

the Behavior Therapist

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President's Column

Summer Update: Warm Weather and Web Redesign

Michael W. Otto, Boston University



As I write this piece, we are securely in the midst of summer, and it seems a fitting time to recount some of the recent activities of the ABCT Board and central office. Members may have noticed some of the results of efforts to increase the visibility and branding of the ABCT name. We have a new logo, a new look to our name, and we are making substantial progress on a new and expanded Web site. These efforts are part of a broader 3-year plan to make sure that we remain responsive to our current membership while working harder to expand the scope of ABCT. From my own perspective, ABCT members have excelled in the organization's clinical research mission to develop the "conceptual and scientific basis of the behavioral therapies as an empirical approach to applied problems." However, as an organization we have been less adept with our dissemination goals. Our mission statement underscores the role of ABCT in facilitating the "utilization and growth of behavior therapy as a professional activity" and "serving as a resource and information center for matters related to behavior therapy." Accordingly, the ABCT Board has been increasingly attentive to the public face of our organization and our organization's ability to reach out to consumers, payers, and nonbehavioral clinicians and researchers.

As you might expect, the Web is crucial to these goals, and our efforts have intensified to make sure that ABCT is especially e-facile, e-friendly, and e-visible. Our solution is a re-

and . . .



Photo ID
(p. 143)

From the Editor

Responding to Disaster: Balancing the Risks of Doing Nothing or Doing Harm

David Reitman, *Nova Southeastern University*

In the months following the tragic events of Hurricane Katrina in August of 2005, we asked ABCT members to offer their perspectives on the event and how to best respond to similar events in the future. We now share several accounts of the tragedy with our readers. Further, we hope that you will contribute your reactions to this issue in the Behavior Therapist in the months to come. Readers will note an absence of contributions to this issue from ABCT members located in the immediate New Orleans area. Of course, recovery efforts are primary at this time, but we hope to hear about and learn from their experiences in future issues of tBT. In the interim, we offer best wishes to our friends and family in those areas as they continue to rebuild their lives, livelihoods, and communities.

Life is risk. Whether we are aware of it or not, the small challenges of each day present us with opportunities. For many of us, these opportunities pass without much fanfare and the costs of inaction are limited. However, when disasters occur, the action or inaction of individuals, including researchers and the organizations they represent, are magnified substantially. One way or another, the contributors to this issue of *the Behavior Therapist* are struggling with how we ought to respond to catastrophic events such as hurricanes, though the issues are broadly applicable to other disasters. Particularly salient to members of ABCT is how to respond in a way that is empirically and ethically defensible (see Dreer's account of the work of Jennifer Cheavens, in *Media Spotlight*, p. 116). Certainly, moving from small-scale, laboratory- or clinic-based demonstration projects to large-scale prevention or intervention projects offers significant risk of failure. The present discussion considers the relative merits of doing nothing or doing harm.

One thing is clear. The impact of a failure to respond is unlikely to be neutral. I learned a relevant lesson years ago while a resident at the University of Mississippi Medical Center. My supervisor at the time, Ron Drabman, frequently made himself available to the media, which surprised me since I had formed the opinion that interac-

tion with the media should be avoided, lest one be misquoted, misunderstood, or exploited. Ron's view was essentially this: It was better that an empirically oriented practitioner speak to the media (with all the risks entailed) than to allow less informed and potentially less-than-ethical persons to gain media access. The fundamental issue is that to bring clinical science to the public (especially during times of crisis), the power of nonacademic communication outlets must be maximized (see Tumlin, 2006, for examples of how to do so). Politicians and government officials read newspapers, surf the Internet, listen to the radio, and watch the news. Alas, they don't read *Behavior Therapy* or *Cognitive and Behavioral Practice*. Much as I might wish it, they don't read *the Behavior Therapist* either.

So, how do we approach the problem of facilitating the dissemination of empirically informed/based interventions? Let's consider the context of the aftermath of major natural disaster such as a hurricane: community leaders and government officials turn to organizations known to have the capacity to help, such as the Red Cross. It is sometimes said, cynically, that public officials "don't care" about effectiveness. It may be more accurate to say that most public officials do not have the luxury of determining what the most effective response is likely to be in a time of crisis. Instead, politicians appear to act on the assumption that the public will expect "action," and days spent researching the most effective way to respond to a disaster are, in their view, likely to invite criticism of their leadership and/or an indictment of their decision-making skills. Most importantly, as illustrated poignantly by Schumacher, Coffey, Elkin, and Norquist (2006), in times of crisis, evidence of effectiveness is not synonymous with trust and credibility. To address the aforementioned concerns, ABCT members and other clinical scientists must not only respond to catastrophic events, we must also respond in advance of them, anticipating needs and developing important relationships that can be leveraged into action when the need arises (see Allen, Saltzman,

Brymer, Oshri, & Silverman, 2006; Schumacher et al., 2006). It should be noted that, certainly in Florida, and increasingly in the nation as a whole, important government functions (broadly inclusive of local, state, and federal agencies), including mental health services, are being "privatized." Privatization represents a prime opportunity for advocates of science-based mental health to influence how public funds earmarked for mental health are utilized. Unfortunately, these opportunities are also likely to be exploited by proponents of pseudoscience or other untested approaches.

In contrast to the activist position outlined above, Lohr, Devilly, Lillienfeld, and Olatunji (2006) urge caution to practitioners seeking to respond to disaster and trauma, pointing out the risks associated with misguided treatment efforts that do more harm than good. While no one should doubt that people may be harmed by the actions of psychologists or other mental health professionals, serious political (and ultimately economic) harm may come to universities and hospitals that fail to respond to such events. In such cases, the mere appearance of "helping," even in the absence of data, is regarded as important and worthwhile. Indeed, when Hurricane Wilma followed Katrina, members of South Florida faculties in psychology and mental health professions were called to provide counseling to persons displaced by the storm. Deserved or not, such efforts appear to cultivate goodwill with the public and the community. Once trust is gained, it is up to the professional to deliver a service that meets the highest standards possible (under the circumstances) and to improve them over time. However, it also seems likely that failure to respond would be met with criticism, however justifiable our reticence to respond might seem from an empirical perspective. More importantly, our refusal to offer a solution makes it more likely that public health officials will turn to others in an effort to meet their constituents' needs. A "middle-ground" approach appears to be offered by Allen et al. (2006), who have developed an empirically informed approach that awaits further validation. What distinguishes the efforts of the behavioral scientists featured in this issue from the "junk science" or "pseudoscience" approaches described by Lohr et al. (2006) is an effort to obtain data that would permit an evaluation of the intervention to ascertain its merit (or lack thereof). A more complete discussion of the ethics of research conducted in the wake of a natural disaster

can be found in Del Ben, McLeish, and Elkin (2006). Interestingly, recent newspaper accounts of fraud associated with expenditures by FEMA and public demands for accountability may signal an important opportunity for ABCT and other scientifically grounded helping professionals to argue the merits of empirically supported interventions. Let's not waste it.

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News and Notes | MEDIA SPOTLIGHT

ABCT Member Jennifer S. Cheavens Featured on CNN's *American Morning*

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

ABCT member Jennifer Cheavens was featured on CNN's *American Morning* on September 27, 2005. The CNN segment highlighted various recovery efforts following the aftermath of Hurricane Katrina. Dr. Cheavens is currently an assistant clinical faculty member at Duke University Medical Center with a specialization in applying positive psychology constructs to treatment outcome research. Thus, it was not surprising that she responded to one of the worst natural disasters in U.S. history by serving as a Red Cross volunteer. Dr. Cheavens volunteered for 2 weeks in the Gulfport, Mississippi, area and attended to the psychological needs of those individuals personally affected by the hurricane, along with emergency personnel and volunteer workers who were also in the area providing assistance with the recovery efforts. A transcript of the interview can be accessed from <http://transcripts.cnn.com/TRANSCRIPTS/0509/27/ltn.01.html>

In the CNN segment featuring Dr. Cheavens, she discussed the different types of reactions that individuals commonly experience following a natural disaster. Dr. Cheavens educated viewers about the immediate psychological reactions as well as the long-term implications on adjustment. Consistent with her research in positive psychology, she also described the resiliency, strength, and determination that often emerge in individuals as a result of experiencing disaster. She reminded viewers that individual differences in emotional responses are large and that even wide fluctuations from day to day may be "normal." However, Dr. Cheavens also advised that individuals that continue to experience distress should consult with a mental health professional. Dr. Cheavens proceeded to briefly discuss how she had been helping those affected by the hurricane meet their most immediate needs.

Overall, this segment did a nice job of highlighting the work of an ABCT member taking on the challenge of serving those who were suffering in the aftermath of Hurricane Katrina, which will be remem-

bered as one of our nation's worst natural disasters. With little notice or preparation as to what to expect, Dr. Cheavens responded quickly and helped those who were in great need. Her research program, which focuses on the role of hope theory and the positive mechanisms of change in CBT, can be traced back to her training with one of the pioneers in positive psychology, C. R. Snyder (Cheavens, Feldman, Gum, Michael, & Snyder, in press; Cheavens & Gum, 2000; Irving, Snyder, & Cheavens, 2004; Snyder & Cheavens, 2000; Snyder, Cheavens, & Michael, 2005; Snyder et al., 2000). Specifically, Cheavens, Snyder, and colleagues have published several innovative papers discussing and empirically examining the role of a two-component model of hope. According to the model, hope is defined as the perceived capability to (a) derive pathways or routes to desired goals, and (b) to initiate and sustain movement along those pathways, agency. Thus, the overall aim of interventions using this model is to assist individuals with examining goal impediments and how they can use pathways to negotiate obstacles to traditional or previously expected goals and cope with goal loss. Additionally, an emphasis is placed on learning new strategies toward "agentic thought" to accept changes and modify goals. This line of research focuses on human strengths and offers a potentially valuable way for understanding and developing interventions aimed at promoting successful adjustment for individuals whose goals and lives have been drastically altered as a result of disasters such as hurricanes.

In light of the large number of persons who suffered and continue to struggle in the aftermath of Hurricane Katrina, ABCT members are encouraged to volunteer and become more involved with continuing relief efforts. ABCT members should consider actively working with organizations such as the Red Cross and the American Psychological Association. ABCT members should also seek to become involved in government efforts to prepare for future disasters, contribute to disaster prevention and

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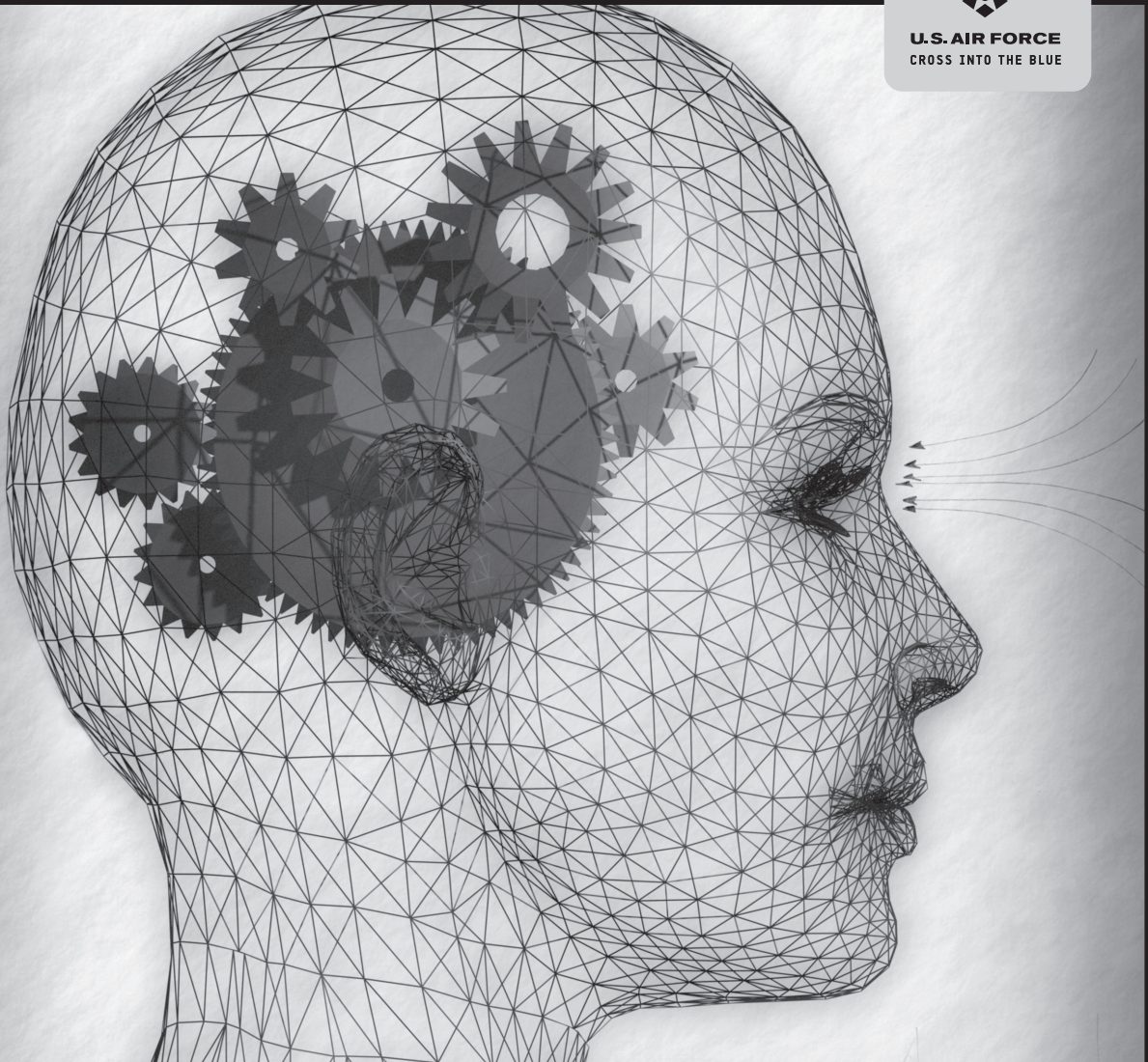
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intervention plans, and develop procedures for mental health worker response. Many innovative prevention and intervention efforts are currently under way in the wake of this devastation. To Dr. Cheavens and the many other ABCT members who dedicated their personal time toward the relief efforts, your dedication and humanitarian efforts have been commendable and inspirational.

