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Clinical Dialogues

Client Curiosity About the Therapist's Private Life: Hindrance or Therapeutic Aid?

Luc Vandenberghe and Angelica Marden Coppede, *Universidade Católica de Goiás*, and Robert J. Kohlenberg, *University of Washington*

Cognitive behavior therapists have a tradition of fostering collaborative relationships and being alert for client diversions that might block productive work. However, even when sessions are structured according to a standardized protocol and an explicit agenda, "the course of therapy, like true love, is not always smooth" (Beck, Rush, Shaw, & Emery, 1979, p. 295). The present paper is intended to draw attention to a particular client diversion that has a distinctive disruptive potential—asking the therapist questions about her or his private life. With an emphasis on how therapeutic progress can be hindered or accelerated, we will discuss how cognitive behavioral therapists can view these questions. We will conclude our discussion with an analysis of client questions from the standpoint of functional analytic psychotherapy (Kohlenberg & Tsai, 1991).

Intrusive questions can be viewed as a technical problem (Beck et al., 1979) that obstructs therapeutic progress and causes difficulties for the therapist. Freud (1961/1915) acknowledged the problem when he said that such questions are intended by the client to "... deflect all her interest from the work and to put the analyst in an awkward position" (p. 163). During cognitive behavior therapy (CBT), the ways such questions interfere with progress include subverting the agenda as well as diverting the therapist's attention and shifting the focus to low-priority items.

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Further, some clients' questions might be personally evocative and the therapist may be conflicted about what to do. For example, the client might ask, "What is your sexual preference?" or "Have you ever been married/divorced?" and if so, "What conflicts led to you getting divorced?" Client questions that affect the therapist on a personal level in this way have great potential to cause the therapeutic interaction to stray from its most productive course. From this technical problem perspective, CBT protocol often calls for the therapist to refocus the client as these "diversions" take away from the time needed to cover the planned work (Beck et al., 1979; Freeman, Pretzer, Fleming, & Simon, 1990). Accordingly, suggestions are offered that the therapist can use to bring the client back on track. Consistent with this view, it would also make sense for the therapist to structure treatment in such a way that these questions will never come up (although, as discussed later, we think this is a mistake). For example, early on in the treatment process, the therapist might let the client know that personal questions will generally not be answered.

On the other hand, it is also possible to view client questions about the therapist's personal life as providing opportunities for beneficial therapeutic interventions. Answering a client's questions is a form of self-disclosure. Walen, DiGiuseppe, and Dryden (1992) encourage the use of self-disclosure to provide clients with models of appropriate thinking and acting in relation to problems therapists have successfully grappled with in the past. Others have proposed even broader therapeutic utility of self-disclosure (e.g., Goldfried, Burckell, & Eubanks-Carter, 2003; Hill & Knox, 2002).

Based on their review of self-disclosure research, Hill and Knox (2002) recommended selective and generally infrequent self-disclosure that includes, for example, professional background but excludes highly intimate topics such as sexual orientation. They suggest that self-disclosure can help build trust, validate reality, strengthen the alliance, and offer alternative ways to think or act. If the self-disclosure mirrors the client's concerns, it can help clients to feel normal and reassured. Accordingly, therapists should note how a client responds to the disclosures and use that information constructively. Along the same lines, Goldfried et al. (2003) recommend that cognitive behavior therapists self-disclose in order to enhance positive expectations and motivation, to strengthen the therapeutic bond, to normalize the client's reaction or reduce fears, and to provide feedback concerning the interpersonal impact made by the client.

Returning to the inner conflict a therapist might have about whether or not to disclose, the client's questions can have another effect. They can personally threaten the therapist in ways that not only interfere with her or his ability to focus on the CBT protocol, but also provoke tensions or relational problems between therapist and client. In other words, they can precipitate a rupture in the therapeutic alliance. Because therapeutic alliance has reliably been related to outcome (Horvath & Symonds, 1991; Orlinsky & Howard, 1975, 1986; Strupp, 1996), a breakdown in the alliance, if not addressed, may lead to poor outcome. As discussed below, however, if taken advantage of, this breakdown can be used to improve outcome (Safran & Muran, 1996).

Client Personal Questions From the Perspective of Functional Analytic Psychotherapy

Both therapist self-disclosure and addressing alliance ruptures are topics at the heart of functional analytic psychotherapy (FAP), a behavioral approach to therapy proposed by Kohlenberg and Tsai (1987, 1991; Kohlenberg et al., 2004). According to Kohlenberg, Tsai, and colleagues, what happens between therapist and client during a session can be analyzed in terms of its similarities to the client's daily interpersonal situations and problems. FAP posits that the outcome of CBT is greatly enhanced if the therapist becomes aware of naturally occurring instances of the client's actions and thinking during the session as either an in-vivo occurrence of the same daily life problem that brought them into treatment or, conversely, an improvement in the same (for empirical support see Kanter, Schildcrout, & Kohlenberg, 2005; and Kohlenberg et al., 2002). In FAP terminology, these in-session occurrences of the client's daily life problems (or improvements) are referred to as *clinically relevant behaviors* (CRBs). Further, CRBs are either rewarded or punished by the reactions of the therapist—regardless of the therapist's awareness. Based on the well-established principle that maximum change occurs when reinforcement is immediate, these rewards and punishments are seen to have particularly powerful effects on the outcome of treatment. The strengthening of new behavior during the session is, in turn, hypothesized to influence future occurrences of improved thinking and interpersonal relating in the client's daily life. Correspondingly, a therapist's inadvertent punishment of in-vivo improvements has particularly strong countertherapeutic effects.

Thus, the occurrence of a CRB provides the opportunity for significant behavior change via the here-and-now reactions of the therapist. One central tenet in FAP is that the therapist should avoid reacting in planned, technique-guided ways and instead use natural reinforcement of in-vivo improvements. This is intended to help with generalization of the gains in therapy to daily life—natural reinforcement is available in the outside world and contrived reinforcement is restricted to the therapy session. Let's say, for example, a particular client's problem is that he does not ask others directly for what he wants or needs. If this client then directly asks the therapist for something he wants, the natural reinforcement is to get what he asked for—not, for instance, the all-too-prevalent contrived therapist response of being praised or congratulated for "sharing that with me."

Therapist self-disclosure can act as natural reinforcement for a variety of improvements the client may emit for the first time during therapy, such as "trying to get to know the person to whom one is relating" or "trying to learn from the other." Alternatively, self-disclosure can be a tactic used by the therapist to intensify the relationship and thus be more apt to evoke CRBs (including thoughts and beliefs) that are related to the client's daily life problems with intense (intimate) relationships. Therapist self-disclosure can also take the form of sharing with the client the effect the client has on the therapist as a person, allowing for the natural consequences of the client's behavior to do their job as reinforcers. This type of sharing on the part of the therapist is seen as making visible or apparent the feelings or thoughts others have in reaction to the client's behavior, but which in daily life situations remain covert and thus invisible to the client.

Alliance ruptures provide in-session, here-and-now opportunities to observe how the client's thinking and behavior contributed to the rupture. Further, ruptures provide an opportunity to observe how the client deals with the event and whether or not this constitutes a concrete case of problem behavior or an in-vivo improvement. Finding out whether the client is showing an improvement or not depends on a comparison between what just happened and the ways the client has responded in the

past and in other important interpersonal relationships.

Case Illustration

Mr. A was a middle-aged man who sought therapy shortly after a schizophrenic episode. He was anxious and depressed about his lack of economic success and about the consequences of earlier episodes that had shattered his plans to go to college or grow professionally. In the recent past, he frequently started and abandoned university courses and grandiose personal or professional projects. He had deficits in social abilities and lived in relative social isolation, feeling angry with his wife, his father, and others whom he held responsible for his lack of success.

Typical questions he asked his therapist were: Are you married? Do you have children? What does your husband do for a living? In what neighborhood do you live? How much do you earn in a month? What do you think about life? Are you afraid of the future? Are you able to apply what you studied [about psychology] to your own life? How do you go about doing that? Does your husband smoke? Why don't you help him quit?

These questions made the therapist falter. She often felt threatened or ashamed and unsuccessfully tried to avoid and discourage the questions. Still, she answered what she considered to be the strict minimum to maintain a collaborative relationship. The continuing interference with her capacity to focus compelled her to reconsider what was going on between her and Mr. A. That the therapist looked young, inexperienced, and professionally (thus presumably financially) not yet firmly established may have set the stage for these questions as well as the fact that these same issues related to the client's problems.

Not only was Mr. A distressed about his financial condition and future, he defined himself as a victim and a failure, and begrudged others their successes. Mr. A understood the adversities of his life as extraordinary events that only could happen to him. The ways in which people reacted to him, according to his reports, indicated that they felt unwelcome and devalued by him. People who had initially offered their support were soon punished and left him to himself. Mr. A's questions had similar effects on the therapist. She viewed them as intrusive and inappropriate. They interfered with her capacity to help him effectively and promoted unproductive escape behavior.

Once the therapist became aware that Mr. A's questions indicated improvement, a major breakthrough occurred. Mr. A was trying, for the first time, to explicitly evaluate his assumptions about others (e.g., the therapist might struggle with personal difficulties). The therapist began to view the questions as evidence that Mr. A had adopted a more functional attitude and had started to test his hypotheses about the world. While the therapist once viewed his questions as intrusive, she now considered Mr. A.'s inquiries as attempts to gain an understanding of how to deal with and view his own problems. While initially the questions ran the risk of being punished, it was after the therapist started addressing them as legitimate attempts by Mr. A to learn from her that they allowed for therapy to take a more effective course.

Asking the therapist about her opinions, her difficulties, and her coping resources also inaugurated an empathic attitude that would help Mr. A improve his interpersonal relations in daily life situations. Furthermore, taking others' struggles seriously also validated them as possible sources of help. Several changes in the client's daily life occurred shortly after the therapist shifted her understanding of Mr. A's questions: he started to analyze the pros and cons of new projects before acting; he began testing his assumptions and beliefs; he discussed his professional plans with his wife and began accepting her advice; and he talked to persons he would previously have despised concerning topics on which they were well informed.

These proximal changes may have been the first steps in a more general process of change that came about gradually. Mr. A started seeking more social interchange and was more successful in relating to others as he stopped rejecting and blaming them. One year later, when he opted out of therapy, his professional initiatives were more realistic and succeeded better than ever before, and the anxiety and depression that had brought him to seek therapy had declined significantly.

Discussion

How can therapist reactions to intrusive questions be curative? Educating the client about keeping an adequate focus in the client-therapist dialogue can be necessary, and can even provide a powerful in-session therapeutic opportunity when the client's daily life problems are related to difficulties in maintaining focus and asking irrelevant questions as a way of avoiding dealing with more relevant issues. But in the worst case, it may result in discouraging precious in-vivo improvement as when the client's problems are related to his or her overrespectful submissiveness or rigid conscientiousness.

When a client "goes off on tangents," asking questions that deflect from the focus of therapy, the clinical relevance may not be in what the client asks, but in what effects the question has on the person of the therapist. Invasive questions by clients can evoke emotional reactions and thoughts of different sorts, including insecurity, fear, and distrust. The therapist can also feel important, honored, or seduced by the client's curiosity. Acknowledging that the therapist's reactions to a client are subject to the same regularities as those of other people interacting in daily life settings, the therapist's reactions may include clues about how a certain behavior affects people outside the session and thus either contributes to daily life problems or to their solutions.

After a therapist considers the possibility that the client evokes similar reactions in others besides the therapist and that these are related to the client's daily life problems, the client's questions might now be seen as providing special therapeutic opportunities. Our position is that self-disclosure makes sense as natural reinforcement if asking those questions is an improvement. In the case of Mr. A the function of the behavior was at first ambiguous. The questions made the therapist feel threatened and disqualified as a source of help. As long as she reacted with escape behavior, she strengthened the client's dysfunctional thinking and behavior and made it more likely he would keep others at a distance and not check out hypotheses during his daily life. But by providing directly or indirectly helpful information in reaction to the questions, she strengthened an entirely different function of that same behavior, and shaped Mr. A's repertoire of obtaining opinions and reports of experiences, listening and discussing.

In other cases, disclosing feelings about intrusive questions may be curative in a variety of conditions. A therapist can try to weaken in-vivo problem behavior by revealing the negative effect the behavior has on him or her. This may be the case, for instance, when a client's intrusive ways make people in his or her natural environment feel invaded or disqualified, when these behaviors keep potentially constructive contacts at a distance or destroy chances to improve interpersonal relations. Alternatively, the therapist may reveal that the questions made her or him feel closer to the

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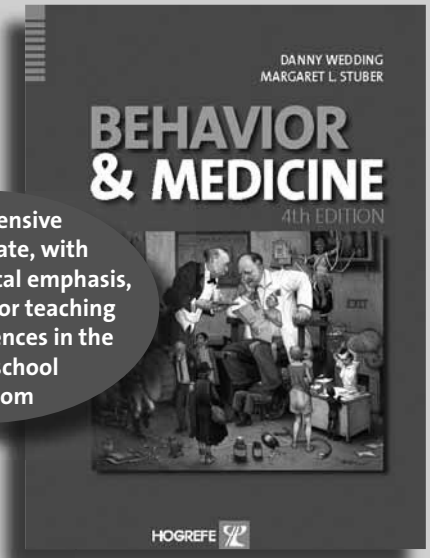

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client, or made her or him feel valued as a person. This may happen when the questions indicate an improvement in the repertoire of a client who has problems maintaining personal relationships, who rarely shows interest in others, or is seen by others as egocentric or uncaring.

Of course there are caveats. Therapists, feeling vulnerable, may refrain from disclosing (Hill et al., 1988). Actually, when answering an intrusive question, therapists do run risks. Acknowledging the client's curiosity as a CRB can conflict with the need for managing the relationship. Furthermore, disclosure gives the client an opportunity to punish the therapist's honesty and openness. However, running the risk may have therapeutic advantages. What Cordova and Scott (2001) call an intimate episode occurs when someone reinforces behavior of another that generally is vulnerable to interpersonal punishment. The curative potential of a relationship characterized by such episodes is suggested by the philosophy of FAP. Only when the therapist allows him- or herself to be personally affected by the behavior of the client will his or her reactions to that behavior be natural consequences of that behavior. When the therapist does not allow for this to happen, the reactions she or he will offer may turn out to be rationally justifiable but profoundly alienated from what is really happening that moment between the two people in the therapy room.

