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Contents

News & Notes

Laura E. Dreer CBT Featured in Boston's NPR Piece "Rising Sleeping Pill Prescriptions" ***89***

Letter to the Editor

Will M. Aklin and C. W. Lejuez A Rose by Any Other Name: Why a Name Change From AABT to ABCT Makes Sense ***94***

Feature

Nicole D. Pleasant Disseminating a Marriage Education Program: The PREP Experience ***96***

Clinical Forum

Jennifer Vecchio and Christopher Kearney Selective Mutism in Children: A Synopsis of Characteristics, Assessment, and Treatment ***102***

Lighter Side

Herman Stickleback The Lighter Side of . . . Professional Development: A Response to Taylor et al. ***104***

Elizabeth L. Moore Please Don't Tell My Mother I Am a Psychologist. She Still Thinks I Play the Piano in a Brothel ***105***

Book Reviews

Reviewed by Leslie J. Heinberg Sarwer et al. (Eds.). (2005). *Psychological Aspects of Reconstructive and Cosmetic Plastic Surgery* ***106*** • ***Reviewed by Keith S. Dobson*** Kazantsis et al. (Eds.). (2005). *Using Homework Assignments in Cognitive Behavior Therapy* ***107***

At ABCT

• Find-a-Therapist ***108***

• ***Kevin D. Arnold*** Report to ABCT of Specialty Activities in Professional Psychology from ABCT's Committee on Specialization in Behavioral and Cognitive Therapies Within Various Professions (Specialization Ad Hoc Committee) ***109***

Classifieds ***110***

and . . .

40 years ABCT EVIDENCE SUPPORTED TREATMENT

Photo ID (p. 111)

News & Notes

CBT Featured in Boston's NPR Piece "Rising Sleeping Pill Prescriptions"

Laura E. Dreer, *University of Alabama at Birmingham*

On February 21, 2006, Boston's National Public Radio (NPR) featured a segment on the recent increase in sleeping pill prescriptions (Brooks, 2006). The guest host, Anthony Brooks, interviewed a number of prominent guests and leaders in the field of sleep disorders to discuss the growing trend. In the introductory segment, Brooks discussed with Melanie Wells, Senior Editor of *Forbes* magazine, the depth and impact of the problem. According to Wells, Americans filled some 42 million sleeping pill prescriptions last year—up nearly 60% over the past 5 years. Drug companies are spending millions each year to push a new generation of so-called Z-drugs (e.g., Lunesta from Sepracor Inc.). Ms. Wells continued by stating, "We're creating a lifestyle drug."

Brooks also interviewed Dr. Gregg Jacobs, Assistant Professor of Psychiatry at Harvard Medical School, to gain a better understanding of this trend. Dr. Jacobs is also an insomnia specialist at the Sleep Disorders Center at the University of Massachusetts Medical School at Worcester, Massachusetts, and author of *Say Goodnight to Insomnia: The 6-Week Drug-Free Program*. Dr. Jacobs warned that "a vast majority of patients who have insomnia do not need sleeping pills. There's a nondrug therapy that's actually more effective, safer, and less expensive. It's called cognitive behavioral therapy or CBT for short." He elaborated on the benefits of CBT for the treatment of insomnia, the definition of insomnia, the

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

distinction between other sleep problems (i.e., insomnia vs. sleep deprivation), and the potential side effects of pharmacological treatment with traditional sleep drugs.

The segment continued with a perspective from another leading expert in the field, Dr. Daniel Buysse, Associate Professor of Psychiatry at University of Pittsburgh School of Medicine, Medical Director of the Sleep Evaluation Center at the University of Pittsburgh, and the Past President of the American Academy of Sleep Medicine. Dr. Buysse pointed out that "one size does not fit all in terms of a treatment for just about any condition." He agreed with Dr. Jacobs's point that persons with insomnia can benefit from nonpharmacological treatment, including CBT and behavior therapy; however, Dr. Buysse argued that when CBT or BT is unavailable or ineffective, sleeping pills may constitute a reasonable alternative. Specifically, Dr. Buysse stated that pharmacotherapy might be appropriate for those who have had insomnia for a long period, or when the problem occurs almost every night and is associated with some type of impairment during the daytime. He then concluded, "In no case would I ever recommend the sleeping pill as the only treatment for insomnia. I think in almost every case a person can engage in behaviors that will improve their sleep and that in combination with medications for the chronic sufferer may be a good strategy."

As the segment continued, Dr. Jacobs concisely explained the application of CBT:

> CBT is based on a simple premise that insomnia, in the majority of cases, has a strong learned component, and if you can unlearn the behaviors that have led to insomnia, you can in many cases overcome insomnia, and those behaviors are actually fairly straightforward. They focus on things like worrying about not sleeping, which is a worry that has been compounded by the pharmaceutical companies and by the media in the last couple of years. People believe you need to sleep 8 hours a night. If you don't, you'll die sooner. So the worry about insomnia becomes the central focus of insomnia. CBT teaches people to challenge and change their distorted sleep cognitions. But CBT also teaches insomnia patients how to enhance their sleep drive and they do that by actually, for example, restructuring their time in bed to more closely match their actual sleep time; whereas insomnia patients do the opposite, they spend more and more time in bed. They become more awake, their sleep is more fragmented and the bed becomes a cue for wakefulness rather than sleep. We get patients to establish a more consistent rising time, to learn to associate the bed with sleep and not frustrating wakefulness, to learn basic relaxation skills and lifestyle practice skills to improve sleep.

Jacobs reviewed the empirical evidence with regard to CBT and pharmacotherapy and described his on-line interactive drug-free program for insomnia (www.CBTforInsomnia.com) designed for those who would otherwise not have access to CBT as an intervention. Dr. Buysse then discussed the action of sleeping pills and how they work, which was followed by calls from the public and a discussion of individual cases.

Near the end of the segment, Dr. Juliet Schor, Professor of Sociology at Boston College, provided her perspective on the trends in sleeping pill use. She attributed this phenomenon to several factors, including people working longer hours. For example, she noted that work is now spilling over into weekends and after hours and that society has lost "winding down hours." In addition, she observed that there may be higher demands and stress levels in the workplace.

This featured piece was remarkable for several reasons. First, it provided an informative discussion of a prevalent public health problem. Second, it featured several experts in the field who contributed their unique perspectives on the topic. Most importantly, it introduced CBT to the lay public in a straightforward, accessible manner. Finally, it illustrated an alternative means to reaching those persons who may not typically have access to CBT (i.e., Jacobs's on-line version of CBT for insomnia).

The efficacy of CBT for the treatment of insomnia has been well-documented empirically (i.e., Edinger et al., 2000; Edinger, Wohlgemuth, Radtke, Marsh, & Quillian, 2001; Morin, Culbert, & Schwartz, 1994; Murtagh & Greenwood, 1995). These interventions have included restriction of time spent in bed (Davies, Lacks, Storandt, & Bertelson, 1986), stimulus control (Bootzin, 1977; Puder, Lacks, Bertelson, & Storandt, 1983), relaxation therapy (Borkovec & Fowles, 1973), sleep hygiene (Hauri, 1982), and a combination of these components (Jacobs et al., 1993). Concern about insomnia has grown over the recent years as insomnia has been linked to decreased quality of life, diminished work productivity, and increased risk for depression and accidents (Smith & Perlis, 2006). Additionally, the majority of persons seeking treatment for insomnia present with comorbid psychiatric and/or medical conditions (Buysse et al., 1994) and frequently do not have access to or familiarity with treatments such as CBT. Consequently, this NPR segment represents an excellent example of disseminating CBT to the general public. (For a more complete review of CBT and insomnia, see Edinger & Means, 2005; Morin, 2004; Smith & Perlis, 2006; and/or Wang, Wang, & Tsai, 2005.)

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{Continued on p. 96}

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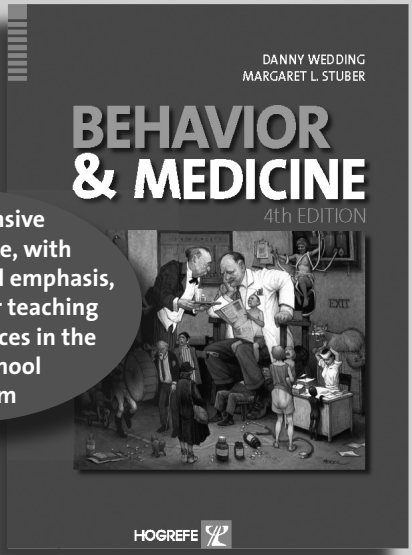

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Letter to the Editor

A Rose by Any Other Name: Why a Name Change From AABT to ABCT Makes Sense

Will M. Aklin and C. W. Lejuez, *University of Maryland, College Park*

The Association for Advancement of Behavior Therapy (AABT) has been recognized as the primary organization for the promotion of scholarly knowledge of behavior theory as well as innovative application in behavior therapy since its inception in 1966. There is no doubt that AABT has been a major contributor to the organized field of psychology, and that this contribution initially grew out of basic behavioral theory and research. Over time, however, the organization evidenced an expansion in acceptance and contribution of cognitive perspectives, with the majority of members now espousing a cognitive-behavioral orientation.

