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From the Editor

Fin

David Reitman, *Nova Southeastern University*

As 2007 draws to a close, and another convention has passed, I give to you Dr. Drew Anderson, your new *tBT* editor. In just a short time, Drew has established himself as a fine researcher and clinician and excellent ambassador for cognitive behavior therapies. Having assembled his own editorial team, I expect the latest incarnation of *tBT* to surpass what we have achieved and continue "to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy." Drew will make an excellent leader and great editor. I wish him well.

As I depart from my role as editor, I'd like to thank, first and foremost, the fine and dedicated staff in New York who fail to get enough credit for the very significant contributions they make to our work. They are humble and most tolerant of our ways, more than many of you could know. I'd especially like to thank Stephanie Schwartz and David Teisler for providing sage counsel and bringing a great sense of humor to their labor—in equal good measure. Most recently, David and Stephanie succeeded in placing all *tBT* issues back to Volume 25 online through our award-winning ABCT Web page, so *tBT* will be more accessible than ever.

Much appreciation is also due to my editorial team. Many of our editors have served dogged and determined for so long that serious neurological damage must be suspected. Specifically, I call for comprehensive evaluations of Drs. David Hansen, Gayle Iwamasa, and Jeff Lohr. As past editors have noted, these three demonstrate an unusual level of commitment to their craft and

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INSTRUCTIONS *for* AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

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

Submissions must be accompanied by a Copyright Transfer Form (a form is printed on p. 56 of the March 2007 issue of *tBT*, or contact the ABCT central office): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Drew Anderson, at **drewa@csc.albany.edu**. Please include the phrase ***tBT submission*** in the subject line of your e-mail. Include the first author's e-mail address on the cover page of the manuscript attachment. By conventional mail, please send manuscripts to:

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their efforts have been most appreciated by this editor. Although all of our editors contributed to the production of Volumes 28 to 30, a few deserve special mention. Dr. Clint Field did a remarkable job of informing members of the excellent training opportunities that exist in our profession. Dr. David Penn was an enthusiastic advocate for persons suffering with schizophrenia and other serious mental health problems. Dr. Andrea Chronis assisted authors in crafting a series of informative reviews of recent publications in CBT and related fields. Drs. David DiLillo and Laura Dreer kept us up to date concerning CBT people in the news. Drs. James Carter, Mark Dadds, John Forsyth, Tim Stickle, Tamara Penix Sbraga, Andrea Seidner Burling, and Ethan Long were always there to serve as reviewers and maintain the high standards of *tBT*. A "tip of the hat and wag of the finger" to Elizabeth Moore, the unofficial *tBT* cartoonist and humorist.

You might have noticed that students had an exceptionally strong voice in recent volumes, which was partly by design, but largely due to the strong editorial hand of recently minted Dr. Megan Kelly. One student, my own Kyle Boerke, somehow managed to keep track of our manuscripts and see that they made their way into the pages of *tBT*.

Looking back on Volumes 28 to 30, my personal favorites:

- *tBT* Associate Editor, Dr. Kelly Wilson's (2005) musings on "The Serious Matter of Humor in Science"
- *tBT* Associate Editor, Dr. Brian Marx's (2007) recent interview with Dr. Terry Keane on our "most cited" *tBT* article (and other important matters in behavior therapy)
- A remarkable review of the parent training literature by AABT Past-President and Parenting SIG trailblazer, Dr. Gerald Patterson (2005)
- A two-part series on publishing and perishing by Dr. Steven Taylor et al. that young academics would do well to pay heed
- Lastly, the occasional contributions by "Dr. Herman Stickleback" (2005, 2006) made me laugh out loud (*reveal yourself!*)

One final note of appreciation goes to the membership of ABCT; your efforts, on behalf of your clients and students, are the lifeblood of this publication and give purpose to our field. For all that you do and will do, our most sincere thanks. Keep up the good work and keep sharing it in *tBT*!

—David Reitman, Ph.D.
tBT Editior, Volumes 28–30

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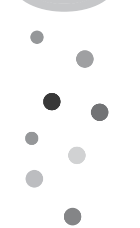

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Student Forum

Supervisee to Supervisor: Making the Transition

Teresa L. Marino and Vidyulata Kamath, *University of Central Florida*

The evolution from graduate student to professional is filled with a variety of role shifts. Those who remain in academia will find themselves editing dissertations rather than writing them. Those choosing to pursue clinical work will transition from studying for competency exams to studying for licensure exams. Perhaps the most ubiquitous role shift is the transition from supervisee to supervisor. Given that requirements for supervised practice are common to nearly all clinical practice settings, it is likely that most graduate students will find themselves in some type of supervisory role shortly after entering the workforce. The supervisor faces many challenges in attempting to balance the development of the trainee's skills and the needs of the client. Unfortunately, there is no steadfast rule concerning how to deal with the unique challenges of being a new supervisor. However, awareness of the challenges and openness to tackling the obstacles can facilitate a smoother transition from the role of supervisee to supervisor.

Putting Your Clinical Skills to Use

As graduate students, you have dedicated a large part of your training to developing clinical skills. This will serve as the foundation on which you build proficiency as a supervisor and can facilitate a trusting relationship with your supervisee. The ability to empathize, communicate, and collaborate with your clients are skills you will need when working with future trainees. Dr. Marijane Fall, a professor in the Counselor Education Department at the University of Southern Maine, who has written over 25 journal articles on clinical supervision, emphasizes the importance of reflecting the meaning and feeling of supervisees' experiences before asking questions. "This helps supervisees feel validated and listened to so that they can hear you better," explains Dr. Fall (personal communication, March 29, 2007). This illustrates how the supervisory process can parallel that of psychotherapy.

In addition, the roles of therapist and supervisor both require the ability to establish a collaborative relationship, make perceptive observations, and conceptualize case information. Your interpersonal skills will be an asset to you as you attempt to apply your knowledge in helping trainees, much like clients, reach their full potential. This "potential" is what Egan (2001) refers to within the skilled-helper model. Within Egan's framework, therapists work with clients to clarify problem situations, explore unused opportunities, and visualize a preferred scenario. Next, therapists help clients establish goals that lead to realization of the preferred scenario and outline a plan to accomplish these goals. This process appears to mirror the supervisory relationship in that the supervisor and supervisee determine areas where improvement is needed, outline goals for supervision, and determine behaviors that can aid supervisees in their quest to develop clinical acumen. Therefore, therapeutic skills can be advantageous as you transition into a supervisory role.

Thinking Like a Supervisor

Though there are similarities between supervision and therapy, it is important to emphasize the ways in which these processes differ. Shulman (2005) stressed the need to differentiate the two, stating that "supervisors who are seduced into a therapeutic relationship with their supervisees actually model poor practice since they lose sight of the true purpose of clinical supervision and their role in the process" (pp. 25–26). L. DiAnne Borders, Chair of the Department of Counseling and Educational Development at the University of North Carolina at Greensboro and author of *The Handbook of Counseling Supervision*, holds a similar viewpoint. She asserts that an integral part of the transition involves a cognitive shift from thinking like a therapist to thinking like a supervisor (Borders, 1992). Dr. Borders shared her belief that "clinical supervision is a deliberate, intentional educational process, so clinicians need to gain skills in learning to think and plan like an educator, as well as the evaluation skills of educators" (personal communication, March 29, 2007). In your role as an educator, part of your responsibility includes ensuring that your trainees attain a certain level of competence. The key to this process involves objective and constructive evaluation. Current research in supervision suggests that it is important to delineate trainee goals and establish supervisor expectations at the beginning of the supervisory relationship. Establishing concrete objectives will likely make the evaluative process less ambiguous for both you and your supervisee.

