

# the Behavior Therapist

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plus . . . { photo ID—win a prize! (p. 39)

### Feature

## Publish Without Perishing, Part 2: More Suggestions for Students and New Faculty

Steven Taylor, *University of British Columbia*, Jonathan S. Abramowitz, *Mayo Clinic*, Dean McKay, *Fordham University*, Sherry H. Stewart, *Dalhousie University*, and Gordon J. G. Asmundson, *University of Regina*

In the previous article in this series (Taylor, McKay, Abramowitz, Asmundson, & Stewart, 2006) we examined the relative importance of scholarly publishing in relation to other academic endeavors, in terms of hiring and promotion. Promising approaches and pitfalls in the publishing process were discussed, along with suggested guidelines for maximizing one's success in publishing. In the present article we examine issues in selecting journals and issues concerning the relative importance of journal articles, book chapters, and books. Although students are often more concerned about whether their work is published, new faculty are more often concerned about whether *and* where their work is published. Accordingly, the present article is intended more for new faculty, although it should also be relevant to graduate students aspiring toward an academic career. As we mentioned in the first article in this series, there is no single recipe for success in academia. We offer here our perspectives and hope this stimulates discussion from other readers.

### What Defines the Status of a Journal?

What makes a "good" journal? There are all kinds of considerations, some of which concern

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The Association for Behavioral and Cognitive Therapy (formerly known as Association for Advancement of Behavior Therapy) 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.

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the status of the journal in comparison to other journals. The major standardized indices of journal performance were developed by the Institute for Science (ISI; Garfield, 1972, 1994); these indices appear on their Web of Science Web site (<http://isi-webofknowledge.com/>) and in the Social Science Citation Index. Despite some debate, the ISI citation indices are the leading objective measures of journal importance. These indices influence the decisions of committees responsible for hiring, promotion, and assigning faculty salary increments, and also shape the decisions of committees allocating research grants.

The ISI provides data, for many journals, on three main citation indices of journal performance. For a given journal, these are computed and interpreted as follows (Amin & Mabe, 2000; Garfield, 1994):

- *Impact factor*: This is derived by computing the number of citations in the literature during a given year (e.g., 2003) for articles published in the journal in the past 2 years (e.g., 2001-2002), and then dividing this number by the total number of articles published by the journal during that 2-year period. The impact factor represents the average number of citations the average article perceives per annum in the 2 years after the publication year.

- *Immediacy index*: This is computed by the number of citations a journal receives in a given year divided by the number of articles the journal publishes that year. This index is a measure of how quickly articles in a given journal, once published, get cited in the literature.

- *Cited half-life*: This is the estimate, for a given year, of number of years required for the number of citations of articles in the journal to decline to 50% of its initial value. In other words, it is an estimate of how long articles in a journal continue to be cited after publication.

Of the three citation indices, the impact factor is the most widely used as an index of the prestige of a journal (Amin & Mabe, 2000; Garfield, 1994). The values of all three indices, for a sample of 30 psychology journals, appear in Table 1. These journals were selected because they publish articles on cognitive-behavioral topics and therefore are of relevance to readers of *the Behavior Therapist*. The journals listed in the table were selected in order to represent a range of impact factors, including low-, middle-, and high-ranking journals. For a given index (e.g., the impact factor), the journals in the table were ranked from highest to

lowest. On a given index, the 10 journals with the highest ranking have their indices in boldface, and the 10 journals of lowest ranking have their indices underscored. This was done to facilitate the comparison among indices. As suggested by the table, journals with high impact factors tended also to have high immediacy indices. Conversely, journals with low impact factors tended to have low immediacy indices. Citation half-life is only loosely related to these other two indices; although high impact journals tended to have high citation half-lives, some low-impact journals also had high half-lives. The table also shows that the journals that publish mainly review articles (e.g., *Psychological Bulletin*) tend to have higher citation indices than journals that publish mainly empirical studies. This reflects the finding that review articles tend to be more widely cited than empirical papers (Amin & Mabe, 2000; Garfield, 1994).

The table lists only psychology journals because journal citation indices vary across disciplines. Medical journals tend to have higher citation indices than psychological journals because the former have more authors per article, and therefore more self-citations per article (i.e., authors in a given article citing their own previous work). This

inflates the impact indices (Amin & Mabe, 2000).

The value of citation indices such as those cited in Table 1 is that students and new faculty can use objective indices for assessing the status of the journals to which they choose to contribute their work, rather than relying on subjective impressions about the status of a given journal. Committees responsible for hiring, promotion, and grant reviews may similarly use such indices as part of their evaluation. Of course, such indices are not universally used or valued. This underscores the importance of local conditions, as described in our previous article.

### Other Considerations in Selecting a Journal

Journal citation indices are only one set of factors for selecting a journal for your work. You also need to consider the goodness-of-fit between your paper and the journal, guided in part by the information for contributors supplied by the journal. If your manuscript describes a groundbreaking piece of research, for example, it may be suitable for a high-ranking journal. On the other hand, if your manuscript describes re-

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Table 1. Citation Indices (2003) of a Sampling of 30 Journals Publishing Cognitive-Behavioral Articles

Journal	Impact Factor	Immediacy Index	Cited Half-Life (Years)
<i>American Psychologist</i>	5.484	1.275	> 10.0
<i>Annals of Behavioral Medicine</i>	2.878	0.467	5.6
<i>Assessment</i>	0.852	0.190	5.9
<i>Behavior Analyst</i>	0.621	0.000	8.1
<i>Behaviour Change</i>	0.268	0.000	6.4
<i>Behavior Modification</i>	0.958	0.079	8.1
<i>Behaviour Research and Therapy</i>	2.024	0.340	8.6
<i>Behavior Therapy</i>	1.046	0.424	> 10.0
<i>British J. Clinical Psychology</i>	1.296	0.094	9.3
<i>British J. Health Psychology</i>	0.881	0.161	4.7
<i>Clinical Psychology Review</i>	2.453	0.355	9.4
<i>Cognitive Therapy and Research</i>	0.963	0.091	> 10.0
<i>Health Psychology</i>	2.347	0.213	8.4
<i>International J. Behavioral Medicine</i>	0.766	0.115	6.6
<i>International J. Eating Disorders</i>	1.540	0.266	7.3
<i>J. Abnormal Psychology</i>	3.351	0.470	> 10.0
<i>J. Anxiety Disorders</i>	1.084	0.174	7.0
<i>J. Applied Behavior Analysis</i>	0.875	0.140	> 10.0
<i>J. Behavioral Medicine</i>	1.015	0.083	> 10.0
<i>J. Behavior Therapy and Experimental Psychiatry</i>	0.939	0.077	9.9
<i>J. Clinical Psychology</i>	0.747	0.330	> 10.0
<i>J. Consulting and Clinical Psychology</i>	3.252	0.617	> 10.0
<i>J. Experimental Analysis of Behavior</i>	1.222	0.273	> 10.0
<i>J. Psychopathology and Behavioral Assessment</i>	0.690	0.214	9.0
<i>J. Traumatic Stress</i>	1.408	0.068	7.1
<i>Psychological Assessment</i>	2.370	1.000	7.6
<i>Psychological Bulletin</i>	8.405	1.000	> 10.0
<i>Psychological Reports</i>	0.277	0.053	> 10.0
<i>Psychological Review</i>	8.357	1.357	> 10.0
<i>Psychological Science</i>	3.558	0.500	6.0

SOURCE: Institute for Scientific Information Web of Science (<http://isi17.isiknowledge.com/portal.cgi/>), data extracted May 8, 2005.

**Boldface** = top 10 rankings on a given index for the journals listed in this table.

Underscored = bottom 10 rankings in this table.

search that is methodologically sound, but simply replicates other research studies, then the chances are that your study will not be accepted by a leading journal; a lower-ranking journal is more likely to be the home for such a study.

Sometimes it is difficult to determine whether to submit to a higher- or lower-ranking journal. Submission to a high-ranking journal can lead to rejection, therefore delaying your article's eventual publication in a respectable but lower-ranking journal. But then again, you've got nothing to lose (but time itself) by aiming reasonably high. If in doubt about whether to submit your work to a high or lesser ranking journal,

then we suggest two things. First, set your paper aside for a couple of weeks, and then reread your paper and a couple of comparable articles from the journal in which you are planning to submit. Ask yourself how your paper compares to the published articles. Second, ask some colleagues or mentors for their frank advice, preferably colleagues who have published in the journal that you are considering. If in doubt, do what they do in archery competitions: aim high, but don't shoot for the moon.

There are several other considerations in selecting an appropriate journal. You should take into account the sorts of articles published by a given journal, guided in part by

the information for contributors supplied by the journal. You can also take a look at recent issues of the journals that you are considering. There are considerable—and important—variations among journals with similar citation indices. Some journals (depending on the editors) prefer creative papers that contain novel ideas. Others, with similar citation indices, prefer methodologically rigorous papers containing a minimum of speculation. Some journals are known for being very efficient (i.e., being quick to review and publish articles), whereas others (with similar citation indices) are known for being slow to review and slow to publish. If you are planning to

publish an article in a mid-level journal, such as the journals in the middle of the middle ranges in Table 1, then we recommend that you talk to your colleagues to decide which journal is best for you. You may wish, for example, to submit to the efficient journals and avoid the tardy ones. After all, if you are applying for a job or for a promotion, a paper that is “in press” carries more weight than one that is simply “in submission.”