To acknowledge this shift in focus, there have been several efforts to change the name of the organization, culminating this year in the transition from AABT to the Association for Behavioral and Cognitive Therapies (ABCT). Although this change required a majority vote, it would be safe to say that many members do not see this as a change for the better. Indeed, 25% of members voted against the name change and the most recent conference was filled with audible grumblings that were reminiscent of a '72 Pinto still proudly lathered with Al Gore bumper stickers.

Arguments for fighting the name change appear largely based on history. The problem, however, is that history does not reflect the current state of the organization. Reinstating the old name will not restore the organization back to its behavioral glory days, but rather alienate the ever-growing base of members who believe in the value of cognitive and cognitive-behavioral approaches with the same fervor as do their behavioral counterparts. If those who favor the old guard are willing to accept the dues of cognitive researchers and therapists, why should they be so opposed to a name that also recognizes their contribution to the organization?

It would be difficult to find members of ABCT who would be considered more "behavioral" than the authors of this piece. The first author learned exposure therapy from the late Samuel Turner and is receiving his Ph.D. under the supervision of the second author who is a graduate of West Virginia University with a thumb full of bites "earned" during countless hours of providing rats (or maybe the other way around) with Sidman avoidance training. We still writhe in pain when someone misuses the term *negative reinforcement* and we think to ourselves, "Did you use concrete?" when a colleague talks of reinforcing someone as opposed to that someone's behavior. Nevertheless, those opposed to the name change may see us as sellouts because we refuse to fight the battle to change the name back like an ivory-tower Captain Ahab. To these individuals we point to comments made by Cyril Franks, the first and cofounding AABT President (1966–1967), who in a special issue of this publication (see Suinn & Ronan, 2003, p. 331) commemorating the contributions of past presidents suggested that the name AABT is too narrow and among other factors fails to address the contributions of those individuals studying other processes including cognitions. Anyone interested in calling him a sellout?

Reference

Suinn, R., & Ronan, G. (Eds.). (2003). The past presidents of AABT [Special issue]. *the Behavior Therapist, 26*(6).

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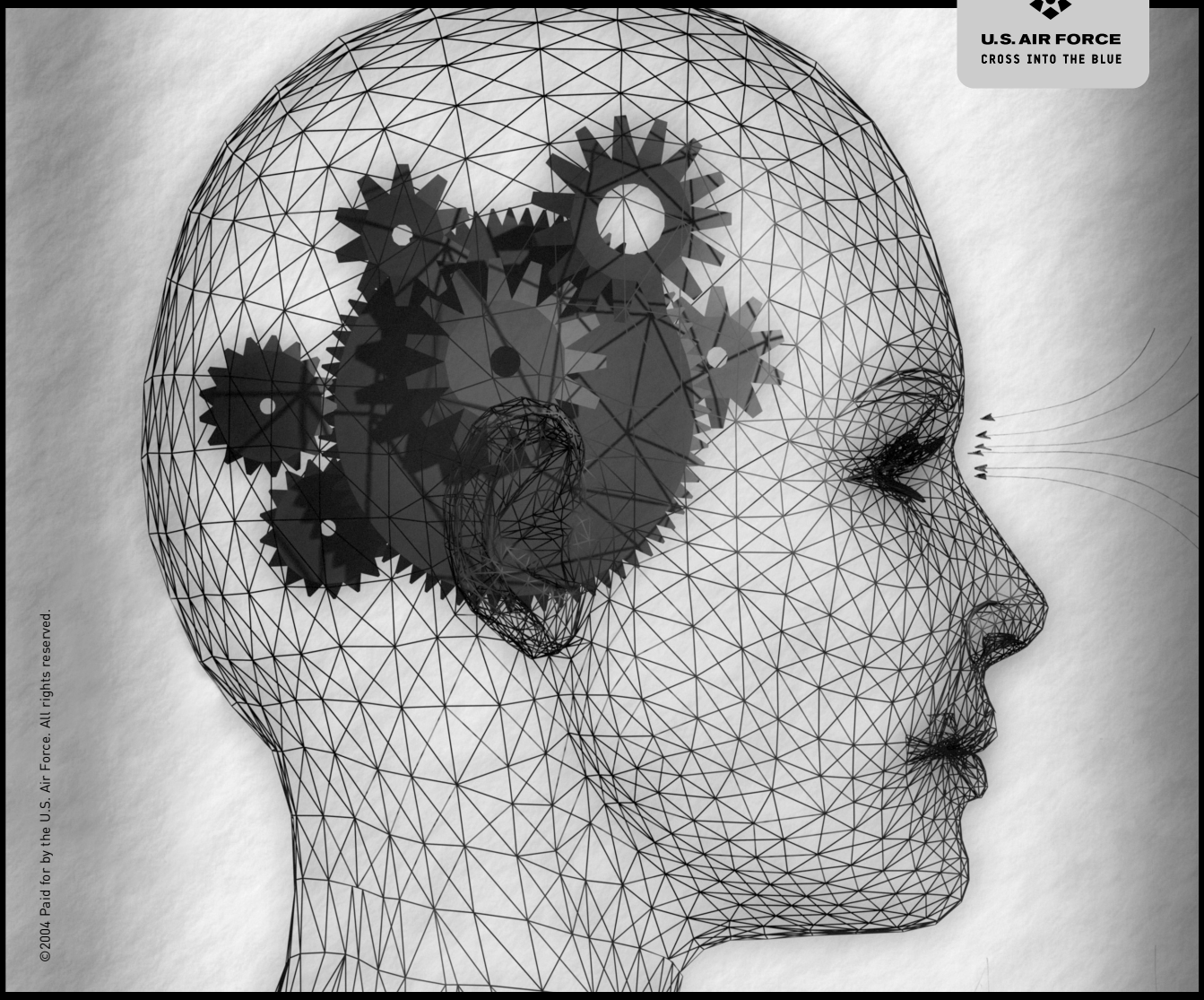

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{Continued from p. 91}

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Feature

Disseminating a Marriage Education Program: The PREP Experience

Nicole D. Pleasant, Howard J. Markman, and Scott M. Stanley, *University of Denver*

There is a growing recognition of the importance of marriage education within both the federal and local government. Examples can be seen in the administration's increased attention to strengthening families as well as state-run initiatives to strengthen marriage, such as the groundbreaking work being done in Oklahoma as part of the Oklahoma Marriage Initiative (see OKmarriage.org). Much of this push for strengthening marriage is due to the growing evidence that marital distress and family fragmentation are associated with a broad spectrum of risks for adults and children (e.g., National Institute of Child Health & Human Development, 2004). In addition, there is evidence that couples can learn skills and principles thought to underlie healthy and stable marriages in a variety of settings (e.g., group classes) and by a variety of service providers (e.g., counselors, clergy, community leaders) and that couples who have learned these skills can maintain them over time and may have increased chances for a stable, healthy marriage (see Markman et al., 2005, for a review).

We have been fortunate to be involved in the development of programs to disseminate relationship education on a large scale through our research, work with the Armed Forces, and more recently the Oklahoma Marriage Initiative. In the sections that follow we will present some of our experiences disseminating an empirically based relationship education program, the Prevention and Relationship Enhancement Program (Markman, Stanley, Blumberg, Jenkins, & Whitely, 2004). From that experience we will highlight the factors we feel are most important to disseminating a relationship education program effectively and end with some specific recommendations we have drafted for working with low-income clients as these are the clients that many marriage education efforts are trying to reach.

The Prevention and Relationship Enhancement Program (PREP) is empirically based, adhering to the "best practices" model with regard to educating couples (Halford, Markman, Kline, & Stanley, 2003). There are three core aspects of the empirical basis for the model: (a) the content of the program is informed by research on couples and families; (b) strategies and curricula are tested in outcome research; and (c) program content and delivery options are regularly refined based on ongoing scientific gains in the field (Stanley, Markman, & Jenkins, 2004). We have spent years testing the efficacy of PREP as implemented by our university-based staff; in the last several years we have progressed to effectiveness trials to test the impact of PREP when utilized in natural, real-world settings.

In the early 1980s, in the midst of publishing some of our early findings on the effectiveness of PREP, we were contacted by Bill Coffin, a prevention specialist with the Navy (now with the Administration of Children, Youth and Families). Strongly committed to the dissemination of empirically supported interventions to large populations through community agencies, Bill approached us about training naval chaplains and social workers to deliver PREP to sailors and marines, thus launching our dissemination efforts. However, from the beginning of our work we had a vision of developing, evaluating, and disseminating a program for preventing (as opposed to more costly treatment) marital distress and divorce. We are fortunate to share this vision with people like Bill in the private, public, and military sectors who care about children, couples, and families and recognize the importance of using research-based interventions to promote healthy families in the larger community through prevention and education programs like PREP. We also recognized that through offering prevention and education programs in the community in general and in religious organizations in particular, it would enable us to reach community members who might not see services from traditional mental health providers.

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intervention programs that hold promise for amelioration of important social problems. One of the take-home messages in this article will be that though we know enough to act now, there is still much we need to learn about how to get these interventions into the hands of people who can put them to use (Stanley, 2003). What follows is a brief summary of some of what we have learned so far.