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An Empirically Informed Intervention for Children Following Exposure to Severe Hurricanes

Andrea Allen, *Barry University*, William R. Saltzman and Melissa J. Brymer, *National Child Traumatic Stress Network*, and Assaf Oshri and Wendy K. Silverman, *Florida International University*

The state of Florida has been plagued with devastating hurricane landfalls in the past, with the most devastating being Hurricane Andrew in 1992. During the 2004 season, Florida witnessed an almost unprecedented series of hurricanes. Of those hurricanes—Alex, Charley, Frances, Ivan, and Jeanne—three were a Category 3 or higher and wide-ranging destruction was seen throughout most of the state. Many communities were heavily damaged, and many families were without homes. Recovery was delayed because some areas were affected by multiple hurricanes. In 2005, concern about hurricanes achieved national prominence with the images of Katrina's multistate destruction in Louisiana, Alabama, and Florida.

As we write this article, Florida is recovering from Hurricane Wilma, which swept through the southern part of the Florida peninsula on October 24. Wilma was the 12th hurricane of the 2005 season—a record number that only has been matched once, in 1969.* Meteorologists believe that the country has entered a cycle of high-intensity hurricane activity likely to span several decades, a documented phenomenon that has been observed since 1900 (Gray, Sheaffer, & Landsea, 1997; Landsea, Pielke, Mestas-Nunez, & Knaff, 1999).

The impact of the hurricanes of the 2004 and 2005 season was felt by hundreds of thousands of children and families who were separated or otherwise traumatized (American National Red Cross, October 13, 2005). In light of the increasing intensity and frequency of hurricane landfalls in the United States, it is urgent to continue to research the impact these natural disasters have on the lives of children. It is necessary to devise intervention programs aimed at educating children about the nature and consequences of storms and to reduce the deleterious effects that a severe hurricane

may have on youths. For example, it is important to help children cope with their hurricane-related fears and concerns about the safety of their families. Further, it is incumbent on the scientific community to develop and evaluate psychosocial interventions to aid the children who have been affected by these hurricanes in both the short term and their aftermath.

Following the 2004 season in Florida, an empirically informed mental health program was developed to assist children and families who were experiencing chronic hurricane-related anxiety. This article highlights one of the empirically informed interventions utilized in this recovery program. We begin by briefly summarizing the types of reactions to trauma that youth experience following catastrophic events.

Reactions to Trauma in Youth

Only recently has research begun to detail the reactions of youth faced with devastating natural disasters such as hurricanes (e.g., La Greca, Silverman, Vernberg, & Prinstein, 1996; La Greca, Silverman, & Wasserstein, 1998). Among those reactions, posttraumatic stress (PTS) symptoms and posttraumatic stress disorder (PTSD) are the most well-documented responses (Gurwitch, Sitterle, Young, & Pfefferbaum, 2002; La Greca & Prinstein, 2002; Silverman & La Greca, 2002). Although it appears that the symptoms of children lessen somewhat over time, accumulating evidence suggests that some children may continue to experience severe impairment in day-to-day functioning (Gurwitch et al., 2002; La Greca & Prinstein, 2002; La Greca & Silverman, 2005; Silverman & La Greca, 2002). For example, after Hurricane Andrew 18% of youth assessed still met diagnostic criteria for PTSD 10 months after

*EDITOR'S NOTE: At the conclusion of the hurricane season Tropical Storm Cindy was reclassified as a Category 1 hurricane, making Wilma the 13th hurricane of 2005. Two more hurricanes and 4 tropical storms followed Wilma and closed out the 2005 season, which was ultimately the busiest on record with 28 storms.

landfall (La Greca, et al., 1996). Youth exposed to traumatic events often also experience increased anxiety following the event (Goenjian et al., 1995; La Greca & Silverman, 2005). Specifically, youth frequently evidence an increase in separation anxiety (La Greca & Silverman, 2005) or develop fears related to the trauma (Vogel & Vernberg, 1993). Thus, treatment approaches need to focus on helping youth deal with the trauma while also addressing symptoms of anxiety. Using empirically informed exposure-based and/or cognitive-behavioral procedures to reduce such anxiety symptoms can help address the needs of affected youth.

Currently, no systematically controlled evaluations of treatments for use with children in the aftermath of natural disasters exist. However, there is a growing literature (e.g., Silverman & La Greca, 2002) on factors that predict children's reactions to catastrophic events. In the following section, we describe a project that we developed based on this literature in collaboration with the National Child Traumatic Stress Network (NCTSN). The NCTSN is a national network whose mission is to raise the standard of care and improve access to services for traumatized children and their families across the United States. Specifically, we address here the treatment of anxiety in youth dealing with the effects of hurricanes.

Florida's Response to 2004 Hurricanes

After the devastating impact of the Florida 2004 hurricanes, the Department of Children and Families implemented a crisis-counseling program funded by FEMA through the Center for Mental Health Services (CMHS). Deemed "Project H.O.P.E." (Helping Our People in Emergencies), the program was intended to provide short-term interventions to those individuals and/or groups experiencing psychological distress due to the hurricanes. As the program continued, it soon became clear that a more systematic and long-term recovery program was necessary to adequately serve persons with chronic psychological needs and individuals experiencing moderate to severe distress. Few studies have evaluated the efficacy of long-term trauma-based interventions for children after large-scale disasters. By contrast, commonly used short-term interventions such as critical incident stress debriefing

continued on p. 122

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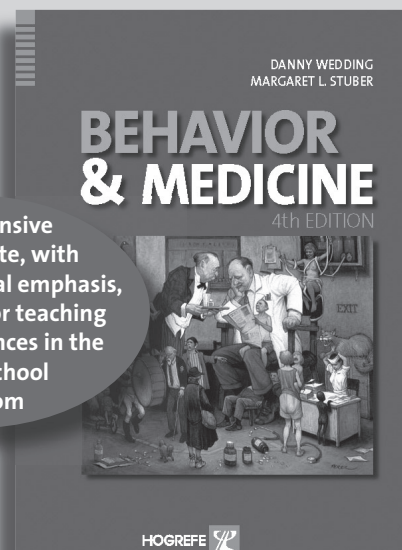
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have been found to be ineffective (for a discussion, see La Greca & Silverman, 2005). Thus, in an effort to develop empirically supported services for youth affected by the storms, the Florida Department of Children and Families commissioned the development of Project Recovery and requested that the NCTSN develop the child and adolescent intervention protocol that consisted of 10 sessions and encourages parent participation (see Saltzman et al., 2005; for more information about the manual, please contact the NCTSN at www.nctsn.org).

To launch the child intervention program, several of the manual's co-authors traveled throughout Florida in September 2005 to train the Project Recovery staff on the intervention program. In addition to learning about how to deliver a manualized evidence-based intervention, the Project Recovery staff was instructed on how to conduct assessments with affected youth. To permit an evaluation of the program's effectiveness, a pre-post evaluation plan was implemented, which includes the UCLA PTSD Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004), the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1985), the Center for Epidemiological Studies Depression Scale for Children (CES-DC; Faulstich, Carey, Ruggiero, Enyart, & Gresham, 1986), and a coping measure. Another component of the program is regular consultation calls with Project Recovery staff to assist them in the implementation of the intervention.

In the following, we describe part of the content of the Project Recovery Enhanced Services manual that deals with treating anxiety symptoms in youth who have lived through hurricanes. We outline specific concerns that children may have and how empirically informed cognitive-behavioral intervention efforts can help address anxiety symptoms in youth who have been exposed to a disaster such as a hurricane. In conceptualizing and writing the manual, we drew upon our work with youth who suffer from anxiety while tailoring our evidence-based intervention to hurricane-specific trauma (see Silverman et al., 1999). We used some of the suggestions provided in *After the Storm* (La Greca, Sevin, & Sevin, 2005), a manual for parents who wish to help their children cope with traumatic hurricane experiences, to put our evidence-based intervention approach for anxiety in the context of hurricanes. Additionally, we drew upon resources tailored specifically toward hurricane and

disaster experiences, such as the FEMA for Kids Web site (www.femaforkids.gov), and the National Child Traumatic Stress Network's Web site (www.nctsn.org).

The Tripartite Model

Exposure-based CBT interventions for anxiety disorders in children have been shown to be efficacious in numerous studies (Silverman & Berman, 2001). The Project Recovery approach represents an adaptation of the tripartite model of anxiety to the traumatic hurricane experiences of children (Lang, 1984; Saltzman et al., 2005). Despite representing a manualized, prescriptive approach to treatment, the intervention is individualized and pragmatic (see Silverman & Kurtines, 1996). Children are first taught to identify three kinds of anxiety symptoms: physiological responses associated with anxious arousal, cognitions associated with anxious arousal, and behaviors such as avoidance. Teaching all three elements of the tripartite model is important because children may differ in their anxiety experiences. For example, one child may have bothersome physiological responses, or an increase in worries, whereas another struggles with safety and security concerns following his or her hurricane experience. Other children may experience all of the above. The following sections describe additional features of the Project Recovery model.

Coping With Physiological Stress and Arousal

Providing children with strategies for managing anxious arousal is an important start to mastering physiological responses to stress. In addressing such concerns, physiological reactions specific to the child or adolescent are elicited. Options for dealing with this kind of physiological stress are proposed and discussed. For instance, relaxation exercises can be introduced and practiced with the child. Also, drawing upon the pragmatic approach (Silverman & Kurtines, 1996), alternatives for dealing with physiological stress can be generated with the child or adolescent who does not respond to relaxation exercises. For instance, going for a walk, reading a book, or playing a board game might all be constructive ways of helping the child and adolescent cope with physiological arousal. In addition to addressing physiological arousal, restructuring cognitions, particularly as they pertain to safety and security issues, can help mitigate the impact of traumatic stress involving hurricanes or disasters.

Cognitive Restructuring

In the aftermath of a hurricane, children may experience an increase in anxiety and worry. They worry that there will be another hurricane soon (anticipatory anxiety) and they worry about the safety of their loved ones, their pets, even their toys. Having their daily routine disrupted can also lead to an increase in anxiety, especially if disruptions are accompanied by power failures and/or the loss of utility services. Using cognitive restructuring techniques can help the child or adolescent examine his or her thoughts therapeutically. Therapists should draw on coping models (Kendall, 1991, 1992), help the child to generate coping options (i.e., disaster preparedness; see www.femaforkids.gov), modify the child's appraisal of the experience, and facilitate the use of cognitive restructuring techniques featured in well-known anxiety interventions for children and adolescents [e.g., "STOP" (Silverman & Kurtines, 1996) and "Coping Cat" (Kendall, 1992)].

