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the Behavior Therapist

Contents

President's Column

Dissemination of CBT Research Results: Preaching to the Uninterested or Engaging in Scientific Debate

Raymond DiGiuseppe, *St. John's University*

The ABCT Board of Directors met for its 3-year planning retreat in June in Philadelphia. Presidents and Board members come and go. But because of these planning retreats, the organization pursues consistent goals and plans over the terms of individuals. I will be reporting on this planning retreat in several columns. In this column, I would like to discuss just one issue that we addressed at the retreat: the association's commitment to the dissemination of scientific knowledge about effective treatments.

At the 2004 planning retreat, the ABCT Board listed the dissemination of information concerning research on efficacious treatment as a high priority. This year, the Board reaffirmed the association's commitment to the goal of disseminating scientific information. Over the years our conversations on dissemination have focused on ways to get the word out. We have focused on what types of workshop, publications, Web pages, and other means of communication will effectively communicate to psychotherapists the results of research findings on empirically supported treatments. Dissemination aims at helping psychotherapists use empirically supported treatments to help serve the public. Successful dissemination usually means that therapists de-

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velop a belief in the cognitive behavioral model, learn to think within the CBT paradigm, and develop the skills to deliver specific empirically supported treatments.

As Michael Otto (2006) pointed out in his *tBT* column last year, only a small percentage of mental health professionals practice CBT, despite the strong evidence for its effectiveness. At this year's retreat we asked ourselves, If we have such strong scientific evidence, why are only a small percentage of psychotherapists using interventions we have espoused?

We considered what perspectives other psychotherapists believe that make our attempts at dissemination fall on deaf ears. Most ABCT members believe that empirically supported research should guide clinical practice. Many ABCT members have actively supported the creation of lists of empirically supported treatments (ESTs) for clinical problems since Division 12 (Clinical Psychology) of the American Psychological Association (APA) created the task force to identify ESTs (Task Force, 1995), and the Society of Clinical Child and Adolescent Psychology (Division 53 of APA) established a similar task force to review the outcome literature for children and adolescents.

However, considerable controversy exists in the field concerning the data base that should guide clinical practice (Goodheart, Kazdin, & Sternberg, 2006; Norcross, Beutler, & Levant, 2006). We suspect that perhaps two competing ideas in the psychotherapy literature have interfered with our dissemination efforts. The first is the idea that all psychotherapies are equally effective, and the second is that common factors, therapist, and relationship variables account for the majority of the variance in therapy outcome studies. Before we embark on dissemination efforts, perhaps we should engage in a conversation with those whom we want to convert and find out why they believe what they do. Such engagement may lead to improvements in CBT as well as winning over potential converts.

The controversy surrounding ESTs resulted in the Presidential Task Force of the American Psychological Association, which explored how clinicians should determine what evidence to consider in making treatment decisions. This task force recommended that "empirically based practice results from the integration of the best available research with clinical expertise in the context of patient characteristics, cul-

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David Reitman, Ph.D., Center for Psychological Studies, 3301 College Avenue, Nova Southeastern University, Fort Lauderdale, FL 33314-7796

ture, and preferences" (APA Presidential Task Force on Empirically Based Practice, 2006).

Many psychotherapists assign less weight to ESTs because they believe that all psychotherapies have demonstrated equal effectiveness or what is called the "Doo-Doo Effect." This expression comes from a line from Lewis Carroll's novel *Through the Looking-Glass* (1941/1871). As spoken by the Red Queen, "All have won and all must have prizes." Several reviews of the psychotherapy outcome literature have concluded that psychotherapy definitely works, and that all types of psychotherapy work equally well (Lambert, 2004; Wampold, 2001).

How many ABCT members have accepted the "Doo-Doo" verdict? An informal, unscientific, unrepresentative sample of members I know suggested not many. Otherwise, why belong to an organization concerned with a specific orientation to treatment? For whatever the reason, we have failed to engage in the scientific debate around this issue. If we want to expand the circle of psychotherapists who practice what we believe to be the most effective psychological interventions, we need to address this issue. Either we rebut these conclusions, conduct new research to show they are wrong, or we accept them and change our message. Perhaps we will learn where our evidence is weak. Perhaps we will learn to improve our interventions.

In every outcome study I have read, some clients remain unchanged by the intervention. Understanding that multiple interventions work for the same disorder could lead to some important findings. Perhaps the same type of people are helped by the intervention. A theory of behavior change needs to account for these results and such a new theory may lead to more effective interventions. Perhaps we could learn why some people respond to one intervention and other people respond to another. Such results could lead to a truly prescriptive psychotherapy. However, ignoring the claims that all therapies are equally effective lends credence to the "Doo-Doo" verdict and suggests that we have a message based on a theoretical model no better than any other.

What is immediately clear from reading the psychotherapy outcome literature is that not all psychotherapies receive the same degree of empirical investigators. What conclusions can we draw when some interventions are underrepresented in the empirical research of treatments for a disorder? The lack of research on a specific treatment for a specific disorder does not lead to the conclusion that the intervention is not effective. It just remains untested. Some psychotherapists may take the "Doo-Doo" verdict as an endorsement for any therapy with any clinical problem despite the lack of evidence. Perhaps we need to ask ourselves if the logic of null hypothesis testing is sufficient to justify the use of clinical procedures. Perhaps those who propose and practice an intervention bear the burden of providing evidence for its efficacy. Justification to practice an intervention may need to rely on a more accountable standard than what is presently acceptable.

An area of research that exemplifies the problem of drawing conclusions where few research studies support the efficacy of other forms of intervention exists for a topic with which I have some knowledge: the treatment of clinical anger (DiGiuseppe & Tafrate, 2007). All but one study in the published and nonpublished outcome literature for anger treatments tests some type of cognitive behavioral treatment. The one exception tested Yalom's existential group therapy. No studies have yet appeared testing client-centered, psychodynamic, Gestalt, or emotion-focused treatments for anger or that compare these alternative treatments for anger to CBT. Thus, we can conclude that evidence supports the efficacy of CBT in treating anger. No evidence exists to support the claims of other treatments or any claim that CBT is more effective than other treatments. Is the practitioner who uses psychological interventions that have not been tested for the treatment of anger justified to continue their use? Or do we expect the practitioner to use empirically supported interventions first before starting a nontested intervention? We need scientifically acceptable and clinically accountable guidelines for drawing conclusions concerning which therapies have the strongest empirical support and should be considered the first-line intervention in treating a clinical problem. It is consistent with our values that clinicians use ESTs when they are well established. Clinicians can use other unsupported interventions when special circumstances dictate that they might work better than the established EST. However, what special circumstance would warrant not using well-researched interventions? The devil is in the details here. Although the APA (2006) guidelines on evidence-based practice partially address this issue, more discussion and clearer decision rules are needed by those who practice to decide what types of evidence would justify avoiding a treatment with strong empirical evidence.

Bruce Wampold (2001) best exemplifies the position that common factors account for a larger percent of the variance in outcomes than technique or theoretical orientation. But others have contributed as well. An attempt to highlight the role of the therapeutic relationship on treatment outcomes led the Division of Psychotherapy (29) in 1999 to establish a task force to identify and disseminate information on the empirically supported relationships on psychotherapy outcomes (Norcross, 2001). This task force reviewed evidence that many relationship variables, such as therapeutic alliance, empathy, positive regard, therapist congruence, and self-disclosure, affect psychotherapy outcomes (Norcross, 2002).

Wampold (2001) proposed a model of psychotherapy based on research that reaches very different conclusions than those espoused by our own. Wampold (2001) believes that most therapy outcome research is driven by the medical model that expects to find differences between treatments and fails to look at common variables. His model maintains that psychotherapy common characteristics exist that cut across all therapies. Finding the common characteristics that operate in all psychotherapies will increase therapy efficacy. He proposes that the common characteristics of psychotherapy are an emotionally charged, confiding relationship with a helper, a healing setting with the expectation of professional assistance, a plausible explanation for symptoms and treatment, and a ritual that requires active participation of therapist and client.

Wampold (2001) and Okiishi et al. (2006) have shown that considerable variation in therapy outcome results from the person of the therapist. Although we do not yet know which therapists are most effective and why, clear differences emerge in therapy outcomes across different therapists doing therapy. Wampold (2001) proposed that the degree of variance in therapy outcome studies is apportioned as follows. Thirty percent of the variance is accounted for by common characteristics. The type of treatment (i.e., CBT, client-centered, psychodynamic, etc.) accounts for 15%. The person of the therapist accounts for another 15%. Many psychotherapists espouse Wampold's perspective. It rests on well-established research with large samples and uses well-accepted multivariate statistical procedures to develop its conclusions.

Although Wampold presents his model as a paradigm shift away from psychother-

apy focused on technique, considerable growth could occur in CBT if we embraced this model and studied the common factors, therapist, and relationship variables in CBT outcome studies. Those who follow the Wampold model often perceive CBT therapists as failing to attend to relationship variables. While this is untrue, CBT research has focused more on the effect of techniques than relationship variables. Dave Barlow (personal communication, 2007) has suggested that techniques, common factors, and therapist variables all account for some percentage of the variance in outcomes, but each could account for different percentages of variance in outcomes with different disorders. Perhaps technique matters more in treating ADHD but less in treating oppositional defiant disorder, where rapport and the alliance might account for more variance than they did in treating ADHD. Such hypotheses could tell us how all these variables interact. By testing therapy effects against therapist and common factor effects, we may come to a better understanding about what leads to effective therapy. Behavior therapists have a long history of research studying human interactions. Think of how far our understanding of marital interactions and parent-child interactions have come. Applying the same research strategies to therapist-client interaction could expand our knowledge of what the most effective therapists do in session.

Our attempts at dissemination have been met by resistance because of the beliefs of our intended audience. We can continue our attempts to convert them or we could engage in real scientific dialogue and investigation. In so doing we could increase our understanding of the field and produce more effective psychological interventions. This, of course, is what we are all interested in accomplishing.

To investigate these issues, the Board created a task force to identify empirically supported treatment principles. We recognize that the Society of Clinical Psychology (Division 12 of APA) and the Society of Clinical Child and Adolescent Psychology (Division 53 of APA) have similar task forces. The ABCT Board believes that the creation of another task force is not redundant. Multiple organizations engaged in defining, identifying, and disseminating ESTs expands the discussion of ESTs, increases the reliability of the findings, and lends greater support to the notion that treatments should be driven by research data. Michael Otto will chair our task force. You will be hearing more about this task force in the future.

References

American Psychological Association Presidential Task Force on Evidence Based Practice. (2006). Evidence based practice in psychology. *American Psychologist, 61*, 271-285.

Carroll, L. (1941/1871). *Through the looking-glass and what Alice found there*. New York: The Heritage Press.

DiGiuseppe, R., & Tafrate, R. C. (2007). *Understanding anger disorders*. New York: Oxford University Press.

Goodheart, C. D., Kazdin, A. E., & Sternberg, Robert J. (Eds.). (2006). *Evidence-based psychotherapy: Where practice and research meet*. Washington, DC: American Psychological Association.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.). New York: Wiley.

Norcross, J. C. (2001). Purposes, processes, and products of the task force on empirically supported therapy relationships. *Psychotherapy: Theory, Research, Practice, and Training, 38,* 345-356.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Norcross, J. C., Beutler, L. E., & Levant, R. F. (Eds.). (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions.* Washington, DC: American Psychological Association.

Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62*, 1157-1172.

Otto, M. W. (2006). Disseminating CBT: By the 10,000 or by the 1. *the Behavior Therapist, 29*, 197-198.

Society of Clinical Child and Adolescent Psychology, Division 53, American Psychological Association, & the Network on Youth Mental Health. (2007). *Evidence-based treatment for children and adolescents*. Retrieved August 13, 2007, from www.wjh.harvard.edu/%7Enock/Div53/EST/index.htm

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically-validated psychological procedures: Report and recommendations. *The Clinical Psychologist, 48*, 3–23.

Wampold, B. (2001). *The great psychotherapy debate: Models, methods and findings*. Mahwah, NJ: Lawrence Erlbaum.

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Journals in Press

C&BP 14(3) — SPECIAL ISSUE

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- Assigning Homework to Couples and Families (*Dattilio & Dickson*)
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Original Research

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- A Preliminary Investigation of the Relationship Between Emotion-Regulation Difficulties and Posttraumatic Stress Symptoms (*Tull et al.*)
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tBT's Greatest Hits: Our 10 Most-Cited Articles

Kyle Boerke, tBT *Editorial Assistant, Nova Southeastern University*

#10 *cited by 10*
Freiheit, S. R., Vye, C., Swan, R., & Cady, M. (2004). Cognitive-behavioral therapy for anxiety: Is dissemination working? *the Behavior Therapist, 27*(2), 25-32.

#9 *cited by 12*
Ladouceur, R., Gosselin, P., Laberge, M., & Blaszczynski, A. (2001). Dropouts in clinical research: Do results reported reflect clinical reality? *the Behavior Therapist, 24*(2), 44-46.

#8 *cited by 12*
Smith, S. G., Rothbaum, B. O., & Hodges, L. (1999). Treatment of fear of flying using virtual reality exposure therapy: A single case study. *the Behavior Therapist, 22*(8), 154-158, 160.

#7 *cited by 12*
Lipke, H. (1999). Comments on "Thirty years of behavior therapy..." and the promise of the application of scientific principles. *the Behavior Therapist, 22*(1), 11-14.

#6 *cited by 13*
Solomon, L. J., & Rothblum, E. D. (1986). Stress, coping, and social support in women. *the Behavior Therapist, 9*(10), 199-204.

#5 *cited by 15*
Zayfert, C., & Black, C. (2000). Implementation of empirically supported treatment for PTSD: Obstacles and innovations. *the Behavior Therapist, 23*(8), 161-168.

#4 *cited by 15*
Azar, S. T., Barnes, K. T., & Twentyman, C. T. (1988). Developmental outcomes in physically abused children: Consequences of parental abuse or the effects of a more general breakdown in caregiving behaviors? *the Behavior Therapist, 11*(2), 27-32.

#3 *cited by 20*
Corrigan, P. W. (2001). Getting ahead of the data: A threat to some behavior therapies. *the Behavior Therapist, 24*(9), 189-193.

#2 *cited by 26*
Foy, D. W., Resnick, H. S., Sipprelle, R. C., & Carroll, E. M. (1987). Premilitary, military, and postmilitary factors in the development of combat-related posttraumatic stress disorder. *the Behavior Therapist, 10*(1), 3-9.

#1 . . . Here it is, your most-cited *tBT* article, *cited by 91*
Keane, T. M., Zimering, R. T., & Caddell, J. M. (1985). A behavioral formulation of posttraumatic stress disorder in Vietnam veterans. *the Behavior Therapist, 8*(1), 9-12.

Note. The order of ranking was determined by number of citations. Ties were broken by awarding the higher ranking to the most recent publication.

