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Introduction

Drew Anderson, *SUNY, Albany*

This is the first issue of *the Behavior Therapist* that you will be reading after the annual conference in Orlando. Like many of you, I always come back from the conference excited and inspired about ABCT and the future of the behavioral and cognitive therapies. In that spirit, I'd like to highlight a couple of new features that will be part of the future of *tBT*.

First, I plan to devote occasional special issues to topics covered at the annual conference. Every year there are a number of panel discussions and symposia that would be of interest to the entire membership of ABCT, not just those able to attend the conference. You hold in your hands the first of those special issues.

The past few years have seen the rise of the so-called "third wave" behavior therapies, including Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), and Functional Analytic Psychotherapy (FAP). While the label of "third wave" may not be embraced by everyone, including the proponents of the therapies themselves, there is a sense among many that these therapies represent a shift, in both theory and practice, from more traditional notions of other behavioral and cognitive therapies. At the 2007 ABCT conference, a panel organized by D. J. Moran, Ph.D., discussed the notions of these "waves" and what they might mean for the future of cognitive-behavioral therapies and ABCT. The discussion was contentious at times, but raised issues that will greatly affect ABCT in the years to come. Thankfully, the panelists agreed to provide written summaries of their positions for this special issue of *tBT*. I can't think of a better topic with which to kick off this series of special issues, and I hope you find it thought-provoking and informative.

Second, based on a thoughtful suggestion by Jeffrey Rudolph, Psy.D., a series on influential

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mentors in the history of ABCT has been established. Dr. Rudolph has kindly provided the first article in the series, a reflection on his mentor Dr. Arnold Lazarus.

If you have ideas/suggestions for either of these new features, please contact me.

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Address correspondence to Drew A. Anderson, Ph.D., SUNY-Albany, Department of Psychology/SS369, 1400 Washington Ave., Albany, NY 12222; e-mail: drewa@csc.albany.edu.

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—Albert Ellis

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

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**. Please include the phrase ***tBT submission*** in the subject line of your e-mail. Include the first author's e-mail address on the cover page of the manuscript attachment. By conventional mail, please send manuscripts to:

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

The Three Waves of Behavior Therapy: Course Corrections or Navigation Errors?

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Preface

On a cold November morning in 2007, in the City of Brotherly Love, six men met to present their ideas about recent developments in cognitive-behavior therapy. The room was full for the Sunday-morning event at the ABCT convention in Philadelphia, and attendees witnessed contention, table-banging, and surprise betrayals from the "wave" that were previously considered alliances. The audience members got in on the debate, too. Some glimpses of reconciliation were there, but at the end of the confrontation it seemed that there is still a long way to go before behavior therapy establishes an evidence-based integration of the different perspectives. If such a journey of 1,000 miles begins with one step . . . this meeting at least demonstrated a willingness to lace up our shoes.

The panel discussion inspired the present article from representatives from the three generations of behavior therapy. The scientist-practitioners summarize their views on the current state of behavior therapy and about the differences and similarities between behavior therapy, cognitive-behavior therapy, and the third-wave approaches.

The following papers were authored by the participants of that presentation: Kurt Salzinger, Robert Leahy, Steven Hayes, Richard O'Brien, Raymond DiGiuseppe, and D. J. Moran. These submissions are reflections, sentiments, and perspectives from that morning.

—**Daniel J. Moran**, *MidAmerican Psychological Institute*

Waves or Ripples?

Kurt Salzinger,
Hofstra University

⌣⌣⌣ My task, as I see it, is to question whether three forms of therapy, namely, cognitive psychotherapy, Acceptance and Commitment Therapy, and behavior therapy, are different waves or mere ripples of the water. I will answer the question with the science of learning and conditioning, which, while still changing, has stood the test of time. Indeed, one form of psychotherapy that is not represented among these therapies, Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991), is a form of therapy that boldly embraces behavior analysis in that it sets out to reinforce particular response classes occurring in the session and does so because they are important in the world outside the therapeutic session.

I will analyze the differences among the therapies by using the behavioral mechanism (Salzinger, 1980; Salzinger & Serper, in press) that details such variables as those that precede the behavior of interest: the reinforcement history, the discriminative stimuli, the physical state of the organism and those that follow the various responses, namely, the consequences. The therapist provides the discriminative stimuli and the consequences for the client's behavior. More specifically, what are the reinforcers that therapists employ and how do they establish themselves as a source of positive reinforcement? When do the therapists employ escape and/or avoidance conditioning to promote the kind of behavior that will help the client? Where do stimulus equivalence (Sidman, 1994) and/or relational framing (Hayes, Barnes-Holmes, & Roche, 2001) help in the process of changing the client's behavior? What is the homework that the therapists suggest? And what are the reinforcement contingencies that the clients are exposed to when doing that homework? Reviewing what takes place in the therapeutic session is important, as we discovered when examining Carl Rogers' (our nondirective, reflective psychologist par excellence) behavior. What actually took place in his sessions was that he methodically reinforced and conditioned classes of verbal behavior (Truax, 1966).

Unfortunately, since we did not have enough time to gather the data for such an approach here, we can only use the hortatory statements by various theoreticians as to what one must do to follow their prescription for therapy. That leaves us with only one fair way to compare different forms of therapy—to divine from their writings just what they might actually be doing when they say they are reasoning with their clients or reframing, or when they say they are getting them to observe their behavior rather than dwell on their feelings. Hayes, Strosahl, and Wilson (1999), to take up Acceptance and Commitment Therapy (ACT) first, supply us with a recommended list of metaphors that they use but it still is not clear how they work. Is each metaphor a discriminative stimulus for some verbal response by the client, such as, "Oh, you mean I spend too much time 'trying to suppress my thoughts?'" In point of fact, however, we are told by ACT practitioners that they avoid providing explicit rules to their clients. Then we have to discover just what response is being sought out by them. I believe we should translate the therapist's behavior during the therapeutic session into basic behavior analytic language.

In that regard, Kohlenberg and Tsai (1991), as we already mentioned, are perhaps the clearest on what they do in FAP. What happens in the course of a verbal interaction has been studied extensively (e.g., Salzinger & Pisoni, 1958; 1960). We've learned that we can increase or decrease various response classes, although their specific composition is sometimes much attenuated by the interlocutor's reinforcement history (Salzinger, Portnoy, Zlotogura, & Keisner, 1963) so that the exact nature of the changing response class depends on that history. Thus, to make our examination of the different therapies productive, adherents of each particular approach should describe their critical activity in behavior analytic terms so that we all are using a common language. All of these techniques share the fact that they all talk with their clients. We already have something in common, namely, employing verbal behavior by means of which we present discriminative stimuli and reinforcers, both positive and negative. We present rules to our clients (I know, not true of ACT in any explicit way but what are metaphors if not disguised rules?) and ask them to explain the rules they follow in various explicit or implicit ways. We emit tacts and mands, to take but two examples from Skinner (1957). We try to discover the membership of various response classes; for example, we try to find out whether certain verbal responses that clients emit are members of classes that most people would consider aggressive but

the client in question considers to be members of the class of love and attention. We must discover much about the verbal behavior of our clients because that's what we have to work with. Some of the verbal behavior must be worked on directly because it is an example of verbal interactions the client might well have outside the therapeutic session. Other verbal behavior must be attended to because it provides information about behavior outside the therapeutic session: The interaction the client had the night before with his wife or she had with her husband, or boyfriend, or boss, etc. How does each of the different ripples—or waves, if you insist—deal with those reports? How does each of the therapeutic systems best discover the rules that, in some way, control the client's behavior?

Since all of us believe that rules play a part in the client's problems, how do we ascertain what they are? And after we do find out, how do we get our clients to give up or change the rule-governed behavior? If the fault lies not in our stars but in our rule-governed behavior that we are clients rather than therapists, how precisely do we alter those damaging rules? The explanation must use words like, "We say *blank* and *blank*" not that we "expose" the patient to the irrationality of their behavior or merely have them learn that their behavior is so controlled. Just what is the role of metaphors, which are so prominent in Hayes et al. (1999)? And as long as we find agreement on finding faults in our rules, what about Verplanck's (1992) interesting work showing that one can reinforce rules about sorting of cards independently of the actual sorting behavior? Are we overrating rule-governed behavior? Are the rules we claim to control our behavior actually controlled by a different reinforcement contingency than the contingency that controls our faulty behavior?

Just exactly what happens when we get clients to "accept"? Do you reinforce their verbal behavior of saying "I understand"? What if they say, "I don't get it!" Is the information that the cognitive therapist provides about the irrationality of the client's behavior a negative reinforcer that we all hope he or she will escape from or avoid? Isn't cognitive behavior therapy simply a misunderstanding of Skinner's approach (Salzinger, 1992)? Do the positive statements that we ask our clients to emit positive reinforcers or discriminative stimuli for new behavior?