Several personality variables have been found to enhance the supervisory relationship. These include flexibility, self-disclosure, permissiveness, outgoingness, genuineness, respect for the supervisee, concreteness, and empathy (for a comprehensive review, see Neufeldt, Beutler, & Banchero, 1997). In addition to personality variables, gender, race, ethnicity, sexual orientation, age, and religious orientation may also influence the supervisory relationship. Clinical supervisors may benefit from familiarizing themselves with some of the models of multicultural supervision proposed in the literature (e.g., Hird, Tao, & Gloria, 2004; Ruskin, 1994). Just as therapists must be culturally competent in order to effectively work with clients from myriad backgrounds, it is important for supervisors to familiarize themselves with the ways in which demographic factors may affect the supervisory relationship.

Creating Your Own Standard

Assuming the role of supervisor for the first time may appear daunting. Your responsibilities double as you indirectly care for the client and aid in the clinical and professional development of the trainee. Given the extent to which supervisors are held accountable and the high level of autonomy that one may be expected to assume, it is surprising that standards for supervisors are not more rigorous. For example, the American Psychological Association (APA) has not issued standards concerning the minimum hours of therapy or special credentials that might be required before a newly licensed psychologist may supervise clinical practica. Further, many universities do not require clinical psychologists to have a license to supervise students' psychotherapy cases. Though APA does require graduate programs to include some form of supervisory training, directors of clinical training are granted the latitude to determine how this training will be integrated into their particular program. As a result, some programs offer courses on clinical supervision seminars as part of their curriculum and others choose to weave elements of supervisory training into existing coursework. Variation in supervisory training can therefore produce very different experiences for graduate students across graduate training programs. Given the lack of standardization in the mode, exposure, and nature of supervisory training, what is the competency expectation for emerging supervisors? And for that matter, how do we know what constitutes competency in clinical supervision?

The literature does identify a handful of skills that appear to be important qualities for supervisors, such as genuine and accurate empathy, a broad knowledge base of therapeutic techniques, and an understanding of the developmental level of the supervisee. However, research in this area is limited and many recommendations do not appear to be empirically based (Lambert & Ogles, 1997). Given the absence of data, an alternative method of gauging which qualities are important for effective and competent supervision is speaking to those with experience. For example, Dr. Jane Campbell, author of *Essentials of Clinical Supervision* (2006) and *Becoming an Effective Supervisor: A Workbook for Counselors and Psychotherapists* (2006), notes that "Supervision is based on a lot of tradition and modeling, but not on a lot of scientific evidence. Therefore, we end up assuming a lot" (personal communication, April 2, 2007). Dr. Janine Bernard, professor and Chair of Counseling and Human Services at Syracuse University and coauthor of *Fundamentals of Clinical Supervision* (1998), notes the complexity of supervision. "It's hard to pinpoint particular characteristics that differentiate the successful novice supervisor from the struggling novice supervisor. There are many skills and dispositions that come together to arrive at success" (personal communication, March 29, 2007).

Seeking feedback from skilled supervisors can shed light on how to hone your skills and optimize your effectiveness as a supervisor. Dr. Stacey Tantleff-Dunn, Associate Professor at the University of Central Florida, with over 10 years of supervisory experience, believes that facilitating the development of thorough case conceptualizations is a particularly helpful component of supervision. "Working with supervisees to develop thoughtful case formulations is essential for constructing the blueprints that will guide the therapy. It is important to teach supervisees to understand clients' struggles in the context of their life experiences. The ability to see patterns and themes empowers supervisees who may otherwise become overwhelmed by their clients' numerous stories, symptoms, and presenting complaints" (personal communication, April 19, 2007). Dr. Tantleff-Dunn also emphasizes the value of encouraging supervisees to view diagnoses within the framework of the case conceptualization: "Arriving at a diagnosis is important for choosing treatment options, but really understanding the diagnosis in the context of a particular client's life is important for treatment success" (personal communication, April 19, 2007).

Important skills needed for effective supervision may also vary as a function of the type of therapeutic techniques being utilized

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by the trainee. For example, supervisees with little to no exposure to cognitive behavioral therapy will require more in-depth instruction on the cognitive model, cognitive case conceptualization, and cognitive and behavioral techniques. One resource, *Handbook of Psychotherapy Supervision* (Watkins, 1997), contains several comprehensive chapters devoted to the supervision of cases involving specific therapies. In one chapter, Liese and Beck (1997) discuss essential components to successful supervision of cognitive therapy cases. Within cognitive supervision, sessions parallel the therapy session as cognitive therapy supervisors engage in weekly sessions that involve agenda setting, bridging sessions, review of homework, and eliciting the supervisee's feedback. The authors note that problems in cognitive therapy supervision can be addressed when the supervisory process is conceptualized and misconceptions of cognitive therapy are addressed. Additional chapters highlight supervision of dialectical behavioral therapy (Fruzzetti, Waltz, & Linehan, 1997) and rational emotive therapy (Woods & Ellis, 1997). Given that some supervisory skills are setting and context specific, it may be useful to seek advice from other supervisors in your program as well.

Building a Safe Environment

Now that you are ready to begin the supervisory process, there will be other factors to consider. Research has demonstrated that positive and negative biases in reporting details of the therapy session and client progress are the norm (Yourman, 2003). Although this is a phenomenon all supervisors must deal with, it may be an especially tricky area for the new and inexperienced supervisor to navigate. Certainly many of the discrepancies between what is occurring in session and what is being reported to the supervisor are not deliberate—after all, we all know how inherently difficult it is to fully capture every aspect of the session during our case presentations. Often, errors in reporting are simply the result of memory lapses or a skewed perception on the part of the trainee. However, a growing body of literature suggests that it is a fairly common occurrence for trainees to deliberately withhold or misrepresent information out of shame or fear of chastisement (Ladany, Hill, Corbett, & Nutt, 1996; Yourman, 2003). Additionally, some supervisees tend to intentionally describe their sessions more negatively than what they actually perceive, perhaps to "set the bar low" and solicit positive feedback and encouragement when the supervisor reviews the session tape or transcript. After reviewing the relevant literature and speaking with professionals in the field, it seems that the best way to encourage disclosure from supervisees is to create a warm, safe, and empathic atmosphere in which the supervisees feel comfortable. Mutual respect and trust are essential for the supervisory relationship and can decrease the likelihood that the process will be marred by defensiveness, shame, or frustration. In addition, it may be helpful to utilize other modalities of supervision aside from self-report (e.g., reviewing tape or using two-way mirrors) in order to help students become knowledgeable about their positive or negative slants. It is important to be mindful that biases and errors in reporting are highly likely to occur. However, providing a safe environment not only facilitates trainee disclosure but also fosters an atmosphere of intra- and interpersonal growth.