For the past three decades, *tBT* has published some extremely important work by many of the most prominent names in behavior therapy. We at *tBT* hope that this top-10 list serves as a token of our appreciation to those of you who have contributed to *tBT,* and we hope that you will continue to provide the readers of *tBT* with the information needed to ensure our continued growth as researchers and clinicians. To the left, we identify the most frequently cited articles appearing in *tBT*. On a related note, we are eagerly anticipating the posting of future issues of *tBT* (as well as many past volumes) on the ABCT Web page, to further enhance the likelihood that work in *tBT* will be read and disseminated.

. . .

In compiling our most-cited list, a number of articles seemed deserving of special recognition. The first is the Baby-on-Board Award, an honor that goes to the most recently published article to make this year's top 10. Coming in at #10 is Freiheit et al.'s (2003) "Cognitive-Behavioral Therapy for Anxiety: Is Dissemination Working?" The Up-and-Comer Award goes to Dr. Patrick Corrigan, for his 2001 article "Getting Ahead of the Data: A Threat to Some Behavior Therapies." Since publication, this work has been cited frequently, jumping up in the rankings with every search. Our final recognition is Most Diversely Cited Paper. It is perhaps no surprise that our most frequently cited paper is also our most diversely cited. Keane et al. (1985) has been referenced in 35 different publications, including 10 peer-reviewed journals outside of the United States. The article has also been referenced in 44 books to date. Again, on behalf of the editorial board, our sincere thanks to all members of the ABCT family for your many valuable contributions to *tBT*. We are confident that the "hits" will keep on coming from the next generation of behavior therapists.

Address correspondence to Kyle Boerke, Nova Southeastern University, 3301 College Ave., Fort Lauderdale, FL 33314; e-mail: boerke@nova.edu

tourette syndrome association, inc.

SKILLS DEVELOPMENT SESSION

Comprehensive Behavioral Management of Tic Disorders in Children and Adults

Douglas Woods, Ph.D., University of Wisconsin-Milwaukee
John Piacentini, Ph.D., University of California, Los Angeles
Alan Peterson, Ph.D., University of Texas Health Sciences
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- a structured functional analytic protocol to identify and ameliorate environmental factors associated with tic expression.

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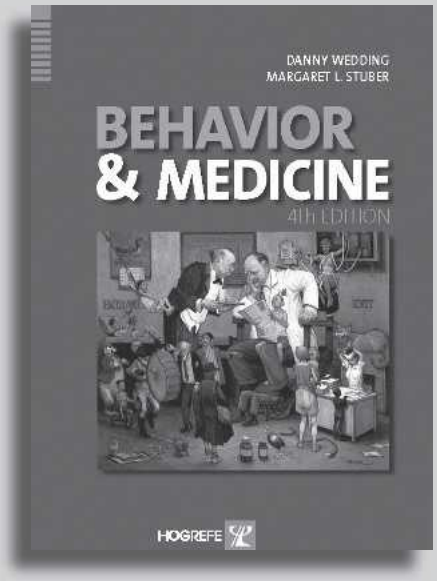

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Clinical Dialogues

A Conversation With Terence M. Keane, Ph.D., Director of the Behavioral Science Division of the National Center for Posttraumatic Stress Disorder

Interviewed by Brian P. Marx, *Boston VAMC*

MARX: The editor of *the Behavior Therapist* asked me to talk with you about your 1985 paper entitled "A Behavioral Formulation of Posttraumatic Stress Disorder in Vietnam Veterans" (Keane, Zimering, & Caddell, 1985). As it happens, that paper is the most cited *tBT* paper of all time. I have a few questions for you about the paper, as well as some questions about contemporary issues in the trauma field. Let's start by talking about the origins of the paper.

KEANE: I think this was the last paper that I wrote at the University of Mississippi Medical Center, where I spent quite a few years early in my career. The paper was invited because we had published a considerable amount of the initial work on this topic (PTSD). This paper was coauthored with Rose Zimering, Ph.D., who is currently at VA Boston Healthcare System and Boston University, and Juesta Caddell, Ph.D., who is a senior scientist at the Research Triangle Institute in North Carolina. Both have remained very active in the trauma field.

Working with people like Patti Resick, Dean Kilpatrick, and John Fairbank, all of whom were very active in the earliest stages of PTSD work, we made a very conscious decision to provide the best PTSD education to AABT members. The result of this was a series of symposia, workshops, and panels on the concepts of PTSD at AABT in the early 80s. We worked very hard to try to educate the AABT members about what we were learning about PTSD. No other conference had as much about PTSD as did AABT! This paper was a result of a communication with the editor of *the Behavior Therapist*, who invited us to provide a behavioral formulation of PTSD.

MARX: Looking back on it now, would you do anything differently? Would you revise the model you presented?

KEANE: There was at the time a considerable amount of tension between those people who were entering cognitive variables into their theoretical models and those who remained purely behavioral in their views. I was very strongly encouraged to remain quite observable in my conceptualization and interventions during the course of my training at Binghamton University and at Mississippi. So what I tried to do here was integrate models that had been applied to anxiety disorders before and extrapolate them to PTSD. The models that I examined included key conceptualizations found in early behavior therapy. Certainly, Dollard and Miller's work was influential, as was the work of Hobart Mowrer and Don Levis. All of these conceptual models influenced my take on this emerging condition. So, the pressure for me was to remain observable in the heuristic model when I knew that this condition was characterized by cognitive and emotional processing problems characterized by the nightmares, flashbacks, and preoccupations with traumatic events. I was, I think, working as hard as I could, perhaps swimming or paddling upstream, to remain true to a strongly behavioral formulation and, at the same time, I knew that the primary contribution that I was making was the notion that we could *treat* cognitions (i.e., thoughts and images of the traumatic event) much the same way that we treated behaviors. In sum, if trauma survivors were avoiding cognitions, then perhaps a treatment that might be helpful would be the presentation of those very cognitions. That was the contribution that was represented in this article. I think that is why it is still cited so often and why people appreciate it. We went a lot further in attributing the disabling psychopathology associated with PTSD to these cognitions. So, would I do it differently? I have done it differently. I certainly have added a wide variety of cognitive components over the years, recognizing some of the limitations. And, actually even writing this manuscript made me realize exactly how limited the more behavioral models were, valuable nonetheless, but limited because you were not really addressing what seemed to be the fundamental sources of conflict for these people—that is, the highly emotionally laden thoughts and images of a traumatic event.

MARX: Let's talk about the cognition piece a bit more. That domain of PTSD has garnered a lot of attention these days from both clinicians and researchers.

KEANE: I was in training from 1973 to 1977 at Binghamton and I can remember attending the first CBT conference in New York City, and hearing many of the people responsible for the cognitive revolution in behavior therapy, including Albert Ellis, Michael Mahoney, and Donald Meichenbaum. I thought that was all very interesting but I never thought it was going to go anywhere [*laughs*]. And, then when I began this work on traumatized war veterans, Peter Lang's paper describing his conceptualization of anxiety was published. It was right at the time that we were beginning to develop programs for PTSD war veterans as well trying to understand the problems of these patients. I can remember having a lengthy conversation with our research group in Mississippi about trying to take Peter Lang's conceptualization of anxiety and apply it to PTSD. I actually had even spoken with Peter Lang on a couple of different occasions and he basically encouraged me to not think of this as a disorder but to think of this as anxiety. He thought that the diagnostic categories might not be particularly useful and that maybe PTSD was not distinguishable on meaningful variables from other kinds of anxiety disorders. Now that's a point that is still open for discussion. It was very clear to me that I was becoming increasingly interested in the cognitive components right from the outset. Yet, when the editor of *the Behavior Therapist* asked me to write what my position was I felt like I needed to rely much more on the observable. I was probably wrong, I probably could have been much more cognitive then, yet I was worried that it wouldn't be received as well. It is hard to second guess things, but it's amazing to me where I see this paper cited; it gets cited in very diverse places, in chapters in other disciplines, and in grant applications. So I think that may account

for some of its popularity. It's very exciting to me.

MARX: Yes, absolutely. My thinking about cognitions has always been very behavioral. I consider thoughts to be another form of behavior.

KEANE: I would encourage you to read Howard Gardner's book, *The Mind's New Science: A History of the Cognitive Revolution* [1987]. He was here at the VA Boston when I first moved here.

MARX: I think I remember that.

KEANE: He probably might have even overlapped with you when you were a technician here. There is nothing more painful for an operant or behaviorally oriented scientist to read Howard Gardner's account of the importance of language and cognitions to a comprehensive understanding of human behavior, and certainly being at VA Boston, which is one of the premiere institutions for behavioral and cognitive neuroscience in the world, led me to feel very comfortable about espousing the importance of cognition in understanding PTSD. You will see over the course of the late 80s, early 90s, the kinds of studies that were done here actually incorporated many cognitive variables and cognitive paradigms.

MARX: Right. And it certainly is the case that your work as well as that of others has led to important advances in understanding cognitive biases related to PTSD.

KEANE: Soon after he moved to Boston, I teamed up with David Barlow to work on an extension of his conceptual model of anxiety to PTSD. That's a model that I personally find extremely important and have been relying upon for designing subsequent projects. I can remember initially reading a paper by Edna Foa, Gail Steketee and Barbara Rothbaum [1989] that appeared in a special issue of *Behavior Therapy* that I edited. This was an important paper in that it was the first paper that extrapolated Lang's theory to forge a cognitive understanding of PTSD. When I read it I was so deeply impressed by it; they really did this in a compelling way. Edna was more advanced in her career and she had already published her *Psychological Bulletin* [1986] paper with Michael Kozak, which took Peter Lang's work and applied it to anxiety disorders. She was more willing than I to take the risk. I appreciated it very much. It was probably more of what I should have done when I wrote the *tBT* piece in 1984, but I didn't have the confidence to do so whereas she was already very well established. This was all very important at this time because there weren't very many people studying PTSD from an evidence-based perspective. Patti, Dean and I and a few other people in the world were at this point already quite active, but there were not that many others. At one of the workshops at AABT that Patti and I conducted in the mid-80s, I remember getting ready to begin when Edna Foa and Barbara Rothbaum entered the room. I can remember commenting to Patti on learning that Edna was applying for NIH grant money to study rape-related PTSD that the field was going to change dramatically—and I was right, absolutely right. The entrance of somebody senior like Edna was going to affect people's interest and the progress that was made in studying PTSD, and she has had a huge impact on the field. When you think of the many academic honors bestowed upon Edna, Dean, Patti, and myself, it's largely due to the early work on PTSD. It opened up an entirely new arena for clinical care, research, and teaching.

MARX: And what do you think that is about? I mean obviously some of this has to do with the fact that the work has been excellent.

KEANE: The work has been consistently strong; the studies borrowed from anxiety disorders but I think this work opened up another whole field of inquiry and practice to behavior therapists. As you may know, there are large numbers of people who study PTSD who were trained in the AABT tradition. And if you go to the trauma conferences, you see just dozens and dozens of the very same people who will the next week go to ABCT and vice versa. It's a very impressive thing. Perhaps a lot of the educational work that we did in the early 80s attracted a lot of very smart and dynamic people to our organization.

MARX: What was the social climate regarding PTSD like when you wrote this paper?

KEANE: The climate had changed already by 1984, but I do remember giving my first lectures on PTSD starting in about 1980, and because there weren't that many people studying or working on the problem I tended to get a lot more invitations than somebody a couple years out of internship. What happened very early was that I was often invited to speak for the sole purpose of becoming a target for

others who had ideas about what shouldn't happen in the field or work that constituted a diversion into areas that were faddish and not scientifically based. It was common for years for me to have to take a deep breath as I walked in front of an audience, because while there would always be people who were very sensitive to the issues that I was raising, there were typically going to be naysayers, and these were at times very vocal, very senior, and very powerful people who would try to point out where I had gone wrong in my thinking about this disorder. But, by 1985 it had changed for the better.

MARX: And it seems now that the pendulum has swung back in that direction.

KEANE: Well, at ISTSS [International Society for Traumatic Stress Studies], this year there was a panel of some very senior people talking about this pendulum and represented were people from Columbia, Harvard, Boston University, Research Triangle Institute, Medical University of South Carolina, etc. The position that I took in my presentation of the various arguments that have emerged in the last 10 years is that this is common, that it is important for there to be controversy, and that it is an important indicator of how central this field is to an understanding of human behavior that people feel very ardently about various issues. But I think it is undeniable that serious, stressful life events and situations can influence the trajectory of people's lives. Most of the time it's short-lived, but for others the effects linger. And certainly there are multiple risk factors, like in any other condition. There are personal risk factors, there are contextual risk factors, and there are biological risk factors. But, we need more information about them as well as how these factors influence the exact shape and form of PTSD longitudinally. I don't believe that even the harshest critics disagree with this summary.

MARX: I guess, for a slew of reasons, professionals who are working with PTSD have had to justify its existence far more so than other *DSM* disorders. There's a whole upcoming issue of *Journal of Anxiety Disorders* focused on problems with the diagnosis. Have you seen that?

KEANE: I did actually get a chance to read virtually all of the papers and, honestly, there wasn't a single criticism that I hadn't heard before. I think those criticisms exist and people who are working scientifically in this field know these criticisms. The *DSM* committees have discussed these as long as I've been on the committees (since 1984) and appreciate what some of the limitations are and that we are working with a categorical system that guides things whether it is the ICD or the *DSM*. We have problems with the boundaries for all these *DSM* disorders. There is nothing about PTSD that's exceptional.

MARX: Well, there may be in one sense, and that is that the *DSM* requires a causal event to meet criteria for PTSD.

KEANE: Well, yes, but so do adjustment disorder and acute stress disorder. But, you are correct that it is seen by some as a concern. Look at the conceptual model with Barlow. It's also referred to by some people as the triple vulnerability model. Triple because of the assigned responsibility to the psychological vulnerability, biological vulnerability and the event itself. So, I don't see that as being particularly troublesome. Rather, I see it as state of the art.

MARX: Neither do I. The diathesis-stress model has been around a long, long time, but for some reason PTSD seems to be disproportionately criticized. Perhaps it's because of the related issue of malingering.

KEANE: I do believe that the problems associated with any of our categories in this system are comparable across the Axis I. I personally think that the measurement of PTSD is as good as, if not better than, any of the Axis I conditions and virtually all except for antisocial personality disorder on Axis II. We have excellent reliability of all kinds, validity information of all kinds, and utility suggesting that we are in the .90 range of sensitivity, specificity, etc. Look at how much explanatory variance PTSD as a construct has contributed to our understanding of how adverse experiences affect people. Parsimony alone should tell you that this is a very useful construct. Structural equation modeling studies like those done by Dan and Lynda King are largely ignored by the critics, yet they predict 70 percent of the variance in psychological outcome variables. How do you dismiss that and say, "Well, it's not a big deal"?

MARX: So, is there a way to satisfy these critics in some way? Is there a solution to these disagreements?