When we examine each of the forms of therapy in behavior analytic terms, we will be able to compare their relative effectiveness, eventually allowing for combination of the techniques to achieve the change in behavior that all of us want.

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Address correspondence to Kurt Salzinger, Ph.D., Hofstra University, Dept. of Psychology, 229 Hauser Hall, Hempstead, NY 11549; e-mail: Kurt.Salzinger@Hofstra.edu

A Closer Look at ACT

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

Innovation in cognitive-behavioral therapy is to be welcomed, but innovators need to take into account empirical evidence and need to temper their statements to conform to reality. Here are some realities that are relevant to the view of the "third wave" of ACT. First, CBT standardized treatments meet the criteria of empirically supported treatments (ESTs) for a wide variety of disorders (Butler, Chapman, Forman, & Beck, 2006). Second, Lars Öst's (2008) meta-analysis indicates that so-called third-wave therapies do not meet the standard of ESTs. Third, there is no evidence that ACT is more effective than cognitive therapy (CT). The implication of the foregoing is that empirically supported treatments are to be preferred in clinical settings—why begin with a treatment that has not been supported by the data? Indeed, studies that purport to show that ACT is equivalent to CT in treating depression or anxiety often have small sample sizes, confounds of experimenter effects, or use nonclinical samples (Forman, Herbert, Moitra, Yeomans, & Geller, 2007; Zettle & Hayes, 1986—which had only six patients in the ACT condition). Those studies do not meet the standards for an EST or for a robust test of treatments.

The idea of "third wave" implies some progressive development in CBT. Yet, a closer inspection of the ideas underlying ACT suggest considerable similarities with much earlier approaches to therapy, such as Morita Therapy (Morita, Kondo, & Levine, 1998—first advanced in the 1920s), Constructive Living (Reynolds, 1984—first advanced in the 1970s), exposure treatments (Pavlov in the 1890s), DBT concepts of mindfulness and acceptance, and Kelly's (1955) fixed role therapy (see Hofmann & Asmundson, 2008). Moreover, if there is a third wave it may be that ACT is riding it alone, since Marsha Linehan and Adrian Wells, sometimes described by Hayes as his shipmates on this voyage, deny that they are part of the third wave. If one wants to make the claim that Mindfulness Based Cognitive Therapy (MBCT) is part of the third wave, then that would be one choice. Yet MBCT has proven effective (so far) only for a limited population—that is, for reducing recurrent episodes of major depression

for individuals with three or more prior episodes. For individuals with two or less prior episodes there is no advantage (Ma & Teasdale, 2004). Moreover, we should be mindful that Öst's meta-analysis indicates that MBCT and mindfulness are not ESTs. If this is a third wave, it is not a tsunami.

ACT proponents have made claims that cognitive therapy involves patients in "struggling" with their thoughts, drawing an analogy with Wegner's famous "white bear" experiments showing that suppression of thoughts leads to rebound effects. For example, Hayes (on Amazon.com, n.d.) is quoted as saying, "The basic research underlying ACT shows that entanglement with your own mind leads automatically to experiential avoidance: the tendency to try first to remove or change negative thoughts and feelings as a method of life enhancement. This attempted sequence makes negative thoughts and feelings more central, important, and fearsome—and often decreasing the ability to be flexible, effective, and happy." He is further quoted in *Time* magazine: "Hayes and other third wavers say trying to correct negative thoughts can, paradoxically, intensify them" (Cloud, 2006, February 5). By comparing cognitive therapy with *suppression of negative thoughts* ACT proponents advance a misconception of what actually occurs in cognitive therapy. In contrast to this misconception, the cognitive therapist encourages the *elicitation* of negative thoughts (examining how situations and emotions are associated with specific negative thoughts), eliciting more negative thoughts by using the vertical descent and Socratic techniques to identify those thoughts. The cognitive therapist is continually asking, "What were your thoughts?" This is not consistent with the claim that we suppress thoughts.

ACT argues that acceptance and commitment therapy *defuses* thoughts and reality, whereas cognitive therapy is viewed as encouraging the patient to place too much emphasis on thoughts which, in ACT's view, are distinct from reality. Indeed, in the very first session of cognitive therapy the therapist asks the patient to distinguish between thoughts, feelings, and reality. In fact, this is equivalent to diffusion, which cognitive therapists call "decentering." Since there are many different thoughts that give rise to different emotions and behaviors and that describe different realities, the first session in socializing the patient to the cognitive model is to diffuse thoughts, feelings, reality, and behavior.

The cognitive therapist is not trying to get the patient to stop thinking thoughts—rather, the goal is to decrease the degree to which these thoughts are *believed* and result in negative affect. ACT proponents even argue that cognitive testing or "challenging" of thoughts *can make matters worse*—and can impede therapy. This is a remarkable and alarming claim—one that has absolutely no basis in reality. What reality shows, however, is that cognitive therapy has more evidence supporting its effectiveness than any other psychotherapy approach. The cognitive therapy "package" —or whatever you want to call it—has established that it is an effective treatment for depression, social anxiety, panic disorder, OCD, generalized anxiety disorder, PTSD, bipolar disorder, psychotic delusions, personality disorders and other problems. How can it be argued that cognitive therapy impedes improvement if it is the most clearly established effective psychotherapy that exists?

Moreover, there is evidence that cognitive change does underpin change in depression for patients in cognitive therapy.

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For example, Strunk, DeRubeis, Chiu, and Alvarez (2007) found independent use of cognitive therapy skills predicted reduced risk for relapse. DeRubeis, Evans, Hollon, Grove, and Tuason (1990) found that change from pretreatment to midtreatment on the ASQ, DAS, and HS predicted change in depression from midtreatment to posttreatment in the CT group and Tang and DeRubeis (1999) found that cognitive changes preceded sudden gains in therapy—and patients who experienced sudden gains maintained their improvement over a year later.

ACT places considerable emphasis on *acceptance of reality,* so that one does not engage in useless protests against reality. But the cognitive therapist also recognizes that reality is a "given"—it is the situation, the feelings, and the thoughts that the patient has. Cognitive therapy traces its origin to the ancient Stoic Greek and Roman philosophers—such as Zeno, Seneca, and Cicero. In the Stoic tradition, acceptance is the first "movement" in the understanding and response to reality. Indeed, the Stoics described this first movement as "fluttering" of the soul—to capture the emotional and human impact of events. The second movement was to stand back and examine exactly what is happening. The third movement was to consider alternative ways of viewing this. And the fourth movement was to focus on one's virtue as a goal—rather than pleasure and pain. Indeed, ancient Stoic philosophy and ACT appear to agree on personal values or virtue as the action commitment. But standing back and examining reality and considering alternatives that may be available are part of cognitive therapy as well as ACT.

ACT emphasizes *mindful awareness* as a process different from the cognitive model. Three years ago I had the privilege of hearing Aaron Beck and the Dalai Lama discuss similarities between cognitive therapy and mindful awareness at the International Congress of Cognitive Psychotherapy in Göteborg, Sweden. The Dalai Lama viewed the cognitive therapy approach as an excellent example of mindful awareness and analysis. However, it is true that mindfulness practice is different from the traditional cognitive therapy "testing" of thoughts. As a result many cognitive therapists incorporate mindfulness into their practice and their lives. A daily adherent of mindfulness practice is Aaron Beck.

Although there are intriguing and creative innovations and techniques that are part of third-wave approaches, we should recognize that criticisms of effective treatments and claims of efficacy for new treatments may need to be moderated by the limitations of the data. Indeed, it would be an advantage to all of us if new, effective treatments are established, thereby empowering the therapist with more tools to alleviate human suffering.

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Address correspondence to Robert L. Leahy, Ph.D., American Institute for Cognitive Therapy, 136 East 57th St., Suite 1101, New York, NY 10022; email: Leahy@CognitiveTherapyNYC.com

Avoiding the Mistakes of the Past

Steven C. Hayes,
University of Nevada

I'm old enough to remember. In the early 1970s when cognitive models were brought into behavior therapy, there was a great deal of struggle over what was being added. The arguments were heated. Those of us with ages that start with a 6 or more can recall it. In my memory, it was not pretty.

Joe Wolpe pleading his case that cognition was already handled in his approach to behavior therapy. Len Krasner saying with a giggle that "cognitive-behavioral" was an oxymoron. And the young Turks of cognitive therapy sweeping through the field like riders on horseback, bringing fundamental change in their wake. Cognitive models and methods were in. Traditional behavioral principles and even some behavioral methods were now to be much less important. Some previously foundational ideas (e.g., behavior therapists needed extensive training in the psychology of learning) began heading toward extinction.

There was a lot of discussion of what was "new" or "old." There were a lot of claims about what was more or less effective.

