

the Behavior Therapist

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Clinical Forum

MINISERIES: THIRD-WAVE PSYCHOTHERAPY

Convention, Tradition, and the New Wave: Assessing Clinician Identity in Behavior Therapy

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“Conventional wisdom” is a phrase introduced in the *The Affluent Society*, by John Kenneth Galbraith (1958), to describe a prevailing opinion held by recognized experts in their field, but with the exegetic implication that those using the term are actually questioning that opinion. In this light, the phrase may be situated against what is being called the three waves of behavior therapy (Hayes, 2004; Hayes, Masuda, & De Mey, 2003). In the first wave, behavior therapists questioned the conventional wisdom that inner experience was central to understanding human behavior. The applied implications drawn of this first wave was the use of classical and operant conditioning principles to explain behavior without recourse to events inside the skin, and the development of treatments dedicated to modifying behavior through stimulus control and contingency management. While private events were not ignored by all (notably, B. F. Skinner), in clinical application, publicly observable behavior became the focus, and attention was directed at changing the environment to achieve it (see e.g., Bandura, 1969; Eysenck, 1959; Fordyce, 1976; Franks, 1969; Kanfer & Philips 1970; Krasner & Ullmann, 1965; Wolpe, 1969).

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Enter the 1970s and the “cognitive revolution” (Hergenhahn, 1994; Holdstock, 1994; Mahoney, 1974, 1977; Meichenbaum, 1977; Sperry, 1993; cf. Krasner, 1976), or the second wave of behavior therapy. The conventional wisdom that cognitive variables were irrelevant to understanding behavior gave way to “cognitive-behavioral” theories, which emphasized the importance of mediating variables in explaining and modifying behavior. Representing a more sophisticated instantiation of early Greek Stoicism or folk psychological notions on the causes of behavior (cf. O’Donohue, Callaghan, & Ruckstuhl, 1998), the cognitive approach liberated theoretical and applied behaviorism over the next few decades. In the clinical arena, the dialogue was dominated by the likes of Albert Ellis’s rational-emotive therapy (RET; 1974) and Aaron T. Beck’s (Beck, Rush, Shaw, & Emery, 1979) cognitive therapy, and such concepts as irrational beliefs, schemas, and self-efficacy expectations entered the behavior therapist’s lexicon. Along the way, second-wave therapies realized great success in clinical trials, expanded the clinical armamentarium of behavior therapists, and made behavior therapy accessible to new generations of behavior therapists.

We are now witnessing the emergence of a third generation of behavior therapists, and the conventional wisdom of the second wave is being questioned. Drawn from basic and applied behavior analysis of language (see, e.g., Hayes, Barnes-Holmes, & Roche, 2001), Eastern mystic traditions, and less empirically oriented therapeutic approaches (see e.g., Hayes, 1984, 2002), this third-wave movement is redefining the behavioral therapeutic landscape. Examples include Acceptance and Commitment Therapy (ACT; Hayes & Strosahl, 2005; Hayes, Strosahl, & Wilson, 1999), Dialectical Behavior Therapy (DBT; Linehan, 1993), Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991), Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002), and Integrative Behavioral Couples Therapy (IBCT; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000), among others (e.g., Marlatt, 2002; Martell, Addis, & Jacobson, 2001). Although the factors that unite these approaches cannot be easily characterized, at their core, they suggest that to behave differently (viz., live well), it is not necessary that one must first feel good or think differently. Philosophically, they tend to be more contextually and experientially based—

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emphasizing such issues as acceptance, mindfulness, cognitive defusion, dialectics, spirituality, and values (Hayes, 2004; Hayes et al., 2003) and tend away from second-wave theories that emphasize behavioral modification via cognitive change (e.g., J. Beck, 1995; Ellis, 1974; Meichenbaum, 1977). While not all have roots in the behavior analytic tradition, one of the primary examples of this third wave, ACT (Hayes et al., 1999), and its allied theoretical framework, Relational Frame Theory (RFT; Hayes et al., 2001), is firmly rooted in a functional contextual philosophy whose lineage includes Skinner's radical behaviorism (see, e.g., Hayes et al., 2001; Kohlenberg, Hayes, & Tsai, 1993).

Based on differing philosophies and assumptions, one might expect that third-wave therapies such as ACT would be clearly distinguishable from therapies aligned with the second wave of behavior therapy. Nevertheless, would they look so different in practice? The extant empirical record would not lend favor to one over the other in terms of clinical outcomes (Zettle, 2003; Zettle & Raines, 1989), and topographical discrimination might prove difficult for several reasons. First, at least some second-wave behavior therapies are strong on the issue of acceptance (see e.g., Ellis, 2000; Robb & Ciarrochi, 2005; Segal et al., 2002; Toneatto, 2002), while some otherwise traditional cognitive approaches have discussed the idea of self-distancing from cognitive content (see J. Beck, 1995; Overholser, 1995). Second, research suggests a fair amount of dissymmetry between clinical theory and its application; that is, theory is not always practiced true to form in the clinical context (Friedman, 1991; Gillett, 1998; Lazarus, 1989; Tuma & Pratt, 1982). Third, it may be argued that ACT practitioners, as members of the broader folk and professional psychological communities, would still be susceptible to pursuing interventions at odds with its philosophical underpinnings.

A quip by Jan L. A. Van de Snepscheut, appearing regularly in lists of famous quotations, observes that, "In theory, there is no difference between theory and practice. But, in practice, there is." However, in light of the foregoing it might be more apt to suppose that in theory there is a big difference between theory and practice, while in practice there isn't. Our purpose in this study was to determine whether self-described ACT or ACT-sensible clinicians (i.e., third-wave behavior therapists) would endorse qualitatively different types of interventions than clinicians who, by

self-description, more strongly identified with second-wave behavior therapy. In addition, we sought to compare each with a group of nonclinicians who could be said to represent the attitudes of a folk psychological or commonsense approach, which may show some affinities with second-wave theories (see, e.g., O'Donohue et al., 1998). Toward this end, we developed a series of 10 clinical vignettes, each offering five possible therapeutic responses or interventions that included "ACT-like," "cognitive," and commonsense or "neutral" choices, and administered them to members of all three groups to rank order in terms of personal preference. We hypothesized that nonclinicians and second-wave behaviorists would show preference for cognitive-type responses, and be more similar in their ranked responses to the vignettes than ACT or ACT-sensible clinicians, who would endorse interventions more consistent with ACT.

Method

Instrument Development

The instrument consisted of 10 clinical vignettes, each with five possible therapeutic responses. Respondents were instructed to rank each from 1 to 5, with 1 being the response that "best fit" with what they might say or do as a therapist, and 5 as the response that "least fit." They were also asked not to give the same ranking to more than one response. The 10 vignettes each contained five unique responses designed to include at least two responses considered face valid from an ACT perspective, two responses that were thought to be consistent with the cognitive-behavioral approach (CBT), and a final response that was constructed as a more commonsense clinical option (neutral), such as contracting for safety or referring for a medication evaluation. The designation of responses as being consistent with ACT or CBT was based less on the topography of the behavior involved than consideration of the theoretical basis or intent behind a therapeutic move or approach. For example, an ACT-consistent response in one vignette was, "Utilize exercises in the service of helping her recognize her thoughts for what they are, not what her thoughts say they are." A CBT response in the same vignette was, "Suggest that her focus is her reality. Work at changing her focus by gently confronting her thoughts and beliefs (e.g., that she deserves to be alone). Engage her in a search for evidence that will challenge her assumptions about life." (While this instrument develop-

ment effort could have begun from the perspective that there are no differences between ACT and CBT, the originators of ACT have made claims regarding differences. If these differences were as claimed, it should be possible to construct items that would highlight the putative differences. This sensibility guided the construction of these vignettes.)

The questionnaire was developed from a comprehensive review of ACT literature. Five of the vignettes were borrowed and slightly modified from the *Acceptance and Commitment Therapy* textbook (Hayes et al., 1999) and the other five were generated through brainstorming sessions between the authors and examining cognitive psychology textbooks.

The content validity of the instrument was examined using a panel of three ACT experts to address how well item content conformed to the aforementioned categories (ACT, CBT, or neutral). All of the experts were recognized doctoral-level, university-based faculty in clinical psychology who specialize in behavior analysis and ACT, but who also had backgrounds in CBT.

An initial screening of the instrument was completed by administering it to 29 first-year graduate students in an introductory behavior analysis class and 12 advanced graduate students with training in ACT. The purpose of the initial administration was to assess the clarity of the questionnaire and its instructions, to measure the total time required to complete it, and to identify spelling or grammatical errors in any of the questionnaire items. Item content was adjusted based on feedback from respondents and a descriptive analysis of response patterns. Items that poorly discriminated between ACT and CBT were revised by the expert panel. The pilot version of the instrument is available from the first author.

Participants and Procedure

Participants consisted of graduate students in clinical psychology, professional clinical psychologists, and undergraduate psychology students. They were recruited at ACT conferences, through an on-line ACT listserv, in classrooms, psychology clinics, and from the psychology departments of three universities. Data were collected anonymously. Participants were asked to report their theoretical orientation, their years of experience as a therapist, and to rate each questionnaire item, as noted above, on a 5-point scale.

Of 69 participants, 27 participants were assigned to a group labeled "ACT," of which the majority so described themselves, but also included individuals who identified as a "radical behaviorist," "behavior analyst," or "functional contextualist." Participants were placed in the CBT group if they self-identified as "cognitive," "cognitive-behavioral," or "cognitive-constructivist" ($n = 21$). Finally, 21 undergraduate psychology students (UG) were administered the instrument as representing the folk psychological viewpoint.

The clinical experience of the participants in the ACT group ranged from 4 months to 26 years ($M = 7.34$ years). The clinical experience of the CBT group ranged from 9 months to 27 years ($M = 11.62$ years). While the CBT group averaged more years of clinical experience than the ACT group, the difference was not statistically significant ($p < .05$). The participants

in the UG group had no previous clinical experience.