KEANE: Of course, scientific inquiry is always a solution. Let me just say that the good news is that the ecological validity of PTSD is established. The attacks on New York and Washington, DC, had such a profound impact on the widespread understanding of what a traumatic event is and what PTSD is. Now, you go to a cocktail party and say you work for the National Center for PTSD and everybody knows what that is. Before, you would have to spell it out or you would have to say you work at a research center that studies the effects of war. Now, everybody understands. Trimming around the edges, which is what I think some of these critics are pushing, isn't a bad thing, necessarily. It's good to reconsider the limits of our definitions, the limits of our field, the limits of our methods, measures, the paradigms that we use and then to move forward.

MARX: What kinds of future challenges do you see for the field?

KEANE: I think that they are the same challenges that are facing mental health broadly. We have treatments that help people. We need people to continue to research and disseminate, effectively disseminate, evidence-based treatments. Under Toni Zeiss (AABT Past President), the VA is making very systematic efforts to train psychologists and others in evidence-based cognitive behavioral treatments. We need to know more about dissemination science. It is the case that there isn't a city in this country that is stronger in terms of the large number of PTSD experts we have, yet it is very hard for us to find a referral in the city of Boston that can do either cognitive therapy, cognitive-behavior therapy, or exposure therapy. We've got to address that issue. I think, secondly, we need to better understand the psychological and biological vulnerabilities for PTSD. We've rounded up the usual suspects at this point, but are there other variables we should be examining to determine the risk factors that might lead to the development of PTSD? Then, there's something that Brett Litz is working on, specifically, to develop interventions to manage PTSD in its early stages among combat soldiers and emergency service responders. I think we need to learn more about cultural differences in response to trauma exposure and then to know how to help other populations to address these problems. I have had the opportunity to go to Southeast Asia, the Middle East, and Africa, and I've seen how few resources exist for people in these parts of the world. The disproportionate allocation of mental health resources in the U.S. versus these other parts of the world is astounding. Yet, PTSD is present

in every country in which it's been studied. It is truly a cross-cultural diagnostic entity. I recently went on a NIMH-sponsored visit to Peking University where they were establishing their Institute of Mental Health and one morning I was reading the English-language Chinese paper where an article estimated that accidents and disaster in China each year affected millions of people. Of course it was a relatively small percentage of the population, but I think it was something in the neighborhood of about 8 million people on an annual basis. And those estimates didn't include other types of violence and abuse. So, we have tremendous challenges still ahead of us.

I'll just close by saying that when I was a Fulbright Scholar at Trinity College Dublin some years ago, I had the pleasure of spending some time with George Albee, Ph.D., formerly of the University of Vermont. He was the distinguished faculty visitor at Trinity for about a week. George was one of the key people in establishing prevention science in the mental health field. When I described my work to him, he responded instantly that there couldn't be and would never be enough professionals in the world to tackle the problems associated with traumatic events. He strongly encouraged me to think about paradigms that would focus on prevention. So, this is the next important set of priorities: prevention and cross-cultural work.

MARX: Thanks very much for your time. It's been a pleasure.

KEANE: Thank you.

References

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*, 20-35.

Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualizations of posttraumatic stress disorder. *Behavior Therapy, 20*, 155-176.

Gardner, H. (1987). *The mind's new science: A history of the cognitive revolution*. New York: Basic Books.

Keane, T. M., Zimering, R. T., & Caddell, J. M. (1985). A behavioral formulation of posttraumatic stress disorder in Vietnam veterans. *the Behavior Therapist, 8*, 9-12.

Clinical Forum

Empirically Supported Self-Help Books

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Search for self-help books at Amazon.com, and you will find hundreds of self-help books for psychological problems. There are books to help individuals overcome everything from alcohol abuse to vaginismus. Many of the books follow this format: description of the problem accompanied by the stories of several individuals who have experienced the problem, information relating to deciding whether one has the problem, description of cognitive and behavioral methods to use to overcome the problem, presentation of stories of individuals who made the changes and benefited, and suggestions about what to do if the problem persists (e.g., see a health professional). Some of the books contain much or all of the content of cognitive-behavioral treatment for a specific type of problem. For instance, in his popular self-help book *Feeling Good: The New Mood Therapy*, David Burns (1980) encourages readers to overcome depression on their own. The book includes information on diagnosing the level of depression, applying cognitive and behavioral techniques, and using relapse prevention methods. Anecdotes of individuals who tried and benefited from the suggested techniques are provided throughout the book.

It is now common for psychotherapists to recommend self-help books to clients as an adjunct to psychotherapy (Adams & Pitre, 2000; Pantalon, Lubetkin, & Fishman, 1995; Starker, 1988). This situation raises a modern version of Hans Eysenck's famous question about whether psychotherapy works: Do self-help books actually help?

Several studies have tried to answer that question. In the typical study that has examined the efficacy of self-help books or a shorter self-help manual created for the study, a mental health professional gives a randomly assigned portion of the research participants with a specific disorder a self-help book or manual, asks them to read it, and tells them that they will be asked later about their progress in reading the book. Sometimes the mental health professional later questions the participants about the content of the book (e.g., Gould, Clum, & Shapiro, 1993). Other conditions might include participants serving as a waiting-list or treatment-as-usual control or participants reading an attention/placebo book (e.g., Carter et al., 2003) or receiving individual psychotherapy (e.g., Gould et al., 1993). Outcomes are usually assessed with self-report measures of the relevant type of psychopathology.

Meta-analyses of bibliotherapy efficacy studies (testing self-help books or unpublished self-help manuals) have shown medium effect sizes for bibliotherapy across various types of disorders (Gould & Clum, 1993; Marrs, 1995), with larger effect sizes found for depression (Anderson et al., 2005; Gregory, Canning, Lee, & Wise, 2004; McKendree-Smith, Floyd, & Scogin, 2003). Overall, the studies have found bibliotherapy effect sizes similar to those produced by individual psychotherapy for the same type of problem (den Boer, Wiersma, & van den

Bosch, 2004; Gould & Clum, 1993; Marrs, 1995; Norcross, 2000).

Although the findings seem promising with regard to the effects of psychological self-help books and self-help manuals in general, the state of evidence relating to any specific book or manual is not so good. We will focus on self-help books because they are much easier to obtain than self-help manuals created for a study. For the purposes of this review, we defined a self-help book as a book intended to help a person overcome a mental health problem. We searched for studies that evaluated the efficacy of a self-help book when used by individuals who received minimal or no professional assistance to go with the book.

Table 1 shows all the empirical support we could find for specific self-help books. There appears to be no single book that meets the standards for what Chambless and Ollendick (2001) call a "well-established treatment" (Category 1 empirically supported treatment). To qualify for this status, a treatment must have evidence of efficacy superior to an attention/placebo treatment, from at least two good between-groups experiments (or a large series of single-case experiments) done by at least two different research teams.

However, two books, all based on cognitive-behavioral treatment principles, qualify as "probably efficacious treatments" when the books are prescribed by a psychologist. One of these books, *Feeling Good: The New Mood Therapy* (Burns, 1980), has been found in seven randomized controlled trials to be more effective for unipolar depression than a waiting-list control. Another one of the books, *Coping With Panic* (Clum, 1990), has two published studies showing it to be more effective than a waiting-list control and thereby qualifies as probably efficacious.

Table 1 shows that several other books have some evidence of efficacy. However, the vast majority of self-help books have no published evidence of efficacy.

Two studies (Schelver & Gutsch, 1983; Scogin, Jamison, & Gochneaur, 1989) compared two different books with each other and a waiting-list control, and found both books about equally effective and significantly more effective than the waiting-list control, raising the issue of whether commonalities among self-help books may lead to different ones being equivalent in effectiveness, similar to different types of therapy (see Wampold et al., 1997).

The absence of empirical support for most self-help books has led to strong criticism of them. For instance, Rosen, Glasgow, and Moore (2003) stated that professional standards take a backseat to commercialism in the production and marketing of self-help books, and cautioned that without having been supported empirically, the effectiveness of a self-help book is unknown.

The dearth of empirically supported self-help books is certainly pitiful in comparison to the hundred-plus psychotherapy applications (many of them cognitive-behavioral) to specific problem types that Chambless and Ollendick (2001) concluded are probably efficacious or well established. This lack of evidence supporting individual self-help books forces psychotherapists who want to use self-help books for problems not included in Table 1 to rely on the recommendations of other clinicians (Norcross, 2006). Norcross et al. (2003) provide a useful list of self-help resources.

There are many factors to consider in deciding whether to recommend a self-help book to a client and in helping the client attain the maximum possible benefit from the book. Joshua and Di Menna (2000) and Norcross (2006) have provided practical suggestions relevant to these issues—for example, assessing prior use of self-help books and attitudes toward them and providing the client with a copy of the book rather than just recommending the book. Some evidence suggests, as one might expect, that individuals benefit more if they read the book closely and follow its suggestions for changes in thinking and behavior (Green & Malouff, 2006; Malouff & Salerno, 2006). Hence, therapists can view the reading recommendation or assignment as an adherence challenge, and apply methods of increasing assignment adherence (see Kazantzis, Deane, Ronan, & L'Abate, 2005; Malouff & Schutte, 2004; Rooke & Malouff, 2006; Tomkins, 2004), for instance, providing the client with an anecdote of the therapist or someone else using the methods in the book and benefiting.

The potential exists for individual self-help books to achieve "well-established" status. Researchers could test the efficacy of self-help books using either randomized controlled trials or multiple baselines across clients. The multiple baseline method (see Barlow, Andrasik, & Hersen, 2006) appears never to have been applied to self-help books, although it has the advantage of requiring only a few participants. At a less formal level, clinicians who prescribe a self-help book could report case studies of

Table 1 Self-Help Books Found Effective in One or More Randomized Controlled Studies

PROBLEM	BOOK	AUTHOR	EMPIRICAL SUPPORT SOURCE
Binge eating	*Overcoming Binge Eating*	Fairburn (1995)	Carter & Fairburn (1998)
Chronic fatigue	*Coping with Chronic Fatigue*	Chalder (1995)	Chalder et al. (1997)[b]
Depression	*Feeling Good*	Burns (1980)	Ackerson et al. (1998)[a]
			Bowman et al. (1995)[a]
			Floyd et al. (2004)[a]
			Jamison & Scogin (1995)[a]
			Landreville & Bissonnette (1997)[a]
			Scogin et al. (1987)[a]
			Scogin et al. (1989)[a]
	Control Your Depression	Lewinsohn et al. (1986)	Scogin et al. (1989)[a]
Panic disorder	*Coping with Panic*	Clum (1990)	Febraro (2005)
			Gould et al. (1993)[a]
Social Anxiety	*A Guide to Rational Living*	Ellis & Harper (1961)	Schelver & Gutsch (1983)

NOTE. We have omitted supporting studies that combined assignment of a self-help book and repeated face-to-face sessions with a therapist, e.g., Dodge, Glasgow, & O'Neill (1982).[a]Researcher or mental health professional spoke with the participants weekly by phone for 5-15 minutes regarding reading of the book. [b]Nurse spent 10-15 minutes discussing book's contents with participants and recommending specific parts applicable to each participant.

how clients used the book and what results followed. It would seem appropriate for self-help book authors to collect evidence to evaluate the efficacy of their book before publishing it (Rosen et al., 2004). They can then present the evidence in the book or in a journal.

References

Ackerson, J., Scogin, F., McKendree-Smith, N., & Lyman, R. D. (1998). Cognitive bibliotherapy for mild and moderate adolescent depressive symptomatology. *Journal of Consulting and Clinical Psychology, 66*, 685-690.

Adams, S. J., & Pitre, N. (2000). Who uses bibliotherapy and why? A survey from an underserviced area. *Canadian Journal of Psychiatry, 45*, 645-649.

Anderson, L., Lewis, G., Araya, R., Rodney, E., Harrison, G., Proudfoot, J., et al. (2005, May). Self-help books for depression: How can practitioners and patients make the right choice? *British Journal of General Practice,* 387-392.

Barlow, D. H., Andrasik, F., & Hersen, M. (2006). *Single case experimental designs* (3rd ed.). Boston: Allyn & Bacon.

Bowman, D., Scogin, F., & Lyrene, B. (1995). The efficacy of self-examination and cognitive bibliotherapy in the treatment of mild to moderate depression. *Psychotherapy Research, 5*, 131-140.

Burns, D. D. (1980). *Feeling good: The new mood therapy*. New York: Signet.

Carter, J. C., & Fairburn, C. G. (1998). Cognitive-behavioral self-help for binge eating disorder: A controlled effectiveness study. *Journal of Consulting and Clinical Psychology, 66*, 616-623.

Carter, J. C., Olmsted, M. P., Kaplan, A. S., McCabe, R. E., Mills, J. S., & Aime, A. (2003). Self-help for bulimia nervosa: A randomized controlled trial. *American Journal of Psychiatry, 160*, 973-978.

Chalder, T. (1995). *Coping with chronic fatigue*. London: Sheldon Press.

Chalder, T., Wallace, P., & Wessely, S. (1997). Self-help treatment of chronic fatigue in the community: A randomized controlled trial. *British Journal of Health Psychology, 2*, 189-197.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*, 685-716.

Clum, G. A. (1990). *Coping with panic.* Pacific Grove, CA: Brooks/Cole.

den Boer, P. C., Wiersma, D., & Van Den Bosch, R. J. (2004). Why is self-help neglected in the treatment of emotional disorders? A meta-analysis. *Psychological Medicine, 34*, 959-971.

Dodge, L. J., Glasgow, R. E., & O'Neill, H. K. (1982). Bibliotherapy in the treatment of female orgasmic dysfunction. *Journal of Consulting and Clinical Psychology, 50*, 442-443.

Ellis, A., & Harper, R. A. (1961). *A guide to rational living*. Englewood Cliffs, NJ: Prentice Hall.

Fairburn, C. G. (1995). *Overcoming binge eating*. New York: Guilford Press.

Febbraro, G. A. R. (2005). An investigation into the effectiveness of bibliotherapy and minimal contact interventions in the treatment of panic attacks. *Journal of Clinical Psychology, 61*, 763-779.

Floyd, M., Scogin, F., McKendree-Smith, N., Floyd, D., & Rokke, P. D. (2004). Cognitive therapy for depression: A comparison of individual psychotherapy and bibliotherapy for depressed older adults. *Behavior Modification, 28*, 297-318.

Gould, R. A., & Clum, G. A. (1993). A meta-analysis of self-help treatment approaches. *Clinical Psychology Review, 13*, 169-186.

Gould, R. A., Clum, G. A., & Shapiro, D. (1993). The use of bibliotherapy in the treatment of panic: A preliminary investigation. *Behavior Therapy, 24*, 241-252.

Green, F. L., & Malouff, J. M. (2006). *Processes involved in improvement associated with reading self-help books for psychological problems*. Manuscript submitted for publication.

Gregory, R. J., Canning, S. S., Lee, T. W., & Wise, J. C. (2004). Cognitive bibliotherapy for depression: A meta-analysis. *Professional Psychology: Research and Practice, 35*, 275-280.