Soliciting Feedback

You have now begun to settle into your new role as supervisor. You understand that you can use your therapy skills to guide your supervision style and are aware of the unique dynamic that can occur when a new supervisor works with advanced graduate students. Furthermore, you have developed some confidence and a new sense of efficacy, have worked to create a positive and safe environment for your supervisees, and feel prepared to work through biases in reporting. Given all the effort you have put into developing your skills, how do you know if you are achieving your supervisory goals?

Though client progress is one way to gauge your effectiveness, client outcome can be attributed to a variety of factors (e.g., therapist skill, treatment modality, or variables external to the therapy). Therefore, client outcome alone may not be a valid basis for assessing your development or success. Seeking direct feedback from others can often be a richer source of information, and is a core component of your development as a supervisor. Dr. Fall believes that to be a good supervisor, you must learn to be a good supervisee. "Supervision for life will assist you in growing, not stagnating or burning out" (personal communication, March 29, 2007). In many work environments, such as a university setting, new supervisors often practice under the guidance of a more senior supervisor. This type of supervisory relationship is typically more egalitarian than that of a supervisor and a trainee, and is often tantamount to peer consultation. If you do not have a supervisor, peer consultation may still be a viable option, depending on the confidentiality regulations of your site. This feedback is vital as you create a foundation for your supervisory skills. Dr. Fall also recommends generating your own feedback of your performance by videotaping and reviewing your supervisory sessions.

Soliciting feedback from your trainees is equally as important. After all, your trainees know firsthand what it is like to be on the receiving end of the supervisory process. Trainees can also provide insight as to how your supervision is being translated into client care. In addition, soliciting feedback from trainees models the collaborative nature that takes place during therapy. One of the authors (T.M.) remembers an incident where a supervisor, after providing her with some feedback that was particularly difficult to hear, asked, "How could I have made the delivery of that message better for you?" The opportunity to provide feedback to the supervisor in the moment enhanced the rapport and trust in the supervisory relationship.

As an inexperienced supervisor, integrating this type of feedback can facilitate your growth and development. However, do not assume that all trainees will spontaneously provide feedback. Due to the inherent power differential in the supervisor/trainee relationship, supervisees may be reluctant to give feedback, especially if the feedback may be perceived as critical of your supervision. However, actively soliciting supervisee feedback may give them "permission" to do so.

In many work settings, supervisees are asked to formally evaluate their supervisors using standardized questionnaires. Research has found that fear of receiving a negative evaluation has prevented supervisors from providing trainees with feedback that might upset or offend them, even if that feedback is honest, accurate, and necessary (Noelle, 2002). New supervisors who are just beginning their careers might be particularly affected by this concern. Most new employees and faculty members want to receive positive evaluations, especially given that these evaluations are likely to be reviewed by peers or administrators. However, the desire for a favorable evaluation should never supersede the provision of honest and accurate feedback for the trainees. By fostering a supervisory climate of openness, trust, and mutual respect, difficult feedback can be more easily delivered and more readily received.

Seeking Out Supervisory Experiences

As with most new endeavors, gaining experience early on will help prepare you for the various situations you will encounter as a supervisor. Graduate school can be an optimal

forum in which to begin practicing supervisory skills. Our experiences in our program's supervision seminar and practicum have made us feel much more prepared and confident about being supervisors. However, even if you aren't able to obtain supervisory training through a formal class, with a little initiative you may still enhance your preparation by reading the literature and initiating discussion with your existing supervisors concerning their view of the supervisory role. You can then build on this foundation experientially. If your practicum site utilizes "vertical" teams comprised of students of varying degrees of experience, take full advantage of this opportunity to practice your supervision skills. You may want to ask your supervisor about the possibility of facilitating or cofacilitating a group supervision session. If neither of these opportunities is available to you, actively engage in peer supervision, and/or participate in some mock role-play supervision sessions. Be mindful to incorporate the knowledge from the literature as well as the insight shared by more experienced supervisors into your practices, and make sure to ask for plenty of feedback throughout, both from your supervisee and from your supervisor.

Finally, keep in mind that you are going to make mistakes. You may even regret a particular decision you made or reflect back on how you would have handled a situation differently. However, all mistakes offer an opportunity to learn and grow. Having the experience provides you with perspective and allows you to embrace the process. It can also provide important insight into whether the role of a clinical supervisor would be a good fit for you. The role of clinical supervisor is not for everyone; becoming an effective supervisor requires both the desire to supervise trainees as well as skillful mastery of the supervisory techniques. Because there are many important distinctions between therapy and supervision, successful therapists may not always make the best supervisors.

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- Emotion Regulation Difficulties Associated With the Experience of Uncued Panic Attacks: Evidence of Experiential Avoidance, Emotional Nonacceptance, and Decreased Emotional Clarity *(Tull & Roemer)*
- Body Vigilance in Nonclinical and Anxiety Disorder Samples: Structure, Correlates, and Prediction of Health Concerns *(Olatunji et al.)*
- Fears in Clinic-Referred Children: Relations With Child Anxiety Sensitivity, Maternal Overcontrol, and Maternal Phobic Anxiety *(Ollendick & Horsch)*
- Effects of Pain Acceptance and Pain Control Strategies on Physical Impairment in Individuals With Chronic Low Back Pain *(Vowles et al.)*

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- Behavioral Activation as an Early Intervention for PTSD and Depression Among Physically Injured Trauma Survivors *(Wagner et al.)*
- Adaptive Inferential Feedback Partner Training for Depression: A Pilot Study *(Dobkin et al.)*
- Translating Empirically Supported Strategies Into Accessible Interventions: The Potential Utility of Exercise for the Treatment of Panic Disorder *(Smits et al.)*
- Adapting Mindfulness-Based Stress Reduction for the Treatment of OCD *(Patel et al.)*
- The Impact of Demand Characteristics on Brief Acceptance- and Control-Based Interventions for Pain Tolerance *(Roche et al.)*
- Integrating DBT and Cognitive-Behavioral Couple Therapy: A Couples Skills Group for Emotion Dysregulation *(Kirby & Baucom)*
- Effectiveness of DBT in a Community Mental Health Center *(Comtois et al.)*

Plus, reviews of these titles: Eifert & Forsyth's (2005) *Clinical Manual for Anxiety Related Conditions* • Schuyler's (2003) *Cognitive Therapy: A Practical Guide* • Heimberg et al.'s (Eds.) (2004) *Generalized Anxiety Disorder: Advances in Research and Practice*

Clinical Training Forum

Didactic Presentations as a Supplement to Graduate Education

Megan Markey, Christine Rufener, Lauren Clary, and Anna Wonderlich-Tierney,
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With many programs offering degrees in clinical psychology across the United States and Canada, it is of little surprise that the training of psychologists before they begin their professional careers often vastly differs from program to program and even from student to student. The training of a clinical psychologist is further complicated by the broad roles that a professional psychologist may assume in his or her career (e.g., clinician, professor, researcher, etc.) in a vast range of working environments (e.g., university, medical school, health care facility, private clinic, etc.) with a variety of populations. In addition, the advent and growth of managed care over the past few decades has placed additional pressures and demands upon practicing psychologists, which adds to the unique challenges of training psychologists who are prepared to meet the demands of a changing health care system (Kenkel, DeLeon, Albino, & Porter, 2003; King, 2006). Given the constant flux of the field, the optimal graduate training experience must be reexamined frequently in order to ensure that students are receiving the highest quality of training that best prepares them for careers in clinical psychology.