Results

Overview of Data Analysis

Results are presented descriptively and by inferential analyses (Kruskal-Wallis ANOVA), with group as the independent variable and the mean rank of responses to the vignette intervention strategies as the dependent variable. In particular, groups were compared on ratings given to ACT-consistent responses, CBT-consistent responses, and on the neutral responses. Planned comparisons contrasted the ACT group with the CBT and UG groups separately, as well as the CBT and UG groups. We hypothesized that mean response rankings for the ACT group would significantly differ from both the CBT and UG groups, but that mean response rankings for the

CBT and UG groups would not significantly differ. In all, 9 planned comparisons were made; thus, to control for experiment-wise error, alpha was set at .006 using the Bonferroni correction (Miller, 1981). Finally, each vignette was examined for internal consistency with respect to rankings between the three groups.

ACT-Consistent Responses

Collectively, there was a tendency to respond differently to the vignettes as a function of group membership (see Figure 1). In considering the ACT-consistent responses, members of the ACT group favored these choices more than members of the CBT or UG groups. Participants in the ACT group tended to assign higher rankings to ACT-consistent items ($M = 1.98$). Those in the CBT group gave these items a lower rank overall ($M = 2.77$) and they appealed the least to the UG group ($M = 3.37$). The overall ANOVA comparing the three groups on ACT-consistent responses was significant ($df = 2, H = 43.94, p < .006$). Planned contrasts indicated that the

three groups significantly differed from each other with regard to the mean rank for all ACT consistent items ($p < .006$).

Since two responses were considered ACT consistent in each vignette, another way to examine group differences was to determine the percentage of participants in each group who assigned a rank of either 1 or 2 for all ACT-consistent responses. Figure 1 (upper right column) shows that 78% of the ACT group participants assigned a rank of either 1 or 2 on each of the 20 ACT-consistent responses, while only 22% assigned a rank of 3 or lower to at least one ACT-consistent response. In contrast, 46% of the participants in the CBT and 28% of the participants in the UG group assigned a rank of either 1 or 2 on each of the 20 ACT-consistent responses. Thus, ACT-consistent responses were ranked 1 or 2 by almost twice as many participants in the ACT group compared to the CBT group and by over three times as many participants compared to the UG group.

CBT and Neutral Responses

On average, the UG group tended to rank CBT-consistent responses higher than did the CBT group ($M = 2.56$ vs. $M = 2.97$), while the ACT group gave the lowest rankings (Figure 1). The overall ANOVA was significant ($df = 2, H = 38.09, p < .006$). Planned comparisons revealed a significant difference between the ACT group and both the CBT and UG groups ($p < .006$), while the comparison between the CBT and UG groups was not significant with the Bonferroni correction ($p > .006$).

The neutral responses were least liked by the ACT respondents, who, as a group, achieved an average rank of almost 4 ($M = 3.95$). The UG group had the highest average rank for the neutral responses ($M = 3.05$), with the average for the CBT group ($M = 3.69$) falling between the ACT and UG groups. The overall ANOVA comparing the three groups on the neutral responses was significant ($df = 2, H = 33.20, p < .006$). Planned contrasts revealed a significant difference between the UG group and both the ACT and CBT groups ($p < .001$), but not between the ACT and CBT groups when applying the Bonferroni correction ($p > .04$).

As with the ACT-consistent responses, the percentage of participants in each group who assigned a rank of either 1 or 2 across the CBT and neutral responses was also examined (see Figure 1, right column). For the CBT responses, 17% of the ACT group participants assigned a rank of either 1 or 2,

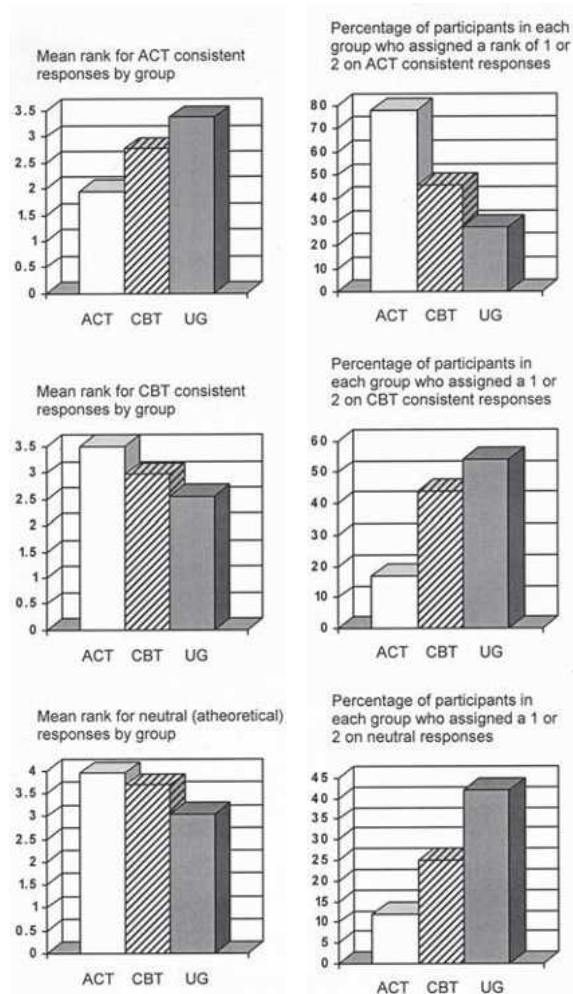


Figure 1. Mean rank of responses by group (column 1), and percentage of participants in each group who assigned a rank of 1 or 2 (column 2).

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while the percentages were 44% and 54% for the CBT and UG groups, respectively. For the neutral responses, only 12% of the ACT group participants assigned a rank of 1 or 2, while 25% of the CBT group and 42% of the UG group did so.

Intra-Group Rank Consistency for Each Vignette

Interrater reliability statistics can be calculated to determine the level of agreement between independent judges. Kendall's Coefficient of Concordance (*W*) is an analogous statistic that can be used to examine rater agreement when the data are ranked (Hendrick, 1981). A high *W* indicates high agreement (i.e., internal consistency); a low *W* reflects variability or a lack of consistency. Table 1 shows the consistency of ranks for the 10 vignettes by group. Overall, the ACT group participants were more internally consistent in their responses compared to the CBT and UG group participants, with a mean *W* = .56 for the ACT group and .35 and .33 for the CBT and UG groups, respectively. Thus, ACT participants showed overall greater uniformity in their ranking of responses compared to the CBT and UG participants. However, in examining the individual vignettes, it is clear that internal consistency varied. As can be seen in Table 1, rankings for the ACT group were most consistent in Vignettes 2, 5, 8, 9, and 10, while the internal consistency for Vignette 6 was particularly poor (*W* = .09), reflecting little agreement between ACT participants in their ranking of responses.

Discussion

As expected, ACT participants preferred ACT-consistent responses overall, with the results revealing significantly higher rankings for the ACT group compared to the CBT and UG groups. Mean ranks for the ACT group and the percentage of ACT participants who assigned a rank of either 1 or 2

over the 20 ACT-consistent responses, indicate that psychology graduate students and clinicians who identify ACT as their theoretical orientation are able to distinguish ACT from more traditional interventions. Moreover, ACT participants demonstrated overall greater uniformity in their responses to our instrument than did the CBT or UG participants, who demonstrated more intra-group variability. Although it is not entirely clear why this would be, it is possible that this is a reflection of the heterogeneity of CBT views. CBT is sometimes viewed from the outside as homogeneous. However, from the inside it is clear that there are many variations within CBT. For example, Beck's cognitive therapy differs substantially from Meichenbaum's, and both of these cognitive therapies differ substantially from behavioral activation (Dimidjian et al., 2006).

These findings and conclusions must be juxtaposed against other results from this study. Not completely supported was our hypothesis that the CBT and UG groups would be more similar in their rankings based on the supposition that they are epistemologically similar (O'Donohue, et al., 1998). While a significant difference in rankings was not found between the CBT and UG groups on CBT responses, and UG participants gave CBT responses their highest ranking on average, CBT participants showed a slight preference for ACT-consistent responses over the designated "CBT" responses. Further analysis of the data indicated that the CBT group ranked as a 1 or 2 an ACT-consistent response and a CBT response about 50% of the time. These data may be interpreted in several ways. One possibility is that some of the CBT responses were ambiguous or not truly representative of traditional CBT, and as such, that they were less attractive to CBT participants. In other words, it could be that the "ACT" responses better reflected ACT than

the "CBT" responses reflected CBT. Alternately, these findings could reflect less homogeneity with regard to participants in the CBT group relative to the ACT group. Since the ACT and CBT groups were defined self-referentially, philosophical homogeneity is not assured. This prospect seems more likely with respect to the CBT group. First, while the philosoph-

ical bases of ACT have been distinguished from those underlying traditional CBT, it is not necessarily inconsistent to term ACT a "cognitive-behavioral" therapy (see Hayes et al., 1999, p. 79). Thus, some participants who identified as CBT may have been more ACT-sensible. Second, some members of the CBT group came by way of attendance at ACT conferences and through an on-line ACT listserv. It is plausible that some of these participants were, or had become, more ACT-savvy through their exposure to ACT. Moreover, as previously mentioned, behavior therapy and cognitive-behavioral approaches are evolving. MBCT (Segal et al., 2002), for example, may be philosophically more aligned with ACT than traditional CBT.

These findings should also be considered in light of internal consistency data. In four of the vignettes, response options did not provide a high level of discrimination between ACT and CBT responses, with Vignette 6 being particularly poor. Also, as noted above, internal consistency was overall poorer in the CBT group. Some refinement of the vignettes is needed to ensure that response variability reflects affinity for the CBT model rather than measurement error.

It is difficult to capture the differences in treatment approaches with a written instrument that constrains the richness and variety of possible clinical responses in the therapeutic context. However, this study suggests that clinicians may not always do as they say, or practice in concert with theoretical labels. Undoubtedly, repeated observations of individual therapists would be necessary to detect theoretically informed variation in clinical practice. Nevertheless, at a molar level, the results of this study suggest differences between third-wave and second-wave clinicians.