Safety and Security Issues

In the aftermath of a disaster such as a hurricane, children frequently exhibit an increase in fears, such as fear of water and thunderstorms. Increased anxiety about general safety and security is also observed (Gurwitsch et al., 2002; Silverman & La Greca, 2002; Vogel & Vernberg, 1993). Concerns about safety are typically addressed by providing information about the nature and characteristics of storms (see La Greca et al., 2005). Psychoeducation has been shown to be an important part of disaster response efforts and appears to be useful to parents, teachers, and school counselors responding to the needs of children.

Behavioral Strategies/Options

A discussion about constructive behavioral options that children have available to them can be beneficial. For example, the importance of social support can be highlighted by helping the child or adolescent to generate a list of "helping friends" from school (school counselor, teacher), home (parent, older sibling), or community settings (peers, religious institutions, relatives). Additionally, activities such as watching TV, reading a comic book, playing a game, or participation in sports and/or exercise could help reduce catastrophizing thoughts. It may also be useful to discuss approaches to managing anxiety that children find counterproductive. For example,

therapists should determine if the child or adolescent engages in pervasive avoidance (i.e., avoidance that interferes with the activities the child or adolescent would normally engage in). Exposure exercises are indicated if the child's pervasive avoidance interferes with his or her level of functioning to a clinically significant extent. Exposure exercises may be particularly useful for reducing the child's level of irrational fear.

Blaming Oneself or Others

Children may engage in a process of blaming themselves or others. Frequently, there is a sense of guilt about surviving the disasters when others close to them have not (Pfefferbaum, 1997). It is necessary to address such feelings and thoughts and to explore them in therapy while allowing children to make their own decisions about what would be best for them in the particular situation. Specifically, children should be instructed on how to correctly identify blaming statements and reframe them. Reframing hurricanes as "acts of nature" can help to reduce self-blaming.

Future Directions

Intervention programs specifically targeted at helping children cope with the impact of a hurricane fulfill an acute need in the aftermath of the 2005 hurricane season. We hope that the anxiety portion of the intervention described in this article serves as an example of how empirically informed exposure-based cognitive-behavioral techniques can be applied to an important community need. Ultimately, we hope that empirically informed treatment approaches will continue to be disseminated and replace less evidence-based ones (e.g., critical incident stress debriefing). We are in the process of gathering data in an effort to provide information about our intervention's effectiveness and to facilitate the development of future intervention programs. Although this article focuses on efforts to develop an evidence-based manualized intervention approach for children who have been affected by hurricanes, we also are engaged in research activities aimed at identifying children who show resilience or positive outcomes despite experiencing a disaster (Silverman, La Greca, & Ortiz, 2004; Silverman & Ortiz, 2004).

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Post-Katrina Mental Health Care in Mississippi: Lessons Learned

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On August 29, 2005, Hurricane Katrina made landfall on the coast of Louisiana, Mississippi, and Alabama. As a result of the storm, more than 485,000 residents of Louisiana and Mississippi were displaced initially, more than 122,000 people have been housed in temporary shelters throughout the United States, and more than 1,300 people died. A Gallup poll conducted between September 30 and October 9, 2005, among a random sample of 1,510 hurricane victims who applied to the Red Cross for assistance provides an indication of the scope of this disaster. The poll found that 40% of residents of the affected area went without food for at least a day, 53% feared for their lives, 51% were separated at least a day from family members with whom they had been living, 7% were victims of a crime, 6% were physically injured or hurt, and half were still out of their homes at the time of the survey (CNN, 2005).

Epidemiological research on large-scale disasters such as Katrina provides substantial evidence that in the months following a natural disaster, there are sharp increases in the rates of posttraumatic stress disorder (PTSD), anxiety disorders, and depression (see Norris, Friedman, Watson, Byrne, et al., 2002, for review). Moreover, a study of Hurricane Andrew survivors suggests that symptoms may not resolve on their own—the proportion of survivors meeting study PTSD and depression criteria did not change from 6 to 30 months following the hurricane. Although mean levels of certain symptoms decreased, others remained stable, and others increased (Norris, Perilla, Riad, Kaniasty, & Lavizzo, 1999). There are also individuals who experience significant distress but do not meet criteria for a psychiatric disorder (Norris, Friedman, Watson, Byrne, et al., 2002). Hurricane Katrina and the events that unfolded in the days, weeks, and months following the storm possessed several characteristics likely

to increase the mental health impact of the event, including: significant property damage, enduring financial burdens, substantial threat to life, and substantial disruption of social networks (Norris, Friedman, & Watson, 2002). It is unknown what effect the degree of displacement caused by the event may have on mental health outcomes.

As clinicians and researchers working and residing in the state of Mississippi in the aftermath of Hurricane Katrina, the actions of the authors of this article were guided by two desires: (a) to assure that survivors in the state had access to empirically supported mental health care, and (b) to conduct meaningful research that might help the field better prepare for the next large-scale disaster. Although a number of well-designed studies of Hurricane Katrina and its aftermath have been conducted (or will soon be conducted), the focus of these studies, as with much of the existing research literature on the aftermath of hurricanes, is largely directed toward counting the numbers of people with clinical symptoms and determining risk factors that increase the prevalence of problems. Efforts to increase the availability of empirically supported mental health care for those with diagnosable psychopathology and to conduct research aimed at developing a stronger empirical basis for the types of interventions

that would be best for posthurricane efforts have been more limited.

Clinical Care Provision

Several faculty from the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center in Jackson (UMMC) developed protocols for strategies to efficiently and effectively identify those in need and provide empirically based care. These protocols, which incorporated information on anticipated prevalence of psychiatric illness (e.g., David et al., 1996), special needs of ethnic and racial minority populations (e.g., Norris & Alegria, 2006), and empirically informed practices (e.g., Gray & Litz, 2005), were submitted to the Mississippi State Department of Mental Health (DMH), an agency eager to ensure that best care was provided to the citizens of the state. Through this process, consultation was also provided about what to expect and how best to address the situation acutely, 6 months postdisaster, 1 year postdisaster, etc. It was thought that the days following Katrina might offer an opportunity to disseminate existing empirically supported and empirically based treatments across the state. Such dissemination would not only ensure that Katrina-related mental health needs were addressed with treatments that had the greatest chance of producing successful clinical outcomes, but would also improve mental health care in Mississippi. Through this process we also hoped to collect data that would inform future decisions about the best interventions to use postdisaster, and determine the feasibility and efficacy of targeting those interventions to those most likely to benefit from them.

Federal Policies on Postdisaster Mental Health Services

Despite enthusiasm by Mississippi DMH staff and UMMC faculty, it was not possible to incorporate these protocols into the grant submitted by DMH to fund Project Recovery. Project Recovery is the Federal Emergency Management Agency (FEMA)-funded, Substance Abuse Mental Health Services Administration (SAMHSA)-administered, crisis counseling program for the state of Mississippi. The guidelines for FEMA's Crisis Counseling Training and Assistance Program (CCP) indicate that the program is intended specifically to serve the needs of individuals "responding normally to an abnormal experience." Hence, the only federal mechanism through which disaster relief mental health

services can be readily funded earmarks the vast majority of funds for provision of services to those who do not develop diagnosable psychopathology after the disaster. In fact, the guidelines explicitly prohibit the use of CCP funds to cover mental health services such as medication, psychotherapy, diagnostic evaluations, and substance abuse treatment, regardless of whether such needs stem from the disaster or its aftermath (SAMHSA, 2001). Existing mental health agencies and resources are expected to absorb the majority of additional mental health needs. As reported in the *New York Times*, this federal funding policy created similar concerns in the state of Louisiana, which is also trying to address the increased prevalence of psychopathology, but is receiving federal aid only for crisis counseling (Dewan, 2006). This is particularly problematic in areas affected by the hurricane, as they were already having difficulty serving the existing needs of people with mental health problems prior to the hurricane.

A precedent for federal recognition and financial support for potential long-term mental health sequelae of traumatic events is evident in the victim assistance grants stemming from the 1984 Victims of Crime Act (VOCA). Rather than explicitly excluding costs related to long-term mental health care, the allowable costs in final program guidelines for the VOCA Victim Assistance Grant Program explicitly include psychological and psychiatric treatment (very broadly defined) to address mental health sequelae of crime (Office of Justice Programs, 2004). Although it remains an untested empirical question at this point, the social and economic costs of failing to provide for treatment of mental illness stemming from large-scale disasters are almost certainly greater than the costs of providing those services.

Crisis Counseling

These limitations notwithstanding, Project Recovery has been very successful in accomplishing the CCP objectives in Mississippi. Through Project Recovery, a crisis counseling intervention developed by the National Center for PTSD and the National Child Traumatic Stress Network, titled Psychological First Aid (PFA; NCTSN & NCPTSD, 2005), was introduced into the state. Consistent with CCP guidelines, PFA is an evidence-informed brief intervention for assisting children, adolescents, adults, and families to adjust psychologically in the immediate aftermath of large-scale disasters. PFA is a very brief

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crisis counseling intervention, administered primarily by trained laypersons, which is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning. Although PFA was developed by respected scientist-practitioners and its development was informed by best existing empirical evidence about what natural disaster survivors might need, it is not at this time an empirically supported practice. Unfortunately, gathering evidence to support the effectiveness of PFA for natural disaster survivors will not be an easy task. CCP funds are earmarked specifically for services, not for research. Moreover, the manner in which the intervention is administered (e.g., anonymously, without follow-up), makes it impossible to collect reasonable outcome data, even if research funds were readily available.

PFA could not be made widely available until months after Hurricane Katrina, and in the interim, as Gray and Litz (2005) would predict, other forms of early intervention “filled the void.” It is unclear exactly what types of interventions were provided, but there is anecdotal evidence that therapies such as critical incident stress debriefing (CISD) were offered to some survivors. There is little evidence to support the use of CISD with survivors of large-scale disasters, and the consensus best practice guidelines for early psychological interventions for survivors of mass violence developed by several federal agencies describe CISD as “contraindicated” for disaster survivors (NIMH, 2002; see also Litz & Gibson, 2006). Although CISD was not the standard of care in Project Recovery, our observations after Katrina confirmed that it is an intervention that remains widely and very rapidly disseminated following disasters. Moreover, it is likely an intervention that will remain widely disseminated until (a) a true evidence-based alternative is widely disseminated in its place and (b) the lack of evidence for the efficacy of CISD is effectively disseminated beyond the academic community to those responsible for making decisions about acute disaster care (see Gray & Litz, 2005, for review).

Long-Term Katrina-Related Mental Health Needs

The ability of mental health providers in the state to provide what the ABCT community considers first-line treatments for PTSD, depression, anxiety disorders, and other conditions likely affecting Katrina survivors is clearly limited, because the number of providers trained in these tech-

niques is low. The state of Mississippi is certainly not unique in this regard, as the sluggish dissemination of empirically supported psychotherapies is a nationwide problem (e.g., NIH, 2005). Broad dissemination efforts must target mental health professionals at all levels, from graduate school to continuing education for seasoned professionals (Calhoun, Moras, Pilkonis, & Rehm, 1998).

As noted in an editorial published in *Nature* less than 2 weeks after Hurricane Katrina, “Knowledge of the risk of a storm-induced flood in New Orleans has been widespread in the scientific community for years. . . . There seems to be a disconnect, however, between the process that identifies such risks and the people who make decisions that might manage them” (“Small-Minded Government,” 2005, p. 169). A parallel situation appears to exist in the area of mental health treatment; the scientific community has knowledge to inform estimates of the types of disorders most likely to emerge and the types of treatments that are most likely to be efficacious in the aftermath of an event such as Hurricane Katrina. Based on observations of the post-Katrina recovery process, this knowledge has had insufficient impact on the federal policies that determine what types of psychological assessments and treatments will be offered to disaster survivors. In a special report in the same issue of *Nature* there was a call to academics to “tailor their research to practical needs,” and a concern about the priorities of academia, which offers “more credit for journal publications than for helping a hospital prepare for a crisis” (Reichhardt, Check & Marris, 2005; p. 176). A similar call to hasten the sluggish dissemination of treatments with demonstrated efficacy has been heard throughout the ABCT organization for years.

