the Behavior Therapist

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News and Notes

MEDIA SPOTLIGHT

FoxNews.com Highlights Behavior Therapy for Kids With OCD

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

On October 26, 2004, FoxNews.com featured a story from WebMD.com entitled "Behavior Therapy Best for Kids With OCD" (Boyles, 2004). The report follows closely on news that the Food and Drug Administration (FDA) has ordered makers of the most frequently used antidepressants to include warning labels on their packaging concerning potential increased risk of suicidal thoughts and behaviors among children. The featured study examined the relative and combined efficacy of cognitive behavior-therapy (CBT) and sertraline (Zoloft) for children and adolescents with OCD (Pediatric OCD Treatment Study [POTS] Team, 2004). The study examined 97 children and teens with OCD who had completed 12 weeks of treatment with either CBT alone, treatment with Zoloft alone, a combination of the two, or placebo. While the detailed findings can be found in the October 2004 issue of the *Journal of the American Medical Association*, overall results showed that more than half of children and adolescents from the 12-week study who were treated with a combination of CBT and pharmacotherapy (Zoloft) for 3 months exhibited no evidence of OCD symptoms 4 months later and were considered to be in remission. All treatments alone and in combination outperformed placebo. Combined treatment also proved superior to CBT alone and to Zoloft alone, which did not differ from each other. Children receiving Zoloft did not ap-

tBT Instructions for Authors

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

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.

- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.

- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.

- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a profes-sional opinion. Letters should be limited to approximately 3 double-spaced man-uscript pages.

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pear to experience an increase in suicidal thoughts in this study.

John S. March, M.D., M.P.H., of Duke University Medical Center, commented, "Cognitive behavior therapy is a lot like physical therapy, but instead of, say, rehabbing a damaged knee you are retraining the brain." As Dr. March explained, "This is a neurobehavioral illness and there are skillful and unskillful ways to treat it. The wrong approach is relying on drugs alone or traditional psychotherapy. The best treatment is clearly evidence-based behavior therapy." He also emphasized that cognitive-behavioral techniques for the treatment of kids with OCD can be relatively easily learned by psychiatrists, psychologists, and social workers.

The Fox.com story exposes laypersons to the benefits of CBT and clinical science. The story, readily understandable, might tempt other health-care professionals to obtain additional information about CBT and the treatment of OCD. The study may also enhance public awareness of the empirically based treatment move-

ment and educate the public about effective pharmacological approaches for treating OCD. Dr. March also makes a number of points about the role of CBT in the treatment of OCD for persons unfamiliar with this approach.

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People in the News

PHILIP C. KENDALL will be the first recipient of the Anxiety Disorders Association of America (ADAA) Research Recognition Award for anxiety disorders in children and adolescents. This award recognizes the contribution and dedication of the recipient to advancing understanding of the psychopathology and treatment of anxiety in youth. The award was presented at the opening session of the ADAA conference on March 17, 2005, in Seattle. Dr. Kendall's research with CBT for anxiety in youth has been translated into six different languages in over a dozen countries worldwide. As author/coauthor of over 300 research publications and books, Dr. Kendall's work has advanced our understanding of the nature of psychological disorders of childhood and the outcomes associated with psychological treatments. Throughout his highly decorated career, Dr. Kendall has been an integral part of AABT. His continued dedication to cognitive-behavioral research and clinical practice makes this award especially well deserved. ✍

Institutional Settings

Building a Treatment Mall: A First Step in Moving a State Hospital to a Culture of Rehabilitation and Recovery

Steven L. Webster, Susan H. Harmon, and Betty T. Paesler, *Dorothea Dix Hospital, Raleigh, North Carolina*

At the dawn of the new century, Dorothea Dix Hospital (DDH), like many state hospitals, could be described as a facility very much out of step with modern psychosocial rehabilitation (PSR) principles and values. For example, DDH's lack of adequate and accessible rehabilitative interventions for patients was one of many concerns brought to the attention of hospital managers by an expert consultant hired by the state of North Carolina

in preparation for United States Department of Justice (USDOJ) tours of the state's inpatient psychiatric facilities. Potential federal liability associated with inadequate "active treatment" provided the impetus for DDH executives to adopt the "treatment mall" model as a means of overhauling the hospital's approach to PSR.

Treatment malls are centralized programming areas, away from a hospital's residential wards, where patients and staff

from multiple residential wards meet for a significant portion of each day. All ward functions, such as charting, meals, and medication administration, are transferred to the mall during this time. The facility's physical and staff resources are pooled and integrated at the mall so that everyone at the hospital has equal access to a full range of services. In best-practice treatment malls, staff and patients work as partners to give and receive treatment, education, skills training, and support. Effective treatment malls facilitate physical and social environments in which participants are more likely than in unit-based programs to become actively engaged in rehabilitation and recovery (Bopp, Ribble, Cassidy, & Markoff, 1996).

This article describes the rehabilitative climate at DDH prior to the implementation of its treatment mall, and provides an overview of the centralized day treatment program that preceded the treatment mall. It is important to understand how the day treatment program facilitated the early suc-

cess of the longer-range mall project. The article then summarizes how DDH designed and implemented its treatment mall. The authors address the ways in which the PSR program is evolving within the established treatment mall, as evidence-based rehabilitation approaches are introduced and as participants are increasingly empowered to direct the shape of their program. Finally, the authors briefly discuss the program's strategic goals in relation to future challenges.

DDH Rehabilitative Environment Prior to the Introduction of the Treatment Mall

During the late 1990s, the section of DDH primarily responsible for delivering rehabilitation services to patients was the Rehabilitation Therapies Department (RTD). The RTD at that time was comprised of the following clinical disciplines: occupational therapy, academic and vocational services, therapeutic recreation, creative expressive arts therapies, horticulture therapy, clinical chaplaincy services, and leisure recreation services. The RTD, much to its credit, placed registered and licensed rehabilitation professionals, rather than support staff, in lead clinical positions within each department section.

The downside of this structure was the manner in which the RTD fell prey to a common tendency toward hierarchical overspecialization of professional staff and managers. This led to an increase in administrative functions for professional staff and managers, with a corresponding decrease in direct patient-related activity. Despite the RTD's commendable efforts to promote professional rehabilitation practitioner competencies and to forge an understanding of the importance of rehabilitative approaches in a medical-model culture, an unfortunate situation emerged: The least severely impaired patients were assigned to the most highly trained staff, while the most severely impaired patients (the majority of the patients) were assigned to the RTD support staff with the least training. Although the RTD offered a number of excellent programs, the department's lack of centralization and its nonintegrated intradepartmental practices provided only a small percentage of patients access to the best interventions. In addition, DDH's treatment teams lacked a sufficient understanding of rehabilitative approaches. In most cases, teams referred patients to RTD programs, perceived by the teams as generalized "activities," in a random fashion. This situation, combined with the sporadic rehabilitative interventions offered by clinical disciplines other than those aligned to the RTD (for example, psychology, social work, and nursing), left the hospital far short of the volume, diversity, and quality of services required to match the facility's census and the rehabilitation needs of individual patients.

Sensing a need for reform, the authors proposed, and took the lead in designing, a centralized program that would later be called Rehabilitation Therapies Department Day Treatment Services. A key objective of the program was to change the ways that staff and patients within the facility perceived rehabilitative practices. The program would increase the volume and diversity of services and, perhaps more importantly, address the clinical rationale for how and why patients moved through the available services. The program placed special emphasis on person-centered approaches and rehabilitation outcomes. It modified the RTD's traditional nonstandardization of initial rehabilitation assessments and staff representation in hospital treatment teams by assigning registered and licensed occupational therapists (OTR/L) to conduct functional rehabilitation intake assessments with patients. The intake assessments had two key elements: (a) measurement of the client's self-identified problems in the categories of self-care, productivity, socialization, leisure, and spirituality, using the Canadian Occupational Performance Measure (COPM; Law et al., 1990); and (b) general classification of the client's level of cognitive function, using the Allen Cognitive Level (ACL; Allen & Blue, 1998). The OTR/Ls were assigned to treatment teams as the RTD's clinical liaisons. The results of the intake assessments were used in working with the teams to identify the best combination of available rehabilitation services to meet the needs of individual patients. The objective was to promote successful outcomes in relation to the patient's projected living arrangement upon discharge from the hospital. In addition, there was a daily RTD clinical team meeting, away from programming times, in which RTD professional and support staff of all department sections discussed each patient's progress in programming and made schedule revision recommendations for treatment teams.

The authors designed the program to maximize the efficiency of all RTD physical and staff resources. The program placed special emphasis on increasing the amount of direct contact between patients and department professionals. An important objective was the breaking down of hierarchical professional tendencies through an acknowledgment of clinicians' roles in the program on the basis of function, rather than perceived "fairness" across clinical disciplines and sections. RTD professional staff were expected to conduct three rehabilitative groups per day or evening and oversee the clinical quality of less formal interventions provided by discipline assistants and other support staff. Support staff performed functions such as escorting patients to and from the program, supervising patients during break periods, and cofacilitating rehabilitative groups under the supervision of RTD professionals. All RTD resources were pooled in central locations, away from hospital residential wards. The intent was to provide a consistent schedule of rehabilitative groups and activities to as many patients as possible, in the context of a 7-day hospital.

The RTD management team spent nearly a year designing the new day treatment program. During this planning period, the team encountered significant resistance from RTD professionals, hospital units, and, in some cases, facility executives. The cause of the resistance on the part of RTD professionals, beyond the typical and expected reaction to any type of change, related to the program's redefinition of professional roles. Many professionals consistently expressed discontent with the expected increase in direct patient-related activity, as well as the professionals' perceived loss of discipline, autonomy, and ownership of preferred rehabilitation group types and client memberships. Hospital units expressed concern with the centralization inherent in the program design, preferring that RTD staff instead be assigned in greater numbers to the residential wards to provide unit-based services. Hospital executives were unsure about approving a new program because DDH was undergoing significant scrutiny by accrediting organizations. Executives feared that the early disorganization of a new approach might prove disruptive to the hospital's efforts to maintain accreditation.

