

# the Behavior Therapist

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### President's Message

## (Trumpets, Please)

## Entering the 21st Century

J. Gayle Beck, *SUNY Buffalo*



In closing my presidential year, I am delighted to announce some major advances in the publication arm of our association. First of all, we have recently finalized a contract with Elsevier to print and deliver on-line *Behavior Therapy* and *Cognitive and Behavioral Practice*. There has been much discussion across the years about turning these two journals over to an outside publisher, with many arguments both pro and con. In the last several years, it had become apparent that the two journals were negatively impacted by the fact that they were not available on-line. A variety of options were visited, with the decision to pursue a contract with a publisher who could provide on-line versions of both journals

An ad-hoc committee, led by Judy Favell (Publications Coordinator) was asked to work on this issue.<sup>1</sup> In response to a solicitation, eight companies submitted proposals to publish *Behavior Therapy* and *Cognitive and Behavioral Practice*. The proposals varied widely, with respect to the relationship between the publisher and the Association, the proposed financial arrangements, production and editorial support, and how back issues would be handled. The committee provided thoughtful input, including consideration of the ease of the manuscript tracking system provided by each publisher and which journals were currently being published by each of these companies. At the end of this process, Elsevier emerged as the clear favorite, with finalization of the contract occurring as this column goes to press. *continued on p. 146*

<sup>1</sup> The Committee included Judy Favell, David Fresco, Tom Ollendick, Rick Heimberg, Stefan Hofmann, Frank Andrasik, Patricia Resick, and myself, working closely with David Teisler (Director of Publications).

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But wait, there's more! I also am delighted to announce that Behavior Therapy has received a favorable review from Index Medicus/MEDLINE and is now slated for indexing within this database. This is an important step forward for the Association's oldest journal and will affect the overall impact of this publication. This achievement is the direct result of Christine Nezu's hard work and research. We were

fortunate to receive abundant support from several prominent behavior therapists, including Alan Kazdin, Richard Suinn, and Isaac Marks, for which we are collectively appreciative. Additionally, thanks are extended to Diwakar Jain (Director of Nuclear Cardiology at Drexel University) for helping to emphasize the importance of behavior therapy to medicine. Great job, Chris!

Perhaps the most salient feature to consider about these changes is the fact that the dues structure will not change. Thanks to the vision of Judy Favell and the Publications Committee and the sharp negotiation skills of David Teisler, the Association's journals are able to move forward in these two very important ways, reflecting greater benefit to membership. These changes also will facilitate diversification of our membership, as colleagues in related disciplines will have access to our journals electronically. In the past several years, it is as if our publications have been living "in the shadow of an idea without grasping it" (Elizabeth Bowen). Well, I think we got it now. ✍

## Instructions for Authors

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

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100- word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion.

Letters should be limited to approximately 3 double-spaced manuscript pages.

Prior to publication authors will be asked to submit a final electronic version of their manuscript and complete a copyright transfer form. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to AABT/ABCT. Electronic submissions are preferred and should be directed to [reitmand@nova.edu](mailto:reitmand@nova.edu). Please include the phrase *tBT submission* in the subject line of your e-mail. Include the first author's e-mail address on the cover page of the manuscript attachment. By conventional mail, please send manuscripts to:

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From the Editor

## The Science of Suffering: On ABCT's Response to Katrina

David Reitman, *Nova Southeastern University*

In the nearly 3 weeks since Hurricane Katrina tore through the Southeast Louisiana, New Orleans, and the Mississippi and Alabama gulf coasts, television and print media have been relentless in their coverage. For those of us that have lived in the region and the many others that have spent time in the area (AABT Conventions in 2000 and 2004 were held in New Orleans), the events have been deeply moving.

Many organizations and individuals have responded vigorously to the needs of the people affected by the hurricane. The extent of that support, like the response to this past winter's Tsunami and 9/11, is remarkable to observe. The American Psychological Association, in collaboration with the Red Cross, has responded to the tragedy and many psychologists and other mental health professionals have been involved in efforts to assist by virtue of their proximity to the disaster.

While many experts have been consulted regarding the meteorological and engineering aspects of the tragedy, there has been limited attention to the science of mental health issues surrounding such disasters. Interestingly, erroneous assumptions about coping and loss (Wortman & Silver, 1989) may result in the delivery of services that do more harm than good (Bootzin & Bailey, 2005). As one of the premier scientific organizations in the mental health arena, it is incumbent upon our members, and especially those with expertise in trauma, to share their knowledge with others (including the general membership), so that we may be better able to contribute to an organized, effective response to this event and future catastrophic events. Lest we be complacent, consider this excerpt from a recently published edited text documenting "lessons learned" from 1992's Hurricane Andrew:

This chapter is a cautionary tale; it is a reminder that traumatic events can outpace contingency plans and that community organizations and government agencies should frequently reassess their disaster plans. It is clear from any review of the literature that the need for immediate, organized intervention following major disasters has been accepted as a fundamental tenet and built into most action plans. Dozens of conferences have discussed Hurricane Andrew and what was learned from it. The world is better prepared for all kinds of disasters because of what the residents of South Florida endured. (Eyerdam, 2003, p. 27)

In light of recent events, we must do more to apply what has been learned about preparation and response to catastrophic events. Scientifically informed work on mental health issues has been conducted. For example, a manual for professionals working with elementary school children traumatized by hurricanes or natural disaster has been produced by Annette LaGreca, Wendy Silverman, and Eric Vernberg and colleagues. Interested parties can access this manual at APA Division 53's Web page (<http://www.clinicalchildpsychology.org>). For those interested in contributing new research, NIMH has opened a number of grant initiatives specifically related to Hurricane Katrina. Interested researchers should visit their Web page at [www.nimh.nih.gov/researchfunding/hurricanekatrina-research.cfm](http://www.nimh.nih.gov/researchfunding/hurricanekatrina-research.cfm). It is my hope that *tBT* serve as a forum for our organization to facilitate this very unique (and important) translation of "research to practice" in the months and years ahead.

Finally, to the people of New Orleans, and the Louisiana, Mississippi and Alabama gulf coasts, we send our most sincere wishes for a speedy recovery. We also extend special wishes to ABCT members who have been affected.

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Thanks to *tBT* Associate Editors Carter, Dadds, Dreer, Forsyth, Hansen, Iwamasa, and Marx for their input on this editorial. ✍

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*People in the News***Andrew Christensen***Contributed by David DiLillo*

Andrew Christensen, Ph.D., UCLA professor of clinical psychology and long-time ABCT member, was featured in an April 21, 2005, article in *The New York Times* entitled "Married With Problems: Therapy May Not Help." As you might guess from its title, much of the article highlighted the difficulties of marital therapy, particularly the challenges of developing interventions that show long-term effectiveness. However, the article highlighted Dr. Christensen's work on integrative behavioral couples therapy—presented at the 2004 AABT Convention—as an example of a cutting-edge approach with promise for having a more lasting positive impact on couples. The article notes findings from a recent study that 67% of high-risk couples participating in integrative behavioral therapy reported improved relationships 2 years later—a more promising outcome than has typically been achieved. As the article notes, Christensen's approach focuses on acceptance of partner differences rather than the more traditional problem solving and communication skills. The article also notes that traditional behavioral marital therapy is among the approaches that have shown more success than others. A newer empirically based approach to couples therapy, Susan Johnson's emotionally focused therapy, is also featured, as are comments from clinical psychologist and couples therapy luminary, John Gottman. The full text of the article can be accessed at [www.nytimes.com](http://www.nytimes.com).

**Reference**

Gilbert, S. (2005, April 19). *Married with problems: Therapy may not help*. Retrieved September 16, 2005, from [www.nytimes.com](http://www.nytimes.com). ☞

*Media Spotlight***The New York Times Features Cognitive Therapy for the Prevention of Suicide**

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

In the midst of recent debates over whether antidepressant drugs increase suicide risk, *The New York Times*, on August 9, 2005, featured a piece by Benedict Carey titled "Talk Therapy Succeeds in Reducing Suicide Risk." In the article, Carey showcases recently published research in this area by ABCT members Gregory K. Brown, Ph.D., Aaron T. Beck, M.D., and colleagues. The original study appeared in the August 3, 2005, issue of the *Journal of the American Medical Association*. In this randomized controlled trial examining cognitive therapy (CT) for the prevention of suicide attempts, 120 adults who attempted suicide were evaluated at a hospital emergency department within 48 hours of the suicide attempt. Several key findings emerged: From baseline to the 18-month assessment 13 participants (24.1%) in the CT group and 23 participants (41.6%) in the usual care group made at least one subsequent suicide attempt; participants in the CT group had a significantly lower reattempt rate and were 50% less likely to reattempt suicide than participants in the usual care group; severity of self-reported depression was significantly lower for the CT group than for the usual care group at 6 months and 18 months; the CT group reported significantly less hopelessness than the usual care group at 6 months; and no differences emerged between the groups for rates of suicide ideation at any of the assessment points. In sum, this rigorous longitudinal study provides compelling support for the efficacy of CT for preventing suicide attempts in adults who recently attempted suicide.

*The New York Times* piece goes on to elaborate the benefits of using CT for reducing

risk. Another ABCT member, Steven Hollon, Ph.D., who was not part of the study but was briefly featured in the piece, commented, "That you could cut by half the number of attempts in this population in just 8 to 10 sessions of therapy is something to write home about." Drs. Brown and Beck go on to describe the CT model in laymen's terms.

*The New York Times* piece are noteworthy for many reasons. First, the results from the featured large-scale study by Brown and colleagues (2005) are very encouraging for the brief treatment of suicide risk. Second, the ABCT members who were highlighted in the piece should be commended for their efforts to educate the public about how CT can be used to overcome self-defeating thoughts before acting on them. Given that attempted suicide is one of the strongest risk factors for completed suicide in adults (Brown, Beck, Steer, & Grisham, 2000; Fawcett et al., 1990), evidence from this brief application of CT offers hope to those at risk for suicide.

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# Critical Ingredients for Improving Mental Health Services: Use of Outcome Data, Stakeholder Involvement, and Evidence-Based Practices

Jim Wotring, *Department of Community Health, Mental Health Services to Children and Families, Lansing, MI*, Kay Hodges, *Eastern Michigan University*, Yange Xue, *University of Michigan*, and Marion Forgatch, *Oregon Social Learning Center*

L. A. Hamerlynck's (1980) article on behavioral contingencies operating in the typical administration of the public mental health system accurately describes many of the processes that still exist 25 years later (see *iBT Classic*—this issue, p. 158). Hamerlynck proposes changes that would make the system less vulnerable to negative and coercive behavioral exchanges between state administrators and providers, which almost always result in the client losing out. We have operationalized several of the suggested changes offered by Hamerlynck for Michigan's public mental health system for children. We agree that this has led to a system that holds better hope for offering more appropriate, effective, and family-friendly services.

In the ideal mental health system, Hamerlynck (1980) advocates for: (a) Ogden Lindsley's notion of data-based services in which data collection focuses on client outcomes rather than provider service activity, in part so that performance indicators do not entirely omit the client (Binder, 2005); (b) responding to client needs rather than labeling clients as deficient when their needs do not fit the services the provider chooses to offer; (c) generation of support for programs or changes from a wide group of stakeholders to assure the broadest possible support; (d) identification of innovative programs that have strong advocates and an empirical basis; and (e) installation of a mechanism for assuring model integrity (e.g., treatment fidelity) when innovative programs are implemented. Hamerlynck's suggestions foretell the current emphasis on the need to monitor client outcomes and treatment fidelity as empirically supported interventions are introduced into community practice (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Kazdin &

Kendall, 1998; Weisz, Donenberg, Han, & Weiss, 1995; Weisz & Jensen, 1999)

Over the last 9 years, Michigan's public mental health system for children has collected outcome data to inform policies and practices. These data have played a major role in the recent efforts to introduce two research and behaviorally based services—cognitive behavior therapy (CBT) and parent management training (PMT). This article discusses the evolution of this effort, which has included implementing a number of the changes advocated by Hamerlynck (1980). However, we would have to admit that at times these changes were accomplished serendipitously.