On the other hand, it must be clear that in a therapeutic relationship, not all that reinforces a specific in-vivo improvement or weakens a certain in-vivo instance of problem behavior would be adequate. A particular self-disclosure could be effective as a response to a particular CRB but could jeopardize the future potential of the client-therapist relationship. This may be the case when, as Goldfried et al. (2003) point out, appropriate boundaries are trespassed.

Summary and Conclusion

Instead of hindering progress, client intrusiveness can provide opportunities to improve outcome. It can be in-vivo improvement that should be reinforced or problem behavior that should be weakened. Avoiding problems may impoverish the relationship as a space for learning about daily life problems. Thus, as seen through the lens of FAP, avoiding disruptive client behavior should not be a priority. This means that therapists may drop much of the control they could have over the therapy process and be vulnerable to client reactions in order to allow for intimate and intense relationships that may offer greater curative therapeutic opportunities.

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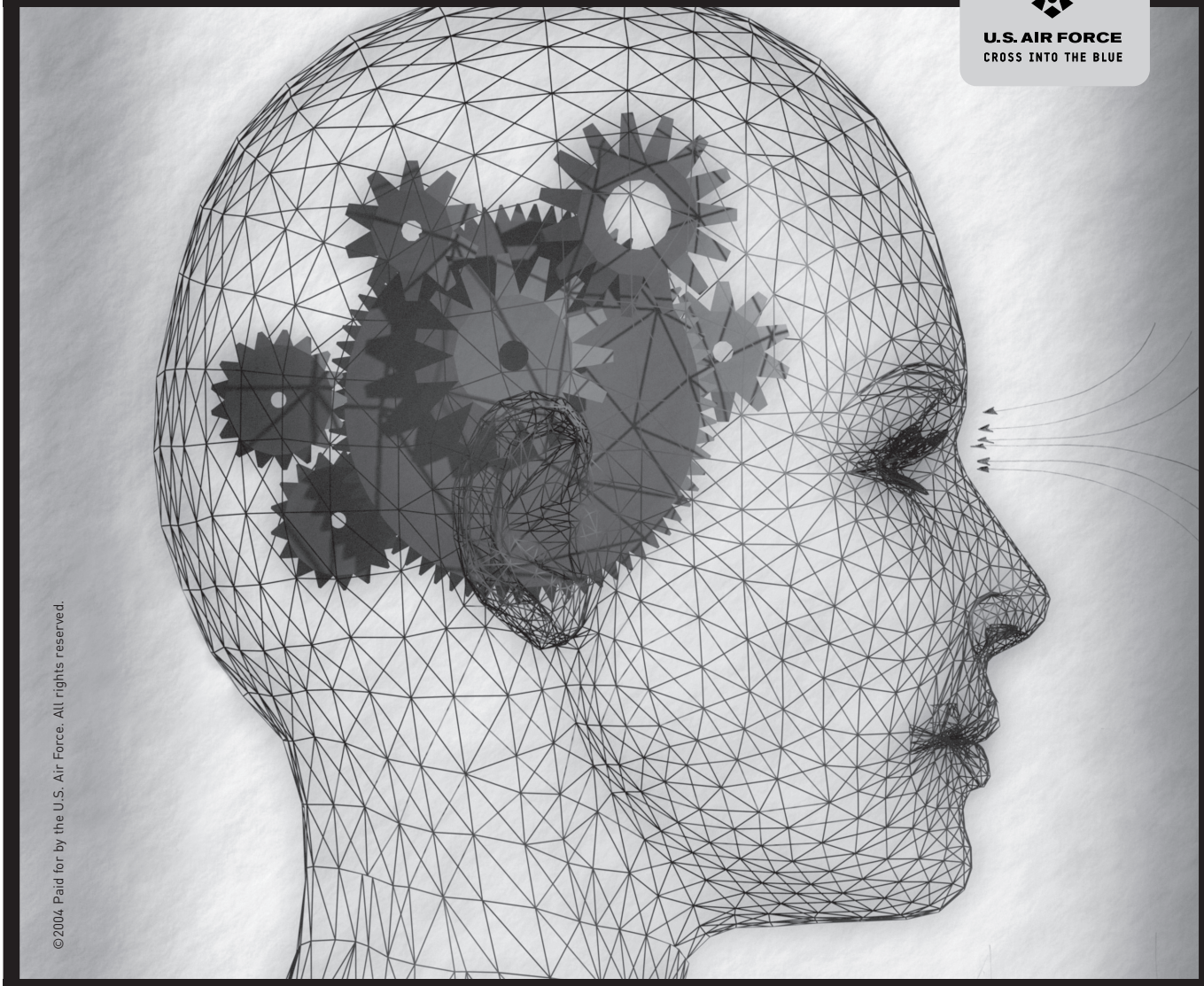

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A Primer on School-Based Functional Assessment

Robert H. LaRue and Jan Handleman, *Rutgers, The State University of New Jersey*

With the passage of the 1997 Individuals With Disabilities Education Act (IDEA) amendments, school psychologists and administrators have been under increasing pressure to implement functional assessment procedures in school settings. The use of these procedures has prompted a debate regarding the applicability of these procedures in the general school system (Scott et al., 2004). There exists a substantial body of work supporting the use of these procedures in clinical settings, yet widespread use of empirically validated functional assessment procedures remains inconsistent. The current article will discuss the purpose of functional assessment and some barriers that may limit dissemination in school systems. We also propose general guidelines for functional behavioral assessment that may be useful in school systems.

Definition

The development and refinement of functional behavioral assessment (FBA) procedures represents one of the most significant advances the treatment of behavior problems in recent decades. FBAs are used to generate hypotheses regarding the function (or cause) of challenging behavior. Specifically, it is a process for gathering information that can be used to maximize the effectiveness and efficiency of behavioral support (O'Neill, Horner, Albin, Storey, & Sprague, 1997). The FBA process involves a broad array of procedures used for gathering information regarding antecedents, behaviors, and consequences that allow clinicians to determine the maintaining factors for maladaptive behavior. Common maintaining factors for maladaptive behavior include positive reinforcement (e.g., behavior results in access to social attention or access to preferred items), negative reinforcement (e.g., behavior results in escape from demands or aversive stimulation), and automatic reinforcement (i.e., behavior that persists independent of environmental events). There are three broadly defined components to functional assessment. These components are indirect assessments (e.g., interviews, rating scales, record review), descriptive assessment (direct observation and ABC data collection), and systematic manipulations (or functional analyses). It should be noted that some professionals have used the terms "functional assessment" and "functional analysis" interchangeably. To avoid confusion, the phrase "functional assessment" here pertains to indirect (informant) and direct (descriptive) forms of assessment, while "functional analysis" will refer only to systematic manipulations of environmental events.

Effectiveness of Functional Assessment

Hundreds of articles from the behavioral literature have documented the effectiveness of functional assessment for developing effective treatments for students exhibiting behavior problems (for a review, see Hanley, Iwata, & McCord, 2003). A strength of FBA is thought to derive from making the intervention process more efficient (narrows down the number of potential interventions) and more effective than topography-based treatment. Recently, the National Institute of Health (NIH) has endorsed utilization of FBAs for persons diagnosed with developmental disabilities. In addition, FBAs are now legally mandated by the 1997 amendments to IDEA. These amendments require schools to provide an FBA and a behavior intervention plan (BIP) when suspensions/placements in alternative settings exceed 10 consecutive days, when a student is placed in an alternative setting for 45 days, when misconduct involves weapons or drugs, and/or when a due process hearing officer places a student in an alternative setting as a result of behavior dangerous to themselves or others (Drasgow & Yell, 2001).

The Challenges

Although functional assessment is expected practice, several challenges to its use in applied settings have arisen in recent years. Several researchers have suggested that, although these procedures are effective when used in highly controlled settings, they may have limited usefulness in applied settings, such as schools (Sasso, Conroy, Peck-Sticher, Fox, 2001; Scott et al., 2004). There are several potential challenges with the use of functional assessment in school settings. First, many school professionals may not be adequately trained to implement FBAs. Although functional assessment is currently a common training component in university-based special education programs, many professionals may have completed their training prior to the passage of the IDEA amendments and therefore have less familiarity with the FBA process.

Another challenge involves inconsistent or improper use of functional assessment techniques. School professionals often use quick, cost-effective functional assessment procedures, such as interviews and rating scales. Unfortunately, these procedures are often less accurate than other, more labor-intensive (and time-consuming) procedures, such as descriptive assessment and functional analysis.

Another significant challenge is the lack of legal guidelines for use of functional assessment. Although FBAs are mandated by the 1997 IDEA amendments, there are no clear guidelines for implementing these procedures. This ambiguity regarding implementation has led to a considerable amount of confusion and has left practitioners and school districts to decide what constitutes an adequate functional assessment.

In all, these challenges can lead to improper use of functional assessment procedures, and may therefore contribute to the perception that FBA is not a viable procedure for use in public schools. Poorly implemented functional assessments are not likely to result in positive outcomes for students and may ultimately decrease the likelihood that FBA procedures will be used consistently in the future.

The purpose of the current article is to provide guidelines for conducting FBAs in schools and to provide strategies to combat some of the challenges to effective implementation. The proposed guidelines are intended to supplement current models of functional assessment. We provide recommendations concerning three main components of functional assessment: indirect assessment, direct assessment, and analogue functional analyses.

Indirect (Informant) Assessment

Indirect assessment procedures represent the preliminary steps of problem solving in functional assessment. Indirect assessment procedures involve the use of rating scales and interviews.

Clinical interviews are extremely important for gathering preliminary functional information about the problem behavior. Teachers, parents, and direct care personnel should be interviewed to obtain several key pieces of information. First and foremost, an operational definition of the behavior should be developed. An operational definition is a precise description of a target behavior. An adequate operational definition has been developed when all people involved with a student can reliably identify an occurrence of the target behavior. For example, self-injurious behavior may be defined as forceful contact between a student's hand (open or closed fist) and his or her head from a distance of greater than 6 inches. It should be noted that operational definitions will often have some degree of error. For instance, an individual may engage in behavior that is topographically similar to the target behavior (e.g., the student may swing his hands while playing a game and accidentally hit his head). Assessors should strive to develop a definition that will effectively capture the behavior the majority of the time.

During clinical interviews, professionals should obtain information about the events that precede the target behavior (antecedents), as well as the events that follow behavior (consequences). Common antecedents to problem behavior include environmental events such as the presentation of demands, periods of low attention and the removal of preferred items. Common consequences for problem behavior may include the removal of demands (e.g., providing a break), reprimands/attention (e.g., "Stop doing that!"), and the presentation of preferred items. The interviewer should ask several questions regarding the relationship between the antecedents, behaviors, and consequences. Commonly asked questions about antecedents to challenging behavior may include the following:

- In what setting does the behavior occur most frequently?
- Are there settings/situations when the behavior never occurs?
- What do you think triggers the target behavior?
- Does it occur more/less frequently in the presence of specific people?
- Does it occur more frequently at specific times of the day?
- Are there events more temporally removed from the behavior that may affect responding (e.g., disruptions in sleep cycles, diet, medical problems, medication changes)?

Frequently asked questions about the consequences of behavior include the following:

- Is there a consistent response to the behavior?
- What does the learner gain from the behavior?
- When they get what they want, does the behavior stop?
- Can they get the same reinforcer (e.g., attention, break, preferred items) using adaptive communication (e.g., asking, using a communication board)?

In addition to antecedent and consequent events, practitioners should also gather information about the frequency and duration of maladaptive behavior.

In recent years, a number of useful rating scales and structured interviews have been developed to facilitate the functional assessment process. Commonly used rating scales include the Setting Event Checklist (Gardner, Cole, Davidson, & Karan, 1986) and the Motivation Assessment Scale (MAS; Durand & Crimmins, 1992). In addition to these rating scales, a number of functional assessment interviews have been developed. A commonly used structured interview is Functional Assessment Interview (FAI; O'Neill et al., 1997).

Indirect methods of functional assessment, such as interviews and rating scales, have the obvious advantage of yielding a wealth of assessment information with relatively little effort. Indirect measures are also particularly useful for guiding other aspects of the assessment process. For example, information obtained during the FAI can help practitioners to ascertain the best times to observe and to prepare for subsequent direct observation. Nevertheless, indirect measures such as parent and teacher reports can suffer from omissions and inaccuracies. Given the possibility of errors associated with these measures, indirect assessment methods should only be used as a preliminary step in the assessment process rather

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than as the sole basis for behavior intervention plan development.

Direct (Descriptive) Assessment

Direct assessment involves the systematic observation of the behavior in its natural setting. Procedures that fall under the category of direct assessment include direct observation and antecedent–behavior–consequence (ABC) data collection.

Informal direct observation involves collecting behavioral data in vivo. This involves the development of data sheets and the collection of behavioral data. The main purpose of behavioral observation is to refine the operational definitions and collect information regarding the prevalence of the target behavior. Data can either be collected by behavior analysts/psychologists or the direct-care staff themselves.

ABC data involves the collection of information regarding the events that precede the behavior, the behavior itself, and the events that immediately follow the behavior. By recording a variety of instances of the behavior (ABC), patterns can be analyzed to develop a better understanding of the function of behavior. Operational definitions need to be developed not only for the behavior itself, but for the antecedents and consequences. Examples of antecedent definitions may include:

Demand: A work task/activity presented within 5 seconds of the behavior.

No attention: No interaction 10 seconds prior to the behavior.

Restricted access: Opportunity to interact with preferred items/activities blocked within 10 seconds of the behavior.

Examples of common consequence definitions may include:

Escape: Break from demands (lasting 3+ seconds) within 5 seconds of the behavior.

Attention: Reprimands or social interaction within 5 seconds of the behavior.

Access: Allowed to interact with preferred items within 5 seconds of behavior.

Descriptive analysis data can be used to calculate the conditional probabilities for the behavior of concern. This is done by dividing the number of antecedents or consequences by the total number of behaviors (or episodes). For example, a student is observed to have 10 instances of self-injury during a behavioral observation. Eight of the 10 episodes are preceded by the presentation of demands. This would indicate that 80% of maladaptive behaviors were preceded by task presentation. A similar calculation could be made for the consequences for the behavior (e.g., 7 of 10 instances followed by a break in demands). It should be noted that the antecedents or consequences need not add up to the total number of behaviors. Frequently, behaviors have several antecedents and consequences that occur simultaneously (e.g., self-injurious behavior that is preceded by both presentation of demands and restricted access to preferred activities). A clear pattern often emerges if a sufficient amount of data has been collected. Descriptive assessment can be the terminal step in the functional assessment process provided that the data clearly indicate the function or functions of the behavior.