While graduate coursework functions to instill the foundations of clinical psychology (i.e., assessment, psychopathology, interventions, research methodology, ethics and professional issues), and practica experiences provide clinical and research training, other means of refining and augmenting graduate training can be used to provide supplementary information, knowledge, or skills that go beyond the scope of formal curricula. However, graduate students often struggle with how to incorporate additional training experiences into their already busy schedules. If additional training opportunities are to be supplemented, these experiences need to be easily accessible and maximally convenient for students. Implementing a seminar or didactic series is one method that can increase both the breadth and depth of graduate training without significantly taxing students' already demanding schedules. For the purposes of this article, the term "didactic presentation" is intended to refer to formal or relatively informal single-event presentations that occur outside of the regular course sequence in graduate training. A series of didactic presentations covering multiple interrelated yet distinct topics may be presented, but these are usually delivered by speakers other than the institution's regular lecturer or instructor.

Advantages of Didactic Instruction in Graduate Training

A review of internship websites suggests that didactics are typically offered at the internship level of training, yet their use and availability in graduate programs is unknown. Didactic instruction may be presented in one or more of several formats, making implementation possible for all types of graduate programs. Depending on the program's goals for the presentations, viable presentation options include brown bags, grand rounds, seminars, question-and-answer sessions, and roundtable discussions. Brief presentations can meet the needs of graduate students who are typically available only for short periods of time due to clinical or research-related tasks, practica, supervision, classes, coursework and various other personal obligations. The didactic presenters may come from a variety of positions, from individuals specializing in a specific form of therapy or a disorder of interest, to students sharing tips on managing statistical programs or creating poster presentations. Graduate programs can easily create a didactic agenda based on topics of most interest to their specific student population. Choosing a theme across presentations can help to more explicitly address the program's goals for the didactic series and can tie together information offered by different presenters. For example, Leffingwell (2006) described a series of seminars on behavior therapy that may be appropriate for a didactic series.

There are numerous benefits to offering didactic presentations as part of graduate-level training. First, they provide an arena for students to obtain information and ask questions concerning topics not specifically addressed in courses. Many issues that might not warrant review in the context of regular coursework, perhaps because of limited interest from the class as a whole, might be profitably addressed in a didactic format (e.g., job announcements, preparation needed for careers in academia, skills needed for successful grant application, or tips for beginning a private practice). Didactic presentations also help students keep abreast of quickly evolving topics in psychology. For example, while diagnostic considerations for various disorders and their associated efficacious treatments are frequently updated in the literature, many students have difficulty staying informed. In addition, since primary coursework is often taken early in graduate training, didactics allow for more advanced students to keep current. Finally, didactics permit a wide range of practical information to be presented by faculty and professionals from many different backgrounds and levels of expertise, which may advance the training program's diversity-promotion efforts.

Didactic presentations may also be designed to allow students to share their personal practica experiences with others, especially those unfamiliar with a given practicum site or persons interested in similar positions. Specifically, less advanced students may learn from more advanced students in their program. Experienced students may share information about specific responsibilities, barriers to success, and the rewards and accomplishments associated with overcoming challenges, while also honing their presentation skills in a small group setting. Didactic presentations can also promote collegiality among students, faculty, and practicing psychologists from the community. In addition, approaching university administrators or professionals in the community for didactic presentations can help establish and maintain professional connections.

Many of the benefits described here are in line with those associated with more conventional graduate training modalities such as clinical supervision, vertical practicum teams, and research mentoring. Yet didactic series can be designed to complement traditional features of clinical training. For example, an issue raised in individual or group supervision between students and a faculty member may become the theme of a series of didactic presentations, allowing the subject to be addressed in more depth, to be discussed by professionals with different perspectives on the topic, or to be presented to a larger number of students who could

potentially benefit from exposure to the topic.

Barriers to the Implementation of Didactics in Graduate School

Several obstacles may hinder the implementation of didactic training within the graduate training curriculum. One question to consider when implementing didactic training is the frequency of presentations. Specifically, it is important to consider the students' prior commitments when deciding how often to offer presentations in order to maximize attendance. Ensuring attendance is essential to the viability of the presentations, as the speakers in didactic presentations may often be community professionals and students, who generally do not receive compensation for their time and efforts. Attendance by graduate students is important in order to show respect and to utilize the presenters' time and expertise appropriately. Various systems could be used to ensure maximal attendance. For example, programs could require attendance at a certain number of presentations per semester or year or could ask students to RSVP for proposed presentations, only holding presentations that meet minimum requirements for attendance. A simple way to overcome these kinds of barriers is to schedule such presentations during lunch and, if possible, to provide a light lunch for attendees and presenter alike. However, resources will be needed to cover food expense and room rental or setup, if these can't be provided for free.

Another potential barrier to the implementation of didactic presentations is designating a student, committee, or faculty member willing to plan and organize the presentations. If a student is not willing to act as the didactic coordinator, it may be difficult to implement the training within the graduate program. An alternative to having a student coordinator may be to have a faculty member serve as the director of didactic training; however, this may present several barriers itself. For instance, a faculty member may not wish to or be able to take on such a task without compensation (usually in terms of teaching load). Offering didactic training for credit may increase attendance and allow for a breadth of training outside the core curriculum, but, in essence, defeats the purpose of this mode of training. If the training is offered as a course, students may be deterred from attending due to costs and the lack of flexibility regarding attendance. A formal class may also restrict the topics of student interest that can be covered and would have to be consistent with both APA and university guidelines—the very reason for offering didactic presentations in the first place.

A final barrier that may be encountered is how to select presentation topics. Though an initial concern may be whether students will suggest an adequate number of feasible topics, in our experience requesting topic suggestions from students has resulted in more topic ideas than there are slots to fill them. Therefore, the challenge may be to prioritize topics and decide which to pursue or postpone until later. Other methods for selecting topics include creating a list of topics based on the availability and expertise of willing presenters and having students vote on topics of interest. Alternatively, more formal resources may be used to identify training topics that are commonly of interest to graduate students (see a list at the end of this article).

Reflections From the Saint Louis University Brown Bags

Saint Louis University's doctoral program in clinical psychology promotes a generalist training model for its 30 to 40 students in residence. Students typically gain training experience through involvement in clinical and research vertical teams and 1 to 2 outside placements per year. Beginning in the fall of 2006, the clinical psychology program at Saint Louis University implemented a student-run didactic program in the form of "brown bags," weekly lunchtime presentations covering a wide range of topics of student interest related to clinical psychology. A number of factors led to the development of these presentations. First, students found it difficult to attend other colloquia held on campus by various programs, including those sponsored by the psychology department and the graduate school, due to conflicts with their schedules. Second, students noted that valuable training information was often being shared on different clinical supervision and research teams, but was rarely passed on to students on other teams, limiting the number of students who were able to benefit from the knowledge of specific supervisors and advisors. In addition, ways of developing and strengthening bonds with other mental health facilities in the community were sought. Lastly, as students advanced through the program, they noticed that some important and valuable information was infrequently and/or unsystematically taught in coursework, such as how to apply for internships, track APPIC hours, learn about the publishing process, and apply for grants. Busy schedules and a lack of knowledge about the location of pertinent information prevented many students from consulting resources that were available to help students tackle some of these important training issues. All of these factors contributed to the idea of implementing didactic presentations to address topics of student interest. The next step involved putting this idea into action.