"New and better" evokes predictable responses from others, at least after the initial stage of defensive disinterest. The response is simple: It's not new and it's not better. I can still hear Wolpe forming the words that argued that nothing was added. But that evokes a predictable response: "It *is* better." The tones that Mike Mahoney shaped in ar-

guing for cognitive models still ring in my ears.

All of these giants are gone now. We can look at those times more dispassionately.

There was never any doubt that CBT was new at the level of procedures, concepts, and focus. Despite what traditional behavior therapists claimed, the students and young professionals knew that to be true. Unlike most of their mentors, they attended the workshops and tried the methods. It was obvious. There was soon also no doubt that CBT produced good outcomes. In the end CBT won the argument because the young moved in that direction. Except for strongly committed behavior therapists, who never were convinced and still are not, it was over.

But many things were left undone. In hindsight, we can see them clearly. The processes of change were unclear and often untested; the components responsible for outcomes were more commonsense than proven; and the underlying principles became looser and less linked to basic behavioral science, resulting in theories that were harder to disprove. The original goal of empirically validated procedures was retained, but the original vision of a translational applied science linked to well-established basic principles weakened.

Now a third generation of CBT seems to be upon us. Instead of modifying thoughts and feelings through evidence and logic so that a causal chain leading to undesirable behavior is disrupted, third-generation CBT is more interested in creating contexts that modify the person's relationship to their own thoughts and feelings, weakening unnecessary and unhelpful causal chains with behavior, and proceeding more directly to the strengthening of values-based actions. In short, "Unlike CBT, there is little emphasis . . . on changing the *content* of thoughts; rather, the emphasis is on changing *awareness of* and *relationship to* thoughts, feelings, and bodily sensations" (Segal, Teasdale, & Williams, 2004, p. 54). That is a different organizing idea—regardless of the term used to describe it. Students and young professionals know that to be true. Unlike most of their mentors, they actually attend the workshops and try the methods.

The claim that there are evolving assumptions in the field (Hayes, 2004) seems to have been treated in some corners as a divisive and premature shout that "we are new and better." And the responses to that self-imagined construction have been coming thick and fast with the predictable counter-theme, "It's not new and it's not better." Third-generation CBT in general and Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) in particular is supposedly old hat (Hofmann & Asmundson, 2008), its ideas are the same as traditional CBT (Arch & Craske, in press), the studies are poor (Öst, 2008), and even if the methods work, they are no better than anything else (Powers, Zum Vörde Sive Vörding, & Emmelkamp, in press). We are busy responding to these criticisms (e.g., Hayes, 2008; Hayes, Levin, Plumb, Boulanger & Pistorello, in press; Levin & Hayes, in press), most of which we think are unjustified.

Unknown to many, but evident in the present series of articles, traditional behavior analysts are also unhappy with ACT researchers for claiming that traditional behavioral perspectives on cognition need to change and for defending an empirically viable behavior analytic alternative: Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001). The response there is also, "It is not new and it is not better." And there too the criticisms are being addressed (e.g., Hayes, Barnes-Holmes, & Roche, 2003).

None of this is surprising. What may be surprising is the heat. I've always argued that we need to rise above "distinctions between behavior therapy and cognitive therapy" (Hayes, 1987, e.g., p. 342) in a way that "synthesizes previous generations of behavioral and cognitive therapy" (Hayes, 2004, p. 658). Perhaps some of the heat came because of a parallel argument (Hayes, 2004) that component and mediational analyses are not very supportive of the traditional CBT assumption that "the therapist's role is to help the patient recognize his or her idiosyncratic style of thinking and modify it through the application of evidence and logic" (Leahy, 2003, p. 1). Subsequent independent reviews of the evidence behind that claim have largely agreed, however (e.g., Longmore & Worrell, 2007). Description of evidence is not an attack, or at least it should not be. Not here—not in *this* organization.

It is time for the field to pause. Breath in. Breath out.

There is not a single quote from a major player in third-generation CBT or in ACT that is dismissive of CBT, behavior therapy, or behavior analysis. We are part of this tradition writ large and we are working toward the common good of our field and those it serves.

We as a field do not need the heat. A better approach is to learn from the mistakes we made in the transition from behavior therapy to cognitive behavior therapy

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and at least not replicate them this time as another generational transition may be taking place. I can think of at least six mistakes that we should avoid.

1. Last time we were either too ready to embrace "new and better" without fully doing our homework or too ready to fight changes without serious training and consideration. This time let's be open, but cautious. Instead of "new and better," let's do "We think it is new or at least different and we shall see that is true and if it is better." Instead of a dismissive, "It's not new" or "That sounds just like what I do," let's do the trainings, attend the workshops, read the studies, and try the methods that make good sense after all of that.

I think the ACT community has been willing to wait and to move cautiously. As we have explained elsewhere (Hayes, 2008; Hayes, Levin, Plumb, Boulanger, & Pistorello, in press), in the 1980s we did several studies on the traditional cognitive model before going in a different direction when the model repeatedly failed us. Even then, despite early successes, we waited more than a decade while we worked out the kinks before presenting our alternative approach.

2. Last time, we argued mostly at the level of procedures and general concepts; this time let's add philosophy, theory, development strategy, and processes of change. That will give us a more substantial answer to claims of difference: an empirical answer focused on processes of change linked to a theory and a progressive strategy of development.

There too the ACT community has been forthright. We've laid out our development strategy (e.g., Hayes, 2008; Hayes et al., in press; Levin & Hayes, in press); we've done the mediational studies—at the last ABCT convention we presented a meta-analysis of over a dozen (Hayes, Levin, Yadavaia, & Vilardaga, November 2007), which we will soon put in publication form; and there has been extensive attention to theory and philosophy as even the most cursory examination of the ACT literature reveals.

3. Last time we tested package after package without understanding their elements. This time let's include a lot of component testing from the very beginning.

The ACT community has done that. At the last ABCT convention we presented a meta-analysis of 17 studies on ACT components (Levin, Yadavaia, Hildebrandt, & Hayes, November 2007) which we will also soon put in publication form.

4. Last time, we tried to move ahead without a careful emphasis on basic psychological principles. This time let's hang on so tightly to that goal that we as clinicians will ourselves create the basic analyses if need be.

The ACT community has done that, as a flip through any RFT text (e.g., Hayes et al., 2001) will prove. ACT is part of behavior analysis, but yet takes cognition so seriously that we spent 15 years developing an account of cognition that works for clinicians rather than accept an applied method without a basic foundation.

5. The last time we did few head-to-head comparisons with existing methods that were supposedly different and more limited. This time let's do some, but only in the context of everything above and without forgetting the need to expand the field into new areas. We need theory, processes of change, and mediational evidence as a central part of needed direct comparisons.

ACT has done that from the very beginning. ACT has so far been compared to traditional behavioral or cognitive methods nine times in the published literature (Hayes, 2008). There is not enough evidence to reach a conclusion about outcome, but there is enough to suggest that these methods are indeed different. *All* of these studies have found differences in processes of change.

In the context of the recent interest, we recently re-analyzed one of the early ACT versus CBT studies with depression (Zettle & Rains, 1989) removing a distracting form of cognitive therapy that did not contain distancing (it was distracting analytically because this hobbled form of cognitive therapy actually did *better* than the full package) and examining both outcome and process differences using modern analytic methods. In a full intent-to-treat analysis ACT had better depression outcomes on the Beck Depression Inventory than cognitive therapy, but much more importantly, that difference at follow-up was mediated by posttreatment levels of cognitive fusion but not depressive attitudes (Zettle, Rains, & Hayes, under review). So even these earliest ACT studies showed both in approach and in data some of the healthy characteristics listed above.

6. And let's not forget our ultimate mission, as sometimes we have. Despite what some have been taught, this is *not* a field founded on DSM diagnoses and manuals focused on 50-minute hours. We in the cognitive and behavioral community have a historical purpose: to help build a comprehensive psychology more adequate to the challenge of the human condition. That means taking seriously prevention, prejudice, and learning; health, love, and community; not just the 4 out of 7 check boxes on a syndromal list.

And there ACT has, I believe, a great deal to be proud of. We have built a sense of community, science values, and mission that has a worldwide reach involving more than 1,300 basic and applied researchers, practitioners, scholars, and students (see www.contextualpsychology.com), with more than 30 books on ACT methods in eight languages (originals, not translations) and list-serves in six languages with more than 2,000 members. Instead of competing with existing CBT and behavior analysis organizations, we are dedicated to supporting and building them, by bringing professionals and students who previously thought of behavioral psychology as part of the problem, into contact with what it has to offer humanity. Instead of certifying therapists, we are giving the technology away. Instead of trying to protect and copyright names and labels, we are focused on developing empirically validated processes and measures that the entire field can use freely. The ACT community is taking third-generation CBT into frontiers rarely visited by our field, such as stigma against people in recovery, racial prejudice, epilepsy among poor South African blacks, or empowering workers to change their workplace, just to name a few. Any fair look at the scope of ACT research has to make note of the willingness to take on hard challenges and to carry these methods into new domains, even using ACT to help clinicians learn methods other than ACT! (Varra, Hayes, Roget, & Fisher, 2008). It is well past time to break down the walls of the clinic and take CBT to the streets, and ACT is part of that mission.