The RTD's management team conducted an audit examining the percentage of direct patient-related activity performed by department staff across position classifications, in part to address the concerns of its professional staff. The audit found that RTD professionals ranked the lowest in terms of direct patient-related activity at 27% per full-time position; rehabilitation therapists averaged 37%; and rehabilitation
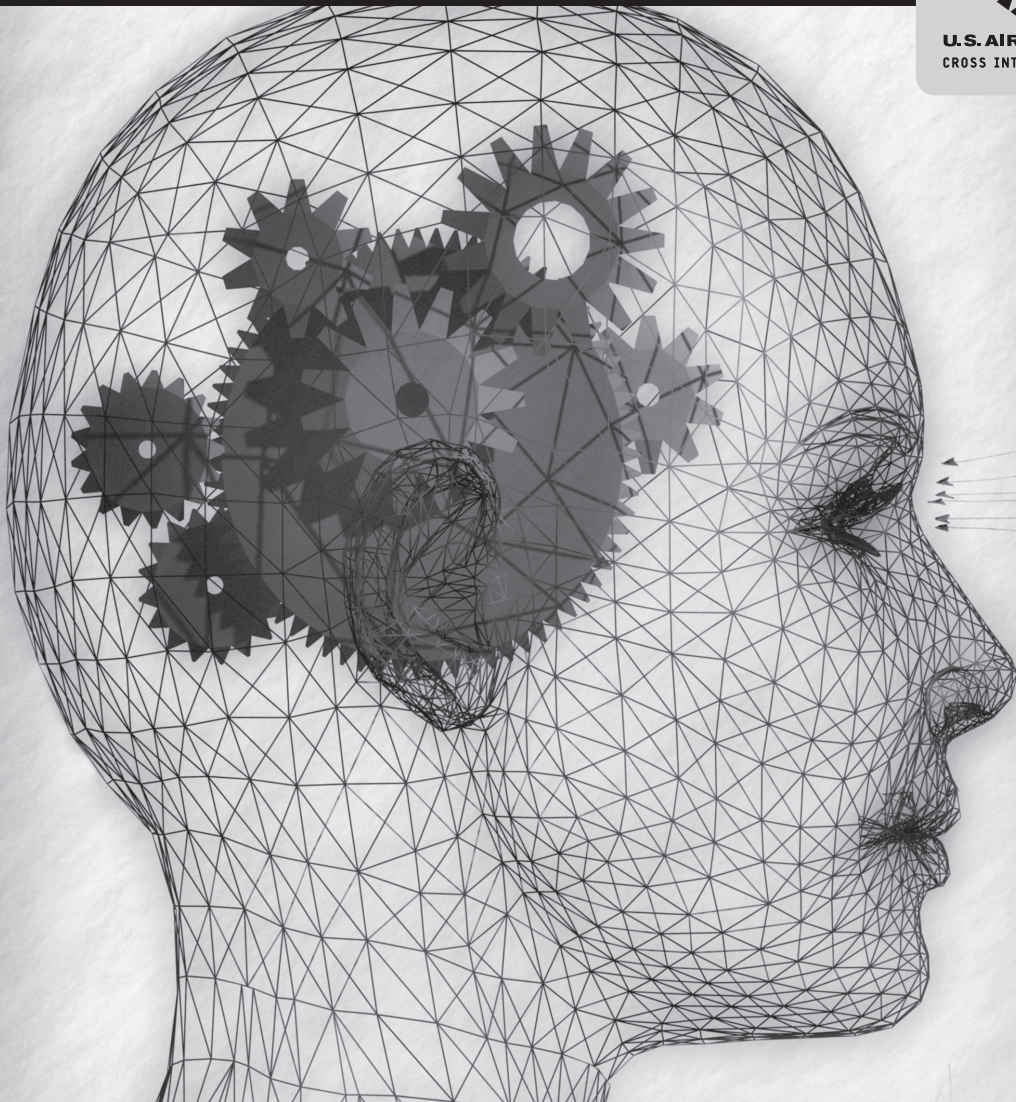
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therapy assistants and rehabilitation technicians averaged 67% and 60%, respectively. The management team used these data with RTD staff to reinforce the rationale for change. In order to address the concerns of hospital units and executives, the authors conducted detailed orientation sessions at discipline meetings and with all hospital unit management teams, as well as with DDH clinical and administrative managers. The DDH clinical management team approved the RTD final program design and implementation date one day before the summary terminations of the hospital director, clinical director, and director of nursing. The day treatment began operations in February 2000.

RTD managers worked with department staff to develop the new program. Rehabilitative offerings for program participants became increasingly more creative and diverse, as discontented RTD professionals resigned and were replaced by new staff with fresh expectations and ideas. The number of daily RTD PSR groups increased from an average of 10 per day to approximately 35 per day. Participant satisfaction with the program, measured through regular surveys, was consistently favorable. The RTD had, in many ways, moved in the direction of reform. In February 2002 the Special Attorney General, accompanying the expert consultant on the first of the consultant's two tours of DDH, referred to the RTD's day treatment as a "mini-treatment mall" (R. Slipsky, personal communication, February 7, 2002).

The improved efficiency and quality of the RTD's operations made a significant contribution to DDH's rehabilitative climate; however, because of the program's limited scope, its independent operations, and its underutilization by the hospital, most of DDH's patients at the time of the initial consultant's tour were significantly underprogrammed. The consultant recommended that DDH, in preparation for its evaluation by the USDOJ, initiate a long-range plan to completely redesign its approach to PSR. The consultant strongly encouraged DDH to develop a programming structure that would allow the vast majority of its patients to receive rehabilitative services outside the residential wards. The consultant suggested the "treatment mall" model as an option for reaching this objective (J. Geller, personal communication, February 8, 2002).

Designing the Treatment Mall

Almost immediately after the consultant's initial tour, DDH executives created a Department of Justice Task Force to address the issues (a major issue being PSR) that the consultant brought to the facility's attention. The assistant hospital director chaired the task force, which was comprised of DDH's clinical director and the chiefs of DDH's clinical sections, as well as staff members throughout the facility who attended meetings ad hoc. The authors, in part due to their experience building the centralized RTD day treatment program, were included as permanent members of the task force. Following the lead of the hospital director, the task force began the extensive planning required to develop a treatment mall. Members of the task force toured three public inpatient psychiatric facilities in Virginia that had, under the scrutiny of the USDOJ, established treatment mall programs. The task force conducted an extensive analysis of DDH's existing physical spaces. During the course of the group's meetings, the chair delegated to the authors the task of creating a 6-month plan for designing and implementing the first phases of the treatment mall. The authors completed the Dorothea Dix Hospital Centralized Treatment/Rehabilitation Services Initial 6-Month Plan, and it was approved by the task force in April 2002.

The initial 6-month plan outlined DDH's strategy for expanding centralized PSR programming to include participation by all hospital clinical disciplines and support from other nonclinical staff. It recognized that the scope of the treatment mall project would require a dynamic planning strategy that would allow ongoing incorporation and coordination of input from virtually every hospital area. The plan was organized in five broad categories, and included many planning elements within each category. The categories were as follows: clinical considerations, physical plant and safety, transition of residential unit functions, staffing and staff training, and information management. The plan included a master time line, with individual planning elements within the broader categories scheduled for completion through the 6-month period. It also included a floor plan detailing projected space utilization considerations. The planning elements were to be revised, deleted, or consolidated as unforeseen variables emerged in the planning process. It was understood that all aspects of the project were interrelated; therefore, the categories, with their corresponding planning elements, would be cross-referenced regularly to ensure continuity in the master plan.

Clinical Development

In August 2002, the task force assigned the job of building the treatment mall to a newly created Clinical Program Design Team (CPDT). The team was cochaired by the assistant hospital director and the clinical director, and included the chiefs of DDH's clinical services (rehabilitation, medical, nursing, psychology, social work, and food and nutrition). This shift demonstrated DDH's commitment to maintaining clinical quality in all aspects of the mall's design. For example, in addition to curriculum considerations, prior to making decisions regarding physical modifications to the hospital building the CPDT collected individual patient data from throughout the facility in areas such as the following: reason for admission or continued stay, projected disposition, diagnosis, problem behaviors, medical considerations, security requirements, and level of cognitive function. These data were used not only to project the kinds of programming spaces needed within the mall, but also to estimate the number, frequency, size, and types of PSR groups to be offered.

The CPDT developed a daily programming structure in which patients were scheduled for four PSR groups per day, Monday through Friday, between the hours of 10:00 A.M. and 3:00 P.M. Professional clinicians from all of DDH's clinical disciplines facilitated or oversaw the groups. The CPDT developed a template for phasing in all residential wards to this structure; the template served as a gauge for long-range progress.

Only the patient's treatment team could order patient enrollment in or removal from individual PSR groups. This prevented the common practice of group facilitators selecting the memberships of their groups, in many cases based on facilitator comfort and convenience rather than patient needs identified in the comprehensive treatment plan. The CPDT placed all PSR group descriptions in a uniform format to promote ease of use by the treatment teams. The format included a brief description of the group and its purpose, selection criteria, methods and procedures, expected outcomes, and criteria for participant success. The CPDT compiled the descriptions in a manual, and distributed copies to treatment teams and group facilitators. The CPDT created a PSR

order sheet for use by the teams and the mall's software administrators. The order sheet included a listing of all available mall groups from which the team could select and prioritize when constructing individual schedules for program participants. The sheet instructed the team to designate problems and goals from the patient's comprehensive treatment plan. This information was then communicated to group facilitators so that the patient's progress in groups could be documented in relation to individual problems and goals. The order sheet provided a space for teams to indicate groups that the mall did not offer, but would be helpful to individual patients. The CPDT used this information when developing the mall's curriculum offerings over time.

