothing in the ACT model that is inherently inconsistent with the judicious use of medication when appropriate.

In a related vein, the authors present the research on experiential control as if it were an open-and-shut case: cognitive and affective control efforts are inevitably harmful. Yet the research is in fact far less clear on this point. Although a growing body of evi-

dence does indeed support the pernicious effects of direct efforts to avoid or control distressing experiences, most of these studies are analogue or correlational in nature, and do not rule out the possibility that some experiential control efforts may in fact sometimes work. In fact, contrary to frequent misunderstanding, this is not inconsistent with the ACT model. The prohibition against experiential control in ACT is not dogmatic or absolute. If such efforts work and do not result in excessive costs, then they are permitted. The key, of course, is determining when they are likely to work and when they are not. This subtlety is lost in the current book, which gives the message that all such efforts are inevitably doomed to backfire.

This raises a related point about situations in which a certain kind of experiential control is actually required. To distinguish useful from dangerous applications of willful control efforts, Forsyth and Eifert repeatedly make use of the “hands-and-feet” principle. That is, control is useful when directed toward overt behavior (i.e., things that involve moving one’s hands and feet), but does not work when directed to the world within the skin. But this principle is not foolproof. Consider the case of test anxiety. A certain degree of attentional control is critical to effective test-taking behavior. It is not enough to defuse from and accept distressing thoughts and feelings; one must also simultaneously focus attention on the material at hand, and such attentional focus cannot be achieved with the hands or feet. By framing all experiential control efforts as verboten, the authors risk missing this distinction. It is important to note that, once again, there is nothing necessarily inconsistent about this idea within the larger ACT model. Rather, the present book misses this potentially important issue.

The final significant shortcoming of the book is something that is shared with most other self-help books on ACT, and in fact with many self-help books on other models of psychotherapy: The unique or characteristic features of the model are highlighted, whereas components that are common to a number of models tend to be given short shrift. In the case of this book, the key issue is systematic exposure. If there is one thing that we can say definitively with respect to the anxiety disorders, it is that exposure of one form or another is a core feature of successful behavioral interventions, including ACT. In our work with acceptance-based interventions for social anxiety disorder, for example, we emphasize the critical role of systematic exposure to fear-inducing stim-

uli (Dalrymple & Herbert, 2007; Herbert & Cardaciotto, 2006). Exposure is both conceptualized and implemented somewhat differently from an ACT perspective relative to other models of behavior therapy, but it remains a critical component. Forsyth and Eifert do discuss exposure, and especially interoceptive exposure, toward the end of the book, and their frequent references to behavioral action directed toward valued goals can be understood as fostering a type of exposure. Nevertheless, they do not emphasize the importance of systematic, sustained exposure to phobic stimuli using the full range of relevant modalities (e.g., in vivo, simulated, imaginal), nor how different types of exposure are typically applied to different types of anxiety disorders. The tendency to emphasize what is new and different in a book of this type is understandable. Nevertheless, this is no justification for downplaying one of the most well-established interventions for anxiety disorders, especially when it is fully compatible with the ACT model.

We recently analyzed 50 best-selling self-help books on the basis of their usefulness and grounding in the scientific literature (Redding, Herbert, Forman, & Gaudiano, in press). Our sample of books was gathered just before the recent proliferation of ACT self-help books, and so the present work was not included. Applying the criteria we used to rate books, Forsyth and Eifert’s book would have undoubtedly done well in our analysis, although not at the very top, due primarily to the occasional overstatement of the research base discussed above. In addition, the book does not adequately address when one should seek professional help. Even under the most optimistic of circumstances, there will be some individuals for whom a self-help book is inadequate, and who will require professional help. Self-help books have an obligation to address this issue directly, and to offer guidance as to when such assistance is indicated and how to locate a qualified clinician.

The book will feel quite familiar to those already versed in the ACT model, as there is little truly new or innovative here. For those unfamiliar with ACT, there are better introductions targeting professionals (e.g., Hayes & Strosahl, 2004) and lay readers (e.g., Hayes & Smith, 2005). As an application of ACT specifically to anxiety disorders, however, Forsyth and Eifert have presented a highly readable, useful, and user-friendly guide. The book’s strength is not its originality, but its translation of complex ideas into an engaging, accessible, encouraging, and gentle style. Despite some

important limitations, this book will be extremely useful as a supplement to therapist-guided ACT for anxiety disorders. Additionally, although research is needed to evaluate its effectiveness as a stand-alone intervention before firm conclusions can be drawn, it may also be a useful resource for the self-treatment of individuals struggling with anxiety.

## References

- Dalrymple, K. L., & Herbert, J. D. (2007). Acceptance and Commitment Therapy for generalized social anxiety disorder: A pilot study. *Behavior Modification*, *31*, 543-568.
- Eifert, G. H., & Forsyth, J. P. (2005). *Acceptance and commitment therapy for anxiety disorders: A practitioner’s guide to using mindfulness, acceptance, and value-based behavior change strategies*. Oakland, CA: New Harbinger.
- Hayes, S. C., & Smith, S. (2005). *Get out of your mind and into your life: The new Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger.
- Hayes, S. C., & Strosahl, K. D. (Eds.). (2004). *A practical guide to Acceptance and Commitment Therapy*. New York: Springer-Verlag.
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford.
- Herbert, J. D., & Cardaciotto, L. (2006). A mindfulness and acceptance-based perspective on social anxiety disorder. In S. Orsillo & L. Roemer (Eds.), *Acceptance and mindfulness-based approaches to anxiety: Conceptualization and treatment* (pp. 189-212). Kluwer/Penum.
- Redding, R. E., Herbert, J. D., Forman, E. M., & Gaudiano, B. A. (in press). Popular self-help books for anxiety, depression and trauma: How scientifically grounded and useful are they? *Professional Psychology: Research and Practice*.

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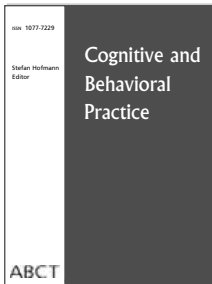
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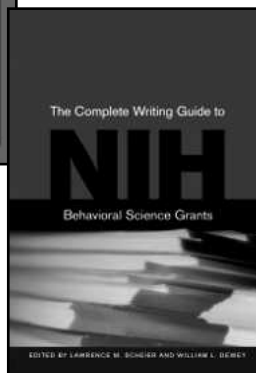
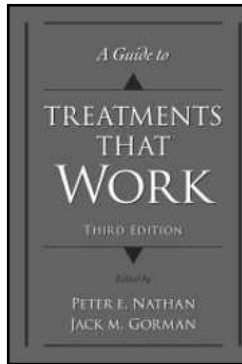
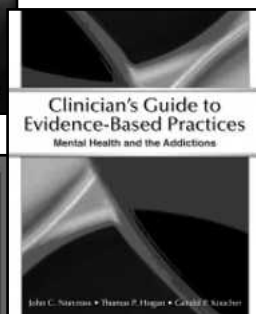
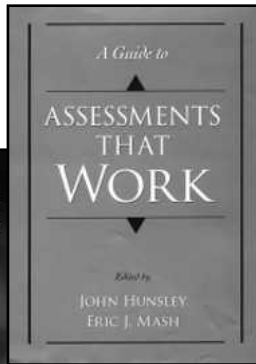
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