### When Should You Aim Low?

Some researchers refuse to read or cite articles from low-impact journals, because they assume that the papers must be inferior. Despite this, some psychologists intentionally publish their work in low-ranking journals. This seems to be for one of two main reasons: either the researcher was unable to get his or her work published in a better journal, or the researcher is at a career point where it doesn't matter where he or she publishes. To illustrate the latter, Hans Eysenck and Paul Meehl, who are among the most widely cited psychologists in the world, have published many articles in *Psychological Reports* (e.g., Eysenck, 1982, 1995; Eysenck & Barrett, 1993; Meehl, 1990, 1993, 2002), which is among the lowest journals in Table 1 in terms of impact factor and immediacy index. Leading investigators may publish in such journals because such periodicals are generally easier than other journals to get into, and because leading researchers are not so dependent on the status of the journal in which they publish. Investigators such as Eysenck and Meehl have established themselves as important scholars, and so their work will be sought out and read regardless of where it is published. The rest of us, and especially new faculty, do not have the privilege of such name recognition. So, if you're a student or new faculty, avoid publishing in a low-ranking journal if you can help it. But also remember that at the early stages of one's career, a publication in a low-ranking journal is better than no publication at all.

### Journals of Uncertain Standing

What about journals for which no impact statistics are currently available? There are a number of journals that are not listed on the ISI Web of Science (e.g., *Behavioural and Cognitive Psychotherapy*, *Clinical Psychology and Psychotherapy*, *Cognitive and Behavioral Practice*, *Cognitive Behaviour Therapy*, and the *Journal of Cognitive Psychotherapy*). Their omission reflects the limited coverage of the ISI database rather

than being a statement about the quality of the journals. In fact, many fine articles have been published in these journals. Nevertheless, we recommend that students and new faculty not limit their publications to such journals; it is important to have at least some publications in other journals that have high scores on the indices listed in Table 1.

The same advice applies to electronic journals published only on the Internet (as contrasted with most regular psychology journals, which are published in hard copy and also available in electronic versions). The status and survival of journals only available on the Internet currently remains uncertain. Two e-journals—*Prevention and Treatment* (published by the American Psychological Association) and the *Journal of Behavior Analysis and Therapy*—enjoyed only limited success, and both are now defunct. The status of e-journals may improve in the future as libraries and academics move toward electronic rather than paper formats of journals in general.

### Book Chapters and Books

How important is it to your academic career to publish book chapters? The answer depends on a range of factors, including the local conditions of your academic institution and the stage of your career. Some departments place little value on book chapters when evaluating a person's publication record for the purposes of hiring, promotion, or salary bonuses. In those departments book chapters are often regarded as the icing on the cake. They are nice to have on one's CV because they may demonstrate that other scholars have thought sufficiently highly of you and your work to invite you to submit a chapter. But book chapters are widely regarded as being less important to one's CV than journal articles. This is because chapters often do not have to meet the standards for scholarship required for journal articles (e.g., chapters may require little or no peer review prior to acceptance for publication). Also, book chapters, unlike empirical journal articles, may make less of a contribution of new knowledge to the field. So, if you had to decide between spending your time on a journal article or a book chapter, we would vote for the former.

The value placed on scholarly books also varies across departments and across the stages of one's career. Some departments place little emphasis on books—especially edited books—in comparison to journal articles. In some departments, authored

books are seen as something important for senior faculty, such as for promotion to full professor. Authored books can be an indication of the maturity of one's research program and expertise. That is, you've done enough work in the area to provide an expert discussion of the big picture. Books enable one to synthesize the research literature, including one's own research, to provide, for example, a perspective on the current status and future directions of a given field. Although we know some highly successful senior colleagues who published books when they were junior faculty, these people are exceptions. We would recommend to most junior faculty that you devote your energy to publishing articles rather than undertaking the time-consuming process of writing a book. You might decide to edit a book, although edited books carry much less weight as a scholarly product than authored books. If you are embarking on a career at a research-oriented university, edited books are no substitute for having a string of empirical journal articles.

### Conclusion

As implied by the title of our two articles—publish without perishing—an important goal of publishing, at least in our view, is to have a stimulating, productive academic career without burning out in the process. Some of the most productive psychologists we have encountered in academia are the ones who get the most enjoyment out of what they do. There is a widely circulated anecdote about Hans Eysenck, who is still probably one of the most widely cited psychologists in the world. Despite his voluminous publication record, including papers in high-ranking journals, Eysenck would be delighted each time one of his articles had been accepted for publication, even if the paper had been accepted in a low-tier journal such as *Psychological Reports*. Eysenck was driven by curiosity and was an expert at the game of publishing, and evidently enjoyed celebrating his many wins.

If you want to play the game of publishing, you should ask yourself, “Why am I doing what I do?” There are many different reasons for doing research and publishing scholarly work. A sense of curiosity, meaningfulness, and enjoyment at tackling the various intellectual “little problems” that one encounters (to paraphrase Sherlock Holmes) can lead to a stimulating, fulfilling publishing career. Indeed, social psychological research shows that a sense of being optimally challenged and absorbed in one's work (also known as a state of “flow”) is an

important element of occupational satisfaction (Csikszentmihalyi, 1975). Painters who experience this state of flow describe working with complete absorption on a given painting, only to stack it with their other works against the wall when it is done, and commence a new absorbing project (Csikszentmihalyi, 1997). Similarly, psychologists experiencing flow are absorbed in conducting their research and writing up their work. Once a paper has been accepted for publication it goes in the drawer along with the others, and a new research project is pursued. Although academia emphasizes *products* (publications), it's the *process* that really counts—the process of doing personally meaningful work—if you want to have a fulfilling, productive career in publishing scholarly works. That probably explains why the group of us has devoted our time to writing these two articles, instead of doing other things.

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## Tobacco Control in the U.S.: Cognitive-Behavioral and Behavioral Principles in Action

Jennifer B. McClure, *Group Health Cooperative, Seattle*

Since 1900 health professionals have speculated that smoking results in adverse health effects, but it was not until the 1964 Surgeon General's report on smoking that there was clear evidence of tobacco's deleterious health effects (U.S. Department of Health, Education, and Welfare, 1964). This report sparked the beginning of the tobacco control movement in the U.S. The ensuing public health campaign to reduce smoking has had a significant impact. According to the Centers for Disease Control (CDC), smoking prevalence dropped from 42% in 1965 (CDC, 1994) to 23% in 2002 (CDC, 2004). Although this success cannot be attributed to any single policy change, antitobacco intervention or cessation treatment, several of the more influential of these activities are grounded in cognitive-behavioral theory, even if they are not typically presented as such. This paper briefly examines the role of cognitive-behavioral and behavioral theory in understanding some of the more successful antitobacco policies and intervention efforts.

### A Cognitive-Behavioral Perspective of Tobacco Control

Smoking is typically initiated during adolescence. Consequently, most prevention activities are targeted to youth. Individual-level and school-based interventions generally have not been effective (Christakis, Garrison, Ebel, Wiehe, & Rivara, 2003; Thomas, 2002), but community-level policy changes have had an impact on youth smoking. Tobacco use decreased by 18% from 2000 to 2002 among adolescents (CDC, 2003).

Two of the more effective prevention efforts are policy changes that restrict tobacco sales to minors and increased tobacco taxation to deter cigarette purchase. At the risk of oversimplification, the effects of each can be explained using basic behavioral and cognitive-behavioral principles. For example, sales restrictions limit access to ciga-

rettes and act as a form of stimulus control. Increased taxation and higher cost deter cigarette purchase through punishment. For example, it is estimated that a 10% increase in cigarette price reduces cigarette demand by 3% to 5% (Levy, Chaloupka, & Gitchell, 2004; Warner, 1990). This effect is especially pronounced among youth and young adults who are more sensitive to price change (Levy et al.). Smoking bans and indoor clean-air acts promote cessation by removing cues to smoke (i.e., stimulus control), providing smokers with more non-smoking models, and supporting social norms to not smoke. As social norms change, individual smokers experience greater stigmatization (i.e., punishment) for continuing to smoke. The combination of these influences and supports smokers' decisions to quit. In states with comprehensive clean-air laws and smoking bans, cigarette consumption is 5% to 20% lower than in states without these laws (Levy et al.).

Legislative changes such as these may prompt more smokers to attempt to quit. When these efforts are combined with use of effective treatments, the odds of success are significantly enhanced. There are many products and programs that claim to be effective cessation treatments, but the most successful cessation interventions are those which break the association between antecedent smoking triggers (emotional, environmental, and physiological), smoking, and the resulting reinforcing consequences of smoking (decreased withdrawal symptoms, pleasurable effects of nicotine, heightened self-efficacy for coping with smoking triggers, and other positive outcome expectations associated with smoking). By breaking the antecedent-behavior-consequence chain, smoking behavior can be "unlearned."