Is any of this enough? No. But it provides a good deal of evidence that third-generation CBT and ACT are evolving in a responsible way that may minimize some of the mistakes of the past. That alone is something to be happy about and to support—at least it should be for those of us old enough to remember.

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Address correspondence to Steven C. Hayes, Ph.D., Department of Psychology, University of Nevada, Reno, NV 89557; e-mail: stevenchayes@gmail.com

What Would Have Happened to CBT If the Second Wave Had Preceded the First?

Richard M. O'Brien,
Hofstra University

By the end of the 1960s, behaviorists had successfully employed models and methods derived from animal learning to the treatment of a broad array of psychological problems. They achieved this success while eschewing DSM labels and documented it by directly measuring the behavior of interest rather than giving out paper-and-pencil tests. These results had been produced without developing a single schema or disputing even one irrational thought.

Cognitive techniques were initially described as adjuncts to effective behavioral approaches. If the behavioral approaches were not already in place when Ellis and Beck introduced their cognitive theories, would we have ever had cognitive behavior therapy?

Imagine that the behaviorists had ventured forth from their labs to find not only various forms of psychoanalysis and nondirective approaches but two other kinds of talking cure: rational emotive therapy and cognitive therapy. With no behavioral activation to use, would cognitive therapy have succeeded with depression? Probably not, since Martell, Addis, and Dimidjian (2004) have shown that behavioral activation is the critical treatment component in Beck's "cognitive" therapy of depression. Without behavioral activation, would the cognitive therapy of depression have looked any different than other verbal therapies?

With no exposure/response prevention, would any of the cognitive therapies have succeeded with anxiety? Not according to Bandura and his associates (Williams, Dooseman, & Kleifield, 1984), who applied a self-efficacy model to anxiety. They need it but go to absurd lengths to avoid calling it exposure, as in: "Some kind of commerce with the phobic activities is of course necessary to effect change in phobic behavior" (p. 505). Would "REBT" have any effects at all if you removed the "B" and left just cognitive restructuring? Gossette and O'Brien (1992) couldn't find any. RET was significantly better than a control treatment in changing actual behavior only 16% of the time. Only self-report measures revealed any positive effects. That might be acceptable if it weren't so easy to change scores on the typical self-report outcome measures. There is so much content overlap between the treatments and the outcome measures, it is likely that any effects reflect only teaching to the test.

The early behaviorists embraced parsimony and continuity across species. The simplest explanation that accounted for all of the facts was the best explanation. If one theory accounted for a behavior that was observed in very different species, that theory was preferable to one that required species specific explanations.

Mowrer's (1939) Two Factor Theory of Avoidance Learning is a parsimonious account of anxiety and avoidance. Let's look at an example: Bob was stuck on an elevator. Prior to that experience, an elevator did not elicit anxiety, but being trapped was an unconditioned stimulus for the unconditioned response of anxiety. Through pairing the elevator with being trapped, the elevator became a conditioned stimulus for anxiety. Bob has learned to avoid elevators

because doing so reduces his anxiety. That is a totally parsimonious explanation of how the fear of elevators developed. It implies what one must do to treat it: expose Bob to elevators and prevent the avoidance response so he learns there is nothing to fear; that is, the fear extinguishes.

This explanation is clean and complete. Contrast that to Beck's (1996, pp. 3-4) almost 2-page cognitive explanation of the same phenomenon partially presented below (italics are in the original): "The progression of events may be analyzed as follows. Initially, as Bob approaches the building, his *orienting* schema signals that there is danger ahead. The signal is sufficient to activate all the systems of the *mode*: the *affective system* generates rapidly increasing levels of anxiety, the *motivational system* expresses an increasing intensity of the impulse to escape, and the *physiological system* produces an increased heart rate, a lowered blood pressure, resulting in faint feeling, a tightening of the chest muscles, and a cramping of the abdomen." This results in fear of passing out, losing control, and being humiliated beginning at the preconscious level.

These internal constructs obscure the controlling variables identified in the two-factor model and depend on verbal description, thus eliminating cross-species analysis. After 6 hours in that elevator, many different species would show fear responses when you brought them back to it. It is unlikely to be their modes, schemas, or fears of losing control that produce the squealing in the elevator. As Bouton, Mineka, and Barlow (2001) have cogently argued, the evidence suggests that conscious cognitive involvement is not necessary for emotional conditioning.

Given the weak outcome data when only cognitive techniques are employed, would Eysenck (1952) have concluded that psychotherapy doesn't work except for Ellis and Beck? It wouldn't seem so. Would the early behaviorists have incorporated cognitive approaches into their behavioral treatments to give us CBT or would they have chosen to fit the works of Beck and Ellis nicely between Adler and Freud on the bookshelf of psychological history?

The third wave of behavior therapy includes some theories that share a return to behavioral roots. Hayes (Hayes, Strosahl, & Wilson, 1999) developed ACT from behavior analysis. He treated thoughts as behavior, he recognized that avoidance conditioning could apply to thoughts as well as other stimuli, and he remained connected to the lab in everything from equivalence relations to verbal satiation.

Is ACT/RFT any more parsimonious than cognitive therapy? In some areas, such as goal setting, it is not. Fellner and Sulzer-Azaroff (1984) presented a clean, parsimonious explanation of the effects of goal setting. Goals functioned as antecedent discriminative stimuli (SDs) that set the occasion for behaviors to be reinforced. They achieved that status by having been associated with reinforcement for that behavior in the past.

ACT proponents O'Hora and Maglieri (2006) reject that parsimonious explanation. They state, without the slightest empirical support, that ". . . the variety of contexts within which goal setting has been examined goes far beyond the contexts for which current behavioral accounts are suitable" (p. 141). Maybe they couldn't give a suitable account doing a functional analysis but many behavior analysts could. O'Hora and Maglieri spend 25 pages theorizing about what Fellner and Sulzer-Azaroff explained in one sentence. That is not parsimony.

How do they justify this pronouncement? They downplay the role of direct contingencies in favor of conscious cognition, rule-governed behavior, and verbal processes. If there were evidence that a functional analysis does not adequately deal with goal setting, they might be justified, but there isn't. Yet it is only fair to acknowledge that behavior analytic explanations that must rely on symbolic statements of the contingencies often include processes that could be more fully developed. ACT/RFT may be an advance in the analysis of these symbolic contingencies. I am not convinced that ACT-RFT is the next step in the natural progression of behavior analysis. But I am convinced that it might be!

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Address correspondence to Richard O'Brien, Ph.D., Hofstra University, 226 Hauser Hall, Hempstead, NY 11549; e-mail: crash61@optonline.net.

Surfing the Waves of Behavior Therapy

Raymond DiGiuseppe,
St. John's University

Behavior therapy has fragmented into a number of different tribes. The recent introduction and popularity of the so-called third wave of behavior therapy (Hayes, 2004) has revitalized debate within behavior therapy. Because of the challenge of the so-called third wave, we are discussing the differences and relative merits of the different models of behavior therapy. This debate between competing models of behavior therapy has been too long in coming. Perhaps we have been too polite to each other and we have avoided the uncomfortable experiences that come with debate.

Presently, groups representing each behavior therapy model claim distinctive features that make their model unique and more effective. Each therapy proposes different hypothetical constructs that it purports will elicit maladaptive behavior. Each model promotes research linking its hypothetical constructs to disturbed emotions or behavior. Each group proposes a psychological intervention that targets their hypothetical constructs for treatment and identifies a pathway or mechanism for change that involves their hypothetical construct. Each group has developed their own Web sites, journals, conferences, and professional training programs. These activities appear independent of each other. A psychologist friend asked me to explain what made them all behavioral therapies united under ABCT. I did pause before answering. It appears we do live in parallel universes. We spend more time promoting our models' uniquenesses than contrasting or testing them against each other.

As a proponent of a therapeutic school (REBT), I am as guilty as anyone of promoting one particular theory and engaging in such insular activities. However, I confess that I think the tribalism and insularity of REBT adherents has prevented REBT from progressing as a theory and has limited its contributions to scientific knowledge and to its becoming a more effective therapy. I suspect that my confession may be true for proponents of other theoretical models as well. The best path to progress is to prune some of the BT and CBT concepts. We can accomplish this best through research that directly compares the different models.