Evidence-based practitioners in New York City described their recognition of the need for, and efforts to disseminate, empirically based approaches for the treatment of PTSD following the terrorist attacks of September 11, 2001 (Amsel, Neria, Marshall, & Suh, 2005). Their observations and experiences, as well as those of the authors, suggest that clinicians and researchers must be proactive in their attempts to disseminate evidence-based treatments on a broad scale. Although federal funds were not readily available to disseminate relevant treatments post-Katrina, the NCTSN has been partnering with agencies nationwide to fund the dissemination of community education programs and trauma services for children. Because of an

existing partnership with the Catholic Charities Diocese of Jackson, Mississippi, funding had been secured prior to Hurricane Katrina for a 4-year project (2004–2008) to make services available in three counties in Mississippi. Additionally, prior to Hurricane Katrina, the Medical University of South Carolina, another partner in the NCTSN, with funding from SAMHSA, developed a Web-based training protocol, Trauma Focused Cognitive Behavioral Therapy, for children. This protocol has facilitated a broad dissemination of this approach, including dissemination in Mississippi. In addition to these large-scale dissemination efforts, smaller-scale efforts are also needed. Clinicians and researchers must reach out to community providers to offer trainings on evidence-based assessment and treatment of psychopathology, continually updating these trainings as additional postdisaster evidence-based treatments are developed.

Recommendations

Out of the lessons learned from the post-Katrina experience in Mississippi come the following recommendations to our ABCT colleagues and clinicians and researchers everywhere:

1. We must work collectively and individually to influence federal policies about allowable mental health expenditures in the wake of large-scale natural disasters and available mechanisms for funding disaster treatment research. With regard to the latter, we must push for a new research agenda, which will enable the field to assemble the necessary body of knowledge to improve outcomes for survivors of large-scale disasters.
2. We must continue conducting research to identify the best intervention strategies for postdisaster psychological needs (see Litz & Gibson, 2006). In addition to identifying problems and counting risk and protective factors, postdisaster research must focus heavily on the development of the best interventions for postdisaster situations as well as development of strategies to identify which survivors are in need of intervention, and what types. Ideally, this research should be community focused, incorporating input from affected communities in the development of interventions.
3. We must increase the dissemination of existing evidence-based psychological treatments. This will require continued research to identify the best methods for disseminating and fostering adoption of evidence-

based practices and greater availability of training opportunities for community providers.

4. As the body of evidence-based mental health practices grows, we must continually educate policymakers at all levels about these practices and advocate for preference to be given to mental health treatments with empirical support, when available.

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Research and Ethics Following a Natural Disaster: From the Public's Point of View

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Ultimately, the profession of psychology is focused on helping people, whether the psychologist is an administrator, teacher, full-time clinician, full-time researcher, or some combination of the many roles in which psychologists function. With full-time clinicians serving "in the trenches" to provide the most obvious form of help to individuals with mental illness, one may overlook the researchers who often provide the empirical evidence to guide that treatment. One area where research has been invaluable in guiding treatment is following devastating events. The knowledge derived from research following a natural disaster has helped psychologists predict how individuals and groups will react in these situations (e.g., Goenjian et al., 2005; Norris, Murphy, Baker, & Perilla, 2004) and shaped the development of interventions to help people recover following a disaster (e.g., Allen, Saltzman, Brymer, Oshri, & Silverman, 2006, this issue). As Kilpatrick (2004) notes, we still have a great deal to learn about the mental health effects of disasters, and ethical questions related to how we acquire this knowledge must also be addressed.

Books and articles on research ethics typically focus on authorship issues, plagiarism, or unethical data-management practices, such as fabricating data. Beginning early in graduate school, and throughout one's career as a psychologist, ethical principles should inform decisions in all areas of practice, including research. Institutional review boards and the APA ethical guidelines (APA, 2002) strive to protect research participants and ensure that the potential harm to participants is addressed and the potential benefits of the research outweigh the risks.

Concerns about the ethics of conducting research with victims and survivors of disasters are certainly not new and have been the focus of debate (formal and informal), empirical study (e.g., Bowman & Anthony-samy, 2006; MacNeil & Fernandez, 2006), and symposia hosted by the New York Academy of Medicine and the National Institute of Mental Health following the attacks on New York and Washington on September 11, 2001 (see Collogan, Tuma,

Dolan-Sewell, Borja, & Freishman, 2004). Researchers must always consider the potential for harm to participants in research. For example, it is required that researchers consider the vulnerability of participants, whether the research will cause any harm, and the overall risks and benefits of the project. Does special care need to be taken when conducting research in the aftermath of a natural disaster? If one of the principles of ethical research is to "do no harm," is attempting to conduct research while victims of a natural disaster are attempting to cope with the crisis in accord with this principle?

Few studies exist to inform psychologists' efforts to conduct ethically sound research in the wake of a natural disaster. Interestingly, current evidence does not appear to support the notion that, as a group, survivors or victims are more easily taken advantage of than those who have not experienced such events (see Collogan et al., 2004, for an expanded discussion of this issue). Although victims of a natural disaster may have been through a harrowing experience, asking them to recount these experiences does not constitute retraumatization. For example, following the 9/11 terrorist attacks, a telephone survey of New York City residents found that while a substantial percentage of survey participants (15% overall, 28% of individuals receiving mental health services) reported experiencing some distress during the survey, only 2% remained upset at the completion of the survey, and only 4 of 2,368 individuals elected to speak with a counselor about their distress (Boscarino et al., 2004). In fact, describing the event in the safety of a research setting could be beneficial for some participants.

Newman and Kaloupek (2004) provided an extensive list of benefits (e.g., material resources, insight, mental health services) and risks (e.g., social risks, inconvenience, disability) of participating in research following a disaster and concluded, based on their review of the literature, that a majority of people do not see participating in research as a negative experience. Two risks that the authors briefly mentioned were "giving science a bad name" and "bad press"; however, this is the only attention

that has been given to the topic of the public's perception of disaster-related research. The devastation caused by Hurricane Katrina and the intense media coverage that followed created a situation in which researchers could easily be viewed as uncaring or opportunistic. By developing strategies to address potential pitfalls prior to a disaster, researchers should be able to enhance their ability to pursue important disaster-related research questions in the wake of future catastrophic events.

Hurricane Katrina

Hurricane Katrina made landfall on August 29, 2005, near Buras-Triumph, Louisiana, as a Category 3 hurricane with sustained winds of 125 mph and was one of the strongest storms to impact the coast of the United States in the last 100 years (National Climatic Data Center, 2005). Katrina then moved to the north and east through the state of Mississippi, still classified as a Category 1 hurricane (winds of 74-95 mph) as it passed through central Mississippi. Individuals in some areas of Jackson were without water for a week, without electricity for a few days to over a week, and confronted with gasoline shortages and the lengthy waits at the fuel pumps. Hundreds of thousands of people were displaced, over 200,000 homes were destroyed, and depending on the source, approximately 2,000 people died as a result of the storm. Many would also argue that a manmade disaster followed the hurricane, as rescuers and aid workers had an extremely difficult time reaching those individuals in need of help. The destruction and subsequent response was well documented on television and in newspapers, and research articles have begun to surface in the scientific literature documenting the impact of Katrina. Even now, a year after the hurricane, dozens of articles have been published, yet few contain empirical data.

The University of Mississippi Medical Center (UMC) was in a unique position following Hurricane Katrina. The hospital and staff were affected, but the damage was not nearly as extensive as many other areas in the region. Thus, UMC employees were able to return to work quickly and begin caring for others. Once back at work, employees faced media inquiries concerning expectations following the hurricane and requesting information about next steps. Basic needs such as food, water, and shelter would be given priority, but it was clear that there would be other, long-term problems that would also need to be addressed (e.g.,

the development of psychological symptoms). Luckily, some of these questions had previously been asked, answered, and published, providing some guidance; however, there were still many unanswered questions. Researchers at UMC were presented with an opportunity to learn from this hurricane and build on previous research. Still, the work presented formidable ethical dilemmas. In particular, how would this research be perceived by the public given the intense media coverage of the disaster?

This paper presents the views of a child psychologist, a member of the IRB at UMC, and a psychologist who works with an adult population, following the events of Hurricane Katrina. As will be shown, our efforts to perform clinical work and research following the storm met with limited success. We discuss some of the reasons for our difficulties in the conclusion of the article.

Reaching Out to Families

In the immediate aftermath of Hurricane Katrina, clinical care and provision of services were primary concerns, especially for vulnerable populations such as children and adolescents. As clinical psychologists, we wanted to ensure that the best in clinical care was provided to those affected by the hurricane. Our research suggested that many evidence-based treatments (EBTs), such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), could be adapted to large-scale disasters. However, a number of logistical problems confronted us as we sought to facilitate implementation of these EBTs. For example, how do we get EBTs to the affected communities? Who in these communities are in the greatest need of services? How much treatment would be needed to maximize effectiveness? How might we track intervention effects over time?

In order to address some of these questions, we proposed running TF-CBT in schools as one of our primary research interventions. Remarkably, the school systems in the affected areas of Mississippi were some of the first institutions to reopen; the schools on the coast were operational by October 1. Our thinking was that children and adolescents would be readily accessible through the schools statewide, even if these individuals had been displaced by the storm. Specifically, most people who evacuated the coast moved to other parts of the state in order to stay with friends and family and subsequently enrolled their children in local schools.

In proposing this project, we attempted to work with the state Department of Health, the Department of Mental Health, the Department of Education, and local state associations. Our rationale was that by utilizing existing connections and infrastructure, we would readily gain access to these affected individuals. The collaboration might also reduce the likelihood that we'd be perceived as outsiders ("research vultures"). By working through state agencies, we could make use of existing institutions that the citizens of the state knew and trusted. However, it soon became clear that the response of most state agencies was being directed by federal agencies. Moreover, the federal agencies appeared uninterested in collaborating, despite the enthusiasm for our ideas within the state. In hindsight, there appears to have been little we could have done (after the fact) to improve the response to Katrina. State agencies were more than willing to work with local mental health providers; however, the decision was out of their hands. In light of this, we would strongly recommend that ABCT and other professional organizations begin the process of advancing EBTs at the federal level rather than solely at the state and local level. For EBTs to be implemented and disseminated, a top-down approach should be pursued along with a bottom-up approach.

Lessons Learned From Our Adult Outpatient Clinic and Outreach Efforts

Adults in treatment at an outpatient clinic are unique in that they have known psychiatric conditions and have previously sought treatment. Psychiatric patients are not by definition a vulnerable population; however, their symptoms may place them at risk for increased impairment following a large-scale stressor such as Hurricane Katrina. Understanding the predictors of response to this kind of event could have important benefits for this outpatient population and their mental health providers.

The day after the hurricane passed through the city, the outpatient clinic was open; however, many providers were not able to come in and only one patient attended his appointment. The following week, after electricity and water had been restored, patients completed a short survey to assess hurricane-related stressors when they arrived for their appointments. The purpose of the survey was to gather information on how the person was affected by the hurricane and whether the stressors influenced his or her symptom presentation.

The survey focused on physical damage from the hurricane, missing and potentially deceased friends and family members, and the amount of time spent watching the intense media coverage that followed Katrina, with the goal of understanding the effects of these "big" stressors on existing symptoms. Most patients at the clinic had become accustomed to completing surveys at the time of their visit, so the introduction of surveys concerned with their hurricane-related experiences did not seem unusual or disruptive to their care. Indeed, patients had previously been educated about the importance of completing self-report measures and had any questions about this process answered. They understood how their responses to these kinds of measures assisted their providers in making clinical decisions. Moreover, clinic patients were able to refuse to complete the new measure or to talk to clinic staff about their concerns with completing the survey. Refusal rates were approximately 1% and an informal survey of those participants who did complete the measures indicated that patients appreciated the fact that the clinic staff were attempting to assess how the hurricane had affected them personally.

Despite efforts to educate clients about the value of our research program, some staff members remained skeptical about it. For example, some staff believed that patients "should not be forced" to participate in a research project. In fact, as noted above, completion of the survey was optional, and its primary purpose was to inform clinical care for that patient. A more proactive approach to conducting research in the clinic might have reduced staff resistance. Specifically, research staff could have spent more time educating the clinical staff about the broader benefits of research and the immediate benefits to patients. Researchers could also have made a more concerted effort to feed research findings back to clinic staff, finding ways to include all staff members in the research process, and helping them to understand the difference between using self-report measures for clinical purposes (as we did in this case) and collection of data as part of a research protocol.