The CPDT assumed clinical oversight for the program. To head the team, DDH's clinical director appointed a PSR program director and an assistant program director, positions that DDH had not had up to this point. The CPDT maintained a fixed meeting schedule to oversee all aspects of program development such as curriculum offerings, mall expansion, rehabilitation assessment and planning strategies, program interface with treatment planning, interdisciplinary groups within the mall, and so on. Each clinical discipline was responsible for the quality of its section's PSR interventions and practitioner competencies.

Physical Spaces

The CPDT recognized that physical renovations to the DDH building should be informed by PSR principles and values. The goal was to create pleasant, community-like spaces and destinations within the mall, through which participants could move safely and as independently as possible, with the least amount of staff intervention. The CPDT determined the footprint for the mall in consultation with representatives from DDH's executive staff and managers from the safety, engineering, and business offices. The CPDT paid attention to safety, ease of access, noise abatement, and required physical modifications. A facility subcommittee, chaired by the assistant hospital director, was established to direct the work of the engineering department in coordinating the substantial in-house and contracted physical renovations throughout the mall. A large area near the center of the hospital, which had been used as storage and staff office space, was remodeled to become the largest section of the mall. A variety of sizes and types of programming

spaces were created within this area and in adjoining sections of the hospital. The space was designed so that program participants could move securely along hallways (including an outdoor breezeway) to reach mall destinations located in various parts of the hospital. A security camera system was installed to further enhance participants' ability to navigate mall spaces independently. White-noise machines were placed in those sections of the mall that contained multiple classrooms. Importance was placed on designing the mall in such a way that individual participants could be scheduled for programming in any of the mall's multiple sections. This allowed the consolidation of specialized groups into fixed spaces by function (for example, exercise, cooking, music, art, etc.) to promote efficiency and to ensure all participants access to the entire program.

The mall's 36 group rooms included three specialized rooms for music, two computer labs, two fully equipped exercise rooms, a kitchen, an art room, and a vocational evaluation room. Apart from group rooms, the mall offered five large check-in and break areas, a large central recreation area, an art museum, a boutique, a cosmetology salon, dining spaces, and a medical suite. Two houses and a greenhouse on the DDH campus were used for horticulture and life skills training groups. Electronic charting areas with computers and printers were established in each mall section.

Transition of Residential Ward Functions to the Mall

DDH's hospital director appointed a PSR nursing coordinator to oversee planning elements related to transitioning ward functions to the treatment mall. This position was responsible for managing all nursing functions and nursing staff at the mall. Additionally, mall coordinators, who reported to the nursing coordinator, were assigned to each section of the mall. These individuals worked closely with the CPDT to plan elements such as a system for escorting patients to and from the mall, plans for medication administration/storage/tracking, meals and snacks, identification of check-in and check-out procedures, coordination of nursing staff supervision assignments, etc. Perhaps the most challenging aspect in this category was determining how the mall would provide medical treatments to patients while outside the residential wards. The hospital director, assistant director, and medical services director took the lead in developing a centralized medical suite within the mall. The suite was de-

signed to resemble a community physician's office, with a waiting room and examination areas. Patients would be able to make appointments to receive medical services in a manner more closely resembling a community setting, rather than having services delivered to them in residential wards.

Mall Staffing and Staff Training

The most important aspect to note in relation to staffing is that DDH did not need additional staff to operate the treatment mall. Staff functions that were previously associated with particular units and clinical departments were simply reassigned to the mall during its hours of operation. The centralized mall model required fewer staff to operate than were required to run multiple residential wards.

Staff were trained in areas such as life safety procedures that corresponded with the newly created mall spaces, and use of the mall's software program. Practice runs were conducted, with open houses for patients and staff prior to the start of operations.

Information Management

The CPDT recognized early in its planning that DDH would need a software program capable of managing high volume and rapidly changing patient information associated with the mall. Western State Hospital in Virginia shared with DDH the shell of its internally developed treatment mall software. The authors then worked with a DDH software programmer to design, using the Western State shell as a starting point, a software program that would meet the specific needs of DDH's mall. The modified program allowed mall administrators to enroll patients in groups and to generate individual patient schedules and group rosters. Facilitators began using the software to complete clinical documentation. Treatment teams throughout the hospital had access to daily attendance and participation ratings, progress summaries, problem alert reports, patient schedules, group rosters, and daily documentation deficiency reports.

Mall Implementation and Initial Benefits

In November 2002, DDH began piloting mall operations with patients and staff from its long-term adult wards and clients of the former RTD day treatment program. In August 2003, approximately a year and a half after the expert consultant's recommendations, DDH opened its treatment

mall. Program users named the treatment mall the "Learning Court."

Inherent benefits of the mall model became evident almost immediately upon its implementation in at least three significant ways. First, entire residential wards could be "shut down," with their resources pooled at the mall. This dramatically increased rehabilitative efficiency. Second, patients and staff, rather than spending most of their time on wards segregated by categories such as age, gender, and legal constraints, could work and learn together in a structure more closely resembling the social diversity of community environments. Finally, patients had opportunities to participate in a structured daily routine. This was a far cry from the inactivity, disorganization, and even hopelessness of typical ward life. It is important to note that, aside from program considerations associated with the mall, the very act of building and involving patients and staff in the mall forced change and was an important first step in the evolution of modern PSR at DDH. This initiative primed DDH for growth. The new treatment mall was in place, but the work of growing a best practice, recovery-oriented program and culture within the mall had just begun.

Learning Court Program Development

Building the shell of the treatment mall had been a staff-centered enterprise. It was necessary, at some point, for hospital managers to simply start the project. Initial group offerings were limited to the types of interventions that staff facilitators had experience with and felt comfortable providing. The role of patient choice in designing personal daily schedules was far from optimal. Patients going to the mall and attending individual groups once there were viewed by staff as mandatory expectations. Once the mall structure was solidly in place, however, the CPDT went to work identifying and implementing practices that would ensure the ongoing rehabilitative relevancy of the program within the mall. A number of key principles emerged to guide this evolution. First, the program would be developed with patients as the primary planners and decision makers. Second, the volume and diversity of PSR offerings within the program would be continuously revised in response to input from patients, group facilitators, and treatment teams. Third, the program would be developed, and its success measured, within the context of modern research about recovery and the role of rehabilitation in the recovery process.

Patients as Decision Makers

The CPDT recognized the need to build into the PSR program within the mall a structure for assuring ongoing input from Learning Court participants regarding program development. Program users also needed ways to consistently represent themselves before hospital management. The Learning Court Quality Council (LCQC) was established as a user-controlled peer representation and decision-making body to address many of these needs (Webster & Harmon, in press). The council employs a variety of means, such as community meetings and surveys, to solicit peer and staff input. Council members use this information to propose and facilitate the implementation of program development projects. The council also advocates to modify hospital policies that are, from program users' perspectives, less than helpful in the rehabilitative process. Membership on the council is offered to all interested program participants as one of many daily Learning Court group options. This is a dramatic shift from traditional DDH patient focus groups that met sporadically and tended to be comprised of "hand-picked" patients who were perceived by staff as being "high functioning." LCQC members are automatic members of the Clinical Program Design Team. Members sit at the planning table with the hospital's clinical director, discipline chiefs, and PSR program managers. It is important to note that this planning practice was (and continues to be, to a lesser degree) extremely awkward for both clinical managers and LCQC members alike. Staff facilitators provided to the LCQC members approximately 1 year of coaching and support before members voted themselves ready to meet regularly as official members of the CPDT. Examples of LCQC program development projects include the design and implementation of a participant satisfaction survey, development of the Learning Court's vision and mission statements, production of a staff training module about recovery, design of the Learning Court library and intramural sports programs, and selection of a recovery-oriented logo for the program, "The Road to Recovery Must First Be Traveled."

Other examples of patient choice emerged as the program developed. Under the strong leadership of the hospital director, it was determined that patients would not be forced to attend the Learning Court or individual groups within the program. Attendance evolved to be a lesser issue over time as the refusal rate for program partici-

pation declined from approximately 11 to just 3 refusals per day. Additionally, nursing staff within the mall implemented engagement interventions for patients choosing not to attend scheduled groups at various times.

Perhaps the Learning Court's most significant development in terms of patient choice is the program's quarterly participant preregistration and group survey process. Participants are given opportunities to provide input concerning the helpfulness of their current schedule, personal goals they would like to address through program participation, and ideas about new groups the Learning Court could offer. Participants are oriented to new group offerings during this process. They work with rehabilitation therapies practitioners to choose their schedule for the next curriculum cycle. The participants' choices are then presented to the treatment teams for further input and possible revisions prior to approval. Participants may initiate at any time a group drop/add process for their treatment team's consideration.

Ongoing Program Revision

The CPDT understood that the Learning Court's rehabilitative program must be flexible and constantly open to change in order to adapt to the individual needs of program participants; therefore, a 3-month curriculum cycle structure was adopted. Suggestions for changes to the program in this structure are formally solicited each 3-month period in the form of patient, staff, and treatment team surveys. The CPDT collects and carefully considers all suggestions. New approaches are attempted regularly: sometimes successfully, sometimes meeting with failure. Each curriculum cycle represents a fresh start with a revised lineup of groups and new individual participant group schedules.

Emphasis on Recovery and the Role of Rehabilitation in the Recovery Process

The CPDT recognizes that the rehabilitative environments, curricula, and practices of the Learning Court must be informed by modern findings about recovery from severe psychiatric disorders and the role of rehabilitation in the recovery process. A critical task of the team is to engender hope among staff and patients, based on the encouraging news about recovery from research and consumer self-help literature.