Science progresses when research contrasts different theories. Eventually one has to ask whether the third-wave constructs contribute some unique variance to emotional disturbance. Perhaps all of the existing constructs and those of the third wave contribute to some common latent variable that predicts disturbance. Perhaps each variable represents a separate pathway to disturbance and there are multiple pathways to disturbed behavior and emotion. Answering such questions requires measuring hypothetical constructs of more than one model. We need research that compares the constructs of the first, second, and third waves to see if they contribute redundant or unique variance psychopathology. Few such studies exist.

Such research means that there will be winners and losers. Being on the losing side means there will be fewer book sales and less attendance at some workshops. On second thought, perhaps it is financially best for all if we forgo the science and focus on dissemination of our own models.

It addition to such comparative research I suggest that we explore what unites behavior therapy. We do share a value for research-tested treatments. However, beyond that, are the treatments we practice similar? What is it that makes the third-wave therapy different from its predecessors? Do the third-wave proponents actually do different things in session from the first in the first two waves? Wampold (2007) suggested that there are common factors that account for much of the change in psychotherapy across theoretical orientations. Could there also be some common factors within our theoretical orientations. Do all first-wave (BT), second-wave (CBT), and third-wave therapies do some things similarly? I hope so. Once we establish the common factors of behavior therapy, we can proceed to test if the unique differences add to the treatment efficacy. I would like to propose some common behavior therapy activities that unit the three waves.

First, behavior therapists perform the common factors identified by Wampold as part of all good psychotherapy, such as developing a therapeutic alliance and displaying empathy. After these factors common with other therapies, behavior therapists do some analysis of the antecedents and consequences of the symptoms. They all conceptualize the problem as a matter of learning and not resulting from unchangeable traits. This suggests hope. They all engage in social problem solving that models flexibility in identifying new responses to the antecedents. They all ask clients to change their thinking in how they respond to the antecedent conditions. The new thoughts are less rigid, blaming, more specific and not overgeneralized, and more hopeful. They all ask their clients to behave differently to the antecedents. They all use some form of rehearsal and coaching to practice the new response. They all ask clients to engage in some activities that represent successive approximations of the treatment goals between sessions. They all use some form of exposure, whether imaginal or in vivo, gradual or flooding. I think we have more to gain by identifying what we share in common. Then, we can debate on whether the unique difference add incremental validity to the client outcomes.

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Address correspondence to Raymond DiGiuseppe, Ph.D., St. John's University, Dept. of Psychology, 8000 Utopia Parkway, Jamaica, NY 11439; e-mail: digiuser@stjohns.edu

Charting a Collaborative Course

Daniel J. Moran,
Trinity Services, Inc.

People who are lost and need direction often seek professional help. It is up to the scientists of the time to provide technological interventions for those who are lost, and to be open to pushing science forward to help more people in different predicaments get to important places in their lives as efficiently as possible. Such people are cartographers.

Anaximander's 6th-century B.C.E. map of the world was one of the first grand attempts at helping people get where they want to be in life. For that era, given the technological constrains, we can argue that he did a good job no matter how poor his picture of the world looks in hindsight. After all, cartography was still in its infancy.

It took about 26 centuries of scientific experimentation, technological development, and pioneering investigators to get us global positioning systems and digitally photographed satellite maps. Now, we can

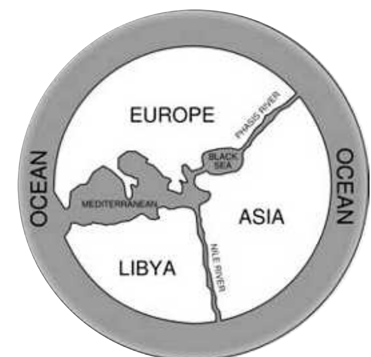

Fig. 1. Anaximander's map from the 6th-century B.C.E.

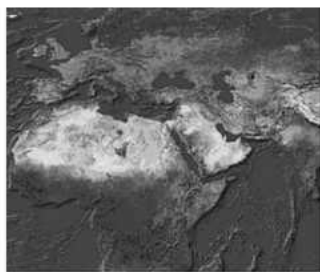

Fig. 2. A map resulting from accumulated knowledge and collaboration from 21st-century A.D.

map out directions to places we've never been before, have a reduced likelihood of getting lost, and can do so cheaply and quickly.

To get to this point in cartography, humankind needed to accumulate lots of information, and also had to experience setbacks and blind alleys. Looking back at the history of cartography, I wonder if cartographers ridiculed each other, vilified new attempts an pushing the boundaries (pun intended), and made statements like: "This map has been shown to work for about 30% of the lost travelers (who don't meet exclusionary criteria of course), especially when compared to the No Map control group. Given that success rate, let's just use the cartography methods we have!" Healthy competition between rival cartographers no doubt fueled improvements, but from the modern perspective, doesn't it seem petty if an ancient cartographer were to say: "That other company's maps are the same maps I've already created *and* they don't work as well!" (This is a weird combination of criticisms if you really think about it. Please do.) Frankly, it is the accumulation and combination of knowledge that leads to the complexity required to go from Anaximander's map to your dashboard navigation device.

Now I will probably have my ABCT card revoked for this, but I have to say that the present state of clinical psychology is a lot more like Anaximander's map than anything remotely close to what Google Earth can produce. Wundt published the first psychology textbook in 1874; James established the first U.S. psychology lab in 1875. Sure, Early Humans were using carrot-and-stick shaping to get oxen to plow, but it was not until last century that Skinner and others started to analyze behavior modification. We are just starting out in this science, so let's reinforce new developments and not eat our own just yet. Because frankly, it is the accumulation and combination of knowledge that leads to the complexity required to go from where we are now in psychology to being able map out behavioral patterns to places our clients would like to go, have a reduced likelihood of getting pathologically lost on the way, and do this endeavor cheaply and quickly.

This is *certainly* not to say I want to avoid conflict or experiments to see which treatments are better. The selectionistic process will help us shed ineffective treatments, and I'm all for helping it along with solid studies. But before we use our empirical razors to slash the superfluous, perhaps the blades should be sharpened by collaboratively establishing basic principles from lab experiments, developing pragmatic philosophical assumptions that comport to those basic principles, and then establish psychological aims with precision, scope, and depth. I do not see psychology there yet, but I see the work among the broader ACT and RFT community as the barber's strap. I think it wise for the ABCT community at large to embrace the current work from the human operant labs and the philosophical underpinnings of functional contextualism. In fact, when folks do, it will likely help make the CBT mechanisms more comprehensively understood. Albert Ellis thought so (Blackledge, Moran, & Ellis, in press).

This is a call to recognize that we have very far to go, and I think we'll arrive at our shared noble mission of reducing human suffering if we collaborate and create a shared language. And as we start improving our teamwork, I would like to mention a few concerns we need to address to make this relationship work.

If I had a nickel for every time someone at an ABCT conference started their critique of ACT with, "The problem with 'Ay-Cee-Tee' is . . . ," I could afford the breakfast buffet at our convention hotel. When I hear this critique, I think to myself, "His problem with 'Ay-Cee-Tee' is that he is ignorant of the 'Ay-Cee-Tee' literature." The four ACT books in arm's reach of my desk explain the pronunciation of ACT in the first few pages. I doubt any ACT workshop leader called ACT "Ay-Cee-Tee" during training. Further, the pronunciation was established in Kohlenberg, Hayes, and Tsai (1993) over 15 years ago. You will have to forgive me if I seem unrefined for correcting scholars' pronunciations, but if you want to seriously critique a psychotherapy, I would expect one to have read a few book intros, attended a workshop, and read a seminal paper on the subject. Many critics I encounter have not. Imagine a psychoanalyst coming up to you and saying, "The 'ABCkiT' organization seems worthless." How seriously would you take that critic?

Now you might question, "Moran, is that all you got? You're defending the ACT work by correcting the pronunciation of your critics. Don't you have anything more scholarly?" I've addressed a number of substantive issues in more detail elsewhere (see Bach & Moran, 2008, pp. 19–35, on differences between ACT, CBT, and BT. Heck, go wild and read the whole book!). But it seems empty to argue at a scholarly level with rank-and-file critics until they have done their due diligence enough to have informed appraisals of ACT. I will highlight a current example of ACT being misunderstood and maligned. In this series, Leahy states: "ACT places considerable emphasis on *acceptance of reality*, so that one does not engage in useless protests against reality" (p. 150). In fact Leahy's characterization is *not* an ACT position. The phase "acceptance of reality" appears nowhere in the primary ACT literature. "Reality" appears about two dozen times in the original ACT text (Hayes, Strosahl, & Wilson, 1999), but in almost every case other than commonsense uses, the term is *criticized* on philosophical grounds. Leahy's claim is a part of a pattern displayed far too often by ACT critics: to attack "ACT ideas" that have never been espoused, and to do so without formal citations placed in fair context so that readers can evaluate the criticism. This style of criticism is a distraction from collaborating on sincere issues. Unfortunately, the only true protection against these distractions is to read the primary ACT literature with care and to attend sufficient trainings to understand the position.