Direct or descriptive assessment has a number of advantages over indirect forms of assessment. One advantage is that the maladaptive behavior is observed in its natural context, which may enhance the social validity of the assessment. In addition, descriptive assessment is based on observations of the action "as it happens" rather than potentially biased impressions formed sometime after the event. However, because there is no systematic manipulation of antecedents or consequences in the functional assessment and because a multitude of factors may affect behavior from moment to moment, interpretation of functional assessment can sometimes be difficult.

Analogue Functional Analyses

Functional analysis involves the systematic manipulation of environmental antecedents and consequences to determine the function of problem behavior. The conceptual basis for functional analysis was established by Carr (1977) and models for clinical practice were developed by Iwata, Dorsey, Slifer, Bauman, and Richman (1982/1994) and Carr and Durand (1985). Functional analysis procedures build upon information already gathered in the functional assessment process (informant methods, descriptive assessment). Functional analysis procedures have been used to treat a wide variety of problem behaviors exhibited by children. These procedures have been widely studied and used effectively in the applied behavior analysis literature (Hanley et al., 2003).

The purpose of a functional analysis is to arrange sample test situations or "conditions" that are representative of contingencies common in the natural environment. These conditions may include brief periods of time with little or no social attention, restricted access to preferred items, or times when demands or work materials are presented. Data are collected on the target behavior (e.g., aggression or self-injury) and are compared across the different functional analysis conditions. Commonly used functional analysis conditions include social attention, tangible/restricted access, escape/demand, alone/ignore, and toy/play control.

Social Attention

The social attention condition is designed to evaluate whether maladaptive behavior is maintained by positive reinforcement in the form of reprimands or other forms of social attention. In this condition, attention is withheld for a period of time and is provided contingent upon the occurrence of target behavior. The session begins with the therapist acting preoccupied (e.g., busy reading) with low to moderate preference items present in the room. Therapist attention shifts to the learner contingent upon the occurrence of target behavior for 20 to 30 seconds (e.g., "Stop hitting me!" or "Why are you doing that?"). If the individual engages in high rates of inappropriate behavior in this condition, it indicates that social attention functions as reinforcement for maladaptive behavior.

Tangible/Restricted Access Condition

The tangible condition is designed to test if the target behavior is maintained by positive reinforcement in the form of receiving access to preferred items or activities. Prior to the start of the condition, the learner typically has access to highly preferred items for about 2 minutes. The session starts with the therapist removing preferred items from the learner and providing the items contingent on the occurrence target behavior (20 to 30 seconds). High rates of maladaptive behavior in this condition indicate that access to preferred items functions as reinforcement for inappropriate behavior.

Escape/Demand Condition

The escape condition is intended to determine if maladaptive behavior is maintained by negative reinforcement (i.e., escape from aversive stimulation or demands). In the escape condition, the learner is prompted to complete nonpreferred tasks (e.g., school work). Instructional materials are removed contingent on the occurrence of target behavior for 20 to 30 seconds. High rates of target behavior in the escape condition indicate that escape from de-

mands functions as reinforcement for maladaptive behavior.

Alone/Ignore Condition

The alone condition is designed to determine if target behavior is maintained by the consequences that the behavior itself produces (i.e., automatic reinforcement). In an alone or ignore condition, there are no programmed antecedents or consequences for target behavior. Typically, the learner is placed in a room alone without toys or materials to interact with. Ignore conditions can also be conducted where a therapist is present but does not interact with the learner. High rates of maladaptive behavior in this condition indicate that the behavior is maintained by automatic reinforcement (e.g., sensory stimulation).

Toy Play/Control

The toy play condition is the control to which all other conditions are compared. In this condition, the learner has continuous access to attention, access to highly preferred toys, and no aversive stimulation (i.e., demands) of any kind. Target behavior receives no differential consequences. Throughout the session, the individual and therapist play together with preferred toys or leisure items. The toy play condition is designed to be an analogue of an "enriched environment."

Analogue functional analyses have a number of obvious advantages as compared to other assessment procedures. Functional analysis is the most sensitive procedure for determining the maintaining factors for problem behavior, and appears to lead to effective and efficient interventions for maladaptive behavior. In addition, hundreds of research articles have validated the effectiveness of these procedures for the assessment of maladaptive behavior (Hanley et al., 2003).

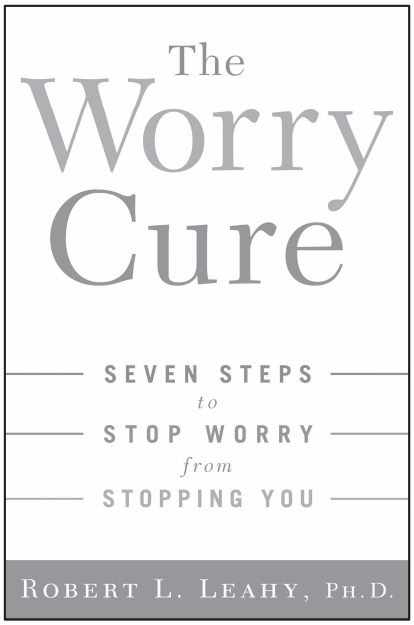
Analogue functional analyses have some drawbacks that can make their use in school settings prohibitive. One of the most common concerns regarding functional analysis is the amount of time required to complete the analyses. Few teachers or administrators have several hours to devote to completing extended functional analyses. However, there are several strategies that have been used to overcome difficulties with time constraints. In recent years, brief versions of analogue functional analyses have been developed with considerable success. One strategy is to present fewer overall conditions. For instance, Northup et al. (1991) proposed a model where brief functional analysis conditions were interspersed with treatment probes (i.e., contingency reversals). Using these procedures, functional analyses could be conducted in approximately 90 minutes and function-based treatment recommendations could be provided. Another strategy to reduce the length of functional analyses is to run shorter conditions. Session lengths of 5 minutes or less have received empirical support in the literature (e.g., Northup et al., 1991). However, brief session durations, particularly those under 5 minutes, may increase the likelihood of errors (false-positives, false-negatives) in the assessment. Another option is to only run specific functional analysis conditions (i.e., hypothesis-driven). It is possible to use prior forms of assessment (interviews and descriptive assessment) to eliminate the need for particular functional analysis conditions.

Another common problem with implementing functional assessments is the level of expertise required. Although these assessment procedures require some level of expertise, several studies suggest that the necessary skills can be taught efficiently (e.g., Iwata et al., 2000). In fact, strategic staff training (e.g., pyramidal staff training) can increase the efficiency of functional assessment (quicker assessment/intervention and application to other situations and students) and ultimately reduce the financial expenditure for hiring outside behavioral consultants. In addition, training teachers to conduct functional analyses has several advantages when compared to hiring outside consultants. When teachers conduct sessions, there is less disruption to ongoing classroom contingencies and recommendations can be implemented and evaluated more rapidly.

Summary and Future Directions

FBA is a process designed to identify the factors that maintain maladaptive behavior. As noted above, a growing literature suggests that these procedures are effective for the assessment of challenging behavior and lead to effective intervention. A flow chart outlining the functional assessment process is presented in Figure 1.

Legal mandates regarding the use of functional assessment in schools have



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placed considerable pressure on school-based administrators. However, while schools are legally obligated to implement functional behavioral assessments, they have been provided with relatively little guidance regarding the use of such procedures. A number of steps may be taken to address these issues. Perhaps the most important step is to ensure that school-based personnel become more knowledgeable about functional assessment. Efforts at dissemination should target psychologists and teachers in training at the university level as well as professionals that are already established in the school system. While training could be costly, pyramidal training procedures (e.g., "train-the-trainer") may enable school administrators to circumvent the substantial costs of large-scale training. Having a small group of school personnel receive in-depth training in the principles of applied behavior analysis and functional assessment for the purpose of training school staff may prove to be a simple and cost-effective way to train others as well as improve services to their students. The importance of training can hardly be overstated.

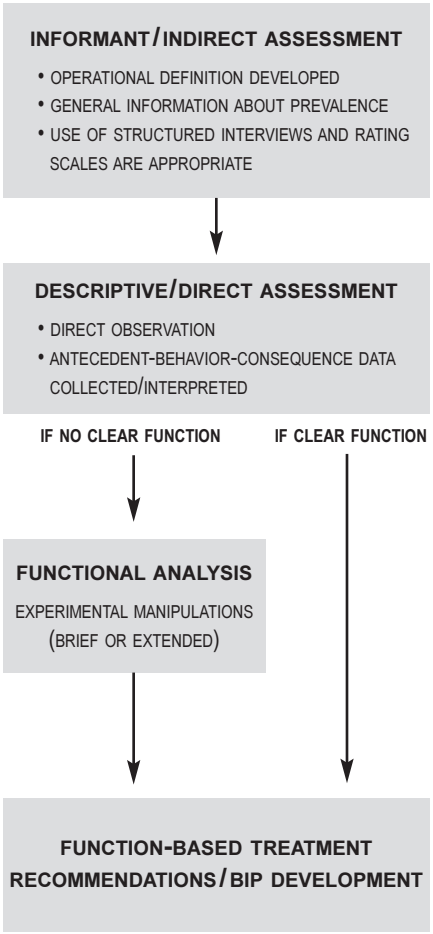

Fig. 1. **Functional behavioral assessment**

Indeed, some researchers have suggested that misapplication of functional assessment presents the greatest challenge to the long-term viability of FBA in the schools (Sasso et al., 2001).

Another way to increase the utilization of functional assessment procedures in schools is for researchers to develop more user-friendly models of functional assessment. Empirically validated functional assessment procedures may not be used in schools because they are considered complicated and time-consuming. Several brief FBA interviews and rating scales have been developed in recent years, but relatively few abbreviated descriptive assessment or functional analysis procedures have been developed. Developing more brief and effective functional analysis procedures should be a priority for researchers in the next decade.

Another future direction for functional assessment research involves the expansion of the use of assessment procedures to novel populations. Over the years, functional assessment and functional analysis have become commonplace in clinical settings with developmentally disabled or autistic children. However, a growing literature suggests that functional assessment and analysis can be used with a wide range of behavior problems across diverse patient populations (e.g., ADHD, Northup et al., 1995). Further replication and refinement of functional assessment and functional analysis procedures to novel populations and behavioral problems would likely have a positive impact on the expanded adoption of these procedures in the educational system.

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Psychoeducation for People With Psychotic Symptoms: Moving Beyond Information and Towards Inspiration

David Roe, *University of Medicine and Dentistry of New Jersey*, and Philip T. Yanos, *University of Medicine and Dentistry of New Jersey* and *Rutgers University Institute for Health, Health Care Policy, and Aging Research*

The doctor-patient relationship in health care has evolved over the last two decades and has gradually become less paternalistic (Charles, Gafni, & Whelan, 1997; Edwards & Elwyn, 2001). The traditional medical model, which held that the "doctor" (as the representative of authority) has all of the knowledge, wisdom, and answers, and which allowed a provider to selectively withhold and share parts of the rationale for treatment with the patient, has been considerably weakened. There is a growing emphasis in general medical training on the importance of sharing information, inquiring about personal preferences, and considering cultural differences (O'Connor et al., 2001; Towle & Godolphin, 1999). Efforts to develop and integrate concepts such as "self-determination," "informed consent," and "shared decision making" into standard medical practice have had a great influence (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1982).

Though it has long paid lip service to such concepts, the mental health system has tended to change more slowly in this arena (Cutler, Bevilacqua, & McFaland, 2003; Drake, Green, Mueser, & Goldman., 2003). The slow shift away from a paternalistic model and toward a more consumer-focused model may be partly due to special considerations posed by the nature of some of the symptoms of severe mental illness, as well as long-standing beliefs about them. For instance, many question whether individuals who present with "lack of insight" regarding their disorder are capable of making treatment decisions about an illness they do not believe they have. In addition, research has shown that cognitive deficits might impair the capacity to understand and process information and get in the way of making meaningful health-related decisions (Palmer, Dunn, Appelbaum, & Jeste, 2004).

Despite these challenges, the "doctor-patient" relationship in the context of mental health treatment has followed the general trend in medicine and begun to undergo profound changes. One major consequence of the growing emphasis on client (and from this point on, called "consumer") participation has been the emphasis on facilitating a more collaborative relationship by providing psychoeducation (Bisbee, 1979; Copeland, 1997; Gingerich & Mueser, 2002; Spaniol, Koehler & Hutchinson, 1994). Psychoeducation involves teaching consumers basic information about their diagnosis, symptoms, causes, course, and effective treatment. While psychoeducation can refer to a service offered to either family members or consumers, in this paper we will focus on psychoeducation that is provided to consumers.

Psychoeducation is currently recommended by practice guidelines throughout all phases of treatment of schizophrenia (American Psychiatric Association, 2004; Lehman et al., 2004). Research has shown that psychoeducation is successful at increasing consumers' knowledge about mental illness (Goldman & Quinn, 1988; Vreeland et al., 2005), though there is less support for an association with outcomes such as improved functioning, or reduced relapse (Mueser et al., 2002). Nevertheless, psychoeducation is a major element of more comprehensive treatment packages that have been found to have an impact on important outcomes, which is consistent with its role as a standard element in cognitive-behavioral treatments (Mueser et al.).

While the circumscribed effectiveness of psychoeducation has been largely established, there are several potentially important questions about its application that have not yet been addressed in the literature. For example, how do consumers experience psychoeducation? Can psychoeducation become more relevant to consumers and go beyond basic knowledge and the memorization of facts? Can psychoeducation sometimes be delivered in ways that might contradict its stated purpose of including consumers in the decision-making process? These questions relate to basic issues about how psychoeducational treatments should be offered so that they can be maximally effective. In order to address these issues, we will briefly discuss the potential promises and pitfalls of psychoeducation and suggest ways that it might be applied to maximize its effectiveness.