Another critical task of the team is to direct staff and patients toward the creation of

a rehabilitative culture that assists, rather than delays, an individual's recovery process.

The CPDT is careful to acknowledge the complexities related to the course of psychiatric disorder and the concept of recovery. As long-term studies researcher Courtney Harding noted, ". . . the course of severe psychiatric disorder is a complex, dynamic, and heterogeneous process, which is non-linear in its patterns, moving toward significant improvement over time and helped along by an active, developing person in interaction with his or her environment" (Harding & Strauss, 1985).

The Learning Court does not contain within its program structure fixed diagnostic or rehabilitative tracks. Participants have continuous access to any portion or combination of the program's PSR curriculum offerings. Individuals are encouraged to try new groups and activities in a tolerant program environment. The Learning Court offers an abundant and diverse array of group options and rehabilitative approaches to address the participant's strengths, aspirations, and needs in multiple functional domains such as living, learning, working, and socializing. The curriculum includes a combination of psychoeducation, skills development, and peer support groups.

Future Challenges

The CPDT's strategies for meeting future challenges are summarized by the Learning Court's strategic goals: (a) continued expansion of the treatment mall; (b) improvement of rehabilitation planning; and (c) staff training and promotion of best-practice practitioner competencies.

The Learning Court currently operates 95 PSR groups per day and has 200 program participants. The program serves the majority of DDH adult inpatients. The next step is the addition of a structured evening and weekend Learning Court program.

The CPDT has identified a need to more effectively integrate DDH treatment planning with the rehabilitation interventions at the Learning Court. Many Learning Court participants report that their treatment plans are far too problem-oriented and have little to do with their lives and individual rehabilitative goals. Staff facilitators report that it is difficult, if not impossible, in many cases, to match progress documentation with goals from the treatment plan. The CPDT is currently piloting with practitioners and Learning Court participants the use of rehabilitation assessment, readiness, and

planning materials from the Center for Psychiatric Rehabilitation at Boston University (BCPR Consulting, Inc., 2001). Practitioners and patients are also being introduced to clinical approaches informed by the strengths model (Rapp, 1998). The CPDT's intent is to test the usefulness of integrating rehabilitation planning with the hospital's comprehensive treatment plan format.

The CPDT's strategy for addressing the need for staff training involves extensively educating a small core of staff and program participants in areas such as fundamentals of PSR and best-practice practitioner competencies. These individuals will then become the trainers of other staff and program participants. Training sessions will be conducted, whenever possible, with staff and patients in the same sessions.

Conclusion

Building a treatment mall is an extremely complex and long-range project. DDH made extraordinary progress on the shell of its mall in a relatively brief period. This was a good first step. Many hospital staff and patients report that DDH is tremendously more effective now in meeting the needs of its patients and staff. Some advances in quality are evident, such as recent news that the hospital's use of restrictive interventions (e.g., seclusion and restraints) declined from a fall 2003/winter 2004 high of 150 hours per month to less than 85 hours per month during fall 2004/winter 2005. The treatment mall's impact on more difficult to identify quality-of-life and cultural change outcomes remains to be measured. The authors assert that it is staff and patients working as equal partners that will ultimately move DDH to a culture of rehabilitation and recovery. As one program participant expressed, "The treatment mall is just a building, it's the people that make the program."

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ERRATUM

On p. 31 of *tBT 28*(2):

Bank, N., Rains, L., & Forgatch, M. S. (2004). *A course in the basic PMTO model: Workshops 1-3*. Unpublished manuscript. Oregon Social Learning Center, Eugene.

The first author should be Knutson, not Bank.

Training Program Update

The 5th Annual AABT Postdoctoral Panel and Overview: November 2004

Richard J. Seime, *Mayo Clinic and Mayo Clinic College of Medicine*, and Antonette M. Zeiss, *VA Palo Alto Health Care System*

TRAINING PROGRAM UPDATE EDITOR'S NOTE: *This is the third and final segment of our series reviewing training highlights from the most recent AABT convention. The focus is on postdoctoral training issues and the authors provide a glimpse into the evolution of this training model.*

38th Annual Convention Training Program Highlights: Part III

Building upon the success of the annual AABT Predoctoral Internship Panel and Overview, a postdoctoral panel and overview was inaugurated in 2000. We chose to use the identical format as the predoctoral panel and overview: a 1-hour segment with a panel of representatives from the postdoctoral training sector followed by a 1-hour segment to meet with postdocs and faculty from the postdoctoral programs. The inaugural panel had an audience of perhaps 20 individuals; the most recent panel and overview had participation of approximately 80 individuals.

The postdoctoral training of psychologists is gaining more attention over the last several years. There have been postdoctoral research opportunities for many years, as well as postdoctoral opportunities with primarily a clinical focus. A more recent phenomenon is the growth of accredited postdoctoral fellowship/residency programs, from only a few in 1999 to currently 33 that have accreditation by the Committee on Accreditation, American Psychological Association. Similarly, an increasing number of postdoctoral training programs are members of the Association of Psychology Postdoctoral and Predoctoral Internship Centers (APPIC). It appears that postdoctoral training is a pathway psychologists are choosing for opportunities to launch research careers or gain necessary expertise for specialization in psychology.

The AABT Postdoctoral Panel and Overview is a venue to learn about a process that in most respects is less structured and standardized than the internship process. Similar to our experience with the internship panel, students often attend not only while on internship but early in their graduate career to learn about the process and requirements. Based on feedback received over the first several years of the panel, we have made a concerted effort to include information relevant to both structured postdoctoral programs with a clinical focus and those opportunities that exist for obtaining primarily postdoctoral research training. With that as background, we will review the presentations at the 2004 convention; we also gratefully acknowledge the panelists' participation.

Panelists and their topics in 2004 were as follows:

Matthew Clark, Ph.D., *Mayo Clinic*— Guidelines for the Applicant's Evaluation of Clinical Postdoctoral Training Programs

Anthony Spirito, Ph.D., *Brown Medical School*—Research Postdocs

Debra Kaysen, Ph.D., Postdoc, *University of Washington School of Medicine*—Independent Research Fellowships: The Road Less Traveled

Antonette Zeiss, Ph.D., *VA Palo Alto Health Care System*—Application and Interview Process for Postdoc Programs

Dr. Clark presented an overview of ways applicants interested in a clinically focused postdoctoral residency might approach evaluating a potential postdoctoral training site. He began by emphasizing the importance of the applicant appraising his or her personal goals for training. How might a structured postdoctoral fellowship contribute to further clinical specialization, research experience, future job opportunities, and fulfilling licensure requirements for psychology practice? His focus was on structured and formal programs offering both clinical and research training. Just as with internship training, postdoctoral training sites can be found in a variety of practice settings. Dr. Clark underscored the importance of matching the patient population, type of clinical diagnoses, and assessment and treatment formats with an applicant's interest. Similar to internship, the amount and quality of supervision is important, and applicants should assess whether they will be able to work with supervisors who match their interests.

The postdoctoral program should also be viewed with opportunities for research experience and training in mind. Dr. Clark suggested that it is important in seeking a clinically focused postdoc to also inquire about dedicated time for research, sources of support for funding, and research assistant or secretarial support. Likewise, when assessing a postdoctoral program, he suggested that applicants also review the allocation of time to seminars, grand rounds, and other educational offerings. Many postdocs are 1 year in duration, which may make it difficult to both initiate and complete a research study; thus, opportunities for collaborating with faculty on existing projects should be explored carefully.

Dr. Clark emphasized the importance of asking about mentors for postdocs in a program. What mechanisms are in place in the postdoc to assure that the fellows are achieving their own goals and those of the program? Dr. Clark also underscored the role of evaluative feedback in a postdoctoral training program. It is important to inquire as to how evaluation is done, how frequently, and by whom. Structured postdoctoral programs usually have formalized evaluation methods outlined, but programs may vary in utilization of skill-based evaluations such as mock board exams or clinical evaluations based on observation.

Finally, Dr. Clark discussed the importance of assessing what happens to graduates of a postdoctoral program. Information about the types of positions fellows have obtained, licensure status, and whether graduates obtain board certification in a specialty following the postdoc are ways an applicant might assess the postdoc program's fit with the applicant's goals.

Dr. Spirito provided an overview of research postdoctoral training (Simon & Spirito, 2003). These opportunities fall into two main clusters: T-32 and F-32 research awards. The T-32's are institutional research service awards, typically at academic medical centers, and they can have many different themes; T-32's are typically of 2-years' duration. Typical activities of postdocs might be running subjects, providing clinical treatment in a research protocol, data analysis of existing data sets, collecting new data, manuscript preparation, and grant writing. The instructional approach

for T-32's is typically an apprenticeship model, and didactic requirements vary. Typical didactic opportunities might include seminars on research ethics, research methodology, grant writing, and content-specific seminars related to a particular specialty interest. Finally, university course work may also be offered to postdocs.

Dr. Spirito suggested that applicants interested in a T-32 consider several factors in evaluating the apprenticeship model for a particular site. How many postdocs have been mentored and what positions have former postdocs obtained who were mentored? What do current and former postdocs think about the experiences obtained with a particular mentor? He underscored the importance of determining if a particular mentor will have sufficient time for mentoring or whether there will be a need for additional mentors. Dr. Spirito also emphasized the importance of knowing a research mentor's expectations of a postdoc. For example, what are the expectations of how many papers to be published and where? What are the mentor's policies on authorship and ownership of ideas?

The F-32's are individual research grant applications. With this award, an applicant must have a faculty mentor identified and propose his or her own research and training plan. Dr. Spirito emphasized that the training component proposed is equally if not more important than the proposed research project. An F-32 award is typically of 2 years' duration but can be up to 3 years. The fundamental difference between the T-32 and the F-32 is that the former is an institutional training award and the latter an individual award to a fellow.