Various decisions had to be made during the initial phases of the didactic development. For the pilot year of the brown bag program, the task of organizing the presentations was given to the student representative, a student elected to communicate program information between the students and the faculty. A large classroom equipped with various media options located in the psychology building was determined to provide adequate space and resources for a variety of presentation styles. Choosing a time for the brown bags proved to be challenging. Student input dictated the choice of day, time, and frequency. Once a time, place, and organizer were identified, students were polled to determine which presentation topics would be of greatest interest. A wide variety of topics were suggested. Faculty input was also sought to attain suggestions regarding appropriate speakers to present on the list of topics that students had generated. Fortunately, faculty, students, and professionals from the community gladly volunteered to participate in the didactics by presenting on their areas of expertise. Presentations covered a variety of subjects, including how to find funding opportunities, tips for the internship application and interview process, research on bipolar disorder in children and adolescents, and tips for screening for intimate partner violence in a pediatric medical setting. Attendance at the presentations varied between approximately 20% to 80% of the clinical student body.

At the end of the school year, a survey was administered to the students to get feedback on the brown bags. Students unanimously voted to continue the brown bag presentations. Student comments were positive and enthusiastic, listing the benefits of the presentations as being new and relevant topics, gaining a sense of community, and learning information not typically covered in coursework. On a 0-to-10 scale (0 = *not at all informative, unclear about its impact on my training* and 10 = *very informative, clear benefit to my training*), average student ratings of the 10 brown bags ranged from 6.6 to 8.9. The most informative presenta-

tion types were those completed by local professionals, closely followed by faculty presentations and student group presentations. In addition, students completing the survey suggested more than 20 unique ideas for future brown bag presentations.

Though this survey suggests that students perceived the brown bag presentations to be beneficial in enhancing their knowledge and skills, formal data testing this conclusion were not available. Future research in this area could systematically explore the potential benefits of didactic series presentations for graduate student training and education.

Resources for Implementing Didactics

While we found polling the students to be a successful method for determining didactic topics of student interest and need, the following is a rough list of recommended resources to use when searching for potential subjects for a didactic series.

Book

Prinstein, M., & Patterson, M. (Eds.). (2003). *The portable mentor: Expert guide to a successful career in psychology*. New York: Kluwer.

Websites and list serves

- American Psychological Association of Graduate Students: http://www.apa.org/apags/
- ABCT Student Special Interest Group: http://groups.yahoo.com/group/aabtstudentsig/

Journals

- *the Behavior Therapist*
- *GradPSYCH*

Just as coursework provides the foundation for graduate training and practica permit opportunities to apply those foundation skills, brown bags address some of the practical issues associated with fostering growth in students' professional careers. In our experience at Saint Louis University, the advantages of holding a didactic series clearly outweighed the barriers, resulting in an overwhelmingly positive experience for the students in the program.

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Lighter Side

Titular Colonicity in Behavior Therapy Publications

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When I was a graduate student, my major professor often quipped that the titles of many psychology journal articles were riddled with colons. The punchline of his joke is obvious so I will not belabor it here. *Titular colonicity* (Dillon, 1981) refers to the inclusion of a colon in a publication title. In the landmark study published in *American Psychologist*, Dillon found that 72% of journal titles included a colon (compared to only 13% of "nonscholarly" publications and to 11% of dissertation abstracts). Colonic titles tended to appear most frequently as lead articles, suggesting that they are afforded scholarly distinction. More so than other titular characteristics, such as meter and length, the inclusion of a colon was the primary correlate of scholarship (but see Lugo & Kopelman, 1987). Moreover, colonic titles across several disciplines have increased steadily in frequency since the 1960s (Dillon, 1981, 1982), and the colon has long overshadowed the dash and semicolon in publication titles.

Do behavior therapists also favor colons? To answer this question, article titles appearing in every published issue of *Behavior Therapy* since its inception were inspected for the presence of a colon. This journal was selected as representative of the behavior therapy literature because of its high standing in the field, because it is the flagship journal of ABCT, and because it has existed from 1970 to the present. Articles listed as case studies, short communications, and editorials were excluded, as were commentaries, introductory papers to special series, and the like. Notwithstanding the close relationship between briefs and colons, brief notes were likewise excluded. These papers were excluded because of the increased likelihood that they would include the respective clauses in their titles (e.g., "Behavior Therapy and Its Colons: An Introduction to the Special Series"), rendering a colon more likely and potentially skewing the results. The colonic tallies were then grouped within decades (1970s, 1980s, 1990s, 2000s), and the percentages of papers evidencing titular colonicity were calculated.

In total, 1,513 titles from 1970 to June 2007 were assessed (144 issues). The percentage of papers within each decade evidencing titular colonicity were as follows:

1970s: 29.43% (151/513)
1980s: 38.12% (146/383)
1990s: 44.32% (156/352)
2000s: 45.66% (121/265)

Significantly more papers evidenced titular colonicity in the 1980s than would be expected given the frequency in the 1970s, $\chi^2(1) = 13.93, p < .0001$. Similarly, significantly more papers evidenced titular colonicity in the 1990s than would be expected given the frequency in the 1980s, $\chi^2(1) = 14.52, p < .0001$. The percentage of colonic papers in the 2000s was higher than the percentages during the 1970s or 1980s, although it did not differ from that of the 1990s. Clearly, many more articles in *Behavior Therapy* (44% to 45%) now include colons than they did during the 1970s and 1980s, suggesting that titular colonicity is exhibited with increasing regularity.

Behavior therapy publications appear to have undergone a sort of colonic irrigation in the past couple decades. The reasons for this trend are admittedly speculative, as conceptual roughage is difficult to digest. The present results cannot be explained by appeal to increased publication rates of non-

experimental articles, as such articles were excluded from data analysis. The results from Dillon (1981, 1982) would seem to suggest that a journal's impact factor might be positively correlated with titular colonicity, although this was not assessed here.

The increase in titular colonicity coincides roughly with the evolution of the cognitive therapy *movement* over the past two decades. This movement has enhanced our understanding of psychopathology, and titular colonicity likely reflects this fact. An alternative explanation might be found by reference to Freudian theory, for which behavior therapists' frequent use of colons has a more sinister interpretation.

Future research might focus on the scholarly correlates of the rare multicolonic article title, journals known to contain high colonic content, or of titular colonicity among article titles that also include the word "colon" (e.g., see the titles of all three cited references). Perhaps it would be most appropriate to direct our attention instead to more useful endeavors, such as evaluating the scholarship of article texts rather than overinterpreting one character in their titles (as was done here). Given the literature reviewed above, however, researchers might expect their papers to be accepted more frequently if they include a colon in the title of their submissions. Such efforts might result also in increased scholarly flow and regular refinement of our conceptual fibers.

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Lupo, J., & Kopelman, R. E. (1987). Punctuation and publishability: A reexamination of the colon. *American Psychologist, 42*, 513.

Note: The present article included 11 colons, but none in the title. Hopefully, someone will read it anyway.

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Found!