Dissemination of PREP Within Religious Organizations

In 1996 we embarked on the Family Stability Project, which is a large-scale community-based prevention trial of PREP delivered in religious organizations (ROs) to premarital couples. The program is designed to lower risk factors and raise protective factors for marital distress and associated mental health problems. Targeting ROs as a delivery system is important as ROs already serve a less stigmatizing resource for prevention and counseling for many people who will not seek services from a mental health professional and ROs provide an opportunity to enhance already existing "natural" interventions in the community (premarital counseling). This project involved recruiting couples from ROs and randomly assigning them to three tracks: (a) to receive PREP training by our university staff; (b) to receive PREP training through their own RO; or (c) to receive the natural occurring relationship education provided by their RO. Two of the main objectives of this project are to longitudinally assess the effectiveness of PREP and to track the dissemination of PREP through ROs. The sections that follow focus on the dissemination portion of this project (see Markman, Whitton, et al., 2004, for a full review).

Derived from diffusion theory (e.g., Rogers, 1995), three key elements guided us in our dissemination of PREP to the community: (a) careful consideration of the target adopters; (b) maximizing the transferability of the PREP curriculum to the community of ROs; and (c) allowing those who may adopt the curriculum the opportunity to try it first with little obligation.

Considering Adopters

The compatibility of a relationship education curriculum with the existing practices, needs, past experiences, and values of the target community is one of the most important predictors of whether curricula are adopted (Rogers, 1995). Thus, it is important to assure that marriage education is seen as relevant to the practitioner's work with couples. The goals of PREP are very much in line with the goals of religious leaders—to help couples have lasting, healthy marriages. Seventy-five percent of first marriages occur in ROs, with most being committed to delivering premarital services. ROs also tend to be deeply embedded in the culture of couples who are the targets of such services (Stanley, Markman, St. Peters, & Leber, 1995)

Transferability

Transferability is the degree to which an education curriculum can adapt to the needs of particular community organizations. As long as the basic integrity of the curriculum is maintained, modifications may be necessary to maintain effectiveness across different settings. Providers who know the target audience are likely to make changes that enhance the extent to which a curriculum addresses clients' needs in their community settings. One way to build this transferability is to give providers clear flexibility in choosing which aspects of a multifaceted curriculum they deem most important to use with their target audience. Providers should have the flexibility to use different formats to place more or less emphasis on various modules and to use examples, stories, and metaphors that are most relevant to the couples they serve.

The practitioner is the focal point of transferring the intervention to the community. Practitioners know the needs and culture of their couples best and should make modifications based on this knowledge in order to transport university-validated relationship education to the community. In our experience, clergy and lay leaders, who represent a passionate group of practitioners with significant access to many couples for marriage education, are unlikely to read scientific journals, but they are highly receptive to summaries of relevant research. Thus, a priority of our dissemination efforts was to translate empirical findings into material useful to practitioners.

Trialability

Adoption of an intervention is influenced by the extent to which it can be tried out while it is implemented on a limited basis. The opportunity to give a new curriculum a test run, without making a major financial or time commitment, tends to lower the uncertainty of its effects and increase rates of adoption. The leaders who were trained in PREP made a relatively small time investment of approximately 12 hours at no charge to them.

The following results are the major dissemination findings based on the 8 years of continued use of PREP by the trained clergy and lay leaders who were originally trained as part of our research project (updated from Markman, Whitton, et al., 2004). The major finding in this study was that most religious organizations offered at least some parts of PREP in premarital training with couples even after the recruitment phase of the effectiveness portion of our study was over. In fact, 31% of the couples who received some form of PREP within their religious organization over the 8-year period were married. Another critical finding was that PREP was used with 2,087 couples, which is much larger than the 225 couples who received PREP premaritally as part of our ongoing effectiveness study. This highlights the radiating effects of training practitioners in organizations that have preexisting, ongoing access to couples: Rather than establishing new systems to deliver empirically based services, disseminating such interventions through organizations that already serve couples in the community may be a more efficient method of reaching large numbers of couples.

Another interesting finding was that the 3-day training of PREP principles appeared to be adequate in order to give leaders confidence using the curriculum. It is another empirical question whether a shorter training period could have been equally effective. In addition, we found that leaders used certain components of PREP more than the full PREP. Most frequently used modules were those on increasing positive communication and reducing destructive conflict, and leaders reported making considerably less use of PREP components associated with increasing protective factors, such as the modules on expectations, core beliefs, and religious practices. Providing practitioners with a range of potential intervention formats with differing time requirements may be important to maximize transferability of the intervention to their existing practice. Future research is needed to clarify the effects of adaptation of PREP by community leaders. There is also a need to assess whether some PREP modules are more useful or effective than others, and what factors, including gender, might mediate or moderate the effectiveness of specific modules.

The broad implications of this dissemination study were that there is acceptance of empirically based strategies by religious

and community leaders and these leaders are effective in reaching young couples and other couples that might not seek out services through traditional mental health channels.

General Recommendations

The bulk of our experience disseminating PREP has been in the context of collaborating with organizations that already serve couples—religious organizations, the military, or the state of Oklahoma. We believe that the general recommendations that follow are applicable in a number of circumstances, whether a practitioner is being contacted to consult with a community organization that is interested in providing research-based relationship education or a research group that has an empirically supported intervention that they want to disseminate to the larger community.

If at all possible, work with an organization that is already serving couples in the community. The dissemination process is greatly accelerated and maximized when the intervention can be incorporated into an existing infrastructure. In addition, existing organizations will likely already have in place comprehensive service delivery systems. Ideally, a marriage education curriculum will be delivered as one of many services available to couples. In any case, we feel it is important to provide participants with a referral document that lists information on local resources as many participants may be struggling with issues that go beyond marital education (e.g., aggression, individual functioning, mental health problems, substance abuse).[1]

Consider the needs of those who will be disseminating the intervention and design programs that are easily transferable to community practice. The way we have done this is to make it easy for practitioners to learn and systematically deliver the key components of the intervention by breaking the materials into modules and then manualizing the information. We provide practitioners with a range of potential intervention formats with differing time requirements that allow them to customize the intervention to their needs. We feel this point is particularly important when you consider that most practitioners working with couples and families are not using research-based approaches (Markman, Stanley, & Kline, 2003), perhaps due to the lack of attention to translating research findings into tools and principles that practitioners can easily integrate into their practice.

If at all possible, use practitioners who already have expertise with couples. Ideally, a leader who is delivering an intervention in an educational format will possess training and knowledge in a field (such as psychology, clergy, social work, nursing, public health or education) that emphasizes educational strategies for helping couples. We have also found that among the most effective leaders are those who are in touch with the community they are serving and can provide vivid personal examples taken from their own experiences to supplement the materials being provided. Comfort in public speaking is important for presenter effectiveness; in that regard, clergy tend to make excellent presenters.

Train more leaders than you think you will need. Personnel changes within an organization can create a barrier to effectively disseminating an intervention over time. When establishing an intervention within an organization, it is important to consider having a number of people trained to ensure continuity in program delivery.

Modules are important. In order to achieve the goal of reaching a diverse population through training leaders, it is important to recognize that leaders will not always use the full curriculum. Therefore, it is recommended that an intervention program be comprised of many modules that leaders can use in a variety of orders and formats. From a public health perspective, providing a million couples with a smaller dose of an effective intervention could have a much wider societal impact than providing a thousand couples the full dose. An important challenge to keep in mind is that others may not carry out the intervention as you would. One approach to mitigating this issue is to personally train those approved to conduct the intervention—and only those who have been trained by you can supervise and train others. In addition, it is important to orient presenters of the intervention to the most pertinent parts of the curriculum so they know what to keep or cut when it becomes necessary to modify the intervention. The bottom line is that we think it is worthwhile to trade some loss of control for greatly expanded community impact.

Track the dissemination of the intervention program. In order to begin to answer questions about the critical components of delivering an empirically based intervention program to the community, we must more

[1] A copy of our referral document and other resources can be found at www.PREPinc.com

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closely document how it is delivered and the factors that affect delivery. How does adaptation of an intervention influence its effectiveness? Which sections or modules of an intervention are most effective compared to others? Do factors such as gender mediate or moderate that effectiveness?

Collaborate with community leaders in diverse populations, and collaborate with them to produce training materials that are more relevant to their population. We strongly believe that the ideal delivery of relationship education occurs when (a) the individual delivering the curriculum is someone the participants can relate to and (b) the individual can provide examples and illustrations that are pertinent to clients' lives. It has been our experience that those persons are among the existing leaders in the community you are trying to reach. Because such individuals know their community best, they are invaluable contributors to producing materials that are going to be relevant to their community.

Recommendations for Working With Low-Income Couples and the Organizations That Serve Them

Much of the relationship education curricula has grown out of experiences with middle-income couples. However, the following factors have led to an increased likelihood that very low income couples will receive various forms of relationship marriage education: (a) the growth of the marriage movement, (b) the new and growing interest among government policy officials to address issues related to family formation and family fragmentation, (c) the specific emphasis within the welfare reform law enacted in 1996 to promote marriage and two-parent families, and (d) the current proposals in welfare reform reauthorization to provide substantial funding for healthy marriage promotion programs and activities (Stanley, Markman, et al., 2004). Increasingly, marriage education is being provided to people who have not typically been the recipients of such services. Not only are there these public policy forces promoting marriage and marriage education but low-income couples express a strong desire to become married and a willingness to participate in marriage education (Stanley, Amato, Johnson, & Markman, 2004).