Another implication of this work concerns the use of this instrument to discover more about the process of learning ACT. Because of the evolution of CBT, the tool may be increasingly unable to distinguish ACT from CBT. However, the instrument does a relatively good job of distinguishing ACT responses from the "conventional wisdom" of psychotherapy espoused by undergraduate students. Thus, the instrument could help to monitor the trajectory of graduate students as they make the transition from lay therapists to ACT therapists with more formal training. We are unaware of any other published assessment tool useful for evaluating a therapist trainee's understanding of ACT. An instrument that mea-

Table 1. Consistency of Ranks for the 10 Vignettes Across Groups Using Kendall's Coefficient of Concordance (*W*)

Group	Vignette									
	1	2	3	4	5	6	7	8	9	10
ACT	.47	.79	.41	.54	.88	.09	.44	.64	.73	.63
CBT	.37	.39	.44	.22	.53	.38	.21	.30	.44	.27
UG	.29	.27	.11	.18	.32	.43	.41	.61	.47	.26

Note. ACT Group *M* = .56 (.61, without Vignette 6); CBT Group *M* = .35; UG Group *M* = .33.

sure the accuracy with which students receiving ACT training are able to differentiate ACT from traditional psychological approaches could be helpful in graduate school training clinics. Such an instrument would enable supervisors to measure the progress of their trainees and aid in the teaching of ACT. As noted in our introduction, the correspondence between what clinicians say and do may be weak. However, an examination of the correspondence between say–do would involve both a measure of “do” in the form of psychotherapy tapes and measures of “say.” This instrument is a step in the direction of the latter.

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Contemplative Psychotherapy: Integrating Western Psychology and Eastern Philosophy

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In recent years, *mindfulness-based practices* (MBP) have drawn considerable attention from the psychology community. Meditation and relaxation techniques are common elements of many therapeutic interventions and have become so accepted that they can be found in general treatment planning publications (e.g., Johnson, 1997). In a recent literature survey, Walsh and Shapiro (2006) stated that meditation has become "one of the most enduring, widespread and researched of all psychotherapeutic methods" (p. 227). Mindfulness-Based Cognitive Therapy (MBCT; Segal, Teasdale, & Williams, 2002) was developed as a method of preventing depressive relapse in formally depressed clients. Dialectical Behavioral Therapy (DBT; Linehan, 1993) has demonstrated effectiveness in reducing the suicidal and parasuicidal behaviors of individuals with borderline personality disorder. Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 2003) has repeatedly demonstrated that it can increase the quality of life and reduce levels of pain for individuals with chronic health problems. Additional research has begun to explore the change factors associated with MBP interventions. Fennell (in press) has operationalized mindfulness as "...metacognitive awareness (acceptance of the idea that thoughts, assumptions and beliefs are mental events and processes rather than objective truths)..." (p. 1). This notion of metacognitive awareness and acceptance has been elaborated on by Hayes et al. (1999) (see also Hayes, Follette, & Linehan, 2004). The developing trend of mindfulness and metacognitive awareness in the behavioral traditions suggests that the form of problematic cognitions is not as relevant as their function (Hayes, 2004). The efficacy of MBCT intervention for depressed individuals (Ma & Teasdale, 2004; Segal et al., 2002; Teasdale et al., 2002; Williams, Teasdale, Segal & Soulsby, 2000) and DBT for individuals with borderline personality disorder (Linehan, 1993) speaks to the importance of this trend toward integration of

MBPs into contemporary empirically based psychotherapies.

The process of integrating Western psychological concepts with Eastern meditative philosophies has been rife with misunderstanding and some loss of the depth for both traditions and what they have to offer each other (Walsh & Shapiro, 2006). In part, this may be due to empirical investigations supporting the efficacy of mindfulness-based treatment interventions without a thorough theoretical understanding of mindfulness and its mechanisms of change (Baer, 2003; Shapiro, 2006). Until recently, the psychological community lacked a comprehensive, operationalized measure of mindfulness that would facilitate further investigations. Using a recently developed, multifaceted mindfulness questionnaire, Baer (2006) reported that mindfulness is composed of four primary factors: "describe, act with awareness, nonjudge, and nonreact" (p. 42).

Contemporary behavior therapies such as Acceptance and Commitment Therapy (ACT; Hayes et al., 1999), DBT, MBCT, and MBSR have all either overtly or covertly emphasized the development of mindfulness through various methods. The purpose of the present paper is to expose readers to a form of psychotherapy, Contemplative Psychotherapy (CP), that has been taught at Naropa University and is a synthesis of Buddhist and Western psychology. The CP model and associated training may be of benefit as an integration proceeds. This paper will present key facets of the CP model, supporting evidence from the contemporary behavior therapies and a brief summary of limitations.

CP and the Nature of Suffering

Although CP is a synthesis of Buddhist and Western psychology (Kissel Wegela, 1996), it is grounded in principles of Buddhist phenomenology and asserts that suffering is ubiquitous, suffering is caused by attachment, there is a method to the cessation of suffering, and the method consists of contextual changes in behavior and cognitive restructuring (Hayes, 2002; Kumar,

2002; Robins, 2002) that are achieved through "right understanding, right thought, right speech, right action, right livelihood, right effort, right mindfulness, and right concentration." De Silva (2002) notes that this strategy toward the amelioration of the symptomatology associated with suffering predates cognitive and behavioral interventions in Western psychology but can be conceptualized as "... systematic use of rewards and punishments; fear reduction by graded exposure; modeling; self-monitoring; stimulus control; overt and covert aversion; use of family members for implementing a behavioral-change programme; and specific techniques, including distraction and overexposure, for unwanted intrusive cognitions" (p. 116). It should be noted that cognition is defined as "... those subjective experiences that one can know or become aware of..." (Toneatto, 2002, p. 73) and that this should be distinguished from cogitative or cogitation so often emphasized in many CBT interventions. "Thus, cognition can include all emotion, mood, feeling, discursive thinking, imagery, memory, dreaming, sensory perception, and somatic sensation" (Toneatto, 2002, p. 73). This operational definition is an important departure from traditional CBT and becomes an integral element of the meta-cognitive processes of decentering involved in MBCT, ACT, MBSR, CP, and DBT. Using Toneatto's operational definition of cognition, meta-cognition entails a conscious awareness of all experience and phenomena that are known or can be brought to awareness.

From the Buddhist perspective, to live is to suffer. How then can there be a cessation of suffering? In Buddhism, the suffering that is targeted is not the suffering of life but "... the flavor of attachment in a world of change..." (Low, 2000, p. 252). We suffer because we do not get what we want; but we do get what we do not want. At its heart, suffering originates from a dualistic perspective (Hayes, 2002). According to Kumar, "Suffering is generated by the mental tendency toward essentialism," which "refers to the assumption of a discrete, fixed self and identity, independent of external environmental influences or internal physical processes" (2000, p. 41). He continues by asserting that the belief in a fixed self necessitates the belief in a fixed other. This dichotomization of experience extends to the "... polarization of thoughts, emotions, and experiences as attractive or aversive..." (Kumar, p. 41). Where Western psychology has emphasized self-efficacy and the individuation of the individual, Eastern per-

spectives have stressed an understanding of the self in context. From Batesonian and dialectical perspectives, the only way to understand phenomena are to consider that phenomena within the context of all the circular interactions relevant to them. Cybernetic epistemology and dialectic philosophy further postulate that to draw a distinction, to create a separation, is actually to articulate a contextual relationship (Flemons, 1991; Linehan, 1993). Suffering is caused when relationship to context is lost and the individual begins to believe that distinctions and separations are literal and real. "The individual, being absorbed in their own view of themselves, finds no gap in the world to enter, no way of speaking or connecting. And the world, other people, seem to present nothing but demands, criticism, shaming perceptions and so forth and so has to be resisted" (Low, 2000, p. 251). Buddhism puts forward that there is no real, discreet and permanent self. Instead, phenomena interdependently co-originate from an infinitely complex and interconnected network of cause and effect (Kumar, 2002; Robins, 2002). "From the perspective of Buddhist dialectics, all phenomena, ranging from feelings to physical structures, are temporary confluences of multiple influences" (Kumar, 2002, p. 41).

Meta-Cognitive Awareness and Decentering as Mechanisms of Change

Suffering is often maintained through the use of overlearned, habitual responses to stimuli, both behaviorally and cognitively. In the CP model, this is accomplished through the utilization of passion, aggression, and ignorance in the service of the ego to avoid the experience of impermanence and the attempt to maintain a separate sense of self. Passion is utilized to cling to pleasurable phenomena; aggression is used to avoid aversive experience; and ignorance is practiced when confronted by the nature of an impermanent self. Buddhist psychology assumes that suffering arises from ignorance of the interdependent nature of phenomena and that it is possible for humans to decrease their ignorance by increasing their moment-to-moment awareness, thereby experiencing the interconnectedness and nondual nature of existence (Kissel Wegela, 1996). For CP and the third-wave behavioral therapies the treatment target becomes increasing metacognitive awareness.

In exploring the mechanisms of change in cognitive therapy (CT) for depression and in the creation of a depression relapse-pre-

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vention treatment, Segal et al. (2002) observed that previous cognitive models have focused on the content of dysfunctional thoughts and further hypothesized that the central factor is the decentering which occurs through the successful process and implementation of CT and CBT (Orsillo, Roemer, Block Lerner, & Tull, 2004). Decentering is the development of metacognitive awareness, an ability to observe one's cognitive process without discursive judgment, which enables successful cognitive restructuring. Consistent with the CBT model of anxiety maintenance (Foa & Kozak, 1986; McGlynn & Lawer, 2000; Newman, 2000; Tsao & Craske, 2000), Segal et al. suggested that avoidance of depressive cognitions does not lead to avoidance of depressive symptoms, but may instead contribute to the frequency, duration, and intensity of relapse episodes, in part because the individual does not habituate to the experience of temporary depressive thoughts. Building on the theoretical and empirically supported model of MBSR, MBCT for depression was designed to provide a psychoeducational framework for depression and specifically target the development of metacognitive awareness. Further research has supported this by suggesting that utilization of thought-observation and acceptance is more successful than thought suppression in the management of intrusive thoughts, which can trigger depressive episodes (Marcks & Woods, in press).