Jamison, C., & Scogin, F. (1995). The outcome of cognitive bibliotherapy with depressed older adults. *Journal of Consulting and Clinical Psychology, 63*, 644-650.

Joshua, J. M., & Di Menna, D. (2000). *Read two books and let's talk next week: Using bibliotherapy in clinical practice*. Brisbane: Wiley.

Kazantzis, N., Deane, F. P., Ronan, K. R., & L'Abate, L. (2005). *Using homework assignments in cognitive behaviour therapy*. New York: Routledge.

Landreville, P., & Bissonnette, L. (1997). Effects of cognitive bibliotherapy for depressed older adults with a disability. *Clinical Gerontologist, 17*, 35-55.

Lewinsohn, P. M., Munoz, R. F., Youngren, M. A., & Zeiss, A. M. (1986). *Control your depression* (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Malouff, J. M., & Salerno, T. (2006). *Characteristics of the effective use of self-help books by sexual assault survivors*. Manuscript submitted for publication.

Malouff, J., & Schutte, N. (2004). Strategies for increasing client completion of treatment assignments. *the Behavior Therapist, 27*, 118-121.

Marrs, W. R. (1995). A meta-analysis of bibliotherapy studies. *American Journal of Community Psychology, 23*, 843-871.

McKendree-Smith, N. L., Floyd, M., & Scogin, F. R. (2003). Self-administered treatments for depression: A review. *Journal of Clinical Psychology, 59*, 275-288.

Norcross, J. C. (2000). Here comes the self-help revolution in mental health. *Psychotherapy, 37*, 370-377.

Norcross, J. C. (2006). Integrating self-help into psychotherapy: 16 practical suggestions. *Professional Psychology: Research and Practice, 37*, 683-693.

Norcross, J. C., Santrock, J. W., Campbell, L. F., Smith, T. S., Sommer, R., & Zuckerman, E. L. (2003). *Authoritative guide to self-help resources in mental health* (2nd ed.). New York: Guilford Press.

Pantalon, M. V., Lubetkin, B. S., & Fishman, S. T. (1995). Use and effectiveness of self-help books in the practice of cognitive and behavioral therapy. *Cognitive and Behavioral Practice, 2*, 213-228.

Rooke, S. E., & Malouff, J. M. (2006). The efficacy of symbolic modelling and vicarious reinforcement in increasing coping-method adherence. *Behavior Therapy, 37*, 406-415.

Rosen, G. M., Glasgow, R. E., & Moore, T. E. (2003). Self-help therapy: The science and business of giving psychology away. In S. O. Lilienfeld, S. J. Lynn, & J. M. Lohr (Eds.), *Science and pseudoscience in clinical psychology* (pp. 399-424). New York: Guilford Press.

Scogin, F., Hamblin, D., & Beutler, L. (1987). Bibliotherapy for depressed older adults: A self-help alternative. *Gerontologist, 27*, 383-387.

Scogin, F., Jamison, C., & Gochneaur, K. (1989). Comparative efficacy of cognitive and behavioral bibliotherapy for mildly and moderately depressed adults. *Journal of Consulting and Clinical Psychology, 57*, 403-407.

Schelver, S. R., & Gutsch, K. U. (1983). The effects of self-administered cognitive therapy on social-evaluative anxiety. *Journal of Clinical Psychology, 39*, 658-666.

Starker, S. (1988). Self-help treatment books: The rest of the story. *American Psychologist, 43*, 599-600.

Tomkins, M. A. (2004). *Using homework in psychotherapy: Strategies, guidelines, and forms.* New York: Guilford Press.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "All must have prizes." *Psychological Bulletin, 122*, 203-215.

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Getting to the South Pole: A Fable for Excrement-Free Treatment Outcome Research

Ian M. Evans, *Massey University*

Six intrepid Antarctic explorers were sitting one evening in a bar in Christchurch, New Zealand, which, as any adventurer will tell you, is where you must start from if you are going to explore the Antarctic. As the night wore on and the single malt flowed, it was inevitable that once the relative merits of Laphroaig and Lagavulin had been decided, the group would debate the best way to reach the South Pole. There was no disagreement that dogs were the only way to go. Flying in by plane was rejected from the start. As one said, dismissively, "Flying to the South Pole is like giving drugs to psychiatric patients. You miss all the subtleties of the situation, you can cause physical damage as side effects, and you might overshoot the target." But there was much disagreement about alternative dogsled procedures. Particularly controversial were how many dogs you needed, the exact breed, what to feed them, even, oddly enough, an argument that the warmth of the mushing adventurer accounted for most of the differences in performance across the ice.

The Contest

By the end of the evening, one thing had been decided. The only way to assess all the different ideas was by empirical test. It was agreed that each explorer would organize a team, conduct empirical trials, and report back in a year's time. It was a great challenge, an opportunity not to be missed. The National Institute for Dog Sledding (NIDS) offered to provide a prize if the empirical test met their strict fundable research criteria. The contest was on.

Only one of the explorers, Dr. D. Bird, seemed mildly disgruntled, continuing to insist that since the only differences would be in the relationship between man and dog, every team would actually win and every team would be likely to get the prize. As a result, he decided not to participate, but promised to write a position paper on this topic once the other five teams completed their investigations. Another small hitch occurred almost immediately, requiring the group to extend the period of their trials to at least 2 years. This was on account of a decision by the Ethical Review Board of the Society for the Protection of Sled Dog Rights (SPOSDR) that all plans had to be approved by them. Their consumer member found some arrangements put forward totally unacceptable. This meant that one of the teams' comparison groups (the no-meat-for-a-week condition) had to be dropped.

Eventually, however, all was sorted out, and 2 years after that first informal meeting in the bar, the teams reassembled, in front of a group of disinterested peers, to present their methods and their results.

The Trials

Team 1: Professor V. Basic

"Our approach was quite simple," she started out. "We believe in the importance of translational research and after thinking about the complexity of interacting variables, decided than an analogue experimental study was needed." (An appreciative murmur went up from some members of the audience, with groans of despair from others.) "We decided against using dogs at all and ran our trials right here in Christchurch, using one of the local ice-skating rinks. We built miniature sleds and conditioned teams of mice to pull these over the ice. We manipulated many variables systematically, including weight of the sled, friction on the runners, hunger level of the mice, training procedures (massed versus distributed practice), and strain of mouse. To make the study really scientific and to increase our funding from NIDS, we taught some individual mice to run on an icy cold refrigerated treadmill while examining brain activity with an MRI."

Professor Basic barely got to finish reporting her findings. There was much derisive laughter, and after vainly attempting to educate the audience on the importance of parametric studies, she sat down indignantly to allow another team to present.

Team 2: Dr. G. Standard

Known to the scientific community by his nickname "Goldie," Dr. Standard was much admired for his methodological skills. With great care, he reported, he had randomly assigned dogs and mushers to four different sled teams, all of them wearing blinkers, so as to be blind to the research hypotheses. He had counterbalanced runner friction type (equating each sled for weight) and controlled food intake so as to examine a new type of seal-meat reward-based training procedure for the dogs, which was compared with training as usual, and with a placebo training in which rewards were simply pats and cuddles for the dogs, to control for attention and for feeling wanted. The fourth group had to wait for their opportunity and would later be offered the training, which appeared the most successful of the three potentially valid programs.

Dr. Standard encountered a problem, however. When he got his teams to Antarctica, it was difficult to find a route to the South Pole that was wide enough for him to run all four teams in parallel. He could, he explained, have run them consecutively, but he could not work out a way of controlling for obvious sequential effects (the track getting smoother, for example) and uncontrollable weather variation. Furthermore, his four mushers were graduate-level trainees who wanted to go home for the summer.

Ever resourceful, Dr. Standard selected a large and surprisingly smooth ice field near a long-abandoned Canadian base camp, which was both long and wide. Once he had cleared it of some odd-looking flat stones, he ran his four groups of dogs, in parallel, all at the same time, and measured their speed. "CBT," he announced emphatically, "rewarding the dogs not for running but for changing their beliefs about the world, produced the fastest performance, and"—here he stopped to glare at Dr. Bird—"was significantly faster than the placebo method of being warm and cuddly to the dogs." Everyone was very impressed with what was clearly an RCT leading to an EST, but there are spoilers in every group, and before long one of the other adventurers blurted out incredulously: "But are you telling us, Goldie, that you didn't actually go to the South Pole? I've been to the Pole often, with many different dogs, and I can tell you that no two dogs are alike, weather conditions constantly change, and endurance is the

proper measure, not speed." Dr. Standard eyed her and the audience scornfully and retorted, "Well, obviously, you lot will have to test the effectiveness of my training method in everyday polar exploration with unruly dogs and badly trained, underpaid mushers. Fortunately for you, however, I have written a very precise manual on my training techniques and any unqualified or incompetent musher could easily use the exact same procedures. . . ." Goldie sat down amid hoots of derision from those in the audience with beards and heavy boots.

Team 3: Dr. Eta Skwared

Dr. Skwared stood up next, looking slightly puzzled. "I'm sorry to say that I somewhat misunderstood the nature of this comparison. I thought that we would all be comparing our results and pooling them to see who achieved the largest effect size." He went on: "To do this I used a simple repeated measures design. First, I surveyed 200 kilometers of typical Antarctic wasteland. Then I randomly assigned dogs to teams and personally mushed the first team one-way, under typical conditions—the comparison condition. At the end of the course I rested the dogs, fed them a high-protein diet, and mushed them back (the experimental condition), recording speed, number of bumps we went over that we shouldn't have, and loudness of yelping and barking (a good measure of canine satisfaction that had been demanded by the consumer watchdog). Before you criticize my design, let me assure you that I randomly introduced the high-protein diet either during the first part of the journey or on the return run. There was considerable variability in the dogs' performance during the comparison condition and during the experimental condition, but by using the formula of the difference between the comparison and experimental conditions divided by the standard deviation of the comparison condition, I can assure you that a protein-rich diet produces a highly meaningful effect size, although only for yelping and barking, and not for the other two measures."

At this point, the leaders of Team 4 and Team 5 both leapt to their feet, unable to contain their frustration any longer. "We can't believe this nonsense," they both exclaimed, "none of you actually got to the South Pole yourselves, which was surely the whole purpose of the exercise." Silence fell. "Okay, Professor Criterion," sniffed Eta, "tell us what your Team 4 did."

Team 4: Professor Criterion

"Outcomes have to be meaningful," he started out, sagaciously. "You have to know if you achieved the critical effect, and if you met the criterion. I talked to my team members—we had quite a large group of experienced mushers and their dogs—and we all agreed that the goal was to reach the Pole. That is what everyone wanted to achieve. Knowing that the weather conditions were poor and getting worse, we set up a base camp near the South Pole about 30 kilometers away, and did short day runs to the Pole, with stringent geophysical measures to determine that we were actually there. However, it was very cold, and we didn't want to take off our gloves to use some of the instruments, so we agreed that 30 kilometers from our base camp in more or less the right direction would meet the criterion of expeditionally significant progress. I'm happy to report that seven of our eight teams met the significance criterion. We measured speed (elapsed time to meet the goal) and have correlated this with various characteristics of the dogs, their food, the mushers' locus of control, and," he added proudly, "we also measured a number of possible unintended consequences, including frost bite, number of noncompliant dogs, and . . ."

Professor Criterion was getting into full swing, but loud mutters around the room and whispers of "hopelessly confounded," "correlation doesn't signify cause," and "this approach really calls for SEM," forced him into silence.

Team 5: Prack Tishonner, Psy.D.

A native of Vail, Colorado, Prack's maiden name was Psyentist, but after many years of actual experience in Polar exploration, she no longer hyphenated it. She smiled warmly at the audience. "How naïve can you all be?" she inquired pleasantly. "My team, which was just me and my lovely faithful and reliable dogs that I've trained myself, started off from Scott Base—as I thought we were supposed to. I did a great deal of careful assessment ahead of time, checking the best route and paying attention to some of the diaries of the earlier explorers, including Dr. Froide, who died of hypothermia and whom many of you seem to despise as a result. I set off and covered the 1,200 kilometers in a number of weeks. I kept detailed notes of each day and checked the dogs' condition on a regular basis, which I have recorded. In addition, I wrote an exhaustive narrative of my impressions, trying to hear the voices of the dogs. The weather kept changing and the route was precarious, with numerous crevices to negotiate. I totally agree with Dr. Bird that my feeling for the dogs was very important, especially during those tense moments when the dogs could easily have panicked. But frankly, I gagged when Dr. Standard told us about his manual. Good lord, you'd need about three hundred different protocols to deal with the storms, the ice, tap-dancing penguins—no, no, you have to individualize, use your judgment, and be mindful. No two days were the same. I got to the South Pole, which I can prove because I left a copy of my advanced CEC Certificate in Polar Exploration, right there, nailed to the Pole, in fact. My detailed descriptions, my thoughts, and my reflections on which were the most useful strategies under which conditions, are all carefully documented in my new book *Polar Intelligence: Dogs Are From Pluto, Mushers Are From Uranus*. Only $39.95," she added, "and it comes with a CD."

As she sat down, chaos erupted in the room. The Chief of NIDS announced that he was withdrawing all funding, and from now on, they would support only expeditions using Hercules transport planes, forget the environmental cost. Dr. Bird earned his nickname of "Dodo" by flapping around offering prizes to everyone. Dr. Standard stormed out, saying he would join another exploration academy entirely, one that had proper scientific standards and recognized true rigor ("mortis!" one smart young musher student shouted after him, but fortunately no one paid attention). Dr. Tishonner was ridiculing Professor Criterion for starting out virtually within sight of his objective, grumbling that if you select easy conditions it is simple to meet your goals, but both of them had managed to find and don T-shirts that read, I ACTUALLY GOT THERE. (Some thought the words in small print above this statement—*Unlike Shackleton and Goldie*—were tasteless and gratuitous.) Professor Basic paid no attention to these goings on as she was working on a revised mathematical model that would predict mouse mushing performance under more extreme conditions of cold than the ice-rink. She had been impressed by Professor Criterion's mention of frost bite and was secretly wondering if she had selected all the right parameters for her model.

Pax Antarcticus

It looked like the entire meeting was about to break up like the Ross Ice Shelf, with no resolution regarding the best way

to get to the Pole. Trainee mushers were bewildered, and so clustered around their respective expedition supervisors, nodding at their every utterance. A number of the senior explorers were refusing to allow their trainees to even look at Dr. Tishonner's book (she had brought along some copies). Dr. Criterion, meantime, was making fun of the others, saying things like "significance has nothing to do with *p* values," while Dr. Tishonner was scornful of instruments, "you can just feel it when you are close to the Pole."