Dr. Spirito also discussed the pros and cons of research postdocs. The pros are many and include developing a relationship with a mentor, protected time for research, extensive research training, and opportunities to pursue in some depth independent research and grant writing. The postdoc also gains experience conducting applied clinical research, practical experience running large studies, and practical experience in supervising research assistants. He also underscored how former fellows can enter junior faculty positions with data in hand from the postdoc, allowing time to establish oneself in a new position. Financially, the stipends are reasonable (i.e., currently $35,568 with 0 years experience and $37,476 with 1 year experience) and include health insurance, and travel monies—and moonlighting opportunities for 10 hours a week also are permitted. These research postdocs also qualify for National

Institutes of Health (NIH) loan repayment provisions. Dr. Spirito mentioned only a few cons for T-32 and F-32 fellowships. Because of the research focus, there is less opportunity to refine and develop clinical skills, and progress toward licensure might be longer because clinical hours for licensure might not be fulfilled as easily. Finally, as is the case with all training opportunities, all that is promised may not come true!

Dr. Kaysen presented her first-person account of having obtained an individual research service award, and she provided detailed information about independent postdocs. She also underscored the importance of the postdoctoral training program as an apprenticeship for the purpose of gaining scientific, technical, and other professional skills to advance one's career. Dr. Kaysen described the F-32 mechanism and explained that all NIH institutes offer these, but that deadlines and specifics vary, and that funding can be up to 3 years for a research fellowship. Other training grants are available from federal and private sources, although some are restricted to a particular location while other grants are portable with an individual. She gave as an example the National Alliance for Research on Schizophrenia and Depression. As a major advantage of the independent research award path, she underscored the establishment of independent grant history early in one's career. Further, she also explained that these awards were easier to obtain than several other federal grants (e.g., K-award, R-21 or R-03 awards.)

Dr. Kaysen emphasized that the application for an individual research award is much more labor intensive than a traditional clinical postdoctoral program. In addition, time lines from application to notification may be quite varied and often long. There are other disadvantages with independent research fellowships. Dr. Kaysen mentioned that an F-32 award provides little money for original research. In addition, postdoc salary support is not as good as starting salaries for jobs, and if a person leaves a research postdoc early, there is a hefty payback. Another potential disadvantage is that mentors sometimes don't mentor!

Dr. Kaysen offered some general tips in applying for independent research grants. She underscored the importance of a good mentor. As part of the application, the mentor should be evaluated for fit, seniority, outcomes, and whether he or she is overextended. The training plan is very important and must complement the research plan

and be specific and achievable. Finally, she suggested finding models of successful applications in preparing a new application. The earliest deadline for applications is July 1; others are in October, and Dr. Kaysen indicated that F-32 funding at the end of the internship year would have to be applied for by December of the previous year. She suggested several practical resources to learn more about funding:

National Research Service Award
http://grants1.nih.gov/training/nrsa.htm

National Science Foundation
http://www.nsf.gov

Community of Science
http://www.cos.com/

The Foundation Center
http://fdncenter.org/

Grant Doctor
http://nextwave.sciencemag.org/pdn/

Dr. Zeiss concluded the panel with an overview of the application and interview process for postdoctoral programs. The application process is more informally handled and less standardized than for applications to an internship. There is no uniform match day, with the exception of clinical neuropsychology postdocs. Unlike most internship programs, postdoctoral programs may not be members of APPIC or accredited by the Committee on Accreditation of APA. Dr. Zeiss suggested casting a broad net in finding postdoctoral programs through searching via word of mouth, APA *Monitor*, APPIC Directory, and listserves or e-mail groups, to name a few. Another excellent resource is the training director of one's own program and previous postdocs from a student's program. Dr. Zeiss also suggested some of the same resources that Dr. Kaysen highlighted.

Dr. Zeiss provided helpful suggestions about the application process. Often the earliest applications are due in December, but new positions can be announced throughout the internship year. The majority of applications are due January through March, and these typically consist of a cover letter, curriculum vitae (CV), and letters of recommendation. Unlike internship application, there is great variability, and an applicant will need to consult with the program regarding specifics such as a work sample. She recommended consulting with other interns who have applied for postdocs, particularly regarding the cover letter. Dr. Zeiss underscored the importance of carefully reading the position announcement

and emphasizing the fit of the CV and cover letter with the position. She recommended that cover letters include a brief introduction of yourself, discussion of your understanding of the position, how, specifically, you are a good fit for the position, and being straightforward about any obvious questions that might be asked about your application (e.g., explain up-front any time gaps in your CV). If the program has a research emphasis, describe specific, not general, research interests. If the application is for a clinically focused postdoctoral program, emphasize and discuss your commitment to the clinical work of the particular postdoc program/site. Dr. Zeiss emphasized the importance of keeping the cover letter concise, usually 2 to 3 pages.

An interview is as important for a postdoctoral program as it is for a predoctoral internship; the interview is an excellent opportunity to ascertain the "fit" of an applicant's interests with the program and for the program to "sell" itself to the applicant. During the visit, it is appropriate to ask about when offers are made, start time, and negotiation of these issues. Dr. Zeiss em-phasized that there are no rules about expressing first choice (in fact, the interviewer may inquire) and to be prepared ahead of time to answer questions about one's interest or intention. Since there is no match day, except for neuropsychology, try to get a good estimate of when offers are made for the postdoc. A follow-up phone call after the interview is acceptable. When extended an offer of acceptance to a program that is not an applicant's first choice but requires a response, Dr. Zeiss advised contacting the preferred postdoctoral program and communicating the situation directly. Likewise, it is acceptable to negotiate for time to consider other offers.

Dr. Zeiss had several recommendations about accepting a postdoc offer. First, she suggested negotiating issues of importance before accepting the offer. Finally, she underscored that reneging on an acceptance of an offer is never appropriate, unless there is a circumstance of a major personal crisis.

After the panel, representatives from approximately 12 postdoctoral programs interacted with prospective applicants. We encourage interns or graduate students reading this article to be part of the panel audience and the open house at ABCT in 2005 (in Washington, DC, November 17–20). We would also appreciate any input regarding future panel topics and encourage you to contact members of the 2004 panel if you want further information that could assist you in making an informed decision about postdoctoral training opportunities.

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Dr. Antonette Zeiss is the Assistant Chief and Director of Training, Psychology Services, VA Palo Alto Health Care System.

Common Language for Psychotherapy Procedures

Isaac Marks, *Institute of Psychiatry, King's College, London*

This article updates a previous *tBT* article ("Invitation for Contributions," 2003) describing a joint AABT/European Association for Behavioural and Cognitive Therapies (EABCT) Task Force project. This project aims to promote adoption of a common language among psychotherapy procedures so as to (a) reduce widespread confusion and misunderstanding among psychotherapists and (b) help psychotherapy come of age as a scientific discipline. The absence of a common language for psychotherapy procedures leads different therapists to use different terms to describe the same procedure (e.g., *exposure* and *stop safety behaviors*) and/or the same term to describe different procedures (e.g., *relaxation*, regardless of diverse methods and additional exposure content). This confusion led to work by the AABT-EABCT joint Task Force toward a common-language dictionary of procedures for approval by a range of psychotherapy associations.

Psychotherapy lacks the centuries of scientific work producing unifying concepts—concepts that enabled chemists and botanists, for example, to give up personally preferred names and instead agree on a common terminology within each field. As a start, the common-language Task Force compiled terms for psychotherapy procedures from around the world and is defining each and hopes to classify them into a limited number of domains. This will lead to a dictionary of psychotherapy procedures that could serve as a reference guide for therapists from diverse backgrounds to choose the same terms to convey what they actually do with clients in therapy. Use of the same terms for common therapy procedures ought to allow psychotherapists to better communicate what they do and catalyze the emergence of a provisional classification. A common language for procedures would reduce confusion and smooth psychotherapy's path toward becoming a science. The dictionary's terms briefly describe procedures, not theory, though procedure and theory can be hard to unravel. A broad range of psychotherapy procedures is portrayed in plain language. For clarity, each description (entry) includes a short case illustration of the procedure in action, demonstrating what therapists do, not why they do it.

The dictionary's entries concern psychotherapy procedures more than wider approaches involving multiple procedures, though approaches and procedures often overlap, and procedures can comprise a mixture of techniques. From the myriad of terms for procedures, the Task Force chooses those that are well described in peer-reviewed journals. When many terms seem to denote a similar procedure, it selects the most common term for that procedure and gives cross-references to other related terms. The danger of neglecting important nuances of difference is reduced by an iterative dialogue between the Task Force and practitioners from the ABCT, EABCT, and other psychotherapy organizations around the world.

For each entry, associated terms for the procedures appear in italics. Terms are being gradually grouped into a few domains (e.g., a domain for *role rehearsal, role reversal, psychodrama, imago relationship therapy,* etc.) and distinguished from other terms in other domains (e.g., *reinforcement, reward, contingency management* vs. *Socratic dialogue, cognitive restructuring, well-being therapy*). Some domains overlap. For example, a therapist may praise (i.e., *reinforce, reward* in one domain) a patient for good *role rehearsal* (in another domain). The Task Force is preparing a Web site to allow all therapists to make suggestions for the emerging dictionary. The dictionary's development is viewed as an ongoing process that will take some years. The dictionary will eventually be sent for approval to sponsoring organizations and will require revision at intervals as psychotherapy advances as a discipline.

The EABCT and ABCT Task Force Editors

The editors are distinguished and widely published experts in psychotherapies in Europe, the United States, and Australia, and many experts contributed entries from around the world. The Task Force was formed at an EABCT meeting in Istanbul in 2000, which was attended by AABT board members. Some Task Force representatives have begun to meet at intervals, and entries have come in from around the world. Major publishers are keenly interested in the dictionary. It has no budget.