Hayes (2004) notes that the third-wave therapies have abandoned an exclusive commitment to first-order change, and have significantly broadened the scope of change by incorporating contextualistic assumptions and experiential or indirect strategies. He describes an underlying premise of ACT as avoiding the cognitive fusion and associated suffering experienced when a presenting problem or chief complaint remains the focus of attention in therapeutic interventions. Hayes suggests that it is akin to asking the client to not think about chocolate cake, noting that the minute the individual attempts to not think of chocolate cake, they have. Any attempt to think of something else in order to stop thinking about chocolate cake fails because chocolate cake is again evoked. When a specific pathology becomes the focus of therapeutic interventions, the associated experiences and cognitive processes associated are reinforced by the shift in metacognitive awareness toward the pathology (Hayes et al., 1999; Hayes, 2002). While ACT incorporates many elements of tradi-

tional CBT into its model, a central feature is cognitive defusion, which targets the content of thoughts rather than the content (Masuda, Hayes, Sackett, & Twohig, 2004). In this manner, thoughts are not labeled as dysfunctional or maladaptive cognitions. Through the development of metacognitive awareness, the individual begins to accept a thought as a thought and recognizes the meaning they have attached to such. This process is believed to facilitate cognitive restructuring and behavioral hypothesis testing necessary for change.

According to the present analysis, third-wave behavioral therapies such as ACT and MBCT promote the development of metacognitive awareness and facilitate the process of decentering, enabling the individual to engage in successful cognitive restructuring and behavioral hypothesis testing (Hayes, 2004; Segal et al., 2002; Segal et al., 2004). CP views mindfulness similarly. Mindfulness is paying attention, in a particular way, without discursive judgment (Kabat-Zinn, 1990; Kissel Wegela, 1996). Mindfulness practice facilitates the development of an "observer-self," one in which thoughts are seen as thoughts, judgments are seen as judgments, and experiences are seen as experiences. Mindfulness has often been associated with traditional practices, such as sitting meditation, yoga, Zen tea ceremonies, or martial arts. All these practices can facilitate a state of mindfulness; however, mindfulness can also be experienced while doing the dishes, eating, walking, and daily living (Hanh, 1975). CP also describes another state: mindlessness. This state is often associated with adherence to passion, aggression, and ignorance. However, as Toneatto's (2002) definition of cognitions suggests, a mindlessness practice can become a mindfulness practice by shifting one's attentional state to the context in which the practice is utilized (Kissel Wegela, 1996).

CP Assumptions and Dialectical Experience

The CP model assumes three marks of existence: impermanence, egolessness, and suffering (Kissel Wegela, 1996). CP asserts that when exposed to these realities, individuals first experience a "sense of shock," which is followed by uncertainty as the individual attempts to make sense of the new phenomena and incorporate these into their current "cognitive maps." The individual then either accepts the new experience and adjusts his/her cognitive maps or ignores the disconfirmatory information and main-

tains existing behavioral responses, cognitive maps and attributional systems. This cycle of shock, uncertainty, and conviction represents the human capacity to be aware of and acknowledge the three marks of existence. It also implies the potential for an individual to "wake up" or become "enlightened" about perpetual attempts to grasp, push away, or ignore phenomena in an attempt to maintain a sense of permanence, a separate self, and avoid pain. In CP, this underlying human potential is referred to as Brilliant Sanity and in Buddhist psychology as Buddha nature or intrinsic health.

CP states that Brilliant Sanity is expressed through five primary phenomenological dialectics (Kissel Wegela, 1996), which can be best understood through a thesis, antithesis, and synthesis model.

THESIS	SYNTHESIS	ANTITHESIS
Claustrophobia	Accommodation/spaciousness	Boundariless
Poverty	Appreciation for the richness of experience	Gluttony
Confusion	Clarity of perspective	Convictions
Loneliness	Compassionate relationship	Passionate grasping
Lack of initiative	Effective action, skillful means	Frantic activity

CP asserts that an experience of claustrophobia or lack of boundaries is an expression of the human capacity to be accommodating; poverty and gluttony are expressions of an appreciation for the richness of experience; confusion and conviction are expressions of clear perception, etc. Viewed in this manner, sanity can be found through the neurosis (Kissel Wegela, 1996).

CP Interventions

CP is similar to the third-wave behavioral therapies in its indirect approach to change. Neuroses are seen as expressions of an individual's intrinsic health and are not necessarily to be directly ameliorated: Mindlessness practices can potentially become mindfulness practices. An integral el-

ement to the CP intervention process is modeling. The CP training program places primary emphasis on the development of the therapist. In addition to traditional didactic education, the program requires regular training in a body discipline (e.g., Aikido, Tai Chi, or Yoga), daily meditation practice, and regular meditation retreats. A specific retreat is designed to trigger and amplify the experience of the thesis and antithesis elements of the dialectics identified above. The overarching goals of these practices are for the therapist to become intimately familiar with the thesis, antithesis, and synthesis; to allow this familiarity to inform the intervention; and to model the synthesis while exploring the dialectical experience.

Limitations of CP

With a basis in Buddhist psychology, many of the underlying constructs and phenomenological assumptions are foreign to most Westerners. The very notion that psychological health (operationally defined in CP as an experience of space, relationship, clarity of perspective, appreciation for the richness of experience, and effective action) is present unconditionally and is actually expressed through neurosis appears to contradict medical models that suggest that health is obtained when symptoms are reduced. I have heard individuals state that to accept that suffering is ubiquitous is pessimistic. Paradoxically, CP practitioners and Buddhists would contend that to accept suffering is the first step to begin experiencing joy, pleasure, and compassion for others. This can be a difficult concept for clients to accept because they often present in distress, looking for a therapist to facilitate the amelioration of such.

Unfortunately, while rich on philosophy, CP is lean on specific interventions, treatment protocols based on client presentation, empirical investigation, and validation. However, it should be noted that while Western psychology has pursued a nomothetic, quantitative approach, many Eastern traditions have followed a more ideographic, qualitative method. This may, in part, reflect the cultural differences between these two traditions. There may also be methodological difficulties in operationalizing the underlying constructs within CP. As the third-wave behavioral strategies continue to evolve, the investigation of such may prove beneficial in the exploration of indirect change mechanisms and operationalizing constructs that have

previously eluded clear definitions and presented confounding variables.

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The Impact of Hurricane Wilma on Alcohol Use Among Hispanic Adolescent Drinkers: A Brief Report

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Negative reactions to natural disasters have been well documented among children and adolescents. Increases in PTSD symptoms have been observed in the months following Hurricanes Hugo (Belter, Dunn, & Jeney, 1991) and Andrew (Garrison et al., 1995), with some individuals reporting PTSD symptoms for a year or more (Garrison et al., 1993; Shaw, Applegate, & Schorr, 1996). Other reactions to natural disasters include symptoms of depression (Goenjian et al., 2001; Goenjian et al., 1995) as well as increases in deviant behavior (Khoury et al., 1997). Studies involving the impact of natural and manmade disasters on adult alcohol use have been mixed. For example, studies have reported increases in adult alcohol use following disasters such as a volcanic eruption (Adams & Adams, 1984) and major flood (Gleser, Green, & Winget, 1981), while other studies have found no increases in alcohol use following an earthquake (Shimizu et al., 2000) and a nuclear power accident (Kasl, Chisholm, & Eskenazi, 1981). To date, no studies have examined the impact that a natural disaster such as a hurricane may have on adolescent alcohol use. Therefore, the purpose of this study was to examine the impact that Hurricane Wilma had on adolescent alcohol use.

Hurricane Wilma struck Miami as a Category 2 hurricane in the fall of 2005. It was the strongest hurricane to hit the Miami area since Andrew in 1992, and resulted in billions of dollars in damage, with some areas experiencing power outages for weeks. We hypothesized that increases in adolescent alcohol use would be observed as a function of stress related to the hurricane. Specifically, we expected that adolescent alcohol use would increase as a function of the extent to which the hurricane affected the daily lives of participants.

Participants ($N = 88$) were already involved in an ongoing NIAAA-funded study designed to examine the impact of a brief motivational intervention with alcohol-

using adolescents. The predominantly Hispanic sample ($n = 67$) must have engaged in at least 3 drinking occasions in the past year to meet inclusion criteria for the study. The Timeline Followback (TLFB; Sobell & Sobell, 1992) was used to measure 30-day drinking behavior both before Hurricane Wilma and immediately post-hurricane. Data were collected during regularly scheduled follow-up sessions. In addition to the standard follow-up interview, participants were asked 15 questions regarding the impact that Hurricane Wilma had on their mood and daily life functioning. Subsequent factor analysis with varimax rotation revealed a two-factor solution. The Negative Affect Scale is a 6-item scale with items related to negative mood states and acting-out behavior (i.e., feeling sad, feeling restless, and getting into more fights than usual). This scale had good internal reliability ($\alpha = .80$) and demonstrated an average inter-item correlation of .41. The Worry Scale is a 6-item scale consisting of items related to worrying about self and family regarding the impact the hurricane had on daily life. This scale was less internally consistent, with $\alpha = .67$ and an average inter-item correlation of .26. Three items did not load on either factor and were discarded.

Several paired *T*-tests were run to examine the differences in drinking behavior pre- and post-Hurricane Wilma. No differences were found with any of the drinking variables, which included: number of drinking days, total number of drinks, average number of drinks and peak number of drinks (see Table 1). In addition, correlational analyses revealed no relationship between drinking behavior and the Negative Affect or Worry scales. Overall, only 8% ($N = 7$) of the sample reported an increase in alcohol use immediately post-hurricane. One-way ANOVAs revealed that participants who did report an increase in alcohol consumption also reported (a) more negative affect

and (b) that Hurricane Wilma had a greater negative impact on their lives (see Table 2).

In addition to the planned analysis, a number of post-hoc analyses were also run. Several one-way ANOVAs were run to test for gender differences in drinking behavior and the Negative Affect and Worry scales. A trend was found for peak drinking behavior, $F(1, 61) = 3.5, p = .07$. Females tended to report decreases in peak drinking behavior, while males reported no change. No other significant results were found. We also conducted correlational analyses to examine potential correlates of increases in drinking behavior, which included: access to friends, access to alcohol, parental supervision, and feelings of boredom. Increases in drinking behavior were correlated with increased access to alcohol, decreased parental supervision, and decreased feelings of boredom (i.e., feelings of boredom and increased drinking were inversely related).