## Background

The Michigan Department of Community Health (MDCH), in partnership with Eastern Michigan University (EMU) and the Community Mental Health Service Programs (CMHSPs) in Michigan, began a collaborative effort in 1996 to determine the impact of treatment-as-usual on youth with severe emotional disturbance (SED; Substance Abuse and Mental Health Services Administration, 1993) served by the public mental health system. This outcome monitoring effort, referred to as the Level of Functioning Project (LOF), is implemented by EMU and is currently in its 9th year (Hodges & Wotring, 2004). CMHSP participation in the LOF project is voluntary, and since its inception, participation has grown to include most of the state.

On a monthly basis, the CMHSPs report client outcome, using the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000), as well as demographic and service delivery information. The CAFAS was selected because it is a clinically useful tool that facilitates designing an outcomes-oriented treatment plan and

has strong psychometric evidence (Hodges, 2004c). The CAFAS score at intake predicts service cost and utilization, including restrictiveness of care and number of treatment days, as well as school truancy and trouble with the law (Hodges, 2000).

The CAFAS measures a child's functioning across eight domains—school or work, home, community, behavior toward others, moods and emotions, self-harmful behavior, substance use, and thinking. Based on the rater's endorsements of behavioral items, the youth's level of impairment in functioning is determined, using a 4-point scale, as follows: *severe* (30), *moderate* (20), *mild* (10), or *minimal or no impairment* (0). The subscale scores can be summed to determine an overall score or used separately to determine different client types (Hodges, 2003, 2004b). The CAFAS is administered at intake, then quarterly and at exit for all of the children served. The CMHSPs can print out individual client assessment reports and treatment plans, as well as some aggregate reports, from the CAFAS software. For each CMHSP, the LOF prepares site-specific reports on a monthly and yearly basis. At the semi-annual LOF meetings, the CMHSPs learn from each other about how they are using the data and receive information on new initiatives that the state is planning.

## Accomplishments

The LOF project has evolved over the years from determining rates of successful outcome with treatment-as-usual to identifying exemplary practices and, recently, helping to identify evidence-based practices that may be helpful. The initial challenge was to simply gather the data and create useful reports for the CMHSPs. The reports provided a natural reward to the CMHSPs for gathering the data, and their input was used to continually modify and improve the reports, which in turn contributed to their buy-in. Each CMHSP received data for their own site as well as statewide averages for the same indicators.

The LOF project provides data to support better decision making by practitioners, managers and directors of provider organizations, as well as managers and policymakers in state government. For example, in the initial data analyses, cluster analysis was used to identify subgroups of the youths served (Hodges & Wotring, 2000). Subsequently, a client typology identified group membership at intake (Hodges, 2004b), and outcomes by client type for the each CMHSP in the state database (Hodges, Xue, & Wotring, 2004b). As



a result, the CMHSPs could evaluate their programs by comparing their outcomes for the different client types to the state benchmarks, making reports helpful in the day-to-day management of their programs (Barckholtz, 2001). These reports identified cases that were not making progress in treatment as well as cases in which the youth's needs did not appear to match with the services the youth was receiving. All CMHSPs were able to achieve average or above-average results with at least one or more types of clients. The better outcomes were typically observed in service areas that were local "points of pride" (e.g., collaborative wraparound program with juvenile justice, home-based behavioral programming), and this appeared to help counter defensiveness associated with poorer outcomes.

The LOF decision support system also helps to identify "best practices" that can be shared with other programs in the state. Two CMHSPs that were identified as achieving superior results across different types of clients were found to be very community centered, strength based, responsive to families, and supported by a strong management structure (R. M. Friedman, written personal communication, Louis de la Parte Florida Mental Health Institute at the University of South Florida, 2004). At one of these sites, the reviewing site team found that families were strongly involved in reviewing their child's progress when the CAFAS was done quarterly, and in fact, kept graphs showing their child's progress

on the eight subscales. This use of outcome data, that actively involves the client as an informant and a consumer, fits with the spirit of Hamerlynck's (1980) suggestion that the system include client outcome as a centerpiece (Hodges, 2004c).

The LOF decision support data can be used to more carefully evaluate best practices as well. For example, propensity analysis was used to demonstrate that the home-based program that was locally developed and highly valued by the community had significantly better outcomes than a comparable sample of youths from the statewide database (Hodges & Grunwald, 2005). In addition, another program produced research results that supported an innovative program that was developed to generate more objective recommendations when conducting emergency evaluations for the local hospital (Wale, Denter, & Barckholtz, 2004).

Implementation of evidence-based practices recently has become a national priority (President's New Freedom Commission, 2003). The adoption and implementation of evidence-based programs makes sense when they can help to solve particular problems faced by communities and states. The LOF decision support data proved to be very useful in these efforts. Two years ago, a committee of various stakeholders was formed to discuss the needs of Michigan's youth in public mental health. The first step was to examine the statewide database to help identify the evidence-based practices that would be the most relevant to youth

served by the public mental health system in Michigan. Data reports were widely disseminated and discussion was encouraged at multiple levels and in different stakeholder groups. Information on the percent of youths with SED who met criteria for seven mutually exclusive, hierarchically arranged client types helped identify consumer needs. The client categories, which were based on the youth's profile on the eight CAFAS subscales, were thought problems, maladaptive substance use, self-harmful potential, delinquent behavior, behavioral problems with moderate mood disturbance, behavior problems, and moderate mood and/or mild behavioral problems (Hodges, 2004b). Figure 1 shows that approximately 50% of youths were best described as having severe behavioral problems (i.e., behavior problems, behavior problems with mood) and 47% had mood disturbances (i.e., self-harmful potential, behavior problems with mood, and mild mood and/or mild behavior problems). In addition, the rates of successful outcomes for these youths ranged from 38% to 58%, depending on the subgroup and the outcome indicator used (Hodges et al., 2004b).

Local CMHSP children's administrators, supervisors, and their staff were provided with information on the percentage of youths they served and outcomes for the different client types, which they could compare to the statewide data. CMHSPs were also given articles about the different evidence-based practices as well as a manual that described different client types and evidence-based treatments that might be used to achieve better outcomes for those client types (Hodges, 2004b). This manual, along with the data, has helped minimize resistance to the idea of using evidence-based treatments for youths with severe behavioral problems and for mood disturbance.

The committee's next step was to invite treatment manual developers who had conducted research in treatment of depression and severe behavioral problems to join our collaborative endeavor. The group consensus was to begin with cognitive behavioral treatment (CBT) for depressed children and to address treatment of behavioral disorders as the second initiative. Drs. Joan Asarnow and Margaret Rea from the University of California agreed to conduct our training. This training was conceptualized as a pilot project, with two sessions of training planned so that we could hopefully implement the lessons we had learned during the second session. The program was funded with limited resources from the state and approximately 50 clinicians from various

*Figure 1.* Client types for youths with SED served by Michigan Public Health.





CMHSPs throughout Michigan participated.

Extensive role-playing was used in the CBT training workshops to illustrate the clinical techniques described in the training manual (Asarnow et al., 2003). During the next 6 months, biweekly telephone supervision/consultation of training cases were held for the clinicians in groups of four. The training proved to be a great success from many perspectives. The trainees were very pleased with the content, the training format, and the support and clinical expertise that characterized the ongoing clinical supervision (Rea et al., 2005). In some CMHSPs, exceptionally skilled trainees helped other staff with learning CBT. In the second training session, we found that approximately 80% of the training cases made significant improvements across life domains, as measured by the CAFAS (Hodges, Rea, Wotring, Pettee, & Asarnow, 2005). The training boosted practitioner morale, resulting in clinicians feeling more empowered to help clients, and dispelled some of the typical fears about evidence-based treatments (e.g., concerns about potential disregard for clinical skills, clinical judgment, or therapeutic alliance with the client).

Despite the overall positive experience, the state collaborative team learned that there were significant challenges to statewide training initiatives. Three major barriers were identified: insufficient release time from normal workloads, lack of timely access to clients who would be good training cases, and lack of sufficient support

from supervisors (Hodges, Rea, et al., 2005). There was considerable variability across trainees and agencies, and without a treatment fidelity measure, there was no way to know who was implementing CBT with fidelity. In addition, an infrastructure to support the training initiative was needed to clarify expectations, monitor compliance with expectations, collect outcome data, and problem solve issues as they arose.

In the interim, the state team intensified the data analysis to learn more about the youths with behavioral problems. A cluster analysis, in which outcomes by cluster were examined, revealed that youths who were behaviorally impaired across settings (e.g., in school, home, and general interactions with others) and had co-occurring mood disturbance had poorer outcomes than other behaviorally impaired youths (Hodges, Xue, & Wotring, 2004a). Regression analyses comparing pervasive behavioral impairment to other predictors of poor outcome found this characteristic to be the strongest predictor of poor outcome with treatment-as-usual (Xue, Hodges, & Wotring, 2004). Surprisingly, pervasive behavioral impairment was found across all age groups, with the range being 28% to 37% for youths 6 to 17 years old (see Figure 2). In fact, 29% of the 6-year-olds were pervasively impaired. With this information, the state could potentially prevent treatment failure by identifying these youths at intake and offering these families an evi-

dence-based treatment specific to pervasive behavioral impairment.

The state responded to an RFA and received funding from a "State Implementation of Evidence Based Practice: Building Science to Service" grant, jointly sponsored by the Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health. The grant funding also paid for a consultant, a clinician with expertise in quality assurance, to visit 48 individual CMHSPs and meet with front-line children's staff and supervisors. During these visits, data specific to the sites were reviewed and ideas were discussed about how to improve outcome and services (Hodges, Wotring, & Wale, 2005). These site consultations increased interest in evidence-based treatments as well as membership in the LOF project. In addition, this funding was used to sponsor the writing of a pamphlet for families on evidence-based practices by an advocacy group, the Michigan chapter of the Association for Children's Mental Health (2004).

By this time, a statewide committee was formed in the Department of Community Health to address implementation of evidence-based treatments. During the discussions of issues for children's programs, emphasis was placed on using data to guide rational decision-making, ensuring input from all stakeholders including family advocates and providers, maintaining outcome monitoring, and the need to introduce a treatment fidelity measure. Data were presented on how many children in the public mental health system could potentially be impacted by PMT. The stakeholders' committee sought developers of PMT programs as the approach of choice for children with pervasive behavior problems, and Dr. Marion Forgatch of the Oregon Social Learning Center (OSLC) expressed interest in joining the collaborative effort. The model of PMT taught by the OSLC is referred to as PMTO (Patterson, 2005). Forgatch had introduced PMTO to Norway in 1998 as part of a nationwide implementation of the program, with an 18-month training cycle to produce a group of trainers.

Figure 3 provides a range of estimates of the number of children in Michigan that could benefit from PMTO, with a breakdown by age group. The sample consists of youths with SED who were referred for services to the LOF sites from 2000 to 2004. Up to 92.6% of all youths could benefit from PMTO, as this is the frequency of youth who have at least mild impairment

*Figure 2.* Pervasiveness predicts poorer outcomes at all ages. Percent of youth with 30 or 20 on School, Home and Behavior Towards Others subscales.

on the Home or Behavior Toward Others subscales of the CAFAS. The Home subscale assesses noncompliance in the home, whereas the Behavior Toward Other subscale mostly captures behavioral excesses that offend or annoy others. If the case were made that PMTO is only needed for more serious cases of noncompliance, then a more conservative estimate would be that 65.8% of the cases could benefit, as this is the frequency of severe or moderate impairment on either of these two subscales. If the goal were to identify cases in which PMTO would almost certainly be the treatment module of choice from the onset of services, a conservative estimate would be 34.8% of youths. This is the percentage of youths who display serious noncompliance in the home (i.e., severe or moderate impairment on Home subscale), have behavioral problems across settings (i.e., also moderately or severely impaired on the School or Behavior Toward Others subscale), and are absent behaviors that might evoke at intake another treatment as the primary treatment module (i.e., no severe impairment on Community [e.g., delinquent-like behaviors], Moods/Emotions, Self-Harmful [e.g., suicidal], Substance Use or Thinking [e.g., rational thought]). These cases could be considered “target PMTO cases,” in that it would be reasonable to ask why the family did not receive PMTO as the primary treatment endeavor.