The Task Force may conduct a panel discussion with ABCT members at the ABCT's annual meeting in Washington, DC, November 17–20, 2005.

Coordinating Editor

• **Isaac Marks, M.D., FRCPsych**, Professor Emeritus at the Institute of Psychiatry, King's College London, UK, and past President of the EABT (now EABCT), who has for decades been interested in integrating the psychotherapies. (i.marks@iop.kcl.ac.uk)

Associated Task Force Editors

• **Stefania Borgo, M.D.**, President of the Center for Research in Psychotherapy at the University of Rome, Italy, and Director of a Postgraduate Diploma in Cognitive Psychotherapy. Published the Italian Dictionary of CBT with Dr. Sibilia, which is being translated into English by Dr. MOORE (see below for both; stefania.borgo@psychomed.net).

• **Marvin Goldfried, Ph.D.**, Distinguished Professor of Psychology at SUNY, Stony Brook, who has long written about the need for a common psychotherapy language (marvin.goldfried@sunysb.edu).

• **Kathleen Moore, Ph.D.**, Associate Professor and Head of School, School of Psychology, Deakin University, Melbourne, Australia (kmoore@deakin.edu.au).

• **Michelle Newman, Ph.D.**, Director of the Center for the Treatment of Anxiety and Depression at Penn State University, who found during her internship and postdoctoral fellowship that multiple supervisors from various approaches used unfamiliar terms for procedures shared with CBT (mgn1@psu.edu).

• **Lucio Sibilia, M.D.**, Senior Researcher in the Department of Clinical Sciences at the University of Rome and a founding member of the Italian Society of Behavioural and Cognitive Therapy and Center for Research in Psychotherapy (now its scientific director; Lucio.Sibilia@uniroma1.it).

• **George Stricker, Ph.D.**, Professor of Psychology at Argosy University, Washington, DC, and a past Distinguished Research Professor of Psychology in the Derner Institute, Adelphi University. He has many

distinguished awards and has served as president of psychological organizations (stricker@adelphi.edu).

• **Mehmet Sungur, M.D.**, Professor of Psychiatry at Marmara University Medical School, Istanbul, Turkey, a past president of the EABCT, recipient of several awards, and director of training courses for professionals in Turkey and many other countries (mz-sungur@superonline.com).

The Task Force welcomes suggestions and comments. We wish to expand the list of organizations/associate editors who are active members of the Task Force. We are especially interested in those from a non-CBT background (which deserves more representation).

Invitation for Readers to Participate

Therapists from all backgrounds are invited to contribute to the *Dictionary of Psychotherapy Procedures* and be named at the start of each entry as its originator. You can contribute in two ways: (1) Suggest terms for procedures to add to the list below and names of individuals who might submit first-draft entries for them; and (2) ask to develop a preliminary draft submission for term(s) from the list (or other terms). Contributions should be sent via e-mail to both i.marks@iop.kcl.ac.uk and aileen@deakin.edu.au (the Task Force secretary). In your correspondence, be sure to note your name, affiliation, e-mail and postal addresses, phone number(s), and term(s) you wish to define.

Preliminary draft-submissions to the Task Force should provide the following: (a) your term for the procedure being defined; (b) your name and co-author names for publication; (c) a definition of the procedure; (d) elements (components) of the procedure, (e) related procedures, in italics; (f) how the procedure is applied; (g) first known use of the procedure with its reference; (h) up to three other references for the procedure; and (i) a brief case illustration (up to 450 words).

Examples of the required format are outlined in the two completed dictionary entries that appear below. The Task Force edits first-draft entries and sends those to the submitter iteratively until the format and style of the new entry fits the template and other entries in the dictionary.

Examples of Completed Dictionary Entries for Procedures

The entries below were provided by contributors from Israel, Japan, Sweden, the United Kingdom, and the United States. The originator of the first draft for each entry appears in bold below each heading. Italics within an entry denote terms to be defined separately in the dictionary. Examples below include cognitive restructuring and Morita therapy.

COGNITIVE RESTRUCTURING

CONTRIBUTOR. Task Force submission

DEFINITION. A method to encourage clients to identify dysfunctional sets of thoughts and beliefs relating to their problem, and to challenge the validity of those in order to produce and use more adaptive alternatives.

ELEMENTS. Helps clients to identify and challenge maladaptive thoughts (e.g., *absolute/all-or-none/dichotomous/black-and-white/catastrophizing/overgeneralizing thinking*) and beliefs concerning the problem through interviews and daily thought diaries. May include: (a) *Socratic questioning* to weigh evidence for/against each thought and belief; (b) *downward arrow* (what if?) technique and probabilistic reasoning to challenge maladaptive thoughts and beliefs; (c) *behavioral experiments* to challenge maladaptive beliefs; (d) *distancing/giving perspective* to generate alternative adaptive thoughts and beliefs.

RELATED PROCEDURES. *Rational emotional therapy, self-instructional training, problem-solving*

APPLICATION: Usually taught individually rather than in groups

FIRST USE? As a concept, by Alexander, J.M. (1928). *Thought control in everyday life*. New York: Funk & Wagnalls.

REFERENCES. Beck, A. T. (1967). *Depression: Causes and treatment*. Philadelphia: University of Pennsylvania Press. • Ellis, A. (1969). A cognitive approach to behaviour therapy. *International Journal of Psychotherapy, 8*, 896-900. • Lovell, K. (1999). *Exposure and cognitive restructuring alone and combined for PTSD*. Ph.D. dissertation, University of London.

Case Illustration
(Lovell 1999) (361 words)

A man of 26 with PTSD for 2 years after being assaulted, injured, and scarred was asked to keep *daily diaries* of thoughts to *monitor* negative thoughts and beliefs. They related to fear of being re-assaulted. When asked, he rated his belief in the probability of being reassaulted as 80%; this belief was challenged by *probabilistic reasoning*—he was asked to calculate how often he'd been out with friends in the years before the assault and to estimate the probability of a future assault. The self-rated difference between his initially perceived

(80%) and the probable (now rated as 10%) risk led him to *identify his thinking error* of overestimation of danger. He reframed his belief as the alternative "My chances of being attacked are no more than other people's," and rated his reframed belief in it as 90%. Soon after this he began to go out with friends and then alone.

He also identified shaming thoughts and beliefs (*diary keeping*), e.g., "I'm a coward as I cried after the attack; men don't cry." He rated their validity as 85%. When challenged to give evidence for and against such thoughts, he recalled his father being upset after the assault and crying when visiting him in hospital, but his father was not a coward. He also recalled that he and his friends had wept at a funeral, which was appropriate and not a sign of cowardice. He then reframed his thought to: "Crying is appropriate in stressful situations."

He *recorded a negative overgeneralizing thought*: "People with scars are thought to be criminals, so others seeing my scar will think I'm a criminal." He rated this thought as 85% valid. He was asked to list the hair color, height, etc., of criminals and to compare these features with his own. Mismatch of the two lists led him to rerate his belief that others would consider him a criminal as 40%. For *homework* he listened to the audiotape of the session and was required to think of people he knew with scars and how much he believed them to be criminals, and to spot his thinking error. At the next session, he said he realized he knew many scarred people but did not think of them as criminals. He generated an *alternative response*: "Acting suspiciously and having a past criminal record suggest criminality, not a scar." He rated his belief in this reframed thought as 100%. He *labeled his thinking error* as mind-reading (false attribution).

The PTSD had markedly reduced by the end of 10 sessions and even more so 1 year later.

MORITA THERAPY

CONTRIBUTOR. Kei Nakamura, kei87@kt.rim.or.jp; ph+81 334801151, Psychiatry Dept, Jikei University, Daisan Hospital, 4-11-1, Izumi-honcho, Komae, Tokyo 201-8601, Japan

DEFINITION. Morita therapy tries to lead patients from preoccupation with and attempts to eliminate neurotic symptoms toward accepting anxiety as natural (*arugamama*) while engaging in constructive behaviors.

ELEMENTS. Morita therapy tries to give corrective experience, over four phases if an inpatient: (1) bed-rest in isolation for 7 days (*time out*), during which patients stay in their room all day with activity restricted to meals, a morning wash, and going to the toilet, and no access to reading, radio, TB, CD, computer or games; (2) light work for 4 to 7 days. During this the patient: (a) initiates, under therapist guidance, graded activity and work needed in daily living at the hospital; (b) writes in a diary what s/he

did by day and everyday submits this to the therapist who reads it, writes in comments, and returns it to the patient (*diary guidance*); (c) has interviews two to three times a week with the therapist, who does not regard symptoms as foremost and focuses on daily activities (strategic inattention to symptoms, *contingency management*); (3) work for 1 to 2 months with gradual engagement in activities such as gardening, caring for animals, and cooking, and eventually doing these together with other patients; and (4) preparation for normal daily living over 1 to 4 weeks, which may include commuting to work or school from the ward. Today Morita therapy is commonly done with outpatients weekly or biweekly. The therapist asks about their daily life and symptoms, encourages them to start constructive activities to return to normal living while remaining anxious, and often also gives diary guidance.

RELATED PROCEDURES. *arugamama, behavioral activation, contingency management, diary-keeping, exposure and ritual prevention, goal-setting, problem-solving, activation of desire for life, time out, work therapy*

APPLICATION. In- or outpatient guidance (individual and group) in clinical, work and school settings and self-help groups such as Seikatsu-no Hakken Kai (Circle for Group Learning of Morita Therapy)

FIRST USE? Morita, S. (1919). Shinkeishitsu no hontai oyobi ryoho. • Morita, S. (1998). *Morita therapy and the true nature of anxiety-based disorders* (*shinkeishitsu*) (A. Kondo, Trans., P. LeVine, Ed.). Albany: State University of New York Press.