In our ongoing experiences training trainers who work with diverse populations in research, clinical, and community settings, and in our general recognition that there is a need to disseminate marriage education to populations traditionally underserved by such services, we have created a set of broad guidelines we feel are important to consider when offering such services to low-income couples. These general ideas may be helpful for those who are in a position to modify an existing program or collaborate with community organizations and other institutions in trying to develop their own programs (for a more thorough review of these guidelines please see Stanley, Markman, et al., 2004).

Know your audience. It is important to understand types of relationships. Couples may be at various stages of commitment (married, planning to marry, not sure they will marry), with or without co-parenting responsibilities. In order to provide examples, metaphors, and stories that are relevant to your audience, it is useful to know what they are up against in supporting themselves and their loved ones.

Develop a broad understanding of what "marriage education" is or can be for your audience. Marriage education can be many things. It can be about helping someone understand the benefits of marriage, develop realistic expectations about marriage, and understand some of the key risk factors for marital and relationship distress. Depending on the commitment level of the couple or individual, marriage education can also be about helping someone learn ways to manage conflict more constructively within a current or future relationship.

Consider the various types of low-income clients and how you can best serve them. You may want to provide services to clients who are at various levels of commitment and relationship status. Some individuals may be married; others may want to work on improving their relationship with a once-intimate coparent; others will want to learn skills so they will feel more confident the next time a potential romance comes into their lives. High school age clients and young adults who are just beginning to engage in romantic relationships can also receive services.

Help your clients be aware of and link to a broad range of services that may be of additional help. When working with a low-income population, marriage education is ideally presented as part of a more comprehensive group of services. Clients should be made aware of marital, relationship, and family therapy services, mental health services, as well as financial support, domestic violence, and substance abuse treatment.

Pay careful attention to ways you can enhance the educational experience of your clients. When dealing with low-income clients, there can be a concern about making changes to the content of the curriculum. We would caution against delivering a watered-down version of the curriculum. It is important to focus on literacy, style of teaching, and format modifications that may help you retain client interest. Those who work with low-income clients recommend more active and experiential experiences as opposed to a didactic style: use fewer words, use less complicated words, try for less sitting and listening and more doing and activity, and use more visual images to make points. It will also be important to check in with your clients and attend to whether the message you meant for them to receive was actually received. In addition, low-income clients may benefit from more intensive services such as more training time, more practice and feedback, and more time for answering questions and applying the concepts to their lives.

Keep in mind the difference between implementing an educational curriculum and a program of services. We see a marriage education curriculum as best used within a larger program of services for low-income clients. It will be important to then have a good understanding of what overall plan of services is available to clients and how your curriculum fits into that plan. This can vary depending on whether you are working with clients in the context of ongoing services or based on a limited exposure to services. In addition, this may affect how clients are recruited for participation and whether there will be financial costs to participation in your marriage education service.

Recognize the dignity of your clients. When dealing with those who have less economic advantage, do not assume that their aspirations and needs are different from those who have more economic privilege. At the same time, it is important not to underestimate the challenges they face in reaching those aspirations and how you can use that knowledge to be most effective in your educational goals.

Conclusion

The next stage in marriage education is dissemination of interventions that have been shown to be efficacious in laboratory research. Not only is there a need to disseminate empirically based interventions to the community, but there is a need to study the effectiveness of that delivery. In our experiences delivering PREP to the community and conducting effectiveness research, we have identified several key factors that facilitate dissemination—for example, design-

ing a curriculum that is transferable through modularity and manualization, using leaders who have experience with couples and the target community, and taking advantage of existing institutions that are already serving couples.

In conclusion, with the high demand for marriage education in communities around the country, this is an exciting time in family psychology. At the same time, just as we used theory and research to guide us in our development of a marriage education curriculum, we must also use theory and research to guide us in delivering that education as effectively as possible.

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Clinical Forum

Selective Mutism in Children: A Synopsis of Characteristics, Assessment, and Treatment

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Selective mutism refers to a persistent failure to speak in public situations where speaking is expected, despite speaking in other situations (American Psychiatric Association, 2000). Many children with the disorder speak well at home but fail to speak in communal situations such as restaurants, malls, supermarkets, parks, and recreational settings. Selective mutism must last at least 1 month, so children who are hesitant to speak during the first month of school are excluded. The diagnosis also does not apply to youths who lack knowledge or comfort with the primary language spoken in the public situation. Children whose parents are non-English speakers, for example, may not qualify for a diagnosis of selective mutism unless the child is quite familiar with English and the disorder supersedes the language discrepancy (Vecchio & Kearney, in press).

Selective mutism affects about 0.2% to 2.0% of children, affects boys and girls equally, and typically begins between 3 and 6 years of age. Parents often delay treatment for the disorder, however, because their children speak well at home and because parents often attribute the problem to shyness. Unfortunately, failure to speak in public settings such as school can hinder a child's academic, social, or language development. In addition, many of these children cannot undergo intelligence and other formal testing that requires verbal interaction. Furthermore, selective mutism has a variable but sometimes chronic course (Andersson & Thomsen, 1998; Bergman, Piacentini, & McCracken, 2002; Black & Uhde, 1992; Ford, Sladeczeck, & Carlson, 1998; Kopp & Gillberg, 1997; Krysanski, 2003; Kumpulainen, Rasanen, Raaska, & Somppi, 1998; Remschmidt, Poller, Herpertz-Dahlmann, Hennighausen, & Gutenbrunner, 2001).

Children with selective mutism are commonly described as shy, timid, sensitive, withdrawn, fearful, inhibited, reticent, clingy, compulsive, anxious, and depressed. Indeed, anxiety disorders and depression are commonly comorbid with the condition. In addition, more than two thirds of children with selective mutism may meet criteria for a developmental disorder or delay (Bergman et al., 2002; Ford et al., 1998; Kopp & Gillberg, 1997; Kristensen, 2000, 2001; Kumpulainen et al., 1998; Steinhausen & Juzi, 1996).

Researchers are gravitating toward a consensus that selective mutism is linked to anxiety and shyness in general and to social anxiety in particular (Steinhausen & Juzi, 1996; Vecchio & Kearney, 2005). As such, behavioral assessment strategies and treatment strategies that rely on exposure-based practices and parent-based contingency management have been preferred. A brief review of our assessment and treatment plan for this population is presented here.

Assessment of Selective Mutism

A traditional assessment approach that relies heavily on formal testing is usually inadequate for youths with selective mutism unless nonverbal tests can be given or if a child is willing to engage an examiner verbally (often in the child's home). A behavioral assessment approach may therefore be more feasible. Our approach involves detailed discussions with parents and teachers and others who are knowledgeable of a child's status, though attempts are made as well to communicate with the child in a rudimentary way. Our primary measures for this population include structured diagnostic interview, parent- and teacher-based instruments, and behavioral observations and daily logs.

Structured interviews are sometimes used for this population, particularly the Anxiety Disorders Interview Schedule for *DSM-IV-TR* (child and parent versions) and Functional Diagnostic Profile adapted for selective mutism (Schill, Kratochwill, & Gardner, 1996; Vecchio & Kearney, 2005). The Anxiety Disorders Interview Schedule for *DSM-IV-TR* (Silverman & Albano, 1996) can be administered to parents and children for various anxiety-related disorders as well as selective mutism. The interview has excellent psychometric properties and is particularly useful for determining whether a particular child has selective mutism and whether such mutism is primarily related to social anxiety, oppositional behavior, depression, or even developmental delay. In our study that utilized this measure, all parents and one third of youths with selective mutism completed the interview. Some youths with selective mutism may be able to participate in an interview by responding nonverbally in a clinic setting or by responding verbally or nonverbally during a home visit. In addition to questions from the structured interview, we try to solicit information about the following key areas:

- settings that best represent a child's mutism;
- how the child's mutism is manifested in each setting;
- how long the mutism has occurred in each setting;
- the contextual variables that surround the child's mutism, such as who accompanies the child when he or she fails to speak to others;
- the specific antecedents and circumstances that surround each instance of a child's mutism, including desires to decrease anxiety, to increase social or sensory feedback from others, to avoid aversive directives from others, or because alternative speaking skills are inefficient or underdeveloped;
- whether a child can be enticed to speak audibly in any public situation;
- compensatory behaviors the child shows to communicate with others;
- how significant others respond to a child's mutism, such as ordering food or completing tasks for the child, allowing whispers in the ear or pointing, or rearranging a setting to accommodate a child's mutism.

Although behavioral questionnaires have not been developed for selective mutism per se, child self-report measures of social anxiety may be quite pertinent. Prominent measures in this regard include the (a) Social Anxiety Scale for Children–Revised, a 26-item instrument that focuses on fear of negative evaluation from peers, social avoidance and distress related to new situations, and generalized social avoidance and distress (La Greca & Stone, 1993), and (b) the Social Phobia and Anxiety Inventory for Children, which focuses on assertiveness, general conversation, physical and cognitive symptoms, avoidance, and public performance (Beidel, Turner, & Fink, 1996). Other measures of general anxiety and depression may also apply to a particular child

with selective mutism. Parents and teachers may also be asked to complete general measures of internalizing and externalizing behavior problems, and the Child Behavior Checklist and Teacher Report Form contain the item "refuses to talk" (Achenbach & Rescorla, 2001).