We're also distracted as a community by quibbling over the "wave" term, by arguing that newer therapies not on the EST list should not be developed further because 30-year-old therapies are already there, and by saying the newer therapies do not have enough data, when there is a good chunk of data being published, especially given the recency of the technical development. This is like high school upperclassmen picking on freshmen because they haven't made the varsity team yet. We are also distracted by implications that ACT *usurped* Buddhism and Morita Therapy (it didn't), while CBT methods get to *have philosophical legacies* in stoicism and hedonism. We are also distracted by critiques of new therapies that don't comprehend the model. But above all, it is distracting to see the wasted potential of collaboration because scientists are more motivated to preserve their cherished models, which, like all theories, will inevitably be outdated sooner or later.

Our clients and communities deserve the partnership of behavior therapists in the pursuit of reducing human suffering. Ralph Waldo Emerson said, "To map out a course of action and follow it to an end requires courage," and I might add that for the mission of cartographers and behavior therapists, it requires collaboration, too.

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Kohlenberg, R. J., Hayes, S. C. & Tsai, M. (1993). Radical behavioral psychotherapy: Two contemporary examples. *Clinical Psychology Review, 13*, 579-593.

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Address correspondence to Daniel J. Moran, Ph.D., 62 W. Washington St., Joliet, IL 60432; e-mail: djmoran@trinity-services.org.

Special Series: ABCT Mentors

Reflections on My Mentor

Jeffrey Rudolph, *Weill Medical College of Cornell University*

EDITOR'S NOTE: I have reproduced Dr. Rudolph's cover letter because I think it captures the spirit of the series nicely.

Reflecting on my career as a clinical practitioner, it has recently occurred to me (I just turned 60) the extent that my professional and personal worlds have intertwined and the pivotal role that my mentor, Arnold Lazarus, has played in both. As senior clinicians and fortunate members of the second generation of behavior therapists, many of us can be considered as members of a "behavior therapy" sandwich generation. On one hand we have been inspired by the masters and seminal thinkers that have been our mentors and, in some cases, close friends. On the other hand, as we are joined and eventually replaced by this next generation of behavior therapist we assume the role of mentor, which should naturally include a responsibility to inspire and share the subtle, however poignant and often personal lessons, we have been fortunate enough to have learned.

I therefore wrote a piece I had originally intended to submit to the Behavior Therapist *that essentially highlighted the influence that Arnold Lazarus had in both my personal and professional life. When I shared the draft with Arnie he suggested that* tBT *feature a special series whereby senior behavior therapists be invited to submit similar accounts related to how they have been influenced in their professional and personal lives by a mentor, and that the piece that I wrote about him could initiate the series. Quite candidly, I believe readers of* the Behavior Therapist *of all stripes would be most interested.*

In closing, I would like to mention that I think it is unfortunate that too many of us, after our mentors are no longer with us, take the time to both reflect and share with others the powerful influence their mentor has had on their life. Why does it have to be through a eulogy or posthumous tribute? Why not now and through this venue?

—Jeffrey A. Rudolph, Psy.D., ABPP
Department of Psychiatry, Weill Medical College of Cornell University

* * *

About 35 years ago in a crowded elevator at Essex County Hospital I found myself facing Arnold Lazarus. He had been giving a workshop on multimodal therapy, and I was a newly minted doctoral student at Rutgers. I nervously asked his permission to take his class in behavior therapy. That moment spawned the beginning of a friendship that profoundly influenced my life.

As a member of the second, and in retrospect, a privileged generation of behavior therapists, I realize that our time on the professional stage is drawing to an end as the next generation of clinicians prepares to take our place. I consider myself more fortunate than most to have been given so much by Arnie through the years. These gifts, while often subtle, have served to strengthen me during times of doubt, inspire me when I felt jaded or empty, and redirect me when I would lose my way—both personally and professionally. Upon reflecting, I now realize that such subtleties often make a lasting impact. I guess that would jibe with what Arnie Lazarus considers the nonspecific variables that transcend manualized techniques. He has taught me that worth can be measured not only by one's supporters, but also by one's critics, and that there is a world of difference between being technically proficient and an effective therapist. As to relishing criticism, I, along with many of his followers, will never take this to the extent that he has; he has a passion to be a contrarian and an appetite for a controversial debate. As for his therapeutic virtues, most of us who have viewed him in action are familiar with his artistry. I for one have benefited through the years by observing his capacity to zoom in on subtle cues that tend to elude the scrutiny of many clinicians.

Another of Arnie's personal contributions to me stems from his determination to counterpunch when cornered or weakened. An apt use of terms when one considers that as a puny kid growing up in South Africa he decided to take boxing lessons and lift weights in order to teach a lesson to a schoolmate who had been bullying him. To this day he proudly displays his muscled physique through a worn black-and-white photo posted on his refrigerator.

Still another gift I value is Arnie's sense of balance and love of fun. He has actually written several articles on the importance of play and replenishment. For those who don't know him well, his demeanor can at times appear serious-minded or dismissive, but in most instances, Arnold Lazarus will tend to leave you with a joke or an anecdote extolling the virtues of the lighter side of life. Because I am a consummate workaholic, I have especially appreciated this. For me it's almost paradoxical to view hanging out with Arnie as ever being a waste of time,

although I will admit it wasn't always comfortable, especially in the early days. I can recall back about 30 years ago when in his office at Rutgers he watered his plants and disposed of his garbage for virtually the whole hour of our supervisory meeting. Interestingly, not much has changed through the years. One weekend last month, I arrived at his home to discuss a matter of personal importance. His first words were, "Let's put the chat on hold. Join me in viewing this terrific episode of *Law and Order* and then we'll shmooze." The point is this: At the tender age of 60 I have come to realize that fun is best when it's shared with someone you can truly "kick back" with, and pretense has no place in real relationships.

One final gift my mentor has given me relates to not taking myself too seriously. This one I try to inject into my clinical work as often as possible. I can readily admit that Arnie, despite my resistance, has succeeded in desensitizing me to criticism. While numerous examples come to mind, I will simply state that Arnie has rarely missed an opportunity to "trash" me for my poor spelling, or upbraid me in public for my deficient and embarrassing use of the English language (and I'm sure he will do so when I show him this draft). Despite this, I have finally acquired from my mentor, through what we could term "nonreinforced exposure," the ability to laugh at myself. Similarly, I've learned that who you are in your professional role is not so different from who you are in your life, and that projecting a professional demeanor can be at times quite limiting. Thus, to naturally project your humanity, warts and all, is to make you more effective as a clinician and more loved as a friend.

As far as relationships are concerned, I have realized that through the vast and diverse body of ideas and writings generated by Arnold Lazarus over the course of this last half century, one pervasive theme can be detected. It is the importance of learning who a person really is and valuing his or her core. Whether it is a therapeutic relationship, a family member, or a meaningful friendship, people are people and taking individual perspectives and sensibilities into account is essential. In multimodal terms, this pertains to "bridging" or meaningful engagement with others through time, effort, and nonjudgmental empathy. Arnold has demonstrated this in a prolific lifetime of devotion to the welfare of people. To me he represents the consummate mensch, an individual true to himself, yet ever concerned for the needs of those who cross his path. I wish him many more years of health and vitality as he continues to build his legacy amongst friends and colleagues.

Department of Veterans Affairs

Clinical/Counseling Psychologists

The Psychology Service and Mental Health Service Line of VA Boston Healthcare System (VABHS) are seeking clinical/counseling psychologists trained in the clinician-scientist model across a number of content domains and inpatient and outpatient clinical settings. Openings reflect significant program expansion across our three major medical campuses (Jamaica Plain, Brockton, and West Roxbury) and include positions in substance abuse, neuropsychology, geropsychology, rehabilitation psychology, posttraumatic stress disorder, mood and anxiety disorders, and psychosocial recovery.

VABHS is affiliated with both Boston University and Harvard University. It is also home to multiple national research centers with strong behavioral science/neuroscience components, clinical centers of excellence, and outstanding Psychology training programs at practicum, internship, and post-doctoral levels. Our rich academic environment provides ample opportunities for integration of clinical duties with research and training. The successful applicant will have strong clinical skills and experience providing evidence-based treatments, and the demonstrated commitment to integrate research and/or teaching into the clinical environment. Qualified applicants for all positions will have, at minimum, a doctoral degree from an APA-accredited graduate program in psychology and completion of an APA-accredited psychology internship. Neuropsychology qualifications also include completion of Division 40-consistent internship and post-doctoral level training. Current licensing or license-eligibility (in any state) is required.

Salary and benefits are competitive. More information about salary and benefits is available at: **www.opm.gov**. Send curriculum vitae, 3 references, and a letter of interest indicating the subspecialty(s) you wish to be considered for as well as your level of interest for inpatient/outpatient or both, to: **Jennifer J. Vasterling, Ph.D.,** at **boston.clin.counsel.psychologist@va.gov**

VA Boston Healthcare System is an Equal Opportunity Employer committed to enhancing diversity within our staff. Must be a U.S. citizen.