REFERENCES: as in first use

Case Illustration 1:
Inpatient Morita Therapy (302 words)

A woman aged 25 had social anxiety disorder for over 2 years. In front of others she trembled and avoided writing, which disrupted her work. During her inpatient bed-rest phase, her hands often trembled when observed and later she felt bored. The therapist wrote in her diary about stepping out of her room to join life on the ward: "Take it a step at a time, while holding anxiety." (Diary guidance to practice *arugamama* including *exposure* but aimed more at helping her do daily activities on the ward than at decreasing her fear.) The patient longed to be active and began wood-carving but became tense and her hands often shook when attending the large group at patients' daily meetings. The therapist did not think her tension and tremor were important (*contingency management*). She was encouraged to be active despite feeling tense, and the therapist commented in interviews and diary entries on her progress toward each goal (e.g., calling her conscientious setting of meals on a table despite her hands shaking a success as her goal was not to abolish tremor but to give patients meals). In her month-long work phase she had

more chances to work with other patients and became less anxious and less preoccupied with her tremor. Thereafter she started commuting to work from the ward. On her first day back at work her hands shook as she held a microphone to address a meeting of colleagues, but she was happy that she could greet them. She wrote in her diary that she had "many things to be anxious about that I want to do" (accepting self as *arugamama*). As she continued commuting she lost almost all fear of writing in the presence of others and communicated better with colleagues. She had no medication during treatment.

Case Illustration 2:
Outpatient Morita Therapy (337 words)

A 33-year-old woman who, from the age of 14, suffered from a fear of contamination developed compulsive washing. When first seen she was over 2 months pregnant and had stopped housework for fear of mercury contamination. She knew her fear was irrational. She had outpatient sessions every 2 weeks, totaling 6 hour-long sessions. The therapist said her fear of illness and misfortune for herself and her family was natural and asked what she wanted. She expressed a strong desire for health and security for herself, her family, and especially her child. The therapist said her fear arose from deep care for her family; it could not be eliminated but did not need to be. He noted the vicious circle of compulsive washing and sensed that this was inadequate, causing yet more washing. He proposed that she wait for her fears to fade away naturally without trying to deny them (*arugamama, exposure and ritual prevention*) and to promote her family's health and security in a more constructive way (*behavioral activation*). As she wanted to be able to cook for children he negotiated with her a goal of cooking at least one dish by the next session. She returned saying she had cooked several times with her husband's help, which the therapist called major progress. She wanted to do more housework but panicked at the thought of being the main person doing it. The therapist pointed out her mindset—that "everything must be in a certain fixed way" (noting *all-or-nothing* or *black-and-white thinking errors*). He suggested that she think about doing housework together with her family, do what she felt like doing without postponing it, and to broaden her goals beyond housework (*problem solving, activation of desire for life*). Though her fear of mercury recurred at times, after cooking with her husband's help for some time she began to cook by herself. She decided to do shopping as her next goal, which she accomplished. She gradually resumed normal living and delivered her baby several months later.

Common Language for Psychotherapy Dictionary: Provisional List of Terms for Procedures

The distinction between a specific "procedure" (e.g., exposure) and a broader "approach" (e.g., behavior therapy) is rather arbitrary, because an approach can contain many procedures. (A separate list of approaches, plus procedures they may contain, will appear in the dictionary). Below is a brief sample list of procedures that remain to be defined. A full list of available procedures is available from Dr. Isaac Marks at i.marks@iop.kcl.ac.uk.

acceptance
competing response training
anger management/control
bell and pad therapy
discrete trial therapy
discrimination training
problem solving
relapse prevention
EMDR (eye movement desensitization and reprocessing)
free association
mindfulness training
motivational interviewing
pleasant activity scheduling
rapid smoking
role play
transactional analysis
virtual reality exposure
working through

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Invitation for contributions to a new international project: Toward a common language for psychotherapy procedures. (2003, October). *the Behavior Therapist, 26*, 378-379. ✍

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Book Review

Kruglanski, A. (2004). *The Psychology of Closed Mindedness.* New York: Psychology Press.

Reviewed by Samantha Levine and C. W. Lejuez, *University of Maryland, College Park*

In a recent article in the *Psychological Bulletin*, Jost, Glaser, Kruglanski, and Sulloway (2003) published a meta-analysis summarizing studies conducted over 50 years dealing with psychological differences associated with left- vs. right-wing thinking. Based on this literature, they found that conservative thinking was correlated with a sense of societal instability, fear of death, intolerance of ambiguity, need for closure, lower cognitive complexity, and a sense of threat. In addition to their drawing commonalities between conservatism and notorious figures such as Adolph Hitler and Benito Mussolini, the central thesis of this work set off a firestorm of commentaries from high-profile "conservatives" including George Will, Ann Coulter, and Cal Thomas. In defending their position in a response published in the *Washington Post* entitled "Political Opinion, Not Psychopathology," Kruglanski and Jost (2004) refute the opinion that a "psychological analysis of ideology entails a judgment that conservatism must be abnormal, pathological or even the result of mental illness."

Following on the heels of this controversy, Kruglanski authored *The Psychology of Closed Mindedness*, in which he provides a more comprehensive account of one of the key variables from the *Psychological Bulletin* article: the need for closure. Despite a focus on the role of this variable on social behavior, this work has proceeded with little discussion of clinical implications (with efforts to actively avoid such discussion in the response published in the *Washington Post*). In a perfect world, psychologists in one domain would have the time and interest to read work in other domains, and clinical psychologists would therefore be able to determine the clinical implications of research in other areas of psychology for themselves. However, due to a focus on specialization combined with time constraints, this rarely happens in the real world, and as a result few clinical psychologists are likely to read *The Psychology of Closed Mindedness*. In a modest effort to bridge psychological domains, the goal of the current review is to introduce clinical psychologists to the concept of a need for closure as conceptualized by Kruglanski and how it might be related to understanding and treating psychopathology.

Kruglanski theorizes that closed-mindedness is both a stable predisposition and also susceptible to the effects of context. "Closed-mindedness" is represented here as the tendency to "seize and freeze" on one option comparatively early in the decision-making process, and then summarily rejecting alternatives that emerge later. Although problems may arise when one seizes and freezes too soon, Kruglanski asserts that if humans were completely open-minded, we would be paralyzed by the smallest necessary decision and unable to survive. Therefore, in contrast to the numerous earlier theories which portrayed closed-mindedness as an entirely maladaptive trait, Kruglanski proposes that all human beings have a need for closure, a necessary mechanism that prevents us from endlessly vacillating between an infinite number of options. Kruglanski explores the many antecedents and consequences of different levels of closed-mindedness. As might be expected, he outlines a variety of limitations of and negative consequences associated with closed-mindedness; however, he also sets forth the more novel view that, within certain parameters, closed-mindedness may in fact sometimes be healthier and more adaptive than open-mindedness.

According to Kruglanski's model, people differ with respect to their innate level of need for closure. One's level of need for closure is manifested in many intriguing and unexpected ways, including the time taken to reach a conclusion, level of confidence in a decision, ability to establish conversational rapport, and political orientation. Aside from this natural predisposition, though, various social, physical, or emotional pressures can also heighten or lower need for closure. Physical or mental states like fatigue, alcohol consumption, stress level or fears of invalidity, time pressure, and even reminders of one's mortality can all alter need for closure. Kruglanski's model of need for closure has two orthogonal dimensions that combine to create four types of this need: seeking versus avoidance of certainty, and specificity versus nonspecificity of the information one seeks or avoids. He proposes that different contexts, as well as different perceived costs and benefits, can evoke each of these four needs in all people. This matrix allows for a comprehensive understanding of the exact ways in which closed-mindedness manifests itself in real-world contexts.

Kruglanski uses heightened need for closure to explicate intrapersonal, interpersonal, and group phenomena, and puts particular emphasis on the results of high need for closure (either innate or experimentally induced) in his examples. For instance, in terms of individual information-processing style, higher need for closure results in a greater reliance on stereotyping, less creativity as measured by number of hypotheses generated to solve a problem, and overconfidence in decisions made after very little time. In interpersonal situations, it leads to less empathy and perspective taking, as well as a less effective exchange of information during conversation with a partner. High-need-for-closure people also are shown to build less conversational rapport with others due to their bias toward asking abstract and impersonal questions. They are also more impaired after working on an unsolvable problem and attribute their failure to global causes. In group situations, high need for closure leads to more in-group favoritism and out-group derogation, an aggressive pro-war stance, and conformity with the majority viewpoint.

In line with his perspective as a social psychologist, Kruglanski provides compelling real-world examples of the impact of one's need for closure. As one example, he discusses the liftoff of the space shuttle Challenger proceeding on schedule despite evidence of potential technical problems, which ended in a catastrophic explosion. Here, Kruglanski believes that NASA officers "froze" on the necessity of displaying their program's cost-effectiveness and adherence to deadline, as their need for closure was raised by intense pressure to appear successful and productive to the government and the public. His arguments necessarily become more speculative as his theories work to encompass larger-scale phenomena, such as when he argues that high need for closure in certain high-ranking Israeli military intelligence officers led to them ignoring evidence of a potential attack before the Yom Kippur War, without

having the need-for-closure scores of these purportedly high-closure officers or transcripts of their behind-the-scenes meetings. Still, it remains quite impressive that these theories are brought so far out of the ivory tower and made directly germane to major world events.

Of note, Kruglanski initially claims to delineate a value-free matrix of the four types of needs for closure, thereby suggesting that his goal is not to target particular levels of need for closure as more or less healthy than others or to diagnose psychopathology. Yet, the majority of the experiments that he cites either explicitly or implicitly illustrate that a lower (as opposed to a higher) need for closure is consistently associated with more positive social outcomes. Nevertheless, it is not difficult to imagine the clinical implications of both low and high need for closure, related to the behavior of both patients and therapists, to which we turn our attention in the following sections.