### Future

Michigan is currently facing the challenge of providing statewide training while assuring fidelity to the model and continuing to assess outcomes to ensure that the treatment has a positive impact on the children and families being served. This requires an intensive training protocol, implementation of a fidelity tool, evaluating client outcomes, and developing an infrastructure to monitor support for, and compliance with, training expectations. The OSLC has experience in installing a behavioral evidence-based intervention, and in partnership with them, we plan to train and import the model to Michigan.

A statewide committee has been meeting to build support for introducing the model and to develop a work plan to implement PMTO statewide. A logic model has been developed with five clear outcomes identified and measures to monitor performance. The outcomes and measures include: (a) implementation of PMTO statewide in 5 years (i.e., PMTO will be available in every CMHSP in 5 years); (b)

improved child functioning as a result of the intervention, as measured by the CAFAS; (c) improved staff performance as measured by the Fidelity of Implementation Rating System (FIMP), a treatment fidelity measure developed by Forgatch and colleagues (Forgatch, Patterson, & DeGarmo, 2005; Knutson, Forgatch, & Rains, 2003); (d) improved family satisfaction with services as measured with a brief satisfaction tool at the end of each session; and (e) improved parenting skills, as measured by a caregiver skills scale (Hodges, 2002). In addition, we are struggling with how to foster sustainability of the model within the local CMHSPs, so that coaching in the model can be maintained (Fixsen et al., 2005). We are learning strategies from the early adopters who currently are being trained in three regions of the state.

### Challenges

Developing the LOF system to support decision making at clinical, managerial, and policy levels has taken time and effort. In the beginning of this project, the data reports were too complicated for CMHSP staff to understand. We provided additional training to help staff interpret the reports, including instructions on how to convert the reports into Excel graphs. Eventually it was decided that LOF should aggregate the data into graphs in order to facilitate the use

of the data by the CMHSPs. Another related challenge at the start was the lack of computer technology at the CMHSPs. Many agencies were just purchasing computers at the time and learning how to use them, which complicated the early adoption of the CAFAS software and added to the training time.

Supervisors also needed time to develop an appetite for data and to learn to use the data with their staff in a positive way. As we discovered how different CMHSPs were using the data, we highlighted these programs at LOF meetings, thereby creating a learning environment with a variety of different “champions.” The sites love comparing themselves to statewide averages because they all have one or perhaps two areas in which their numbers are better than the state’s. In fact, for some CMHSPs, publicity about their good outcomes has resulted in other child-serving agencies in their area (e.g., juvenile justice) being more willing to collaborate with the CMHSP on cases as well as generating grant applications for the community.

At the state level, it took time to develop confidence in the data. This was the first time we have been able to drill down and get client-level outcome information. Sometimes the data paint a larger picture that is very different from what clinicians tend to focus on. When asked about needs,

*Figure 3.* Percent of youths with behavioral impairment in the LOF dataset for the period from 2000–2004 ( $N = 16,767$ ). *Note.* PMTO target cases = 30 or 20 on Home subscale of the CAFAS, 30 or 20 on School or Behavior Towards Others (BTO), and no 30’s on Community, Moods/Emotions, Self-Harm, Substance Abuse, and Thinking subscales. Severe or moderate = 30 or 20 on Home or BTO subscales. Severe, moderate, or mild = 10, 20, or 30 on Home or BTO subscales.

clinicians often focus on cases that are the most discouraging because of the presence of challenges in the caregivers or cases that appear to have no effective treatments (e.g., atypical cases in which multiple trials of medication have produced no improvement). However, when looking at their own data, clinicians could see that these were not the most common cases and that, even for the less difficult cases, rates of attrition and outcome were less than desirable. This is very powerful information and has to be used with an eye toward improving the service delivery system rather than used aversively against CMHSP staff. Using the information in a positive and supportive way promotes genuine continuous quality improvement activities. Used aversively, it would discourage voluntary participation in collecting outcome data and encourage attempts to “game” the outcome monitoring system.

A significant amount of time has to be devoted to planning and networking with stakeholders for the successful adoption of any new practice on a statewide basis. Involving others in this decision-making process will help ensure successful adoption of PMTO statewide. We have made the effort to ensure that CMHSP staff have input in the process. Staff at all levels have been involved in the decision making over which evidence-based services to introduce, assisted in planning the introduction of the model, and helped identify potential barriers to successful implementation of the training. In the implementation of PMTO in Norway the length of training for first-generation trainers was 18 months. In Michigan, some administrators have asked that we shorten the length of time and yet maintain fidelity to the model. In the current training of early adopters, the time has been shortened to 13 months. We hope to study the implementation of our large-scale training, and if possible, determine factors that influence the length of training needed to achieve good fidelity.

As a guide, we use the skills taught in PMTO as a framework for thinking about the processes for continued successful implementation. We want to use positive rewards whenever possible (e.g., recognizing exemplary programs), monitor behavior (e.g., use data to keep track of outcomes), promote positive involvement with the use of data (e.g., share data openly and avoid punishment), and problem solve together (e.g., introduce training in PMTO and the use of other best practices such as cognitive behavior therapy). Hopefully, with the use of outcome monitoring, positive rewards,

supportive orientation, fidelity monitoring, and collaborative problem solving, we can eliminate the aversive behavioral exchanges between those governing and those being governed and keep the welfare of the client in the forefront.

Building capacity in a human service system to collect and use client-level outcome information requires involvement of all stakeholders and is a complex process. One must be willing to listen to providers and produce reports they find useful to gain their buy-in to the process of outcome management. Consumer-level outcome information has the potential to increase an administrator's level of understanding about what is going on in their “marketplace.” We can now determine who and what types of clients are improving with what types of services. Consumer-level outcome information helps reduce the “noise” from providers, who generally complain that they do not have enough resources or that their clients are much worse than those served by others. The latter claim is used to support their belief that their clients cannot benefit from proven evidence-based practices. Consumer-level outcome information allows everyone to view consumer needs from the same perspective. It precludes arguments about many hypothetical issues and helps dispel unjustifiable concerns.

Consumer-level information must be handled with care. An administrator's focus should be on system improvement rather than on individual organizations. Additionally, the emphasis should be on shaping desired behaviors, modeling and encouraging with positive reinforcement, and organizational behavior that is supportive of genuine, continuous quality-improvement activities. The goal is to avoid unproductive negative coercive exchanges between state administrators and providers as described in Hamerlynk's (1980) article. Without question, this is difficult to achieve and we still have a lot to learn. However, when used properly, client-level outcome information is a powerful tool that can be helpful in achieving this goal, and ultimately, in improving services to consumer families.

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## 1980 *tBT* Classic

[Original Editor's Comments] As research demonstrates the success of behavioral procedures, attempts will be made at large scale implementation of these procedures. However, the aspects necessary for successful large scale implementation are often divergent from those research activities, and even small scale implementation. Unanticipating this difference can doom large scale implementation to failure. The following solicited article by Dr. Hamerlynck offers a behavior analysis of a state-wide mental health and developmental disabilities program implementation from his view as director of these services over a four-year period.

Editor

[Excerpt]

### “When You Pass the Behavioral Buck — Make It Contingent” or Reflection Upon Service in State Government

L. A. Hamerlynck, *Oregon Social Learning Center*

Early in 1969 most of us were celebrating the reaffirmation of the Law of Effect by accelerating the drumbeats for “behavior modification.” My colleague Jerry Patterson, described the period as the “whoopie” stage of development. It seemed that everyone was pinpointing, recording, and reinforcing which was followed by a thunderous, “Whoopie, it works.” Thorndike rested easily while the Freudians and Rogerians pulled their wagons into circles. It was an exciting time for many as we saw the means for change appear to deal with the problems of living for the poor, the retarded, the underachievers, and the mentally ill. Most of us visualized a time when policies such as those of “War on Poverty” could lead to the vivid and valid developments. We talked about a world where human rights could be operationalized for all. This would be by demonstrating that, in part, deviance of the retarded and mentally ill was the result of deviant environments, not incubate and a host of related demons within the mind.

It was in the foregoing context that my colleagues and I at the University of Calgary planned the First Banff International Conference on Behavior Modification. The topic was Ideal Mental Health Services as a reflection of the interest of our sponsor, Dr. W. R. N. Blair. Buck Blair had just finished a white paper on mental health services for the provincial

government and offered his honorarium for the support of a conference on the topic. So we proceeded to invite as many leaders of the behavior modification movement as our budget would allow. The final roster was Gerald Patterson, Nate Azrin, Todd Risley, Dick Stuart, and Og Lindsley. Each agreed to present a paper at the conference reflecting their “blue sky” view of dimensions of Ideal Mental Health Services.

The conference was of significant success and initiated the series of which next year is the thirteenth. The speaker, the scenery, and the skiing combined for a memorable experience. Lindsley's presentation was dramatic as he argued for data-based services. In concluding, he challenged the audience with the statement, “The blood of your patients is on your hands.”

The proceedings were published, but there wasn't a chapter by Lindsley. It wasn't that he failed to fulfill his contract. He presented me with a one-line, nine-word paper. It read, “When you pass the behavioral buck—make it contingent.” As Chairman and Senior Editor of the proceedings, I was instrumental in the decision to exclude the Lindsley paper. Now, after more than a decade, which included a 4-year period in my career where I held the titles of Coordinator of Mental Health and Retardation, Administrator of Developmental Disabilities, and Coordinator of Mental Retardation, I publicly acknowl-

Reprinted from Hamerlynck, L. A. (1980). “When you pass the behavioral buck—Make it contingent” or reflection upon service in state government. *the Behavior Therapist*, 3, 5-9.

edge the genius of Og Lindsley. His unpublished paper pinpoints the essential factors in the design and operation of any human service, as well as understanding why so many fail.

To follow my reflections, two assumptions must be accepted. First: Any system, institution, agency can be viewed as a behaving organism. In other words, "it" responds to environmental events in the same manner as an individual. It learns in approximations, it escapes, it avoids, it punishes, it satiates, it effects and is effected by its environment. Second: Any agent of change, such as I played, is part of the system and is also subject to the control of the environment while trying to influence it. I stress this assumption because it accounts for some of the difficulty scientist-practitioners often have in relating their experiences to their researcher colleagues. To clarify, suppose three observers are attempting to understand a river or stream. One is in a balloon, one is standing on the beach, and one is wading in the water to his chest. Their accounts will obviously have differences. The wader might frequently refer to personal conditions, such as the cold, slippery footing and not focus upon the physical and geological conditions. However, these are significant observations if put in their context. Apparent bias due to the personal involvement can be interpreted as a significant aspect of the phenomena. I mean to present my in-stream-based generalizations about the design, implementation, and conduct of human services.

In 1974 I was invited to Montana by the Governor's Director of the Office of Budget and Program Planning. Although it meant surrendering my tenured position, my family was unanimous in support for the change. The basic task was to lead the final planning and implementation of a dramatic reform—the deinstitutionalization of the mental retardation and mental health programs. When I was deliberating over the offer, my wife, Marilyn, observed that the position was "a chance to put my behavior with my words." One of her rules for the conduct of our relationship had long been that she refused to listen to complaints about conditions I wasn't investing my behavior in solving. It is a powerful screen.

This paper elaborates upon Lindsley's prescription to the extent of proposing three general cases.

A. Human Services Involve Aversive Control: Human service systems are com-

posed of interactions which primarily involve negative reinforcers with consequent aversive control and countercontrol.