Behavioral observations are especially important for evaluating children with selective mutism. Such observations may be conducted in the clinical setting, at the child's home, over the telephone, in various public places, and at the child's school. During our observations, we concentrate on the following: number of words spoken; volume level of spoken words, such as audible or inaudible; to whom a child is willing to speak; key antecedents such as demands or requests from others; key consequences such as parent or teacher acquiescence or accommodation of a child's mutism; child's social and communicative skills; child's level of anxiety as indicated by escape, withdrawal, or avoidance; and child's compensatory behaviors such as whispering, pointing, nodding, mouthing, frowning, crying, stomping, temper tantrum, pushing, or pulling.

We utilize daily logs as well to monitor fluctuations in a child's behavior and whether treatment procedures are progressing effectively. Our logs are relatively simple and completed by children, parents, and teachers. Each party completes daily records of a child's level of anxiety on a 0-to-10 scale as well as number of words spoken, whispered, and mouthed. Audibility of statements is also rated. In addition, each party records to whom a child spoke, whispered, or mouthed any particular word.

Treatment of Selective Mutism

Given that selective mutism is commonly associated with social anxiety and with accommodation from others, we prefer an exposure-based and contingency management approach. Exposure-based practices are designed to increase a child's audible speech in public places and contingency management is designed to enhance these exposures and establish an expectancy that a child will speak in public situations.

In vivo exposure to various situations is utilized so that a child can practice speaking to others. This process is typically a very gradual one that covers several main stages: child's home (with the therapist), clinical setting, public nonschool situations, and school situations. Home visits are often conducted first so that a child becomes comfortable interacting with the therapist. These visits often involve playing games with the child to build rapport and decrease anxiety. As rapport is developed, the therapist may purposely make mistakes that the child will try to correct nonverbally. These nonverbal attempts are ignored or the therapist will prompt spoken words, whispers in the ear, or other barely audible speech.

Parents may also be asked to audiotape or videotape their child at home as he or she engages in good speech. The audiotape or videotape is then played before the therapist and family members as the child watches and is reinforced by the therapist for appropriate speech and voice. Early exposures also include telephone conversations between the child and therapist, speaking to the therapist through a door, speaking to the therapist from some distance such as 50 feet away, or speaking to the therapist via cell phone. In some cases, children may also be asked to stay with a therapist for an extended period of time until at least one word is uttered.

Once a child with selective mutism can speak regularly to the therapist, exposures are scheduled for public situations such as restaurants, ice cream places, pet stores, malls, parks, and playgrounds. Children are expected to order their own food, ask questions, answer questions from others, and initiate short conversations under the supervision of the therapist and parents. A therapist can accompany the family to help prompt the child to speak and to model appropriate interactions with others. These exposures are often supplemented with instructions to answer the telephone or door as appropriate, talk to visiting relatives, and initiate telephone calls to the therapist or others. Exposures in this stage of treatment can cover several weeks or months.

Once a child can speak regularly and appropriately in public and home-based situations, school-based exposures can begin. As a transition from previous exposures, a child is required first to speak to the therapist in an empty classroom. Once this is accomplished, a peer or teacher is added to the room at a distance as the child speaks to the therapist or reads a story. Over time more peers may be added, and at a closer distance, to resemble normal classroom activity. Final exposures should involve speaking to others audibly, initiating contact with peers and teachers, answering questions in class, taking standardized tests that require verbal interaction, and reading stories or otherwise performing before others.

Contingency management is the other key element for treating children with selective mutism. Appropriate consequences are established for completing (or not completing) therapeutic homework assignments that require a child to speak audibly to others. Parents are also asked to establish routines that encourage a child to encounter others and to speak to others appropriately. Examples include accepting a call from the therapist or family members, asking a child to say hello to someone in public, or taking a child to recreational activities that require some social interaction.

Parents are also encouraged to engage in short, specific commands to their children and to ignore inappropriate compensatory behaviors, especially as treatment progresses. As a child with mutism speaks more comfortably in public situations, social reinforcers can replace tangible reinforcers. Parents are encouraged as well, even when a child successfully speaks in all public and school-related situations, to continue to place their child in interactive settings and restrict accommodations for unwillingness to speak. Teachers are also instructed to engage in appropriate contingency management during and following treatment. Clinicians should bear in mind that addressing selective mutism can be an extensive and time-consuming process that usually requires assessment and intervention in various public settings.

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Lighter Side

The Lighter Side of . . . Professional Development: A Response to Taylor et al.

Herman Stickleback, *University of Munster*

In their recent articles in *the Behavior Therapist*, Taylor and colleagues (Taylor, Abramowitz, McKay, Stewart, & Asmundson, 2006; Taylor, McKay, Abramowitz, Asmundson, & Stewart, 2006) offered a number of useful recommendations for how students and new faculty can succeed at academic publishing. Taylor et al. also noted that the goal of their articles was not necessarily to be comprehensive, but simply to offer some perspectives that may stimulate dialogue on the topic. Accordingly, I would like to offer some of my own views, based on my long and distinguished career in academia.

I was frankly surprised that Taylor et al. ignored one of the most important keys to academic success—self-citation. In their works, authors should strive to cite as many of their other articles as possible, in order to enlighten colleagues about their important findings and psychological insights. I advise my students to use a minimum of 12 self-citations in each of their articles. If you haven't published that many articles, then you can cite conference presentations, memos, and letters to faculty, friends, or relatives (cited as "personal communications"). Another vital self-citation tool is to cite your "in preparation" works. The beauty of this approach is that you only need to have a vague idea and a title for a forthcoming paper. Once that's done, your paper is officially "in preparation." Also, your self-citations will look a lot more impressive if the "under review" papers have been submitted to highly prestigious journals. I first send all of my "under review" papers to *Science* or *Nature*, even though they usually end up being published in *Psychological Reports*.

If students and new faculty follow these recommendations, they can be sure of making a name for themselves. For further discussion of the important topic of self-citation, see Stickleback (1964, 1972, 1980, 1994a, b, c, d, 2004, 2006, and in-preparation a, b, c, d, e to z). Also see Ellis (1962, 1970, 1988a, b, c, 1990, 1995, 2001a, b, 2004).

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now forming

Neurocognitive Therapies/Translational Research SIG

The Neurocognitive Therapies/Translational Research SIG seeks to bridge the gap between basic and applied science in understanding the nature and treatment of psychiatric disorders. We are interested in multidisciplinary research and the application of cognitive and affective neuroscience to improve the conceptualization and effectiveness of interventions. Researchers and practitioners in this SIG are interested in brain imaging, neuropsychological and cognitive training, and related techniques as tools for increasing our understanding of anxiety, depression, addictions, schizophrenia, ADHD, and other disorders. Those interested should contact Jan Mohlman: jmohlman@rci.rutgers.edu.

Lighter Side

Please Don't Tell My Mother I Am a Psychologist. She Still Thinks I Play the Piano in a Brothel*

Elizabeth L. Moore, *Mayo Clinic*

Recently I became friends with a chemical engineer. I know this is typically a sign of desperation, but she's actually very nice. She noted one day that, in her experience, mentioning her profession at a social engagement is the single most effective way to snuff out small talk. People abruptly excuse themselves as they suddenly notice an old friend by the punch bowl, remember they left the stove on at home, etc. It brought to mind how very different things are for us as psychologists. Party guests flock to a psychologist like housewives to a Dr. Phil book-signing. Any other entertainment falls by the wayside. "Twister with supermodels in bikinis anyone? Hey no, wait, we've got a psychologist over here!" Folks seem to have two main types of interest. There's the "I've got a friend whose aunt's cousin's gardener [insert odd behavior here, e.g., can't throw anything away, has 17 cats, only speaks in rhyme]; and the "Wow, so what do you know about [insert unempirical and/or pop psychology topic here, e.g., multiple personalities, split personality, schizophrenia (meaning multiple/split personalities)]? And of course, no party would be complete without being asked to hypnotize someone, interpret a dream, or infer some profound insight based on the contents of a wallet or one's outfit. As a professional who has completed roughly 3,000 years of school, I refuse to engage in such degrading parlor games unless I am offered the standard $3.95 per minute, which all entertainers of such quality receive.

Given the number of parties I have had derailed by such attention, I have taken the liberty to design a fool-proof response plan to stymie such assaults.

1. If someone introduces you as being in psychology, you reply, "Oh, no, I'm sorry you misunderstood: I'm *in therapy—a lot* of it! It takes a long time to get rid of as many personalities as I have."

2. If you are unavoidably pinned down as a psychologist, immediately begin describing your dissertation. Five minutes on your methods section and data analytic strategy should induce a coma in the most pesky party-goer. (I have personally used this strategy on airplanes where it is very hard to make someone actually go away. I have found that my dissertation can at least cause them to go away psychologically—which is good enough.)

3. And most effective, if you have the good fortune of being able to introduce yourself, say you're a chemical engineer.

ACKNOWLEDGMENT

I would like to name my first-born child after Dr. Kelly G. Wilson for his careful editorial work on this manuscript. Without the countless minutes he devoted, seeking out qualified reviewers, correcting spelling errors, and completing sentences, this article might never have seen print.

ADDRESS ORRESPONDECNCE TO Elizabeth Moore, Mayo Clinic, 911 41st St. NW, Rochester, MN 55901. ✍

*The title of this article was attributed to a psychologist of some note. However, having not been able to corroborate the source, we will leave that individual's name unbesmirched by citation.

