

# the Behavior Therapist

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## From the Editor

## Thoughts About *tBT*



**H**appy New Year! As I write this column, 2003 is drawing to a close. Winter storms have hit the East Coast and holiday shoppers have begun to mob. I have a ton of term papers to grade. In one sense I am solidly grounded in 2003 as I have not yet hit the mall, but in another I'm already looking ahead. After a long stint on *the Behavior Therapist's* editorial team (Associate Editor from 1996 through 1998; Editor from 1999 through 2004), my term ends this year. David Reitman takes the reins in January 2005.

For 2004, I anticipate continuing the *tBT* tradition of publishing submissions that highlight a cross-section of AABT interests and concerns. We have had articles on the development of behavior therapy outside of North America, reports on innovative behavioral interventions, discussions on the future of behavior therapy, advice columns presenting tips to our junior members, opinions on this and that issue, and those Letters to the Editor! All of this emphasizes that the source of AABT's strength as a professional scientific organization stems from the enthusiasm, energy, and dedication of the members. *tBT* often reveals the more human side of its contributors and, in many ways, represents the heart of AABT.

I know that some regard *tBT* as the "light-weight" publication of AABT. Both *Behavior Therapy* and *Cognitive and Behavioral Practice* are well-regarded journals with high-quality, empirically based articles, and both maintain a substantial rejection rate. *Behavior Therapy* typically publishes well-designed and controlled investigations into cognitive-behavioral interventions. *Cognitive and Behavioral Practice* typically features clinically oriented descriptions of empirically supported cognitive-behavioral interventions. While *tBT* does not aspire to the lofty standards set by these two premiere journals, it does offer something else—a

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venue for talking about everything else of  
interest to AABT members. One clear  
strength of *tBT* is the short lag time be-  
tween when a manuscript is received and  
when it is published, allowing for rapid dis-  
semination on timely topics. Another bonus  
is the flexibility of format for the pieces we  
publish: The last 8 years has seen every-  
thing from APA-format research papers to  
essays to biographies—even jingles, car-  
toons, and crossword puzzles (thanks to the  
creativity of Managing Editor Stephanie  
Schwartz). Finally, editing is usually limited  
to touching up grammar and flow, or reduc-  
ing length. We try to leave the affective  
tone alone (thanks to the forbearance of the  
Director of Publications, David Teisler).

As I begin my final year as Editor of *tBT*  
I want to express my thanks to the  
Association for allowing me to serve in this  
capacity and to various groups that have  
consistently provided help. The central of-  
fice in NYC works wonderfully in sustain-

ing *the Behavior Therapist*. Without the cen-  
tral office staff (the admittedly lesser-  
known offspring of AABT), *tBT* would be  
unable to maintain its timely, vibrant role as  
a venue for discourse among AABT mem-  
bers. The continuing support from past edi-  
tors, as well as past presidents of the  
Association, has also helped to keep *tBT*  
afloat. Finally, I'd like to thank the AABT  
members, who continue to use *tBT* as an  
outlet for their work and ideas, and who  
keep abreast of what's up among AABT  
members by reading *tBT*. I hope I keep  
hearing from you during my last year as  
*tBT* editor.

I look forward to seeing my fellow  
AABT members in November at the 38th  
Annual Convention in New Orleans.  
Information for making submissions is con-  
tained in this issue of *tBT*. Hope to see you  
there and don't forget—bring a friend.  
Happy New Year!

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■ **Feature articles** that are approximately 16 dou-  
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Psychology, Central Michigan University, Mount  
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## Reflections on the Annual Meeting and the Year to Come

Patricia A. Resick, *National Center for PTSD, VA Boston Healthcare System*



What an exhilarating conference we had this year! Not only were there high-quality presentations to energize us for our work back home, but there were more of us to

share in the experience. For those of you who didn't hear, we set an all-time attendance record with over 3,100 participants. Our previous record was the conference in New York in 1996 with 2,563 attendees. I'm sure that some people are not happy with the sudden boost in conference attendance when it entails being turned away from a presentation that one had planned on attending. Others may be excited by such growth because it means we can cover our expenses or that the word is getting out on what a great conference AABT holds. (Many people asked me during and since the conference how many people attended, and the universal response was to be pleased at the large turnout.)

We made a few changes this year, such as the ease of on-line registration and the availability of CE credits for the entire conference, that may have helped to increase the number of conference participants. Of course the allure of Boston, my new hometown, could also be credited with drawing some people to the meeting. Unfortunately, for those who were unhappy with crowded rooms, there is no way to guess 5 years in advance what the attendance at a conference will be and there are now only 12 cities that can accommodate our meeting at a single hotel. We are not large enough or rich enough to rent out city convention center space; thus, we must rely on free meeting rooms within the host hotel with the promise of enough occupants to make it worthwhile to the hotel. Planning a meeting is a very complex set of arrangements with calculated guesses about how many will attend and who will attend which presentation. Altogether, however, I'd say that the meeting was excellent. There was a good mix of topics, populations, "famous

folk," and talented young researchers and clinicians. AABT continues to be vibrant, and the conference reflects that.

Aside from the facts that we were bursting at the seams at a few presentations and had the usual array of excellent research and clinical presentations, there was a lively and entertaining debate during the conference on the association's possible name change. Also, at the Board of Directors meeting, one of the main discussions was on the topic of our organization's identity and goals. The convergence of these variables is very interesting. Although the topics of our name and identity are recycled for discussion every few years, it appears particularly appropriate to consider these issues now in light of the record attendance at the conference. The question is, *Do we really want to grow?*

Those who want to retain the name of the organization believe that our current name captures both cognitive and behavior therapies and that our brand name should not be altered. Those who favor a change argue that the general public and potential new members, who do not have the level of training and inculcation into the field as current members, do not understand that "behavior" includes cognition and emotions (not to mention mindfulness). They just know the term that they hear repeatedly, CBT, cognitive behavior therapy. So the question arises: Who do we want to be? Do we want to appeal to those who already understand the encompassing breadth of behavior or are we trying to draw in new members?

As a small organization, we tend to be a guild organization or an academy of researcher-practitioners, almost entirely clinical psychologists, who trained in a limited number of graduate programs, internships, and postdoctoral training sites. The conference is partly an exchange of research progress and ideas and partly class reunion. I have always preferred AABT over APA because I can find the people I am looking for, can get to and into the presentations, catch up with old friends, and make new convention friends. From that viewpoint,

the stagnant membership rate of the organization is just fine. We have about 3,900 members, with about 13% leaving or arriving every year. However, the downside is that our dues rate may not keep pace with salary increases at the central office or the expense of some of the services that we want to maintain, such as LCD projectors at the conference, on-line registration and membership renewal, or the membership directory. At some point we may have to determine what activities and services to cut in order to maintain viability.

On the other hand, we are victims of our own success. With the increasing evidence of the efficacy of cognitive behavioral treatments, more providers are seeking out training and may be looking for an organization that will meet their needs. We all know that there are many therapists claiming to be conducting cognitive behavior therapy as a set of techniques or manualized protocols without the basic knowledge that underlies these treatments. Then when the treatment needs to be adapted in some way, they may not have sufficient background in the theory or approach to modify the therapy successfully. In her presidential address, Jackie Persons made a strong argument for a case formulation approach in clinical practice, but such an approach requires a broad-based education in CBT that many practitioners, particularly those with only master's-level training, may not have received. So, are we to provide that training in a "bring them in and bring them up" approach or do we wait for other CBT organizations to emerge that will provide such training? Are we serious about the "advancement" part of our name? The plus side of attempting to bring in a greater variety of professionals (e.g., clinical social workers, psychiatrists) is that our membership might grow and we could provide more and better services to our members. We could also help shape the next generation of therapists and disseminate our therapies more effectively. The alternative might be to lose control of the very therapies that we developed over the last 40 years.