Based on a large meta-analytic review of the literature, the most efficacious cessation interventions are those which combine pharmacologic treatment (nicotine replacement therapy or bupropion SR) with cogni-

tive-behavioral intervention including problem solving, coping skills training, and social support (Fiore et al., 2000). Smokers are taught how to identify their smoking triggers, avoid these triggers, and, when necessary, cope with the resulting cravings using a variety of cognitive and behavioral strategies (including reciprocal inhibition and stress management skills). Successful practice of these actions builds self-efficacy and reinforces the belief that one can quit smoking. Pharmacological interventions aid this process by lessening the underlying physiological cravings of nicotine withdrawal. Relapse prevention counseling seeks to build appropriate expectations for the quitting process, help smokers problem solve how to deal with high-risk trigger situations, and help them recognize that slips are temporary setbacks (not abject failures) that provide valuable learning experiences for future success (Marlatt & Gordon, 1985).

Other common behavioral cessation treatments include scheduled smoking reduction (Cinciripini et al., 1995; Cinciripini, Wetter, & McClure, 1997; Riley, Jerome, Behar, & Zack, 2002), nicotine fading (Bercona & Garcia, 1993), and aversive smoking techniques such as rapid smoking. The empirical support for some of these strategies is mixed (Fiore et al., 2000; Hajek & Stead, 2004), as fewer well-controlled studies have been done in these areas.

### Conclusion

Although many feel that the tobacco control movement will not be fully successful until smoking is eradicated, this movement has had a notable impact in the U.S. over the past 40 years. Numerous community-level and individual-level efforts responsible for this change have a grounding in cognitive-behavioral and behavioral principles of change, though they may not commonly be perceived in this way. Nevertheless, the U.S. tobacco control movement is a good example of the public health impact that can be achieved when cognitive-behavioral and behavioral principles are applied to modifying maladaptive health behavior.

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## Behavior Therapy and Its Contributions to Obesity Treatment

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Behavior therapy has been utilized as an obesity treatment since the early 1960s (Ferster, Nurnberger, & Levitt, 1962) and is considered an appropriate treatment for persons of all overweight and obesity classes (National Institutes of Health, National Heart, Lung, and Blood Institute & North American Association for the Study of Obesity, 2000). Behavior therapy is recommended even when pharmacologic or surgical weight loss techniques are employed (National Institutes of Health, National Heart, Lung, and Blood Institute & North American Association for the Study of Obesity, 2000; Wadden, Berkowitz, Sarwer, Purs-Wisniewski, & Steinberg, 2001). With 64.5% of U.S. adults overweight and 30.5% obese (Flegal, Carroll, Ogden, & Johnson, 2002), clinicians are likely to treat patients who desire to lose weight. In this article, I review the contributions of behavior therapy to the treatment of obesity, present information on the new role of behavior therapy in prevention research, and provide resources for clinicians.

### History

Until the late 1950s, obesity treatment involved mostly psychoanalytic treatment and was not very effective (Stunkard & McLaren-Hume, 1959). The first published account of behavior therapy for obesity was written by Ferster and colleagues (1962) and laid the groundwork for a functional analytic approach to weight management. Stuart (1967) published the first behavioral case study of obesity treatment (mean 12-month weight loss = 38 lb). His frequent (thrice weekly) individual treatment sessions introduced clients to self-monitoring, stimulus control, and contingency management aimed at reducing caloric intake.

Not until 1971 did Penick, Fillion, Fox, and Stunkard report on the first controlled treatment outcome study of behavior modification for obesity. Compared to traditional group psychotherapy, behavior modification performed much better; 53% of the behavior modification group lost more than 20 lb compared to only 24% of the control condition (Penick et al.).

### Current Treatment Model

Over the next 30 years treatment components were added, removed, and "tweaked" to form the core treatment package of self-monitoring, contingency management, and stimulus control (Brownell & Jeffery, 1987; Brownell & Kramer, 1989). Treatment components, such as cognitive therapy and increased attention to nutrition and exercise, have been added in order to improve the outcome of behavior therapy for obesity. The following are examples of skills taught in behavioral weight loss programs: self-monitoring of food and exercise, behavioral goal setting (e.g., walk daily for 30 minutes), modification of conditioned patterns of eating (e.g., do not eat while watching television), stimulus control (e.g., shop from a grocery list), and identification of automatic thoughts and subsequent cognitive restructuring aimed at preventing relapse.

### Treatment Outcome

In the short term, behavioral treatment yields an average weight loss of 23.59 lb (Wadden & Butryn, 2003). Unfortunately, between 30% and 35% of weight is regained by 1 year posttreatment (Wadden & Butryn, 2003). Continued contact with a health professional for maintenance treatment, however, has been shown to prevent some weight regain (Perri et al., 1988). Despite regained weight, improving the fitness of patients may be more important

than alleviating obesity. For example, Lee, Blair, and Jackson (1999) found less relative risk of cardiovascular mortality in fit obese men than unfit lean men.

Behavior therapy targets weight loss, but also seeks to influence medical comorbidities associated with excess weight and sedentary lifestyle. Behavior therapy is more effective than pharmacotherapy in preventing comorbidities, such as diabetes, despite regained weight (Diabetes Prevention Program Research Group, 2002).

### The New Role of Behavior Therapy: Prevention

Studies utilizing behavior therapy are currently under way to prevent obesity-related morbidity and mortality. The Diabetes Prevention Program (DPP) and the Look AHEAD (Action for Health in Diabetes) Program are two such programs. The DPP was designed to prevent or delay the onset of non-insulin-dependent (Type 2) diabetes mellitus in at-risk populations. The behavioral intervention was not only more efficacious in preventing incidence of Type 2 diabetes compared to medication, but participants lost more weight and had the greatest increase in physical activity (Diabetes Prevention Program Research Group, 2002).

The Look AHEAD program was designed to study the effects of behavior therapy versus diabetes support and education on cardiovascular-related morbidity and mortality, as well as all-cause mortality in persons with Type 2 diabetes. Sixteen treatment centers are following approximately 5,000 patients until the year 2012. Data from this study will be made available in the coming years (Look AHEAD Research Group, 2003).

Behavior therapy continues to be a foundation of obesity treatment in a variety of settings and for diverse treatment populations. The increased prevalence of obesity

and related health morbidity in adults (Flegal, Carroll, Ogden, & Johnson) and in children (Ogden, Flegal, Carroll, & Johnson, 2002) suggests that a growing number of health care providers need to address weight management with their patients. The DPP treatment materials ([http://www.bsc.gwu.edu/dpp/lifestyle/dpp\\_part.html](http://www.bsc.gwu.edu/dpp/lifestyle/dpp_part.html)), the LEARN Program for Weight Management (Brownell, 2000), and *The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults* (National Institutes of Health, National Heart, Lung, and Blood Institute & North American Association for the Study of Obesity, 2000) are excellent resources for clinicians and patients.

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# ABCT

# Schizophrenia Rehabilitation Program at the Institute of Living: Combining Neurocognitive, Motivational, and Vocational Rehabilitation

James C. Seltzer, Matthew Kurtz, and Warren Thime, *Institute of Living*

The Schizophrenia Rehabilitation Program (SRP) at the Institute of Living aims to increase productive and meaningful activities in the lives of individuals with schizophrenia spectrum disorders. The program combines neurocognitive rehabilitation, physical exercise, and supported employment in a long-term intensive psychiatric rehabilitation center. The first treatment goal is to improve patients' neuropsychological abilities and motivation. As these skills are developed, the clients are helped to improve the quality of their lives by finding jobs or returning to school. These interventions are set in a milieu that offers a high level of consistency and support with a comprehensive range of more traditional mental health services, including psychopharmacology, skill-building classes, family support and therapy, individual therapy, and case management.

## Rationale for a Different Treatment Approach

SRP was opened in 1995 to address the problem of poor functional outcomes for these individuals. It was assumed that cognitive deficits were partially responsible for the chronic disability faced by these patients and their inability to benefit from treatment (Kern, Green, & Satz, 1992). These deficits often remained, even after treatment with antipsychotic medications, and continued to impair the individual's ability to function effectively. More specifically, evidence over the past 15 years has shown that the majority of patients with schizophrenia exhibit significant neurocognitive deficits on measures of attention, learning and memory, problem solving, language, and sensory-motor skill, with some evidence that verbal learning is an area of selective deficit across this background of diffuse impairment (Seltzer, Cassens, & Conrad, 1997; Wexler, Jacob, Stevens & Donegan, in press). These deficits are evident at disease onset, prior to neuroleptic exposure

(Saykin et al., 1994), and are highly stable over time in young-adult and middle-aged patients (Heaton et al., 2001; Kurtz, 2005). Particular significance has been attached to these deficits as several syntheses of the literature have indicated that neuropsychological deficits account for 20% to 60% of the variance in psychosocial outcome as measured by levels of community function, social problem-solving, and progress in rehabilitation programs (Green & Nuechterlein, 1999). The success of neurocognitive remediation to treat these deficits with closed-head-injury patients (Sohlberg & Mateer, 1987) suggested that practicing cognitive skills might help people with psychosis. In fact, cognitive remediation has become a routine component of treatment in many head injury treatment centers. A recent methodological review of 655 published studies investigating cognitive rehabilitation for patients with stroke or head injury revealed that a growing number of carefully controlled studies have shown therapeutic effects of remediation on measures of attention, memory, functional communication, and executive function (Cicerone et al., 2000).