In addition to the work done with our adult outpatients, the first author (KDB) was also part of a team that followed hurricane survivors on the coast of Mississippi. The purpose of the research was to explore the effect of the hurricane on a variety of biological markers to better understand how a large stressor, and subsequent psychological symptoms, would alter an individual's immune system functioning. This research

project was approached more delicately, as no mental health services were provided directly to participants as part of this effort (a small monetary incentive was offered). To address this issue, the research team met prior to beginning the project to ensure that everyone involved in it understood the potential benefits and agreed that it was a worthwhile endeavor. Interestingly, although no mental health services were offered, part of the research protocol involved obtaining some basic physiological measures (e.g., blood pressure; one individual, surprised by his elevated blood pressure reading, immediately sought treatment from his primary-care physician). Thus, even though mental health services were not provided, projects may occasionally have other, unintended, benefits (though we understandably focus on unintended negative consequences). Unsolicited feedback from participants suggested that they were glad to be involved in a project that would benefit others in the future.

Discussion

From the researchers who must first carefully consider the ethical implications of any scientific inquiry to the IRBs that approve that research, the consensus view appears to be that research following a disaster is not categorically unethical. Like other research projects, disaster-related research must be evaluated on its merits. The knowledge that has been acquired following natural disasters has the potential to benefit many people. While it would be naïve to assume that all prior research placed the highest priority on potential benefits to the public, it would be equally foolish to presume that the public will readily appreciate the legitimate benefits stemming from research. Understanding how the public perceives research and the circumstances under which they perceive research as opportunistic or worthwhile is itself an important task facing clinical researchers. Without a better understanding of the issues associated with communicating about the merits of research following natural disasters, our ability to improve our efforts to alleviate future suffering may be compromised. Finally, while the issues raised in this paper have been framed within the context of disaster research, research conducted with survivors of pediatric cancer (Stoppelbein, Greening, & Elkin, 2006), multiply victimized youth (Stevens, Ruggiero, Kilpatrick, Resnick, & Saunders, 2005), and survivors of genocide (Hagengimana, Hinton, Bird, Pollack, &

Pitman, 2003) is also relevant to the work described here.

The authors of this paper were all directly affected by the hurricane and are members of the community where the research projects were proposed. Two consistent themes emerged from our experiences. First, the research that was successfully implemented conferred meaningful benefits to the participants. Whether it was a better understanding of how a large-scale stressor affected their existing symptoms or information regarding their health status, direct benefits for the participant went beyond a monetary incentive and influenced their sense of well-being. In postdisaster research, research with the potential to produce direct benefit to participants should generally take priority over research that addresses other issues of less direct benefit to the participant. Second, when the researchers were viewed as part of a larger team consisting of treatment providers or representatives from other state agencies, our work appeared better received. By teaming with existing organizations that held clinical service provision as their highest priority, we were able to support their mission while also developing a database that could inform their (and other organizations) future helping efforts.

With the benefit of hindsight, asking research participants for their impressions about the purpose and merit of our research could have provided valuable data concerning the perception of research held by the public in the aftermath of disaster. In addition to guiding future research endeavors, this empirical data might also be valuable when communicating with local IRBs, allowing all involved parties to rely on empirical data rather than opinions concerning what the public perception of research efforts might be. One should also consider that in the aftermath of disasters such as Katrina, members of an IRB will be asked to comment on multiple studies and that, in some cases, researchers will have to make a strong case for why their project merits approval when resources are scarce and/or the proposed study population is considered vulnerable. Few consider the ethical issues surrounding failure to conduct research needed to inform treatment. With additional research we may be able to improve future efforts to assist survivors of catastrophic events.

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First Do No Harm, and Then Do Some Good: Science and Professional Responsibility in the Response to Disaster and Trauma

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Victim Traumatology

There is little question that mental health practitioners have the ethical obligation of *Primum non nocere*: First do no harm. This obligation is most directly applied to acts of commission for which the public will incur significant cost and/or damage. It also applies to acts of commission where there is evidence that the purported benefits of a treatment are absent, or where there is an absence of evidence that the treatment is beneficial.

The field of "traumatology" has rapidly expanded since 1980 when posttraumatic stress disorder (PTSD) was first listed as a diagnosable anxiety disorder. The rapid expansion of this field has occurred because of the pain and suffering experienced, the apparent refractory nature of the disorder, the "victim status" of those diagnosed, and often compensable consequences of the diagnosis. However, many trauma treatments that purport to be novel and extraordinary are based on little more than personal testimony and vivid case studies (Herbert et al., 2000; Lohr, Hooke, Gist, & Tolin, 2003). In this context, there has arisen a genre of treatments collectively called Power Therapies (Deville, 2005; Figley, 1997) that promise rapid, strong, and lasting effects. Because they are prescriptive, structured, and time-limited procedures, they may mimic the formalities of cognitive-behavioral therapy (CBT) and serve as alternatives to cognitive-behavioral interventions

for trauma-related problems. Thus, a comparison of the evidence base for CBT and Power Therapy is warranted.

Evidential Warrant

Treatments That Do Good: Cognitive-Behavioral Therapies for PTSD

Exposure-based treatments are predicated on the notion that deliberate exposure to feared stimuli facilitates habituation of conditioned stimuli and extinction of the fear response. An early controlled efficacy study of exposure for PTSD used imaginal exposure with combat veterans. Compared with a wait list, exposure produced greater reductions in PTSD symptom severity on both standardized measures and clinicians' ratings (Keane, Fairbank, Caddell, & Zimering, 1989). Similar results were reported by Brom, Kleber, and Defares (1989) using systematic desensitization for civilian PTSD symptoms. A treatment combining imaginal and in vivo exposure was superior to supportive counseling and wait list for sexual assault PTSD (Foa et al., 1999; Foa, Rothbaum, Riggs, & Murdock, 1991).

Cognitive therapy (CT) has received less empirical study than has exposure, although two randomized controlled trials (RCT) suggest that it can be helpful. Tarrier et al. (1999) compared CT with imaginal exposure for mixed civilian trauma; both groups showed significant and comparable symptom reduction. In another study, CT

was superior to a wait list and to relaxation training, and comparable with combined imaginal and in vivo exposure (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998). Anxiety management training (AMT) refers to an assortment of cognitive and behavioral strategies designed to help reduce symptoms of anxiety, irritability, and hyperarousal. These techniques include relaxation training, breathing retraining, psychoeducation, self-instruction, communication training, and CT. AMT packages have been compared with exposure in two RCTs. Foa et al. (1991) showed that AMT reduced symptoms of PTSD, although the effects were slightly less than were those produced by combined imaginal and in vivo exposure. In a later study, Foa et al. (1999) compared exposure, AMT, their combination, and a wait list using assault victims. AMT produced decreased symptoms of PTSD as shown by standardized measures. Thus, there appears to be substantial evidence to consider CBT as an efficacious treatment for trauma-related disorders (Chambless, Baker, Baucom, Beutler, Calhoun, Crits-Christoph, et al., 1998).

Pretention to Science-Based Practice

Pseudoscience

Despite the availability of efficacious treatments, evidence-based practice for trauma victims confronts two substantial threats: pseudoscience and junk science. The difference between science and pseudoscience is not categorical or distinct, but a number of features can help us to identify pseudoscience: (a) the goal of promotion of an idea or product through persuasion, (b) misappropriation of constructs and concepts from allied disciplines to provide the trappings but not the substance of scientific inquiry, (c) opposition to skeptical inquiry regarding claims, (d) avoidance of rigorous test of claims, and (e) absence of self-correction in tests of claims (Herbert et al., 2000). One fundamental difference between science and pseudoscience is based on the con-

continued from p. 130

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cept of falsifiability (Lakatos, 1970; Popper, 1959). Empirically supported practices build upon scientific theory and state the terms under which data would falsify the theory. It is the adherence to empirically sound methods providing for falsifiability that is absent from pseudoscientific promotion. Moreover, widespread promotion and marketing of such practices may be a tell-tale sign that the practices lack scientific merit (Herbert et al., 2000).

Junk Science

Junk science is not incompatible with pseudoscience, but it is distinguished by its means of promotion. This includes both a good deal of expert legal testimony (Huber, 1991; McCann, Shindler, & Hammond, 2003; Park, 2000) and promotion of popular psychology in the mass media (Wilson, 2003). The former involves the dissemination of expert opinions that do not meet judicial standards of scientific evidence; the latter involves dissemination based on fad and entertainment value. The common thread within pseudoscience and junk science is persuasion and promotion rather than constructive criticism and the growth of knowledge (Lakatos, 1970). Trauma and victims services are vulnerable to both forms of dissemination (Sommers & Satel, 2005).

Harms to Be Done by Pretention to Science

Harms that can be perpetrated need not be directly imposed on the person seeking help. Indeed, a treatment may be merely innocuous and ineffective. If an ineffective treatment is promoted and delivered as if it were effective, the individual may spend time, energy, and financial resources that could otherwise be spent on treatments that have greater evidential warrant. If this happens, the individual has incurred an "opportunity cost." Moreover, if the individual views the experience as a waste of resources, he or she may be reluctant later to seek services that possess greater evidential warrant.

However, harm can sometimes be more direct. Harmful effects can be multidimensional: symptoms may worsen, new symptoms may appear, concern for extant symptoms may worsen, and dependency on therapy may develop. Some treatments may make certain symptoms better but others worse. Decrements in functioning may be reported by some individuals and not others. Finally, treatments may produce harm in relatives or friends of clients in ad-

dition to clients themselves. For example, recovered memory treatments may produce memories that result in false allegations of abuse by others.

Questionable Treatments

Opportunity Cost

Traumatic Incident Reduction (TIR). TIR (Gerbode, 1987) is derived from Dianetics (Hubbard, 1985), which is the mental health application of Scientology. Repeated visual reexperience of traumatic memory under conditions of safety and concentration is alleged to be the process by which the emotional content of such memories is altered (Gerbode, 1989). Valentine and Smith (2001) reported the only RCT of TIR efficacy. Participants were 123 female correctional inmates who were randomly assigned to either a wait-list control condition or the TIR protocol. Analyses of verbal reports of distress revealed a nonsignificant trend in favor of TIR at the end of treatment and a larger significant difference between conditions. However, the wait-list control design allows only for the control of measurement and historical artifact. Nonspecific factors such as expectation of improvement, allegiance and enthusiasm of therapist, and merely receiving treatment permit only the most limited conclusions: TIR may be more efficacious than no treatment, but it is unproven against extant effective interventions.

Thought Field Therapy (TFT). TFT (Callahan, 1995) has been applied to a variety of anxiety disorders, including PTSD. The treatment theory asserts that small bioenergetic perturbations (disturbances, blockages, or imbalances) at specific points along the energy meridians cause negative emotions. Physical palpation (tapping) provides physical energy that is transformed into the energy of the meridian system, which then removes or transforms the blockages. The treatment is applied with a number of procedural variations called "algorithms." The algorithms consist of a series of activities that are followed in prescriptive fashion, with different algorithms for different emotional problems such as PTSD. Clients are palpated with fingertips (or tap themselves) on a variety of points on the face, hands, and body while staying attuned to the thought field. Following the palpation, the individual takes a deep breath, rolls the eyes, and hums a happy tune. The algorithm may be repeated a number of times.

There is but one uncontrolled published study in which TFT was applied to trau-

matic memories but not to PTSD per se (Carbonell & Figley, 1999). Treatments included TFT, TIR, Eye Movement Desensitization and Reprocessing (EMDR), and Visual-Kinesthetic Dissociation (VKD). Clients at a trauma treatment center were nonrandomly assigned to one of the four treatments based on the next available treatment practitioner. The authors reported that those who received TFT experienced reduced severity of their subjective reports of emotional discomfort and standardized questionnaire indices of PTSD symptoms. However, there were no formal statistical tests performed, and there was no control group with which to compare TFT.

It appears that the scientific research on TFT is minimal in quantity and quality despite the wide claims of effectiveness for trauma symptoms made by its promoters (Callahan, 1995; Gallo, 1998). Despite the fact that there are no adequately controlled clinical trials of TFT, the treatment has been marketed extensively through the Internet, has been promoted on numerous television talk shows (Gaudio & Herbert, 2000), and promoted through both the American Psychological Association (1996) and Australian Psychological Society. Thus, the most obvious sign of TFT as junk or pseudoscience is the overpromotion of the treatment relative to the available evidence.

EMDR. EMDR is a structured, prescriptive, and time-limited treatment designed to alter the affective and semantic content of memory images developed as a consequence of emotional or physical trauma (Shapiro, 2001). EMDR has acquired its popularity in part because of its relationship to behavior therapy, and the relationship is not coincidental. Indeed, the use of the term "desensitization" is not a semantic accident. Wolpe (1990) argued that EMDR was only a variant of systematic desensitization, and recognized behavior therapy experts were involved in the early promotion and dissemination of EMDR (e.g., Marquis, 1991). In 1992, an EMDR Special Interest Group was established within the Association for Advancement of Behavior Therapy (AABT, now ABCT).