Psy 307 — Intervention
Psychotherapy Research E-2455
Psychology 3351 — Clinical Psychology
Psychology 3355 — Behavioral Medicine
Seminar in Psychotherapy (Graduate Level)
Psychology 71[illegible] — Research Methods and Ethics
Advanced Clinical Assessment II —(Graduate Level)
Psychology [illegible]70 — Psychometrics and Clinical Inference
PY 728 BC — Empirically Validated (Supported) Therapies
Psychology 785 — Seminar in Cognitive-Behavioral Therapy
Psychology 622 — Theory & Methods of Psychotherapy (Child Psychotherapy)
Psychology [illegible] — Seminar in Psychotherapy - Treatment of Children & Adolescents
Psych 709-301 — Special Topics in Clinical Psychology: Empirically Supported Tx
PSCL 529a — Cognitive-Behavioral Psychotherapy mindfulness-based interventions
Psychology 779A — Integrating Acceptance & Mindfulness into Psychotherapy
PSCL 530a — Applications of Cognitive-Behavioral Therapy
Psychology 371 — Intervention Process and Outcome
Psychology 626 — Advanced Clinical Assessment II
Psychology 619 — Psychological Intervention
Psychology 636 — Systems of Psychotherapy
Psychology 614 — Behavioral Therapy
Psychology 3340 — Psychopathology

syllabi

of all shapes, sizes, and methodologies

http://www.abct.org/educators/?fa=syllabi

Lighter Side

Witch Doctor

Elizabeth Moore, Mayo Clinic

As the only witch doctor in the tri-tribal area with APA-approved training, Todd soon had a wait-list many moons long.

Clinical Forum

The CARE System: User-Friendly CBT

David Bricker, *Private Practice, New York*, and Mark Glat, *Princeton University*

A cornerstone of cognitive-behavioral therapies (CBT) is enhancing the quality of the client's life outside the consulting room. To anyone familiar with the literature on treatment efficacy and effectiveness, this should come as no surprise. One of the most powerful nonspecific variables predictive of positive outcomes in CBT is becoming a better observer of the complex and interdependent relationships that exist among thoughts, feelings, and behaviors. It is the development of such awareness, in conjunction with clinician competence and compassion, that may often determine the success or failure of a given course of CBT.

CBT often begins with a series of in-session instructions or exercises designed to teach the client about how learning history may affect one's maladaptive behaviors, feelings, and cognitions. As therapy progresses, the clinician collects information about the particulars of the client's life and present circumstances to ensure that these interventions and instructions are relevant to this client. The skilled clinician knows that the case formulation is critical, because the ultimate success of the treatment will rest on whether what is being taught in the consulting room is relevant to what is happening outside the consulting room. Thus, the concept of generalization is of the utmost importance in the CBT treatment paradigm.

CBT is rich in procedures and interventions that have withstood experimental scrutiny and are readily available in the form of various treatment and procedural manuals (e.g., Barlow, 2001; Leahy & Holland, 2000). On the other hand, our reading of the literature also suggests that additional clinical tools might be needed to address the problem of dissemination and, specifically, increase the likelihood that practitioners will use efficacious treatments. Dissemination thus brings us closer to rendering efficacious therapies effective. To promote this objective, this paper will present an easy-to-remember and user-friendly clinical template that can be captured by the simple mnemonic CARE (cognitions, actions, relaxation, emotional expression). CARE is designed to assist the client in strengthening adaptive behaviors learned in therapy, generalizing these behaviors to their natural environments, and thereby enhancing the self-awareness that is so important to the ultimate success of therapy.

Let us begin with several disclaimers about what CARE is and what it is not. First and foremost, CARE is not a substitute for careful data collection and case formulation; however, attention to the domains of the CARE system could be of assistance in the assessment process. CARE is also not a comprehensive theoretical system with clearly delineated therapeutic dictums that follow logically from it. Those who use CARE must work hard to identify and analyze the patterns of reinforcement that maintain problem behaviors. Good outcomes in therapy need to be guided by good theoretical understanding.

So what is CARE and why should we care about it? CARE is an easy way to remember that most, if not all, client problems and therapeutic interventions in CBT involve some combination of four basic elements that can be captured in a simple four-category system:

Cognitions
Actions
Relaxation
Emotional Expression

On another level, CARE is a rhetorical tool that calls to mind the power and the potential of the CBT approach. CARE focuses attention on the critical interplay of thinking, feeling, and doing in both the patient's life and clinician's interventions. CARE reminds therapists to think in the broadest possible terms regarding techniques, constructs, and formulations. It brings to mind the clinical flexibility and inventiveness that seems common to many effective therapists.

CARE can also function as a mantra to be used by clients in their day-to-day lives. CARE may serve to strengthen focus and attention, as new patterns of behavior and reinforcement are being learned, established, and reinforced. As a methodology for assessment and intervention, being mindful of the domains of CARE first directs the attention of patients to their experience of the various levels of arousal and affect that accompany both thinking and acting. Using the CARE model might enable them to more easily identify how much of their current behavioral repertoires are being shaped by patterns of experiential avoidance that are themselves being supported by behavioral chains that include cognitions, actions, responses to stress, and emotional states (Hayes, 2005). Keeping CARE in mind may then set the stage for reducing avoidance by directing attention toward the development of personalized strategies for cognitive flexibility and restructuring, behavioral change, arousal management, and emotional acceptance.

Cognitions. In the CARE system, cognitions assist both the therapist and the client by keeping in the forefront of their awareness the powerful role that dysfunctional thinking plays in the origins and maintenance of the client's concerns and difficulties. At the same time, the term cognitions also refers to the equally powerful role that thinking can play in the amelioration of these same problems and concerns. In recent years it has become evident that there are at least two levels of thinking, and many different interventions, that the effective practice of CBT requires.

The first level refers to the moment-to-moment thoughts that are causing problems for the client. This kind of cognition, captured in a powerful way by Beck's term "automatic thinking," is very often the first place that the therapist will intervene and the first level of new awareness that the client might reasonably achieve in the course of a therapeutic encounter. Clients are cautioned that these automatic thoughts can have far-reaching effects and consequences.

For the clinician, working with cognitions at this level from the beginning of treatment can have both therapeutic and strategic benefits. In the first place, the research literature has documented the efficacy of cognitive interventions for a broad spectrum of mood disorders ranging from anxiety and phobia through depression (Beck, Rush, Shaw, & Emery, 1979). Accordingly, the prescriptive use of thought records (Beck et al., 1979) and mood logs, or the simple suggestion that the client "pay attention to your angry thoughts over the next week" can have immediate and salutary effects and may enable the client to quickly identify irrational or dysfunctional thoughts, learn to challenge them, and effectively replace them with thoughts that are more helpful. Clients may return to their next session with a new awareness of how often they entertain irrational

thoughts or are reactive to situations in ways that cause more problems than they resolve.

In keeping with the broad spectrum clinical focus that characterizes modern CBT, the CARE system also includes a second, more complex and heuristic level of cognition. In recognition of this "deeper" level of thinking, the CARE system provides for the use of new tools to evaluate complex thought structures and schemas (see Young, Weinberger, & Beck, 2001). For example, Young, Klosko, and Weishaar (2003) presented a system of 18 maladaptive schemas that form early in life as a result of repetitive interactions with significant others. The client and therapist work together to identify and systematically examine these schemas. Clients come to better understand and identify dysfunctional patterns as a result of this exploration, feeling more understood by their therapists and, more importantly, by themselves.