Finally, a small group made their way hesitantly to the podium and the microphone, crowding around their spokeswoman. "We just wanted to thank everyone tonight. By listening carefully to all of you, we have learned something of value. You see, we're behavior therapists who just happened to wander in from our conference next door, which claimed we weren't properly dressed . . ."—at which moment they turned around to reveal the back of their T-shirts, which read "AABT." "Goodness," whispered someone in the audience, "we thought they'd been plutoed." The spokesperson raised her voice: "Professor Basic, surely your work has been able to test various hypotheses about enhanced performance under extreme conditions? Dr. Prack Tishonner here quite probably used some of those concepts in deciding on her approach, but she may not know your work." (In the interests of peace, the spokesperson refrained from adding, ". . . probably because she doesn't read much.") "The rich detail she has provided about her experiences helps all of us to see the complexities of an actual journey to the South Pole. But her descriptions are so idiosyncratic that it would be hard to generalize from them and very hard for anyone to apply them . . ." "I run licensed training syndicates in three countries," Prack interjected, but the spokesperson ignored her, and continued: "A major part of your task is really to be able to link Professor Basic's work to the actual experiences of those who got to the Pole. Has Goldie's expedition helped with making these links? Somewhat, but not nearly as much as he thinks. The idea that his manual is now somehow validated as the true path for those of you young explorers wanting to go to the Pole is a myth. You might be able to follow it for a while, but if you had bad weather, or a hiccup with your dogs, you'd never reach the South Pole. His self-efficacy beliefs are stronger than his trial's efficacy.

"Dr. Skwared has provided some useful information because you can standardize his effect size and thus be able to compare different measures of outcome across a range of teams and conditions, and if there were enough such trials you could make better choices. But the fact that he didn't really achieve the critical objective is a major problem. Success in seven out of eight attempts is surely a much better index. Professor Criterion has therefore emphasized something important, but the magnitude of his effect remains largely unknown, since his base camp was so close to the goal. Starting points are important. Professor Criterion also measured unintended side-effects, so when it comes to evaluating his approach, or estimating its true costs for policymakers and those of you planning future expeditions, this is valuable information."

Not really enjoying these statements of the obvious, one of the mushy trainees brashly raised his hand to distract everyone from the main point, and asked: "Haven't you got one too many As on your T-shirts, and completely forgotten your C?" "Oh no," the group cried out in unison, "we are a much older society than that. We are the Anti Acronym-Based Therapies group." Consternation ensued. What appeared to be movement toward reconciliation disappeared. "Without our acronyms, how can we claim to be unique?" some whined, when the doors burst open and a group with the wild look of social activists strode in, handing out to everyone little shovels and biodegradable paper bags. "We are the Green Peas," they shouted. "You and your dogs have produced a whole lot of crap. Now go back to Antarctica and scoop it all up."

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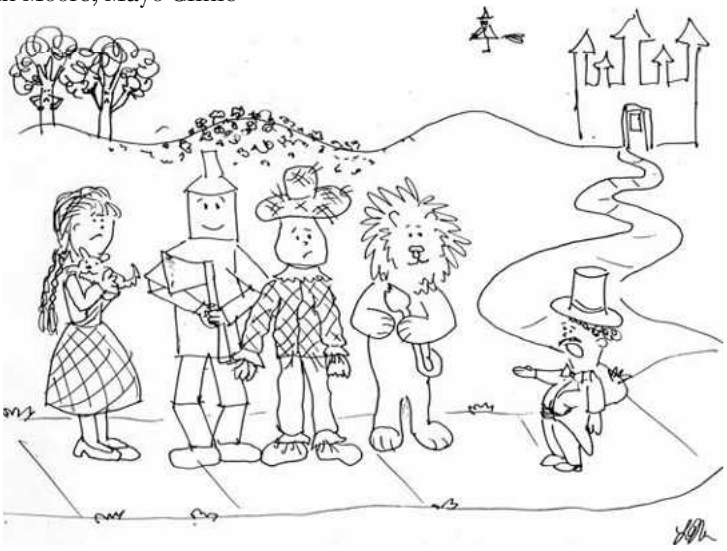
Lighter Side

Elizabeth Moore, Mayo Clinic



"Lion, Tin Man, I'd like to give you both CBT referrals. Scarecrow, I scheduled you for a neuropsychological evaluation. And Dorothy, I'm afraid you're going to need some very extensive reality testing."

Book Review

Allan M. Leventhal & Christopher R. Martell (2005) Forword by Marsha Linehan

The Myth of Depression as Disease: Limitations and Alternatives to Drug Treatment

Westport, CT: Praeger Publishers

Hardcover ISBN: 0-275-98976-3, 200 pp.

Review by Norman B. Epstein, *University of Maryland, College Park*

The title of Allan Leventhal and Christopher Martell's book might give readers the impression they are simply trying to challenge the current dominance of the medical model of depression. While that most certainly is one of Leventhal and Martell's top priorities, the issues that they take on are far broader, ranging from the undue and inappropriate influences that the pharmaceutical industry can exert on clinical research, limitations in government agencies' oversight of the pharmaceutical industry, and bias in the education of consumers and health providers about mental health treatment options and their effectiveness. The authors' style is an interesting mix of scholarship and investigative reporting, as they provide vivid examples of problems in the conduct and reporting of research on the efficacy of antidepressants and other widely used medications. As highly experienced and respected clinicians with backgrounds as behavior therapists, Leventhal and Martell also devote considerable attention to describing for the lay reader as well as for mental health professionals an alternative to the medical model of mental illness and its treatment that is based on learning principles and peer-reviewed research. Thus, in a mere 152 pages of text and appendices, the authors address some of the central current controversies in the mental health field and provide a detailed rationale for behavioral rather than drug treatments for depression, anxiety disorders, and a variety of other mental disorders. As Marsha Linehan notes in her foreword, the reader may not agree with everything that Leventhal and Martell say, but one cannot ignore the authors' messages or fail to respect them for their scholarly approach.

Structure and Content of the Book

The Myth of Depression as Disease includes seven chapters and four appendices with resources for mental health services consumers. Chapter 1 ("Societal Views of Mental Disorder") provides a concise and informative history of evolving (but not always improved) conceptions of the causes and treatments of physical and mental disorders. Of particular relevance to the focus of this book, Leventhal and Martell trace "swings of the pendulum" between conceptions of mental disorders as caused by biological factors or by psychological processes, including responses to life events. They challenge the core assumptions of the medical model, arguing that there is no clear evidence that depression and other disorders are caused by imbalances in neurotransmitters in the brain. They also describe the influences that competition among professions for status and economic advantage has had on the extent to which biological determinants of psychological disorders have been emphasized. Among the factors that Leventhal and Martell cite in the swing toward medical intervention over the past several decades was the length and cost of psychoanalytic therapeutic models that were once the predominant psychosocial treatment option. The authors trace scientific developments in the American Psychiatric Association's *DSM* system for conceptualizing and diagnosing various disorders, but quickly move beyond this to reveal how political forces influencing scientific inquiry and failures in the application and interpretation of controlled treatment outcome research have influenced this complex system of classification.

Chapter 2 ("Welcome to the Brave New World") expands the authors' argument that the effectiveness of pharmaceutical treatments for mental health problems have been exaggerated, and that individuals who are seeking assistance for such personal problems should be made more aware of psychosocial treatments that can be equally or even more effective. Leventhal and Martell review several factors known to influence the acceptability of psychosocial treatments, including the persistent stigma associated with seeking assistance for psychological problems and the comparative ease of medication self-administration. Of course, acceptance of the medical model may itself reduce the individual's sense that they are responsible for and capable of change. Leventhal and Martell present an alternative biopsychosocial model of mental disorders that recognizes biological vulnerabilities but also considers how maladaptive learned behavioral responses may exacerbate the impact of stressful life events. For example, they point out that although diabetes commonly is used as a metaphor for the disease conception of mental disorders, the onset and maintenance of Type II diabetes is influenced greatly by individuals' lifestyle behaviors and also is treatable by modifications in those behaviors. Leventhal and Martell also review the empirical literature on the effectiveness of antidepressant medications in comparison to psychotherapies and placebo controls, arguing that evidence of undesirable side effects, relapse rates, and limited effectivness have been underplayed. Despite their criticisms, the authors acknowledge that antidepressant medications may be the treatment of choice for some individuals.

A particularly provocative part of Chapter 2 is Leventhal and Martell's account of the sophisticated and extensive marketing of pharmaceuticals to physicians and the public. Specifically, the authors review the many avenues through which drug companies attempt to influence the acceptance and dissemination of their product, including their sales representatives' interactions with physicians, continuing education programs for doctors, internal research on their own drugs, financial support provided to NIH researchers, use of the media and advertising campaigns, funding of mental health consumer advocacy groups, and monetary and in-kind contributions to the funding of the American Psychiatric Association. Thus, Leventhal and Martell address a major issue in the mental health field, involving scientific integrity and protection of consumers. Readers, both lay and professional, are likely to find this material disquieting.

Chapter 3 ("The Context of Depression and Anxiety") presents the authors' alterna-

tive model of anxiety and mood disorders, based primarily on operant principles. While acknowledging the role that biological processes play in learning, the authors emphasize avoidance behavior as central to the development and maintenance of both anxiety and depression. A central premise in their model is that in avoiding situations that elicit physical or emotional discomfort (especially anxiety), the individual removes himself or herself from sources of reinforcement (e.g., rewarding relationships with other people; sources of career success). Although the avoidance is adaptive in terms of reducing short-term discomfort, in the long run it produces a sense of helplessness, hopelessness, sadness, and depression, as the person views the self as failing to have successes in life comparable to those of other people. Leventhal and Martell point to the high comorbidity of anxiety and depression as support for their functional link, and they note that the theoretical base for their model can be found in earlier writings by learning theorists such as Ferster (1973). They briefly note that individuals' cognitions regarding their experiences, such as attributing one's failures to global, stable characteristics of the self, can contribute to further avoidance (less active problem-solving behavior), hopelessness, and depression. However, their emphasis is clearly on avoidance behavior, rather than the cognitive processing that has been the foundation of cognitive models of depression (e.g., Beck, Rush, Shaw, & Emery, 1979) and the reformulated attributional version of Seligman's learned helplessness model (Abramson, Seligman, & Teasdale, 1978; Beach, Abramson, & Levine, 1981). They describe rumination as avoidance behavior that detracts from active coping, although they do not consider how ruminative negative "automatic thoughts" can themselves elicit depressed mood states. Although the authors later cite Lewinsohn's learning model (Lewinsohn & Arconad, 1981; Lewinsohn & Gotlib, 1995) that focuses on depression resulting from a low rate of response-contingent positive reinforcement (due to a variety of causes such as poor social skills or limited availability of reinforcement in the individual's environment), it is not discussed in this chapter on learning and depression. Thus, Chapter 3 presents an important learning-based alternative to the medical model that is likely to be very enlightening to the lay reader as well as mental health professionals who lack training in psychological research, but it tends to downplay cognitive processes in anxiety and depression.

Chapter 4 ("Psychology as Science") provides an overview of the scientific method that has been a hallmark of the field of psychology, introducing the lay reader to the importance of systematically assessing and evaluating treatments for depression and other disorders. The chapter continues the authors' presentation of basic learning principles and processes in classical and operant conditioning. Again, the role of cognition is given brief coverage, in a description of Bandura's (1977) seminal paper on expectancies and self-efficacy as determinants of coping behavior. Leventhal and Martell argue that although there is evidence that cognitive processes influence behavior, they have limited impact, and that much behavior occurs without cognitive mediation. The remainder of the chapter describes behavioral aspects of mental disorders (behavioral deficits, defective and inappropriate stimulus control of behavior, defective or inappropriate reinforcement, and aversive control strategies with oneself and other people). In what seems to be an overstatement, Leventhal and Martell conclude that these behavioral principles fully account for all of the forms of disordered behavior covered in the *DSM* (psychotic, mood, anxiety, eating, and other Axis I disorders, as well as personality disorders), but in terms of the individual's interactions with his or her environment rather than biological or other internal causes. They argue that the behavioral functional analytic taxonomy should replace the *DSM* system.

Chapter 5 ("Behavior Therapy") describes psychosocial forms of therapy that are major alternatives to medication for a wide range of mental disorders. Leventhal and Martell emphasize a behavior therapy that is based on the learning principles detailed previously. In what seems an overgeneralization, the authors describe other forms of treatment as seeking to facilitate change through management of the therapist-client relationship. The chapter includes brief sections summarizing psychoanalysis and psychodynamic psychotherapy, as well as client-centered therapy, as the major alternatives to behavior therapy. Interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984), which is one of the empirically supported treatments for depression (Craighead, Craighead, & Ilardi, 1998), is strangely absent here, as are marital and family interventions that also have been demonstrated to be effective (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Beach, 2001). Cognitive-behavior therapy (Beck et al., 1979), which is the most extensively researched and supported psychosocial intervention for depression (Craighead et al., 1998), is given a half page of coverage in this chapter, with no comments from the authors regarding its substantial empirical support. The chapter includes five case examples to illustrate the relative merits of the authors' approach to behavior therapy (which appeared to include several examples of cognitive restructuring). Overall, the chapter makes a strong case for the efficacy of psychosocial treatments as alternatives to pharamacotherapy, yet the coverage of alternative, empirically based psychosocial interventions (e.g., individual and couple/family therapy for depression) seems fairly limited.

Chapter 6 ("Behavioral Analysis, Behavior Therapy, and Outcome Research") returns to a description of factors in the etiology of depression, with an emphasis on Ferster's (1973) learning model, as well as more recent derivations of his model by Lewinsohn, Seligman, and others. Cognitive models by Beck and by Ellis (1962) are described in a half page, again with no references to existing empirical support; yet the authors take a key stance in favor of an integrative approach that takes biology, cognition, and learned behavior into account. The chapter then presents concise descriptions of several major behavioral interventions (relaxation training, behavioral rehearsal, relabeling, exposure), emphasizes strategies for behavioral activation in depressed individuals, and finally cites empirical support for cognitive-behavioral therapy, notably DeRubeis et al.'s (2005) report on their outcome study comparing effects of antidepressant medications, cognitive therapy, and placebo pills with a large sample of individuals diagnosed with moderate to severe depressive disorders. Hollon et al.'s (2005) companion article on significantly lower relapse among individuals who were withdrawn from cognitive therapy than among those withdrawn from medication adds to the support for Leventhal and Martell's argument concerning the limitations of drug treatments. While the authors note that cognitive-behavioral therapy has been shown to be at least as effective as medication for depression (see Craighead et al., 1998), they nevertheless conclude by suggesting that the cognitive components of CBT may not be necessary for its effectiveness. Of particular interest here is Dimidjian et al.'s (2006) recent outcome study, which presented evidence for the superiority of behavioral activation over cognitive therapy for severely depressed individuals.

Chapter 7 ("Summary and Conclusions") summarizes the rapid growth of biological approaches to conceptualizing and treating depression, factors detailed in the book that appear to have contributed to this major trend, and alternative approaches to understanding and treating mental disorders. At this point the authors acknowledge Klerman et al.'s (1984) interpersonal psychotherapy as a promising empirically supported psychosocial treatment, in addition to positive findings for behavioral activation and cognitive therapy, and they reemphasize arguments concerning the overselling of drug treatments.