Classified

ASSISTANT OR ASSOCIATE PROFESSOR (RESEARCH). The Department of Medicine at Rhode Island Hospital, one of the affiliated hospitals of The Warren Alpert School of Medicine at Brown University, seeks a research faculty member on or before July 1, 2009. This is a renewable, non-tenure track position. The successful candidate must qualify for a faculty position at the rank of Assistant or Associate Professor (Research). Associate Professor level candidate should have a national reputation and scholarly achievements.

Applicants must have a doctoral degree in psychology, sociology, social work or equivalent with research experience and interest in women's health, correctional health, international health, cancer screening, pain medicine, substance abuse, mental health, and/or HIV disease. Primary responsibilities include the applicant is expected to develop an independent funded research program and participate in Brown's funded research program working with multidisciplinary group of investigators whose adult and adolescent studies include behavioral interventions, health services research, international research, community-based research, and work with incarcerated populations.

Please send CV and letter of interest to: Peter Friedmann, MD, MPH, Rhode Island Hospital, Division of General Internal Medicine Research, 593 Eddy St.-Plain St. Bldg., Providence, RI 02903. Review of applicants will begin immediately and continue until the search is successfully concluded. Rhode Island Hospital is an EEO/AA employer and actively solicits applications from minorities and women.

The ABCT Convention Workshop Proposal Submission Process: Frequently Asked Questions

Carolyn M. Pepper, *University of Wyoming*

As the current chair of the Workshop Committee, I receive a lot of questions about the process of getting a workshop accepted into the convention. The workshop submission deadline is earlier and the review process is different from other conference submissions. Unfortunately, detailed information is not available on the ABCT website (a problem we will be addressing soon). In an effort to clarify the process, here are some Frequently Asked Questions (and answers!).

What is a workshop?

A workshop is a 3-hour presentation, typically presenting an overview of a treatment. Conference attendees must purchase tickets to attend workshops.

How do I propose a workshop?

To propose a workshop, send a 250-word abstract and CVs of all presenters to me at cpepper@uwyo.edu. The deadline for submissions is February 1, 2009.

How quickly are decisions made?

We try to send out acceptance and rejection emails by early March, prior to the regular conference submission deadline.

How competitive is the selection process?

We receive 50 to 80 proposals each year. We are able to accommodate about 20 workshops.

How are workshops evaluated?

Our primary goal is to select workshops that will be of interest to ABCT conference attendees. We use data from the past several years on attendance numbers at all workshops to guide these decisions. If we are considering repeating a workshop, we also look at participants' evaluations of workshops, selecting those that were highly rated in the past. We also take into account how well the submissions fit the conference theme. And of course, consistent with ABCT values, treatment approaches must have empirical support.

The trickiest part in putting together a program of workshops is creating balance among various topics. We strive to cover a wide variety of therapy approaches, psychological disorders, and age groups. We often get multiple strong submissions for very similar workshops, particularly for anxiety disorder treatments and couples treatments, but we can only select one or two. Popular previous workshops are often repeated, but we like to offer new workshops as well.

Finally, we work with the rest of the Program Committee to balance possible workshops with offerings for institutes and the master clinician series. With so many fascinating potential topics, the Program Committee makes every effort to create a program that will offer something for everyone. We work together through meetings at the annual convention, conference calls, and lengthy e-mail discussions to develop an enticing program.

Are there particular topics that you are looking for?

Many states require continuing education units in ethics to maintain licensure, so we try to offer a workshop that will fulfill those requirements. We also look for workshops on newly developed treatments and approaches with culturally diverse populations. If you have an idea for a workshop, send in a proposal.

Do you ever invite presenters for workshops?

Yes. In the Program Committee meeting at the convention, we begin to develop a list of topics that we would like to see presented at the following conference. If we do not have an appropriate proposal, we extend invitations to possible presenters.

How do I submit a proposal for a master clinician series or an institute?

You don't. Master clinician series (a 2-hour format limited to 40 participants) and institutes (a 5-hour format) are by invitation only. Workshops serve as the "gateway" to these other formats. The most successful workshops (large enrollments and high evaluations) are invited to present in these formats.

Are workshop proposal reviewers blind to the presenters?

No. We want to know who the presenters will be. Our most popular workshops are often presented by well-known scholars.

Are workshop presenters paid?

Up to two presenters can receive free conference registration. We do not reimburse travel expenses.

Where can I go for more information?

Feel free to e-mail me at cpepper@uwyo.edu with any additional questions.

. . .

Address correspondence to Carolyn M. Pepper, University of Wyoming, Department of Psychology, Dept. 3415, 1000 E. University Ave., Laramie, WY 82071; e-mail: cpepper@uwyo.edu

Call for

WORKSHOP SUBMISSIONS

43rd Annual Convention | November 19–22, 2009

New York

Please send a 250-word abstract and a CV for each presenter to:

Carolyn M. Pepper, Ph.D.
University of Wyoming
Dept. of Psychology, Dept. 3415
16th and Gibbon
Laramie, WY 82071
or email: cpepper@uwyo.edu

DEADLINE for submissions: February 2, 2009

Find-a-Therapist

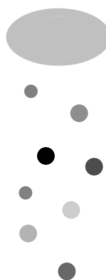
...and like-minded professionals on the ABCT website.

The Clinical Directory and Referral Issues Committee continues its online interview series, accessible on the home page of the ABCT website. These interviews highlight outstanding, lifetime ABCT members, discussing their clinical practice, professional activities, and views on CBT. This series also features the unique ability to look up topics of interest from within the body of the interview. In our current interview, we invite readers to learn more about **Gerald Stein, Ph.D.**, who has been a member of ABCT for over 35 years. Dr. Stein has a private practice in Skokie and Oak Brook, Illinois, and he has been, and remains, actively involved in his local community. His clinical focus is on the treatment of depression and anxiety disorders, and provision of marital therapy. In the interview, Dr. Stein shares his views on starting a private practice in the current economy, "must reads" to improve clinical skills, the future of behavior therapies, and other important topics. To read the interview with Dr. Stein, go to www.abct.org, and select MEET ABCT'S FEATURED THERAPIST, located under the SPECIAL TOPICS column. For an archive of ABCT's featured therapists, go to:

http://www.abct.org/mentalhealth/findTherapist/

Don't forget to be listed in the Find-a-Therapist directory. To become listed or to update your listing, select member log in on the ABCT home page, log in, and select *Find-a-Therapist Directory and Referral Service* "join now."

This
will
be your
last issue
of *tBT*



if you do not renew your ABCT membership by Dec. 30

complex cases · *master clinicians* · *live sessions*

Clinical Grand Rounds

TWO NEW SESSIONS!

➔ **OCD Never Rests, So Why Should Treatment? Using Scripts to Enhance Exposure and Response Prevention**

JONATHAN GRAYSON, *Anxiety and Agoraphobia Treatment Center, Bala Cynwyd*

Grayson focuses on helping the OCD sufferer to understand OCD through the creative use of guilt, Socratic reasoning, and individualized therapeutic scripts to foster both the acceptance of treatment goals and the motivation to follow through with EX/RP. Special attention will be given to the use of scripts, which can be thought of as evolved imaginal exposure tapes, representing a true fusion of cognitive and behavioral techniques.

DVD $55 (ABCT members)
$100 (nonmembers)

➔ **Preparation, Change, and Forgiveness Strategies for Treating Angry Adults**

HOWARD KASSINOVE, *Hofstra University*, and **RAYMOND CHIP TAFRATE**, *Central Connecticut State University*

Kassinove and Tafrate show how to reduce adult anger based on an anger-episode model. The program is based on the repeated analysis of specific anger episodes. The goal is to reduce angry reactivity to aversive stimuli by repeated practice of more adaptive responses and/or by changing the cognitive perspective about the anger trigger.

DVD $55 (ABCT members)
$100 (nonmembers)

orders: www.abct.org

Do You Have the Vision to Take ABCT Forward? Then Run for ABCT Office!

Kristene Doyle, *Albert Ellis Institute, Chair, Leadership & Elections Committee*

Why not make this the year that you share your vision with fellow members of your professional home? Be part of a wonderful democratic process of getting your voice heard and your ideas communicated by nominating yourself or someone you think who has what it takes! Now is your opportunity to make a difference. By serving in one of these offices, you will not only gain a sense of accomplishment for contributing to your profession's growth, you will also get the chance to work closely with ABCT's central office staff, connect with old colleagues, and make new friends.