Of course, the downside of growing larger is that we may lose that cozy fraternal organization feel that we have become accustomed to. Like this year, if the convention grows, we might have trouble finding our colleagues or old classmates and we might even outgrow one hotel. All those new members could oust us and take over the organization; and then a splinter group might have to develop a new organization (à la APS) to represent the current AABT. Heavy sigh. What to do? We are nearing a

choice point. We can debate and procrastinate for a while longer, but eventually we will need to make some hard choices before they are made for us (finances, other competing organizations). In the meantime, the board decided to take the stance of trying to grow without losing our soul. We will walk on a tightrope for a while to see how that goes. In the spring we will have a strategic planning meeting to direct our course for the next 3 years. Our new listserve is now up and running (however, if you were formerly enrolled, you will need to reenroll), so there is a venue for you to express your viewpoints on these identity issues. The bottom line is that the AABT name change is not just a rose that would smell as sweet. The name change could alter the very essence of the organization. Whether that is for the better or worse is something for which we must make another calculated guess. ✍

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## Clinical Forum

# Making Diagnostic Labels Reflective of Environmental Influences: A Rose by Any Other Name May Not Be So Thorny

Stephen D. A. Hupp and Stacey L. Adams, *Southern Illinois University-Edwardsville*

**T**he *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Text Revision* (DSM-IV-TR; APA, 2000) represents the culmination of many revisions to previous versions of the manual. However, the current version still prompts many criticisms. Hickey (1998) summarized major criticisms, suggesting the manual (a) implies too much homogeneity within diagnostic groups, (b) implies *qualitative* distinctions rather than a *quantitative* continuum, and (c) fails to encourage the exploration of the etiology and maintenance of problem behavior. Indeed, the DSM authors have admittedly attempted to eliminate the use of causative language, which attributes internal causes to behavior; however, causative language still exists throughout the manual (e.g., “accounted for,” “attributable to,” “due to,” etc.; Hickey, 1998).

In response to criticisms of the DSM, several suggestions have been made to place a greater emphasis on environmental influences. For example, Scotti, Morris, McNeil, and Hawkins (1996) proposed that the multi-axial assessment format of the DSM should be modified to facilitate functional assessment. In Scotti et al.'s proposal, Axis III would be broadened to include information about the strengths and weaknesses of the family. Secondly, Axis IV would be expanded to include detailed information about the antecedents and consequences of behavior. Tryon (1999) took the functional descriptions one step further by proposing a taxonomy completely based on operant conditioning. Tryon emphasized the importance of behavior therapists presenting alternatives to the current classification system.

Hickey (1998) and others have described the circular reasoning involved in using disorders as explanatory concepts, suggesting the “only evidence for the disorder is the very behavior it purports to explain.” Regarding childhood disorders, Hickey also suggested that circular reason-

ing lets adults in the child's life free themselves from any obligation to modify their own behavior by placing the blame on internal characteristics of the child. For example, the labels “Attention-Deficit/Hyperactivity Disorder,” “Oppositional Defiant Disorder,” and “Learning Disorder” focus on “deficits” within the child. Of course biological influences have consistently been demonstrated to relate to behaviors associated with these disorders; however, many environmental conditions have been revealed which affect etiology, development, and prognosis.

A minority of DSM labels do reflect environmental influences. Most notably, Posttraumatic Stress Disorder and Acute Stress Disorder emphasize stressors in the environment. Additionally, Adjustment Disorder and Reactive Attachment Disorder appear to tap interactive forces (although ironically many behavioral psychologists are less likely to provide these diagnoses). Finally, the DSM includes a V-code section titled “Relational Problems Related to a Mental Disorder or General Medical Condition,” which emphasizes family relationships. Unfortunately V-codes are much less likely to be reimbursed through managed care.

In some situations diagnostic labels may have beneficial effects such as less negative peer judgments, higher peer acceptance, and more positive adult judgments of some child behaviors (Bak & Siperstein, 1986; Foley, 1979; Kurtz, Harrison, Neisworth, & Jones, 1977; Wood & Valdez-Menchaca, 1996). On the other hand, researchers have demonstrated many harmful effects of diagnostic labels with children. For example, in several studies half of the adult participants were provided with labeling information about a child (e.g., “developmentally delayed,” “expressive language disorder,” “serious emotional disturbance”) and the other half were not provided with any labeling information. Adults in the labeling groups rated children as less socially competent,

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less intelligent, and less mature (Fox & Stinnett, 1996; Vogel & Karraker, 1991; Wood & Valdez-Menchaca, 1996).

Short of moving away from a diagnostic system altogether, it is imperative we move toward a system that minimizes the harmful effects of the labels we choose to use. The present paper provides some alternative labels in an attempt to represent interactional influences rather than focusing solely on the child. Common childhood disorders will be the focus of this paper; however, the model could also be applied to many other disorders throughout the lifespan.

### Moving From Disorders to Discorders

Before specific labels are discussed, revising the term "disorder" should be considered. Disorders are typically defined as "abnormal physical or mental conditions." Thus, when saying a child "has a disorder," one implies the child has an abnormal condition, and typically practitioners and laypeople fall into the trap of assuming exclusively internal causes for the condition. Similarly, the term "mental illness" implies the child has some type of disease. On the other hand, Barker (1978) described mental illness as "behavior poorly fitted into a setting." Additionally, Conoley and Haynes (1992) suggested that mental illness is not a disease but rather a discordance, or failure to match between the child and environment. In some situations behaviors associated with common childhood disorders may actually be advantageous for the child. For example, oppositional child behavior is certainly appropriate when adults or peer groups tell the child to engage in inappropriate behavior. Additionally, high levels of activity may pay off in sports settings. Thus, it is not just the behavior that leads to adaptive impairment but rather behavior in a mismatched setting.

If we are to move away from the current disease model pervasive in the *DSM*, we may benefit from moving away from the term "disorders." A similar, but strikingly different, term could easily be inserted in its place. That is, the term "discord," defined as "a failure to match between the behavior and environment," better represents environmental influences. "Discorder" automatically moves people away from saying "the *child* has a disorder," and prompts one to say "the *family* has a discord" or "the child *is part of* a discord." Below alternative discorders to common childhood diagnoses are described.

### Environment-Attention Disorder

The term Environment-Attention Disorder (EAD) is intended to replace Attention-Deficit/Hyperactivity Disorder. The ADHD label implies some children do not attend as often as other children, when actually children meeting the diagnostic criteria for ADHD are always attending to something; they are simply not attending to stimuli preferred by an adult at the time. The new label, EAD, represents discordance between the focus of the child's attention and the part of the environment to which attending is expected. The new label could also include a "Predominantly Environment-Activity Discord" subtype to replace the current classification of "Predominantly Hyperactive-Impulsive." Additionally, symptoms should also be rephrased. Here are two examples: (a) "frequent discordance between sustained attention and task requirements" and (b) "frequent discordance between fidgeting and environmental expectations." Regarding assessment and treatment, the new label may force more adults to consider environmental antecedents and consequences that are contributing to behaviors associated with EAD.

### Caregiver-Child Disorder

The label Caregiver-Child Disorder (CCD) is intended to replace Oppositional Defiant Disorder. Although caregivers ("caregiver" is used over "parent" to more broadly reflect daycare workers, teachers, family members, and other adults influential in the child's life) should not be blamed for all child behavior, they often significantly contribute to hostile interactions. Indeed, modifying the behavior of the caregiver is usually a crucial element of effective interventions (Hembree-Kigin & McNeil, 1995). The description of symptoms would also need to be modified. For example, "often argues with adults" would be changed to "frequent arguments between child and adults." With this new label, adults may be more likely to consider the caregivers' behavior when assessing and treating the discordance.

### Society-Youth Disorder

The term Society-Youth Disorder (SYD) is intended to replace Conduct Disorder. This new label reflects discordance between society and the aggressive, destructive, deceitful, and rule-violating behavior of the youth. Rather than placing the burden squarely on the shoulders of the

youth, this new label spreads the burden among the youth, family, community, and the media. Regarding SYD, it is more difficult to make changes in the description of symptoms, and no suggestions will be made at this time. This new label may help communities and professionals shift from the emphasis of *treating* a youth's conduct problems to *preventing* the discordance.

### Instruction-Student Disorder

The term Instruction-Student Disorder (ISD) is intended to replace Learning Disorder. The new label opens the door for greater acceptance of alternative styles of instruction for some children. In fact, a majority of students diagnosed with learning disorders are able to learn material effectively when the instructive style is modified. The diagnosis could be broken down into Math-ISD, Reading-ISD, and so on. The *DSM-IV-TR* does not currently include specific symptoms of learning disorders, thus no alternatives will be proposed. The new label may increase the likelihood that instructors change their teaching style for a student rather than teaching all students in similar ways.