In the CARE system, action refers to behaviors the client performs, performs inadequately, avoids, or desires to learn. Initially, clients are encouraged to look for instances in which they are acting against their own best interests or avoiding key problems. Clients are empowered to expand their behavioral repertoires via exposure exercises and other learning strategies (as appropriate). The rationale for including this domain is twofold. The first has to do with the power and efficacy of behaviorally focused CBT interventions across a broad spectrum of problem behaviors (Martell, 2003). The second rationale, of no less importance than the first, is the heuristic value of the CBT paradigm in directing the attention of clients to the relation of behavioral action to affect and cognition.

In the CARE system, action interventions are likely to include assertiveness training, response prevention, scheduling positive activities, decisional-balance exercises (e.g., Burns, 1989), and the expression of emotions in effective and appropriate ways. In keeping with the goal of strengthening a client's mindfulness about the roles of self-awareness and self-direction in the initiation of behaviors, any time the client opts to work within one of the other categories, this would also be identified as an action intervention. Engagement and practice are consistently emphasized over avoidance throughout treatment.

The relevance and importance of dysfunctional states of arousal in the origins and maintenance of problem behaviors is a core concept in CBT. Accordingly, the CARE system emphasizes the crucial role that relaxation plays in effective treatment experiences. Clients are first taught about the many "faces" of anxiety, including muscle tension, shortness of breath, body temperature changes, as well as obsessive, compulsive, and avoidant response. Clients are encouraged to practice relaxation in a variety of different forms and to do so regularly. This can include deep muscle relaxation, autogenic training, deep breathing, self-hypnosis, and meditation. In the CARE system we are always cognizant of the need to better bridge the gap between procedures shown to be efficacious under experimental conditions and those that are effective in real-time therapeutic conditions; accordingly, clients are encouraged, in collaboration with their therapists, to fashion shortened versions of each of these techniques in order to accommodate their real-life situations.

The final clinical pillar of the CARE system is that of emotional expression (EE). In the CARE system EE refers to any activity in which emotions are expressed for reasons other than to effect a change in other people. During the course of the clinical evolution of the CBT paradigm, the place of emotions and emotional regulation has undergone significant changes. Early formulations of CBT treated affect as a variable to be subsumed within more powerful constructs of cognition and behavior. However, in practice, clinicians were forced to acknowledge various affective states and resultant behavioral patterns that did not fit the prevailing formulations. Moreover, researchers of other models were reporting that the expression of affect was viewed as a therapeutic factor in treatment by clients themselves (e.g.,Yalom, 1995). It became clear then that empirically minded researchers would need to explore these troubling and often chronic feelings and suggest ways in which they might be addressed in CBT.

In recent years CBT researchers (e.g. Greenberg, 2002; Leahy, 2002; Pennebaker, 1997, 2004; Young et al., 2003) have argued that affect has an important role to play in CBT and that many clients come to us with long-term deficits in this area. Not surprisingly, they are often the same clients that present with more complex personality disorders and respond poorly to treatment. In this regard, the recent interest in the cognitive-behavioral treatment of personality disorders mentioned above is of direct relevance to the question of emotional expression and its effects. Clients with problems related to emotional expression may be described as "avoidant" or present as "repressed" or "nonassertive" by some practitioners. Others may cycle through episodes of avoidance followed by sudden shifts toward behavioral excess. In the end, unexpressed emotional problems are thought to contribute to disturbances in mood, self-image, and interpersonal relationships that may have profound and long-lasting consequences.

EE takes into account both the simple expression of feelings as well as a consideration of more complex forms of emotional expression. Several techniques may be used to help clients explore their emotions in a constructive manner. Pure emotional release techniques include writing unsent letters and verbalizing feelings out loud in a safe environment. Therapists can also use imagery techniques to help the client to express uncomfortable emotions. In some cases, clients may be asked to confront people in vivo and express feelings directly to them. Clinicians are asked to contextualize these experiences to increase the client's awareness of how these patterns affect emotional regulation. In addition, clinician and client alike must be prepared for the possibility that the same "habits" of thinking, feeling, and behaving that are causing difficulties outside the consulting room may cause disruptions within the consulting room. Clinicians using the CARE system and dealing with the challenges of EE will certainly benefit from familiarizing themselves with the work of master therapists such as Marsha Linehan, who has written about both the CBT skills training that can contribute to better emotional regulation and behavioral control, as well as therapy management techniques that can maximize the effectiveness of the collaboration of client and clinician (see Linehan, 1993).

A final point to note is that all categories of CARE are not always relevant. For instance, a simple phobia might only focus on cognitions, action, and relaxation. Or, an extremely inhibited male with marital difficulties might have to focus almost exclusively on EE at the beginning of therapy. The CARE Coping Behaviors form (Figure 1, p. 195) is used to help clients to keep track of specific problems and interventions according to the four categories. Typically, this form is completed in collaboration with the therapist during sessions. It can be used as a guide for either specific homework assignments or as a reminder of what to do between sessions.

In order to get a better feel for the CARE system in practice, below we present a brief

case summary. It is designed to highlight the basic algorithms that guide assessment and intervention strategies.

Abby is a 36-year-old married woman with no children. She entered therapy because she was depressed as a result of her inability to conceive a child. She and her husband had tried unsuccessfully to conceive for 2 years on their own and then for over a year of fertility treatments. Her husband was making a substantial living in financial services and Abby had been working as a freelance graphic artist. During the 12 months preceding therapy her mood had become more and more depressed, she lost interest in friends and other activities and she was neglecting her physical self-care and appearance. In addition, she was spending less and less time attending to her professional clients.

Abby began therapy when she was confronted with the choice of doing in-vitro fertilization in an effort to become pregnant. She was scared that if she failed at this it would be too devastating for her to bear. She was also anxious about the invasive medical procedures involved. Regarding treatment goals, Abby said that it was most important for her to be able to go through with the in-vitro procedures, to get over her depressed mood, and to return to her work.

Her background included a childhood in an intact family with little emotional connectedness. She described her father as a workaholic who was generally extremely demanding and critical during the times he spent with her. Her mother was described as a good homemaker who obviously loved her children but who was emotionally unavailable and rigid.

Her husband was described as being a likable person but insensitive to her needs and feelings. When she would confront him about problems he would generally respond well to her, but she was frustrated by his lack of caring and reaching out to her. She felt that for years she had to do a disproportionate amount of work in keeping up the household and in keeping the relationship going.

Assessment with the Young Schema Questionnaire (Young et al., 2003) and follow-up discussion showed her core schemas to be emotional deprivation, self-sacrifice, and unrelenting standards. Her Beck Depression Inventory (BDI) score at the beginning of therapy was 33. The intake procedure took two sessions to complete. During the third session the CARE system was explained to her in the following manner:

"Abby, we agreed during the last session that the first problem we would work on would be helping you to get through the in-vitro procedures. I'd like to explain to you a little bit about how we'll do that and where we go from here. In treating these kinds of problems we've found that there are a number of ways of looking at the problem, and each one leads to its own treatments and solutions. For the most part these approaches are going to be complimentary to each other and the more each one of them is effective the more it will help in all the other areas. It might be like taking on the responsibility for the public health of a city. There's rarely one magic bullet that solves all problems. But we might put resources into things like sanitation, public education, and health care in order to improve the health of the citizens.