Those members who receive the most nominations will appear on the ballot. Members then vote on the candidates of their choice to serve for 3 years. The candidate elected as President serves as elect, sitting, and past; the Secretary-Treasurer also serves as the Chair of the Finance Committee. The candidate who wins the Representative-at-Large position in the 2009 election will serve as the liaison to Convention and Education Issues. The individuals elected serve a year as "elect" to make certain all the fine details are learned, ensuring a seamless transition. Once every 3 years a strategic planning meeting is held to guarantee that all elected members participate in at least one planning session during their term of office. However, given that ABCT is co-sponsoring the 2010 World Congress with Boston Univeristy's Center for Anxiety Disorders and School of Social Work, the next strategic planning retreat will be held in 2011.

Don't forget, ABCT's bylaws were amended to permit electronic voting. Even if you do not run for office, please make sure to vote for the individuals you believe will do the best job as soon as you receive your ballot.

How to Get Nominated

If you believe you or someone you know have the vision, skills, and commitment to serve, then take a risk! Visit the membership sign-up booth at this year's convention and drop your nominations in the CALL FOR NOMINATIONS box. You can also mail in your form to ABCT's Central Office, or fax it to (212) 647-1865. Original signatures are required, so please do not email your nominations. All full members in good standing are eligible to be nominated. You can nominate as many members as you wish. For detailed descriptions of each of the positions, visit our website, www.abct.org.

Specifics: The individual elected as President-Elect (2009-2010) will serve as ABCT's President from 2010 to 2011. The Representative-at-Large candidate will serve November 2009 through November 2012. The year of transition for Secretary-Treasurer will be 2009-2010, with the official term of office being November 2010 to November 2013.

The Annual Meeting of the Board takes place the Thursday of the convention, with monthly conference calls the remaining 10 months of the year, the only exception being August. The President, Immediate Past President, President-Elect, and the Secretary-Treasurer comprise the Executive Committee. Conference calls are scheduled when necessary to guarantee ABCT continues to run efficiently and effectively. It is expected that candidates have knowledge of ABCT's mission, bylaws, strategic plan, and existing priorities. If you believe you have what it takes, or know a colleague who does, we strongly encourage you to nominate yourself or someone else.

NOMINATE the Next Candidates for ABCT Office

I nominate the following individuals for the positions indicated:

PRESIDENT-ELECT (2009–2010)

____

____

REPRESENTATIVE-AT-LARGE (2009–2012)

____

____

SECRETARY-TREASURER (2010–2013)

____

____

NAME (printed) ____________________

SIGNATURE (required) ____________________

2008 Call for Nominations

Every nomination counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 2, 2009, will be counted.**

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

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

Call *for* Award Nominations

The ABCT Awards and Recognition Committee, chaired by David A. F. Haaga of American University, is pleased to announce the 2009 awards program. Nominations are requested in the following categories:

Outstanding Contribution by an Individual for for Educational/Training Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions toward educating and training behavior therapists. Past recipients of this award include Gerald C. Davison in 1997, Leo Reyna in 2000, Harold Leitenberg in 2003, and Marvin R. Goldfried in 2006. Please complete an on-line nomination form at www.abct.org. Then, e-mail the completed forms to dhaaga@american.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Education/Training, 305 Seventh Ave., New York, NY 10001.

Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Past recipients of this award include Binghamton University Clinical Psychology Program, University of Washington Clinical Ph.D. Program, the Psychology Internship and Postdoctoral Programs at Wilford Hall Medical Center, the May Institute, and Hofstra University's Ph.D. Program in Combined Clinical and School Psychology. Nominations for outstanding educational/training programs should be accompanied by a summary of information in support of the program, as well as other supporting materials essential for reviewing the program. Please complete an on-line nomination form at www.abct.org. Then, e-mail the completed forms to dhaaga@american.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Avenue, NY, NY 10001.

Student Dissertation Awards:

- **The Virginia A. Roswell Student Dissertation Award**
- **The Leonard Krasner Student Dissertation Award**

New this year, we are pleased to announce that we will be presenting two student dissertation awards! Family and friends of ABCT founding member Leonard Krasner wanted to commemorate Dr. Krasner's memory and contributions to the field of the behavioral therapies by offering this named award in the same manner as the Virginia A. Roswell Student Dissertation Award.

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

Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include Jon Kabat-Zinn, Nora Volkow, John Allen, Anne Fletcher, Jack Gorman, Art Dykstra, and Michael Davis. Please complete an on-line nomination form at www.abct.org. Then, e-mail the completed forms to dhaaga@american.edu. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT Award, 305 Seventh Ave., New York, NY 10001.

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include Albert Ellis, Leonard Ullman, Leonard Krasner, Steve Hayes, and David H. Barlow. Please complete an on-line nomination form at www.abct.org. Then, e-mail the completed forms to dhaaga@american.edu. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement Award, 305 Seventh Ave., New York, NY 10001.

NOMINATIONS FOR THE FOLLOWING AWARD ARE SOLICITED FROM MEMBERS OF THE ABCT GOVERNANCE:

Outstanding Service to ABCT

Members of the governance, please complete an on-line nomination by visiting www.abct.org. Then, e-mail the completed forms to dhaaga@american.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT Award, 305 Seventh Ave., New York, NY 10001.

Questions? Contact: David A. F. Haaga, Ph.D., Chair, ABCT Awards & Recognition Committee; e-mail: dhaaga@american.edu

Nominate on line: www.abct.org

Deadline for all nominations:
Monday, March 2, 2009

Named Awards

What better way to acknowledge the contributions made to the field and celebrate the love of learning of a member than a named award? The Awards and Recognition Committee is actively working on an array of options to commemorate colleagues. As we develop a named awards program, please feel free to contact David A. F. Haaga (dhaaga@american.edu), Awards and Recognition Committee Chair, or Mary Jane Eimer (mjeimer@abct.org), Executive Director, with questions. Once the program is developed, we will have information posted on our website.

ANNOUNCING

The Neil S. Jacobson Research Awards for Outstanding and Innovative Clinical Research

Colleagues, friends, and family of Neil S. Jacobson are pleased to announce the Neil S. Jacobson Research Awards for Clinical Research.

On June 2, 1999, Neil S. Jacobson died suddenly and unexpectedly of a heart attack. He left behind a stunned and grieving family, cadre of students, and colleagues and collaborators. In the years since his death, Neil's work has stood the test of time, and his ideas and visions continue to shape his three areas of scholarship: marital therapy, domestic violence, and the treatment of depression.

The week prior to his death, Neil told his graduate student, Sona Dimidjian, that he was most proud of two aspects of his professional life. The first was developing and maintaining his three distinct and remarkable programs of research--marital therapy, domestic violence, and the treatment of depression. The second was that he was gifted at selecting the best possible graduate students. To honor that which Neil valued most as a scientist, we have created three graduate student/early career research awards that will be announced at the November 2009 ABCT meeting in New York City.

About the Award: The award will fund graduate student clinical research (including those who are within 5 years of having completed their Ph.D.), with an emphasis on dissertation research. The award will provide up to $5,000 for research projects that are relevant to the understanding and treatment of people with difficult life problems. Projects that involve new initiatives that help to move the field in creative directions and that demonstrate promise for continued, ongoing development and investigation are particularly welcome. This award is not limited to graduate student members of ABCT, and is open to all clinical research students and those in their early career.

Application: Proposals should describe the aims, background and significance, and methods, and should clearly state how the project will advance clinical research efforts. Proposals should be a maximum of 3 single-spaced pages in length, plus references, and should include a 1-page budget. Finally, proposals should be accompanied by a letter of support from a faculty mentor.

Download an application form at www.abct.org.

Review Process: Proposals are due May 1, 2009. Please e-mail 1 copy of your proposal to Virginia Rutter, Ph.D., at vrutter@gmail.com, and mail 1 hard copy of your proposal to ABCT, The Neil S. Jacobson Research Awards for Outstanding Innovative Clinical Research, 305 Seventh Ave., New York, NY 10001. Applicants will be notified of the committee's decisions by September 1, 2009. Award recipients will be announced at the November 2009 ABCT convention in New York City and invited to a reception in their honor and in honor of Neil S. Jacobson.

The Neil S. Jacobson Research Awards Committee includes Professors Andrew Christensen (UCLA), Sona Dimidjian (UC Boulder), Steven Hollon (Vanderbilt), Bob Kohlenberg (UW Seattle), and Virginia Rutter (Framingham State College).

Archives

videos

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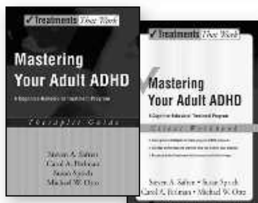

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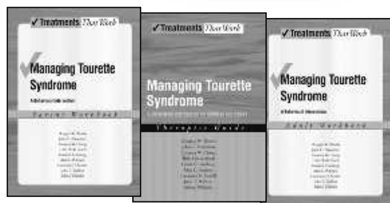

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