### Conclusion

The present proposal may be only a small step toward minimizing the harmful effects of labels. However, previous revisions of the *DSM* provide evidence that giant leaps are not likely in a brief period. The "disorders" framework also matches well with other proposed modifications of the *DSM* (Scotti et al., 1996; Tryon, 1999). These and other proposed modifications to the *DSM* set the stage for empirical research regarding labeling. For example, researchers are encouraged to compare harmful and beneficial effects of different classification systems. Empirical support of alternative systems will make their adoption more likely.

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## call for papers

Trish Long, Ph.D., Program Chair

# C O M O R B I D I T Y

*The Reality and Challenges of Clinical Practice and Research*

Over the past several decades, significant advances have been made in the development and empirical validation of cognitive-behavioral treatments for a broad range of disorders and problems. We have also begun the important work of disseminating these therapies in a way that is accessible to clinicians and clients. Unfortunately, we still face many challenges that arise in understanding and effectively working with people with comorbid conditions.

Despite the advances that have been made in working with single diagnoses, many clients who suffer psychological distress display problems in multiple areas. How can clinicians work most effectively with individuals who have co-occurring problems? How does/should research explore comorbid conditions and evaluate treatment effectiveness in these cases?

What are the implications of having problem conditions that fit in multiple diagnostic categories? How does comorbidity affect theory development? How do issues of comorbidity intersect with issues of gender, education, socioeconomic status, race, sexual orientation, and (dis)ability status?

The theme of AABT's 2004 Annual Convention, "Comorbidity: The Reality and Challenges of Clinical Practice and Research," has been selected in the hope that examination and discussion of the questions described above, as well as others, will enhance the practice and evaluation of the behavioral therapies. Submissions that highlight these areas will receive special consideration. Submissions may be in the form of symposia, roundtables, panel discussion, or posters. Research and clinical presentations are sought.

### INFORMATION

including deadlines  
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## 2004 **STUDENT AWARDS PROGRAM**

### President's New Researcher Award

AABT's President, Patricia A. Resick, Ph.D., invites submissions for the 26th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of \$500. Submissions will be accepted on any topic relevant to behavior therapy.

Eligible papers must (a) be authored by an individual with five years or less posttraining experience (e.g., post-Ph.D. or postresidency); and (b) have been published in the last two years or currently be in press. Submissions can consist of one's own or any eligible candidate's paper. Papers will be judged by a review committee consisting of Patricia A. Resick, Ph.D.; Jacqueline B. Persons, Ph.D., AABT's Immediate Past-President; and J. Gayle Beck, Ph.D., the AABT President-Elect. Submissions must be **received by Monday, August 16, 2004**, and must include four copies of both the paper and the author's vita. Send submissions to: AABT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.

### Virginia A. Roswell Student Dissertation Award

This award will be given to a student based upon his or her approved 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., pay participants, purchase testing equipment) and/or to facilitate travel to the AABT convention. Eligible candidates for this award should be student members, have already had their dissertation proposal approved, and be investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor should send a letter of nomination and provide a 3- to 5-page summary of the proposal. Anything longer than 3 to 5 pages will not be considered. The summary should minimally include a brief introduction to the area of research, methodological design, and a description of the participants. Please send an e-mail version as well as a hard copy of all materials to the program chair, John C. Guthman, Ph.D., AABT Awards and Recognition Committee, 131 Hofstra University, Hempstead, NY 11549; e-mail: [cccjcg@hofstra.edu](mailto:cccjcg@hofstra.edu). In addition, send 1 duplicate copy of your submission to AABT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001.

### Elsie Ramos Memorial Student Poster Awards

These awards will be given to three student poster presenters (student first authors only), member or non-member, at AABT's 38th Annual Convention in New Orleans. The winners will each receive a 2004 AABT Student Membership, a 1-year subscription to an AABT journal of their choice, and a complimentary general registration at AABT's 2005 Annual Convention in Washington, DC. To be eligible, students must complete the submission for this year's AABT convention by **March 1, 2004**. The proposal must then pass AABT's peer review process. AABT's Awards and Recognition Committee will judge all student posters. See page 9 for submission information.

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## Research-Practice Link

### Psychometric Properties of the Multidimensional Blood/Injury Phobia Inventory

Amy Wenzel, *University of North Dakota*, and Craig N. Sawchuk, *University of Washington*

Blood/injury (BI) phobia represents a unique and heterogeneous specific phobia subtype. Individuals with BI phobia not only report fears of blood and injury, but they also often endorse fears of medical procedures, hospitals, mutilation, illnesses, and their own physiological reactions to such stimuli (Page, 1994; Rachman 1990). Delay and avoidance of seeking needed medical care is a common behavioral consequence among BI phobics (Kleinknecht & Lenz, 1989; Öst, 1992), with death occurring in extreme cases (Hamilton, 1995). Fearful responding toward and subsequent avoidance of specified objects, situations, and one's own somatic reactivity is generally consistent with the traditional conceptualization of phobic states. However, the emotion of disgust also appears to uniquely contribute to BI-related concerns and will often co-occur with fear upon exposure (Tolin, Sawchuk, & Lee, 1999). Such phobic individuals frequently report repulsion and aversion upon exposure, exhibit facial expressions characteristic of disgust, and can experience nausea, dizziness, bradycardia, and potential fainting in the presence of BI stimuli.

Although it is well established that BI phobia is a multidimensional construct, most existing assessment instruments measure only a narrow range of characteristics associated with this disorder. For example, BI concerns are assessed among other domains of fearfulness in inventories such as the Fear Survey Schedule-III (Wolpe & Lang, 1964) and the Fear Questionnaire (Marks & Mathews, 1979). However, the limitation of these measures is that they each assess only one type of anxiety response, either fearfulness or behavioral avoidance. Other inventories have been designed for the sole purpose of assessing BI distress, such as the Mutilation Questionnaire (MQ; Klorman, Weerts, Hastings, Melamed, & Lang, 1974), the Injection Phobia Scale (IPS; Öst, Hellstrom, & Kaver, 1992), the Blood-

Injury-Injection Symptom Scale (BISS; Page, Bennett, Carter, Smith, & Woodmore, 1997), and the Medical Fears Survey (MFS; Kleinknecht, Kleinknecht, Sawchuk, Lee, & Lohr, 1999) and its companion, the Medical Avoidance Survey (MAS; Kleinknecht, Thorndike, & Walls, 1996). Although each of these measures represents an important development in this literature, all have shortcomings that prevent them from encompassing the full range of BI situations and responses in a comprehensive manner. For instance, the MQ and IPS cover only a limited range of BI-related situations. The developers of the MFS and MAS improved upon these earlier inventories by expanding the scope of phobic stimuli, but their measures fail to assess disgust or fainting responses in feared situations. Alternatively, the BISS assesses the presence or absence of a number of phobic responses experienced in situations involving blood and injections (e.g., anxiety, faintness, and tension). No information is assessed, however, regarding the intensity of their response or the presence of these symptoms upon exposure to other BI-related stimuli.

The Multidimensional Blood/Injury Phobia Inventory (Wenzel & Holt, 2002) was therefore developed to identify and fully characterize individuals with a range of concerns relating to BI phobia. It consists of 40 items that encompass a full factorial design of four types of BI-related situations (injections, injury, hospitals, blood), five types of phobic reactions (fear, avoidance, worry, disgust, fainting), and a self versus other focus. Six factor-analytically derived scales comprise this inventory: Injections, Hospitals, Fainting, Injury, Blood-Self, and Blood-Other. The latter two scales illustrate the utility of distinguishing between the person experience of BI-related situations and the witnessing of others' experience with these situations. Although Wenzel and Holt (2002) provided limited data suggesting that this measure is psy-

chometrically sound, more work needs to be done to demonstrate the measure's convergent and discriminant validity, which will address the MBPI's overall construct validity (cf. Campbell & Fiske, 1959). To address this aim, 46 University of Arkansas students (mean age = 20.8; 65% female) completed the MBPI and a number of self-report inventories assessing BI concerns, general anxiety, and disgust sensitivity.

#### Distribution Statistics and Psychometrics

Table 1 presents means and standard deviations for males and females on the total score of the MBPI as well as the mean item scores for each of its scales. As is often seen with other measures of BI concerns (e.g., Kleinknecht et al., 1999), females scored higher than males across all of the inventories. Gender differences were significant for the MBPI total score,  $t(44) = -2.41$ ;  $p = .02$ , and the Injections scale,  $t(44) = -2.48$ ,  $p = .02$ . There were trends toward gender differences on the Hospitals, Injury, Blood-Self, and Blood-Other scales that were significant at levels between .06 and .09. Each of the MBPI scales had good internal consistency, with coefficient alphas ranging from .82 to .97 with a median of .90.