The Promise of Psychoeducation

Empowerment

Sharing information with a person about a problem he or she has conveys several important messages, including faith in the person's ability to learn, the value of the information shared, and the principle that knowledge should be accessible to everyone. Conveying such messages may be particularly powerful when integrated into services delivered to persons with severe mental illness who have not traditionally been viewed (or treated) as having the capacity to understand and benefit from information. Thus, on the most basic level, psychoeducation can contribute to consumers' empowerment (specifically, sense of respect, dignity, and sense of being valued and viewed as a collaborator in their treatment). This can also enhance the therapeutic alliance, since the sharing of information sets the tone for a respectful and hope-inducing working relationship. For instance, several consumers' feedback on a recent group revealed how much they valued the actual educational structure of learning. The content and context of learning and the effort it demanded, which they described as being "like in university," made them value the group more. Similar comments were received from consumers participating in a recent research study of a psychoeducational program (Vreeland et al., 2005); for example, one participant wrote, "We learn more—no one ever told me these things before."

Reduction of Self-Stigma

Sharing information about diagnosis and course with consumers can help demystify many of the more damaging impres-

sions that individuals hold—impressions that reflect widely held stigmatizing attitudes about mental illness. For example, through psychoeducation, individuals can learn that many people are able to recover; that widely held assumptions that people with mental illness are violent are largely unfounded; and that views that people with mental illness are "lazy" or personally at fault for their problems are erroneous. Other widely held beliefs, such as rumors that antipsychotic medications are addictive, can also be defused. Learning information in these areas can help to instill hope and a sense of relief for many individuals. For some it may lead to efforts to educate family members, which can further improve functioning. For example, in one group, common myths about schizophrenia were addressed. One client responded with great surprise to information that it is a myth that people with schizophrenia can never get better. In a subsequent group, he informed everyone that he shared this information with his family in an emotional exchange, and that his family was greatly relieved.

Enhancement of Awareness

People with psychotic disorders have traditionally been told that they are mentally ill and need treatment. Before psychoeducation, these individuals were rarely given an explanation regarding why their experience met criteria for mental illness. Directive statements to a person that they have a mental illness and require treatment understandably trigger "reactance" in many individuals (Brehm, 1966). Ideally, psychoeducation can provide a person with information about psychiatric disorders in a nonthreatening way that can help to enhance his or her awareness of symptoms and make him or her more amenable to receiving effective treatment. To gain an understanding of how this might work, one can think of the legendary impact that medical education has on medical students—namely, the students begin to examine their own symptoms and come to wonder if they are suffering from some of the ailments that are being described to them. In the case of people with psychotic disorders, the idea is not to lead people to believe that they have all symptoms of mental illness, but to describe specific symptoms and disorders in a nondirective way that can help them identify their own problems. Although not all studies of psychoeducational interventions have shown success in increasing awareness, at least a few interventions have found an effect in this area (Henry & Ghaemi, 2004).

To illustrate further how psychoeducation can increase awareness, consider this example: In a group, the topic of hallucinations was discussed and different types of hallucinations were described and explained. An individual in the group was surprised to hear about tactile hallucinations, and stated that she didn't realize that what she experienced was in the hallucination category. She stated that she previously did not think that she had any psychotic symptoms because she had never heard voices.

Validation

Although no two people have the exact same experience with mental illness, one of the many important contributions of descriptive psychiatry has been the growing sophistication in describing different symptoms and clusters of classification. Sharing this information with consumers can be extremely useful and particularly rich when consumers can share information based on their personal experiences. Hearing examples directly from each other can help people feel less isolated and alone in their experience and may lead to exchanges that can foster bonds between persons with similar experiences (Yalom, 1983). Such content and processes can often help consumers feel that they are not the first or only person to have had such experiences. It may be less threatening for consumers to know that some of their experiences, remote or strange as they may seem, have actually been identified and reported by others. For example, during a group a young man with bipolar disorder described the relief that he felt when his clinician opened the *DSM* and went over common symptoms of his disorder; until that point he thought he was "making them up" which was horrifying for him, since he perceived "making them up" as "really crazy."

Potential Pitfalls of Psychoeducation

While, as argued above, sharing knowledge can be very useful and therapeutic, the actual way this occurs is crucial. Just as sharing information can be helpful, it can also have unintended consequences. Below is a list and brief discussion of some of the ways in which psychoeducation could be delivered that might not be beneficial, or might even cause harm.

Following the Letter, but Losing the Spirit

When acquired knowledge is presented as an authorized absolute truth or as a "correct view," it may be experienced as quite threatening and disempowering. The "correct view" may not be consistent with the person's experience and difficult or painful to incorporate into a tolerable framework. In such situations, the presentation of knowledge as only or absolute truths can be experienced as devastating and confining. Beyond the possibly devastating personal meaning the actual knowledge may have for the person, psychoeducation, when not offered in a way that is sensitive to individual experience, could simply repeat the familiar paternalistic pattern of the clinician as the expert who "knows" and "has the answer," which the consumer (if good, motivated, compliant…) may learn. This contradicts the spirit of psychoeducation, which is to freely share information with consumers without claiming it to be the only truth and forcing them to accept it. For instance, at a training event for a psychoeducational program, the trainer stated unequivocally that going off medication leads to relapse. When the scientific validity of this statement was questioned, she indicated that it was, from her perspective, an absolute truth. Although no consumers were present, this brought out powerful feelings of not being respected or listened to, and one can only imagine how a consumer might have felt if such a response were given in the context of a group. As an alternative approach, however, we have addressed group members' questioning of the validity of the concept of delusions by emphasizing that no one completely knows what is true or not, but that we can look to our past experience and the people that we trust to achieve a consensus on what is plausible or likely to be true. This approach encourages a person to conduct his or her own reality testing rather than dictating that their ideas are "crazy."

Ignoring the Person

There is a danger that psychoeducation, if not delivered in a sensitive manner, will overlook the broader personal story of the individual and be delivered as "frozen food" to be heated in the microwave and served, with the simplistic rationale that "knowledge is good." However, psychoeducation is not a one-size-fits-all treatment and should not be delivered in exactly the same way in every context, without taking into consideration individual persons, their experiences and reactions. By considering the individual, we do not mean to say that psychoeducation should not be delivered in a group format, but rather that the facilitator should be responsive to the makeup of the group (cultural background, diagnosis, age, education, etc.) and how each group mem-

ber is reacting to the material being presented. For instance, stress is often viewed as something negative that can increase the risk to decompensate. However, an oversimplified construct such as a hypothetical "stimulus window," which holds the mechanistic view that "too much" stimulus (an amount that exceeds the "window") is stressful, carries the risk of overlooking the diversity in consumers' perceptions and responses to potential stressors. A more nuanced version of this will allow for a consideration of individual differences in responsiveness to stress.

Lack of Engagement

It is well established in the educational field that there are different kinds of learning and that knowledge acquired using active learning strategies is more long lasting and effective than passive learning strategies (Kalem & Fer, 2003). Thus, attention must be given not only to the content and information but also the process by which this information is shared and acquired. We can all recall educational experiences (e.g., courses in college or graduate school) from which we learned a great deal, internalized and were able to make use of the knowledge. Conversely, we can also probably recall educational experiences from which the most we can recollect is that we might have learned something at the time. It is likely that we were most engaged by the teaching style of the instructors in the experiences from which we learned a great deal. Greater emphasis therefore should be placed on how psychoeducational groups need to be conducted in order to maintain engagement to facilitate learning. For example, in one group participants role-played either a consumer or a clinician during a clinical interview. The group then discussed what sort of information the clinician and client collect and share, and whether there were other sources of information from which each or both could benefit. The lively nature of the group as well as the opportunity to take on different roles and discuss the interaction and sharing of information from both perspectives enhanced participants' interest and involvement to explore the content and context of knowledge/information.

Worshiping Insight

Insight is commonly viewed positively as it has been found to be related to greater treatment adherence and better outcome (Perkins, 2002). As discussed earlier, psychoeducation can be an opportunity to increase insight by providing information that will help consumers become more educated and perhaps more aware of their illness (along with its treatment options). However, our concern is that some psychoeducational approaches may narrowly define insight as synonymous with sharing the clinician's perspective or definition of the problem. Such a position fails to convey the complexity of acquiring information and the possibility that psychoeducation may also leave individuals feeling hopeless, helpless, and demoralized (Roe & Kravetz, 2003). For example, a young woman who was diagnosed with schizophrenia was consistently careful about adopting this diagnosis. She was curious and eager to learn about psychiatric disorders more generally and was clearly invested in trying to understand and even identify and classify her own, but at the same time was careful and persistent to avoid "schizophrenia." A first-degree relative with that same diagnosis had recently committed suicide and one can only imagine how threatening it must have been to accept having a diagnosis which carried such personally threatening and devastating meaning. We certainly find little clinical utility in "forcing" someone to accept a specific diagnosis. Alternately, we advocate encouraging clients to engage in treatment from which they might benefit, without "insight" (as acceptance of a specific label) being a prerequisite for such engagement. Insight as "acceptance" may increase the motivation to engage in treatment for some, but not necessarily for everyone—and for others, it might even be a reason to take on the "patient role" and give up trying to recover (see the literature on "engulfment" [Lally, 1989; McCay & Seeman, 1998; Williams & Collins, 2002], which suggests that taking on the patient role is associated with high insight and poor functioning). Perhaps what is more important than insight is the process of constructing a personally meaningful and sensible story that helps to create a framework to understand and better tolerate the experience and consequences of mental illness, and find a way to incorporate treatment into one's personal story (Roe & Davidson, 2005).

Discussion: Toward Person-Centered Psychoeducation

Psychoeducation has shown to be effective in enhancing consumers' knowledge about their illness and is now a recommended part of standard care for people with severe mental illness (Lehman et al., 2004). Considering the long history of hopelessness and paternalism that dominated the attitudes toward consumers in mental health treatment, it is exciting to witness the proliferation of an intervention that can facilitate hope, empowerment, and reduce stigma. Along with these positive developments, however, we believe there are a number of important considerations that should be taken into account to ensure that psychoeducation is delivered in a manner that preserves its spirit. Importantly, no matter how "good" of a manual or workbook is being used for a particular psychoeducational intervention, the practitioner's clinical skills will heavily determine how it is experienced and its degree of usefulness, relevance, and applicability. Emphasizing clinical competence is particularly important in light of the increased reliance on implementing manual-based treatments without always emphasizing the actual clinical skills that need to be integrated into their delivery. Examples of essential clinical skills include the capacity to relate, connect, accept, validate, enable, confirm, and convey faith and encouragement within a genuine context of respect and attunement to personal goals and needs. In addition to clinical skills, it is useful to consider techniques that have been recommended and found to be effective in psychoeducation. A recent review of these techniques (Gingerich & Mueser, 2005) emphasizes conveying hope and optimism, treating the person as the expert in his or her own experience, emphasizing interactive teaching (rather than lecturing), pacing the sharing of information to the ability of people to understand and process, encouraging sharing among group members, providing opportunities to learn strategies for coping and trying them out, avoiding confrontation, and creating opportunities for significant others such as family members to learn the information.

In light of the above we recommend that psychoeducation be viewed as a way of engaging consumers to learn information that might help them construct and organize their personal stories about their illness and recovery. Though the information typically shared in psychoeducation is important, evidence based, and more accurate and reliable than outdated stereotypes, beliefs, and myths, it is still information that has been gathered and organized into a packaged "story." Consumers rely on the human process of constructivism, and use a wide range of ways to gather and evaluate information about their illness, recovery, and ways to get better. The negotiation process by which a person learns, rejects, collects, forgets, and attributes meaning may be an important part of the recovery process. The

impact of psychoeducation on this process must therefore be considered. Psychoeducation might be helpful to the degree that it provides an additional piece of knowledge or story with which a patient can negotiate his or her illness and perhaps find parts of it useful and relevant. When delivered as the unequivocal truth that the person must now adopt, it may not be beneficial and may even potentially be harmful. Along with its promise and pitfalls, clinicians should be aware of the complexity of psychoeducation and the crucial clinical aspects involved in its delivery. Thus, psychoeducation may be viewed as an art as much as a science. The goal is to move beyond information and toward inspiration, focusing on the process of how knowledge is experienced and incorporated into the person's personal framework and integrated into a useful story that has personal meaning and relevance.

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Help Celebrate Our 40th Anniversary

We are looking for members who have belonged to ABCT for 25 years or more.

Please visit our Web site at www.abct.org and complete our mini-survey so we can acknowledge your support and hear your comments.

40 years ABCT EVIDENCE SUPPORTED TREATMENT

Lighter Side

Random Effects

Robert L. Leahy, *American Institute for Cognitive Therapy, NYC*

X looked down into the crib at his smiling newborn, "b." He was surprised that at this early age the non-gender-specific child of his imagination could speak intelligibly. "Well, b, what would you like to be when you grow up?"

"I don't want to be a DEPENDENT VARIABLE like my brother. No, I don't want to rely on others, who are unpredictable. I want to be an INDEPENDENT VARIABLE. Someone that makes a difference."

"You don't want to end up like your uncle—MEASUREMENT ERROR. He never knows what he is or where he's going"

"No. He's all over the place. But at least he does his own thing."

"Yeah. When I was a kid I used to hang out with some other variables—Y and Z. You know we would sit around and think, "If we got together we could really become an INTERACTION EFFECT—really screw it up for M—override any of his 'Main Effects.' If we got enough of our random variables together we could create a THREE-WAY INTERACTION EFFECT. No one could interpret us."

"Wow, Dad. You used to think that way?"

"Oh, yeah. I was rebellious. I remember when I was in my late teens I was fascinated with the NUMBER ZERO— I used to feel, 'I really understand Sartre now.' I thought, 'No one could bother me.' No one kicks a sleeping dog. Or the NUMBER ZERO."

"What happened?"

"Well, I began doing some heavy drugs. I began to space out. One day, out of nowhere, so to speak. I thought I was AN IMAGINARY NUMBER."

"You mean . . . ?"

"That's right, b, I thought I was the square root of minus one."

"What's that like?"

"As you can imagine, it's hard to put into words."

"Don't you remember?"

"Sort of—at least some of it. I remember the NUMBER ONE and feeling overly confined by the SQUARE ROOT. But it's hard to say—it's like describing colors to a blind man. I can break it down into the pieces but I can't put it together"

"Wow—D—you were really far out. Did you think of yourself as a rebel?"

"I thought I knew the truth. Let's put it this way. My friends—the other variables that no one wanted anything to do with—used to hang out TWO STANDARD DEVIATIONS BEYOND THE MEAN."