Qualitative reviews and meta-analyses of peer-reviewed EMDR outcome studies have consistently found that there is overwhelming evidence that eye movements are neither a necessary nor useful component of the general clinical protocol (e.g., Davidson & Parker, 2001; Devilly, 2002; Lohr, Lilienfeld, Tolin, & Herbert, 1999); there is strong and consistent evidence that EMDR is better than no treatment and ineffective treatments, but no more effective than

other treatments that use some aspect of exposure therapy (Deville, 2002; McNally, 1999); and there is growing evidence that a cognitive-behavioral treatment including exposure is superior to EMDR for long-term effectiveness (Deville & Spence, 1999; Taylor et al., 2003). In sum, "what is effective in EMDR is not new, and what is new is not effective" (McNally, 1999, p. 619).

Harm Done

Critical Incident Stress Debriefing (CISD). CISD is designed to prevent PTSD symptoms among individuals, such as emergency service personnel, exposed to extreme stressors. CISD is predicated on two basic assumptions: first, that exposure to traumatic life events is a sufficient precursor for the development of psychological symptoms that can develop to pathological proportions in the form of PTSD and other disorders. The second assumption is that early and proximal intervention is necessary for prophylaxis of such disorder. The result has been the aggressive development, promotion, and delivery of the intervention through importation of proprietary practitioner treatment teams to the scenes of disaster. As the procedure became more widely promoted, however, so did the claims of its preventive efficacy and breadth of application. In the process, it has been promoted as an indispensable and empirically supported means of providing help to those at risk for dysfunction (Mitchell 1988a, 1988b, 1992).

CISD is a single-session procedure typically administered to groups of people within 24 to 72 hours of their exposure to the traumatic event (McNally, Bryant, & Ehlers, 2003). Treatment rationale is based on the premise of the therapeutic effect of group disclosure, primarily that of normalization. It is a 7-step procedure conducted by mental health professionals trained in the CISD protocol (Mitchell & Everly, 1993, 1995): (1) introduction to the debriefing, (2) statement of facts regarding the nature of the traumatic event, (3) disclosure of thoughts regarding the event, (4) disclosure of emotional reactions (specifically focused on those with strongest negative valence), (5) specification of possible subsequent symptoms, (6) education regarding consequences of exposure, (7) planned re-entry to the social context. The duration is usually from 2 to 3 hours and participants are discouraged from withdrawing before the end of the process. Frequently, attendance by emergency ser-

vice personnel is made mandatory by the employing agency.

Litz, Gray, Bryant, and Adler's (2002) meta-analysis of RCTs of CISD versus no treatment or alternative control conditions yielded an effect size of $d = -.11$ for PTSD symptoms. Equally important, two controlled studies provide evidence that CISD may exert harmful long-term effects. Bisson, Jenkins, Alexander, and Bannister (1997) found that burn victims assigned to CISD showed significantly higher PTSD and anxiety symptoms at a 13 month follow-up than did victims assigned to an assessment-only control condition. Mayou, Ehlers, and Hobbs (2000) showed that vehicular accident victims who received CISD exhibited significantly higher levels of psychopathology and travel anxiety than individuals in an assessment-only control condition 3 years after treatment. It has been suggested that CISD causes harm by impeding the natural recovery process (Deville, Gist, & Cotton, in press; McNally et al., 2003). Moreover, it is possible that CISD provides for truncated and inadequate exposure (steps 3 and 4) without adequate emotional processing, which may lead to exacerbation of symptoms (McNally et al., p. 66; Rachman, 2001, p. 166).

Recovered Memory Therapy (RMT). There are no randomized controlled trials of the harmful effects of RMT. However, there is considerable evidence that therapist prompting, guided imagery, and hypnosis can sometimes produce subjectively compelling but false memories (Lynn, Lock, Loftus, Krackow, & Lilienfeld, 2003). Specifically, there are numerous reports of adult clients reporting histories of childhood sexual abuse, satanic ritual abuse, and space alien traumatic abductions following recovered memory methods. Moreover, data from recovered memory legal claims filed in Washington State reveal that suicidal ideation increased nearly seven-fold over the course of therapy, and hospitalization increased nearly five-fold (Dineen, 2001).

Grief counseling. Studies of grief therapy for individual who have suffered serious loss of loved ones suggest harmful effects, at least among those experiencing normal bereavement reactions. Neimeyer (2000) conducted a meta-analysis of 23 controlled studies of grief therapy and found only a small mean effect size of $d = .13$. Moreover, Neimeyer found that 38% of the people who received grief therapy would have achieved superior end-state functioning if they had been assigned to the no-treatment control condition, suggesting the possibility

of iatrogenic effects of grief counseling among a sizeable subset of individuals.

Professional Issues

Dissemination Versus Promotion

Despite little evidence of efficacy, many clinicians and practitioners obtain training in these treatments and then apply them in the clinical setting. Grief counseling has become a cottage industry in the mental health field. About 25% of doctoral-level therapists regularly use one or more recovered-memory techniques to uncover suspected child sexual abuse (Polusny & Follette, 1996; Poole, Lindsey, Memon, & Bull, 1995). Counselors who administer CISD probably number in the thousands. For example, following the September 11, 2001, terrorist attacks, one purveyor of CISD based in Atlanta sent CISD therapists to 200 companies in New York City (McNally et al., 2003).

The dissemination of efficacious treatments has become a recent goal of cognitive-behavioral therapists (AABT, 2001). However, it is important to distinguish promotion from dissemination. The goal of promotion is pecuniary persuasion, whereas the goal of dissemination is education. The promotion of clinical pseudoscience often fails to acknowledge boundary conditions of theory and limitations of application. Questionable techniques are often popularized as panaceas in the popular media long before they are subjected to experimental tests of efficacy (Gaudiano & Herbert, 2000; Herbert et al., 2000). The distinction between dissemination and promotion, however, is too frequently lost in the clinical marketplace, including the practice of behavior therapy (Corrigan, 2001; Lohr, Meunier, Parker, & Kline, 2001).

Ethics

The practice of pseudoscience raises major ethical implications for the mental health profession. For instance, the preamble to the American Psychological Association Ethical Principles and Code of Conduct (1992) states that psychologists work to develop a valid and reliable body of scientific knowledge based on research. The General Standard (1.06) states that psychologists rely on scientifically and professionally derived knowledge when making judgments. Thus, some authors (Singer & Lalich, 1996) have argued that the use of techniques that are not based on scientific knowledge perpetuates unethical behavior. That is, an ethical obligation to avoid harm applies to acts of commission where there is

evidence that the purported benefits of treatment are absent, or where there is an absence of evidence that the treatment is beneficial. In the latter case, the application of such treatment can be ethically defensible if the clinician is aware that little evidence exists, and when the clinician informs the client of that fact. That is, the client should be informed that the treatment is not usual and customary, should be informed whether there are empirically supported customary treatments, and should be informed of the rationale for applying the treatment in addition to, or instead of, customary treatment. If a clinician fails to provide such information and act on it, ethical sanctions could apply. For example, the Arizona Board of Psychologist Examiners (1999) placed sanctions on the practice of a psychologist who used TFT as his principal therapeutic modality, and foremost among the reasons for the Board's action was the psychologist's inability to substantiate his advertised claims of effectiveness (American Psychological Association, 1996). The same caution applies to the practice of TIR and other widely promoted pseudoscientific treatments.

Ethical obligations also apply where there exists evidence that treatment efficacy is due to factors other than the specificity of the treatment (cf. Jacobson et al., 1996; Lohr, Olatunji, Parker, & DeMaio, 2005). Given such circumstances, the clinician has the obligation to inform the client that the specific features of the treatments are inert components of the clinical procedure, as in the administration of EMDR. In this way, clients can make informed decisions about participating in treatments for which evidential warrant of treatment specificity is questionable.

The more primary ethical obligation, however, is to do no harm. The obligation is most directly applied to acts for which the public could incur significant cost or damage. Therefore, practitioners have the ethical obligation to be informed of clinical procedures for which there is empirical evidence for the potential of harm, such as CISD, RMT, and grief therapy. For example, the dissemination and practice of CISD should be accompanied with a clear caution for the potential of harmful effects and with consumer education information for alternative services. Neither should it be administered by mental health professionals when it is mandated or made compulsory by employers or service agencies (McNally et al., 2003). Finally, practicing clinicians must keep abreast of the research on the efficacy and effectiveness of those treatments to

which they have formed professional allegiances to avoid doing harm and use practices that are known to be specific and effective in order to do some good.

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Don't miss this **SPECIAL PANEL DISCUSSION** on **Thursday, November 16** at ABCT's convention:

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ABCT in the Windy City

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Stewart A. Shankman, *Associate Chair, University of Illinois-Chicago*

Mark your calendars and hold onto your hats—ABCT's 2006 convention will be held in Chicago, November 16–19. Dubbed the “Windy City” for the boastings of its hot-aired politicians (or for the strong breeze off the lake, depending on who you ask), Chicago was home to the 1893 World's Fair and has since become well known for its impressive museums, theatre district, and world-class restaurants. “Chi-town” (or “the Chi” if you are local, Grammy-award-winning artist Kanye West) is famous for its lively music scene and energetic nightlife.

While also known as the “Second City,” it is home to 3 million people and is second to none in its architecture and lakefront parks. It is a friendly big city with all the convenience and culture of an urban metropolis coupled with genuine Midwest hospitality. The “City of Big Shoulders,” as Carl Sandburg wrote, is a working city proud of its diverse heritage and long history of industry. A major destination for conventioners and corporations, it is truly a city that knows how to get things done.

Our city has many names but, whatever you call it, you are sure to enjoy the ABCT convention program and exploring this beautiful city. For more information on “the Chi,” check out www.metromix.com or www.cityofchicago.org.

Hotel and Immediate Surroundings

The meeting will be held at the Hilton Chicago (720 S. Michigan Avenue, 312-922-4400). Hilton Chicago is a landmark, downtown, pet-friendly property overlooking Grant Park, Lake Michigan, Millennium Park and near to the Museum Campus. It is only minutes from the loop business center, shopping, and theatre. The hotel houses fitness facilities and several dining options including a bistro, a steakhouse, and even an Irish pub. From here, many of the attractions listed below are easily within walking distance or are a short cab or bus ride away. But even if you don't plan on leaving the hotel, be sure to bring comfortable shoes—the Hilton Chicago has 234,000 square feet of meeting and exhibit space.

O'Hare and Midway Airports: Getting to Chi-town

The two major airports in the Chicago area are O'Hare (ORD) and Midway (MDW). Chicago is one of the few major cities in America in which both airports are easily accessible to downtown via the train (orange line from Midway, blue line from O'Hare—cost: \$2.00). A cab from O'Hare will cost around \$30 to \$35 and a cab from Midway will cost around \$20 to \$25. Continental Airport Express is a shuttle service from both airports and fares are \$25 from O'Hare and \$20 from Midway (though discounts are available on-line if you make a round-trip reservation, www.airportexpress.com). Look for coupons for further discounts in your convention registration confirmation.

During most times of the day, the subway is often the fastest (and cheapest) way of getting downtown. From O'Hare, take any blue train (Forest Park or 54/Cermak) to the Jackson Blvd. stop and from there, it's about a ½ mile to the Chicago Hilton (head east on Jackson, then south on Michigan Ave.). From Midway, you'd take the orange line to Library (formally known as State/Van Buren) and from there, it's about ½ mile to the Chicago Hilton (head east on Van Buren St., then south on Michigan Ave.).

There's a full schedule of Amtrak trains that go into Union Station, which is about 1.5 miles from the Chicago Hilton. For those of you who are thinking of driving to Chicago, be aware that there is a major construction project on I-90/94 just south of downtown so this will most likely cause delays for those of you driving from the south. Finally, for the adventurous among you, there are many harbors along the Lake Michigan lakefront if you want to take a boat to Chicago (the St. Lawrence Seaway and Calumet River can get you there).

The Block System and the El: Getting Around Chi-town

The Chicago Transit Authority (www.yourcta.com) runs Chicago's bus and famous elevated train system (aka, “the El”). A one-way fare on a bus or train is

\$2.00 or you can purchase a 1-day visitor pass for \$5.00 on-line. Every major train line goes into downtown, so taking public transportation from the Chicago Hilton is extremely convenient and there is really no need to rent a car. Most train lines run 24 hours a day, but check the schedules if you're planning a late night out.