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CALLS *for* EDITORS

Calling candidates for EDITOR of *Cognitive and Behavioral Practice*

Volumes 16–19. The official term for the Editor is January 1, 2009, to December 31, 2012, but the Editor-Elect should be prepared to begin handling manuscripts approximately 1 year prior.

Letters of intent due by July 1, 2006. Vision letters will be required by August 15, 2006.

Calling candidates for EDITOR of *the Behavior Therapist*

Volumes 31–33. The official term for the Editor is January 1, 2008, to December 31, 2010, but the Editor-Elect should be prepared to begin handling manuscripts approximately 1 year prior.

Letters of intent due by July 15, 2006. Vision letters will be required by August 15, 2006.

Candidates should send a letter of intent and a copy of their CV to Judy Favell, Ph.D., Publications Coordinator, ABCT, 305 Seventh Avenue, New York, NY 10001-6008, or via e-mail to teisler@abct.org.

Candidates will be asked to prepare a vision letter in support of their candidacy. David Teisler, ABCT's Director of Publications, will provide you with more details on the selection process as well duties and responsibilities of the Editor. Letters of support or recommendation are discouraged. However, candidates should have secured the support of their institution.

Questions about the responsibilities and duties of the Editor or about the selection process can be directed to David Teisler at the above email address or, by phone, at (212) 647-1890.

Book Review

Sarwer, D. B., Pruzinsky, T., Cash, T. F., Goldwyn, R. M., Persing, J. A., & Whitaker, L. A. (Eds.). (2005). *Psychological Aspects of Reconstructive and Cosmetic Plastic Surgery: Clinical, Empirical, and Ethical Perspectives*. Philadelphia: Lippincott Williams & Wilkins

Reviewed by Leslie J. Heinberg, *Case Western Reserve University School of Medicine*

If there was ever any doubt about the need for this text, it disappeared the first evening I eagerly began reading this multidisciplinary overview. My husband was in the next room flipping through channels and briefly stopped on *Dr. 90210*, *Plastic Surgery: Before and After*, and a *Nip/Tuck* rerun. Three programs glamorizing plastic surgery ran concurrently. More recently, the public has been captivated by the news reports of the first face transplant recipient in France while last television season, the water-cooler talk revolved around *The Swan* and *Extreme Makeover*. Obviously, reconstructive and cosmetic surgery has entered the public's consciousness at an amazing rate in the last few years. Concurrently, there has been an explosion in the popularity and acceptability of plastic and cosmetic surgery—with over 13.5 million plastic surgical procedures performed in 2004 (American Society of Plastic Surgeons, 2005). Unfortunately for professionals seeking guidance in the face of this unprecedented increase, the last textbook on the subject of psychological aspects of this type of surgery was published 25 years ago. The current text aspires to provide a comprehensive and practical review of the scientific and clinical literature on the psychological aspects of plastic surgery. Although primarily written for plastic surgeons, it is likely of great interest to psychologists, psychiatrists, and other professionals interested in the psychological life of plastic surgery patients.

The editorial team combines the expertise of three psychologists and three plastic surgeons. The psychologist editors (Drs. Sarwer, Pruzinsky, and Cash) represent individuals who have consistently performed seminal and outstanding work in the intersecting fields of body image, plastic and reconstructive surgery, and psychology. I can not imagine a better team of researchers to lead this ambitious endeavor. Similarly, the chapter authors selected by the editorial team represent clinical and empirical leaders within their subspecialties. Chapters provide in-depth literature reviews, practical guidelines, and case examples. Most chapters conclude with questionnaires and structured interviews that may be copied (with the express permission of the publisher) for use with patients and their families.

The book (and this review) is divided into four sections: (1) understanding the psychology of plastic surgery; (2) psychological perspectives on reconstructive surgery; (3) psychological perspectives on cosmetic surgery; and (4) ethical and professional issues in plastic surgery.

The first section of the book, understanding the psychology of plastic surgery, begins with an overview of the history of plastic surgery, its growing popularity, and the need for close collaboration between mental health professionals and plastic surgeons. Next, Dr. Goldwyn discusses potentially problematic patients from a psychological perspective. Interestingly, he goes beyond the usual discussion of patients with comorbid psychological complaints to include the challenges of the VIP patient, the perfectionistic patient, and the patient who appeals to the surgeon's ego. The next chapter provides a concise review of the very large literature on psychology of physical attractiveness and the sociocultural influences on physical appearance while summarizing the findings in relation to plastic surgery. The next chapter in this section, authored by Tom Cash, provides an overview of the extant body image literature, again with an overarching focus on plastic surgery. The epidemiology of body image discontent, the historical and developmental determinants of body image and the various etiological theories (with a cognitive-behavioral model) are reviewed. Body image disturbances, disorders, and consequences are also briefly addressed. Most importantly, Cash reviews his CBT program for negative body image. Although conceding that the audience is unlikely to see this as an alternative to plastic surgery, I would have liked to have seen the authors more strongly emphasize the importance of this type of CBT as adjunctive to plastic surgery—particularly for troubled patients. The effectiveness of this type of treatment is well-established but, quite likely, relatively unknown to medical professionals.

Psychological perspectives on reconstructive surgery are reviewed in the second section of the book. Excellent discussions are offered on psychological adjustment, clinical care, and surgical care for craniofacial conditions, pediatric and adult burn injuries, as well as patients with facial trauma, facial cancers, and hand trauma. More controversial issues such as breast augmentation and genital reconstruction/gender identity disorder are addressed in chapters within this section. The need for social skills intervention to address stigma and other interpersonal challenges confronted by persons with pain and disfigurement are also reviewed. A broad array of questionnaires and measures is provided and clinical case examples help illustrate the research findings. More than any other part of the book, this section may present difficulties for the mental health professional without a medical background. Many of the descriptions are highly technical and require a medical dictionary to fully appreciate the conditions and interventions described by the authors. Although most readers will read specific chapters of interest in the text, when read chapter by chapter, some sections are repetitive (e.g., PTSD) and could have benefited from greater cross-referencing to other sections.

The third section, psychological perspectives on cosmetic surgery, reviews the findings from the psychological literature on cosmetic surgery of the face and body. A history of psychological studies is divided into first-, second-, and third-generation studies. This delineation illustrates the disparate conclusions that have been reached as the methodology, reliability, and validity of assessment has improved. Thus, although plastic surgery was originally conceptualized as highly pathological when examined 50 years ago from the psychodynamic perspective, more recent studies demonstrate some psychological benefits

for some types of plastic surgery (e.g., decreased postoperative anxiety and neuroticism scores in facial cosmetic surgery patients). Further, the very interesting epidemiological link between breast augmentation and suicide is reviewed. This section also includes an in-depth overview of body dysmorphic disorder and how it may present in a plastic surgery practice. This section concludes with an admirable overview of psychological assessment of cosmetic surgery. It provides helpful guidelines for assessing motivations and expectations, when to refer for psychological evaluation and how to motivate patients to comply with psychological referrals. Although providing a rough outline of topics to be assessed, mental health clinicians would have benefited from more in-depth information on how to conduct such an evaluation.

The final section of the book, ethical and professional issues in plastic surgery, provides a fascinating overview of the complex ethical questions surrounding both reconstructive and cosmetic surgery (e.g., "When is enough, enough?"). This section provides numerous illustrative case examples that demonstrate the difficulty of always "doing no harm." This section is written for surgeons but will be highly valuable for psychologists and other professionals who need to assess competence and help ensure informed consent in these populations.

The editors state that the book has one primary goal: "to summarize what is currently known about the psychological experience of reconstructive and cosmetic surgery patients so that plastic surgeons can more effectively help patients reduce their emotional distress and attain the highest quality of life possible" (p. ix). I emphatically believe that the editors have achieved their stated goal. Similarly, it should help psychologists and other mental health professionals to more effectively treat these patients as well, although it is not written expressly for this audience. Nevertheless, the text is an outstanding resource for mental health researchers and clinicians interested in health psychology, body image, or the psychology of physical appearance. For those unfamiliar with reconstructive or cosmetic surgery, this book provides a wealth of information and guidance on psychological issues affecting these patients, appropriate assessment, treatment, and follow-up. However, even individuals who have worked with these populations in the past will likely find that *Psychological Aspects of Reconstructive and Cosmetic Plastic Surgery: Clinical, Empirical, and Ethical Perspectives* provides them with valuable and up-to-date information that may be used in their research or clinical practice.

Reference

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Book Review

N. Kazantsis, F. P. Deane, K. R. Ronan, and L. L'Abate (Eds.) (2005). *Using Homework Assignments in Cognitive Behavior Therapy.* New York: Routledge

Reviewed by Keith S. Dobson, *University of Calgary*

Everyone knows that an integral part of CBT is the use of homework: What clients do between treatment sessions is just as important, perhaps even more important, than what happens in the actual session. The translation of ideas learned in treatment sessions into practical and concrete exercises is part of the behavioral heritage of CBT. The use of homework is also a reflection of the desire of most CBT therapists to have real-world consequences for the client, with the goal of solving actual life problems. Yet, remarkably little is known about how CBT therapists actually engage in the process of structuring homework assignments, whether the nature of homework makes a practical difference in treatment outcome, or how to optimize the use of homework within an overall CBT framework.