Research supported by Hartford Hospital and the Spencer T. and Ann W. Olin Foundation suggested that some of the deficits in schizophrenia may be reduced through cognitive rehabilitation techniques (Seltzer, Cassens, Ciocca, & O'Sullivan, 1997). These rehabilitation techniques require that the patients repeat a series of drills to practice their concentration. For instance, the patients practice their ability to concentrate on what people say to them by listening to a tape recording of someone talking and pressing a button when they hear certain words or answer questions about what they heard. The patients repeatedly practice these exercises in much the same way an actress practices a role in a play. They review the script until they say the lines perfectly. In cognitive rehabilitation, the drills become harder and more complicated as the patients become more proficient at focusing their attention. First, they listen for 5 minutes, then 10 minutes, then an hour. Next they listen to one person speaking, then two at a time. Ultimately, they learn to focus on conversation and visual images at the same time. As the patients experience more success they become willing to attempt more difficult tasks and devote greater energy to their own lives and initiatives. The aggressive neuropsychological rehabilitation techniques being evaluated at SRP have shown promising outcomes (Bell, Bryson, Greig, Corcoran, &

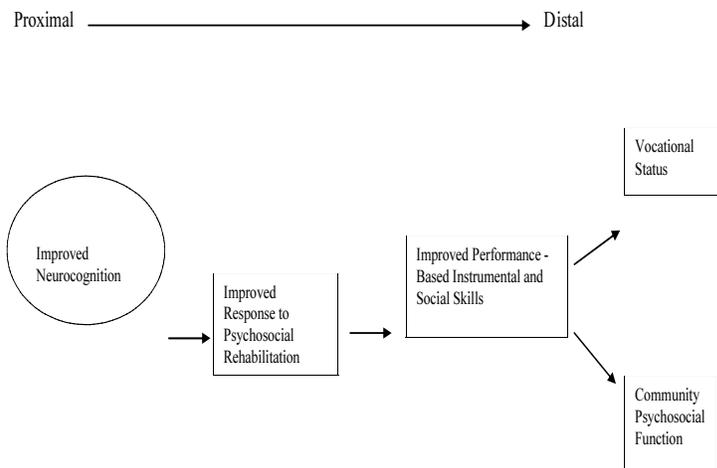


Figure 1. Potential effects of improved neurocognition on outcome in schizophrenia.

Wexler, 2001; Bellucci, Glaberman, & Haslam, 2003; Kurtz et al., 2005) and researchers hypothesize that these procedures may facilitate the patients' return to work. These techniques may also promote improvements in the quality of patients' lives in other areas, such as improved relationships and increased capacity to experience joy.

The model of remediation utilized at SRP includes this intervention as part of a broader array of services rather than as a stand-alone treatment. An underlying assumption is that remediation-related improvements in elementary information processing will allow the patient to capitalize on more traditional skills training and supported employment services. The model of treatment mechanism is outlined in Figure 1 and is similar to that described by Green and Neuchterlein (1999) and others.

### Program Description

The Center offers two specialty tracks. The Early Intervention Track provides training to individuals during the first few years of illness and the Prolonged Illness Track provides training for individuals with persistent and pervasive disabilities. Clients with schizophrenia spectrum disorders between the age of 18 and 60 who have cognitive deficits and some interest in having a job and are without significant current substance abuse problems are accepted in the program. The program is based on several assumptions:

1. Improved functioning requires the development of cognitive abilities and motivation as the foundation for learning and

skill acquisition. For example, adequate concentration is required to interpret what a therapist says about the benefits and risks of medication or to understand how a boss wants a job completed.

2. Improved functioning also requires taking skills mastered in treatment and systematically translating these skills into real-life settings. For example, adhering to a schedule in a supervised treatment environment does not mean the patients will arrive at work on time without direct supervision. Generalization of learning from the treatment center to the patient's home or job may not spontaneously occur, but can be realized by having staff work directly with the patients in their communities.

3. Motivation does not necessarily improve spontaneously with the remission of acute psychosis; but it can be increased with social expectations, the experience of success, and direct intervention. For example, a patient may initiate more at work if assertiveness on the basketball court yields success.

4. Special educational approaches need to be implemented to help patients learn critical coping skills. For example, traditional lectures about treatment options may be divided into smaller parts, with patients asked to frequently repeat the information in written and verbal exercises. Frequent reminders about the purpose of the lecture and need to focus on the material may assist in the learning process.

Figures 2 and 3 illustrate a conceptual overview of the key therapeutic modalities and how they are operationalized in the daily routine of the program. SRP provides a high level of nurturance and frequent

praise to each patient. Staff are high spirited, warm, welcoming, informal, and very available to patients (rather than staff maintaining a formal, authoritarian, and reserved presentation). Staff routinely share food with patients to foster a comfortable milieu. Very frequent verbal praise is offered throughout each therapeutic activity. In addition, awards are given to patients in gatherings of the entire therapeutic community to recognize their successes. Within this supportive milieu, staff design each interaction to shape increased productive and meaningful activity through experiences of success. For example, patients are given reasonable goals in physical exercise (i.e., score 2 more points in basketball drills than the prior day) and receive coaching. Reaching those goals is met with loud praise and community recognition. The patient's success in showing more motivation and persistence is framed in the context of their preparing to use this persistence in future community-based competitive employment.

The daily routine follows a sequence of six stages, where staff members help patients:

- organize themselves for the day in a Breakfast Club where treatment goals are reviewed;
- energize themselves and increase their alertness for the upcoming treatment day in a motivation group where physical exercise is used to improve persistence and initiative;
- train in cognitive rehabilitation exercises to improve their reaction time, concentration, memory, and executive functioning;
- practice their improved motivation and cognitive abilities in skills training classes;

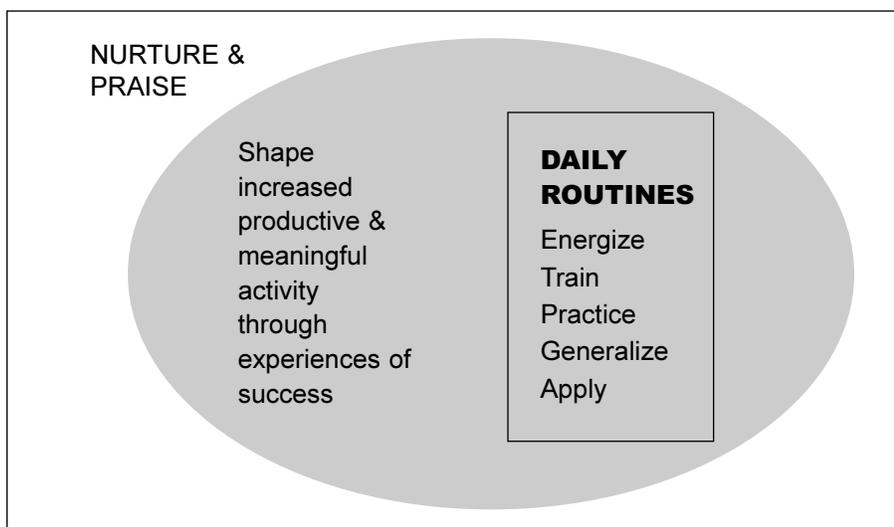


Figure 2. Conceptual overview of therapeutic modalities

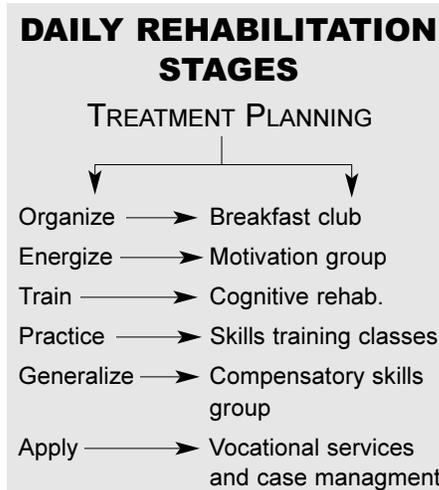


Figure 3. Daily routine in the schizophrenia rehabilitation program

where they learn how to cope with their illness and how to function on a job;

- generalize these new skills to community-based activities in a compensatory skills group where they unwind from the program day, receive praise for accomplished goals, and are given homework assignments to practice new skills at home or work; and
- apply their new skills with the help of supported employment and case management services that lead to jobs, return to school, and more participation in social and leisure activities.

Initially, patients attend the program 3 to 5 days per week from 9:00 A.M. to 3:00 P.M.