These findings suggest that Hurricane Wilma did not have a pervasive or profound impact on adolescent alcohol use among our sample of Hispanic adolescent drinkers. However, those few participants who reported an increase in alcohol use also reported greater hurricane-related distress compared to participants who reported no increase in alcohol use. Furthermore, increased access to alcohol, as well as decreased parental supervision, was also related to increased alcohol use. Lastly, gender may play a role in drinking behavior immediately following a natural disaster. Results indicated that female teenage drinkers may be more likely to reduce alcohol use following a natural disaster. Although speculative, it is possible that girls may have been responsible for disaster responses (e.g., caretaking, housekeeping) incompatible with drinking.

Several limitations merit caution in the interpretations of these results. Hurricane Wilma was a relatively minor hurricane and over 50% of the sample reported that the hurricane affected their lives "not at all" or "very little." A larger hurricane may have had a greater impact on the daily lives of adolescents and resulted in increased stress and/or alcohol use. In addition, the majority of the sample consisted of adolescents who do not use alcohol on a regular basis. Heavier drinking adolescents who may rely on alcohol to cope with stress may have demonstrated an increase in alcohol use following the hurricane. Finally, the current study's sample consisted exclusively of adolescents participating in a randomized clinical trial of motivational interviewing for reducing adolescent drinking—every par-



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This workshop will provide an overview of the clinical phenomenology of TS and a standardized approach for assessing tic symptomatology, common comorbidities, and relevant psychosocial variables. Developed by our clinical research consortium, a comprehensive behavioral protocol for tic management will then be described. This protocol includes psychoeducation about TS for the patient and family, habit reversal training, a structured functional analytic procedure for identifying and ameliorating environmental factors contributing to tic expression, and relaxation training. Various instructional approaches will be employed, including didactic instructions, videotaped samples of actual treatment, and role-play demonstrations.

Participants will learn:

- a comprehensive approach to the assessment of children and adults with tics
- an updated approach to the use of habit reversal training (HRT) for tic management
- a structured functional analytic protocol to identify and ameliorate environmental factors associated with tic expression.

Although this session is free of charge, you must register as seating is limited. Preregister by Oct. 19 at:

www.abct.org

DATE & TIME

**Wed., November 14,
12:00–6:00
(1- hour break)**

CE CREDITS

5 credits: CEU, NBCC, NAADAC, NASW, CME (jointly with Univ. of Illinois, Chicago, College of Medicine)

ABCT'S ANNUAL CONVENTION

**November 14–18
Philadelphia**

LOCATION

**Philadelphia Marriott,
1201 Market St.
Independence Ballroom**

The information provided in this material was supported by Grant/Cooperative Agreement Number 04211 from the Centers for Disease Control and Prevention (CDC). The contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

Table 1. Change in Drinking Behavior After Hurricane Wilma ($n = 88$)

	M (SD)	T	p
Change in number of days drinking	-0.3 (1.9)	1.2	0.2
Change in total number of drinks	-0.5 (9.3)	0.5	0.7
Change in average number of drinks	-0.4 (3.0)	1.0	0.3
Change in peak number of drinks	-0.3 (3.4)	0.6	0.5

Table 2. Participants Who Increased Alcohol Use After Hurricane Wilma

	Increased Alcohol Use	M (SD)	F	p
How much did Hurricane Wilma affect your life (range 1-4)	Yes	2.6 (0.5)	5.6	.02
	No	1.9 (0.8)		
Negative Affect Scale (range 6-24)	Yes	12.0 (4.8)	10.2	.002
	No	8.3 (2.7)		
Worry Scale (range 6-24)	Yes	10.6 (2.4)	1.9	.17
	No	9.0 (2.9)		

participant had been extensively assessed on drinking measures, and two-thirds had received personalized drinking feedback intervention. It is conceivable that intervention helped prevent Hurricane Wilma from having a significant impact on our adolescents' alcohol use. As a result, the current findings may underestimate the strength of association between natural disaster stress and alcohol use among general population teenagers. Of course, additional research will be needed to ascertain whether such a protective effect is possible through a personalized feedback intervention.

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Lighter Side

Halloween

Elizabeth Moore, Mayo Clinic



"I know our copy is high, but really, Marv..."

What's Your Hat Size? Multiple Roles and Ethical Dilemmas

David R. Castro-Blanco, *Long Island University*

In the course of a given day, mental health professionals may find themselves asked to step into, and out of, multiple roles and responsibilities. As clinicians, supervisors, administrators, teachers, and researchers, we are frequently called upon to shift our focus and actions. Under the best of circumstances, this can be a daunting task, but juggling several hats can expose ethical dilemmas that require us to clarify our definitions and responsibilities. This article focuses on ethical questions and concerns associated with multiple roles in an academic setting. While referencing some personal experiences and perspectives, it also brings to the fore issues that touch on the ethical responsibilities of cognitive-behaviorally trained and oriented professionals.

As cognitive and behavioral clinicians and teachers, we hold an unyielding respect for empirical investigation and evidence-based practices. Ethical questions don't always lend themselves to objective, empirically supported analyses. Many ethical concerns are ambiguous and complicated by mitigating factors such as regulations or standards that render as many interpretations as interpreters.

As the majority of ABCT's membership is composed of psychologists, the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (APA, 2002) served as the primary resource for defining ethical standards. The ethical guidelines for physicians, social workers, and counselors are sufficiently similar to those of psychologists for these suggestions to generalize. More to the heart of the question: What is one to do when confronted with apparently unclear or conflicting options and guidelines?

In the interests of full disclosure, let me take a moment to outline how this paper came to be. Some of the information here was presented as part of a symposium on ethical conduct for anxiety researchers, which took place at the annual meeting of the Anxiety Disorders Association of America in 2006. I am a faculty member in the psychology department of a large,

urban university, whose Ph.D. program in clinical psychology has a psychodynamic training orientation. As the "house CBT guy," my position in the program has occasionally left me feeling like a lone voice in the wilderness, and has brought into stark relief several concerns about ethical demands and practice that arise, at least in part, because of different theoretical orientations and interpretations.

Below, I present some of the questions that have caused the greatest concern (and, occasionally, consternation), along with suggested responses. The questions are grouped by the varying roles of teacher, supervisor, and researcher. The ideas offered here are mine, and shouldn't be taken as the only, or even the best, options for addressing these concerns. Rather, I hope they stimulate discussion and thought about how our training as cognitive-behavioral specialists can help inform our ethical decision-making as behavioral scientists and as mental health providers.

The CBT Professional as Teacher and Trainer

The APA Ethical Principles of Psychologists and Code of Conduct (2002) identifies the obligation of teachers and trainers to report scientifically and professionally accurate knowledge. Domain B of the APA accreditation criteria for doctoral programs (APA, 2000) also emphasizes a commitment to science and empiricism in the teaching and training of professional psychology practice:

3. (b) Students shall be exposed to the current body of knowledge in at least the following areas: individual differences in behavior, human development; dysfunctional behavior or psychopathology . . .
3. (c) Diagnosing or defining problems through psychological assessment and measurement and formulating and implementing intervention strategies, including training in empirically supported procedures

Anxiety and mood disorders are among the most prevalent and the most responsive to treatment in the U.S. (NIMH, 2006). Some of the best defined and most frequently studied interventions for anxiety problems utilize cognitive and behavioral change strategies (Turner, 2006). The robust literature supporting cognitive-behavioral interventions for anxiety with children, adolescents, and adults suggests a need to teach this intervention approach rather than those aligned with alternative models (David & Szentagotai, 2006). What happens when this does not occur?

Ethical Dilemma 1: The CBT Therapist in a Non-CBT Training Program

Despite the empirical support for cognitive-behavioral treatment methods, many training programs maintain a focus on other, nondirective theoretical models. Training in these models frequently emphasizes therapy process over outcome, and teaches the trainee to rely more on the interpersonal relationship than on specific treatment techniques. Frequently, these models lack the extensive empirical support enjoyed by cognitive-behavioral approaches. This can lead to ethical concerns, particularly if the approaches taught ignore or fail to give adequate attention to the empirical evidentiary base. This concern is further complicated by APA's decision to broaden the definition of evidence-based practice (Norcross, Beutler, & Levant, 2006).

Ethical Dilemma 2: The CBT Supervisor in a Non-CBT Training Program

A second potential ethical pitfall arises when students seek "shadow supervision." While being supervised in one modality, the student may seek guidance, consultation, or even full-blown supervision from a CBT perspective. While consultation is a recognized professional activity, and professional courtesy dictates offering assistance where it is sought, it is all too easy to lapse into providing student trainees with specific guidance and techniques. Not only is it unethical for a psychologist to offer or provide supervision on a case in which the trainee is already being supervised by another (APA, 2002), it can be seen as antagonistic and provocative. A more adaptive approach would involve sending the trainee back to the original supervisor to request a consultation. Remaining available to offer suggested references, research findings, or consultation in a nonthreatening manner will likely attract more positive interactions

Ethical Quandary	Potential Action
Treatment models that don't emphasize empirically based treatment models	<i>Stay current and knowledgeable, and keep both your colleagues and students informed.</i>
Case supervision that doesn't use or agree with empirically derived treatment models	<i>Proceed with caution! Suggest resources that may be helpful to students and supervisors alike.</i>
Colleagues or outside supervisors are antagonistic regarding empirically based treatments	<i>Stay respectful. You're more likely to gain and retain credibility by showing how what you do works rather than why another person has it all wrong!</i>
Students seek "shadow supervision"	<i>Keep the ethical guidelines in mind. You can't presume to interfere in another supervisor's case. Make students aware of the limits and the need to observe the limits, but stay available as a consultant to both supervisors and trainees.</i>

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with trainees and colleagues who don't share a CBT orientation, than will providing "under the table consultation."