As evident in the values of kurtosis and skewness, the shape of each scale's distribution is somewhat different. Injury was the only scale with a negative kurtosis and a slight positive skew. These psychometric properties approximate those of the Fear of Mutilation scale of the MFS (Kleinknecht et al., 1999). Similar to the MFS, all other scales had a positive kurtosis value and were skewed in the positive direction to a greater degree than the Injury scale. The Fainting and Blood-Self scales were particularly leptokurtic and positively skewed, suggesting that extreme forms of the characteristics comprising these scales are not well represented in the general population.

#### Validity

Convergent validity reflects the extent to which a measure should correlate highly with those with which it is theoretically related (cf. Anastasi, 1988). Correlations between the MBPI total score and its scaled scores with other self-report measures of interest are presented in Table 2. Although it was predicted that all of the MBPI scales would correlate significantly with all other BI phobia measures, it was expected that correlations would be particularly high between MBPI scales that measured a specific domain (e.g., Injections) and other instru-

ments that assess the same construct (e.g., IPS). As expected, the MBPI total score and all of its scaled scores generally correlated significantly and positively with the IPS-Anxiety, the IPS-Avoidance, the MFS, the MAS, and the MQ. Notable exceptions were that the Hospitals scale did not correlate significantly with IPS-Avoidance, and the Hospitals and Injury scales did not correlate significantly with the BISS. The following BI phobia measures correlated most highly with each of the six MBPI scales: Injections scale with IPS-Anxiety ( $r = .91$ ),

Hospitals scale with the MQ ( $r = .69$ ), Fainting scale with the MFS ( $r = .64$ ), Injury scale with the MFS ( $r = .56$ ), Blood-Self scale with the MFS ( $r = .76$ ), and Blood-Others scale with the MQ ( $r = .69$ ).

In addition to expecting that the MBPI total score and its scales would correlate positively with other BI phobia measures, it was also predicted that they would correlate positively with disgust measures, as empirical evidence suggests that the emotion of disgust plays a prominent role in this phobia (Page, 1994; Tolin et al., 1999). To ex-

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amine this relation, participants also completed two measures of disgust, the Disgust Emotions Scale (DES; Walls & Kleinknecht, 1996) and the Disgust Scale (DS; Haidt, McCauley, & Rozin, 1994). Each of the MBPI scales, except for the Hospitals scale, was significantly and positively correlated with the full scale DES ( $r$ s range from .29 to .63). Only the Injury scale, however, was correlated significantly and positively with the full scale DS ( $r$  = .45). Total scores on the DES and DS are composed of five and seven scales, respectively, assessing a fairly diverse range of potential disgust elicitors. Previous researchers (de Jong & Merckelbach, 1998; Sawchuk, Lohr, Tolin, Lee, & Kleinknecht, 2000) have noted that certain domains of disgust (e.g., mutilation, injections) are more strongly correlated with measures of BI-related fear than other domains unrelated to BI concerns (e.g., animals, smells). We therefore examined the interrelationships between the DES, DS, and MBPI scales to further determine convergent and discriminant validity.

Consistent with earlier research, the strongest correlations emerged between MBPI scales and similar disgust domains assessed by the DES and DS. MBPI Injections was significantly correlated with the DES Injections ( $r$  = .87) and Mutilation ( $r$  = .53), and DS Envelope Violations (i.e., puncture wounds;  $r$  = .46) and Death ( $r$  = .31) scales. MBPI Hospitals was significantly associated with DES Mutilation ( $r$  = .49) and Injections ( $r$  = .35), and DS Envelope Violations ( $r$  = .42) and Death ( $r$  = .39). MBPI Fainting was significantly correlated with DES Injections ( $r$  = .57),

Mutilation ( $r$  = .41), and Smells ( $r$  = .30), and DS Envelope Violations ( $r$  = .38). MBPI Blood-Self was significantly associated with DES Injections ( $r$  = .67) and Mutilation ( $r$  = .41), and DS Envelope Violations ( $r$  = .42) and Foods ( $r$  = .32). MBPI Injury was significantly correlated with DES Smells ( $r$  = .55), Mutilation ( $r$  = .53), Injections ( $r$  = .49), Rotting Foods ( $r$  = .49), and Small Animals ( $r$  = .30), and DS Death ( $r$  = .51), Food ( $r$  = .36), Envelope Violations ( $r$  = .34), Animals ( $r$  = .32), and Sympathetic Magic ( $r$  = .29). Finally, MBPI Blood-Others was significantly associated with DES Injections ( $r$  = .51) and Mutilation ( $r$  = .49), and DS Envelope Violations ( $r$  = .53) and Death ( $r$  = .38). Whereas MBPI Injections, Hospitals, and Blood-Others were exclusively associated with disgust domains directly related to BI concerns, MBPI Fainting, Blood-Self, and Injury were also correlated with a range of generalized disgust elicitors (e.g., foods, smells) independent of BI-related stimuli. Several researchers have speculated that increased sensitivity to a diverse set of disgust stimuli may be implicated in the etiology and maintenance of BI phobia, especially among those prone to fainting (Page, 1994; Sawchuk et al., 2000; Tolin et al., 1999). The finding that a broader range of disgust elicitors was associated with the MBPI scales assessing fainting and revulsion to the sight of one's own blood and injuries underscores the potential role of generalized disgust reactivity in the unique phobic response observed in this disorder.

Discriminant validity reflects the extent to which a measure does not correlate

highly with variables with which it is not theoretically related. In order to demonstrate optimal specificity, a measure of BI phobia ideally would not correlate significantly with other measures of anxiety or general distress. However, it is well established that all anxiety disorders, including BI phobia, are characterized by undifferentiated negative affectivity that often accounts for comorbidity between various expressions of general distress (Zinbarg & Barlow, 1996). That is, this negative affectivity factor represents a source of common variance among various anxiety constructs. Thus, we expected that correlations between the MBPI and measures of general anxiety characteristics would be significantly correlated but substantially lower in magnitude than correlations with other BI phobia and disgust measures. Although the State-Trait Anxiety Inventory-Trait Version (STAI-T; Spielberger, Gorsuch, & Lushene, 1970) did not correlate significantly with the MBPI total or scaled scores, the STAI-State Version correlated significantly and positively with the MBPI total score ( $r$  = .34) and the Injections ( $r$  = .34) and Blood-Self ( $r$  = .35) scales. The Anxiety Sensitivity Index (ASI; Reiss, Peterson, Gursky, & McNally, 1986) correlated even more strongly with the total score ( $r$  = .50) and the Injections ( $r$  = .41), Fainting ( $r$  = .53), Blood-Self ( $r$  = .46), and Blood-Others ( $r$  = .44) scales.

In contrast, we predicted that the MBPI total and scaled scores would not correlate with the total score of the Spider Phobia Questionnaire (SPQ; Klorman et al., 1974), as this measures a phobic domain that is theoretically separate from BI-related concerns. Although the MBPI total score did not correlate significantly with the SPQ, the Injury and Blood-Self scales both correlated with the SPQ at  $r$  = .40. One explanation for these findings is that disgust is a third variable that spuriously inflates the relation between these BI phobic constructs and that of spider phobia. Recent work suggests that disgust is as common a reaction to spider-related stimuli as it is to BI-related stimuli (Sawchuk, Lohr, Westendorf, Meunier, & Tolin, in press; Sawchuk et al., 2000). Partial correlations between these two MBPI scales and the SPQ controlling for DES scores were not significant, thereby supporting the notion that disgust accounted for the relation between these variables. A similar pattern of findings emerged when controlling for the DS.