Appendix A lists several questions that clients should ask a provider before accepting a prescription for an antidepressant medication, Appendix B provides guidance in finding a behavioral or cognitive-behavioral therapist through on-line resources and local professional associations, Appendix C lists questions that one can ask a potential behavior therapist in order to evaluate his or her expertise and treatment procedures, and Appendix D is an annotated bibliography on mental disorders and their treatment. These appendices will be very useful to clients.

Summary

This book was written for the lay reader who has experienced problems with depression and is considering available treatments, as well as for health and mental health practitioners who are involved in the evaluation of individuals with mental disorders and referrals to mental health specialists. The authors' didactic explanations of alternative theoretical conceptions of depression and its treatment are clear and will be very helpful to these audiences. The reading level of the text is sophisticated, so it may prove too challenging for some lay readers, but therapists could use it as a psychoeducational aid in their work with a wide range of depressed clients.

The authors' direct and persuasive arguments against the current dominance of the biological model of depression and its treatment make this important reading for both mental health services consumers and practitioners. However, at times the authors make such a strong case for their learning-based avoidance model and behavioral approach to therapy, that they appear to downplay the strong body of empirical support for other psychosocial treatments of depression and other mental disorders, such as cognitive-behavioral therapy, interpersonal psychotherapy, and couple and family therapies. In Leventhal and Martell's defense, it was beyond the scope of this book to describe each of these major treatment approaches in detail, and the authors' detailed explanation of the avoidance model is an important contribution that should influence the clinical practices of therapists who treat depressed clients. Nevertheless, downplaying alternative psychosocial treatments that include foci on internal processes and/or relational interaction patterns is unfortunate, because these other approaches bolster Leventhal and Martell's central argument that the biopsychosocial model is a worthy alternative to the prevailing model of depression and other mental disorders.

In summary, this book should serve as a valuable source of empirically based information for consumers who are attempting to educate themselves about effective treatments for their mental health problems, as well as for health professionals who seek guidance concerning how to evaluate potential referrals for their patients. I strongly recommend this book to clinicians and to individuals who are experiencing symptoms of depression and who want to have a broader understanding of mental disorders and treatment options.

References

Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*, 49-74.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*, 191-215.

Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology, 66*, 53-88.

Beach, S. R. H. (Ed.). (2001). *Marital and family processes in depression: A scientific foundation for clinical practice*. Washington, DC: American Psychological Association.

Beach, S. R. H., Abramson, L. Y., & Levine, F. M. (1981). Attributional reformulation of learned helplessness and depression: Therapeutic implications. In J. F. Clarkin & H. I. (Eds.), *Depression: Behavioral and directive intervention strategies* (pp. 131-165). New York: Garland.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: The Guilford Press.

Craighead, W. E., Craighead, L. W., & Ilardi, S. S. (1998). Psychosocial treatments for major depressive disorder. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 226-239). New York: Oxford University Press.

DeRubeis, R. J., Hollon, S. D., Amsterdam, J. D., Shelton, R. C., Young, P. R., Salomon, R. M., O'Reardon, J. P., Lovett, M. L., Gladis, M. M., Brown, L. L., & Gallop, R. (2005). Cognitive therapy vs medications in the treatment of moderate to severe depression. *Archives of General Psychiatry, 62*, 409-416.

Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmaling, K. B., Kohlenberg, R. J., Addis, M. E., Gallop, R., McGlinchey, J. B., Markley, D. K., Gollan, J. K., Atkins, D. C., Dunner, D. L., & Jacobson, N. S. (2006). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *Journal of Consulting and Clinical Psychology, 74*, 658-670.

Ferster, C. B. (1973). A functional analysis of depression. *American Psychologist, 28*, 857-870.

Hollon, S. D., DeRubeis, R. J., Shelton, R. C., Amsterdam, J. D., Salomon, R. M., O'Reardon, J. P., Lovett, M. L., Young, P. R., Haman, K. L., Freeman, B. B., & Gallop, R. (2005). Prevention of relapse following cognitive therapy vs medications in moderate to severe depression. *Archives of General Psychiatry, 62*, 417-422.

Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. S. (1984). *Interpersonal psychotherapy of depression*. New York: Basic Books.

Lewinsohn, P. M., & Arconad, M. (1981). Behavioral treatment of depression: A social learning approach. In J. F. Clarkin & H. I. (Eds.), *Depression: Behavioral and directive intervention strategies* (pp. 33-67). New York: Garland.

Lewinsohn, P. M., & Gotlib, I. H. (1995). Behavioral theory and treatment of depression. In E. E. Becker & W. R. Leber (Eds.), *Handbook of depression* (pp. 352-375). New York: The Guilford Press.

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Special

Forty Years of Behavior Therapy: Reflections, Musings, and Commentary

Howard A. Paul, *University of Medicine and Dentistry of New Jersey, Rutgers University*, and *Private Practice, North Brunswick, NJ*

I have had the good fortune to be part of the last 40 years of behavior therapy (BT) and cognitive behavior therapy (CBT) and to observe the recent surge in interest in such concepts as mindfulness and acceptance. In recent years, I have taken great pride in the emergence of empirically supported treatments that have made more efficient and effective patient care possible. In the following reflection, I trace the metamorphosis that has occurred within the behavioral tradition. I first review the growth in therapeutic tools available to behavior therapists and cognitive behavior therapists, detailing the growing pains felt by early practitioners as treatments have evolved. The paper moves from an account of initially strictly behavioral approaches to the cognitive movement, and finally to the more recent development of techniques based on mindfulness and emotional enhancement. Finally, I discuss the increasing importance of the therapeutic relationship in current cognitive behavioral thinking.

Early on, validation of clinical procedures meant demonstration of experimental control. Multiple baseline and ABAB designs were the accepted strategies for "proof." I devoured the early texts and journals, with each issue seeming to contain new procedures to expand the impact of therapy. In the 1960s and 1970s, I provided BT for children and their families using contingency-based methods developed by the founders of BT (e.g., Azrin & Lindsley, 1956; Bijou, 1954; Skinner, 1938), and later, did so with contributions from social learning theory (Bandura, 1961). When dealing with children or with the developmentally delayed, these procedures were most potent and effective. Often, after successfully resolving a child's behavioral problem, parents would return, hoping to address their own issues. It was humbling to realize that while BT provided a technology to manage a broad range of problems, a good deal of the existential pain being presented by adults seemed poorly managed within the contingency management and social learning model I was exposed to in my training. By the mid-1980s, my enthusiasm and anticipation over the next edition of *Journal of Applied Behavior Analysis* (*JABA*) abated. I found it harder and harder to tell the difference between *JABA* and *JAMD*, the *Journal of the Association on Mental Deficiency* (now the *Journal on Mental Retardation*). Clearly, something was missing.

I greeted the nascent development of CBT with great excitement. While I had been trained to carefully analyze antecedents and understand the valence and potency of reinforcements and consequences, I found that people actually wanted to *talk* to me. With CBT, there emerged a new set of procedures that seemed well suited to meeting the needs of children, but which also seemed appropriate to the challenges posed by adults and adolescents. During the late 1970s and early 1980s, attending AABT (then the Association for Advancement of Behavior Therapy, now ABCT) meetings, one could observe the field taking important steps forward in expanding and integrating behavioral therapy with other then-forbidden and eschewed theories. The so-called "black box" seemed to be opening up.

By adding talking, believing, and thinking to the behavioral repertoire, CBT not only grew, it flourished. Recently, the AABT acknowledged this growth by changing its name to the Association for Behavioral and Cognitive Therapies (ABCT). Even with the addition of previously eschewed concepts (talking, believing, and thinking), CBT stayed true to its behavioral roots and maintained a dedication to empiricism and validation of treatment efficacy. Recently, there have been new challenges to the CBT model. Both Zajonc (1984) and LeDoux (1996) note that cognitions may not be central in emotional processing. By the early 1990s randomized controlled trials (RCTs) were becoming the standard for documenting the efficacy of CBT interventions. Nathan and Gorman's (1998) *A Guide to Treatments That Work* was released, followed by a second edition in 2002. In recent years, other evidence-based volumes touting the broad range of effective interventions have also appeared (e.g., Barlow, 2001; Kazdin & Weisz, 2003).

Interestingly, while progress was being made, concerns about the RCT approach began to emerge. Practitioners knew that the fundamental base of empiricism was important, yet much of what was being seen "in the office" did not match what was being presented in the books describing empirically supported treatments (ESTs) and evidence-based procedures (EBPs). Clinical observations sometimes revealed that patients were not getting as well as the ESTs said they should! Also, patients often came into treatment with problems not addressed in the EBP literature. For those that did present with problems addressed by EBPs, many patients saw improvement, yet still were symptomatic. Some were not helped at all.

Recent Trends

Over the past several years, many new tools have been made available to behavior and cognitive behavior therapists. Tools such as motivational interviewing (Miller & Rollnick, 1991) and interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) have received empirical support and have been added to the list of expanding, efficacious procedures. Functional analytic psychotherapy (Kohlenberg & Tsai, 2003) and research in the radical behavioral tradition has been (re)discovered and made more available to mainstream CBT practitioners. Presentations on mindfulness, acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), and related procedures (Linehan, Cochran, & Kehrer, 2001) have also emerged. Presentations on the aforementioned topics at AABT/ABCT have been both exciting and well attended. Newer therapies are now more directly targeting those who remain symptomatic or resistant to traditional CBT and, in a particularly interesting development, most view the therapeutic relationship as core. It is particularly notable, and perhaps surprising, that the therapies that derive from radical behaviorism are intensely interpersonal and, unlike early BT and CBT, focus heavily on the nature and quality of the therapeutic relationship.

There are additional emerging theories and therapies that serve to round out the armamentarium of behavior therapists. At one time, it was common for persons hostile

to behavior therapies to suggest that BT or CBT was only applicable to "the simple cases"—when personality disorder or serious psychopathology due to trauma and abuse existed, a referral to a more dynamically oriented therapist was seen as essential. Fortunately, this is no longer the case. Young, Klosko, and Weishar's (2003) *Schema Therapy* is a good example of the maturation of BT/CBT treatments. Developed over the last decade, Young et al. argue that the presence of an Axis II disorder often contributes to the reduced efficacy of CBT with more impaired patients. Young suggests that it is necessary to address such topics as early trauma, poor parenting, and family experiences to maximize the effectiveness of traditional CBT. Schema therapy is conceptualized as evolving from traditional CBT, integrating elements of Gestalt and more dynamic (not necessarily Freudian) interventions. Additionally, Young notes that certain patients with characterological problems have difficulty observing their thoughts and feelings accurately, which is a requisite for successful CBT. Young believes that core CBT strategies such as empirical analysis, logical discourse, experimentation, gradual steps, and repetition are often insufficient to alter the distorted thoughts and self-defeating behaviors of individuals with certain characterological challenges. Such individuals are often exceptionally rigid and rarely able to respond to short-term treatments. They have difficulty establishing a collaborative relationship with the therapist, making focus on the relationship more important. Paralleling Young's greater emphasis on interpersonal relationships, Borkovec (2006) has developed a therapy focusing on emotional processing. The therapy includes procedures for emotional deepening, not typically focused upon in traditional CBT. Borkovec's (2006) techniques for emotional deepening are combined with CBT elements, as well as procedures associated with mindfulness, interpersonal skills training, empathy training, and exposure.

In conclusion, within the behavioral tradition, there seems to be a rounding out of therapeutic procedures consisting of behavioral, cognitive, emotion, and mindfulness-enhancing elements. Collectively, these tools should serve to facilitate treatment of a wider array of patient presenting problems. Most importantly, there is an emerging acceptance and acknowledgment of the importance of the therapeutic relationship. Feelings and relationship dynamics are receiving more attention than ever before. Nevertheless, all of these treatments and the theorists who are developing them maintain a core commitment to empiricism and research. Combining sensitivity to what emerges in the therapy session with a research emphasis has created an ever-expanding set of therapeutic tools. BT/CBT is far from mature; however, there has been significant growth and improvement in our ability to accommodate more seriously impaired patients. While we cannot be complacent, looking back over the last 40 years, it is remarkable how far we have come and what a striking metamorphosis has occurred.

References

Azrin, N. H. & Lindsley, O. R. (1956). The reinforcement of cooperation between children. *Journal of Abnormal and Social Psychology, 52,* 100-102.

Bandura, A. (1961). Psychotherapy as a learning process. *Psychological Bulletin, 58*, 143-159.

Barlow, D. H. (Ed.). (2001). *Clinical handbook of psychological disorders* (3rd ed.). New York: The Guilford Press.

Bijou, S. W. (1954). Therapeutic techniques with children. In L. A. Pennington & I. A. Berg (Eds.), *An introduction to clinical psychology* (2nd ed.). New York: Ronald Press.

Borkovec, T. (2006). *CBT plus emotional processing for worry and GAD*. Master lecture series, NJ-ACT.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: The Guilford Press.

Kazdin, A. E., & Weisz, J. R. (Eds.). (2003). *Evidence-based psychotherapies for children and adolescents*. New York: The Guilford Press.

Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. S. (1984). *Interpersonal psychotherapy of depression*. New York: Basic Books.

Kohlenberg, R. J., & Tsai, M. (2003). *Functional analytic psychotherapy*. New York: Springer.

LeDoux, J. (1996). *The emotional brain*. New York: Simon and Schuster.

Linehan, M. M., Cochran, B. N., & Kehrer, C. A. (2001). Dialectical behavior therapy for borderline personality disorder. In D. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual*. New York: The Guilford Press.

McLuhan, M., & Fiore, Q. (1967). *The medium is the message*. New York: Bantam Books/ Random House.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: The Guilford Press.

Nathan, P. E., & Gorman, J. M. (1998). *A guide to treatments that work*. New York: Oxford University Press.

Nathan, P. E., & Gorman, J. M. (2002). *A guide to treatments that work* (2nd ed.). New York: Oxford University Press.

Skinner, B. F. (1938). *The behavior of organisms*. New York: Appleton-Century-Crofts.

Young, J. E., Klosko, J. S., & Weishar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: The Guilford Press.

Zajonc, R. B. (1984). On the primacy of affect. *American Psychologist, 39*, 117-123.

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At ABCT

ABCT Creates Standing Committee on Specialization in Behavioral and Cognitive Therapies Within Various Professions

Kevin D. Arnold, *Committee Chair*

The Board of Directors, in May 2007, acted to have the Committee on Specialization a standing committee and no longer an ad hoc committee. It will now report to the Academic and Professional Issues Coordinator. As the chair, I am very excited to announce this action, and to inform the ABCT membership that the present mission of the committee is as follows:

> (a) information collection and dissemination to ABCT regarding specialty efforts within the disciplines of nursing, psychiatry, social work, professional counseling, school psychology, and addiction professionals, and
> (b) within the above identified disciplines, the committee will serve ABCT to structure leadership and facilitation efforts for establishment of behavioral and cognitive therapies as a specialty or subspecialty in these disciplines.