Ethical Dilemma 3: The CBT Faculty Researcher in a Non-CBT Training Program

This situation can be particularly daunting. While CBT is based on empirical investigation, and CBT interventions enjoy a robust body of research support, many of the variables and phenomena studied in a CBT framework may not be warmly received by non-CBT colleagues. As an example, a psychology training clinic that eschews regular data keeping, formal treatment plans, and symptom-focused inventories will not likely prove a fruitful site for developing an empirically based body of psychotherapy outcome research. This is not limited to the design and execution of randomized control trials (RCTs), but even modest translational research in real-world settings may be compromised by a lack of basic infrastructure, due more to a disregard for evidence-based practice than to a paucity of available resources.

The ethical concerns raised by this situation are many and complex. As a clinician, what is the CBT therapist/researcher's responsibility to inform clinic administrators about the evidence base for various approaches, techniques, and procedures? What can the researcher do to encourage data keeping, not only for study purposes, but as a mainstay of clinical practice? At

what point do the researcher's goals give way to the clinician's ethical mandates for beneficence and informed, empirically supported practice?

What's an Ethical Cognitive-Behavioral Therapist to Do?

The preceding ethically challenging scenarios were intended to provoke thought and question basic assumptions. Above, I offer some suggestions for ethical dilemmas arising out of differences in theoretical and practical orientations.

Conclusions

Ethical guidelines exist as a barometer of commitment to professional ideals and standards. As such, they shouldn't be viewed as unyielding rules or injunctions. Given the tradition of empirical investigation and respect for data-driven, evidence-based practice, cognitive-behavioral therapists are uniquely poised to provide a wide array of services and assistance in adherence to ethically grounded, best practice.

With this potential for positive influence comes great responsibility. CBT therapists are behavioral scientists. As such, we generate, analyze, and interpret data. We provide consultation for colleagues who aren't as conversant in data-driven techniques. Rather than be satisfied with the success of our models, and robust support for our techniques, we have an ethical obligation to provide the rationale, as well as techniques,

for empirically supported treatment approaches. How can we do all this? When juggling as many hats as we do, it pays not only to have a big head, but to keep it.

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Albert Ellis, Ph.D.

1913 – 2007

Dr. Albert Ellis died on July 24, 2007. Dr. Ellis, who was 93 years old, died of natural causes. Born in Pittsburgh in 1913, Albert Ellis grew up in New York City and received a master's degree and doctorate in clinical psychology from Columbia University. Dr. Ellis was the founder of rational-emotive behavior therapy (REBT) and he considered himself the grandfather of cognitive-behavior therapy (CBT). Several professional societies have honored him: He holds the Humanist of the Year Award of the American Humanist Association, the Distinguished Psychologist Award of the Academy of Psychologists in Marital and Family Therapy, and the Distinguished Practitioner Award of the American Association of Sex Educators, Counselors and Therapists. The American Psychological Association has given him its major award for Distinguished Professional Contributions to Knowledge. Also, the American Association for Counseling and Development has given him its major Professional Development Award. He has published more than 70 books and over 700 articles on psychotherapy, sex, love, and marital relationships. In 1996, Ellis received the Outstanding Clinician Award from ABCT, and in 2005, he received the Lifetime Achievement Award from ABCT for his development of REBT and CBT. His humor, hard work, quick wit, and great intelligence will be missed by all.

A formal obituary will appear in the next issue of tBT.

Call

for Award Nominations

We invite all members of ABCT to nominate exceptional colleagues for one of the following awards. For 2008, we seek nominations for the following awards to be presented at the Annual Convention in Orlando, Florida:

Outstanding Contribution by an Individual for Clinical Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Past recipients of this award include Marvin Goldfried, Albert Ellis, Marsha Linehan, and Frank Dattilio. Please complete an on-line nomination by visiting www.abct.org, and completing the appropriate application forms. Then, e-mail the completed forms to ABCTAwards@gmail.com. Also, mail a hard copy of your submission to ABCT, Outstanding Researcher, 305 Seventh Ave., New York, NY 10001.

Outstanding Mentor

This is a new award category which will be recognized on a rotating annual basis. On alternate years, recognition will be given to an Outstanding Training Program. This year we are seeking eligible candidates for the Outstanding Mentor award who are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement and activities aimed at providing opportunities for professional development, networking and future growth. Appropriate nominators are current or past students of the mentor. The first recipient of this award, in 2006, was Richard Heimberg. Applications should include a letter of nomination, three letters of support, and curriculum vitae of the nominee. Please complete an on-line nomination by visiting www.abct.org, and completing the appropriate application forms. Then, e-mail the completed forms to ABCTAwards@gmail.com. Also, mail a hard copy of your submission to AABT/ABCT, Outstanding Mentor, 305 Seventh Avenue, NY, NY 10001.

Virginia A. Roswell Student Dissertation Award

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

Distinguished Friend to Behavior Therapy

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

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Questions? Contact: M. Joann Wright, Ph.D., Chair, ABCT Awards & Recognition Committee; e-mail: ABCTAwards@gmail.com

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 Jenny C. Yip, Psy.D.

ABCT lottery

Here's how it works. Encourage a colleague or student to join. If they join—and if they indicate your name on their membership application where it says “RECOMMENDED BY FRIEND/COLLEAGUE PROFESSOR NAME”—you and the new member are entered into the ABCT Membership Lottery. Prizes include free journal subscriptions, training tapes, or a free membership for 1 year. Drawings are held at the convention in November.

2007 Voluntary Contributors

The following members made financial contributions to ABCT in 2007

Adele R. McDowell, Ph.D.	K. Gunnar Gotestam, M.D.
Amy Elizabeth Gooding	Kimberly P. Foley, M.A.
Andrea M. Victor, Ph.D.	Laura D. Wilding, Psy.D.
Andrea Seidner Burling, Ph.D.	Leo J. Reyna, Ph.D.
Andrew L. Berger, Ph.D.	Linda D. Fama, Ph.D.
Anne Marie Albano, Ph.D.	M. Jean Formati, Ph.D.
Anthony H. Ahrens, Ph.D.	Monica C. Skewes, Ph.D.
Beverly K. Lehr, Ph.D.	Nina Josefowitz, Ph.D.
Casey T. Taft, Ph.D.	Nivine T. Shenouda, Ph.D.
Christine A. Padesky, Ph.D.	Peter G. AuBuchon, Ph.D.
David L. Roll, Ph.D.	Peter W. Dowrick, Ph.D.
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Elaine Wilson, Ph.D.	Richard Seim
Elizabeth A. Pawlikowski, Ph.D.	Robert A. Zeiss, Ph.D.
Erin Clarke	Robert C. Glazeski, Ph.D.
G. G. Neffinger, Ph.D.	Robert K. Madsen, Ph.D.
Gail A. Brownell, Ph.D.	Robyn L. Greene, M.A.
H. Katherine O'Neill, Ph.D.	Ronald W. Thebarga, Ph.D.
Issei Uchida, Ph.D.	Sandra Grundfest, Ed.D.
J. Faye Dixon, Ph.D.	Scott J. Scotilla, Psy.D.
Jennifer L. Strauss, Ph.D.	Steven J. Phillipson, Ph.D.
Jeri Breiner, Ph.D.	Tricia Cook Myers, Ph.D.
Jody L. Kamon, Ph.D.	Wendi E. Marien, M.A.
John J. Boren, Ph.D.	William T. Lawhorn, Ph.D.
Julie E. Lindsay, M.S.	

Member-Referring Members

The following members helped us grow by referring new members to the association. Please check the convention program addendum for prize drawing times. You don't need to be there to win but it sure would be nice! Prizes include choice of journal, videotapes, and free membership in 2008

Alan Fruzzetti, Ph.D.
 Brian P. Marx, Ph.D.
 Carol Glass, Ph.D.
 David J. Miklowitz, Ph.D.
 Debra Hope, Ph.D.
 G. Kelly Wilson, Ph.D.
 Janet A. Kistner, Ph.D.
 Keith Renshaw, Ph.D.
 Lynn E. Alden, Ph.D.
 Lynn Marcinko McFarr Ph.D.
 Micheal de Arellano, Ph.D.
 Micheal W. Otto, Ph.D.
 Monika Hauser, Ph.D.
 Rebecca Brock
 Robert DiTomasso, Ph.D., ABPP
 Sandra A. Brown, Ph.D.
 William Johnson, Ph.D.
 George Ronan, Ph.D.*

*Let it be known that George Ronan recruited the most members in 2007!

*
* *

**Have you
been a member
of ABCT for 5 years?
(or a multiple of 5)?**

If so, you get a gold star.
Report to the membership booth
at the Philadelphia meeting
(November 15–18)

* *
*

“Practice
interpersonal
influence . . .”

—Marsha Linehan,
Presidential Panel, 2006

**Recommend ABCT membership
to a friend, colleague, or student.**

Find-a-Therapist

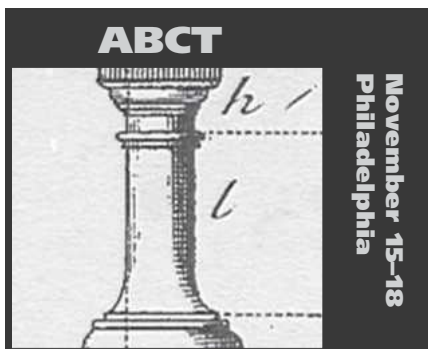
Find-a-Therapist This Fall . . . in Houston, Palm Beach, London, New Zealand . . .

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

It's almost time to convene for the 41st annual conference of the ABCT! The conference is a wonderful opportunity to focus on one's professional development and therefore a great time to update your listing in the Find-a-Therapist directory. This online directory allows members to market their practice and provide a valuable referral service to the public. Did you know that you can expand the information provided in your listing to include practice philosophy, areas of specialization, and other relevant information by signing up for the Practice Particulars option? The additional information can ensure appropriate patient referrals from the community as well as from other ABCT members who can refer patients directly to you without having to post requests on the listserve.

To be listed in the Find-a-Therapist directory and/or to add on Practice Particulars to your listing in the referral directory, select MEMBER LOG-IN on the ABCT home page, log in, and select Find-a-Therapist Directory and Referral Service "join now." Once your request is processed, you can log onto the member's home page at any time to make edits and ensure your information remains current.