"Were you above or below the MEAN?"

"Like everything in life, it depends on the scale."

"How did other people feel about you?"

"They thought we were TWO STANDARD DEVIATIONS BELOW THE MEAN."

"What did that make you think?"

"I liked to think of myself as another CATEGORY. But they wouldn't have any part of that. They thought I was JUST MAKING UP UNNECESSARY CONCEPTS."

"But don't we have the right to define ourselves the way we want to?"

"Not if you want to be part of the EXPERIMENT."

"I certainly don't want to be in the CONTROL GROUP, Dad. I mean, nothing is happening."

"Well, not exactly, b. Even in the CONTROL GROUP things happen. But we never know why. So I guess the satisfaction is in not knowing and not caring."

"But why can't I be another CATEGORY?"

"Well, I admire your ambition, b. But you will find in life that one of the satisfactions that others will have is to define you by THE LOWEST COMMON DENOMINATOR."

"But aren't the differences important?"

"That's what poets and insane people like to think. But if you want to be part of the experiment we have to EXPLAIN YOU."

"Doesn't that mean…?"

"That's right. You have to be PREDICTABLE or CONTROLLABLE."

"Or what?"

"Or you will simply be labeled as ERROR VARIANCE and cast away with the other variables that are always there but never quite get the respect they deserve."

"Well, I'm going back to sleep, Dad."

Dad looked down at b. He smiled as he saw b close his eyes and fall into a deep satisfying slumber.

His rebellious anarchistic imaginary number mentality clicked in. He thought, "Isn't this amazing? I'm the father of A SLEEPER EFFECT. He will strike when no one expects him."

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(i)

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Minutes of the Annual Meeting of Members

November 19, 2005 • Washington, DC

I. Call to Order

The Annual Meeting of Members of the Association for Behavioral and Cognitive Therapies was called to order by President J. Gayle Beck at 12:15 P.M. in the Jefferson Room of the Washington Hilton Hotel, Washington, DC. Notice of this meeting was sent to all Full Members of ABCT in August 2005 in the 39th Annual Convention Program Book.

II. Minutes

The Minutes from the November 20, 2004, Annual Meeting of Members held in New Orleans, Louisiana, were accepted as distributed.

III. Service to the Organization

President Beck extended the gratitude of the Association to the following members who have been of service to ABCT: Patricia A. Resick, Ph.D., rotating off as Immediate Past President; Marty Antony, Ph.D., Representative-at-Large, 2002-2005.

President Beck expressed a very special thank you to several members who spent untold hours reviewing practice guidelines generated by the American Psychiatric Association. Barbara McCrady reviewed their guidelines on Substance Abuse and Mark Zimmerman reviewed their guidelines on Psychiatric Evaluations. She remarked how pleased she was that the American Psychiatric Association has ABCT on their list of essential reviewers and we expect to participate in the review process of future guidelines.

The president continued acknowledging the following members for their contributions: Ronald Fudge, Ph.D., Special Interest Groups Committee Chair, 2002-2005; Carrie Winterowd, Ph.D., Nominations and Elections Committee Chair, 2003-2005; Lynn Marcinko, Ph.D., for Hosting the ABCT List Serve; Frank Gardner, Ph.D., 2005 Top Membership Recruiter; Mark Terjesen, Ph.D., Continuing Education Committee Chair, 2002-2005; Kristine A. Doyle, Ph.D., Institutes Committee Chair, 2002-2005; Arthur M. Nezu, Ph.D., International Associates Committee Chair, 2001-2004; Christine M. Nezu, Ph.D., Deputy to World Congress on Behavioral and Cognitive Therapies, 2001-2004; David A. F. Haaga, Ph.D., *Behavior Therapy* Editor, Volumes 33-36; Timothy A. Brown, Psy.D., *Behavior Therapy* Associate Editor, Volumes 34-36; John Lochman, Ph.D., *Behavior Therapy* Associate Editor, Volumes 33-36; Melinda Stanley, Ph.D., *Behavior Therapy* Associate Editor, Volumes 35-36.

The President commented that we all know that to put together a program of this size takes a lot of time and dedication. This year we had an astonishing 132 members help review program submissions. Many thanks to the following members: Joanne Davila, Ph.D., 2005 Program Committee Chair, Wesley D. Allan, Drew A. Anderson, Karla Anhalt, David C. Atkins, Alisa Bahl-Long, Sonja V. Batten, Carolyn Black Becker, Debora J. Bell, Michele Boivin, Joaquin Borrego, Carolyn E. Brodbeck, Elissa J. Brown, Steven E. Bruce, Randy S. Burke, Andrea Seidner Burling, Annmaire Cano, Cheryl N. Carmin, Corinne Cather, Alexander L. Chapman, Brian C. Chu, Mari L. Clements, Rebecca J. Cobb, Heather M. Cochran, Scott F. Coffey, Marlene J. Cohen, Dennis R. Combs, James V. Cordova, Lisa W. Coyne, Ronda L. Dearing, Thilo Deckersback, Crystal M. Dehle, David DiLillo, Linda A. Dimeff, Brian D. Doss, Laura E. Dreer, Greg M. Dubord, Jill T. Ehrenreich, Frank D. Fincham, Paige Fisher, Victoria M. Follette, Martin E. Franklin, Sharon Morgillo Freeman, David M. Fresco, Michael A. Friedman, Alan E. Fruzzetti, Abbe Marrs Garcia, Scott T. Gaynor, Kristina Coop Gordon, Melanie Harned, Joseph A. Himle, Debra A. Hope, Jennifer L. Hudson, Sue C. Jacobs, Matthew D. Johnson, Maria Karekla, Debra L. Kaysen, Shalonda Kelly, Robert S. Kern, Barbara R. Kistenmacher, John W. Klocek, Brett R. Kuhn, Jennifer Langhinrichsen-Rohling, Robert H. LaRue, Penny A. Lesring, Steven A. Lisman, Patricia L. Long, Andy Lopez-Williams, David J. Martin, Gerald F. McKeegan, Robert McMahon, John R. McQuaid, Elizabeth A. Meadows, Stephen Melby, Douglas S. Mennin, Terri L. Messman-Moore, Catherine R. Michas, Candice M. Monson, Todd M. Moore, Tracy L. Morris, Douglas W. Nangle, Amy E. Naugle, Tara M. Neavins, Larissa N. Niec, Holly K. Orcutt, Susan M. Orsillo, Carolyn M. Pepper, Michael R. Petronko, Melissa A. Polusny, Sheila A. M. Rauch, Jennifer R. Read, David Reitman, Melisa Rempfer, Deborah L. Rhatigan, George R. Ronan, Frederick Rotgers, Steven L. Sayers, Kathleen J. Sexton-Radek, Tamara Goldman Sher, Julie A. Shumacher, Jillian C. Shipherd, Marian Sigman, Sandra T. Sigmon, Jennifer A. Snyder, William D. Spauling, Paul S. Strand, Amy E. Streeet, Gregory L. Stuart, Maureen A. Sullivan, Daniel J. Taylor, Giao Q. Tran, Kimberli R. H. Treadwell, George C. Tremblay, W. Douglas Tynan, David P. Valentiner, Amy Williamson Wagner, Angela E. Waldrop, Kimberly S. Walitzer, Robyn Walser, Karen L. Weigle, Robert L. Weiss, Mark A. Whisman, Kamila S. White, Nathan L. Williams, Carrie L. Winterowd, Deborah C. Wise, Lisa F. Wood, Claudia Zayfert, and Michael J. Zvolensky.

The President thanked Kelly J. Rohan, Ph.D., Local Arrangements Committee Chair, and Leigh Johnson, Ph.D., Assistant Local Arrangements Committee Chair, noting that the convention attendees appreciated all the "local talent and expertise." She also thanked the following Washington, DC, Local Arrangements Committee Members: Lynn F. Bufka, Maria Dittrich, Martha M. Gillis, Joanna Kaplan, Jaslean J. La Taillade, Robert Lippy, Arthur MacNeill Horton, Jr., Aisha Massac, Elicia Nademin, Amy Nguyen Portella, Rolf Peterson, Kathryn Roecklein, Crescent Seibert, Melissa A. Tanner, Hoa Vo, and Thomas White.

IV. New Appointments

President Beck announced the new members to ABCT's governing structure: Susan Orsillo, Ph.D., 2005-2008 Academic and Professional Issues Coordinator; Maureen Whittal, Ph.D., 2006 Chicago Program Chair; Pamela Wiegartz, Ph.D., 2006 Local Arrangements Committee Chair; Dean M. McKay, Ph.D., 2007 Philadelphia Program Chair; John Klocek, Ph.D., 2005-2008 Continuing Education Issues Committee Chair; Patricia Averill, Ph.D., 2005-2008 Master Clinician Seminar Committee Chair; Joseph Scardapane, Ph.D., 2005-2008 Institutes Committee Chair; Stephanie Felgoise, Ph.D., 2005-2007 Nominations

and Elections Committee Chair; Laura J. Dreer, Ph.D., 2005-2008 List Serve Committee Chair; Trevor Hart, Ph.D., 2005-2008 Special Interest Groups Committee Chair; M. Joann Wright, Ph.D., 2005-2008 Awards and Recognition Committee Chair; Steven Bruce, Ph.D., 2005-2008 Committee on Research Agenda Chair; Arthur M. Nezu, Ph.D., 2004-2007 Deputy from ABCT to the World Congress Committee; Patricia J. Long, Ph.D., 2005-2007 Self-Help Book of Excellence Ad Hoc Committee Chair; Kevin D. Arnold, Ph.D., 2005-2007 Ad Hoc Committee on Specialization in Behavioral and Cognitive Therapies.

V. Coordinators' Reports

A. *Academic and Professional Issues Committee*

Sue Orsillo, Academic and Professional Issues Coordinator, reported that the Academic Training Committee Chair serves as the representative to the Behavioral Psychology Specialty Council (BPSC). The BPSC is a member "synarchy" of the American Psychological Association's (APA) Council of Specialties in Professional Psychology (CoS). During their recent meeting, the ABCT Board of Directors approved the "Ad Hoc Committee on Specialization in Behavioral and Cognitive Therapies Within Various Professions," which will deal solely with these issues, thus freeing up the Academic Training Committee to focus on more training issues. Kevin Arnold has been named the chair of the new Ad Hoc Committee. Updates of their progress will be published in *the Behavior Therapist*.

Dr. Orsillo noted that the Awards and Recognition Committee does an outstanding job, referring to the results of their efforts at the Friday-night Awards Presentation as they honored both those in the field and those who affect the field. This year's award winners included: Albert Ellis, Ph.D., Lifetime Achievement; Frank M. Dattilio, Ph.D., Outstanding Clinician; The May Institute, Walter P. Christian, Ph.D., President and CEO, and Dennis C. Russo, Ph.D., Chief Clinical Officer, Outstanding Training Program; Jon Kabat-Zinn, Ph.D., Distinguished Friend to Behavior Therapy; G. Terence Wilson, Ph.D., Outstanding Service to ABCT; Sharon L. Cohan, M.S., 5th Annual Virginia Roswell Dissertation Award; Carl W. Lejuez, Ph.D., President's New Researcher Award; Matthew K. Nock, Ph.D., President's New Researcher Honorable Mention; Will A. Aklin, Yoshihiro Kanai, and Sandra Yu Rueger, Elsie Ramos First Author Poster Session Awards; and we recognized Denise A. Chavira as the 2005 ADAA Travel Award Winner. She also said the committee is looking for new members to serve on the committee. The Call for Award nominations is already on-line, and we're highlighting nominations for Outstanding Educator and Outstanding Mentor in 2006. The deadline for next year's nominations is March 1, 2006. Dr. Orsillo reminded everyone that the Winter issue of *the Behavior Therapist* will have a call for nominations for the 2006 Awards Program.

The International Associates Committee is working hard with our sister organizations in preparation for the next World Congress, to be held in Barcelona in 2007. A Call for Papers has already been issued. Check our Web site under Resources, International Organizations for an update.

The Professional Issues Committee surveyed members last year. Based on those results, they hosted a clinically relevant poster session and are developing training manuals.

The Committee on Research Agenda continues to locate and post relevant research-focused links on ABCT's Web page. This is an expanding resource for researchers, and members should be sure to visit the site.

B. *Convention and Education Issues*

Cheryl Carmin, Coordinator, reported that the total number of registrants for the Washington, DC, convention stood at 3,065 as of the moment. She thanked President Beck for her support in her first year as Coordinator, and thanked Joanne Davila for the great convention that she put together. Dr. Carmin also thanked Mary Ellen Brown, Convention Manager, for her excellent work, wondering aloud, "I don't know how you do it." She noted that next year we'll be in Chicago for our 40th anniversary. She's open for suggestions on how we could best celebrate this milestone. Following meetings are in Philadelphia in 2007, Orlando in 2008, and New York City in 2009. She reported that CMEs were offered for the first time at this meeting; hopefully they will allow us to diversify our offerings and our membership. This year, much of the program book was on-line, and we will be posting the full, searchable proceedings on-line after the meeting.

C. *Membership Issues*

Coordinator Gayle Iwamasa reported that membership is growing, and we're at the record level of 4,606, and on our way to a goal of 5,000 members.

The Clinical Directory and Referral Committee, chaired by Doreen DiDomenico, is responsible for the Find-a-Therapist sections on our Web site. This also includes the Expanded Find-a-Therapist section, previously called the Clinical Directory. They've been actively promoting the service through *tBT*, at the convention, and via the Web. They recently conducted a survey to assess member satisfaction and awareness. The committee has been working with central office staff to make the service more visible on our Web site and they are working to increase the hits.

Ron Fudge is stepping down as the Special Interest Groups Program Chair, and Trevor Hart will begin a 3-year term. SIGs have been enforcing the recently mandated rule that each SIG have 100% ABCT membership. New SIGs continue to be added, and they are providing a wonderful professional home for our members.

Student Membership Chair Curtis Hsia is assessing student members' needs. Students have developed an on-line mentoring system through the Student SIG list-serve, with some of ABCT's board members serving as mentors.

The Nominations and Elections Committee has put forth the Call for Nominations. The Chair, Carrie Winterowd, has said that self-nominations are encouraged. We are seeking nominations for President-Elect, Representative-at-Large, and Secretary-Treasurer in 2006. The nominations form will appear in October, Winter, and January issues of *tBT*, and will be available via our Web site, too.