In sum, the MBPI demonstrates excellent convergent validity, as it correlates highly with other self-report inventories

TABLE 1. Distribution Characteristics of the MBPI Total Score and Scales

	Mean (SD): Males	Mean (SD): Females	Kurtosis	Skewness	$\alpha$
Total Score	15.23 (19.75)	35.30 (29.96)	0.92	1.27	.97
Injections (6)	0.42 (0.64)	1.29 (1.31)	0.22	1.17	.95
Hospitals (6)	0.28 (0.54)	0.71 (0.82)	1.17	1.41	.92
Fainting (6)	0.19 (0.50)	0.33 (0.61)	3.15	2.09	.82
Injury (4)	0.97 (1.02)	1.51 (0.92)	-0.62	0.36	.88
Blood-Self (4)	0.20 (0.56)	0.77 (1.23)	3.86	2.14	.97
Blood/Injury- Others (4)	0.38 (0.58)	0.80 (0.75)	0.37	1.21	.82

*Note.* Numbers in parentheses following each scale name are number of items in those scales. Scaled scores are presented in terms of mean item responses to adjust for differences in the number of items per scale.

also designed to measure BI phobia. Moreover, it also correlates positively with measures of disgust, with the strongest associations emerging with disgust domains directly related to BI concerns (e.g., injections, mutilation, death). In addition, certain MBPI scales produced significant correlations with disgust domains unrelated to BI phobia, which has been argued to serve as a potential diathesis factor in this disorder (Tolin et al., 1999), and may contribute to its unique responses of aversion, nausea, and fainting not observed in other disorders of anxiety. The discriminant validity of the MBPI is adequate. Although it appears to measure a construct that is different than trait anxiety, it correlates significantly with state anxiety and anxiety sensitivity. These correlations make theoretical sense—the more people experience discomfort in answering questions about an unpleasant subject, such as BI-related situations, the more state anxiety they should report. In addition, the correlations between some of the MBPI scales and the ASI likely reflect the common focus on physiological reactivity in feared situations.

### MBPI—What Is the Advantage?

Although results from the present study suggest that the MBPI has good psychometric properties, it is only one of many reliable and valid instruments for assessing BI phobia. In fact, its 40 items are more than the other instruments designed specifically to assess this construct. However, we argue that there are several advantages for selecting the MBPI over other existing measures for use in clinical and research settings.

First, the MBPI is a more comprehensive measure than the other self-report inventories, as it includes a number of situations typically feared by BI-phobic individuals as well as a range of phobic responses characteristic of this disorder. It is the only known BI phobia measure to assess worry about and disgust in BI-related situations and to incorporate a self versus other focus. Second, it includes a separate Fainting scale, a phobic response that is especially important to consider in clinical settings. Endorsement of fainting in the presence of phobic stimuli or situations has significant bearing on the treatment modality selected. Training in applied tension (AT), as opposed to traditional progressive muscle relaxation (PMR), is often taught to BI phobics prone to fainting, as the repeated tensing and releasing of large muscle groups serves to maintain the individual's blood pressure for

the duration of the exposure trial (Bodycoat, Grauaug, Olson, & Page, 2000).

Third, the MBPI is a potentially important vehicle to advance our theoretical understanding regarding the nature of BI phobia. Wenzel and Holt (2002), for example, conducted a factor analysis on a large sample of undergraduates' responses to the MBPI in order to test whether BI phobia is a unitary construct or composed of a constellation of distinct (but related) specific phobias (i.e., injection phobia, injury phobia, etc.). Their results confirmed that each of these phobic domains is part of the higher-order construct of BI phobia. Another useful dimension to explore further is the self versus other focus. Our clinical experience suggests that individuals with BI phobia vary considerably in their discomfort when exposed to their own blood or when viewing blood or injuries of other people. This distinction has rarely been considered in the empirical literature, and further systematic examination may help delineate the boundaries of BI phobia, as well as to identify potential subtypes of this disorder (cf. Page, 1994).

The next step in the validation of this measure is to consider its properties in individuals with relatively severe BI phobia. Although Wenzel and Holt (2002) presented profiles of scaled scores for undergraduate students diagnosed with BI phobia, it has not yet been administered to a treatment-seeking population. It will be important to replicate the MBPI's reliability and validity in a clinical sample, determine its utility in characterizing distinct clinical presentations of this heterogeneous specific phobia, and examine the degree to which it is sensitive to change across the course of behavioral treatment. We believe that the MBPI has the flexibility to identify unique concerns of treatment-seeking individuals, such that results from the scaled scores will be useful for therapists in constructing individual hierarchies for exposure.

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TABLE 2. Correlation Matrix of the MBPI and Related Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. MBPI Total Score	1.0																		
2. MBPI Injections	.85	1.0																	
3. MBPI Hospitals	.75	.44	1.0																
4. MBPI Fainting	.78	.55	.76	1.0															
5. MBPI Injury	.67	.50	.45	.37	1.0														
6. MBPI Blood-Self	.84	.68	.49	.76	.46	1.0													
7. MBPI Blood- Others	.84	.61	.80	.65	.52	.63	1.0												
8. IPS-Anxiety	.75	.91	.32	.52	.42	.65	.51	1.0											
9. IPS-Avoidance	.63	.81	.20	.41	.32	.59	.43	.81	1.0										
10. MFS	.87	.83	.56	.64	.56	.76	.68	.83	.30	1.0									
11. MAS	.65	.67	.42	.35	.40	.48	.45	.57	.40	.68	1.0								
12. MQ	.76	.67	.69	.42	.51	.51	.69	.63	.31	.81	.64	1.0							
13. BISS	.51	.61	.14	.35	.22	.50	.23	.63	.65	.65	.68	.56	1.0						
14. DES	.59	.58	.29	.41	.63	.46	.37	.62	.13	.46	.50	.64	.50	1.0					
15. DS	.29	.19	.21	.15	.45	.23	.26	.26	-.06	.40	.08	.45	.16	.69	1.0				
16. STAI-S	.34	.34	.18	.22	.25	.35	.19	.28	-.01	.42	.37	.36	.41	.47	.31	1.0			
17. STAI-T	.18	.10	.08	.17	.27	.27	.07	.15	.04	.26	.23	.13	.25	.28	.23	.62	1.0		
18. ASI	.50	.41	.29	.53	.25	.46	.44	.47	.11	.55	.41	.39	.47	.57	.36	.31	.11	1.0	
19. SPQ	.29	.29	.16	.12	.40	.40	.15	.23	.15	.34	.25	.29	.29	.64	.44	.42	.16	.28	1.0

Note.  $r > .30, p < .05$ ;  $r > .38, p < .01$

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## Student Forum

# Novel Tobacco Products and Herbal Cigarettes: Implications for Prevention

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The National Youth Tobacco Survey found that 12.8% of middle school students and 34.8% of high school students had used tobacco in the past 30 days, either in the form of cigarettes, smokeless tobacco, cigars, pipes, kreteks (clove cigarettes), or bidis (Centers for Disease Control and Prevention, 2000).

According to this survey, which was the first study to specifically document adolescent use of novel tobacco products such as bidis and kreteks, the prevalence of cigarette smoking, including novel tobacco products, increased among adolescents during the 1990s. Of middle school students surveyed, 5.4% of students had smoked bidis in their lifetime, 2.5% had smoked bidis in the past 30 days, and 1.9% had smoked kreteks in the past 30 days. Of high school students surveyed, 14.1% of students had smoked bidis in their lifetime, 5% had smoked bidis in the past 30 days, and 5.8% had smoked kreteks in the past 30 days (Centers for Disease Control and Prevention, 2000). Similarly, the Nebraska Middle School Youth Tobacco Survey measured the tobacco use of 3,429 students in grades 6 to 8. This survey found that in the past 30 days, 3% of students had smoked bidis and 4% had smoked clove cigarettes (Nebraska Health and Human Services System, 1999).

The results of these surveys reveal that the use of novel tobacco products may be an emerging health problem among America's adolescent population. Because the increased use of these products is significant, there may be a need to incorporate herbal and novel tobacco cigarettes into existing

tobacco prevention programs. In addition, because tobacco-free herbal cigarettes and 100% natural tobacco cigarettes were not included in either survey, more research is needed on these products in order to specifically determine the current use of all existing alternative tobacco products. Additionally, reasons for the use of alternatives to tobacco might also be explored.