Timely Tip: Make flight, hotel and restaurant reservations for the ABCT conference in Philadelphia.



Who's an ABCT AMBASSADOR?

ABCT NEEDS YOU TO

The ABCT Ambassador 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.

Serve as a local source of association activities

Support convention attendance & provide related information

Serve as a role model, encouraging participation & membership

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.



Who Says You Can't Be President?

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

Now's your chance! You probably can't run for President of the United States, but you can nominate yourself or another member for President-Elect of ABCT. The Representative-at-Large position is also open for nominations. It's that time of year when members have the opportunity to make a difference in their professional home by running for office.

Here's how it works: The members who receive the most nominations will appear on the ballot. Members then vote on the candidates of their choice to serve for 3 years. Representative-at-large serves as a liaison to either Membership; Convention and Education; or Academic and Professional Issues. To provide a seamless transition, the candidates who are elected serve an extra year as "elect" to become familiar with all of the details of the position. A strategic planning meeting is customarily held once every

3 years, ensuring that everyone participates in at least one planning session during their term of office.

How to Get Nominated

Don't be shy. If you think you have what it takes, or know someone who does, come by the membership sign-up booth at this year's convention and drop your nominations form in the CALL FOR NOMINATIONS box. You can also mail in your form to ABCT's Central Office, or fax it to (212) 647-1865. Please refrain from emails because original signatures are required. You can nominate as many members as you like, but they must be full members in good standing.

The call for nominations form will be printed in the Winter and January issues of *tBT*. You can also look on our website for detailed descriptions of each of the positions.

Specifics

The person elected as President-Elect (2008-2009) will serve as President from 2009 to 2010. The person elected Representative-at-Large will serve from November 2008 to November 2011, and will also operate as liaison to Membership Issues. There is a face-to-face Board meeting the Thursday of the convention, with monthly conference calls the rest of the year. The Executive Committee is comprised of the President, Immediate Past-President, President-Elect, and the Secretary-Treasurer. Conference calls are held when necessary to ensure the continuance of ABCT's efficiency. Candidates are expected to have knowledge of the mission statement, bylaws, strategic plan, and existing organizational priorities. If you think you're up for the challenge, or you know someone who is, please nominate!

Make this the year you get involved. Serving in one of these offices is a great way to connect with other colleagues, work closely with ABCT's staff, and contribute to our growing profession.

Nominations must be submitted before February 1, 2008, to Kristene Doyle, Ph.D., Nominations and Elections Chair, c/o ABCT, 305 Seventh Avenue, Suite 1601, New York, NY 10001.

NOMINATE the Next Candidates for ABCT Office

I nominate the following individuals
for the positions indicated:

PRESIDENT-ELECT (2009-2010)

REPRESENTATIVE-AT-LARGE (2008-2011)

NAME (printed)

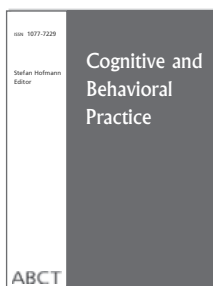
SIGNATURE (required)

2008 Call for Nominations

Every nomination counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2008, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Contact the Nominations and Elections Chair for more information about serving ABCT or to get more information on the positions. **Please complete, sign, and send this nomination form to Kristene Doyle, Ph.D., Nominations & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.**

Cognitive and Behavioral Practice



Special issues
& case conferences
from the journal's
inception to present

- 1996** 3(2) *Special Series*: Ethnic and Cultural Diversity in Cognitive and Behavioral Practice
- 1998** 5(2) *Special Series*: Stigma
Case Conference: The Case of Joe—BPD Lite
- 1999** 6(1) *Case Conference*: The Case of Anna: Major Depression and Borderline Personality Disorder
6(2) *Special Series*: Adolescent Health
Case Conference: Trichotillomania in Youth
6(3) *Special Series*: Innovations in Treatment for Anxiety Disorder
Case Conference: The Case of Mary: Major Depression with Anger Attacks
6(4) *Special Series*: Treatment of OCD: Progress, Prospects, and Problems
Case Conference: The Case of Julio—Assessment of a Client with Chronic Fatigue Syndrome
- 2000** 7(1) *Special Series*: Empirically Based Prevention and Treatment Approaches for Adolescent and Young Adult Substance Use
Case Conference: The Case of Howard—PTSD and Depression
7(2) *Special Series*: Couples and Illness
Case Conference: The Case of Mike—A Socially Rejected Adolescent in Residential Care
7(3) *Special Series*: Accentuating the Role of Therapist Emotion in Behavior Therapy Training
Case Conference: The Case of Ryan—A Child Who Suffered Multiple Episodes of Sexual Abuse
7(4) *Special Series*: Dialectical Behavior Therapy
Case Conference: Katrina—Borderline Personality
- 2001** 8(1) *Special Series*: Religion and REBT
8(2) *Case Conference*: The Case of Aleisha—ADHD With Oppositionality, Anxiety, Peer/School Difficulties
8(3) *Special Series*: Primary Prevention of Eating Disorders: A Noble Calling or an Unrealistic Ideal?
8(4) *Special Series*: Pushing the Envelope of Empirically Based Treatments for Children
- 2002** 9(1) *Special Series*: Integrating Buddhist Philosophy with Cognitive and Behavioral Practice
9(3) *Case Conference*: ACT in the Treatment of an Adolescent Female With Anorexia Nervosa
9(4) *Special Series*: Science-Based Responses to Terrorism
- 2003** 10(1) *Special Series*: Going Beyond the Manual
10(2) *Special Series*: Obesity and Eating Disorders
10(4) *Special Series*: Strategies for Moving Evidence-Based Interventions Into Clinical Practice
- 2004** 11(1) *Special Series*: Anxiety Disorders in Children and Adolescents
Case Conference: Case of Mrs. A: Health Anxiety
11(2) *Special Series*: Current Perspectives on Implicit Cognitive Processing in Clinical Disorders: Implications for Assessment and Intervention
- 2005** 12(1) *Special Series*: Adapting CBT for Recalcitrant Populations
Special Series: CT of Bipolar Disorder
12(2) *Special Issue*: Treatment for Adolescents With Depression
12(4) *Case Conference*: The Case of Sam—OCD and Schizophrenia
- 2006** 13(1) *Special Series*: Involving Fathers in the Delivery of Psychological Services
Case Conference: A Case Study of PTSD and Comorbid Problems Arising From a Road Traffic Collision
13(3) *Case Conference*: ACT in the Rehabilitation of a Girl With Chronic Idiopathic Pain
13(4) *Special Series*: Culturally Sensitive CBT
- 2007** 14(1) *Special Series*: Advances and Future Directions in CBT for Resistant Anxiety Disorders
14(2) *Case Conference*: A Case of Attention Training With Auditory Hallucinations
14(3) *Special Issue*: Using Homework in CBT With Challenging Patients

Yearning for that certain special issue of C&BP?

All members can view past, current, and in-press issues at ScienceDirect.com.
Activate access today at <https://www.sciencedirect.com/abct/activate/members>

Classifieds

Classified ads are \$4.00 per line. For a free price estimate, attach the text of your ad in the form of a Word document and email sschwartz@abct. For information on display ads, deadlines, and rates, contact Stephanie Schwartz at the email above or visit our website at www.abct.org and click on ADVERTISE.

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. email hrrhbjm@omh.state.ny.us.

ABCT's Job Bank is free to all job seekers and provides you with access to the best employers and jobs in CBT. It features

- Advanced job searching options including states, type of job, and more
- Control over your career advancement: you can describe yourself, your objectives, salary needs, and more, all with your resume
- Increased exposure for your résumé
- Optional email alerts of new jobs

EMPLOYERS

- Quick and easy job posting
- Quality candidates!
- Online reports that provide job activity statistics
- Simple pricing options

JOB BANK

JOB SEEKERS | EMPLOYERS
<http://jobbank.abct.org>

You've changed.

So that we
may continue
to grow with you,
please update
your membership
profile.

- go to www.abct.org
- click "MEMBER LOG IN"
- click on "UPDATE YOUR DIRECTORY LISTING"

 ABCT

Answers to Some Perplexing Questions About the Annual Convention

41st Annual Convention, November 15-18, 2007, Philadelphia Marriott

You are strongly urged to preregister by the deadline of October 19, 2007.

Preregister on-line at www.abct.org. Admission to Workshops, Master Clinician Seminars, and AMASS is by ticket only. Preregistration is strongly advised as tickets are sold on a first-come, first-served basis.

What Are the On-Site Registration Hours?

- Thursday
Preregistration pick-up: 11:00 a.m. - 8:00 p.m.
On-site registration: 3:00 p.m. - 8:00 p.m.
- Friday 7:30 a.m. - 3:00 p.m.
- Sat. 8:00 a.m. - 3:00 p.m.
- Sunday 8:00 a.m. - 11:30 p.m.

What Does the General Registration Fee Cover?

The General Registration fee entitles you to attend all events (see below for descriptions of types of events) on **November 16-18** except for ticketed sessions (Workshops, Master Clinician Seminars, and AMASS). Your canceled check is your receipt. Email confirmation notices will be generated automatically for on-line registrations and will be sent via email the same day you register. If you do not receive an email confirmation within 24 hours, please call the central office: (212) 647-1890.

Do Presenters Have to Pay?

All presenters (except for the first two Workshop and Master Clinician Seminar presenters) must pay the general registration fee. Workshop and Master Clinician Seminar leaders will receive information as to their registration procedure from the ABCT Central Office.

What Are "Preconvention Activities"?

The preconvention activities will be held on Wednesday, November 14, and Thursday, November 15. All preconvention activities are designed to be intensive learning experiences. Preregister on-line to ensure participation. On-site registration for the 2-day Clinical Intervention Training only will take place on Wednesday from 8:00 a.m. to the 8:30 a.m. start time. For Thursday Clinical Intervention Seminars only, on-site registration is from 7:30 to the 8:30 start time. On-site registration for Thursday Institutes and AMASS is open at the designated registration booth in the ABCT registration area, which opens at 11:00 a.m.

How Do I Preregister?