B. Political Goals = Professional Goals or Don't Do as I Say Unless You Clear It with Me First. Professional and political goal statements for human services are convergent in the abstract and become divergent with operational definition.

C. Innovation and Change - You Can't Do Your Thing If They Don't Have That Pain. Innovation and change in human services are dependent upon the presence of a political pain and the ability of an innovation to reduce the pain . . . ●

The full text of Hamerlynck's article can be accessed at

[www.aabt.org](http://www.aabt.org)

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## Is Comorbidity Really a Problem for the Dissemination of Evidence-Based Treatments for Youth?

Amanda Jensen Doss, *Texas A & M University*

Cross-fertilization between research and practice has garnered much attention in the area of youth psychotherapy. In their 2001 report on the current state of research on youth mental health, the National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment discussed the burgeoning literature on promising treatments and recommended that investigators be strongly encouraged to conduct studies to disseminate these evidence-based treatments (EBTs) to public sector mental health settings. The National Institute of Mental Health (NIMH) has responded to this call by posting requests for applications related to this topic (e.g., RFA-MH-05-004, State Implementation of Evidence-Based Practices II—Bridging Science and Service). Division 53 of the American Psychological Association, the Society for Clinical Child and Adolescent Psychology (SCCAP), has also gotten involved by creating an on-line guide for providers and consumers of mental health services on evidence-based treatments for children and adolescents ([www.effectivechildtherapy.org](http://www.effectivechildtherapy.org)).

In response to this movement to disseminate EBTs in clinical practice settings, researchers and clinicians have raised concerns regarding the appropriateness of these EBTs for clients seen in clinical practice settings. One of the variables most frequently cited in these criticisms is diagnostic comorbidity. Concerns about diagnostic comorbidity as a barrier to using EBTs in clinical practice is based on four assumptions:

1. Rates of comorbidity are high in clinical populations.
2. Clients with comorbidity have worse treatment outcomes.
3. Randomized clinical trials (RCTs) exclude participants with comorbidity.

4. EBTs are single-problem focused and therefore not useful for clinicians working with highly comorbid clinical caseloads.

Here, I will discuss the data supporting (or refuting) each of these assumptions as they pertain to youth clinical practice settings and the youth treatment outcome literature.

### Assumption 1: Rates of Comorbidity Are High in Clinical Populations

Multiple studies using evidence-based diagnostic interviews provide clear support for this assumption. For example, in one study of youth seeking services in community clinics, the average number of diagnoses per child was 2.44 and 49% of the sample had multiple diagnoses (Jensen & Weisz, 2002). Given that an additional 20% of the children in this sample did not meet formal criteria for a diagnosis, the vast majority of children with a diagnosable condition in this sample met criteria for multiple diagnoses based on a structured diagnostic interview.

Related to this assumption, however, is the notion that clinicians diagnose their clients with multiple diagnoses and treat them as multiproblem clients. Here, the data are less supportive. In the Jensen and Weisz (2002) study, for example, despite the high rates of comorbidity generated by a structured diagnostic interview, clinicians' chart diagnoses painted a very different picture. The clinicians assigned an average of 1.22 diagnoses per child and only assigned multiple diagnoses to 17% of the sample. These data suggest that, despite the concern raised about high rates of comorbidity in clinical samples, clinicians might not detect and treat these multiple diagnoses.

### Assumption 2: Clients With Comorbidity Have Worse Treatment Outcomes

Little data exist on the relation between comorbidity and treatment outcomes in samples from clinical settings. We conducted a broad-based study on this issue (Jensen Doss & Weisz, in preparation), predicting treatment outcomes for 325 youth seeking services in community clinics from co-occurrence between all possible pairs of narrowband scores from the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001). Despite the large number of analyses we conducted, we found little support for the notion that comorbidity predicts worse treatment outcomes. A small minority of analyses indicated a relation between comorbidity and worse outcomes, but the majority of our analyses were not significant.

The results from RCTs are quite mixed on whether comorbidity is related to worse treatment outcomes. As an example, take three studies that have looked at the relation between comorbid anxiety and treatment outcomes for youth receiving cognitive-behavioral treatments for depression. Brent and colleagues (1998) found that comorbid anxiety was associated with worse treatment outcomes; Jayson, Wood, Kroll, Fraser, and Harrington (1998) found no effects of comorbid anxiety on outcomes; and Rohde, Clarke, Lewinsohn, Seeley, and Kaufman (2001) found greater pre- to post-treatment changes for adolescents with comorbid anxiety disorders. I would argue that much of the RCT literature has actually found that comorbidity is not related to treatment outcomes, and when authors do find a relationship between some form of comorbidity and treatment outcomes, it is often the case that their analyses for other forms of comorbidity were not significant. For example, Brent and colleagues (1998) indicated they they planned analyses predicting outcome from "comorbid diagnostic conditions" measured by a full diagnostic interview, but only reported comorbid anxiety as predictive of treatment outcomes, indicating that other disorders were likely not significant predictors. Given the mixed, and often nonsignificant, results of analyses predicting treatment outcomes from comorbidity, it may be that the concern regarding the impact of comorbidity on outcomes is overstated.

### Assumption 3: RCTs Exclude Participants With Comorbidity

As part of the movement to identify and disseminate EBTs, the MacArthur Found-



ation has funded a group of researchers, led by John Weisz, to conduct a meta-analysis of the youth psychotherapy literature. This ongoing project currently consists of 298 RCTs of child psychotherapy for depression, anxiety, conduct problems, and ADHD published before December 2002 (Weisz, Hawley, & Jensen Doss, 2004). One hundred forty-one of these studies indicated that exclusionary criteria were applied to their participants. Of these, 65 (46.1%) made no mention of comorbidity in their exclusionary criteria (here comorbidity was considered any Axis I disorder or symptoms; mental retardation, developmental disorders, and learning disabilities were not considered comorbidity for this article). Twenty-five of the studies (17.7%) specifically mentioned including study participants with some form of comorbidity; 15 of these allowed some forms of comorbidity but excluded cases with comorbid psychosis or suicidality. Fifty-one studies (36.1%) excluded cases with comorbidity; 16 of these only excluded comorbid psychosis or suicidality but did not mention other forms of comorbidity. It is important to note that many of the studies that did indicate that they excluded some forms of comorbidity only listed some disorders as exclusionary criteria and did not mention excluding other forms of comorbidity. These data indicate that the criticism that RCTs exclude cases with comorbidity is also likely overstated.

#### Assumption 4: Evidence-Based Treatments Are Single-Problem Focused and Inappropriate for Comorbid Cases

Surveys of clinicians have indicated that they believe that EBTs cannot address the needs of multiproblem clients (Addis, Wade, & Hughes, 1999). Given the lack of convincing literature demonstrating that children with comorbidity do worse in clinical trials of these treatments (see Assumption 2), the real issue may not be that these treatments do not work with multiproblem clients. Rather, the central problem may be that there is a lack of guidance for clinicians as to which EBT to use when faced with a child presenting with multiple problems. While there are EBTs that are structured to allow therapists flexibility to address multiple problems (e.g., Multisystemic Therapy; Henggeler & Borduin, 1990), the reviews of EBTs for children to date have taken the approach of organizing the literature on these treatments into single problem areas (e.g., EBTs

for depression, anxiety, etc.; see e.g., the 1998 special section of *Journal of Clinical Child Psychology*). Clinicians attempting to use these lists to choose treatments for youths with comorbidity are left wondering whether to treat the primary presenting problem only, to use more than one treatment manual to address the comorbid conditions, to try to apply the skills presented in one manual to the symptoms from both conditions, or to not use an EBT at all.

#### Reconsidering Our Assumptions About Comorbidity and Cross-Fertilization

The data reviewed above challenge many of the assumptions underlying the concern about comorbidity and cross-fertilization in the area of child psychotherapy. While it does appear that youth seeking services in clinical settings present with high levels of comorbidity, it is less clear whether therapists actually treat them as such and whether this comorbidity has an impact on treatment outcomes. What clearly lingers as a concern is how clinicians should go about using EBTs, which are often presented as a treatment option for a single problem area, with youth who come to therapy with multiple problems.

Studies comparing different approaches to using EBTs with comorbid cases would provide useful guidance to clinicians faced with this problem. Also useful would be more studies explicitly testing manual-based treatments with comorbid populations (see Rohde et al.'s 2004 trial of the Coping With Depression course for adolescents with comorbid depression and conduct problems). New approaches to packaging EBTs, such as modular approaches (Chorpita et al., 2004), might also prove useful for cases with comorbidity, as therapists would be able to use a single set of materials to conduct therapy techniques common to manuals for both problems being treated. For example, a therapist working with a child with comorbid depression and anxiety might start treatment with modules on cognitive-behavioral techniques common to EBTs for both disorders and then assess whether additional treatment is needed focusing specifically on one problem or the other. Thoughtful research designed to address these practical issues will do much to alleviate concerns about comorbidity as a barrier to cross-fertilization.

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# Five Strategies for Bridging the Gap Between Research and Clinical Practice

Martin M. Antony, *St. Joseph's Healthcare and McMaster University*

Over the past decade or two, there has been heightened interest in clinical research and training in the areas of evidence-based assessment and treatment. Financial pressures (e.g., from managed care) have forced mental health professionals to take steps toward ensuring that their interventions are both clinically effective and cost-effective. Still, there often remains a gap between what actually happens in clinical practice and what research tells us should be happening. Many practitioners continue to practice psychotherapies that are not supported by research (Norcross, Hedges, & Castle, 2002), and clients often receive treatments that are not empirically based (Rowa, Antony, Brar, Summerfeldt, & Swinson, 2000). This article suggests five strategies for closing the gap between science and practice. Some of these are strategies that we can engage in as individuals, and others are efforts that can only be implemented on a larger scale (e.g., through the professional associations that represent us, or through our institutions).

## 1. Don't Assume That Everyone Wants to Be Disseminated to

Many of us behave as though we believe that if only we can expose practitioners to information about evidence-based treatments and assessments, they will embrace these procedures with open arms and start using them in their practices. Of course, that simply isn't the case. The average clinician is probably just as reluctant to give up his or her theoretical orientation as is the average member of the Association for Behavioral and Cognitive Therapies (ABCT). Simply offering workshops and publishing books on behavioral and cognitive therapies will not necessarily affect the ways in which the average clinician practices if he or she is not taking advantage of these training opportunities. Rather, it is often external pressures (e.g., demands from one's clients; financial pressures from insurance companies) that force practitioners into doing things in new ways. In addition to educating practitioners, it is important to continue efforts to educate governments, insurance companies, those

who refer clients for treatment (e.g., family doctors), and consumers themselves (see Strategy 4, below) about effective psychological treatments.

## 2. Expand the Scope of Research to Ensure That Evidence Is Relevant to Practitioners

One of the criticisms of the empirically supported treatment (EST) movement is that the treatments often considered to be evidence-based are not relevant to routine clinical practice. For example, ESTs typically include very specific interventions designed to treat very specific problems, even though clients presenting for treatment often seek help for a number of concerns. We have evidence-based treatments for marital discord, obsessive-compulsive disorder, substance abuse, and depression, but we know very little about how to treat someone who has all of these problems. We are only now just beginning to study ways of treating people with more complex symptom profiles.

Second, advocates of ESTs (e.g., behavioral and cognitive therapists) have tended to pay little attention (at least relative to therapists who practice other psychotherapies) to evidence concerning nonspecific factors (e.g., therapist factors, patient factors, process variables) that are known to be important in the outcome of psychotherapy (e.g., Norcross, 2002). My guess is that clinicians who practice psychotherapies that give greater emphasis to the therapeutic relationship might be more open to learning about research on evidence-based treatments if it spoke to some of the nonspecific factors that impact upon outcome.