One thing that helps getting around Chicago is knowing the block system. Chicago is made up of a grid where any north-south street will always have a constant east-west coordinate and any east-west street will always have a constant north-south coordinate. For east-west streets, zero occurs at Madison Street; for north-south streets, zero occurs at State Street. Two important things to remember is that every 800 is 1 mile and the lake is always to the east. So to get from 400 S State St. to 200 W Madison, one has to travel a ½ mile (400) north and a ¼ mile (200) west. There are a few diagonal streets outside of downtown, so you may have to call upon your knowledge of the Pythagorean theorem to calculate those particular distances.

Things to Do in Chicago

There is literally an overwhelming array of things to do in Chicago, from opera to roller derby. We've listed our favorites below but be sure to stop by the ABCT Local Arrangements table for more food and entertainment recommendations and travel tips.

The Lakefront and Parks

Chicago has 7,300 acres of parkland, 552 parks, 33 beaches, and 18 miles of lakefront trails. From the hotel, you can easily access the lakefront running path, but November in Chicago can be unpredictable—either arctic or springlike—so if you are planning on running outside be sure to bring appropriate gear. If you are more the strolling type, take a walk over to Millennium Park, a 25-acre park with world-class art, music, architecture, and landscape design. Rent some skates and take a spin in the skating rink or simply admire “the Bean,” a large elliptical sculpture that reflects Chicago's famous skyline.

Museums

Chicago has many outstanding museums and most of the well-known ones are close to downtown and the Chicago Hilton. The Museum Campus hosts the Adler Planetarium (the first planetarium in the Western Hemisphere: www.adlerplanetarium.org; 1300 S. Lake Shore Dr.), the Shedd

Aquarium (1200 S. Lake Shore Dr.; www.sheddaquarium.org), and the Field Museum of Natural History (1400 S Lake Shore Dr.; www.fieldmuseum.org). During the ABCT conference, the Field Museum will still be showing the famous Tutankhamun and the Golden Age of the Pharaohs exhibit. This is a hot ticket so be sure to make your reservations in advance.

Near the University of Chicago on the south side of the city is the mammoth Museum of Science and Industry (www.msichicago.org; 57th Street and Lake Shore Drive). In the fall, this museum will be housing a much-publicized exhibit entitled "Target America: Opening Eyes to the Damage Drugs Cause." They also have many kid-friendly exhibits, including a submarine, coal mine, and Omnimax theater. Near the Museum of Science and Industry, on the campus of the University of Chicago, is the Oriental Institute (www.oi.uchicago.edu; 1155 East 58th St.) a must-see for archeology buffs.

A few blocks north of the Chicago Hilton is the famous Art Institute of Chicago (www.artic.edu; 111 S. Michigan). The Art Institute is one of the premier art museums in the U.S. The museum houses all styles of art but is most known for its impressionist collection (such as Seurat's famous *Sunday on La Grande Jatte* and many of Monet's *Haystacks*). It also houses many important works by Van Gogh, Picasso, and Matisse, among others. The American collection is also particularly impressive with such well-known pieces as *American Gothic* and *Nighthawks*.

If you are bringing along the kids, be sure to visit the Chicago Children's Museum located at Navy Pier (www.chicchildrensmuseum.org), three floors of interactive learning adventures for toddlers to 10-year-olds. Most museums in Chicago have "free days" so check out their Web sites to see when these might be.

Architectural Tours

One of the most popular tourist attractions in Chicago is its architecture. The Great Chicago Fire burned the city to the ground in 1871 (though whether Mrs. O'Leary's cow was to blame, as the legend states, is up for debate). After the fire, many of the world's greatest architects converged on the city to rebuild it. During the course of its architectural revival, Chicago became the birthplace of the skyscraper and the famed Chicago School style of architecture.

In the summer, there are many river tours of downtown architecture, but during

November, one of the few river tours available is the shoreline-architecture tour (www.shorelinesightseeing.com/archboat-tours/rivercruise.htm). It runs only on weekends, but exploring the city's architecture via the river is one of the best ways to see it. In addition, there are many walking and driving tours of the city's architectural wonders, so check the Chicago Architecture Foundation's Web site for more information (www.architecture.org/tours.aspx). For Frank Lloyd Wright fans, the foundation leads a very popular tour of the Frank Lloyd Wright-designed homes in Oak Park, a suburb just west of the city (and accessible by the el).

Music

Chicago is, of course, famous for its blues. It was in our town that artists such as Howlin' Wolf, Muddy Waters, and Sonny Boy Williamson made their mark. Throughout the city, there are many wonderful blues bars and clubs that have live music nearly every night. All of the clubs tend to be crowded on weekends, so get there early.

Right around the corner from the Chicago Hilton is the famous Buddy Guy Legends (www.buddyguys.com, 754 S. Wabash). At Buddy Guy's, not only will you hear great live blues, but the menu of Southern and Cajun cuisine is fantastic. Buddy himself is often there to host.

On the north side of the city, in the upscale neighborhood of Lincoln Park, there are two famed blues bars across the street from each other—Kingston Mines (www.kingstonmines.com; 2548 N. Halsted) and B.L.U.E.S. (www.chicagobluesbar.com; 2519 N. Halsted). If you're going to get a nice dinner up in the Gold Coast, Blue Chicago (www.bluechicago.com; 736 N. Clark St.) or its sister club, Blue Chicago on Clark (536 N. Clark St.), are great places to pop in to see live blues (one cover charge gets you into both places).

If jazz is more your thing, there are many jazz clubs in town as well. The Jazz Showcase (www.jazzshowcase.com; 59 W. Grand Ave.) is an upscale club in the River North neighborhood, just north of the loop. If you're looking to explore a little further for your jazz, the Green Mill is the place for you (www.greenmilljazz.com; 4802 N. Broadway). The "Mill" was founded in 1908 as one of the first jazz clubs in the world and is in the Uptown section of the city, about 7 miles from the Chicago Hilton. In the 1920s, it was a speakeasy for Al Capone and the club still has that 20s-style

charm (as well as that great Big Band sound).

Comedy

Home to many household names in comedy such as John Belushi, Bill Murray, and Chris Farley, Chicago is a city that likes to laugh. Stop by the Second City (www.secondcity.com; 1616 N. Wells) to catch the hilarious improv and sketch comedy and see the photo gallery of the hundreds of famous comedians who got their start there. Or, you could pop right down the street to Zanie's (www.chicago.zanies.com; 1548 N. Wells) to see some fresh new stand-up or take a trip to the north side to the iO Theater to see the best long-form improvisational comedy in the city. Alums of the iO include Mike Myers, Vince Vaughn, and most of the current cast of SNL.

Shopping

Don't miss Chicago's legendary Magnificent Mile for upscale shopping (www.themagnificentmile.com). Just 1.5 miles north of the hotel on Michigan Avenue you'll find over 400 exclusive stores and boutiques. Armani, Gucci, Cartier, Neiman Marcus, and Tiffany are just a few of the names you may encounter on your shopping excursion. Turn the corner on Oak Street and you'll stroll past Jil Sanders, Hermes, Kate Spade, Prada, and Barney's, just to name a few. After you've shopped 'til you drop, rejuvenate with a drink in the Signature Room (www.signatureroom.com). Located on the 95th floor of the John Hancock Building on Michigan Ave., it offers spectacular views of the city and is a wonderful place to catch the sunset and unwind.

For those of you who like crowds, be sure to catch the Magnificent Mile Lights Festival scheduled for November 18 this year. After a parade, grand marshal Mickey Mouse illuminates the trees along the Mag Mile with over 1 million lights, signaling the official start of the holiday season in Chicago. The lights, along with fireworks over the Chicago River, are quite a breathtaking spectacle, but be advised that the light-to-person ratio is roughly equal-close to a million attend this annual event!

For an authentic Chicago shopping experience, check out Marshall Field's (www.fields.com; 111 N. State Street). While the Macy's conglomerate may have pasted its name on the historic building by then, you can't miss this true Chicago tradition. Designated a national historic land-

mark in 1979, the store boasts the largest unbroken example of Tiffany glass in the world—over 1.6 million pieces—in the 5th floor atrium and, during the holiday season in the Walnut room, a 45-foot tree decorated and shining with over 250,000 lights. Outside see the trademark clocks and 13 animated window displays telling a holiday story.

Theatre and the Arts

Chicago's theatre district is located about a mile north of the hotel near the intersection of State and Randolph streets. It is a vibrant scene with major Broadway shows and musicals. There are several venues in the area, including the Chicago Theatre, the Cadillac Palace, and the Ford Oriental Theatre. For up-to-date listings, visit www.theatreinchicago.com.

For aria lovers, the Lyric Opera is a can't-miss experience. The majestic Civic Opera House opened in 1929 and has been home to a world-class roster of singers, conductors, and directors. Check their Web site (www.lyricopera.org) for tickets to the November performances of Richard Strauss' *Salome*.

A Great Sports City

Home to those "lovable losers," the Chicago Cubs, as well as the 2005 World Champion Chicago White Sox, Chicago is a great city for a sports lover. Of course, no baseball will be played in November and

the Bears will be playing football away the weekend of the convention, but sports fans may be able to check out a Bulls (www.nba.com/bulls) or Blackhawks (www.chicagoblackhawks.com) game at the nearby United Center, only about 3 miles west of the hotel. And for the curious, or the vicariously violent, Chicago even has its own all-female flat-track roller derby league (www.windycityrollers.com).

Restaurants: Whatever You Like

It's very difficult to summarize the outstanding culinary options in Chicago as you can literally find whatever type of cuisine you're in the mood for. Chicago is a city of neighborhoods from Little Italy to Greektown to Chinatown and more (see <http://www.notfortourists.com/ch-pdfs.aspx?city=CH.com> for a great map of these areas). You can also search the *Chicago Tribune*—sponsored Web site for restaurants by neighborhood, price, and type of food and see reviews and recommendations (www.metromix.com).

Some of the more upscale restaurants in Chicago may require reservations well in advance. These are just a handful of our recommendations: For four-star French cuisine towering 40 floors above the Chicago Stock Exchange, try Everest (440 S. LaSalle, 312-663-8920). For great steak and possibly some celebrity spotting, we'd recommend Gibson's Steakhouse (1028 N. Rush St.). For great Mexican food, don't miss Topolo-

bampo (445 N. Clark, 312-661-1434) or its more casual and cheaper sister restaurant next door, Frontera Grill. With a spectacular view of Lake Michigan, Spiaggia is possibly the best upscale Italian restaurant in the city (980 N. Michigan, 312-280-2750). And, if your big grant just got funded, you won't want to leave town without a truly incredible dining experience at Charlie Trotter's (816 W. Armitage, 773-248-6228), the namesake restaurant of Chicago's celebrity chef (jacket, tie, and a credit card with a very high limit required).

And, of course, we can't talk about food in Chicago without mentioning the deep-dish pizza that it is famous for. Sinfully good Chicago-style pizza can be found at Pizzeria Uno (29 E. Ohio), Gino's East (162 E. Superior), and Giordano's (223 W. Jackson Blvd.).

We hope you enjoy the 2006 ABCT convention and our wonderful city. Please come visit us at the Local Arrangements table where we Chicagoans will be glad to brag about our hometown and do whatever possible to help to make your trip to the Windy City a memorable one. ✍

At ABCT

Listserve Update

David Teisler, CAE, *Director of Communications*

ABCT will be switching its listserve hosting from UCLA to Maryland. This represents a huge shift in several ways. First, we're moving from a site that was contributed to us by a member and her institution to one that is owned by ABCT (the server and lines aren't; the Lyris construction is); second, administration will be moving from the member to staff; and, what will be most visible to our members, we're changing the way members join the listserves.

We will continue to have the two listserves: general membership and student SIG.

All members will automatically be listed in the general membership listserve; and all

students in the student listserve, in addition to the general membership listserve. However, each list will afford you the opportunity to unsubscribe. Staff will be updating the lists with great frequency in the very beginning and at busy times, such as renewals and convention registration, so that anyone wishing to unsubscribe can be accommodated quickly.

We owe a great debt of gratitude to Lynn Marcinko-McFarr who got the listserve off the ground and kept it running for more than 4 years before turning it over to Jerry Tarlow, who has been managing it for the last year. Our thanks go to UCLA-Harbor Medical Center for the use of their servers during this period.