Using Homework Assignments in Cognitive Behavior Therapy was produced by a group of scholars with an interest in the promotion of optimal homework in CBT. They have formed the Cognitive Behavior Therapy Homework Project to study this process. The current volume is related to this overarching interest. It seeks to pull together both conceptual and practical discussions related to both the theory and practice of homework in CBT. Thus, the first three chapters review models for evaluating the importance of homework, what is known about the importance of homework in both outcome and process research, and the clinical implications that can be drawn from the literature to date. The main body of the volume comprises 12 chapters that highlight the importance of homework in different populations (children, adolescents, older adults, couples, families) and patient populations (panic, agoraphobia and generalized anxiety, obsessions and compulsions, depression, substance abuse, delusions and hallucinations, sexual problems, borderline traits). Each of these chapters generally outlines the conceptual and practical issues in the assignment and monitoring of homework and then provides clinical suggestions and case materials to help the reader understand how to optimally implement homework assignments. The next two chapters provide "A guiding model for practice," which reflects an effort to distill the ideas represented in the previous chapters into an integrative framework, and a final chapter focuses on the (many) areas for further theory, research, and practice developments.

The outline of the book is sound. The conceptual flow, from a broad discussion of conceptual issues to a more focused review of specific client populations and ending with an integration and summary, makes great sense. I found the 12 clinically focused chapters to be generally thoughtful, and the ideas for practice to be helpful. There was a fair bit of overlap in these chapters, which on the one hand could be taken as a limitation of the book, and which on the other hand underscores how the principles of CBT can be applied fairly consistently across diverse problems and populations. Some of the authors wrote more formally, whereas others were informal and provided therapist-client dialogues to personalize the ways that homework derived from in-session processes. Because the different writing styles made it somewhat more difficult to compare and contrast the approaches taken by the various contributors, I would have appreciated some more uniformity among the various chapters. An alternative would be to include a chapter distilling the elements from the previous

chapters and identifying which homework issues are common or unique among the different client types and problems (but I would not want to be the person to attempt this challenge!). Overall, the writing of these chapters is strong, the citations are current, and there are many good ideas embedded in these chapters.

In contrast to a summary of the common and unique aspects of homework for various disorders and populations, Chapter 17 offers a summary of the conceptual and practical issues associated with homework in CBT and a description of the approach being taken by the Cognitive Behavior Therapy Homework Project to study this phenomenon. To my mind, this chapter is the real pearl in this oyster for the reader is seeking a general model for practice. This chapter also provides a series of practical ideas for optimizing homework in clinical practice and evaluation strategies for determining the additive value of different types of homework with an individual client.

Overall, *Using Homework Assignments in Cognitive Behavior Therapy* is a strong contribution to the literature. This book presents expertise from some of the best CBT minds in the world on this topic, and provides a thoughtful and relatively efficient discussion of the theoretical and practical issues associated with CBT homework. I believe that students and relatively junior therapists will find very practical ideas in this book about how to structure and follow through with homework assignments. More seasoned CBT therapists will be forced to consider if their homework practices measure up to what the available evidence suggests. This volume also provides challenges to some aspects of how homework is practiced in CBT. Throughout the book, there are also many germinal ideas for process and outcome research (many of which are highlighted in the last chapter). So, for many reasons, this book has much to recommend itself. ✍

At ABCT

Find-a-Therapist

Ensure a Productive Summer: Utilize Find-a-Therapist to Increase Summer Referrals

Summer is a traditionally slower time for clinicians as both patients and referral sources are often away on vacation. Utilizing the Find-a-Therapist feature on ABCT's Web site can ensure your practice is visible to the general public and can provide a valuable source of new patients. Spending a few minutes to update your listing will save you time and energy you can apply toward grilling, fishing, and other summer pursuits!

• • •

As ABCT's 40th anniversary approaches, we prepare to celebrate those individuals who have been loyal members since the early years of ABCT. Look for the "Featured Therapist" series coming soon on ABCT's Web site. This series will highlight different ABCT members and their professional careers, including their contributions to the field of cognitive and behavioral psychology, research, and clinical practice.

Remember: For most changes to your listing in Find-a-Therapist, you can log in and make edits yourself. For licensure and credentialing changes, or to subscribe to Practice Particulars, please contact ABCT at (212) 647-1890.

Featured Therapist

The Clinical Directory and Referral Committee is pleased to announce an exciting new feature. Each month the committee will acknowledge and highlight the work of one clinician from the Find-a-Therapist section of ABCT's Web site. The committee will select members who utilize evidence-based therapies in their practice. The goal is to educate the public users of the Find-a-Therapist site on the benefits of the behavioral and cognitive therapies. The Featured Therapist Web page will include a picture of the therapist, a brief biographical sketch, and the therapist's answers to a series of questions. These questions will cull information about the therapist's professional development, promotion of their practice, practice tips, personal details, and ways the therapist utilizes ABCT.

During the first year the committee would like to recognize therapists who are long-standing members of ABCT. In subsequent years the committee would like to select therapists from different specialties, geographic areas, and therapists who work with underserved or special populations. In conjunction with the ABCT's 40th anniversary celebration, the committee is pleased to announce the selection of Leo J. Reyna, Ph.D. as the first featured therapist. Dr. Reyna has been a member of ABCT since 1966. Please check the Find-a-Therapist Web page each month for a new featured therapist. ✍

Summer Tip

Find lower fares for flights to the ABCT conference in Chicago by booking early.

2006 ABCT ELECTION RESULTS

They will take office Saturday, Nov. 18, 2006, at the Annual Meeting of Members

Anne Marie Albano, Ph.D. President-Elect (2006–07)

Robert K. Klepac, Ph.D. Representative-at-Large (2006–09)

George F. Ronan, Ph.D. Secretary-Treasurer (2006–2010)

Report to ABCT of Specialty Activities in Professional Psychology from ABCT's Committee on Specialization in Behavioral and Cognitive Therapies Within Various Professions (Specialization Ad Hoc Committee)

Kevin D. Arnold, Chair, *ABCT Specialization Ad Hoc Committee* and *President, Behavioral Psychology Specialty Council*

Activities of the Council of Specialties in Professional Psychology (CoSPP)

ABCT's Specialization Ad Hoc Committee serves as a liaison to national groups that have specialty in behavioral or cognitive therapies as a part of their work. The Council of Specialties (COS) is one such group in professional psychology that coordinates specialty areas and represents them to other organizations. The Specialization Ad Hoc Committee is involved with COS through representation on the Behavioral Psychology Specialty Council. One role of the Specialization Ad Hoc Committee is to provide information about actions or trends that affect ABCT's members and the specialty of behavioral and cognitive therapies.

The COS had its most recent meeting in November 2005 in Washington, DC. Several important actions were taken that have relevance, particularly for ABCT's psychologist members. COS formally opposed a proposal at the American Psychological Association (APA) that would have potentially created an entity in APA that would have credentialed specialties. Presently, APA has as one of its functions the recognition of specialty areas, along with recognition of proficiencies in professional psychology. The movement into expansion beyond recognition of areas and into the possible credentialing of specialists was opposed in a letter to APA. As stated in the COS presidential highlights, "CoSPP has proposed that an interorganizational effort to ensure that competency-based criteria for specialty certification be developed in order to protect the public. The criteria should include a single certification board per specialty. . . ." This position from COS would lead APA to identify boards such as the American Board of Cognitive and Behavioral Psychology as solely responsible for credentialing professional psychologists in behavioral and cognitive therapies.

Another important action at the meeting was the endorsement of the Committee on Accreditation's new policy and procedures that establish mechanisms for all recognized specialties to apply for accreditation of their postdoctoral residency programs. Prior to the new policy and procedures, the areas of clinical, counseling, and school psychology were largely the only areas able to apply for accreditation. Now, the other specialties, including behavioral psychology, have a mechanism to have nationally recognized accreditation for their residency programs. This step is another in the formal recognition of areas such as behavioral and cognitive therapies in professional psychology.

Actions Taken by the Behavioral Psychology Specialty Council (BPSC)

The BPSC held a meeting via teleconference in February 2006. It welcomed new representatives from Division 25 of APA (Michael Dougher), the Association for Behavior Analysis (Janet Twyman), and the American Board of Cognitive and Behavioral Psychology (Arthur Freeman). The BPSC affirmed the importance of both applied behavioral analysis and of behavioral and cognitive therapies as general subspecialty areas within behavioral psychology. The BPSC also reviewed revisions to the draft of its Education and Training Guidelines, including the addition of diversity and a correction to language. The general consensus was that the Education and Training Guidelines were positioned for approval from the BPSC, and it is anticipated that the approval will be forthcoming. Once approved, these guidelines will proceed through a vetting process that will culminate in their use by the Committee on Accreditation as the basis for establishing accredited postdoctoral residency training in behavioral psychology. The BPSC also established two face-to-face meeting dates, one in 2006 at ABCT, and the other in 2008 at the ABA convention. The next major activity of the BPSC will be the revision and submission of the renewal application to the APA Commission for Recognition of Specialties and Proficiencies in Professional Psychology. It is anticipated that the renewal application will include language to broaden the name of the specialty to include both behavioral and cognitive psychology.