Finally, evidence-based treatments are sometimes provided in formats that are not paid for by many insurance companies (e.g., sessions that are longer than 1 hour, sessions that occur more frequently than once per week), and they are often studied in centers where therapists are much better trained in the procedures than therapists might be in some other settings. For practitioners to pay attention to what the research says, the research will need to become increasingly relevant to the settings in which practitioners work. The recent increase in effectiveness

research (as a complement to efficacy research) is a step in the right direction. In particular, efforts such as the Pennsylvania Practice Research Network (Borkovec, Echemendia, Ragusea, & Ruiz, 2001) can serve as models for how research and clinical practice can be mutually enhancing enterprises.

## 3. Get Practitioners on Board From the Start of Their Training

In his classic book, *The Structure of Scientific Revolutions*, Thomas Kuhn (1996) argued that when a paradigm shift occurs in science, it is typically not the established scientists who change their views first, but rather the younger, and perhaps more open-minded, scientists and students. Practitioners' theoretical orientations are perhaps most strongly influenced by those of their mentors. In order to see a paradigm shift toward greater use of evidence-based interventions, it will be necessary to first see a shift in the types of treatments taught during the earliest stages of professional training. Increasingly, evidence-based treatments are being taught to students in psychology and psychiatry. However, there is still a long way to go. Furthermore, in the case of other professions (e.g., social work, occupational therapy, psychiatric nursing, etc.), there is often no training whatsoever in evidence-based assessments and treatments. Finding ways to influence training across a wide range of disciplines should be a priority for ABCT and other organizations with the mission of disseminating evidence-based interventions.

## 4. Educate the Consumer

The pharmaceutical industry has known for a long time that effective marketing is essential for selling their products. Healy (2003) distinguishes between the ways in which the pharmaceutical industry sells products and the ways in which it markets products. Selling involves convincing people to buy a product, usually after it is available (e.g., convincing physicians to prescribe a particular medication). Marketing, on the other hand, starts long before the product becomes available, and the strategies used may be much more subtle than those used by a company's sales staff. The purpose of marketing is to make people aware of a need for a given product (or in some cases, to create such a need). For example, one way in which pharmaceutical companies market their products is by educating physicians and the public about how to identify the disorders for which their

products work. Not surprisingly, as people become better at identifying that they have a particular disorder, they will soon begin seeking out treatments for that condition.

Although many of the ways in which pharmaceutical companies market their products would be considered distasteful (and in some cases unethical) to many practitioners and scientists, there are some strategies that we should consider borrowing to ensure that our clients are getting the most effective treatments possible. One such strategy is to educate consumers about evidence-based approaches to care, in addition to educating practitioners. If those who seek treatment are more aware of the available options, they may start to select their practitioners based on the types of treatment offered, and I imagine that practitioners' practices might change as a result. Consumers can be reached in many different ways, including public lectures, psychology courses, the Internet, associations (e.g., the Anxiety Disorders Association of America), self-help books, brochures in their family doctors' offices, and increased exposure to evidence-based treatments in the media (for example, as a result of press releases from ABCT and its members announcing findings from new studies).

### 5. Conduct Research on Dissemination

Ironically, these suggestions provided for closing the gap between science and practice are not evidence-based. Very little is known about how to best disseminate findings regarding evidence-based practice, and there is a need to fund studies on this topic. Many questions need to be answered. For example, under what conditions do continuing education workshops and other efforts to educate practitioners actually change clinical practice? Are different strategies needed to reach practitioners working from different orientations or from different disciplines? How can scientists involve practitioners in designing their research studies to ensure that the outcomes are relevant? What are the most effective ways to train our students? What are the most effective ways to educate consumers who seek treatment?

### Conclusion

In closing, this article highlighted five strategies for bridging the gap between clinical practice and empirical research. Specifically, it was suggested that scientists do a better job at ensuring that research is relevant to the needs of practitioners, and that improvements are needed in the ways by which evidence-based treatments are taught, marketed, and disseminated.

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## Student Forum

# Student Involvement Within ABCT

Todd A. Smitherman, *Auburn University, Student SIG President*

Recent activities within the field of psychology reflect a national interest in attracting more students to our profession. Major initiatives within several divisions of the American Psychological Association (APA) have perhaps been most apparent. For example, 2 years ago, a task force was established within Division 2 of APA with the goal of recruiting and retaining more graduate student and early career members interested in the teaching of psychology. As a result, the Graduate Student Teaching Association now has a standing voting interest at the executive committee meetings of Division 2. Division 12 of APA (Clinical Psychology) is in the process of forming a new section geared toward gradu-

ate students and early career psychologists broadly interested in clinical psychology. Psychology as a whole appears to have become more student-focused.

Why is psychology, and clinical psychology in particular, making such concerted efforts to attract and retain more students and young professionals? One answer is that this trend is a function of the rising number of graduate degrees awarded each year in psychology (e.g., Robiner & Crew, 2000). Many psychology organizations hope to capitalize on this influx of students and young professionals by attracting and retaining new recruits and preparing them to become tomorrow's leaders and policy-makers.

From the student perspective, there are many reasons why one might seek professional affiliation. First, involvement offers students a remarkable opportunity to network with like-minded colleagues. In fact, many accomplished psychologists will tell you that they owe much of their career success to attending and being involved in a particular organization (e.g., by acquiring a first job or obtaining a leadership position). Membership in professional societies also provides students with opportunities to build their curricula vitae at a very critical time in their careers.

Organizational involvement also fosters creative thinking and provides opportunities to learn from and collaborate with others (sometimes across disciplines), and helps students develop their identities as psychologists. For students, this latter benefit is perhaps most salient. At a time when our lives are filled with endless stressors, deadlines, and demands, professional societies often keep us grounded. They help us stay focused on the big picture, support us in navigating the hurdles of graduate school,

and provide feedback on how to improve our work. It is within the arena of professional societies that many psychologists develop and refine their areas of specialization and expertise.

It is hard to deny the advantages of membership in professional organizations such as ABCT. As young professionals who value scientifically informed treatment, being actively involved in ABCT is one of the best ways to stay abreast of innovations in cognitive-behavior therapy. For example, symposia and poster presentations may precede publication of research by 6 months to a year or more. Despite these benefits, you may be unaware of efforts within ABCT to enhance the quality of the student experience in ABCT. Although ABCT initiatives have not received the attention of many APA efforts to accommodate students, there are many ways to maximize your experience as a student member.

Many of the avenues for student involvement in ABCT are overseen by the Student Membership Committee. For example, to offset the cost of travel, ABCT provides many opportunities for students to win awards for high-quality presentations at the annual convention. Many of the SIGs within ABCT offer awards for research presented at the SIG Poster Exposition, as well as discounted membership fees for students. Students may also have opportunities to enhance their scholarship. One particularly unique aspect of *the Behavior Therapist* is the Student Forum. This section is explicitly devoted to the publishing of articles by and for students, such as empirical papers, review articles, or articles addressing issues particularly relevant to graduate school and professional development (e.g., successfully writing a dissertation, navigating the internship hunt).

In addition to the opportunities within ABCT as a whole, there exists a SIG within our organization that is specifically geared toward student interests. The Student SIG provides numerous ways for students to become active within the field of behavioral and cognitive therapies, and membership is completely free. One way to become involved in the Student SIG is to join the Student SIG listserv, which is free of charge and receives relatively low traffic. The purpose of the listserv is to promote communication among students, discuss ideas on how to increase membership and student benefits within ABCT, and to address issues of particular relevance to students. A unique aspect of this listserv is our Online Mentor Program. Each month, a professional member of ABCT joins the list-

serve to answer students' questions about particular issues. Efforts are made to secure mentors with a variety of professional interests and select persons at different stages of career development. Recent mentors have included Drs. Jacqueline Persons, Steven Hayes, Stefan Hofmann, Christopher Correia, and Alex Chapman. Students may even develop long-lasting professional relationships with mentors who have interests congruent with their own. Members of the listserv are encouraged to suggest individuals they would like to have as on-line mentors in the future.

The upcoming mentors, their institutions, and their interests are listed below:

- **October:** Dr. Michael Otto (*Boston University; President-Elect; anxiety and depressive disorders, schizophrenia*)
- **November:** Dr. Patricia Resick (*National Center for PTSD-Boston; Past President; PTSD, interpersonal and domestic violence*)
- **December:** Dr. Gayle Iwamasa (*DePaul University; multiculturalism, CBT for diverse populations*)

The Student SIG also provides opportunities for students to present their own research, such as submitting an article for publication in the Student SIG newsletter. Past articles have ranged from empirical to theoretical in nature. Another opportunity to present student work is available through the SIG Poster Exposition at the annual convention. Each year, the Student SIG reserves space at the exposition so that student members can present original research in the form of a poster presentation. A panel of judges reviews each poster and awards a cash prize for the best student poster. Submissions for the newsletter are taken year-round, and the call for posters for the SIG Poster Exposition goes out a few months prior to the convention. Members of the SIG are kept informed about these events through postings on the listserv.

Finally, there are leadership opportunities within the Student SIG that are open to all Student SIG members. At our meeting each year, we elect a President-Elect and Communications Coordinator. This past year, we decided to consolidate the position of Communications Coordinator into a Vice President position. Students interested in leadership positions will find these opportunities both challenging and rewarding.

This year's ABCT convention in Washington promises to be another exciting time for the Student SIG. As usual, we will be holding a meeting for current and prospective Student SIG members. Dr.


Steven C. Hayes is presenting a talk specifically for the Student SIG entitled "The Implications of Acceptance and Commitment Therapy and Relational Frame Theory for Students Studying Behavioral and Cognitive Therapies." Dr. Hayes' talk will occur on Sunday morning in the State Room (see p. 52 of the convention program). We will also be electing new officers and soliciting input about how to make even more opportunities available to students within ABCT. I hope you will plan to attend, whether or not you are a member of the Student SIG.

In short, clinical psychology is becoming increasingly more student-oriented. As students with high aspirations, becoming involved in organizations such as ABCT prepares us well for our future careers by keeping us abreast of current developments, helping us network with colleagues, and providing support as we develop our own identities within the field. In addition to the opportunities offered by ABCT at large, there are multiple opportunities for students to become involved within the Student Special Interest Group. These opportunities provide avenues to communicate with respected professionals in ABCT, present original research, and transition to leadership positions within the organization. Perhaps most importantly, being involved often leads to life-long professional relationships with your colleagues.

If you are a student interested in behavioral and/or cognitive therapies but are not a member of ABCT, I hope you will consider joining. Programs are in place to ensure that you receive the professional and developmental guidance you desire. If you are a student member of ABCT, consider becoming actively involved, especially in the Student SIG. You will find many benefits and educational experiences available to you. After all, as students, we are the future of this organization and an important part of the future of empirically based clinical psychology.

If you are a member of ABCT, you may join the Student SIG and the listserv at no charge. Email Todd Smitherman, Student SIG President, at [smitht7@auburn.edu](mailto:smitht7@auburn.edu). Please include your contact information (name, address, phone, and email).

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*Lighter Side*

## Letter to the Editor

In recent years there have been many exciting developments in diagnosis and cognitive-behavioral treatment. I would like to share some new findings from our clinic, which are likely to have a great impact on the treatment policies of managed care companies. We have recently identified a new behavioral disorder, Cognitive Zombie Syndrome (CZS), which has emerged in villages throughout Germany, and threatens to overrun Europe, and possibly elsewhere. People suffering from CZS are commonly found rising from graveyards and lurching through village streets in search of human flesh. They are commonly heard to utter irrational beliefs, such as "Must eat brains." People with this

disorder engage in various safety behaviors, which consist primarily of biting unsuspecting bystanders. Older, toothless people with CZS are known to suck and slobber on the ears of unsuspecting victims, in the attempt to tongue out some brains.