A fast pace is encouraged during these highly structured activities to help combat the patients' withdrawal, apathy, and lack of initiative. Emphasis is placed on maintaining productive activity, rather than spending time ruminating. Thus, more time is spent doing rehabilitation tasks than talking about problems. Patients are expected to fully participate in a minimum of 5 hours of rehabilitation per day. The SRP attempts to maintain a 4:1 patient-to-staff ratio in group rehabilitation exercises to provide a high frequency of coaching. Clinicians may also visit the patients' homes to help them apply the skills acquired in SRP to their lives in the community.

### **Program Components**

*Breakfast Club.* The therapist starts each Breakfast Club by asking the patients to share what they accomplished the previous day and what gave them some joy. These activities are shared with the group to reinforce the goal of increasing productive activity and to foster motivation. Particular attention is paid to helping clients develop a sense of themselves as competent individuals and learn ways to compensate for the deficits associated with schizophrenia. These compensatory strategies include stress-management techniques, maintaining repetitive daily routines to reduce capacity demands on planning abilities, developing more efficient communication styles, designing the home environment to improve organization, and other methods. Following this discussion, the staff helps patients orient themselves to the day's tasks and goals. Goals and strategies to improve performance during the upcoming rehabilitation exercises are discussed. This goal setting over a coffee cup mirrors how nondisabled people may review a daily planner to set priorities.

*Motivation group.* In this group, physical activities are used to increase motivation and self-confidence, develop social skills and teamwork, improve concentration and the ability to maintain effortful activity, shape increased self-initiative, and practice behaviors incompatible with apathy and withdrawal. The group is designed to increase the patients' blood flow and raise their energy level as the training day begins. Activities may include adventure-based counseling, team and individual sports, or other exercises. The group is not intended to be recreational, but rather to push the patients to sustain a higher energy level and increase their effort. The staff act as coaches to facilitate goal acquisition and measure the patients' performance throughout the group. For example, the group may include a basketball clinic, where patients are expected to complete a series of shooting, dribbling, and passing drills. Their percentage of completed shots, accurate passes, and time to run individual races is recorded. Patients review their successes daily in this group and they are rewarded by watching their performance improve. Although the group is run as a very rigorous and structured activity, many patients find it enjoyable and stimulating.

*Cognitive rehabilitation program.* The patients participate in the Cognitive Rehabilitation Program for 60 minutes each day. Goals for improvement on specific cognitive skills are formulated based on each individual's initial neuropsychological evaluation. Rehabilitation techniques are applied to recover attention, memory, and organization skills. During these rehabilitation activities, the patients complete computerized exercises that require them to exert mental effort to strengthen their intellectual skills. Theoretically, a person may be able to strengthen his or her ability to concentrate by practicing tasks that require attention. This is similar to a person who strengthens his or her cardiovascular system by doing aerobic exercises. The computer exercises become progressively more difficult as the patients master each skill.

The remediation intervention includes a 6- to 8-month course of cognitive remediation (100 hours) consisting of a sequence of computerized exercises that require repeated drill-and-practice. Exercises are started at a level of difficulty at which all patients will be successful (e.g., 80% accuracy). Goals are modified as performance improves. All training on computer exercises is conducted with coaching from staff trained in these procedures. Included in the intervention are the following tasks:

♦ **SIMPLE VISUAL REACTION TIME** (Bracy, 1995): The participant is asked to respond as quickly as possible by clicking a computer mouse whenever a yellow square is presented on the computer screen. The task is made more difficult by varying the size of the square (large or small) and its location (fixed or random). Reaction time, misses, false positives and trial-to-trial reaction time variability are recorded. This exercise aims to improve visual sustained attention and response time.

♦ **SIMPLE AUDITORY REACTION TIME** (Bracy, 1995): The participant is asked to click on the mouse as quickly as possible whenever a tone is presented. Reaction time, misses, false positives, and trial-to-trial reaction time variability are recorded. This exercise aims to improve auditory sustained attention and response time.

♦ **SIMPLE CHOICE REACTION TIME VISUAL** (Bracy, 1995): The participant is asked to respond as quickly as possible by clicking a mouse whenever a high-pitched tone is administered. The participant must inhibit responding whenever a low-pitched tone is played. Reaction time, misses, false positives and trial-to-trial reaction time variability are recorded. This exercise aims to improve sustained attention, response time, and response inhibition.

♦ **SIMPLE CHOICE REACTION TIME AUDITORY** (Bracy, 1995): The participant is asked to respond as quickly as possible by single-clicking a mouse whenever a high-pitched tone is administered. The participant must inhibit responding whenever a low-pitched tone is played. Reaction time, misses, false positives and trial-to-trial reaction time variability are recorded. This exercise aims to improve auditory sustained attention, response time, and response inhibition.

♦ **PROGRESSIVE ATTENTION TRAINING—RESPOND TO A SELECTED COLOR** (Wang Neuropsychological Lab, San Luis Obispo, CA): The participant is asked to choose whether he or she will respond to red or black cards. The participant is then presented with a random series of playing cards and must press the space bar whenever a card with that color appears. Difficulty level is modified by varying stimulus-exposure time. Hits, misses, and false positives are recorded. This exercise targets sustained visual attention.

♦ **PROGRESSIVE ATTENTION TRAINING—ALTERNATE BLACK AND RED BY A SIGNAL** (Wang Neuropsychological Lab, San Luis Obispo, CA): The participant is presented with a series of playing cards and begins by

responding whenever the color of the card is black. After every 10 to 15 cards, the word "switch" is presented at the top of the screen. The participant must then shift the sorting rule from red to black. Difficulty level is modified by varying stimulus-exposure time. Hits, misses, and false positives are recorded. This exercise aims to improve sustained visual attention and set shifting.

◆ **SEQUENCED RECALL DIGITS AUDITORY** (Bracy, 1995): The participant is orally presented with a series of 2 to 10 digits. The participant must remember the order of the numbers, because after a delay the participant is asked to select the numbers in the order they were presented from a bar at the bottom of the screen. Total number correct across trials and most correct on one trial is recorded. This exercise aims to improve auditory attention and memory.

◆ **SEQUENCED RECALL DIGITS VISUAL** (Bracy, 1995): The participant is presented with a series of 2 to 10 digits displayed serially on the computer. The participant must remember the order of the numbers because after a delay the participant is asked to select the numbers in the order they were presented from a bar at the bottom of the computer screen. Total correct across all trials and most correct in one trial are recorded. This exercise aims to improve sustained visual attention and memory.

◆ **SEQUENCED RECALL WORDS VISUAL** (Bracy, 1995): The participant is presented with 2 to 10 words on a monitor. After a study period, the participant is asked to select the studied words from a list of 16 words in the order the words were presented. The number of correct and incorrect responses is totaled. This exercise aims to improve memory for verbal material and serial position.

◆ **VERBAL MEMORY CATEGORIZING** (Bracy, 1995): The participant is asked to sort a series of 20 words into four semantic categories. After sorting, the words are removed from the screen and the participant is asked to select the 20 studied words out of a list containing both the 20 target words and distracter items. Percent categorized and percent recalled are computed. This exercise aims to improve semantic processing and verbal memory.

*Skills training classes.* Classes in skills training are available for education about mental illness, social skills, vocational skills, relaxation techniques, and leisure issues.

Each content area is taught in a manner that helps patients with cognitive deficits master and apply the material through an active learning process.

*Compensatory skills group.* At the end of each rehabilitation day, patients meet again with their Breakfast Club. The focus is on identifying accomplishments during the day, remembering coping strategies that worked, and rewarding individual rehabilitation efforts. This is a time to unwind from the day, reflect on successes, and plan how to use compensatory strategies to cope with the future. Staff members guide patients in discussions concerning how to use the skills in the program in their daily lives at home or on the job. Staff may assign homework to help clients generalize ways to compensate for their symptoms and cognitive weaknesses. The main goal of the group is to facilitate verbal interactions between clients and staff that help the patients use behaviors that allow them to overcome the deficits associated with schizophrenia.

*Home visits.* Offered to help clients apply the skills learned in the program in their community or homes, these visits are used to: (a) evaluate functioning outside SRP, (b) help train family members or counselors in the patient's group home on ways to foster their adaptive functioning, or (c) accompany the patients on activities in their community to teach new skills. For example, staff may teach patients how to go food shopping or register for an art class.

*Vocational services.* Vocational services follow a modified Individual Placement and Support model (Twamley, Jeste, & Lehman, 2003) that also uses some more traditional approaches. Patients participate in SRP until they can demonstrate work readiness. Work readiness is assessed by an objectively defined set of behaviors called the CHAMPION criteria. CHAMPION is an acronym for eight skills needed for successful employment, including: communication, hygiene, attendance, motivation, perseverance, interpersonal skills, openness to working, and naming an achievable vocational goal. When clients consistently demonstrate these abilities, they receive job development/placement and job-coaching services to transition them into community-based employment. Clients may also receive individual vocational counseling, vocational interest and aptitude testing, and situational work assessments. Clients interested in returning to school receive similar supports for their academic goals. Clients who persistently fail to progress on the CHAMPION criteria may participate in a work-skills training program that provides

supported employment opportunities on the hospital grounds. This program provides the client with a temporary job as a means to the development of work behaviors, to increase self-esteem and self-confidence, and to enhance work tolerance. For the most severely impaired individuals, SRP operates MagicGlass, a bead jewelry-making business. Clients not yet ready for employment in the work skills program may be employed in MagicGlass, where they make and sell beaded jewelry or complete other related tasks (i.e., bookkeeping, ordering, etc.). MagicGlass provides clients with some work experience and opportunities to learn elementary work behaviors.