Dr. Iwamasa reported that Laura Dreer had been appointed as Chair of the Ad Hoc Committee reviewing ABCT's list-serve policies and procedures. She reported that the committee had done a thorough job looking at our policies and procedures and comparing them to those of 13 other organizations. She said it was an amazingly thorough job; one that they'd like to see continue. Dr. Iwamasa thanked Lynn Marcinko-Farr, who has been running ABCT's list-serve since its inception more than 3 years ago.

Membership Chair Kristen Sorrocco is looking at psychiatry residency programs as a potential recruitment source now that psychiatry requires CBT training as part of its residency requirement. Dr. Iwamasa applauded the use of stars to indicate 5 years of service. She said that she loves these, and that she hadn't received any since kindergarten. She used this as a segue into more tangible reinforcers, for those who recently joined and those who sponsor them.

Dr. Iwamasa then had President Beck draw the membership lottery winners: new members Christoffer Grant and Tracy Kisner won journal subscriptions; new members Lesley Graves and Cecilia Lam won videotapes; sponsors Robert Ditomasso and Adam

Radomsky won journal subscriptions; sponsors Marsha Linehan and Cami Lokken won videotapes; and sponsor Frank Gardner won a complimentary membership in 2006.

Dr. Iwamasa thanked Martin Antony, Representative at Large, who served as the liaison to Membership, for his steadfast work, and M. J. Eimer, declaring her "the Empress of ABCT" for all her help. She also thanked Lisa Yarde, ABCT's new Membership Services Manager, and Teresa Wimmer, ABCT's staff liaison to SIGs, who, together, make her work so much easier to do.

D. *Publications Committee*

Reporting for the Publications Committee was Committee member Sue Orsillo in Coordinator Judy Favell's absence. She said that she wished that Judy were here to present the report because things in Publications are so exciting. She thanked Judy Favell and David Teisler for making so much come to fruition. Among the highlights is the coming redesign of the Web site. ABCT has hired Matrix, a firm with great experience working on nonprofit association Web sites and experience with the database that drives most of ABCT's electronic interactions. She said we should look for much better navigation and easier use when completed. She noted that we have signed a contract with Elsevier creating a partnership in which Elsevier will put both *BT* and *C&BP* on-line, including all back issues. She noted that members will continue to receive their choice of print journal and have free electronic access to both journals as part of their membership, and all this at no additional cost to members. Dr. Orsillo commended Chris Nezu, who successfully applied for *BT*'s indexing in MedLine; she said that Dr. Nezu will be assisting us in applying for inclusion for *C&BP* once the journal is on-line.

Dr. Orsillo said that both journals are quite healthy by any measure: Citations and impact ratings are up for both journals; institutional subscriptions are holding for *BT* and increasing for *C&BP*; and decision times remain short. She thanked outgoing *Behavior Therapy* Editor David A. F. Haaga for the outstanding job he did over the past 3 years.

She also noted that we are looking for a Web Editor to serve on the Committee. She asked interested parties to contact either Judy Favell or David Teisler; calls for the Web Editor will appear in *tBT* and, appropriately, on the Web.

VI. Executive Director's Report

Mary Jane Eimer, Executive Director, welcomed everyone to the first ABCT meeting. She noted that the new governance approach adopted by the Board identified three main priorities, and that we are happily moving forward on all three. She reported that we are now officially ABCT. A second priority was getting our journals on-line, and we have a signed contract with Elsevier to do just that, including back issues. She noted the hard work of an ad hoc committee charged with this task, headed by Judy Favell and David Fresco and ably served by Gayle Beck, Patti Resick, Michael Otto, Tom Ollendick, Stefan Hofmann, and Rick Heimberg. She noted that the third priority is a revised Web site; she is happy to report that we have already had our initial meeting with Matrix, a nonprofit Web design firm. She recounted that the Web site was first created and hosted by member Jack Finney, and has grown as needed, without real attention to its internal structure. She expects that we will be able to improve the functionality of the Web site by improving its internal structure and its external navigation, and implementing some sort of content management overlay. She thanked the Board for the vision that made these three projects possible by making them priorities.

Ms. Eimer said we are blessed with fabulous leaders who give of their time selflessly on monthly Board calls and twice monthly Executive Committee calls, which allows for timely dealings with issues.

She said that there is no way we can do all that we do without a full partnership with an incredible staff. She explained that Teresa Wimmer, Publications Secretary and Staff Liaison to the SIG Program, also does double duties at the convention, serving both SIGs and staffing the membership booth, where she handled more than 200 new member joinings and member renewals. She introduced Lisa Yarde, our new Membership Services Manager who replaced Rosemary Park, who served us faithfully for 17 years and left to pursue a career in programming and who, incidentally, was just married. M.J. noted that one of the things that endears Lisa to the staff is that she says she "likes iMIS," our database program whose power is surpassed only by its difficulty in use. M.J. noted that Patience Newman, Projects Manager, lives up to her name. She is the person behind all that we do on the Web, in addition to handling the pagination of the program book, program brochure, signs, and so much more. She said that Tonya Childers has blossomed this year, serving as Exhibits Manager, CE Coordinator, and, now, Convention Registrar. She has also taken a much more active role in the database and internal finances. M.J. also mentioned that Stephanie Schwartz, Managing Editor, is running the central office single-handedly during the convention. In addition to her careful editing of all three periodicals, you can see her creative design work in the new covers for our Archives and Clinical Grand Rounds videos. Catalina Morales has taken hold of finances, and has been praised by the auditors and the two most recent Secretary Treasurers for her accuracy and organizational skills as our bookkeeper. David Teisler, Director of Publications, has shown himself to be a tenacious negotiator, getting ABCT excellent contracts with Matrix and Elsevier. He will be heading up the transition to the on-line journals and the Web redesign. She also thanked Mary Ellen Brown, "my best buddy for 30 years" and ABCT's Convention Manager, who helped make this very successful convention a reality. She invited members to think of the ABCT Central Office and staff as resources.

VII. Finance Committee Report

Frank Andrasik, Secretary-Treasurer, gave the first-ever Finance Committee report as a multimedia event. He explained the Committee's charges include assuming oversight of the annual financial condition, monitoring fiscal projections, ensuring funds are available for achieving specified goals, making recommendations regarding personnel and capital equipment, ensuring that reserve funds are invested prudently, and evaluating financial considerations related to ownership of permanent headquarters. The Committee consists of the Secretary-Treasurer, two hand-selected members, Pat Friman and George Ronan, plus the President-Elect, Michael Otto.

He noted that the committee reviews a budget that has more than 400 budget lines. The Committee meets in the spring, but its members have frequent communication during year. He said that the central office, comprised of the staff, "The Big 3," and Catalina Morales, continues in the fine tradition of fiscal health. He noted that in the last 20 years, AABT has been "in the black" 17 of those years, with one of the off years due to the purchase of headquarters. He noted that 2005 is no exception. In the 2005 budget year, ABCT had total income of $1,546,575, with expenses of $1,281,169, leaving us with a projected net income of $265,406. He noted that this is 17.2% net of revenue. He then explained where this money comes from: 38% Convention ($586,492); 31% Dues/Fees ($484,738); 26% Publications ($400,384); and 5% Other ($74,961). He thanked the members for paying dues, subscribing to publications, and supporting our annual meeting!

Dr. Andrasik reviewed our "Rainy Day Fund," with $544,258 in restricted reserve, plus other funds to cover technology enhancement, central office overhaul, and ABCT's retreat held every third year. He said that the financial state of the Association is fiscally sound; we always pass yearly independent audits; we follow accepted accounting principles (GAAP); and we are compliant with all state and federal regulations. He noted that our budget is completely transparent and that we track staff time and task allocation. He said that there are no corporate scandals here.

For the near future, the Committee is revising its investment policy in order to get more value for the same dollar. He said that this year, there is no dues increase. He noted a number of important projects under way, including Web enhancements, the journals on-line, and more. He said the future continues to look bright.

VIII. President's Report

J. Gayle Beck reported that members' full on-line access to both journals is not costing them or the association a single penny. They will still be getting the print version of their choice plus electronic access to both journals for the same money. Student members will have on-line access to both journals at no additional charge. We are in the process of revamping the Web site and changing the face of the Association. She noted that *BT* is now indexed in Index Medicus, which should increase citations and access. We are linking with NIMH to facilitate outreach for clinical and research efforts. The Association is looking at the possibility of credentialing as well as the potential formation of a division in APA that represents CBT.

The President noted that the name change is official. She reported that the Executive Committee is working with design firms to create a new logo, and we're examining marketing plans for the future. She concluded her report by saying, "It's been a very good year for the Association."

IX. Transition of Officers

President Beck announced the new officers. The President-Elect is Ray DiGiuseppe; the Representative-at-Large is Jonathan Abramowitz; and the new President is Michael Otto, to whom she handed over the ceremonial gavel.

X. Adjournment

President Otto thanked Dr. Beck for her service and asked if there were any comments from the membership.

There being none, the meeting was adjourned at 1:15 P.M. ✍

ABCT JOURNALS IN PRESS

Behavior Therapy 37(#1)

Original Research

• RICHARD G. HEIMBERG *From the Editor: Behavior Therapy Moves Into the Future*

• TWOHIG et al. *Increasing Willingness to Experience Obsessions: Acceptance and Commitment Therapy as a Treatment for Obsessive-Compulsive Disorder*

• TAYLOR & ALDEN *Parental Overprotection and Interpersonal Behavior in Generalized Social Phobia*

• GRATZ & GUNDERSON *Preliminary Data on an Acceptance-Based Emotion-Regulation Group Intervention for Deliberate Self-Harm Among Women With Borderline Personality Disorder*

• WEERSING et al. *Effectiveness of CBT for Adolescent Depression: A Benchmarking Investigation*

• MYSTKOWSKI et al. *Mental Reinstatement of Context and Return of Fear in Spider-Fearful Participants*

• BUSCH et al. *Sudden Gains and Outcome: A Broader Temporal Analysis of Cognitive Therapy for Depression*

• ENGLER et al. *Predicting Eating Disorder Group Membership: An Examination and Extension of the Sociocultural Model*

• ROTHBAUM et al. *Virtual Reality Exposure Therapy and Standard (In Vivo) Exposure Therapy in the Treatment of Fear of Flying*

• ANDERSON et al. *CBT for Fear of Flying: Sustainability of Treatment Gains After September 11*

Cognitive and Behavioral Practice 13(#1)

Cognitive Behavioral Case Conference

• Trauma to the Psyche and Soma: A Case Study of Posttraumatic Stress Disorder and Comorbid Problems Arising From a Road Traffic Collision (Wald & Taylor) • Addressing Shared Vulnerability for Comorbid PTSD and Chronic Pain (Asmundson & Hadjistavropolous) • Commentary on "Trauma to the Psyche and Soma" (Bryant & Hopwood) • Treatment of a Case Example With PTSD and Chronic Pain (Shipherd) • Synthesis and Outcome (Wald & Taylor)

Involving Fathers in the Delivery of Psychological Services

• 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 & Hunsley) • A Cognitive Therapy Approach to Increasing Father Involvement by Changing Restrictive Masculine Schemas (Mahalik & 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)

Book Reviews • Cummings and Wright (Eds.), *Destructive Trends in Mental Health, and Sommers and Satel, One Nation Under Therapy* (Reviewed by Richard Gist) • Hayes et al.'s (2004) *Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition* and Hayes & Strosahl's (2004) *A Practical Guide to Acceptance and Commitment Therapy* (Reviewed by Brandon A. Gaudiano) • Kingdon and Turkington's *Cognitive Therapy of Schizophrenia* (Reviewed by Shirley M. Glynn) • Rygh and Sanderson's (2004) *Treating Generalized Anxiety Disorder: Evidence-Based Strategies, Tools, and Techniques* (Reviewed by David Mellinger)

Welcome, New Members!

FULL MEMBERS

Jennifer J. Bodart, Psy.D.
Mary B. Bonamer, Ph.D.
Valerie Brooks Klein, Ph.D.
Beverly A. Brosky, Psy.D.
Dean M. Busby, Ph.D.
Samuel Jurado Cardenas, Ph.D.
Ajeet Charate, M.A.
Jeff A. Cigrang, Ph.D.
Mark D. Cooperberg, Ph.D.
Lee D. Crump, Ph.D.
Bob G. Davis-Coelho
Lisa Ann Douglas, M.A.
Kimberly S. Duris, M.A.
Jack D. Edinger, Ph.D.
W. Frank Ellis
Michael Fellner, Ph.D.
Lisa R. Fenton, Psy. D.
Laura E. Forsyth, Ph.D.
Jennifer S. Funderburk, Ph.D.
Rachel Goodman, Psy.D.
Lynn Heroux, Ph.D.
Michael R. Hollander
Sharon Howard
John T. Hower, Ph.D.
Leon A. Hyer, Ph.D.
Michael T. Hynan, Ph.D.
Sunna Jung, Ph.D.
Steven R. Krebaum, Ph.D.
Steven J. Lynn, Ph.D.
Angela E. McHolm, Ph.D.
Kevin M. McKiernan, Ph.D.
Stephanie E. Meyer, Ph.D.
Christopher J. Mosunic, Ph.D.
Jennifer Nam, MSW
Michelle Antoinette Nealon-Woods, Psy.D.
Amanda O'Hearn, Ph.D.
Karen Oliver, Ph.D
Ronald C. Savage, Ed.D.
Keith Saylor, Sc.M., Ph.D.
Brad Schmidt
Steven M. Schmidt, Ph.D.
Jean W. Smith, M.D.
Jesse Tamplen, MSW
Alison M. Tufts, M.A.
Michelle Van Setten, M.A.
Roy W. Van Tassell, M.S.
Shona N. Vas, Ph.D.
Christopher C. Wagner, Ph.D.
Robert Weis, PhD
Chelsea Wogsland, B.A.