For purposes of this article, the following definitions will be used:

- *commercial cigarette*: any rolled cigarette containing tobacco and sold commercially under a brand name
- *novel tobacco cigarette*: any rolled cigarette containing tobacco that also contains herbs or vegetable matter within the cigarette or wrapper
- *herbal cigarette*: any rolled cigarette made without the use of tobacco or controlled substances, and with any other combination of organic matter or flavorings that reasonably mimics tobacco cigarettes in their use and appearance
- *natural tobacco cigarette*: whole-leaf tobacco products that contain no chemical additives, preservatives, reconstituted sheet tobacco, stems, flavorings, moisteners or burning agents

## Novel Tobacco Products and Commercial Cigarettes

Novel tobacco cigarettes became popular in the United States in the 1980s (AMA Council on Scientific Affairs, 1988) at a time when a trend toward health and fitness

sparked a renewed interest in the ancient medicinal method of healing with herbs (Williamson & Wyandt, 1997). Currently sold in drug stores, supermarkets, and convenience stores in various forms such as capsules, tinctures, and teas, herbs have gradually evolved into a popular method of healing without the use of drugs. Thus, because consumers may have come to accept the idea that herbs are healthy alternatives to drugs, they may perceive that novel tobacco products and herbal cigarettes are healthier alternatives to tobacco.

As stated previously, the National Youth Tobacco Survey and the Nebraska Middle School Youth Tobacco Survey found that the prevalence of cigarette smoking, including novel tobacco products, had increased among adolescents during the 1990s. Thus, continued research on the public's use of novel tobacco products may be necessary in order to determine increases and decreases in use. In addition, further research on the effects of novel tobacco products may also be necessary so that the consumer may form a more realistic perception about these products.

## Types of Novel Tobacco Products

The clove or "kretek" cigarette is the major delivery service in Indonesia for inhaled nicotine (AMA Council on Scientific Affairs, 1988). Clove cigarettes are a combination of 30% to 40% shredded clove buds and 60% to 70% tobacco (American Committee on Substance Abuse, 1991). Because clove cigarettes are tightly rolled and therefore burn for longer periods of time than regular cigarettes, they must be puffed harder and more frequently to remain lit (American Committee on Substance Abuse, 1991), resulting in deeper inhalation of smoke. When burned, 1 gram of dry clove buds contains 120 to 130 mg of eugenol, a substance that has been used as a mild dental anesthetic, and can also inhibit the gag reflex (AMA Council on Scientific Affairs, 1988). Thus, it is possible that when smoking a clove cigarette, the numbing properties of eugenol can prohibit

the smoker from getting the cues normally associated with heavy smoking, such as pain and discomfort to the throat.

According to the American Medical Association, clove cigarettes are classified as tobacco products, and are therefore subject to the same hazards associated with smoking tobacco products (AMA Council on Scientific Affairs, 1988). Yet because of the lack of research and education available on cigarettes with herbal properties, clove cigarettes may be perceived as more natural and thus less harmful or addictive than tobacco cigarettes. Because clove cigarettes have been associated with severe lung injury in a few susceptible individuals with existing upper-respiratory-tract infections (AMA Council on Scientific Affairs, 1988), more research in evaluating awareness and knowledge among users and nonusers may be necessary in order to determine these perceptions more accurately.

Bidis, another type of novel tobacco product, are filterless cigarettes containing unprocessed, natural tobacco flakes, and come in candy flavors, such as chocolate, strawberry, and vanilla. Bidis, first imported to the United States from India in the mid-1990s, derive their herbal properties from the porous tendu or temburni leaf (*Diosyros melonoxlon*) that they are rolled in (Centers for Disease Control and Prevention, 1999). Since bidis are wrapped in leaves and not paper, they bear a strong resemblance to a marijuana joint, which may make them more alluring to adolescents.

Although each bidi contains less tobacco than a typical filter cigarette, because they are filterless, they produce higher levels of carbon monoxide, nicotine, and tar than regular cigarettes (Centers for Disease Control and Prevention, 1999). One study found that bidis produced approximately three times the amount of tar, carbon monoxide, and nicotine than regular tobacco cigarettes (Rahman & Fukui, 2000). Because bidis are not wrapped in paper and are instead wrapped in a highly porous tendu leaf lacking burning agents, those who smoke bidis must inhale more often and more deeply (Centers for Disease Control, 1999).

Natural tobacco cigarettes, considered novel tobacco because they contain 100% natural tobacco without the additives found in traditional cigarettes, produce smoke that contains greater levels of toxic agents—carbon monoxide, hydrogen cyanide, ammonia, and carcinogenic hydrocarbons—than do regular tobacco cigarettes (American Lung Association of California, 1999). This may be misleading,

as marketing a cigarette as 100% natural may cause consumers to perceive that “natural” cigarettes are healthier than commercially marketed tobacco products.

Tobacco-free cigarettes, which can be purchased over the Internet, in tobacco shops, and in health food stores, are commonly marketed as a solution to the problem of tobacco addiction. These “herbal cigarettes” do not contain tobacco but contain varieties of herbs, grasses, and vegetable matter, some of which serve to mask coughing symptoms (Ritchardson, 1995). A concern may be that smokers who sincerely want to quit smoking and break their nicotine addiction may not know that smoking tobacco-free herbal cigarettes still results in the inhalation of a level of carbon monoxide that is equal to commercial tobacco cigarettes (Groman, Bernhard, Blauensteiner, & Kunze, 1999). In being unaware of the known harms of these products, the consumer may perceive that smoking tobacco-free herbal cigarettes is a healthier solution to breaking the smoking habit.

Research on tobacco-free herbal cigarettes was done in 1999 by a team of researchers from the University of Vienna. This team investigated the health effects of smoking a vegetable-based cigarette that was being offered in Austrian pharmacies and in other countries as an aid to help smokers stop smoking. Printed on each pack was the following: “Vegetable-based cigarettes: no tobacco, no nicotine, helps to quit smoking” (Groman et al., 1999). Their research, published in the *Lancet* in 1999, concluded that vegetable-based cigarettes produce a level of carbon monoxide similar to that produced by tobacco cigarettes (Groman et al., 1999). In addition, Groman and his colleagues found that the combustion and inhalation of vegetable-based cigarettes may produce toxic and/or carcinogenic substances. Thus, Groman and his colleagues concluded, these vegetable-based products are a potential hazard to health.

The existing research on the effects of novel tobacco products and herbal cigarettes on the respiratory system may indicate that it is necessary to incorporate novel tobacco products and herbal cigarettes into existing smoking prevention and cessation programs. Further research and education on the effects of burning vegetable matter is also warranted. In addition, research on the perceptions of those who use novel tobacco products and herbal cigarettes is indicated so that further methods of prevention can be determined.

## Discussion

Cigarette smoking is the largest preventable cause of death in the United States, claiming more than 430,000 victims a year (Centers for Disease Control and Prevention, 2000). Smoking is typically initiated in adolescence by inhaling the smoke from commercial tobacco cigarettes. Approximately 80% of tobacco users initiate use before the age of 18 (Centers for Disease Control and Prevention, 2000). The initiation of smoking in adolescence results in the self-administration of nicotine, a powerfully addictive psychoactive drug (Bates, 2000). The psychoactive rewards of nicotine, combined with the social rewards of obtaining a certain image, gaining peer acceptance, and achieving weight loss, make smoking especially attractive to youth (McGahee, Kemp, & Tingen, 2000). Since most smokers begin to smoke as adolescents, a key in reducing smoking as a whole might begin with programs geared toward preventing tobacco use by young people.

Many smoking prevention programs have been established within the past 15 years that have been successful in reducing smoking initiation among teenagers. Traditionally, only commercial tobacco cigarettes are targeted within these programs. However, incorporating novel tobacco products and herbal cigarettes into existing smoking prevention programs may be useful in preventing the future consumption of these products.

Knowledge-based smoking prevention programs have been incorporated in schools in an attempt to deter preadolescents from smoking (Langlois, Petosa, & Hallam, 1999). These programs focus on the negative health aspects of smoking, particularly the physical consequences of smoking from a medical standpoint. Data on cancer, other diseases caused by smoking, and the biology of reproduction are presented in an attempt to change students' perception of high-risk behavior as normative (Stipek, de la Sota, & Weishaupt, 1999). Including novel tobacco products and herbal cigarettes into existing knowledge-based programs may help school administrators and health care professionals to better assess students' use of these products. However, although knowledge-based prevention programs are effective in increasing knowledge about the consequences of smoking, they are often ineffective in actually preventing students from beginning to smoke (Langlois et al., 1999). Social influence or psychosocial programs, which focus on social pressures to smoke and skill devel-



opment to resist social pressures, have proven to be more effective in halting smoking initiation (Langlois et al., 1999).