In line with prevailing cognitive theories, we believe that CZS is caused by cognitive beliefs. The core maladaptive assumptions are "I can't be a worthwhile individual if I'm just a rotting corpse," and "Brains are a tasty source of nourishment." In our clinic we vigorously challenge these irrational beliefs with various cognitive and behavioral methods. Following from the work of Bandura, we make use of participant modeling, in which CZS patients get to observe "normal" people grimacing as they tuck into a meal of live brains. We also have had some success with behavioral experiments. For example, patients with CZS are asked to predict what will happen if they ate, say, a veggie dog instead of a brain. Typically, the sufferer harbors unrealistic, catastrophic thoughts of what might happen, usually expressed with statements such as "Arrggghh ... must eat brain." We point out that this is

musturbatory thinking, and that veggie dogs can be consumed with enjoyment. Even the ones containing bits of real dog can be quite tasty.

This treatment, like all cognitive-behavioral interventions, is almost completely effective. In fact, we have obtained a 99% success rate in a study that is soon to be published in the *Bulgarian Behavior Therapist*. In that study, we found that CBT was much more effective than psychoanalysis. Most CBT patients achieve high end-state functioning, although some were left with residual symptoms, such as a lingering urge to bite their therapist. We are also currently investigating the efficacy of EMDR, in which our therapists wear special patented gloves in order to protect the fingers.

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### **WORKSHOP SUBMISSIONS**

Suggestions for workshops are welcomed. A 250-word abstract and a CV for each presenter must accompany any suggestions.

**MAIL TO:**

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**DEADLINE FOR SUBMISSIONS:  
 January 15, 2006**

**ABCT's 40th ANNUAL CONVENTION \* November 16-19, 2006, Chicago**

## Convention 2005

# Live Like a Washington Local at ABCT: Fun and Unique Activities Off the Beaten Path in DC

Kathryn A. Roecklein and Kelly J. Rohan, *Uniformed Services University of the Health Sciences, Bethesda, MD, Local Arrangements Committee*

The Local Arrangements Committee is committed to helping you make the most of your ABCT convention experience in Washington, DC, November 17–20. Here, we venture off the beaten path and provide you with a local's take on fun and unique things to do near the Hilton Washington, our convention hotel. Our focus is on slightly out-of-the-way places to dine and shop and smaller music and gallery venues that, although not typically covered in DC area tourism guides, contribute to a pleasant and memorable stay in the capital region.

### First Things First: Update on the Baby Panda

Before launching into our local's guide, we cannot help but comment on the *soupedu-jour* of mainstream DC tourism—the giant panda cub at the National Zoo—because the little fellow is just too cute. The indoor area of the Fujifilm Giant Panda Habitat is closed for an unspecified amount of time, but at least until early October, to minimize disturbing Mei Xiang and her new cub. We remain hopeful that things will open up in time for ABCT attendees to get a look at DC's most famous and, as of yet unnamed, celebrity. There is a contest underway to name the panda cub by popular vote. The possibilities include: Hua Sheng (“China Washington, magnificent”), Sheng Hua (“Washington China, magnificent”), Tai Shan (“peaceful mountain”), Long Shan (“dragon mountain”), and Qiang Qiang (“strong, powerful”). At the very least, you can check out his progress via the daily reports and live, streaming video pandacams at <http://nationalzoo.si.edu/Animals/GiantPandas>. If the National Zoo's pandacam Web site is overwhelmed (and it frequently is), you can more easily log on to Animal Planet's pandacams at <http://animal.discovery.com/cams/pandavidr.html>. The active little tyke has recently begun “barking” and doing “wheelies” while trying to crawl.

### Feast Like a Washingtonian

#### *Kramerbooks & Afterwords*

In Dupont Circle, the neighborhood that is home to the Hilton Washington, consider a visit to Kramerbooks & Afterwords Café (1517 Connecticut Ave., NW; 202-387-1462; [www.kramers.com](http://www.kramers.com)), just a couple of blocks south of the hotel. It has been said that you are not a true Washingtonian until you receive a call that begins with an invitation for drinks after work and ends with “I'll meet you at Kramer's.” This institution and cultural landmark became well-known among locals by word-of-mouth. Here, you can casually browse the bookstore and enjoy coffee, cappuccino, espresso, a glass of wine, a martini, or a beer. Afterwords, the café attached to the bookstore, is a complete restaurant with table service and a lengthy and assorted menu of seasonal and regional entrées and pastas, featuring items such as a steak sandwich topped with crumbled blue cheese and butternut squash ravioli. Afterwords also includes a separate full-service bar area where you can order appetizers, drinks, and coffee. Afterwords is open daily for lunch, dinner, and late dinner and serves brunch on Saturdays and Sundays. Kramerbooks & Afterwords is open 7:30 A.M. to 1:00 A.M. every day and all night on Fridays and Saturdays with live music Wednesday through Saturday.

#### *Teaism*

Teaism, as the name implies, is *the place* to go for tea, but is also a favorite local lunch and light dinner place. Teaism (Dupont Circle, 2009 R St., NW; 202-667-3827, <http://teaism.com>) is a couple of blocks south of the hotel on R Street, just west of Connecticut Avenue. The atmosphere is peaceful and serene and offers many healthy alternatives without sacrificing taste. Teaism features an ever-changing inventory of dozens of teas as well as an interesting, Eastern-inspired menu containing items

such as cilantro scrambled eggs with tea-smoked salmon and yogurt-based lassis. The lunch and dinner menu features “small dishes,” “big dishes,” soups, sandwiches, and Bento boxes (i.e., cold Japanese meal boxes). The vegetable Bento box is fantastic, as is the “big dish” Thai chicken curry with sticky rice. The menu includes burgers, too—organic ostrich burgers on focaccia with a side of Asian slaw. Teaism serves breakfast, lunch, and dinner daily and serves brunch on Saturday and Sunday, 9:00 A.M. to 2:30 P.M. Teaism is open Monday - Thursday 8:00 A.M. to 10:00 P.M., Friday 8:00 A.M. to 11:00 P.M., Saturday 9:00 A.M. to 11:00 P.M., and Sunday 9:00 A.M. to 10:00 P.M.

#### *Ethiopian Cuisine*

DC has an abundance of Ethiopian restaurants, many of them within blocks of each other in the Adams Morgan neighborhood. For an interesting and exotic experience, try Meskerem (2434 18th Street; 202-462-4100), both a local and tourist favorite. Meskerem is moderately priced and offers a comfortable atmosphere with bright décor, including African murals and instruments. Make a reservation and request seating on the top (third) floor to enjoy dining on knee-high Ethiopian basket tables and low stools. Please be aware that this is communal dining with family style orders to be shared with a group, so bring an intimate group of friends. Foods arrive on a large tray lined with *injera*, the thick fermented pancakes that double as scoops to eat with. The dishes include mild and hot stewed meats, vegetables, and seafood. The vegetarian sampler is heavenly and includes puréed chickpeas, mashed lentils, potato salad with green chilies, and soothing chopped greens. You might also try the Ethiopian wine, but only once we'll venture.

#### *Classy Local Dining Favorites*

Two noteworthy places to enjoy an excellent classy or romantic dinner out on the town are the Iron Gate Restaurant (1734 N St., NW; 202-737-1370) and the Tabard Inn (1739 N St., NW; 202-331-8528; <http://www.tabardinn.com>), located right across the street from one another on N Street between 18th & 17th Streets. Both restaurants are set in historic homes from the Victorian age and offer multiple, cozy dining rooms with fireplaces. The Iron Gate used to be a stable and carriage house and features an eclectic Middle Eastern menu. The Tabard Inn is one of Washington's old-

est hotels and specializes in New American cuisine. At both restaurants, dinner entrees are between \$18 and \$27, and reservations are necessary.

### Hanging Out on the Local Music Scene

#### Rock Out at the Black Cat

A great place to go for live independent and alternative rock music is the Black Cat (1811 14th St., NW; 202-667-7960; <http://www.blackcatdc.com>), which is in the heart of the U Street district on 14th Street between S and T Streets. To get there from the Hilton, you would need to take a cab, walk about 15 minutes, or take the Metro (green line to the U St./Cardozo stop, 13th & U St. exit). As DC has not effected a smoking ban, be prepared for a heavy haze in virtually any bar, no exception here. The Black Cat includes the no-cover Red Room Bar and two live music performance spaces, the 7,000-square-foot Mainstage and the downstairs cabaret/coffee house-style Backstage. Echo and the Bunnymen are playing the Mainstage at 9:30 P.M. on Friday, November 18 (tickets are \$20, available through Ticketmaster, 202-397-SEAT or <http://www.ticketmaster.com>). Other local indie rock bands performing during the ABCT convention will likely be announced closer to November. The Black Cat is open Sunday - Thursday 8:00 P.M. to 2:00 A.M. and Friday - Saturday 7:00 P.M. to 3:00 A.M.

#### Jamming Blues and Jazz at HR-57

If you are more into the blues and jazz than indie rock, check out HR-57 (1610 14th St., NW; 202-667-3700; [www.hr57.org](http://www.hr57.org)), the U Street district nightclub within the Center for the Preservation of Jazz and Blues. HR-57 is named after House Rule 57, a 1987 U.S. House of Representatives resolution that designated jazz as a national treasure. At this no-frills, friendly bar, you are guaranteed a great jam in the midst of a crowd that eats it up. You can hear well-known jazz artists perform live, watch aspiring amateurs perform at one of the best open-mike jazz venues in

town, and even play chess or checkers at some of the tables. The cover charge is \$6, and you can bring your own wine for a cork fee or choose from a limited selection of drinks sold there. A short Southern menu, featuring items such as collard greens and red beans and rice, is sometimes offered. Look very carefully for the tiny HR-57 sign along the west side of 14th Street between V and W Streets or you just might miss the place.

#### Dupont Local's Choice for Art: Washington Printmakers Gallery

Of the many small art galleries in Dupont Circle, the Washington Printmakers Gallery (1732 Connecticut Ave., NW; 202-332-7757; [www.washingtonprintmakers.com](http://www.washingtonprintmakers.com)) is regarded by locals as one of the very best. Plus, it is the closest gallery to the Hilton Washington, only half a block south of the hotel on Connecticut Avenue, just above the Athens Taverna restaurant. The gallery, which is celebrating its 20th anniversary this year, features contemporary, original, hand-pulled prints. During the dates of the ABCT convention, the gallery will feature the exhibit "Loose Change/Twisted Figures, Etchings and Woodcuts" by Trudi Ludwig in the front room with a selection of works by the cop's members on display in the second room. Visiting the gallery is a great way to view some fantastic work by local artists without risking disappointment. The Washington Printmakers Gallery is open Tuesday - Thursday noon to 6:00 P.M., Friday noon to 9:00 P.M., and Saturday - Sunday noon to 5:00 P.M.

#### Shoe Shop Like a DC Native

One well-guarded locals' secret about DC: You can actually find women's shoes that you can walk to work in without killing your feet. A local's favorite place for shoes is Shake Your Booty in Adams Morgan (2439 18th St., NW; 202-518-8205; [www.shakeyourbootyshoes.com](http://www.shakeyourbootyshoes.com)). This neat little shop with a memorable name is a rare find and offers a great assortment of comfortable and stylish shoes at af-

fordable prices. Another good choice is Wild Women Wear Red (1512 U St., NW; 202-387-5700; <http://www.wildwomenwearered.com>), which is a short-to-medium walk from the hotel. The shop is hard to miss—it is orange, lavender, and red on the outside, with great shoes on the inside. They have hard-to-find styles from Camper and carry handmade crocheted hats and bags as well as jewelry from local artists.

#### Back to the Beaten Path: Mainstream Tourist Attractions in DC

Please refer to our prior article, "ABCT Convention Returns to Our Nation's Capital," which appeared in the September issue of *the Behavior Therapist*. There, we provided information about the DC area airports and airport shuttles to the Hilton Washington, a description of the public transportation and Metrorail system, an overview of the major neighborhoods and shopping areas, and practical information you will need to take in many of the major tourist attractions in the DC area, particularly the National Mall, the Smithsonian, and the museums.