Clinical Implications

In its current form, Kruglanski's efforts have clear social psychology relevance, but its clinical implications have not yet been explicitly identified or researched. Yet, one can easily identify several clinical disorders that appear to be characteristic of the extremes on the need-for-closure spectrum. For example, too high a need for closure may be relevant for seizing and freezing on early cues that may approximate the depressive tendency to overgeneralize, as high-closure people will expect the worst in any situation that initially appears similar to one in which they have previously failed. Indeed, they ignore new information that may lead to a more objective and positive view of a given situation, and all possible activities are seen as fitting into an existing pattern of probable disappointments. On the other end of the need-for-closure spectrum, certain depressive individuals tend to be indecisive; they are unable to seize and freeze on any choice in life due to the possible downsides envisioned for each. In depression, therefore, we can see that both too-high and too-low needs for closure may very well impair clients and limit treatment response. Too low a need for closure may also be relevant for understanding obsessive-compulsive behaviors or generalized anxiety disorder, where an unwillingness to come to confident decisions can have debilitating effects. Additionally, the root of addictive behaviors often is based in the effort to provide closure on issues that are emo-

tionally difficult, despite the fact that no actual closure on the issues at hand is achieved through the addictive behaviors utilized. Interestingly, the rigidity that is characteristic of obsessive-compulsive personality disorder might be best considered as too high a need for closure, whereas the continued engagement in obsessions and compulsions that characterize obsessive-compulsive disorder seem to indicate too low of a need for closure.

Beyond the development of psychopathology, need for closure may bear on the treatment of psychopathology in several important ways. First, it is easy to envision that a client's level of need for closure could be a major deterrent to successful treatment, particularly at the extremes of the need-for-closure spectrum, irrespective of whether this level is too high or too low. Kruglanski's evidence for the malleability of closed-mindedness has novel and exciting implications for the treatment of high-need-for-closure clients who see only one viable life path or means to achieve a goal, and are miserable when this narrow approach proves ineffective. Such clients may be enormously hampered by their underestimation of the breadth of life choices available to them, or unable to see how even their efforts to take a new approach may be hampered by their old patterns. In the latter case, a therapy such as Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 2003) actually discusses such problems with patients pursuing initial solutions to complex problems and how they are limited by a specific (positive in this case) need for closure in terms of their psychological concerns. For a patient who is intent to seize and freeze on a solution immediately, they recommend the development of creative hopelessness to prevent the continuous generation of new solutions based in the same old problematic patterns of behavior. With this said, too low a need for closure and an inability to seize and freeze (i.e., commit) on a particular intervention approach outlined by a therapist may lead to a variety of concerns, including off-topic discussion in session and uncompleted homework. Addressing the need for closure in therapy might involve an assessment of clients' dispositional need for closure, a review of the situations in their lives that induce different closure responses, and answers to many crucial questions designed to help us gauge exactly how large a part need for closure can play in a person's mental distress.

Although need for closure certainly is relevant to patient behavior, there also is clear relevance for therapist behavior.

Indeed, too high of a need for closure from a therapist may result in quick conclusions regarding the root of patient problems and the best method for addressing these problems. This can be especially problematic with patients with more severe psychopathology and/or a good deal of comorbidity, and also touches upon a common complaint leveled against behavior therapists, who are often accused of focusing only on the surface presentation of a problem and overburdening patients with forms and assignments before the deeper root (or in behavioral terms, "function") of the problem is even identified. Thus, a therapist's attention to his/her own need for closure (unspecific type in terms of the second dimension of Kruglanski's matrix) may help limit seizing and freezing on the most obvious and apparent problem. Although less of a concern typically with behavior therapists, the obvious counterexample is a reluctance to move from assessment to intervention.

Summary

The Psychology of Closed Mindedness succeeds as an interesting and novel look at a subject that has been of interest to social psychologists for decades. However, Kruglanski's most impressive contributions are in offering evidence that temporary states are as important as innate disposition in determining one's need for closure, and in elucidating the many real-world consequences of his four types of need for closure. These accomplishments extend the value of this work beyond that of a helpful didactic tool for social psychologists and make it relevant to clinical psychology as well. Clinical psychologists will undoubtedly recognize the personality types and interaction styles of many of their clients in this book, and may appreciate the necessity of working to instill a more balanced level of need for closure in their clients. Thus, the context-dependent manipulability of need for closure that Kruglanski demonstrates in this book may lead to a productive area of clinical research. Furthermore, Kruglanski's boldness in applying his findings not only to factors affecting decision making in a laboratory, but also to dealings in the loftiest areas of international politics, makes this book unique in the psychological literature. Rather than purely appealing to academics, this book will intrigue anyone with an interest in the forces of human nature that drive everything from the most trivial conversation to the most pivotal world event.

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Book Review

C. C. Swenson, S. W. Henggeler, I. S. Taylor, & O. W. Addison. (2005). *Multisystemic Therapy and Neighborhood Partnerships: Reducing Adolescent Violence and Substance Abuse*. New York: The Guilford Press.

Reviewed by Matthew Goldfine and Andy Lopez-Williams, *West Virginia University*

Multisystemic Therapy and Neighborhood Partnerships: Reducing Adolescent Violence and Substance Abuse is a recent text that guides the reader through the step-by-step processes involved in transforming one of the highest crime-rate neighborhoods within the state of South Carolina into a model community. It details a group of clinical researchers' collaborative experiences with various community members and the neighborhood in general. The text is a blend of instruction manual and anecdotes aimed at helping persons from various backgrounds and training (e.g., policymakers, clinicians) understand how to effectively change the lives of children, adolescents, and families by changing the systems (i.e., neighborhood) in which they are embedded.

As stated by the title, "partnerships" advocate the use of Multisystemic Therapy (MST) as a broad philosophy for working with the individual client and family, as well as the entire neighborhood. The book provides real-life examples of how MST can work, while at the same time explaining the

intricate nature of using such a comprehensive form of therapy. Each chapter begins with a statement of its goals, and charts, graphs, and diagrams are found throughout the text to aid the reader in understanding the main points. The book is written without much technical jargon and thus should appeal to a wide range of readers.

The book begins with a brief review of the empirical literature on the causes and consequences of youth violence, community violence, and substance abuse; evidence-based treatments for these social problems; and an overview of MST as a model for intervention. As the authors report, MST therapists are guided by a comprehensive set of principles, including focusing on the youth's strengths, understanding the problem in the context of their multiple systems, and utilizing present-focused, action-oriented interventions to combat an explicit problem. Adherence to these principles has been shown to be associated with positive outcomes for youth and families. Similarly—although not explicitly detailed—the authors' recommendations

for intervention at the community level follow a "principle" approach.

The following sections of the book consist of detailed accounts and anecdotes of how MST was used in the real-life neighborhood of Union Heights. It is unlikely that this level of description would be found in other sources (e.g., journal article), and this is certainly a strength of the text. For instance, the issue of gaining trust is a recurring theme in their story. Almost every step of the way, from the neighborhood leaders to the families to the drug dealers, the authors depict gaining one's trust as the first and possibly the most important stage in helping them. Moreover, information about the value of using food in neighborhood socials, having safe houses throughout the neighborhood, and the importance of not being too friendly with the police are just some of the intriguing and informative tidbits that could be useful to those interested in community interventions. Such details add a certain dimension to the book, making it a must-read, to the point where it should be recommended to anyone considering a large-scale MST project. Although the multiple facets of the book provide a great deal of information, the transitions between explaining how MST works, illustrating how to properly utilize MST, and the detailed account of how the authors used MST in Union Heights are swift and may be confusing to the reader.

The book continues with multiple case applications dealing with specific problems such as substance abuse, school expulsion, and antisocial behavior. Such cases reaffirm the MST approach to treating all the systems in which the youth is embedded. In "one fit circle"—a type of functional assessment—for an antisocial youth, one might note the diversity of relevant factors such as anger-management problems, his mother's cocaine use, and the town's poor health-care

system. The subsequent chapters provide additional guides for improving the neighborhood's health and wellness activities, health services, and law enforcement. Again, the book is at its best when the authors provide "insider" information based on their time spent in Union Heights. For example, a narrative of the pitfalls the authors encountered when attempting to create an affordable, professional health center located within the community may prove helpful to a service provider or policymaker. Having a better understanding of what it takes to implement a manualized treatment within a real-world community is often enlightening to the most experienced practitioner. The final two chapters are devoted to recommendations for obtaining funding for such projects. As stated above, such practical information is often forgotten or left out of treatment manuals, and its inclusion here is one of the more valuable aspects of the book. The book concludes with a short question-and-answer chapter, which sums up the authors' main points.

As stated above, the text is replete with anecdotes and is less focused on the presentation of scientific evidence in support of the neighborhood intervention in Union Heights. In fact, although the authors offer a critical review of previous studies conducted in the substance abuse literature and cite limitations such as lack of appropriate comparison groups in treatment outcome studies and foci on self-report measures instead of more objective measures (e.g., urine drug screens), the authors proceed to present data demonstrating the supposed effectiveness of their neighborhood intervention with the very same limitations. Although the recommendations provided for intervention at the neighborhood level are often intuitive and have strong face validity, it is difficult to place much confidence in their scientific merit based upon the limited data presented.

Multisystemic Therapy and Neighborhood Partnerships: Reducing Adolescent Violence and Substance Abuse is an important resource for anyone interested in implementing MST within a community. Although the book's weakness is at times its lack of scientific support for the efforts described within, it is an otherwise useful text with many beneficial aspects—namely, a realistic account of the processes, barriers, and successes in addressing the needs of youth and families via changing the neighborhood system. In such a context, this book is a vital tool for anyone looking to practice MST within a troubled community.   ✍

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