STUDENTS

Lisa S. Aberbach, M.A.
Jacqueline Abrardo
Beena E. Alex, B.S.
William R. Aue, B.A.
Katherine C. Bailey, B.A.
Lauren E. Baillie
Grayson L. Baird
Angela A. Banitt
Sarah Kate Bearman, Ph.D.
Kristyna L. Bedek, M.A.
Anton Berzins
Laurie F. Better, M.A.
Kelly Anne Constant Bhatnagar
Leslie A. Blanchard, M.A.
Jennifer L. Brereton
Kristen Broussard
Donna Angele Burgess
Chris Campbell
Erica L. Carlos
Chee N. Chan, B.A.
Joanne Chan, M.A.
Nora Charles
Gregory S. Chasson
Catherine A. Cheely, B.A.
Yelena Chernyak, Ph.D.
James T. Chok, M.A.
Kirstin J. Choma
Kahni Clements, B.A.
Mark Closson
Tara M. Cole, M.A.
Amanda L. Collins, M.A.
Rowena C. Conroy
Deborah A. Corbitt-Shindler
Liliana Cortes, B.A.
Megan E. Costello
Teri Ann Cox, Ed.S.
Brian Creasy
Christopher C. Cushing
Tania A. Czarnecki
Farimah Danesh
Gloria Watson Daniels
Christine M. Davis, B.S.
Alicia K. Delgado-Agudio
Heidi L M DeLoveh
Heena Y. Desai, M.D.
Dawn J. Dore, M.S.
Jessica A. Dreifuss, B.S.
Randi A. Dublin, B.S.
Jennifer L. Duffecy, B.A.
Alexandra L. Duncan-Ramos
Lindsey A. Einhorn, M.A.
Erica L. England, B.A.
Maria A. Esposito, B.A.
Qijuan Fang, M.A.
Coreen A. Farris, B.A.
David A. Fazzari, M.S.
John Barrington Fischer
Kate E. Fiske, B.A.
Jaime B. Fleckner
Kerry K. Fluharty
Nicholas R. Forand, B.A.
Megan L. Freese
Kathryn E. Gallagher
Genevieve M. Garratt
Joseph A. Giorgio
Ariel Glick
Stephenie A. Gold, M.A.
Michael J. Goldblatt
Araceli Gonzalez, B.A.
Eric S. Grady
Christoffer A. Grant, B.A.
Erin Green
Leyla G. Gualdron, M.A.
Rita Guimaraes, M.A.
Kimberly A. Haala, M.S.
James M. Hadder, B.S.
Mark Hatzenbuehler, B.A.
Caron P. Heigel
Nicole E. Heitler, M.A.
Nikki Hernandez, B.S.
Michael J. Hirschel
Celia E. Hoggatt
Suzanne A. Horsager, M.A.
Junjie Hou
Lora R. Hunter
Narissa R. Hutchinson
Christopher S. Immel, B.A.
Rebecca E. Isaacs
Jeff Jaeger, B.A.
Katherine Jakle
Lisa M. James, B.A.
Matthew G. James, B.A.
Abigail M. Janney
Lisa E. Jobe
Robert W. Johnson, B.S.
Alanna K. Jones
Kimberly M. Jorgensen
Ellen T. Kahn-Greene
Kristen M. Kalymon, B.S.
Jennifer Q. Kane, B.A.
Jessica D. Keyser, B.A.
Nathan A. Kimbrel, M.A.
Tracy J. Kisner, M.A.
Alicia K. Klanecky
Amber Knott, B.A.
Meredith B. Kuenzi, Ph.D.
Grace Kwak
Cecilia W. Lam, B.A.
Matthew M. Leahy
Sarah Levinson, B.A.
Jioni Lewis
Melissa Ardelle Lewis, Ph.D.
Leslie E. Lichtenstein, Ph.D.
Mary B. Lindsay
Rachael Lunt
Guillermo E. Macbeth
Jessica L. Malmberg
Brianna Mann, B.A.
Lydia Colleen Mariam
Donald R. Marks, M.A.
Lyssett Deniss Martinez, M.A.
Lauren McCormick, Psy.D.
April R. McDowell
Anne B. McHugh
J. Murray McNiel, M.A.
Michael R. Mecozzi, B.A.
Christine Megan, Ph.D.
Jill Melton, Ed.S.
Keith R. Milligan, M.A.
Suzanne Milnes
Shokooh Miry
Kristine M. Molina, B.A.
Matthew C. Morris, B.A.
Alexis B. Munk, H.S.
Magdalena Murawska
Casey E. Murray
Taryn A. Myers, B.A.
Natashia L. Nagy
Mary E. Neff, B.A.
Jennifer Nguyen
Laura A. Nichols, Ph.D.
Jessica L. Norman
Kelly A. O'Brien, M.S.
Amanda J. O'Dell
Sean O'Hagen
Kimberly D. O'Kelley
Kerry Anne V. O'Toole, M.A.
Brooke E. Owen
Charlotte E. Parrott, B.A.
Julie A. Pelletier, M.S.
Jason E. Perry
Jemima F. Petch
Chad Peters, B.S.
Michael Poet
Dana M. Powell, M.A.
Yesmina N. Puckett
Deirdre Radosevich, B.A.
Amanda M. Rahimi
Aaron Rakow
Mona Raouf, B.S.
Devon G. Reckmeyer
Alexander W. Renelt, M.A.
Elise M. Resnick

Welcome, New Members *(continued)*

David Reynolds, Ph.D.
David T. Richardson, B.A.
Lorraine E. Ridgeway, B.S.
Carla A. Rime, B.A.
Stephanie Rodrigues
Jamie L. Rodriguez
Anna Rosenberg, B.A.
Jacob Rossmer, Psy.D.
Alicia Roth
Jennifer J. Runnals, M.S.
Jennifer L. Russell
Koke Saavedra, M.A.
Deena Sadiky
Emily Sandoz
Nicholas J. Sansone
Neshe Sarkozy
Sayaka Sato, B.E.
Cara L. Schmid, B.A.
Kristin L. Schneider, M.A.
Jamie L. Schumpf, M.A.
Peter J. Scoma, B.S.
Ashley C. Senior, M.A.
Kimberly T. Sibille
Rachel A. Simmons, M.A.
Edyta A. Skarbek, M.A.
Kent David Smallwood, M.A.
Sara Rachel Smith
Tarik A. Smith, M.A.
Rachel J. Snyder, M.A.
Laura E. Sproch
Jessica J. Stanford
Nadine Sutton, B.A.
Candyce D. Tart
Meghan F. Tomb, B.A.
Sandra E. Torres
Jennifer V. Tran
Hollister Trott, M.A.
Lisa Dulgar Tulloch
Sarah R. Uzenoff, B.A.
Ruth L. Varkovitzky
Lori A. Wagner, B.S.
Megan L. Wagner
Stephanie C. Wallio, M.A.
Bronwyn L. Watson, B.S.
Jennifer Weiand
Tony T. Wells, M.A.
Emily K. Wetter
Jeannie B. Whitman
Kendall Wilkins, B.A.
Carol S. Willeford
Monica T. Williams
Jennifer L. Wisneski, M.A.
Kate S. Witheridge, B.A.
Pamela A. Wolper
Julie J. Wren, B.S.
Catherine A. Yeager, M.A.
Amanda J. Zacharias
Stephanie A. Zamorski, B.S.
Megan M. Zurlage, B. A.

NEW PROFESSIONALS

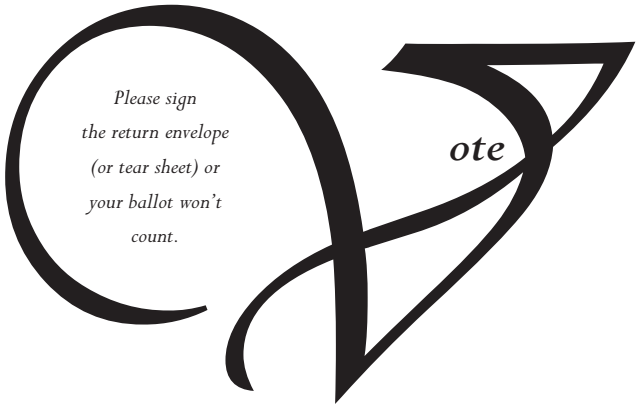
Annalise L. Caron, Ph.D.
Jessica Coyer, Psy.D.
Mariana K. Falconier, Ph.D.
Catherine M. Gaze, Ph.D.
Miles Gilliom, Ph.D.
John W. Lee, Ph.D.
Makiko Matsuoka, M.C.
Elena W. Ostroy, Ph.D.
Michael A. Schonberg, Ph.D.
Stewart A. Shankman, Ph.D.
Kathy Short
Cristina M. Sorrentino, Ph.D., MSW

This could be your last

issue of tBT

Only those individuals who have renewed their ABCT membership or subscriptions will continue to receive tBT after this issue. **RENEW NOW** to prevent an interruption in service.

QUESTIONS? Call Lisa Yarde, ABCT's Membership Services Manager, at 212-647-1890.



APRIL IS ABCT ELECTION MONTH

Your ballot must be postmarked by 4/30!

Behavioral Psychology as a Specialty Area in Psychology: An Important Role for ABCT in the National Movement Toward Specialties in Professional Psychology

— *Call for Committee Member Volunteers* —

Kevin D. Arnold, *Chair, ABCT Committee on Specialization in Behavioral and Cognitive Therapies Within Various Professions*, and *President, Behavioral Psychology Specialty Council*

Establishment of New Ad Hoc Committee

The Ad Hoc Committee on Specialization in Behavioral and Cognitive Therapies Within Various Professions (Specialization Committee) was established at the 2005 Convention by the Board of ABCT. The Specialization Committee will function to advise ABCT on issues regarding the specialty of practice in cognitive and behavioral therapies and to make an impact on other organizations that have interests in specialties. The first efforts will be directed at professional psychology, although, as the name of the committee indicates, the long-term focus will be in other disciplines such as psychiatry, professional counseling, social work, etc. The Chair of the Specialization Committee will be Kevin D. Arnold, Ph.D. ABPP.

Relationship of the Specialization Committee to Professional Psychology

Within professional psychology, the Council of Specialties (COS) is the organization that represents various specialty areas through its participation on various committees and groups in psychology, including COS's advisement to the Committee on Accreditation (COA; the body that accredits psychology predoctoral and postdoctoral programs). COS also advises and consults to the American Board of Professional Psychology (ABPP), the American Psychological Association (APA), the Association of State and Provincial Psychology Boards (ASPPB), the Council of Certifying Organizations in Professional Psychology (CCOPP), the Committee for Recognition of Specialties in Professional Practice of Psychology (CRSPPP). The COS is comprised of members representing various specialties, each specialty having met certain criteria for eligibility on the COS. One criterion is the formation of a stakeholder group, known as a *synarchy*, which speaks with one voice for the specialty. In cognitive and behavioral therapies, the synarchy is the Behavioral Psychology Specialty Council (BPSC), and the ABCT Specialization Committee Chair represents ABCT on the BPSC. Presently Kevin Arnold also serves as the President of the BPSC and its representative to the COS. In addition to ABCT, the BPSC has the following members—the American Academy of Cognitive and Behavioral Psychology, the American Board of Cognitive and Behavioral Psychology, the Behavior Analyst Certification Board, Division 25 of the American Psychological Association (Division of Experimental Behavior Analysis), and the Association for Behavior Analysis. The BPSC serves in a leadership capacity in the specialty of behavioral and cognitive-behavioral psychology within professional psychology, charged with developing such things as education and training guidelines in behavioral psychology for accreditation of postdoctoral training sites, and specialty guidelines in the practice of behavioral psychology.

Call for Volunteers to Serve on the Specialization Committee

The Specialization Committee is asking any ABCT members with experience in the accreditation process or an interest in the specialty issue to consider volunteering for the committee. Specifically, if you have experience with the CCOPP or the COA, or if you have served as a COA site reviewer, please consider how valuable those experiences can be in promoting the work of the committee. If you have those kinds of experiences or interests, and are a professional counselor or clinical social worker, please consider that your role is particularly important at this formative stage.

ABCT now has the opportunity to assist in the completion of important work that will undoubtedly shape the direction of psychology, and other professions, for years to come. The Specialization Committee needs your help. Please contact Kevin Arnold at kda1757@earthlink.net to join the committee and contribute to this important work. If you are interested, please place the words "Specialization Committee" in the "Re" of the e-mail.

ABCT

- *complex cases*
- *master clinicians*
- *live sessions*

Clinical Grand Rounds

DEEPEN YOUR UNDERSTANDING

Observe the decision-making and clinical techniques demonstrated in these videotapes that capture renowned CBT practitioners in session with simulated clients.

TRAINING VIDEOS ORDER ONLINE AT http://abct.org/members/source/Orders/index.cfm?Task=0

Strengthening Find-a-Therapist From Within

Doreen DiDomenico, *Chair, Clinical Directory and Referral Issues Committee*

COMMITTEE MEMBERS: *Jerry Tarlow, Katherine Martinez, Denise Davis, Bruce Hyman*

Greetings from the Clinical Directory and Referral Issues Committee! We should begin by letting the ABCT membership know that we did have a serious discussion during the year about changing our name to the "Find-a-Therapist Committee" to alleviate any confusion about the clinical directory. The change was vetoed, however, as we anticipated further puzzlement when members contemplate the activities of the "FAT Committee."

For those of you unfamiliar with Find-a-Therapist, this refers to the on-line clinical directory that provides listings about the practices of ABCT's clinician members. The directory, available as a free service to ABCT members, lists only those members who have indicated on their membership applications that they see clients and are willing to be listed on the Web site. Clinical listings are accessed via a search engine that allows users to locate members by name and/or geographical information, combined with specific practice information like populations treated and specialty areas.

For a nominal fee ($50 a year), members may elect to add "practice particulars" to their listings. This feature allows practitioners to provide additional information of specific interest to prospective clients, including: multiple addresses, hours, languages spoken, insurance accepted, Web site address, and special services. Perhaps the most valuable information one can add is the "practice philosophy," wherein members can describe what they believe consumers should know about their practice.

Thank you to all members who participated in our on-line survey last year. Although the number of overall respondents was low, ratings were largely consistent. Average ratings in all categories were between moderate and positive. Members rated the user-friendliness and their likelihood to use the directory again as more positive than their experience with the comprehensiveness of search criteria and the efficacy of the search mechanism. For those individuals who have not utilized Find-a-Therapist, the majority revealed that it was a result of lack of awareness of the ABCT Web site and/or the Clinical Directory database.

One of the primary goals of the Clinical Directory and Referral Issues Committee is to lessen the numbers of those of you unfamiliar with Find-a-Therapist! We are committed to assist in providing a user-friendly and comprehensive clinician listing to serve both our members and the public at large. But we can only do that with the extensive participation of our members, and with comprehensive and accurate listings.