*Family support program.* Twice a month, the patients' families are invited to meetings that aim to reduce stress, develop a working alliance with the families, teach families how to better cope with the illness, and provide support. They participate in a traditional support group where families share experiences with each other and learn coping strategies, plus attend presentations by experts on topics related to the medical, emotional, and financial aspects of schizophrenia.

*Medication treatment program.* SRP provides an aggressive medication treatment program. The program is supervised by a psychiatrist who meets regularly with the patient and their families. The psychiatrist is supported by a medication treatment team, including an APRN, consultant psychopharmacologist, a doctoral-level clinical pharmacist, a postdoctoral fellow in clinical pharmacy, and clinical pharmacy interns. This team is an integrated part of the rehabilitation staff. Routine weights, blood pressures, symptom rating scales, compliance with treatment reviews and blood levels are obtained to better manage the patient's medication regimen. In addition to symptom reduction, the aim of the psychopharmacology program is to improve patients' cognitive skills.

*Assessment.* In addition to the routine psychiatric intake and history, all patients receive a comprehensive battery of tests, including: diagnostic evaluations (Structured Clinical Interview for DSM-IV), symptom rating (Positive and Negative Syndrome Scale), occupational therapy evaluations (UCSD Performance-Based Assessment, Performance-Based Assessment of Self-Care Skills) and a social-skills assessment measure (Social Skills Performance Assessment). A neuropsychological evaluation is also completed (Wechsler Adult Intelligence Scale III, Continuous Performance Test, Trailmaking Test, California Verbal

Learning Test-II, Penn Conditional Exclusion Test, Controlled Oral Word Association Test, Category Fluency, and Wisconsin Card Sorting Test). These data provide a platform for the development of individual treatment plans. In addition, information is gathered from the patient's family to support the initial evaluation and assess both the needs of the family as well as the patients. Some tests are repeated as needed to monitor progress in treatment

### *Generating Institutional Support for Novel Programs*

Hospital leaders were convinced to start the program based on pilot data gathered at the facility. While these data were very preliminary, it provided the hope for better treatment outcomes and encouraged the hospital to take the financial risks of starting a long-term rehabilitation program without clear reimbursement. Most patients in need of these services had Medicare and Medicaid. Given the poor prospects for reimbursement, the program was started with a research grant from Hartford Hospital that supported 50% of the program expenses for 2 years. Limited insurance reimbursement was able to cover the other 50%. The outcomes were promising enough to interest the Olin Foundation to fund the program's operations for an additional 3 years. Over this time, the staff and patient's families successfully lobbied the state Medicaid program to cover the long-term treatment.

### *Outcomes*

In a retrospective review of 52 patients treated in the SRP intensive outpatient program from April 2004 to April 2005, 91% were able to develop a routine of productive and meaningful activity (53% held competitive jobs or were attending college, 26% held supported employment positions in the hospital, and 12% held volunteer positions in the community). Of the 24 patients who held competitive jobs, 88% had stayed in those jobs for 3 months or longer. Several within-subject and between-group design research protocols completed at the SRP have suggested that the cognitive rehabilitation is associated with improvements in neuropsychological test performance (Kurtz et al., 2005; Seltzer et al., 1997). Anecdotal evidence suggests that the program is more helpful to patients without negative symptoms, but still is useful to patients with apathy and withdrawal. We have been particularly successful with individuals with dependent or borderline per-

sonality traits, but less successful with patients with narcissistic traits. Currently, research is being conducted in SRP to look at the characteristics of patients that predict positive outcomes in the program. In addition, investigators are trying to understand the mediating relationships between improved neurocognitive function, improved participation in the rehabilitation program, and improvements in community function and employment status.

### *Dissemination of Program Technology*

The strong outcomes seen in SRP have encouraged us to translate these treatment methods to other settings. The Institute of Living (IOL) has started a cognitive rehabilitation and motivational training program for psychotic adolescents in a special education school. It was hoped that even more robust outcomes could be achieved by offering these treatments to younger clients. In addition, cognitive rehabilitation programs are being planned in substance abuse treatment and dual diagnosis ambulatory programs at IOL. Yearly, the IOL's approximately 3,000 admissions present with schizophrenia or related disorders. Despite very pronounced cognitive impairments, many of these patients have intact expressive vocabulary (Seltzer et al., 1997). Clinicians in acute care settings may not appreciate the degree of attention or memory difficulties that may hide behind relatively intact vocabulary. To address this problem, a hospital-wide staff education program was implemented to increase awareness of the need to adjust treatments to compensate for clients' cognitive deficits. This program included a series of grand rounds presentations, and in-service training to staff on acute care units and new employees. In addition, a neurocognitive treatment-planning tool was developed and disseminated to help clinicians understand the nature of cognitive impairment in schizophrenia and the options for treatment. Currently, an effort is being made to administer brief cognitive screenings of all patients with psychotic disorders in ambulatory programs to provide clinicians with information about patients' neurocognitive strengths and weaknesses.

### *Discussion*

The SRP has been successful in improving patients neurocognitive skills, and many of these patients have been able to return to productive lives in competitive jobs. However, the program needs to continue to evolve. Plans for the future include using

fMRI to monitor progress in treatment and understand the nature of cerebral impairment in schizophrenia; expanding capacity for patients early in their illness; developing and testing shorter forms of cognitive rehabilitation; developing tools to screen patients who will not benefit from the program through the use of predictive longitudinal follow-up studies; investigating how medications may be used to enhance or prime the cognitive rehabilitation techniques; and developing rehabilitation techniques for patients who do not benefit from SRP treatments.

In summary, treatment programs that combine neurocognitive and vocational rehabilitation with motivational approaches may help individuals with schizophrenia improve the quality of their lives. Finally, while empirically based program development and outcome studies have facilitated the evolution of SRP, it is the efforts of our clients and their families that make the program successful and it is their pride in achieving a more productive life that is our benchmark for good therapeutic response.

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# Call for Award Nominations

ABCT'S 40TH ANNUAL  
CONVENTION  
November 16-19, 2006  
CHICAGO

- Outstanding Contribution by an Individual for Education/Training
- Outstanding Mentor
- Virginia A. Roswell Student Dissertation
- Career/Lifetime Achievement
- Distinguished Friend to Behavior Therapy
- Outstanding Service to ABCT

Questions about the award nominations, contact:

DEADLINE FOR NOMINATIONS:  
**Wed., March 1, 2006**

Guidelines, instructions for nominating, and award descriptions appear in the December issue of *tBT* or at [www.aabt.org](http://www.aabt.org)

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## STUDENT AWARDS PROGRAM

**President's New Researcher Award** ABCT's President, Michael W. Otto, Ph.D., invites submissions for the 28th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of \$500. Submissions will be accepted on any topic relevant to behavior therapy, but submissions consistent with the conference theme emphasizing translational research are particularly encouraged. Eligible papers must (a) be authored by an individual with five years or less posttraining experience (e.g., post-Ph.D. or postresidency); and (b) have been published in the last two years or currently be in press. Submissions can consist of one's own or any eligible candidate's paper. Papers will be judged by a review committee consisting of Michael W. Otto, Ph.D.; J. Gayle Beck, Ph.D., ABCT's Immediate Past-President; and Ray DiGiuseppe, Ph.D., the ABCT President-Elect. Submissions must be received by Monday, August 14, 2006, and must include four copies of both the paper and the author's vita. Send submissions to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.

**Virginia A. Roswell Student Dissertation Award** Please visit [www.aabt.org](http://www.aabt.org) and click on "2006 Awards" to view the description/instructions for this award.

**Elsie Ramos Memorial Student Poster Awards** These awards will be given to three student poster presenters (student first authors only), member or non-member, at ABCT's 40th Annual Convention in Chicago. The winners will each receive a 2007 ABCT Student Membership, a 1-year subscription to an ABCT journal of their choice, and a complimentary general registration at ABCT's 2007 Annual Convention. To be eligible, students must complete the submission for this year's ABCT convention by **March 1, 2006**. The proposal must then pass ABCT's peer review process. ABCT's Awards and Recognition Committee will judge all student posters.



## Book Review

Eifert, G. H., & Forsyth, J. P. (2005)

### *Acceptance and Commitment Therapy for Anxiety Disorders: A Practitioner's Treatment Guide to Using Mindfulness, Acceptance and Values-Based Behavior Change Strategies.*

Oakland, CA: New Harbinger

Reviewed by Daniel J. Moran, *Trinity Services/MPI, Joliet, IL*

I can still remember the first time I was introduced to Acceptance and Commitment Therapy (ACT). In 1994, I was a graduate student attending a symposium and the presenter was describing her client's obsessive sacrilegious thoughts, such as "God lives in the toilet." I expected the presenter to tell me how she disputed the thought, restructured the thought, "rubber-band punished" the thought, or thought-stopped the thought. Instead, the presenter described how she encouraged the client to "have" the thought while moving forward in a "valued life direction." It was a refreshing alternative to my graduate student ears, and I wanted to learn more about an approach that allowed someone with scrupulosity OCD to go ahead and have the thought that a divine being lives in the commode.