In conclusion, the activities detailed above have a local's flare and represent some of our favorite things to do in the Dupont Circle, Adams Morgan, and U Street neighborhoods—all easily accessible to the Washington Hilton. We hope you will sample a couple of these activities and find them to be enjoyable. During the ABCT convention, please remember to stop by the Local Arrangements table right outside of Exhibition Hall for other adventurous and more mainstream suggestions. We will have information about easy in-and-out lunch options and moderately priced restaurants near the hotel; major shopping areas; and museums, theatres, and other places of cultural interest. At the Local Arrangements table, you can also sign up for "Dine with a Washingtonian," small dinner group outings, each of which is hosted by a DC area local. Welcome to our city; we are glad to have you! ✍

## Clinical Grand Rounds

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- **SESSION 1: Using Cognitive Behavioral Case Formulation in Treating a Client With Anxiety and Depression** (JACQUELINE B. PERSONS, PH.D.)
- **SESSION 2: Using an Integrated Psychotherapy Approach When Treating a Client With Anxiety and Depression** (MARVIN GOLDFRIED, PH.D.)
- **SESSION 3: Comparing Treatment Approaches** (MODERATED BY JOANNE DAVILA AND PANELISTS BONNIE CONKLIN, MARVIN GOLDFRIED, ROBERT KOHLENBERG, AND JACQUELINE PERSONS)



## Time to Toss Your Hat Into the Ring!

# Run for ABCT President-Elect, Representative-at-Large, or Secretary-Treasurer!

Stephanie Felgoise, *AABT/ABCT Nominations and Elections Committee Chair*

Ever wonder how ABCT's decisions get made at the national level? It's simple. Dedicated members give generously of their time by participating in a very democratic process. The members who receive the most number of nominations appear on the ballot and the membership votes the candidates of their choice into office. Our seven-member Board of Directors set policy and make the decisions that govern our organization.

Three is the magical number at ABCT. Each candidate serves 3 years in office either as President (elect, sitting, and past); Representative-at-Large (serves as a liaison to either Membership; Convention and Education; or Academic and Professional Issues); the Secretary-Treasurer also serves as the Finance Chair. The person who is elected serves an extra year as "elect" to learn all the details to ensure a smooth transition. Traditionally, a strategic planning meeting is held once every 3 years (coordinators attend too) so everyone participates

in at least one planning session during their term of office.

### How to Get Nominated

Nominate yourself. Nominate your colleagues. You can drop your nominations form in the CALL FOR NOMINATIONS box at the membership sign-up booth during the convention, you can mail it to the ABCT Central Office, or you can fax it to (212) 647-1935. Sorry, no e-mails. We need original signatures. You can nominate as many people as you want but only once—we do check! All nominees must be full members in good standing.

The Call for Nominations form will be printed in the October, Winter, and January issues of *the Behavior Therapist*. We will have it posted on our Web site along with job descriptions for the President-Elect, the Representative-at-Large, and the Secretary-Treasurer positions.

**SPECIFICS:** The person elected as President-Elect (2006–2007) will serve as President from 2007 to 2008. The person

elected as the Representative-at-Large will serve from November 2006 to November 2009 and will serve as the liaison to Convention and Education Issues. The Secretary-Treasurer will begin their transition year beginning April 2007 and his/her office will officially take place from November 2007 to November 2010.

The Board meets once a year the Thursday of the convention and conducts monthly conference calls the other 11 months of the year. The Executive Committee consists of the President, Immediate Past-President, President-Elect, and the Secretary-Treasurer. They hold conference calls on an as-needed basis to ensure the smooth running of the organization.

Yes, it is a commitment of time. Candidates are expected to be familiar with the mission statement, bylaws, strategic plan, and current organizational priorities. If you are not quite ready to run for office but would like to get more involved, there are lots of ways. Take a look at our current governance and contact the coordinators and committee chairs directly.

Please be sure to ask your friends and colleagues in ABCT if they are interested in running for these offices! It is a wonderful way to make new friends and give back to your profession. So be sure to submit your nominations before February 1, 2006, to Stephanie Felgoise, Ph.D., Nominations and Elections Chair, c/o ABCT, 305 Seventh Avenue, Suite 1601, New York, NY 10001.

### NOMINATE the Next Candidates for ABCT Office

*I nominate*

the following individuals for the positions indicated:

PRESIDENT-ELECT (2006–2007)

\_\_\_\_\_  
\_\_\_\_\_

REPRESENTATIVE-AT-LARGE (2006–2009)

\_\_\_\_\_  
\_\_\_\_\_

SECRETARY-TREASURER (2007–2010)

\_\_\_\_\_  
\_\_\_\_\_

NAME (printed)

SIGNATURE (required)

## 2006 Call for Nominations

**Every nomination counts!** Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2006, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Contact the Nominations and Elections Chair for more information about serving ABCT or to get more information on the positions. **Please complete, sign, and send this nomination form to Stephanie Felgoise, Ph.D., Nominations & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.**



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IT'S  
TIME  
TO  
RENEW

*your membership*

*your membership*

*your membership*

*your membership*

# Welcome, New Members!

—from AABT/ABCT and our new Membership Services Manager, Lisa Yarde—

## New Professionals

Jarrold M. Leffler  
Moria Smoski  
John S. Volpe

## Full Members

Steven A. Alper  
Mudita A. Bahadur  
Yvonne Bohr  
Scott Brandhorst  
Donna E. Burns  
Jennifer H. Byrnes  
J. Lee Chernoff  
Bill Cooper.  
Donna M. Costa  
Roseanne DeFronzo Dobkin  
William L. Edwards  
Jill M. Emanuele  
Murray W. Enns  
Maren C. Erickson  
Bonnie L. Fraser  
Lana Gaiton  
Anthony L. Gallo  
Arthur J. Garvey  
Patricia L. Gieselman  
A. Antonio Gonzalez-Prendes  
Eric L. Granholm  
Carolyn R. Henderson  
Craig M. Hunter  
Matt J. Hutt  
Andreas Ulf Karlsson  
Paresh N. Kasabwala  
Betsy D. Kennard  
Kenn Kihui  
Katherine M. Kilgore  
James Randall Korman  
Thomas R. Kwapil  
Linda R. Leiphart  
Martin Lepage  
Neil Levitsky  
David L. Loveland  
Stephen C. Luce  
MaryJean C. MacDonald  
Gunnhildur L. Marteinsdottir  
Suzanne G. Martin  
Gail L. Martz-Nelson  
Kathleen McCarty  
Kevin J. McLendon  
Leonard B. Miller  
Nobukazu Nagae

Eric S. Nicely  
Britt A. Nielsen  
Lynn Northrop  
Miyako Oguru  
Carolyn D. Orr  
Ali Redjaian  
Nancy Ring  
Elisa Romano  
Nicole A. Shiber  
Marsha S. Singer  
Candice Warren Skaletsky  
Catherine D. Snow  
Jane G. St John  
Mariann Suarez  
Michael R. Tilus  
Martha C. Tompson  
Lisel L. Virkler  
Paul R. Walters  
Joan Warmbold-Boggs  
Patricia E. Wicks  
Denis L. Zavodny  
Ann Zimmerli

## Student Members

Mizpah Achampong  
Kevin N. Alschuler  
Anna Ayzenberg  
Jill K. Ballman  
Lauren K. Barefield  
Diana M. Basilice  
Don J. Bearden  
Jamie D. Bedics  
Alyssa Braaten  
Lisa M. Brodie  
Lauren J. Brown  
William Albert Campbell  
Jocelyn S. Carter  
Frank Castro  
Beth Chase  
Frank Cicero  
Amanda Cobb  
Christine A. Conelea  
Jennifer L. Copen  
David Cosmar  
Amy Lynn Cunningham  
Kelly A. Davis  
Tamara L. DeHa  
Kate R. Doherty  
Jeanne M. Duax  
Stephanie Dumoulin

Dan Edmunds  
Amanda R. Fabbro  
Melissa Ferrarese  
Amanda J. Flanders  
Steven C. Frantz  
Dinorah R. Frontera  
Ashley E. Furr  
Gabriel A. Ghanoum  
Carly J. Gibbons  
Stephanie V. Gironde  
Twain Gonzales  
Pamela L. Greene  
Meredith G. Grossman  
Seung-Soo Ha  
Daniel R. Hawthorne  
Nicholas A. Hazel  
Nicole Heilbron  
Rebecca Helms  
Kyle Holleran  
Emily Hugo  
Colleen M. Jacobson  
Archana Jajodia  
Matthew A. Jarrett  
Kamauru R. Johnson  
Christine Johnson-Erickson  
Regina Kakhnovets  
Heather A. Kattalia  
Bridget Kehn  
Sheryl Kent  
Charlene M. Key  
Andrea S. King  
Lindsay T. King  
Rebecca B. Klein  
Andrea Konig  
Amy E. Lawrence  
Michael Lee  
Joanna Legerski  
Julia Lesiczka  
Lindsay Levy  
Yan Leykin  
Crystal S. Lim  
Rachel C. Manos  
Jennifer Manuel  
Teresa L. Marino  
Hirofumi Matsuoka  
Brian E. McCabe  
Jean E. Mennuti-Washburn  
Michael G. Messina  
Ethan L. Moitra  
Jessica Moore

Whitney A. Moore  
Jun Moriya  
Katie Lynn Mosunic  
Mary E. Nenzel  
Sara M. O'Neal  
Isa Okajima  
Kaori Osawa  
Brian D. Ostafin  
Jill Panuzio  
Acacia C. Parks  
Trisha L. Pataki  
Monica Pignotti  
Olivia M. Pine  
Lisa Pollitt  
Nicole R. Prause  
Christopher K. Redfearn  
Gina M. Restivo  
Denise Rodriguez  
Dana L. Rofey  
Angela T. Rouse  
Nina K. Rytwinski  
Jun Sasaki  
Jennifer E. Scott  
Crescent Seibert  
Eric L. Sullivan  
Dahamsara R. Suraweera  
Geri Leanne Weber  
Courtney L. Weiner  
Sarah M. Weisberg  
Zofia A. Wilamowska  
John C. Williams  
Sarah A. Williams  
Kristen Wilson  
Michael W. Wilson  
Sylia Wilson  
Amanda M. Woods  
Jamie O. Workman  
Alecia A. Zalot

## 2005 Voluntary Contributors

The following members made generous financial contributions to AABT/ABCT in 2005.

Anne Marie Albano  
Lynda Albert  
Wesley D. Allan  
Mark S. Aloia  
Sharon P. Austin  
Jon A. Bell  
Andrew L. Berger  
John J. Boren  
Jeri Breiner  
Jillian D. Buchwald  
Andrea Seidner Burling  
Thomas A. Burling  
P. Douglas Callan  
Erin L. Cassidy  
Yael D. Efreom  
Ruby A. Engel  
Mary R. Faucette  
Al S. Fedoravicius  
Leilani F. Feliciano  
Jason M. Fogler  
Dianne C. Goodenough  
Diana E. Hearst-Ikeda  
Patricia A. Jolly-Fleece  
Thomas C. Kalin  
Judith S. Kolman  
Terri M. Landon  
John N. Marr  
Robin A. McCann  
Paolo Meazzini  
Celia A. Michael  
Jan Mohlman  
Andrew B. Molchon  
Joyce D. Nash  
Sidney D. Nau  
G. G. Neffinger  
Larissa N. Niec  
Elizabeth A. Pawlikowski  
Jacqueline B. Persons  
Jacqueline Pistorello  
Anna Marie Resnikoff  
Leo J. Reyna  
Diana M. Ronell  
Elizabeth J. Santa Ana  
Joseph P. Santoro  
R. Keith Shaw  
Annette A. Shimizu  
Wendy K. Silverman  
Kieran T. Sullivan  
Dahamsara R. Suraweera  
Detta S. Tate  
Ellen C. Tsui  
Kikuo Uchiyama  
Monroe Weil  
James P. Whelan  
Antonette M. Zeiss

## Members Refer 193 New Members This Year!

AABT/ABCT welcomes its new members and appreciates those members who helped us grow. We will reinforce both with our lottery. Please check the convention program addendum for prize drawing times. You don't need to be there to win but it sure would be nice! Prizes include choice of journal, videotapes, and free membership in 2006! Asterisks next to the names below indicate that these members were the source of 3 or more new members. Special recognition goes to FRANK GARDNER for recruiting 5 new members.