In addition to our goal of increasing the number and scope of the listings, we also seek to continually improve the directory by making the search mechanism as effective and user-friendly as possible, and to promote the directory to the public as a valuable resource for locating CBT/EST professionals in their areas.

In recognition of the ever-increasing use of on-line resources by the world community, ABCT is in the process of a major revamping of the organization's Web site. It is expected that this redesign will improve the site's accessibility and user-friendliness by both members and the general public. While we enthusiastically anticipate the benefits yielded by a state-of-the-art Web site, the effectiveness and value of Find-a-Therapist will also continue to depend on you!

A highly efficient search engine can only locate the information that is available to it. In that regard, we need to ensure that our clinician members have the most accurate and comprehensive listings possible. Our committee has the following suggestions for our members to help make their listings as informative and useful as possible:

- ✓ **Include the county in which your practice is located.** Directory users are typically willing to locate a clinician within a reasonable geographic region; however, this is limited when members only include the city or town and state they practice in.
- ✓ **Check your listing every 3 to 6 months for accuracy.** Be sure to update information about your practice that may have changed.
- ✓ **Check the Find-a-Therapist search page as often as possible for new search criteria options—most importantly, specialty additions.** We are now proud to feature over 100 specialty categories, including such timely topics as Mindfulness, Social Skills, Media Psychology, Divorce Mediation, and Virtual Reality. *Other professionals and potential clients can't find the type of clinician they're looking for unless your information is there!*
- ✓ **Consider using the "practice particulars" option.** Including important information like other languages spoken, insurance participation, and appreciation of your practice philosophy may be the determining factor as to whether or not you receive that referral call.

Thank you for your assistance in strengthening Find-a-Therapist from within! Our accessibility to the public and each other is a vital component in promoting familiarity, acceptance, and, most importantly, the value of cognitive behavioral therapies and empirically supported treatments.

If you are not already listed in Find-a-Therapist and would like to be, or if you would like to add the additional optional information in your listing, please contact the always pleasant and accommodating staff at ABCT (212-647-1890) to make your request. ✍

40th

ABCT Annual Convention

NOVEMBER 16–19

CHICAGO

THIS YEAR'S CONVENTION THEME:

Translational Research

Classifieds

positions available

POSTDOCTORAL FELLOWSHIP IN OBESITY AND RELATED DISORDERS: Duke Diet and Fitness Center (DFC), Durham NC (1-2 years). The DFC is seeking a clinician/researcher with a doctorate in clinical psychology who wishes to pursue specialized training in obesity treatment and research. The position supports clients working toward weight loss and healthy lifestyle goals through the application of evidence-based cognitive behavioral intervention. Duties include: leading lectures/CBT skills groups, discussion groups, mind-body/stress management sessions, telephone coaching, and also individual psychotherapy for related psychosocial issues. Duties also include multidisciplinary treatment planning and program development. Research avenues include current collaborative research on treatment outcomes, pain management, sleep, liver disease and quality of life issues. Opportunities to explore additional research interests in the field of obesity are also available. Qualifications: Candidates must have completed a PhD in clinical psychology from an APA accredited program and an APA approved predoctoral internship in clinical psychology (behavioral medicine specialty preferred). They should be self-motivated and possess strong organizational and presentation skills. E-mail (preferred) cover letter & curriculum vitae to Martin Binks PhD martin.binks@duke.edu or fax to (919) 688-8049. Applications will be accepted and reviewed until the position is filled. Position begins July 1, 2006 (will negotiate based internship completion date). Duke is an Affirmative Action/Equal Opportunity employer.

RESEARCH CLINICIAN IN PTSD. The Institute for Trauma and Stress at NYU has a postdoctoral position available for someone with clinical and research experience in the area of PTSD and cognitive-behavioral treatment. This position is for a research clinician in PTSD assessment, treatment and dissemination. Responsibilities include 50% time providing empirically supported treatment in a NIMH funded study of a life skills oriented treatment for women with PTSD related to childhood abuse and 50% time dedicated to grant and manuscript writing. Job responsibilities include participation in writing manuscripts and grants related to archival data. Position is available now. The candidate should be interested in a research career in these areas as demonstrated by at least 1 publication. Salary is commensurate with experience. Interested candidates should fax their CV to 212-263-2476 or email it to Stephanie.cherry@med.nyu.edu attention Stephanie Cherry.

PROJECT DIRECTOR NYU CHILD STUDY CENTER INSTITUTE FOR TRAUMA AND STRESS. The candidate will direct all aspects of the day-to-day functioning of a NIMH funded study investigating three psychotherapy treatments designed for women with PTSD related to childhood abuse. Position requires administrative and clinical experience. Responsibilites include aiding in hiring staff and volunteers (recruiting and interviewing) and providing each with systemized training in both day-to-day operations as well as clinical assessments and treatment; advertising and overseeing the budget; overseeing all amendments to the protocols and manuals, and ensure that all changes are clinically appropriate and logistical in their application; coordinating any additional grant submissions related to the current funded grant(s); provision of psychotherapy treatments to participants. Interested candidates should contact Stephanie Cherry at stephanie.cherry @med.nyu.edu or 212-263-2474.

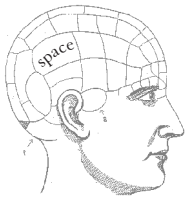
PSYCHOLOGIST: Department of Psychiatry, School of Medicine and Biomedical Sciences, State University of New York at Buffalo is seeking one academic psychologist, Assistant Professor. Tenure track. Candidates must have a PhD from an APA-accredited clinical psychology program, have completed an APA approved internship, and be licensed or eligible for licensure in New York State. Experience with short-term cognitive and behavioral interventions with proven efficacy is essential. Previous research experience is essential and experience with grant funding / submission is desirable. High comfort level working in a medical school training site located in an urban hospital, which is a training site for residents and medical students.

Applicants will be expected to develop programmatic research, engage in clinical activities, and contribute to the teaching mission of the department. Applicants will have opportunities to conduct independent research and will be provided with research time commensurate with experience. Although the specific area of research is open, we are most interested in applicants with clinically oriented research in anxiety disorders, obsessive-compulsive disorder, and/or post-traumatic stress disorder. Clinical activities will include development and implementation of cognitive behavioral treatment programs, providing individual and/or group therapy and supervising other clinical staff.

The Department of Psychiatry is a large program committed to quality care and empirical research. Opportunities for teaching and supervising residents and medical students. Women and minorities encouraged to apply. The University at Buffalo is an Equal Opportunity/Affirmative Action Employer. Send cover letter describing clinical and research interests, resume, sample publications, and three letters of recommendation to: Kenneth Leonard, Ph.D. Director of Psychology, UB Dept. of Psychiatry, Erie County Medical Center, 462 Grider Street, Buffalo, NY 14215.

DEVEREUX SENIOR CLINICAL LEADERSHIP POSITIONS. Devereux, a nation-wide network of behavioral health and human service programs, is seeking experienced clinical professionals for several senior leadership positions. At the corporate office in Villanova, PA two positions are available: (1) a Clinical Program Development Consultant/Researcher who will work with senior management to develop and support clinical treatment and special education programs consistent with evidence based practices; and (2) a Corporate Clinical Quality Improvement Coordinator, who is responsible, under the direction of the Corporate Quality Improvement Director, for organizing and facilitating program development and performance improvement activities. At Devereux Centers Nationwide: clinical leadership positions available at our NY, FL and CA programs. Staff psychologist/program director/clinician positions also available at our NJ, PA, MA treatment programs. Requirements/qualifications vary by position. To learn more about Devereux, and for details regarding these and other clinical positions, please visit our home page and Career site at www.devereux.org. For consideration, apply online or mail a CV with salary requirements to Fran Wilson, Ph.D., Chief Clinical Officer, Devereux, 444 Devereux Drive, Villanova, PA 19085. Devereux is a drug-free workplace, drug testing required, EOE.

TRAINING IN COGNITIVE THERAPY. The American Institute for Cognitive Therapy provides a year-long Professional Training Program as well as individual weekend workshops in cognitive therapy in NYC. Please contact us at training@CognitiveTherapyNYC.com or go to www.CognitiveTherapyNYC.com/training.asp for more information. Upcoming workshop topics include: Eating Disorders, Personality Disorders, Worry, Couples Therapy, and Mindfulness.



Thinking of Advertising in tBT?

CLASSIFIED ADS are only $4.00 per line.

E-mail classified ads directly to Stephanie Schwartz at sschwartz@abct.org and she'll give you a price estimate. Camera-ready art may be sent electronically; *or:* mail hard copy to ABCT, Advertising Dept.

AD SIZES	INCHES (width x depth)	RATE
back cover	7 1/8 x 7	$550
full page	7 1/8 x 9 7/16	$400
2/3 page	4 11/16 x 9 7/16	$275
1/3 page H	4 11/16 x 4 3/4	$175
1/3 page V	2 3/16 x 9 7/16	$150
1/6 page H	4 11/16 x 2 3/16	$75
1/6 page V	2 3/16 x 4 11/16	$75
1/2 page V	4 11/16 x7 1/4	$250
1/2 page H	7 1/8 x 4 3/4	$250

ISSUE	DEADLINE
Jan.	December 2
Feb.	January 3
March	February 3
April	March 3
June	May 3
Sept.	August 2
Oct.	September 2
Winter	November 3

40 years

ABCT

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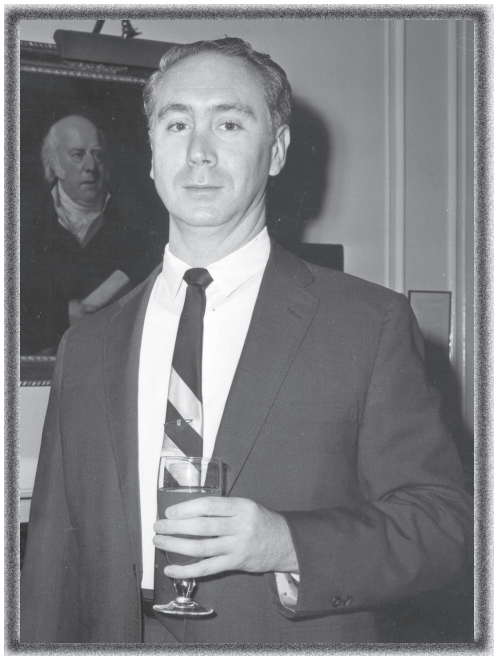


Who is this ABCT original?

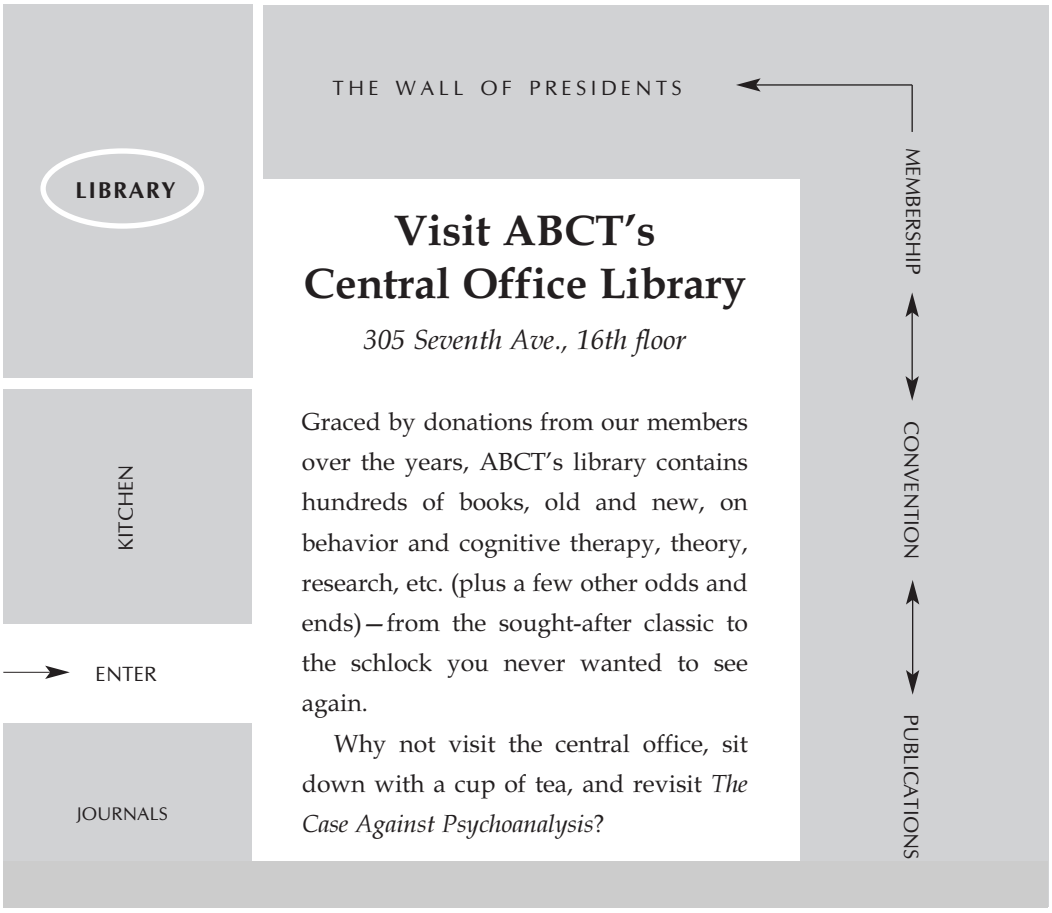
The first five people to identify the individual pictured above win **CB*Tea*** (a tin of the world's first cognitive and behavioral tea, complete with thought-provoking quotes from pioneers of the field).

Send answers to

Stephanie Schwartz, Managing Editor

- sschwartz@abct.org
- FAX: 212-647-1865
- REGULAR MAIL: ABCT, 305 Seventh Ave.
  New York, NY 10001

and include your contact information



Visit ABCT's Central Office Library

305 Seventh Ave., 16th floor

Graced by donations from our members over the years, ABCT's library contains hundreds of books, old and new, on behavior and cognitive therapy, theory, research, etc. (plus a few other odds and ends)—from the sought-after classic to the schlock you never wanted to see again.

Why not visit the central office, sit down with a cup of tea, and revisit *The Case Against Psychoanalysis*?

the Behavior Therapist
Association for Behavioral and Cognitive Therapies
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