Social influence or psychosocial smoking prevention programs seek to promote student learning by discussing the short-term consequences of smoking, addressing the social pressures to smoke, and developing the behavioral capability to resist positive images of smoking (Langlois et al., 1999). One example, a psychosocial smoking prevention program with documented effectiveness, is the Minnesota Smoking Prevention Program. Two-year follow-up data on this six-lesson smoking prevention program has been documented to reduce smoking initiation by 20% (Langlois et al., 1999). The goals of this program were to help students identify reasons why people start using tobacco, to discuss the concept that nonuse of tobacco is normative behavior, to practice skills for resisting peer pressure, to recognize covert messages in tobacco advertising, and to identify personal reasons for not using tobacco. This program requires students to identify sources of pressure to smoke, perform role-plays centered around smoking-refusal strategies, and to discuss barriers to refusing cigarette offers. Thus, students are provided with the skills to help them resist all types of direct and indirect offers of cigarettes (Langlois et al., 1999). Including novel tobacco products and herbal cigarettes into existing social influence smoking prevention programs may be helpful in assessing students' perceptions of these products.

Another smoking prevention program, based on a cognitive-developmental stage model, has also proven to be effective in reducing smoking initiation. This three-session program was pilot tested with 315 students in an urban public school, and included having students view three smoking-prevention films. Students made written comments on the films, focusing on their experiences associated with the different stages of smoking (Hirschman & Leventhal, 1989). Students in the program discussed their own cognitions about smoking and began to develop ideas and skills to resist influences to smoke. In an 18-month follow-up to this program, it was revealed that a significant number of students who were exposed to this program were successfully prevented in making the transition from a first try to occasional or regular smoking (Hirschman & Leventhal, 1989). Role-plays involving novel tobacco products and herbal cigarettes might easily be incorporated into these types of programs

so that students' perceptions can be assessed and refusal skills discussed.

Bandura's social cognitive theory may also help health practitioners and therapists to understand the various psychosocial dynamics that can lead to certain addictive behaviors. The social cognitive theory states that the expectation of personal mastery and success is the prime influencer of whether or not a person will engage in a certain behavior, and that behavior itself is driven by expectancies and incentives (Bandura, 1977). According to this theory, a person's self-efficacy beliefs, which are beliefs in one's own ability to perform or not perform a behavior, may influence behavior when confronted with obstacles. Thus, another possible smoking-prevention program might focus on helping adolescents increase their self-efficacy. Health care practitioners, including physicians, dentists, and therapists, can achieve this through positive role modeling and by teaching new skills to patients to help them manage threatening activities (McGahee et al., 2000).

The Theory of Reasoned Action has also been used to examine smoking-related attitudes, beliefs, intentions, and behaviors in adolescents aged 12 to 18, and children in grades 5 to 6 (Ajzen & Fishbein, 1980). This theory focuses on a person's intention to perform a certain behavior, and involves gauging a person's attitude toward a particular behavior as well as their perception of social pressures to perform or not perform this behavior. Thus, a person will generally intend to perform a behavior he or she evaluates positively and believes that others will positively reinforce. Because studies have indicated that younger children, aged 7 to 9, have been found to have more negative attitudes toward smoking, and preteen children tend to view smoking as more positive and desirable (McGahee et al., 2000), health care professionals and therapists may find success in interviewing preteens about their perceptions of commercial cigarettes, novel tobacco products, and herbal cigarettes in order to gauge their intention to smoke, while continuing to discuss strategies for them to develop refusal skills.

Life Skills Training programs, which are school-based programs that focus on helping children develop social competence, communication, and decision-making skills, have also proven to be effective in preventing smoking initiation. These programs have been designed to help children develop certain skills that are assumed to have direct and indirect effects on their behavior and psychological well-being. A typical Life Skills Training program helps

students develop skills in decision-making, emotional and stress management, self-esteem, and assertiveness. Students are also taught to deal with coercion, threats and challenges, and to develop an understanding of the effects of media on their perceptions and beliefs (Stipek et al., 1999).

## Conclusion

In order to prevent consumers from perceiving that herbal cigarettes, alternative tobacco products, and nontobacco products are healthier alternatives to tobacco, they should be educated about the effects of inhaling smoke of any sort. Consumers should be made aware that all cigarettes, regardless of whether they contain tobacco, produce tar and carbon monoxide upon combustion and inhalation, which is harmful to health (Groman et al., 1999; Toma, 2000). They should also be made aware that because of the lack of research on the effects of inhaling smoke from novel tobacco products and herbal cigarettes, there are unknown risks associated with inhaling gases created by the combustion of herbs, flavorings, and other additives that are present within these products (Groman et al., 1999; Toma, 2000). More research on the effects of novel tobacco products and herbal cigarettes is needed in order to better assess the health risks associated with these products.

Because the prevalence of cigarette smoking, including novel tobacco products, has increased among adolescents during the 1990s, it would seem that novel tobacco products and herbal cigarettes should be incorporated into existing prevention programs that are built on social learning theory, which have taught young people how to become aware of pressures that influence them to smoke and teach them how to resist these pressures through discussion and role-playing. In addition, health care professionals such as physicians, nurses, dentists, and therapists can, in their assessment of smoking behavior, expand a clinical interview to address novel tobacco products and herbal cigarettes in the event that this may be an issue for patients. These professionals should also foster the development of smoking-refusal behaviors that emphasize problem solving and counter negative peer pressure, reinforcing these behaviors whenever possible (McGahee et al., 2000). Therapists may especially find success in discussing possible smoking refusal techniques with their preadolescent and adolescent patients and in addressing whether they perceive novel tobacco products and

herbal cigarettes to be healthier alternatives to tobacco.

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## Dissemination

# Report of the Committee on Academic Training: Medical Specialty Training on Panic Disorder

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Panic disorder is a straightforward mental health problem that is easily diagnosed by cognitive-behavioral therapists. Several highly effective treatments are available that are well tolerated and relatively inexpensive (Gorman et al., 2002). These include various cognitive-behavioral interventions (e.g., Arnoud, 2002; Elsesser, Mosch, & Sartory, 2002) as well as pharmacological treatments, especially the SSRIs (e.g., Bakker, van Balkom, & Spinhoven, 2002). Not surprisingly, combining cognitive-behavioral treatment with medication significantly lowers the risk of relapse once medications are withdrawn (Biondi & Picardi, 2003).

Unfortunately, despite the straightforward nature of the disorder and the efficacy

of the available treatments, many panic patients suffer for years without a name for their condition or access to appropriate care. One reason for this is that panic often masquerades as medical illness. Patients with panic disorder experience an array of physical symptoms such as chest pain, tachycardia, shortness of breath, gastrointestinal upset, and dizziness. As a result, they seek care from a variety of medical specialists, including cardiologists, cardiovascular specialists, neurologists, gastroenterologists, and otolaryngologists, who may not recognize panic disorder as the underlying etiology of their patients' complaints. During that time, they often undergo a series of expensive, unwarranted, and frequently invasive medical procedures and treatments. In

the overwhelming majority of panic patients, physical exams and diagnostic tests (e.g., cardiac stress tests, MRIs, colonoscopies, etc.) are unremarkable or reveal physical pathology that is minor in comparison to the patients' symptoms. Despite benign findings, medical specialists often feel compelled to offer patients some form of relief from their inexplicable physical symptoms. Unfortunately, symptomatic treatments are rarely successful because they do not address the fundamental clinical problem. Patients continue to suffer and may become quite debilitated as a result of the underlying anxiety disorder.

For example, Beitman and Al-Basha (1992) reviewed the evidence for panic disorder in patients with chest pain and angiographically normal coronary arteries. They concluded that there was compelling evidence that a substantial subset of these patients (at least 34%) met diagnostic criteria for panic disorder. Gorman et al. (1988) found that panic disorder patients were more likely to have mitral valve prolapse (MVP) than normal controls, but that the MVP was typically mild and not associated with thickened mitral leaflets or small left ventricular size. Moreover, Coplan, Papp, King, and Gorman (1992) found that the symptoms of MVP were ameliorated after successful treatment for panic disorder.