An early item of business for the committee is the establishment in professional psychology of site reviewers (who are ABCT members) for conducting accreditation reviews through the Committee on Accreditation (COA). COA is the main entity that accredits training programs in professional psychology (e.g., clinical, school, counseling). The typical levels of training accredited by COA are doctoral programs, internships, and postdoctoral programs. The Committee on Specialization is pleased to announce that COA will be offering two trainings at the 2007 ABCT Convention. Both on November 15 (Thursday), one will be an all-day training for site reviewers conducting accreditation reviews for internship programs or postdoctoral training programs and eligible for 7.5 CE credits. This program has been reviewed and approved by the APA Office of Continuing Education and the APA Continuing Education Committee. The APA Continuing Education Committee maintains responsibility for the content of the program. You must attend entire training to receive CE credits. The other will be a half-day, on November 15, 2007, from 12:00 noon to 5:00 P.M., on completing the COA self-study for internship or postdoctoral training sites, but this half-day workshop will not earn continuing education credits.

It is the intent of the Committee on Specialization to develop a cadre of trained site reviewers and competent self-study applicants who are practicing or academic psychologists in behavioral and cognitive therapies. This step will facilitate ongoing recognition of the specialty of behavioral psychology in professional psychology, particularly as the renewal application for behavioral psychology is prepared for the APA Committee on Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). If you are interested in attending either of the trainings, please contact Kristen Thompson at kthompson@apa.org or (202) 336-5995.

Please join us for Shabbat
at the ABCT Conference in Philadelphia!

Friday, Nov. 16, 2007 Conference Suite I (3rd Floor)

- 6:00 P.M.
  Kosher Friday-night dinner
  To sign up, please e-mail Dr. Evelyn Behar (behar@uic.edu)
- 8:00 P.M.
  Informal Shabbat Oneg (gathering) with refreshments

Shabbat @ ABCT 2007 *All are welcome!*

Find-a-Therapist

Increase Patient Referrals—Include Practice Particulars in Your Find-a-Therapist Listing

From early career psychologists to distinguished master clinicians, the on-line Find-a-Therapist Directory and Referral Service allows ABCT members to post their name and contact information to generate patient referrals. The membership, other professionals, and the public can access this on-line service to locate therapists throughout the country. Did you know that you can improve this service by adding on the Practice Particulars option? Practice Particulars enables members to describe their practice in further detail, including practice philosophy, areas of specialization, and other relevant information. Practice Particulars can increase the likelihood of appropriate referrals by enabling individuals to use this information to match their treatment needs with your area of specialty.

To add your Practice Particulars to your listing in the referral directory, simply choose the REFERRAL SERVICE AND CLINICAL DIRECTORY option on p. 4 of the 2008 dues renewal form or go to https://www.abct.org/mentalhealth/join/ and select JOIN THE EXPANDED FIND-A-THERAPIST REFERRAL SERVICE, join now. Once your request is processed, you can log onto the member's home page at any time to make edits and ensure your information is current.

Coming soon to ABCT's Web site:

Featured Therapist Interview

The City of Brotherly Love Hosts the 2007 ABCT Convention

Amy Wenzel, *University of Pennsylvania*, and LeeAnn Cardaciotto and Randy Fingerhut, *LaSalle University*

ABCT's Annual Convention returns to Philadelphia this year, November 15–18, 2007. Philadelphia is the proud home of many historic figures like Ben Franklin and Betsy Ross, as well as the birthplace of notable contemporaries such as Hall and Oates, Bill Cosby, Richard Gere, and, of course, home of our esteemed colleagues at the University of Pennsylvania, La Salle University, Temple University, Drexel University, and the Philadelphia College of Osteopathic Medicine. Philadelphia is notable for a number of "firsts" in the nation— the first zoo, the first paved turnpike, the first bubble gum (Double Bubble), and the first professional sports team to lose 10,000 games (the Phillies accomplished this feat over the summer). Philadelphia is also well known among ABCT members as the site of the first clinical trial evaluating the efficacy of cognitive therapy for depression! Some of you may have already visited Philadelphia by way of the "big screen," as Philadelphia was the setting for movies such as *The Sixth Sense*, *Philadelphia*, and the *Rocky* series. Whether you are interested in history, the arts, theater, sports, fine dining, not-so-fine dining (such as our famous cheesesteaks!), or a lively nightlife, you'll find that Philadelphia has something for everyone.

Philadelphia is the nation's sixth largest city, and, although it has the amenities of a major metropolitan area, it has the feel of a smaller city because it is only a short distance to many points of interest and is easy to negotiate. Many tourist sites, restaurants, and bars are within walking distance of the convention, and if they are not, then they are just a short ride away on our public transportation system or by cab. Whatever you decide to do, the Local Arrangements Committee will be available to help you with your plans. For more information on planning activities while you are here in Philadelphia, check out http://www.gophila.com/ or http://www.phillyfunguide.com/.

Hotel and Immediate Surroundings

The convention will be held at the Philadelphia Marriott Downtown (corner of 12th and Market Streets; 1201 Market Street, 215-625-2900; http://www.marriott.com/hotels/travel/phldt-philadelphia-marriott-downtown/), the same hotel that hosted ABCT (then AABT) in 2001. It is located in the heart of "Center City" Philadelphia and is adjacent to our famous Reading Terminal Market (http://www.readingterminalmarket.org/), within two blocks of a major indoor shopping mall (http://www.galleryatmarketeast.com/), and within eight blocks of Independence Hall and the Liberty Bell. It has six on-site restaurants and lounges, including a bar and grill, a sports bar (great for watching the Eagles game on Sunday!), a sushi bar, a steakhouse, a lounge/martini bar, and a Starbuck's. There is wireless connectivity in public areas, and you can get Internet connectivity in your guest room for $9.95 per day.

Attractions, Restaurants, and Nightlife

Philadelphia comprises over 100 different neighborhoods. Center City, the heart of Philadelphia, has about 15 distinct areas, each with its own climate and attractions. William Penn atop City Hall (adjacent to the Marriott Hotel) looks north—let him guide your way…

Historic Philadelphia: Old City and Society Hill

A short walk east down Market Street will lead you to one of Philadelphia's most historic and lively neighborhoods. At 6th and Market, stop off at the Independence Visitor's Center (http://www.independencevisitorcenter.com/), where you can pick up free tickets to Independence Hall and information about historical attractions including the Liberty Bell, Betsy Ross House, and National Constitution Center. Nearby you'll also find Jeweler's Row, the nation's oldest diamond district. Interspersed within the signature redbrick homes of Old City and Society Hill are many shops, galleries, restaurants, and night spots. This area is home to many of the hip Stephen Starr restaurants (www.starr-restaurant.com/), where "atmospheric drama is paired with edgy, delicious cuisine"; you'll find Buddakan (Asian), The Continental (global tapas and martini bar), Jones (American "comfort food"), Tangerine (Mediterranean), and Morimoto (contemporary Japanese) in this area. Whether you are looking for an old-style pub, trendy lounge, or a place to relax and unwind, Old City has something for every night owl.

South Street

For a walk on the wild side, head south from Old City to South Street (http://www.southstreet.com). Between 8th and Front Streets, you'll find a very wide variety of shops and eateries, including New Age gift shops, punk record and clothing stores, Atomic City Comics, and parlors to get your next tattoo or body piercing. If you want a Philadelphia cheesesteak without the walk, visit Jim's Steaks. Although many of the bars offer live entertainment, consider visiting the Theatre of the Living Arts (TLA) for a small venue that hosts local and national bands or The Laff House for a good laugh. Continue walking east on South Street to Penn's Landing, the waterfront area along the Delaware River where a few historic ships and the Independence Seaport Museum are docked. Originally, South Street was known as a garment district—today, you'll find Fabric Row just south of South Street.

South Philly

Just past Fabric Row is South Philly, a neighborhood in which many residents have lived for several generations. At the intersection of 9th Street and Passyunk Avenue, you'll find the famous Geno's Steaks and Pat's King of Steaks, fierce competitors in the cheesesteak business. Beware of the cultural etiquette that determines what's on your cheesesteak—the "classic" order is "Whiz, wit," denoting "with Cheez Wiz and fried onions." While in South Philly, be sure to visit the Italian Market (9th Street between Fitzwater and Wharton Streets), an area of Philadelphia featuring grocery shops, cafes, restaurants, bakeries, butchers, and cheese shops. The actual market consists of ground floor shops in Philadelphia rowhomes that line the streets, and they are generally open 9 A.M. to 5 P.M. Some of the city's best Italian

restaurants can be found within a few blocks of the market.

Chinatown

From the Marriott, walk a few blocks north on 10th Street, and you will arrive at the Friendship Arch in the heart of Chinatown. Only a few blocks wide, this area of the city is packed with Asian markets, fruit and vegetables stands, import stores, and restaurants. Come feast on a variety of Asian cuisines including Dim Sum, Chinese, Vietnamese, Malaysian, and Burmese food. For an exotic coffee experience and some light fare, try Ray's Café & Tea House—an elaborate Bunsen burner system brews fine coffees from around the world. For those traveling to the ABCT meeting by Greyhound or the Chinatown Bus lines, your bus ride ends here. It is only a two-block walk from the bus terminal to the Marriott (you can enter the Marriott through its back entrance on Filbert Street), but there are cabs in front of the bus terminal if you prefer.

Avenue of the Arts

Located on Broad Street, primarily south of City Hall, you'll find many of Philadelphia's concert halls and theatres, including the Kimmel Center, Merriam Theatre, Wilma Theatre, and Academy of Music. Visit www.avenueofthearts.org for a calendar of events. There are many high-end restaurants interspersed on this strip, including Capital Grille and Ruth's Chris Steakhouse.

Rittenhouse Square

For a posh Philadelphia experience, walk west past City Hall to Rittenhouse Square (18th and Walnut Streets), one of the five original open-space parks planned by William Penn. Brave the crisp fall weather and grab a cup of joe at La Colombe or Tuscany Café before strolling through the square. In addition to being home to luxury apartments, a five-star hotel, and several well-appointed spas, Rittenhouse has been called Restaurant Row and houses many of the eateries that have earned Philadelphia's acclaim as one of the world's best food cities. Some unique spots include Alma de Cuba (Cuban), another Stephen Starr restaurant, and Roy's Philadelphia (Hawaiian fusion). After dinner, treat yourself to some delicious gelato at Capogiro.

Art Museum Area

The central landmark in this area is, not surprisingly, the Philadelphia Museum of Art (home of the "Rocky" steps). In fact, it is a short walk from the Marriott to our well-known Benjamin Franklin Parkway, which runs one mile from City Hall to the Philadelphia Museum of Art. Along the way on Benjamin Franklin Parkway, you will encounter museums (e.g., Academy of Natural Sciences, Franklin Institute, Rodin Museum), landmarks (e.g., LOVE statue, Cathedral of Saints Peter and Paul), and many other fountains, small parks, and memorials (e.g., Philadelphia Holocaust Memorial). The parkway is lined with flags from every country in world. The Philadelphia Museum of Art is a fabulous destination at the end of this parkway, whether you simply want to run up the steps like Rocky Balboa (don't be self-conscious—we see tourists doing this every day!) or you want to take advantage of the full collection at the museum, which includes European art from all periods, American art, Asian art, modern and contemporary art, costumes and textiles, and (one of our favorites) arms and armor. During the convention, the museum will be holding a special exhibition, "Renoir Landscapes." On the backside of the museum is Boathouse Row, a nice place for a run, stroll, or bike ride. You can rent a bike from Trophy Bike Rentals (http://www.trophybikes.com/).

Manayunk

For those looking to explore beyond Center City, take a trip to Manayunk. Located on the banks of the Schuylkill River, it has become a trendy neighborhood, its Main Street lined with restaurants and shops. Some may know "the Manayunk wall" from the annual Philadelphia International Championship bicycle race—the 17% grade gives riders a workout. Although Manayunk is about 20 minutes from Center City, there's a train stop in the heart of Manayunk (R6 Norristown line), or you can take a cab for $20-25.

Events in Philadelphia the Weekend of the Convention

If you're a professional football fan, you're in luck—the Eagles have a home game on Sunday, November 18, against the Miami Dolphins. However, be sure you know what you're getting into—Eagles fans take their football very seriously (yes, these are the fans that actually booed Santa Claus). Be sure you purchase your tickets early, as they sell out quickly. For hockey fans, the Philadelphia Flyers are at home against the NY Rangers on Thursday, November 15, and the New Jersey Devils on Saturday, November 17. Great games between fierce rivals! For the athletically inclined who prefer individual rather than team sports, the Philadelphia Marathon will take place on Sunday, November 18 (http://www.philadelphiamarathon.com). Although you cannot register on race day, registration is extended until November 14, 2007, and there are few restrictions for entering the race (other than the requirement that you must maintain a 16-minute-per-mile pace!).

For those of you who are interested in arts and theater, there are many events that will occur during the convention. On Thursday, November 15, and Friday, November 16, the Philadelphia Orchestra, one of the country's finest symphonies, will be playing Tchaikovsky and Brahms (see events at http://www.kimmelcenter.org). At this same venue on Saturday, November 17, jazz trumpeter Toru "Tiger" Okoshi and his band will play a range from traditional Japanese music to Louis Armstrong. There is a host of shows in Philadelphia during the convention (http://www.philadelphialiving.com/theater/index.html). For instance, the Walnut Street Theater (http://walnutstreettheatre.org/; within walking distance of the Marriott) is hosting *Peter Pan* during the dates of the convention.

Getting Around in Philadelphia

Philadelphia has the fifth largest transit system, called SEPTA (Southeastern Pennsylvania Transportation Authority), consisting of buses, subways, and trolleys within the city and a regional railroad to the surrounding suburbs. All routes and times can be accessed through www.septa.org. Within the city, the Broad Street subway (Orange Line) runs north-south underneath Broad Street, and the Market-Frankford subway (Blue Line) runs east-west underneath Market Street; they intersect at City Hall, where you can transfer from one line to the other for free. Also at this intersection you will find the hub of the Green Line trolleys, which travel to neighborhoods in West Philadelphia. Subway lines operate 5 A.M.–12 A.M., and during 12 A.M.–5 A.M. there are after-midnight service buses. At street level, you will find SEPTA buses numbered by route that run 24 hours daily and will take you to most areas of the city. Although a one-way fare on all buses, sub-

ways, and trolleys is $2.00, it is more economical to purchase tokens for $1.30 each or a DayPass for $5.50 online or at a sales location (http://www.septa.org/fares/sales_locations.html).