ON-LINE. The quickest method is to register on-line at www.abct.org. Use this method for immediate feedback on which ticketed sessions you will be attending. To receive members' discounted rates, your ABCT dues must be up to date. If your membership has lapsed, use this opportunity to renew. To get member rates at this conference, your ABCT dues must be paid through October 31, 2008. The ABCT member year is November 1- October 31. On-site you can renew prior to registering at the ABCT Membership Booth located in the ABCT Registration area.

For preregistration rates, please register **BEFORE** the deadline date, October 19. From October 20 through October 31 registrations will be accepted at the on-site rates. No registrations will be accepted in any format from November 1 until November 15, when on-site will open in Philadelphia.

ABCT sends email **confirmation** shortly after you register on-line. Hard copy confirmation letters are also sent. If you have registered and do not receive a letter by November 1, please email Tonya Childers at tchilders@abct.org detailing the date you registered and the fees you paid.

FAX. You may fax your completed registration form, along with credit card information and your signature, to (212) 647-1865. If you choose this method please **DO NOT** send a follow-up hard copy. This will likely cause double payment. For preregistration rates, please register **BEFORE** the deadline date of October 19. Faxed registrations received from Oct.19 through Oct 31 will be accepted at the on-site rates. No registrations will be accepted in any format from November 1 until November 15, when on-site will open in Philadelphia.

MAIL. All preregistrations that are paid by check (made out to ABCT) must be mailed to ABCT, 305 Seventh Avenue, New York, NY 10001. For preregistration rates, forms must be **postmarked by the deadline date: October 19**. Forms postmarked from October 20 through October 31 will be processed at the on-site rates. Forms postmarked after October 31 will be returned. There will be no exceptions.

What Is Your Refund Policy?

Refund requests must be in writing. Refunds will be made only until the October 19 deadline, and a \$40 handling fee will be deducted. Because of the many costs involved in organizing and producing the Convention, no refunds will be given after October 19.

What's the Difference Between a Workshop and a Master Clinician Seminar...? Some definitions:

Symposia (S) Presentation of data, usually investigating efficacy of treatment protocol or particular research. **Panel Discussions (PD)** and **Clinical Round Tables (CRT)** Discussion (sometimes debate) by informed individuals on a current important topic. **Special Sessions (SS)** These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years our Internship Overview and Postdoctoral Overview have been helping people find their educational path. Also offered are several "how-to" sessions on career development assembled by the ABCT Membership Issues Committee. **Poster Sessions (PS)** One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees. **Special Interest Groups (SIG)** Try to schedule in time to attend one or two of the 30+ SIG meetings: Another great way to share your knowledge with people working in your interest area. **Clinical Intervention Training** One- and two-day events allowing for exceptional interaction (7 hours or 14 hours of CE credit). **Institutes** One full-day and six half-day sessions with limited enrollment (8 hours or 5 hours of CE credit). **Advanced Methodology and Statistics Seminars (AMASS)** One on Thursday, one on Sunday, these are designed to enhance researchers' abilities (4 hours of CE credit). **Master Clinician Seminars (MCS)** Throughout the Convention attend these useful sessions where the most skilled clinicians explain their methods and show tapes of client sessions (2 hours of CE credit). **Workshops (W)** Covering many concerns of the practitioner/educator/researcher, these remain an anchor in CBT education (3 hours of CE credit)

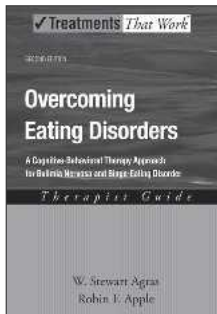
About Treatments That Work™

The Treatments *ThatWork*™ series offers you the tools you need to help your clients overcome a range of problems, including anxiety, panic, phobias, eating disorders, addictions, PTSD, and emotional and behavioral aspects of many medical problems, among others. Whatever the condition or diagnosis, we have a program for you.

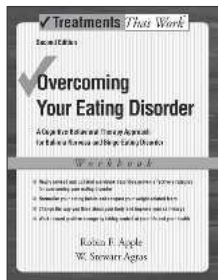
Comprised of guides for therapists and workbooks for clients, the series contains all of the step-by-step details involved in delivering scientifically-proven treatments for psychological disorders. All programs have been rigorously tested in clinical trials and are backed by years of research. A prestigious scientific advisory board, led by series Editor-in-Chief David H. Barlow, reviews and evaluates every treatment to ensure that it meets the highest standards of evidence.

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 contain psychoeducational information, forms and worksheets, and homework assignments to keep clients engaged and motivated. A companion website (www.oup.com/us/tw) offers downloadable clinical tools and helpful resources.

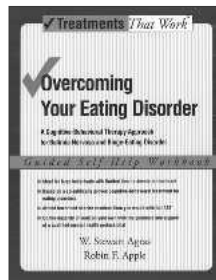
Treatments *ThatWork*™ represents the gold standard of behavioral healthcare interventions. Our books are reliable and effective and make it easy for you to provide your clients with the best care available.



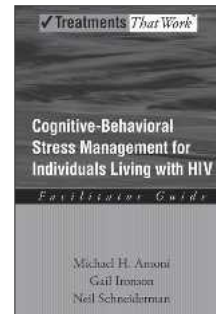
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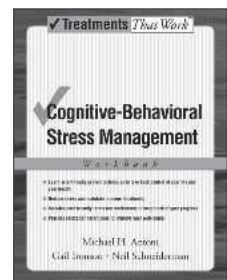
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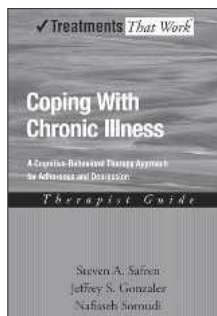
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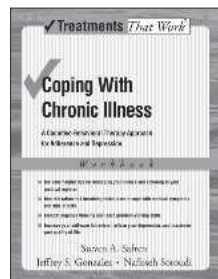
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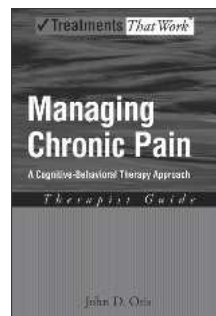
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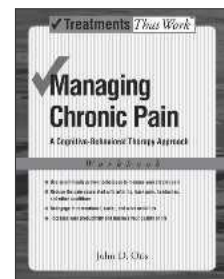
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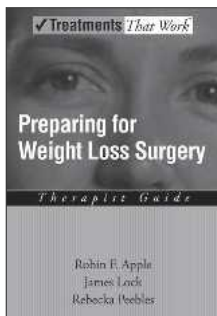
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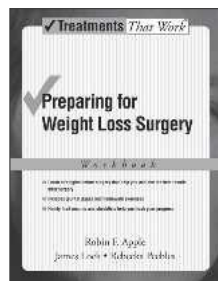
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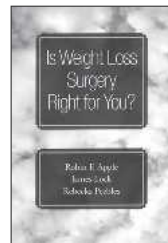


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ALSO OF INTEREST



IS WEIGHT LOSS SURGERY RIGHT FOR YOU?
Robin F. Apple, James Lock, and Rebecca Peebles, *all at Stanford University*

"[This book] provides a neutral and simple guide to assist in making this major decision. [The authors] are careful to point out that surgery is not always the correct choice, and the book provides the reader with enough information to be well informed about what to expect at each stage of the decision."
—PsycCRITIQUES

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Special Sessions on Sunday!

41st Annual Convention | November 15–18, 2007 | Philadelphia



SPECIAL MEMBERSHIP SESSION 1

November 18, 2007

9:00 A.M. – 10:30 A.M. • Franklin 3

The “How to” Clinic: What You Need to Know About Group Practice

MODERATORS: **Kristen H. Sorocco** & **Angela W. Lau**

PANELISTS: **Kristen H. Sorocco**, University of Oklahoma Health Sciences Center

Ann Layne, Private Practice, Anxiety Treatment Resources and University of Minnesota Medical School

Elizabeth Turk-Karan, Southampton Psychiatric Associates

Loretta S. Malta, Weill Medical College of Cornell

In response to a prior survey of ABCT members indicating a need for more practical guidance of clinical opportunities for cognitive-behavior therapists, the Membership Committee has previously sponsored “how to” panels on private practice, continuing education workshops, and publishing books, workbooks, and/or manuals. This year’s “how to” clinic will provide the audience with the nuts and bolts of how to get started and be successful in group practice. Panelists are cognitive-behavior therapists who have successful private practices ranging from a year to many decades of therapy experience. Panelists serve child, adult, and older adult clients, treating a range of diagnoses. A special emphasis will be on how to incorporate evidence-based treatments into group practices. The panelists will share their experiences and provide advice on aspects to consider and outline the active steps to take when starting or joining a group practice. Panelists will provide insight and guidance on business considerations and marketing strategies that are vital for success but that typically are not taught or discussed in graduate school or postgraduate training.

SPECIAL MEMBERSHIP SESSION 2

November 18, 2007

10:45 A.M. – 12:15 P.M. • Franklin 3

Issues in Professional Development: Keys to Establishing and Maintaining a Successful Career

MODERATOR: **Kristen H. Sorocco**

PANELISTS: **Simon Rego**, Montefiore Medical Center

Gail Steketee, Boston University School of Social Work

Donna Sudak, Drexel University College of Medicine

Gerald Tarlow, Private Practice and UCLA

As a new professional, figuring out what that first job should be or how to balance all of your professional responsibilities can be a confusing and daunting process. The purpose of this session is to help individuals in the earlier stages of their career learn the keys to successful career development and to discover how one can negotiate/balance personal and professional interests and responsibilities.

The panelists will share their experiences and wisdom with regard to establishing and maintaining a successful career, whether as an academic, clinician, or somewhere in between. They will share with you a breadth of available professional opportunities, how to get started in these various endeavors, and how they handled decision-points that affected their personal interests. Among other topics, they will provide advice and suggestions on (a) how to organize your time and activities for tenure; (b) how to establish a career in nonacademic settings; (c) how to balance research, teaching/training, and/or clinical practice; (d) how to remain active in professional activities and organizations in spite of life’s many demands.

Coordinated by the Membership Issues Committee

the Behavior Therapist

Association for Behavioral and Cognitive Therapies

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