To help you to keep track of these parts of the problems and the treatments, we've devised a simple acronym: CARE. Each letter stands for a different part of your experience. *C* stands for cognitions, which basically means any thoughts you have that might be contributing to the problem. For instance, when we were talking about schemas last week we talked about your tendency to think you have to do everything perfectly. We might try to question some of those patterns. *A* stands for actions, or the things that you are actually doing, like speaking up for yourself, or facing challenges. You had talked about how you've been avoiding certain aspects of the fertility treatments and how doing so has resulted in your being even more scared of them. *R* stands for relaxation; when we spoke last time you indicated that you don't have any set relaxation or meditation procedures which you use, even though you tend to get very anxious when you're upset. This is something we'll look into helping you with. And finally, *E* stands for emotional expression. You had indicated that you have a tough time connecting with your husband about how you need his support and how hurtful this experience has been for you. Now let's look at this a little more closely and see if we can identify some other aspects of the problem and look at some treatment options."

Together, the therapist and Abby came up with the following list of problem behaviors related to the presenting complaint about the in-vitro procedures:

Cognitive:	*If I can't have children, I'm a total failure.* *I'll never get over this depression.*
Actions:	*Avoidance of medical situations, such as doctor's appointments and reading about her options.* *Lack of pleasurable activities.*
Relaxation:	*No skills in relaxation or meditation.*
Emotional Expression:	*Not discussing hurt or feeling of loss.* *Not discussing resentments about the infertility.*

Abby decided she would like to work on the EE issues first, so it was decided to invite her husband to the next session. He was taught to validate Abby's feelings as a means of encouraging her to talk. He was a willing participant and was eager to learn and practice his new skills. Abby reported an immediate improvement in her mood and an increase in their communication. In subsequent sessions the following treatments were utilized:

Cognitive restructuring. Abby was taught to identify and challenge negative thoughts. In addition, she was taught "defusing techniques" (Hayes, 2005). The negative thoughts were connected primarily with the schemas identified earlier. For instance:

- **Emotional deprivation**: *I never get what I want.*
- **Self-sacrifice**: *My husband will fall apart if I don't give in*.
- **Unrelenting standards**: *I have to stay on this until it's perfect.*

Scheduling activities. Abby was instructed to chart her hourly activities and her mood during each time period. She was pleased to see that her overall mood was not as bad as she had thought it was, and saw that when she was active she was almost always in a good or neutral mood. She and her therapist worked on steadily increasing the amount of time she spent doing things where she felt competent, such as her graphic arts profession, and activities which she enjoyed, such as spending time with close friends and relatives.

Relaxation training. Several relaxation and meditation techniques were taught and Abby was encouraged to practice them between sessions. She was also requested to buy *Total Relaxation* (Harvey, 1998) and to practice the relaxation exercises contained in it. She found that breathing exercises were particularly helpful and was able to use them to lower her overall arousal level.

Emotional expression. Abby was encouraged to continue talking to her husband about her needs and feelings. She also began to take more chances in expressing feelings to close friends and relatives. Her skills quickly improved in these areas as she reported almost immediate success in conversations with various people.

After the 8th session, Abby's BDI score was 11, and after 12 sessions it was 7. She had completed an in-vitro cycle after her 10th session. When she failed to conceive she reported intense sadness for about a week but no significant increase in other depressive symptoms. She stated that her husband and friends were very supportive and she was able to express all her feelings to them. At a follow-up session 4 weeks after the 12th session Abby reported that she had conceived on her second try and was coping well with the pregnancy, with no return of the depressive symptoms. In addition, she reported that she was maintaining her progress in all of the target areas.

To summarize, it is the intention of the CARE system to help the therapist and client organize the numerous possibilities for positive change. The CARE system is explained to the client as being similar to a four-legged stool. There is no one intervention that is likely to be a panacea. Rather, it is our responsibility to find several ways for the client to become active in solving problems. A four-legged stool will be more stable than one with fewer legs. So, the more ways we have to solve the problem, the more stable the solution will be. In this way, the CARE system puts a premium on the value of skills acquisition and generalization to the client's natural environment. The mnemonic itself is designed to remind the client of the skills and tools available to him or her in the arsenal of efficacious CBT techniques. Finally, while we believe that the CARE acronym may serve as a useful framework for keeping the work of therapy focused, effective, and relevant to the needs of the client, we acknowledge that the benefits of the CARE approach still require empirical validation.

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***Figure 1*. CARE Coping Behaviors**

Target Behavior:___________________________

COGNITIVE

Identify and confront the automatic thoughts and underlying schemas. Use strategies such as: look for the evidence, consider the odds, identify distortions. Use Thought Records or Flashcards.

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ACTION

What can I do to fix this? Speak up for myself? Pay attention to other peoples' needs?

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RELAXATION

Is anxiety part of the problem? Can I use any short-term or long-term relaxation strategies to cope better?

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EMOTIONAL EXPRESSION

What emotions am I failing to express completely? What exercises can I use to express them?

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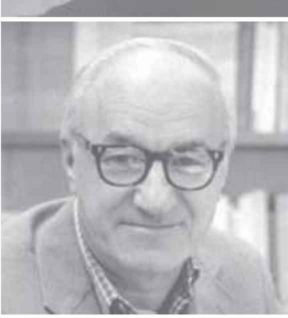

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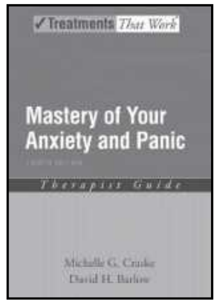

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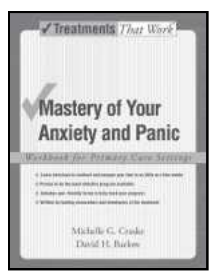

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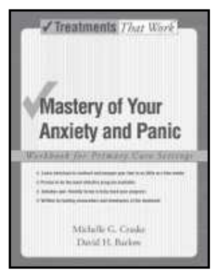

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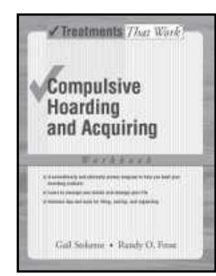

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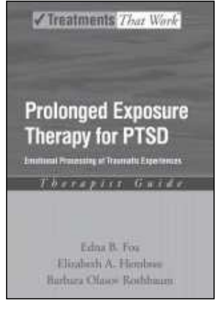

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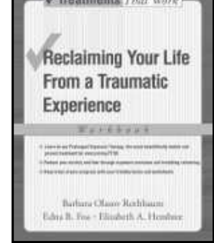

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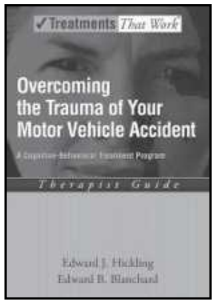

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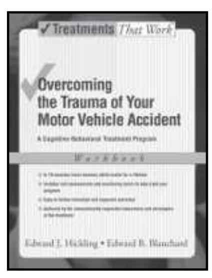
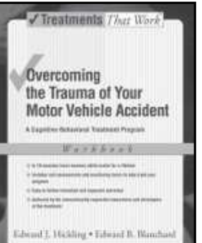

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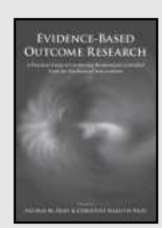

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