Formalization of the Specialization Ad Hoc Committee Members

Presently, the Specialization Ad Hoc Committee has established several members in its initial year. Arthur Freeman, E. Thomas Dowd, Robert Klepac, and Sharon Morgillo Freeman have graciously agreed to serve. While Drs. Freeman, Dowd, and Klepac represent various specialty groups in psychology, Dr. Morgillo Freeman represents nursing and is certified by the Advanced Practice Registered Nurses Board. The Specialization Ad Hoc Committee continues to invite participation, particularly from ABCT members who are psychiatrists, social workers, and counselors.

Please contact Kevin Arnold at kda1757@earthlink.net to join the committee and contribute to this important work. If you are interested, please place Specialization Committee in the "Re" of the e-mail. ✍

Can Your Colleagues Find You?

Be sure your ABCT Membership Directory is UP TO DATE with all your contact information. We've added new specialties and updated the SIGs listing. Be visible to your colleagues; visit www.abct.org and click the Membership Directory

➤ *link* ◄

Classifieds

positions available

POSTDOCTORAL FELLOW POSITION, starting August 1, 2006, for at least one year and possibly longer, at UCLA, Department of Psychology. Position involves coordination of a NIMH prospective longitudinal evaluation of risk factors for emotional disorders in adolescents, including diagnostic, life stress, symptom, cortisol, information processing and laboratory assessments. Send statement and references to Michelle G. Craske, Ph.D. at craske@psych.ucla.edu.

CLINICAL DIRECTOR (Northern, NJ). Devereux, "The Employer of Choice," is a leader in providing services to individuals with behavioral, developmental, and/or emotional disabilities. The Clinical Director is responsible for the clinical oversight of the behavioral health operations, to include children, adolescents residing in community-based programs in northern and central NJ. Duties include consultation, training, evaluation and supervision of clinical staff. ABA exp. is desired. Doctorate degree in psychology or an MSW licensed in NJ. 3 years experience supervising and/or coordinating clinical services for Behavioral Health populations. State travel required. E-mail: hrfreehold@devereux.org; Fax: 732-625-2975. Drug-free workplace/testing required AA/EOE

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POSTDOCTORAL FELLOWSHIPS IN ALCOHOL ETIOLOGY AND TREATMENT. The Research Institute on Addictions (RIA), a research component of the University at Buffalo, The State University of New York, has multiple openings for NIAAA-funded postdoctoral fellows in alcohol etiology and treatment. The program provides specialized postdoctoral training for individuals seeking to pursue a career in alcohol research. The interdisciplinary training program emphasizes two primary areas: (1) etiology and course of alcohol use and misuse and (2) treatment for alcohol use disorders. Fellows develop and pursue research interests under the supervision of faculty preceptors. Seminars on alcohol use disorders, current alcohol research, grant writing, and professional issues and career development are an integral part of the training program. A start date is negotiable. Established in 1970, RIA has a staff of over 180 persons working on over 30 separate research projects. RIA occupies a five-story building, and offers outstanding resources in support of its research endeavors. Visit the RIA Web site at http://www.ria.buffalo.edu. Inquiries can be made to either Gerard J. Connors (connors@ria.buffalo.edu) or R. Lorraine Collins (collins@ria.buffalo.edu), Co-training Directors. Applicants should forward a vita, representative reprints, letters of reference, and a cover letter describing research interests and training goals to: Alcohol Research Postdoctoral Training Committee, Attn: G. Connors and R. L. Collins, Research Institute on Addictions, 1021 Main St., Buffalo, NY 14203. Applications from minority candidates are particularly welcome. Applicants must be citizens or noncitizen nationals of the U.S. or must have been lawfully admitted for permanent residence. AA/EOE.

IMMEDIATE OPENING for clinical/behavioral medicine psychologist in busy, well-established private practice in Lake Charles, LA. Contact Cindy at cindyperritt@bellsouth.net.

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Behavior Therapy 37(3)

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- MACKINTOSH et al. Induced Biases in Emotional Interpretation Influence Stress Vulnerability and Endure Despite Changes in Context
- HIRSCH et al. Imagery and Interpretations in Social Phobia: Support for the Combined Cognitive Biases Hypothesis
- HOLMES, et al. Positive Interpretation Training: Effects of Mental Imagery Versus Verbal Training on Positive Mood
- REE & HARVEY. Interpretive Biases in Chronic Insomnia: An Investigation Using a Priming Paradigm
- HERTEL & EL-MESSIDI. Am I Blue? Depressed Mood and the Consequences of Self-Focus for the Interpretation and Recall of Ambiguous Words
- JOORMANN et al. Adaptive and Maladaptive Components of Rumination? Diagnostic Specificity and Relation to Depressive Biases
- MOBERLY & WATKINS. Processing Mode Influences the Relationship Between Trait Rumination and Emotional Vulnerability
- GORTNER et al. Benefits of Expressive Writing in Lowering Rumination and Depressive Symptoms
- VAN DEN ELZEN & MACLEOD. Facilitated Cognitive Disengagement in Depression
- MATHEWS. Towards an Experimental Cognitive Science of CBT

Cognitive and Behavioral Practice 13(3)

- HOFMANN et al. Full Steam Ahead: An Editorial Update

Commentaries

- ASMUNDSON & HADJISTAVROPOLOUS. Acceptance and Commitment Therapy in the Rehabilitation of a Girl With Chronic Idiopathic Pain: Are We Breaking New Ground?
- McCRACKEN. Toward a Fully Functional, Flexible, and Defused Approach to Pain in Young People
- HAYES & DUCKWORTH. Acceptance and Commitment Therapy and Traditional Cognitive Behavior Therapy Approaches to Pain
- RUDD & TROTTER. The Elaboration and Evolution of CBT: A Familiar Foundation and Creative Application With Chronic Pain

Regular Articles

- OSTAFIN et al. Intensive Mindfulness Training and the Reduction of Psychological Distress: A Preliminary Study
- HUPPERT et al. The Interaction of Motivation and Therapist Adherence Predicts Outcome in Cognitive Behavioral Therapy for Panic Disorder: Preliminary Findings
- CHAPMAN et al. Stop-Think-Relax: An Adapted Self-Control Training Strategy for Individuals With Mental Retardation and Coexisting Psychiatric Illness
- MOUTON-ODUM et al. StopPulling.com: An Interactive, Self-Help Program for Trichotillomania
- SLOAN & MARX. Exposure Through Written Emotional Disclosure: Two Case Examples

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40 years

ABCT

EVIDENCE SUPPORTED TREATMENT

Who is this guy?

He wrote:

"Charting progress is a task not merely for historians but also for planners. We could plan better the type of research we want or believe is needed and try to move toward that. . . . What do we wish to know about therapy and its effects? What do we already know?" (2000)

The first 11 people to respond with the correct answer will receive a piece of ABCT history: a letter (carbon copy; dated 1976) from Cyril Franks and his associate editors (one of whom was the guy in the photo above), inviting various luminaries to serve on the board of the journal *Behavior Therapy*.

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)

Workshops

- Natural Setting Therapeutic Management: A Multiple-Model Approach to Maintain Individuals With Developmental Disabilities and Severe Behaviors in Community Settings [Petronko, Kormann, & DiDomenico]
- CBT for Adolescent Depression: A Modular Treatment Approach [Reinecke, Curry, & Albano]
- Advanced Cognitive Processing Therapy [Resick & Monson]
- Acceptance and Commitment Therapy With the Difficult Client [Strosahl & Hayes]
- Applications of Dialectical Behavior Therapy to Trauma-Related Problems [Wagner & Rizvi]
- Recent Advances in the Assessment and Cognitive Treatment of OCD [Wilhelm & Steketee]
- Using Cognitive-Behavioral Treatment Techniques With Eating Disorder Patients [Wisniewski & Becker]
- Group CBT for Diverse Populations: The San Francisco General Hospital Depression Treatment Manuals [Muñoz et al.]
- *The Ethical Principles and Code of Conduct for Psychologists*: Clinical, Assessment and Forensic Issues [Neil H. Pliskin]
- Research in Schools and Communities: Getting In and Staying In [Atkins & Frazier]
- Teaching Cognitive Behavior Therapy to Psychiatric Residents [Beck & Sudak]
- Psychotherapy Integration: Possible Strategies to Improve Cognitive-Behavior Therapy [Castonguay, Safran, & Goldfried]
- How to Use Appetite Awareness Training to Enhance Treatment for Eating and Weight Concerns [Craighead, Hill, & Smith]
- Matching Intervention Strategies to the Process of Addictive and Health Behavior Change [DiClemente]
- Cognitive-Behavioral Couple Therapy for Domestic Abuse [Epstein, LaTaillade, & Werlinich]
- Acceptance and Commitment Therapy for Anxiety Disorders [Forsyth & Eifert]
- Improving Cognitive Behavior Therapy With Challenging Children and Families [Friedberg]
- Schematic Mismatch in the Therapeutic Relationship: Using Roadblocks as Opportunities for Change [Leahy]
- Behavioral Activation in Treatment for Depression [Martell, Dimidjian, & Herman-Dunn]
- Beyond Stimulus Control: How to Translate State-of-the-Art Research Into Effective Clinical Management of Insomnia [Morin, Edinger, & Carney]
- State of Practice Update: Family Therapy for Major Mental Illnesses [Yoman, Mueser, & Glynn]
- How to Conduct Problem-Solving Therapy for a Variety of Mental Health and Medical Populations [Nezu & Nezu]

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