Wesley Allan	Frank Fincham	Stephen Lisman	Matthew J. Sanjay
Lauren Alloy	Rex Forehand	Cami Lokken	Tamara Sbraga
Nader Amir	Evan Forman	Robert LoPresti	Joseph Scardapane
Bruce Arnow	John Forsyth	James Marchman	Mitchell Schare
Nathan Azrin	Martin Franklin	Gayla Margolin	Karen Schmeling
Don Baucom	Christine Frazita	Brian Marx	Tamara Sher
Abbie Beacham*	Arthur Freeman	Mary E. Lorimer	Paul Silverman
Aaron Beck	David Fresco	Stephen Masito	Kenneth Small
J. Gayle Beck	Robert Friedberg	Naomi McCormick	Shelly Smith-Acuna
Kathryn Bell	Freda Friedman	Michelle McFalls	Jasper Smits
Elizabeth Benjamin	Maru Fristad	Lata McGinn	Nancy Smyth
Kelly Brownell	Frank Gardner*	Kelly Mclure	William Spaulding
Leon Caldwell	Janet Gillespie	Daniel McNeil	Ann Steffen
Glenn Callaghan	Carol Glass	Anthony Menditto	Jane St. John
Mary Louise Cashel	Barbara Golden	Andrew Meyers	Kirk Strosahl
Karen Cassidy	Robert Gorden	Roe Minnatti	Gregory Stuart
Bruce Chorpita	Jennifer Gordon	Ellen Mitchell	Beberly Thorn
Karen Christoff	Ken Graap	Arthur Nezu	Dozier Thornton
Emil Cocco	Matthew Gray	Lars Nielsen	Charles Tingley
Lindsey Cohen	Alan Gross	Nora Noel	David Tolin
Kate Comtois	Lisa Hale	Marie O'Hara	Kimberli Treadwell
Joseph Constans	Leslie Halpern	Michael O'Hara	William Vanderwill
Brian Cox	Constance Hammen	Erin O'Hea	Jennifer Waltz
Linda Craighead	David Hansen	Thomas Ollendick	Carl Weems
Michelle Craske	Steven Hayes	Susan Orsillo	John Welsz
John Curry	Flora Hoodin	Michael Otto*	Brooke Whisenhunt
George Davis	Arthur Horne	Howard Paul	Mark Whisman
Joanne Davis	Stephen Hupp	Joel Pava	John Williams
Crystal Dehle	Warren T. Jackson	David Penn	Nathan Williams
Robert DeRubeis	Sue Jacobs*	Scott T. Perkins	Donald Williamson
David DiLillo	Thomas Joiner	Alan Peterson	Reid Wilson
Robert DiTomasso	Jonathan Kanter	Carol Pilgram	Samantha Wine
Keith Dobson	Mary Lou Kelley	Adam Radosmky	LaPearl Logan
M. Kirk Dougher	Kelly J. Rohan	Neil Rector	Winfrey
Jean Dumas	Philip Kendall	Simon Rego	Sally Winston
Michael Dunn	Lynda King	Robert Reiser	Janet Woodruff-
Christine Edmondson	Lindsay Kiriakos	David Reitman	Borden
Drew Edwards	Robert Klepac	Mark Roberts	Eric Youngstrom
Robert Emery	Laurie Greco	Clive Robins	Bruce Zahn
Renee Erchman	Erika Lawrence	George Ronan	Robert Zettle
Norah Feeny	William Lawson	Jennifer Ronnals	Lori Zoellner
Stephanie Felgoise	Marsha Linehan	Philip Saigh	

**Have you been a member of AABT for 5 years?**

(or a multiple of 5)?

**If so, you get a gold star**

Report to the membership booth

**at the DC meeting**

(November 17-20)

# Call

## for Award Nominations

**This is an OPEN CALL to the AABT/ABCT membership to provide nominations for the following awards, to be presented at the 2006 convention in Chicago, IL.**



*On a rotating annual basis, one of the following three types of distinguished contributions by an individual member of AABT/ABCT will be recognized at the Annual Convention: research, clinical, or educational/training. For 2006, we seek nominations from AABT/ABCT members for outstanding educational/training contributions.*

### **Outstanding Contribution by an Individual for Educational/Training Activities**

Eligible candidates for this award should be members of AABT/ABCT in good standing who have provided significant contributions toward educating and training behavior therapists. Past recipients of this award include Gerald C. Davison in 1997, Leo Reyna in 2000, and Harold Leitenberg in 2003. Please complete an on-line nomination by visiting [www.aabt.org](http://www.aabt.org), and completing the appropriate application forms. Then, e-mail the completed forms to [aabt@hofstra.edu](mailto:aabt@hofstra.edu). Also, mail a hard copy of your submission to AABT/ABCT, Outstanding Education/Training, 305 Seventh Ave., New York, NY 10001.

### **Outstanding Mentor**

This is a new award category which will be recognized on a rotating annual basis. On alternate years, recognition will be given to an Outstanding Training Program. This year we are seeking eligible candidates for the Outstanding Mentor award

who are members of AABT/ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement and activities aimed at providing opportunities for professional development, networking and future growth. Appropriate nominators are current or past students of the mentor. Applications should include a letter of nomination, three letters of support, and curriculum vitae of the nominee. Please complete an on-line nomination by visiting [www.aabt.org](http://www.aabt.org), and completing the appropriate application forms. Then, email the completed forms to [aabt@hofstra.edu](mailto:aabt@hofstra.edu). Also, mail a hard copy of your submission to AABT/ABCT, Outstanding Mentor, 305 Seventh Avenue, NY, NY 10001.

### **Virginia A. Roswell Student Dissertation Award**

This award will be given to a student based on his or her doctoral dissertation proposal. The research should be relevant to behavior therapy. Accompanying this honor will be a \$1,000 award to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the AABT/ABCT convention. Eligible candidates for this award should be student members who have already had their dissertation proposal approved and are investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor should complete the nomination. Please complete an on-line nomination by visiting

www.aabt.org, and completing the appropriate application forms. Then, e-mail the completed forms to aabt@hofstra.edu. Also, mail a hard copy of your submission to AABT/ABCT, Virginia A. Roswell Dissertation Award, 305 Seventh Ave., New York, NY 10001.

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*The Awards and Recognition Committee proudly opens the nominations for the following awards to the AABT/ABCT membership at large:*

### **Career/Lifetime Achievement**

Eligible candidates for this award should be members of AABT/ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include Albert Ellis, Leonard Ullman, David Barlow, and Leonard Krasner. Please complete an on-line nomination by visiting [www.aabt.org](http://www.aabt.org), and completing the appropriate application forms. Then, e-mail the completed forms to aabt@hofstra.edu. Also, mail a hard copy of your submission to AABT, Career/Lifetime Achievement Award, 305 Seventh Ave., New York, NY 10001.

### **Distinguished Friend to Behavior Therapy**

Eligible candidates for this award should NOT be members of AABT/ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three

letters of support, and a curriculum vitae of the nominee. Past recipients of this award include Jon Kabat-Zinn, Nora Volkow, John Allen, and Anne Fletcher. Please complete an on-line nomination by visiting [www.aabt.org](http://www.aabt.org), and completing the appropriate application forms. Then, e-mail the completed forms to aabt@hofstra.edu. Also, mail a hard copy of your submission to AABT/ABCT, Distinguished Friend to AABT Award, 305 Seventh Ave., New York, NY 10001.

. . .

*Nominations for the following award are solicited from members of the AABT/ABCT governance:*

### **Outstanding Service to AABT/ABCT**

Members of the governance, please complete an on-line nomination by visiting [www.aabt.org](http://www.aabt.org) and completing the appropriate application forms. Then, e-mail the completed forms to aabt@hofstra.edu. Also, mail a hard copy of your submission to AABT, Outstanding Service to AABT/ABCT Award, 305 Seventh Ave., New York, NY 10001.

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## **Nominate on-line at [www.aabt.org](http://www.aabt.org)**



All questions regarding the award nominations can be directed to:

**M. Joann Wright, Ph.D., Chair  
AABT/ABCT Awards & Recognition  
Committee  
131 Hofstra University  
Hempstead, NY 11549  
Tel.: 516-463-6791  
e-mail: aabt@hofstra.edu**

General suggestions about the annual AABT/ABCT awards program are appreciated. Please forward your suggestions to the committee chair.

*If you would like to serve on the committee, contact the committee chair.*

***Deadline*** FOR ALL NOMINATIONS:  
**WEDNESDAY, MARCH 1, 2006**

# AWARDS & RECOGNITION

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## **Lifetime Achievement**

*Albert Ellis, Ph.D.*, President Emeritus and Founder, Albert Ellis Institute

## **Outstanding Service to AABT**

*G. Terence Wilson, Ph.D.*, Oscar K. Buros Professor of Psychology  
Rutgers, The State University of New Jersey

## **Outstanding Clinician**

*Frank M. Dattilio, Ph.D., ABPP*, Harvard Medical School

## **Outstanding Training Program**

THE MAY INSTITUTE

*Walter P. Christian, Ph.D.*, ABPP President and CEO

*Dennis C. Russo, Ph.D.*, ABPP, Chief Clinical Officer

## **Distinguished Friend to Behavior Therapy**

*Jon Kabat-Zinn, Ph.D.*, Professor of Medicine Emeritus  
Founding Director: Stress Reduction and Centre  
for Mindfulness in Medicine, Health Care, and Society  
University of Massachusetts Medical School

## **5th Annual Virginia Roswell Dissertation**

*Sharon L. Cohan, M.S.*, San Diego State University



**When?** FRIDAY, NOVEMBER 18, 2005, 5:00 P.M.

**Where?** AABT/ABCT ANNUAL MEETING AT THE HILTON WASHINGTON,  
GEORGETOWN MEETING ROOM

## Classifieds

Classified ads are charged at \$4.00 per line (approximately 42 characters per line). Classified ads can be e-mailed directly to Stephanie Schwartz, Advertising Manager, at [sschwartz@aabt.org](mailto:sschwartz@aabt.org).

### positions available

**IMMEDIATE OPENINGS FOR CLINICAL FELLOWSHIPS IN COGNITIVE BEHAVIOR THERAPY AND REBT:** Part-time one year pre-doctoral Internships and two year post-graduate Fellowships are being offered at the Albert Ellis Institute. Intensive supervision of individual, couples, and group therapy will be given by Ray DiGiuseppe, Ph.D., Michael Broder, Ph.D., and Kristene Doyle, Ph.D. Candidates will carry a diverse caseload of clients, co-lead therapy groups, participate in special seminars and ongoing clinical research, and co-lead public workshops. Stipend is given for 20 hours per week of involvement in a wide variety of professional activities. Contact Dr. Kristene Doyle at [krisdoyle@albertellis.com](mailto:krisdoyle@albertellis.com) for application.

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## 1<sup>ST</sup> ASIAN COGNITIVE BEHAVIOR THERAPY CONFERENCE

**Campus of Chinese  
University of Hong Kong  
Shatin NT, Hong Kong  
May 29-30, 2006**

**contact: Professor Tian Po Oei  
email: [asiancibt@psy.uq.edu.au](mailto:asiancibt@psy.uq.edu.au)**

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- KASHDAN & WENZEL, Transactional Approach to Social Anxiety
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## 39<sup>TH</sup> ANNUAL CONVENTION

Washington, DC • November 17 – 20

Washington Hilton Hotel

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Now that you have ... Renewed your 2006 ABCT membership;  
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It's time to schedule Convention opportunities for your active social participation.

- ✓ **SPECIAL INTEREST GROUP** meetings are a great place to meet people who share your particular concerns. There are more than 30 scheduled for this Convention so there may be one that you have been thinking about for awhile. This is the year to attend that SIG meeting.
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and
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See you in DC!

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