Some things, however, will remain the same. The rules that govern the listserve will remain in place. You can find them at <http://www.aabt.org/Listserve/listserve-rules.html>. And the team that has been monitoring the listserve and reviewing rules and such remains the same: Laura E. Dreer (Chair), Debra Kaysen, Jerry Tarlow, Jean-Philippe Laurenceau, Kelly A. Phipps, and George F. Ronan. ✍

Find-a-Therapist

Include Practice Particulars in Your Find-a-Therapist Listing to Increase Patient Referrals

Katherine Martinez, *San Francisco Bay Area Center for Cognitive Therapy*

Now that summer has ended and you're back at work, increasing patient flow may be a priority. One of the benefits of being an ABCT member is the on-line Find-a-Therapist Clinical Directory and Referral Service. This service allows members to post their contact information to generate patient referrals. All Full Members and New Professionals who indicate that they take referrals and have allowed us to post their practice are listed in the Find-a-Therapist directory. Did you know that you can improve this service by adding "practice particulars" to your listing? *Practice particulars* enables members to describe their practice in further detail by including practice philosophy, areas of specialization, and other relevant information. Enhancing your listing with *practice particulars* can increase the likelihood of appropriate referrals by enabling individuals to use this information to match their treatment needs with your area of specialty. ABCT members have found this service highly beneficial in keeping their practice full and active, and report the following:

"... it is true, more people have said they found me through the ABCT website than through any other referral source."

—F. Michler Bishop, Ph.D., New York (ABCT member since 1989)

"Thanks for the terrific therapist referral directory service that you provide. It has been an essential resource for patients who are trying to locate CBT therapists in their area, as well as a fabulous resource for me to receive patients who are specifically seeking the treatment that I provide."

—Lynn Martin, RN, MS, NP, Orinda, CA (ABCT member since 1989)

How Do I Add *Practice Particulars*?

Simply choose the "List My Practice in the Expanded Find-a-Therapist" option on your dues renewal form or log on to the member's home page at: www.abct.org/members/ and select Find a Therapist Directory and Referral Service: *join now*.

Please note that an additional \$50.00 is required to participate in the Expanded Find-a-Therapist service.

If you have already submitted your dues renewal or signed up on-line without adding *practice particulars*, please download a form:

- go to www.abct.org
- click on MEMBERSHIP SERVICES
- click on DOWNLOAD A CLINICAL DIRECTORY FORM (EXPANDED FIND A THERAPIST)
- fill out the form and mail or fax (212-647-1865) to ABCT and include credit-card information (or if mailing, send a check to ABCT)

Once your request is processed, you can log onto the member's home page at any time to make edits and ensure your information remains current.

Questions?

Contact Lisa Yarde at lyarde@abct.org

Fall Tip

Plan ahead now by booking your hotel and flight for the ABCT conference in Chicago.

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positions available

HUDSON RIVER REGIONAL PSYCHOLOGY INTERNSHIP PROGRAM, NEW YORK STATE OFFICE OF MENTAL HEALTH: offers full-time pre-doctoral internship positions in professional psychology for 2007-2008 in its APA-accredited program. Weekly seminars in a variety of clinical and professional areas supplement extensive supervision. Clinical assignments are to inpatient and community services programs at facilities of the New York State Office of Mental Health: Hudson River Psychiatric Center and Rockland Psychiatric Center. Preference is given to students enrolled in APA-accredited clinical or counseling psychology programs. For further and application materials contact: Paul Margolies, Ph.D., Training Director, Hudson River Regional Psychology Internship Program, Hudson River Psychiatric Center, 10 Ross Circle, Poughkeepsie, NY 12601-1078; email hrrh-pjm@omh.state.ny.us; phone (845) 483-3310.

PSYCHOLOGIST. A Psychologist Position at the CARES Institute at the University of Medicine & Dentistry of New Jersey-School of Osteopathic Medicine is currently available. This represents an exciting opportunity for career development by joining a dynamic, multidisciplinary team who adheres to the scientist-practitioner model and are committed to developing and providing the highest caliber evidence-based clinical services to children and families in which abuse has occurred. Institute staff consists of medical, mental health, social work, and research professionals who provide clinical services, expert testimony, community outreach, legislative advocacy, training and NIMH-funded research.

Our faculty members, Drs. Esther Deblinger and Melissa Runyon, have co-developed our evidenced based treatments for child sexual and physical abuse. NIH funding supports the development and evaluation of these treatment models.

This position offers a variety of clinical, research, and training opportunities in the area of child maltreatment. Responsibilities include conducting psychological evaluations of children involved in investigations of alleged abuse and providing individual and/or group therapy to families and children who are victims of child physical and/or sexual abuse. The program also serves children who have been exposed to domestic violence and other violent crimes as well as challenging populations including adolescents engaging in high risk behaviors and parents who

engage in punitive/abusive parenting practices. Opportunities may also be available to supervise Institute staff in our evidence-based treatment models and to train professionals. Other opportunities are available to assist in the implementation of research protocols and dissemination of findings. Applicants should have a Doctoral degree in Psychology with child clinical experience. Preferred applicants will be licensed or license-eligible in the State of New Jersey and will have some experience with cognitive-behavioral therapies. We will begin reviewing applications immediately and will continue until the position is filled. The position is full-time with a variable starting date.

The CARES (Child Abuse Research Education and Service) Institute has been designated by the State of New Jersey as a Regional Child Abuse Diagnostic and Treatment Center. The Institute is a member of the National Child Traumatic Stress Network (NCTSN) which is funded by SAMHSA.

The campus is located in the Philadelphia metropolitan area approximately 8 miles from center city Philadelphia, 1 hour from the beach, 1 1/2 hours from New York City, and 3 hours from Washington, DC.

We offer a competitive salary and comprehensive benefits package. Please apply on-line at www.umdj.edu/hrweb. Reference job #06SS929583 UMDNJ is an AA/EOE, M/F/D/V.

UNIVERSITY OF CALIFORNIA, LOS ANGELES. The UCLA Department of Psychology invites applications for a tenured position in Clinical Psychology at the Associate or early Professor level. Candidates should have a well-established program of original research in child/adolescent clinical psychology focused on prevention and/or intervention. Areas of expertise might include evidence-based treatments, randomized controlled trials, therapy process and outcomes, effectiveness research, treatment dissemination and services research, or prevention science. Teaching duties will include both undergraduate and graduate courses in clinical psychology. Please send a curriculum vitae and statement of research interests, and also arrange for three letters of recommendation to be sent to: Clinical Psychology Search Committee (Job #: 0875-0607-01), UCLA Department of Psychology, Box 951563, Los Angeles, CA 90095-1563. Inquiries can be addressed to the search committee chair, Bruce L. Baker (baker@psych.ucla.edu). Application review will begin on October 16, 2006. UCLA is an Equal Opportunity/Affirmative Action Employer; women and minorities are encouraged to apply.

We are seeking a **FULL-TIME POSTDOCTORAL FELLOW** to coordinate a large NIMH grant related to the treatment of PTSD in adults. Candidates should have a solid cognitive-behavioral background preferably in treating adults with PTSD or other related experience. Position available to start July 1, 2007. Please submit a CV and cover letter describing training and experience to Lori Zoellner, Ph.D., via email at zoellner@u.washington.edu or mailing address: University of Washington, Department of Psychology, Box 3 51525, Seattle, WA 98195.

The University of Washington is an equal opportunity, affirmative action employer. To request disability accommodation in the application process, contact the Disability Services Office at 206-543-6450; 206-543-6452 (tty) or dso@u.washington.edu.

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.

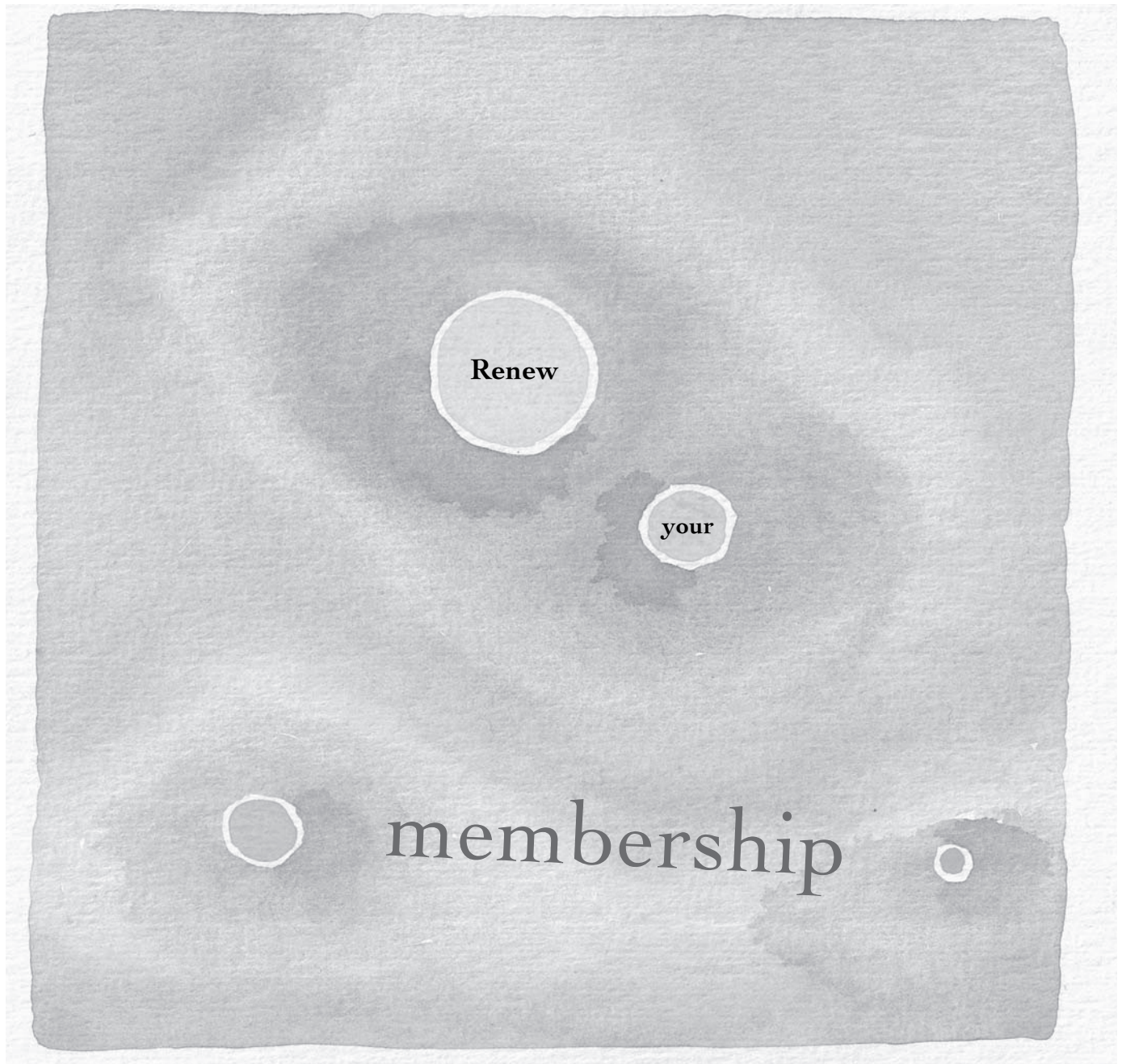
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ABCT

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Clinical Intervention Trainings

Wed. & Thurs., Nov. 15 & 16
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1

Dialectical Behavior Therapy: From Soup to Nuts | 14 CE credits

Marsha M. Linehan & Kathryn E. Korslund,
University of Washington

Thursday, Nov. 16
8:30 a.m. – 5:00 p.m.

2

Having Trouble With Your Chronically Depressed Patients? Try CBASP 2006 | 7 CE credits

James P. McCullough, Jr., *Virginia Commonwealth University*
Marilyn L. Spiro, *Private Practice, Richmond, VA*
J. Kim Penberthy, *University of Virginia, Charlottesville*
Toshiaki Furukawa, *Nagoya City University Graduate School of Medical Sciences*
Elizabeth Schramm, *University of Freiburg*
Sian Rawkins, *Mt. Sinai Hospital, Toronto, and University of Toronto*

Thursday, Nov. 16
8:30 a.m. – 5:00 p.m.

3

CBT of Health Anxiety (Hypochondriasis) | 7 CE credits

Paul Martin Salkovskis,
King's College London Institute of Psychiatry and Maudsley Hospital, London

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