Over the past 11 years, we have witnessed the development of a growing community of scientist-practitioner-educator-philosophers with a distinct and vibrant research agenda. As interest in this exciting new branch of behavior therapy has grown, there has been increasing need for ACT training resources. Fortunately, *Acceptance and Commitment Therapy for Anxiety Disorders*, by Georg H. Eifert and John P. Forsyth, has answered the community's call.

Eifert and Forsyth appear to understand that scientist-practitioners are cautious when adopting new principles and applications. Healthy skepticism and caution has certainly surrounded the dissemination of ACT. Some have suggested that the scientific and philosophical foundation of ACT, Relational Frame Theory (RFT), is too difficult, too philosophical . . . too dense. Fortunately, for these skeptics, Eifert and Forsyth have simplified matters considerably. There is precious little about RFT in *ACT for Anxiety Disorders*. The authors use accessible language to explain the ACT approach, and occasionally provide colloquial

explanations alongside explanations technical enough to satisfy even the most pernickety empiricists. They manage to use words like "tinge" and "tweak" in a scholarly manner, and provide details about ACT as your favorite professor might have: with a passion for the material, and for "student" learning. The book is written clearly enough to be used in a senior undergraduate course, and comprehensive enough to be the basis for a professional workshop.

*ACT for Anxiety Disorders* begins with a discussion of the general ACT principles and concepts, and then presents the ACT view of psychopathology. While the authors do not burden readers with the technical language and concepts associated with RFT and functional contextualism, readers may be challenged by an approach to conceptualizing and treating anxiety that breaks rank from the traditional cognitive-behavioral model. Conventional CBT generally teaches anxious clients that thoughts and feelings cause suffering, and that controlling thoughts via CBT methods such as disputation, distraction, or mastery is the best way to ensure optimal health. Eifert and Forsyth ask the reader to consider whether it is the control agenda itself—and the associated distraction and avoidance of the feelings and thoughts—that diminishes one's quality of life.

In session, the client is asked, "Can you have this experience, private or public, fully and without defense?" Clients that answer no typically spend much time obsessing, worrying, and remembering, and especially resisting these events. In CBT, problem-solving exercises are often employed to reduce obsessions and compulsions. However, Eifert and Forsyth argue that "problem solving" is often the problem. According to the authors, eliminative problem-solving techniques work wonders for the external environment: If I have raw chicken juice on my hands, I wash. But washing doesn't uncontaminate my thoughts, at least not for

long. In fact, attempts to eliminate "private events" may actually exacerbate suffering. For example, when research participants are asked to suppress thoughts, thoughts actually increase compared to participants not given suppression instructions (Gold & Wegner, 1995). Wegner, Schneider, Carter, and White (1987) suggest that these rebound effects of suppressed thoughts occur more frequently in contexts where the person attempted earlier suppression. The person may again try to "problem-solve" by avoiding the contexts where suppression was attempted, which exacerbates the anxiety problem. Ultimately, the anxious client begins avoiding his or her own experience. Eifert and Forsyth explain that helping our clients answer yes to the question "Can you have this experience?" is a more effective and constructive long-term approach to living a full life. ACT's alternative suggestion—that the client learn to "have" or accept the experience of anxiety—is a frequent oversimplification, and Eifert and Forsyth go on to elucidate additional aspects of ACT as the text unfolds.

Most of the book is devoted to delineating the 12-session anxiety treatment sequence, complete with session outlines and timed agenda items, so the new ACT therapist can get a sense of the amount of time each phase might require. The authors make the obvious caveat that these are treatment guidelines, not a script, and that each client and therapist will require a flexible application of these tenets. The approach of each chapter seems to focus on the question, "How do I do ACT?" while supporting the idiographic approach of therapy. Each treatment chapter presents new handouts (along with PDF and Word document files on the included CD-ROM) and a rationale for the presentation of each. Therapy transcripts are also presented alongside new and revised metaphors. However, this is not just a collection of pithy quotes and examples for the clinician to haphazardly apply. The authors provide a rationale for experiential life enhancement exercises, metaphors directly tied to anxiety disorders, and also how to conceptualize where to take the client next, given his or her response to treatment. In addition to making ACT conceptually accessible, the authors offer practical accessibility to the ACT materials. The CD-ROM provides digital copies of measures such as the revised Acceptance and Action Questionnaire and the White Bear Suppression Inventory, as well as other assessment tools and worksheets.

Throughout the book, the authors maintain allegiance to basic behavioral principles and applications. Exposure, contingency management, and response remain important components of ACT treatment. These evidence-based therapy “moves” fit into the ACT framework in two ways. First, ACT’s behavior analytic roots embrace the use of effective, data-based interventions, and dictate the use of empirically supported treatments. Second, and more closely tied to the philosophy of ACT, is that creating exposure opportunities maintains the importance of being open to new experiences without defense. Exposure is no longer conceptualized as an aim to reduce frequency of negatively reinforced responses that avoid CR elicitation. Repeated presentation of conditioned stimuli is not aimed at decreasing SUDS or reflexive responses, nor is it to test the accuracy of irrational predictions. “Exposure within ACT is always done in the service of a client’s valued life goals” (Eifert & Forsyth, 2005, p. 200). Imaginal and in vivo experiences allow the practice of clinically relevant acceptance and mindfulness exercises while supporting the defusion of evaluative language that arrives during the exercise. Eifert and Forsyth rename exposure “FEEL exercises” (Feeling Experiences Enrich Living), and add that another purpose of “FEELing” is to illustrate the impotence of verbal obstacles in the context of a value-driven life. Exposure encourages “clients to be with, and not act upon, the urge to avoid and escape anxiety, while doing what is important to them” (p. 201). Again, the aim is broadening life, not reducing symptoms.

One may ecclesiastically state that there is nothing new under the sun with ACT’s

dawning, and that much of the aforementioned acceptance and values-based techniques are implied in much of established behavior therapy. In the end, *ACT for Anxiety* presents a framework of behaviorally sound principles useful in treating persons with anxiety disorders that should complement conventional CBT interventions. In many parts of the text, Eifert and Forsyth offer suggestions for readers to incorporate ACT into a CBT framework. If you’ve long been curious to learn more about incorporating ACT into your practice, but the rumors of it being too dense or lacking a solid treatment manual inhibited your efforts, Eifert and Forsyth have published a fantastic rational dispute to that maladaptive schema . . . but maybe you should “just have” that evaluation, and read this valuable book anyway.

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### Classifieds

**LICENSED PSYCHOLOGIST.** Allied Health Providers PC is a multisite group practice on Cape Cod. We are looking for licensed Psychologists (full or part-time) with 2 or more years postlicense as a health-care provider, trained/experienced with children/adolescents. We will use our group HMO contracts to facilitate credentialing on all our panels. Reimbursement is better than competitive. Send resume, copy of license, and graduate transcript to: AHP 1074 Rte 6A W. Barnstable, MA 02668-1142. Tel: 508 362-1180.

**POSTDOCTORAL RESEARCH FELLOWSHIP WITH AARON T. BECK.** The Psychopathology Research Unit and the Center for the Prevention of Suicide of the Department of Psychiatry at the University of Pennsylvania are seeking applicants for a postdoctoral research fellowship and research associate position in cognitive therapy beginning July or September 2006. Under the direction of Aaron T. Beck, M.D., this program offers research seminars and ongoing clinical training. Fellows may participate in clinical outcome research studies for preventing suicide behavior among patients with substance use or severe mental disorders such as borderline personality disorder. These studies focus on implementing cognitive therapy interventions in community mental health and addiction centers. Other cognitive therapy research projects involve schizophrenia and anxiety disorders. Applicants who have earned a Ph.D. or equivalent in psychology or other related field should have a background in cognitive therapy of severe mental disorders and applied research methodology. Send a curriculum vita with a cover letter and two letters of recommendation before February 28, 2006 to Aaron T. Beck, M.D., Psychopathology Research, Room 2032, 3535 Market Street, Philadelphia, PA 19104-3309. The University of Pennsylvania is an Equal Opportunity/Affirmative Action Employer.

### Letter to the Editor

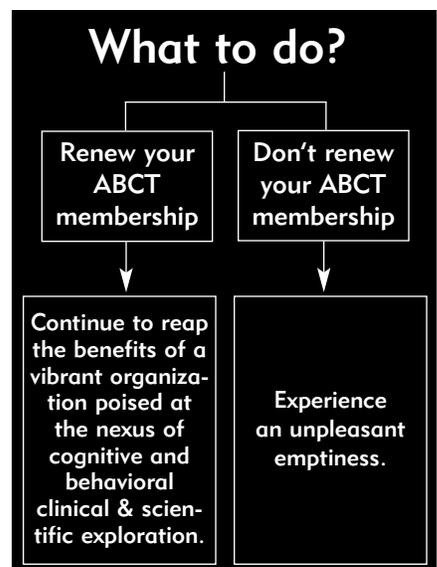
## Who Are the Veterans of AABT/ABCT?