SEPTA Regional Rail will connect you to the surrounding neighborhoods and suburbs of Philadelphia. Fares vary by zone and peak/off-peak hours. There are three Regional Rail stops in the Center City area: 30th Street Station (30th & Market St.), Suburban Station (near City Hall), and Market East Station (12th and Filbert St.). In addition to SEPTA, service between Philly and New Jersey can be reached via the PATCO rail service (http://www.ridepatco.org) and between Philly, New Jersey, and New York City via NJ Transit (http://www.njtransit.com).

Taxis can be found everywhere and are a convenient way to reach your destination. The Philadelphia Parking Authority currently regulates tariff fare rates, which are an initial flat rate of $2.70, with a $0.30 charge for each 1/7 mile or 54 seconds. You will be charged $1.50 extra for rides outside of Center City.

Philadelphia has many public modes of transportation, but it also is repeatedly rated as one of the best walking cities in the country. Center City is built upon founder William Penn's easy-to-follow grid street design that spans just 25 blocks between two rivers—the Schuylkill and the Delaware. Broad Street is the main north/south street, and Market Street is the main east/west street; they intersect at City Hall. In between, the north/south streets are numbered, and the east/west streets have tree names (e.g., Walnut, Locust, Spruce, Pine). For example, when walking along Market Street, if you notice cross streets with decreasing numbers, you are heading east (toward the historical sites and the Delaware River), and if you notice cross streets with increasing numbers, you are heading west (toward Rittenhouse Square and the Schuylkill River). Colorful directional signs—WALK! PHILADELPHIA—have been added throughout Center City to help you navigate.

Getting to Philadelphia

If you are coming into Philadelphia from out of town, getting into Center City is very easy. The Philadelphia International Airport is 7.2 miles southwest of Center City. The cost of a cab is a flat rate of $26.25. Moreover, Center City is easily accessible via the SEPTA R1 train for $6.00 one-way or $11.75 for a round-trip ride (note that the fare is $7.00 one-way and $14.00 round-trip if you buy a ticket onboard). The train departs from the airport at approximately 10 minutes and 40 minutes past the hour (schedule: www.septa.com/service/sched/pdfs/R1Airport.pdf). To get to the Marriott, take the R1 train to the Market East Station stop, and follow signs to the 12th Street/PA Convention Center exit, which is opposite the Transit Police Booth. Take the escalator to street level, turn right, and walk down Filbert Street to the Marriott (back entrance) on your left. If you are coming in by Amtrak, you will debark at 30th Street Station; to get to the Marriott, you can either take a taxi (follow signs for the taxi stand) or transfer to a SEPTA train and take it two stops to Market East Station (a free ride if you have your Amtrak ticket stub).

Local Arrangements at Your Service

The Local Arrangements Committee is already hard at work to ensure that your stay in Philadelphia is a memorable one. We will have a table located in the registration area on Thursday, November 15; Friday, November 16; and Saturday, November 17 staffed by Philadelphia ABCT members who can answer your questions. At this table, we will have materials on local tourist attractions for you to peruse at your convenience. In addition, we will have information on transportation, including travel to and from the airport, to and from Philadelphia train stations, public transportation around the Philadelphia vicinity, and taxi cabs. We also will have information on any services you might need, such as copying and printing (to avoid the exorbitant costs at the hotel office center), dry cleaning, shoe repair, and beauty salons. Our committee members are in the process of compiling a list of restaurant reviews for your convenience, so that you can get a sense of the types of cuisines available, distance of restaurants from the convention hotel, and whether restaurants require reservations and accept large parties.

The Local Arrangements Committee is also planning several organized activities to introduce you to Philadelphia culture. In the "Dine With a Philadelphian" program, you will have the opportunity to accompany a Philadelphia ABCT member to a local restaurant with fellow convention attendees on the Friday or Saturday evening of the convention (for more information, contact Leah Behl at behlle@umdnj.edu). We are also organizing an excursion through the Italian Market to get cheesesteaks at Pat's and Geno's in South Philly (for more information, contact Jennifer Connor at jconno2365@gmail.com). Furthermore, we are planning a "fun run" from the convention hotel, up the "Rocky" steps at the Philadelphia Museum of Art (for more information, contact Kelly Foran at forank1@lasalle.edu). Whether you choose to experience Philadelphia with some of us, or on your own, we are sure that you will have a rewarding visit, and we are excited for you to get a taste of our vibrant city. For more questions about Philadelphia or more information about the Local Arrangements Committee, please contact the committee's chairperson, Amy Wenzel, at the email address below.

Address correspondence to Amy Wenzel, Ph.D., Psychopathology Research Unit, University of Pennsylvania, 3535 Market St., Room 2029, Philadelphia, PA 19104
e-mail: awenzel@mail.med.upenn.edu

Who's an ABCT AMBASSADOR?

It Could Be You!

ABCT NEEDS YOU TO

- ***Serve as a local source of association activities***
- ***Support convention attendance & provide related information***
- ***Serve as a role model, encouraging participation & membership***

The ABCT Ambassadors program is a brand-new initiative promoting leadership, participation, and membership in ABCT.

ABCT Ambassadors are easily recognized by their special ribbons. They also receive a certificate of recognition and are featured on our website and in tBT.

WANT TO KNOW MORE ABOUT HOW TO GET INVOLVED?

Join us in Philadelphia, November 15-18.
Visit the Help Desk for more information
and to submit your name for consideration.

ABCT

Call for Candidates for Editor

of *Behavior Therapy*

Candidates are sought for Editor-Elect of *Behavior Therapy*, volumes 41 to 43. The official term for the Editor is January 1, 2010, to December 31, 2013, but the Editor-Elect should be prepared to begin handling manuscripts at least 1 year prior.

Candidates should send a letter of intent and a copy of their CV to Philip C. Kendall, Publications Coordinator, ABCT, 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008, or via email to teisler@abct.org

After an initial screening by the Publications Committee, successful candidates will be asked to prepare a vision letter in support of their candidacy. David Teisler, ABCT's Director of Communications, will provide you with more details at the appropriate time. Letters of support or recommendation are discouraged. However, candidates should have secured the support of their institution.

Questions about the responsibilities and duties of the Editor or about the selection process can be directed to David Teisler at the above email address or, by phone, at (212) 647.1890.

Letters of intent MUST BE RECEIVED BY October 1, 2007. Vision letters will be required by November 1, 2007. The Editor will be selected at ABCT's Board of Directors meeting in November.

Classifieds

POSITIONS AVAILABLE

UNIVERSITY OF CALIFORNIA, LOS ANGELES. THE UCLA DEPARTMENT OF PSYCHOLOGY invites applications for an Assistant Professor position in Clinical Psychology. Candidates should have a well-defined and innovative program in any area of clinical research and will be expected to offer both undergraduate and graduate courses. Please send a curriculum vitae and statement of research interests, and also arrange for three letters of recommendation to be sent to: Clinical Psychology Search Committee (Job #: 0875-0708-01), Department of Psychology, Box 951563, UCLA, Los Angeles, CA 90095-1563. Application review will begin on October 15, 2007. UCLA is an Equal Opportunity/Affirmative Action Employer; women and minorities are especially encouraged to apply.

HUDSON RIVER REGIONAL PSYCHOLOGY INTERNSHIP PROGRAM, NEW YORK STATE OFFICE OF MENTAL HEALTH: offers full-time predoctoral internship positions in professional psychology for 2008-2009 in its APA-accredited program. Weekly seminars in a variety of clinical and professional areas supplement extensive supervision. Clinical assignments are to inpatient and community services programs at facilities of the New York State Office of Mental Health: Hudson River Psychiatric Center and Rockland Psychiatric Center. Preference is given to students enrolled in APA-accredited clinical or counseling psychology programs. For further information and application materials, contact: Paul Margolies, Ph.D., Training Director, Hudson River Regional Psychology Internship Program, Hudson River Psychiatric Center, 10 Ross Circle, Poughkeepsie, NY 12601-1078; phone (845) 483-3310; e-mail hrrhpjm@omh.state.ny.us.

NW EATING DISORDERS & BEHAVIORAL MEDICINE seeks Psychologists and/or Lic Clinical Social Workers for two halftime positions. Our dynamic 15 member multidisciplinary clinical team specializes in careful treatment coordination for eating disordered individuals, CBT for anxiety & affective disorders, chronic pain and behavioral medicine. MA licensure & supervised training in CBT, DBT, Behavioral Medicine &/or eating disorders treatment required. ED treatment experience preferred. Supervision provided to develop new clinical skills. Offices located in Brookline & Newton, MA. See www.nwedbmed.com for more details. Mail CV (hardcopy) & cover letter to Perry Belfer, PhD, NWEDBMED, 1101 Beacon St, Suite 8E, Brookline, MA 02446 or email inquiries to: perry_belfer@hms.harvard.edu

Earn CE/CME Credit!

Association for Behavioral and Cognitive Therapies

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41st Annual Convention

PHILADELPHIA MARRIOTT
November 15–18, 2007

Why Attend?

Because the criteria for ABCT events are what you believe in: empirically supported, thoughtful, useful, positive, practical, effective.

Because dozens of the more than 200 events are directly relevant to your daily needs.

Because you can earn CEs as well as CME credit through our cosponsorship with the University of Illinois School of Medicine.

Because you will learn about classical cognitive and behavioral therapies as well as the third-wave therapies, such as Dialectical Behavior Therapy, Acceptance and Commitment Therapy, and Functional Analytic Psychotherapy.

Attend a FREE Panel Discussion

Dissemination of CBT to Psychiatrists

Thursday, November 16, 5:00 p.m. – 7:00 p.m.

With the emphasis on evidence-based treatment and the growing empirical support for CBT, psychiatry residency programs have mandated that CBT be part of residency training. There are a growing number of mental health professionals from various disciplines who are interested in providing collaborative treatment. Thus, it is important to understand how to disseminate these treatments, work collaboratively, and how to best approach the training of physicians in CBT.

A panel of distinguished psychologists and psychiatrists, who are involved in education, research, and clinical work, will describe the current guidelines for training psychiatrists in CBT, how they are functioning in practice, and what the future holds for CBT training in other disciplines.

For intensive full-day learning experiences, join

Steven C. Hayes and **Jacqueline Pistorello:**
Acquiring the Skills to Implement Acceptance and Commitment Therapy

Zindel V. Segal and **Mark A. Lau:**
Mindfulness-Based Cognitive Therapy and Prevention of Relapse in Major Depression

Thomas H. Ollendick:
Evidence-Based Psychosocial and Pharmacological Interventions for Phobic and Anxious Youth

A small sampling of the ABCT events:

- Neurocognitive Therapies: Novel Approaches to Treating Psychiatric Disorders
- Advancements in the Treatment of OCD: Strategies for Enhancing Outcome in SSRI Treatment-Refractory Patients
- Integrated Post-Combat Care for Iraq and Afghanistan War Veterans
- Psychological Adjustment in Medical Patients: Basic Research and Behavioral Interventions
- Childhood Abuse Experiences, Gender, and Sexual Orientation: Links to Mental Health and Functioning
- Obsessions and Anxiety in the Postpartum Period
- The Empirical Diagnostic System: Anticipating DSM-V

FOR FULL INFORMATION: **www.abct.org**

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Comprised of guides for therapists and workbooks for children and young adults, each program in this series contains everything you need to effectively deliver scientifically-proven treatments and interventions to young clients. Our therapist manuals come complete with session agendas and outlines, as well as sample dialogues, metaphors, and step-by-step instructions for delivering treatment. Our corresponding workbooks are designed specifically for youngsters and contain easy-to-read and understand psychoeducational information, interactive forms and worksheets, and homework assignments to keep them engaged and motivated.

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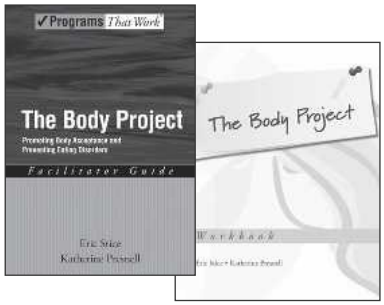

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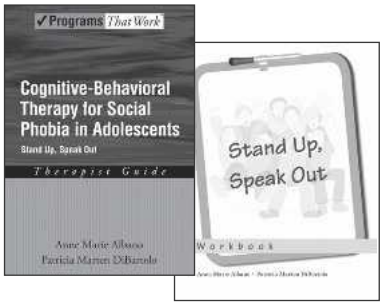

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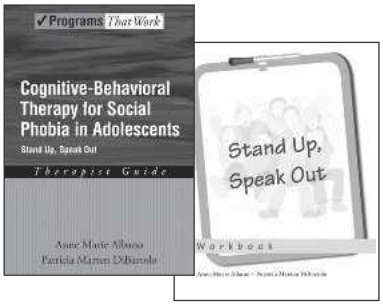

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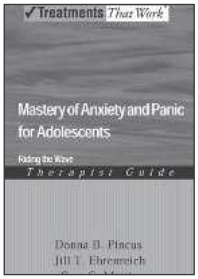

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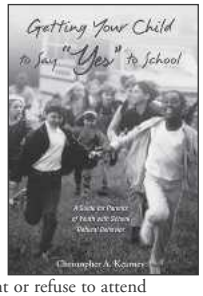

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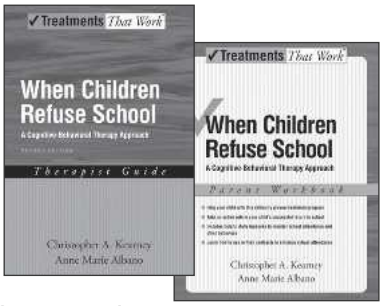

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Accreditation Workshops

APA Site Visitors Needed!

Become an APA Site Visitor

7.5 CE credits

This program has been reviewed and approved by the APA Office of Continuing Education and the APA Continuing Education Committee. The APA Continuing Education Committee maintains responsibility for the content of the program. You must attend entire training to receive CE credits.

Thursday, November 15
8:00 a.m.–5:00 p.m. (*breakfast & lunch provided*)

This workshop is a full-day training that includes both didactic and experiential exposure to the Guidelines and Principles of Accreditation and the role and functions of the site visitor. This workshop is open to new site visitors and experienced site visitors who would like retraining.

- For additional information about the accreditation process, please visit: http://www.apa.org/ed/accreditation/sitevisitinfo.html
- If you are participating in this workshop, please contact Kristen Thompson: kthompson@apa.org or (202) 336-5995

How to Compile an APA Self-Study

Thursday, November 15
12:00 – 5:00 p.m. (*lunch provided*)

This half-day workshop is designed to provide Training Directors with specific information about preparing a self-study and what to expect during a site visit. The workshop is also open to anyone interested in learning more about the overall internship/post-doc accreditation process. No CE credits available.

- For additional information about the accreditation process, please visit: http://www.apa.org/ed/accreditation/sitevisitinfo.html
- If you are participating in this workshop, please contact Kristen Thompson: kthompson@apa.org or (202) 336-5995

Don't miss these special sessions at ABCT's annual meeting in Philadelphia Nov. 15-18

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