I would like to know if there are any other 30-year veterans out there in AABT/ABCT-land. Specifically, I want to know if anyone has both been a member for at least 30 years and had 30 years of CONTINUAL attendance at the annual conventions.

I joined AABT in 1977 and attended my first conference that year. I have attended every one since, so the 2006 meeting will be my 30th. If there are others who have that distinction, I’d like to hear from

them. Perhaps it is deserving of an ABCT award (a longevity award? or at least a party?).

— E. Thomas Dowd  
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# ABCT Journals On-Line

David Teisler, CAE, *Director of Publications*

Many of you already know that this year you'll be able to access both *Behavior Therapy (BT)* and *Cognitive and Behavioral Practice (C&BP)* on-line. But we thought you might like to know the whole story.

First, all members get this benefit regardless of their membership category, so all Full and Associate, New Professional, and Student members get full on-line access to both *BT* and *C&BP* regardless of the print journals to which they subscribe. Of course, all Full, Associate, and New Professional members still automatically get their choice of *BT* or *C&BP* as part of their membership, and have the option of choosing both print journals at a discounted rate. Students retain the option of purchasing one or both print journals at a heavily discounted rate. Even better, although your membership benefits have dra-

matically increased, you won't be paying a penny more. You keep your print journals, and, for no additional money, you get on-line access to both journals.

We are working with Elsevier to have the first issues of *BT* and *C&BP* available on-line and in print in March. Elsevier is already working on digitizing all the back issues of both journals, going back to Day 1. The plan is for Elsevier to digitize the most recent 10 years first. These, once done, will be available to members for free. Later, Elsevier will digitize prior years, which will be made available at a nominal fee.

Access to the on-line versions of the journal will be through your membership number (your log-in). Supply your log-in and password via ABCT's portal to either *BT* ([www.aabt.org/publication/BT/bt.html](http://www.aabt.org/publication/BT/bt.html)) or *C&BP* ([www.aabt.org/publication/cbp/c&bp.html](http://www.aabt.org/publication/cbp/c&bp.html)) and you're given access to the journals.

Both *BT* and *C&BP* are members of ScienceDirect, which gives you access to all the journals that are members so you can follow the references to their sources.

Considering submitting an article? We have new submission portals in place for the two journals. For *C&BP*, go to <http://ees.elsevier.com/candbp> and follow the instructions (those submitting revisions to manuscripts already under consideration should continue through the existing JBO portal. *BT* is not yet ready to accept manuscripts through the new portal, but when it is, you can go to <http://ees.elsevier.com/beth>. You can also go through ABCT's web site. Click on PUBLICATIONS and go to the respective journal. Please note that we are in the process of redesigning and restructuring our web, so things may change slightly for this process. For those of you who have submitted articles already and are sending revisions, please use the original portal. If you have questions, please contact the action editor with whom you've been dealing.

ABCT	JOURNALS IN PRESS
<p style="text-align: center;"><b><i>Behavior Therapy</i> 37(#1)</b></p> <p style="text-align: center;"><b>Original Research</b></p> <ul style="list-style-type: none"> <li>• RICHARD G. HEIMBERG <i>From the Editor: Behavior Therapy Moves Into the Future</i></li> <li>• TWOHIG et al. <i>Increasing Willingness to Experience Obsessions: Acceptance and Commitment Therapy as a Treatment for Obsessive-Compulsive Disorder</i></li> <li>• TAYLOR &amp; ALDEN <i>Parental Overprotection and Interpersonal Behavior in Generalized Social Phobia</i></li> <li>• GRATZ &amp; GUNDERSON <i>Preliminary Data on an Acceptance-Based Emotion-Regulation Group Intervention for Deliberate Self-Harm Among Women With Borderline Personality Disorder</i></li> <li>• WEERSING et al. <i>Effectiveness of CBT for Adolescent Depression: A Benchmarking Investigation</i></li> <li>• MYSTKOWSKI et al. <i>Mental Reinstatement of Context and Return of Fear in Spider-Fearful Participants</i></li> <li>• BUSCH et al. <i>Sudden Gains and Outcome: A Broader Temporal Analysis of Cognitive Therapy for Depression</i></li> <li>• ENGLER et al. <i>Predicting Eating Disorder Group Membership: An Examination and Extension of the Sociocultural Model</i></li> <li>• ROTHBAUM et al. <i>Virtual Reality Exposure Therapy and Standard (In Vivo) Exposure Therapy in the Treatment of Fear of Flying</i></li> <li>• ANDERSON et al. <i>CBT for Fear of Flying: Sustainability of Treatment Gains After September 11</i></li> </ul>	<p style="text-align: center;"><b><i>Cognitive and Behavioral Practice</i> 13(#1)</b></p> <p style="text-align: center;"><b>Cognitive Behavioral Case Conference</b></p> <ul style="list-style-type: none"> <li>• Trauma to the Psyche and Soma: A Case Study of Posttraumatic Stress Disorder and Comorbid Problems Arising From a Road Traffic Collision (WALD &amp; TAYLOR) • Addressing Shared Vulnerability for Comorbid PTSD and Chronic Pain (ASMUNDSON &amp; HADJISTAVROPOLOUS) • Commentary on "Trauma to the Psyche and Soma" (BRYANT &amp; HOPWOOD) • Treatment of a Case Example With PTSD and Chronic Pain (SHIPHERD) • Synthesis and Outcome (WALD &amp; TAYLOR)</li> </ul> <p style="text-align: center;"><b>Involving Fathers in the Delivery of Psychological Services</b></p> <ul style="list-style-type: none"> <li>• Introduction (CATHERINE M. LEE) • Getting Fathers Involved in Child-Related Therapy (PHARES ET AL.) • Addressing Coparenting in the Delivery of Psychological Services to Children (LEE &amp; HUNSLEY) • A Cognitive Therapy Approach to Increasing Father Involvement by Changing Restrictive Masculine Schemas (MAHALIK &amp; MORRISON) • Eliciting Change in Maltreating Fathers: Goals, Processes, and Desired Outcomes (CROOKS, SCOTT, ET AL.) • Preventing Violence Against Women: Engaging the Fathers of Today and Tomorrow (CROOKS, GOODALL, ET AL.) • Commentary (CARR)</li> </ul> <p style="text-align: center;"><b>Book Reviews</b> • Cummings and Wright (Eds.), <i>Destructive Trends in Mental Health, and Sommers and Satel, One Nation Under Therapy</i> (REVIEWED BY RICHARD GIST) • Hayes et al.'s (2004) <i>Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition</i> and Hayes &amp; Strosahl's (2004) <i>A Practical Guide to Acceptance and Commitment Therapy</i> (REVIEWED BY BRANDON A. GAUDIANO) • Kingdon and Turkington's <i>Cognitive Therapy of Schizophrenia</i> (REVIEWED BY SHIRLEY M. GLYNN) • Rygh and Sanderson's (2004) <i>Treating Generalized Anxiety Disorder: Evidence-Based Strategies, Tools, and Techniques</i> (REVIEWED BY DAVID MELLINGER)</p>



**A grouping of AABT originals,  
circa 1965. Who are they?**

The person who can identify each individual  
pictured above wins a tattered copy of  
Breland & Breland's *Animal Behavior*,  
once owned by Andrew Salter  
(with marginalia).



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Send answers to

Stephanie Schwartz, Managing Editor

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and include your contact information



# ABCT's 40<sup>TH</sup> ANNUAL CONVENTION

## Translational Research

• Maureen L. Whittal, Ph.D., PROGRAM CHAIR •

Bridging  
Basic  
Science  
and  
Clinical Practice

November 16–19, 2006  
in Chicago

Inherent in being an evidence-based practitioner is the active translation of treatment-outcome findings and theory to the needs of the next patient at the door. A hallmark of CBT is the interplay of psychopathology research, analogue studies, outcome trials, and daily clinical practice. The theme for the 40th Annual ABCT Convention celebrates this interplay while underscoring recent efforts by the National Institute of Mental Health to encourage and expand translational research.

Translational research is a broad term that encompasses basic research that contributes to the treatment of mental disorders. Studies that focus on the brain or behavior that could lead to novel treatments or modifications to existing treatments are considered examples of translational research. Therefore, the call for papers for the 40th Annual Convention stresses (a) the ways in which basic science informs our conceptualization of disorders and (b) the process of change; further, it calls for work that invigorates new innovations in the field. Specifically, submissions that emphasize translational research or the use of laboratory-based experimental studies to inform clinical practice are encouraged and will receive special consideration.

Submissions may be in the form of symposia, round tables, panel discussions, and posters. In addition, discussants will be specifically encouraged to bridge the gap between experimental research and clinical practice.

Workshop submissions can be emailed to Dr. Lizabeth Roemer at [Lizabeth.Roemer@umb.edu](mailto:Lizabeth.Roemer@umb.edu). Include 250-word abstract and CV for each presenter (deadline: January 15, 2006).

**SUBMISSION DEADLINE: March 1, 2006**

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### *the Behavior Therapist*

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