In the world of gastroenterology, irritable bowel syndrome (IBS) is a nonspecific syndrome characterized by abnormal intestinal motility, gastric discomfort, diarrhea and/or constipation. IBS is difficult to treat, and is known to be exacerbated by stress. Interestingly, there is a great deal of comorbidity between IBS and panic disorder. For example, Kaplan, Masand, and Gupta (1996) found that 48% of a sample of patients seeking treatment for panic disorder also met criteria for IBS. A number of studies have reported that the gastrointestinal symptoms of IBS resolve when the patient is successfully treated for panic (e.g., Lydiard, Laraia, Howell, & Ballenger, 1986; Woodman & Noyes, 1992).

Finally, neurologists and otolaryngologists are often called upon to treat patients with severe, debilitating, but nonspecific dizziness. Yardley, Own, Nazareth, and Luzon (2001) surveyed a representative community sample of individuals with dizziness. They found that nearly two-thirds of the sample reported having panic attacks, and 1 in 4 met criteria for panic disorder. Swinson et al. (1993) tested the otoneurological functioning in panic disorder patients with prominent dizziness. They detected no clinically significant abnormalities. Interestingly, Simon, Pollack, Tuby, and Stern (1998) found that panic patients with vestibular symptoms incur particularly high costs and levels of disability, yet systematic investigations of treatment for this group were lacking.

These studies, and many others, point to the importance of educating our medical colleagues about panic disorder. These specialists are in an ideal situation to diagnose panic disorder and make appropriate treatment and referral recommendations. If all GI, ENT, cardiac and neurology specialists knew how to recognize panic disorder, understood the cognitive-behavioral model, and were familiar with treatment guidelines, the savings in dollars would be significant, and the savings in human suffering would be immeasurable. We hope that educational interventions at the level of residency and fellowship training will increase the number of accurate diagnoses made, increase appropriate referrals, decrease the cost of medical management, and improve patient satisfaction and long-term outcome.

As a first step toward this goal, we conducted a national survey of residency training program directors in these specialty areas. We were interested in determining the actual training practices of existing programs and their interest in further educa-

tion. It is our hope that with this knowledge in hand, we can begin the process of setting up a national clearinghouse to match interested residency programs with willing cognitive-behavioral therapists. The membership of AABT is an obvious resource in this regard.

## Method

### Sample

We sent out surveys via e-mail to all residency training programs in specialties most likely to encounter patients with panic disorder. These specialties included neurology, gastroenterology, cardiology, cardiovascular medicine, and otolaryngology. We selected the residency training programs as they were listed on the FREIDA database, which is managed by the American Medical Association and linked to the AMA Web site. In most cases, the recipient of the survey was the training director, whose contact information was provided in the database.

### Procedure and Instruments

A short questionnaire was e-mailed to each director of every individual training program for the selected specialties. The surveys varied slightly by specialty regarding treatment options, but the overall format remained the same. For example, all surveys included SSRIs as a treatment option, but only the gastroenterologists were asked if they regularly prescribe lomotil, an anti-diarrheal agent. The survey contained several multiple-choice and fill-in-the-blank questions, and doctors were asked to respond to questions such as the following: "How much training is currently provided to residents about the etiology and treatment of panic disorder?"; "Please estimate the percentage of patients you treat whose difficulties can be attributed to panic disorder"; and "Please rate how important further training regarding panic disorder would be." Additionally, respondents ranked their treatment preferences and provided us with some insight into the nature of currently existing training models on the topic of PD.

### Results

The response rates were as follows: 21% of otolaryngologists, 19% of gastroenterologists, 18% of cardiovascular specialists, 21% of neurologists, and 5% of cardiologists, combining to an overall average response rate of 17% (excluding cardiology, this rate increases to 20%). This is a modest response rate, at best, and we can assume

that the respondents were highly self-selected. However, it represents 96 different training programs, which jointly train hundreds of medical specialists each year. Even if these were the only programs to be interested in collaborative training efforts, the potential impact on patient care in subsequent years is enormous.

Regarding etiology, we asked training directors in all the specialties how likely they were to teach that panic disorder results from biological abnormality, stress, cognitive distortions, or other causes. Some directors indicated more than one response, but the overall rates are as follows:

biological abnormality: 42%  
stress: 23%  
cognitive distortion: 15%  
other: 6%  
no response given: 22%

We also asked training directors to indicate their preferences among various treatment options. Results are below:

Refer back to primary care physician: 28%  
Prescribe an SSRI: 23%  
Prescribe a benzodiazepine: 22%  
7% first choice, 8% second, 7% third  
Recommend general psychotherapy: 31%  
8% first choice, 16% second, 7% third  
Recommend cognitive behavioral therapy: 9%  
4% first choice, 1% second, 4% third

All of the training directors believed that a significant minority of their patients (ranging from 4% to 10%) presented with panic disorder, with gastroenterologists consistently reporting the highest numbers. Hours of training currently provided across 4 years of residency training ranged from none at all to 3 hours, with the majority reporting none or 1 hour of training. All of the respondents rated the value of further training fairly highly, noting that it would be either "somewhat" or "very" helpful. Not surprisingly, the percent of patients seen was significantly positively correlated with the perceived value of further training ( $r = .42, p < .001$ ).

## Discussion

Our results suggest that increased training on the topic of panic disorder, including cognitive-behavioral models and interventions, would not only be welcomed, but

could have an enormous impact. All respondents, regardless of specialty or number of panic disorder patients seen, rated the value of further training fairly highly. Although gastroenterologists report that over 10% of their patient population likely suffers from panic disorder, GI residents receive less than an hour, on average, of training on the subject of panic disorder. The training that residents do receive is often no more than a lesson in differential diagnosis, and rarely includes education about cognitive-behavioral models of etiology and/or treatment. In fact, most residents learn that panic disorder is a result of biological abnormalities.

The good news is that at the cutting-edge of academic training, 40% of respondents already train their students to recommend some form of psychotherapy, and almost 25% recommend the use of an SSRI. The bad news is that almost 1 in 4 still recommend prescribing a benzodiazepine, while only 9% of responders train their students to recommend cognitive-behavioral therapy. Despite demonstrated efficacy, cognitive-behavioral interventions are almost never recommended as a first choice treatment. Many training directors simply tell their students to turf these difficult patients back to their primary care doctor with no other intervention or recommendation.

Doctors in these various specialties are perfectly situated to detect panic disorder and recommend appropriate treatments for patients, yet the results of this survey suggest that most specialists are failing to capitalize on this opportunity. Some residency-training directors were quite enthusiastic about the idea of educational interventions, and replied with lengthy responses indicating their receptivity to incorporating additional training about panic disorder into their curriculum. Respondents often requested further information, and several local programs spontaneously extended invitations to the authors to deliver

lectures on panic disorder to their residents during grand rounds.

Given the dearth of appropriate training in regards to panic disorder, we have an enormous opportunity for collaboration with these specialists in order to better serve our joint patient population. We believe that such training falls under the mandate of AABT's Committee on Academic Training. Our proposal is that we establish a national database of interested residency training programs and AABT members who would be willing to deliver periodic grand rounds and training workshops on the diagnosis, etiology, and treatment of panic disorder in their locality. If desired, the committee could supply speakers with training materials (PowerPoint slides, talk outlines, handouts, etc.) specifically geared to the medical specialty in question. We would be most eager to have interested colleagues contact the first author at [mhunt@cattell.psych.upenn.edu](mailto:mhunt@cattell.psych.upenn.edu)

Eventually, we hope to demonstrate empirically that increasing the amount and quality of training improves patient outcomes. With that information in hand, we will be better able to incite all relevant programs to take part in our initiative and hopefully generate a significant improvement in panic disorder patient care.

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## AABT People

AARON BECK is the winner of the 2004 University of Louisville Grawemeyer Award for Psychology.

BARRY EDELSTEIN is President-Elect of APA's Division 12 (Society of Clinical Psychology), Section 2: Clinical Geropsychology. ✍

## The CEO Theory of Catastrophic Misinterpretations and Panic: A Cognitive Executive-Control Economic-Organizational Model

Ronald Ley, *University at Albany, State University of New York*

The catastrophic cognition theory that proposes that catastrophic misinterpretations of normal bodily sensations are the cause of panic attacks (e.g., Clark, 1986) is widely accepted by clinical psychologists in both research and treatment (space limitations prevent a complete list of references). Although cognitive theories of executive control of thought and action have been studied in many areas of psychological research (Logan, 2003), the homunculus paradigm has not been applied to cognitive theories of panic. The primary purpose of the present paper is to provide a cognitive executive-control theory to account for the cognitive processes that produce catastrophic misinterpretations and thereby evoke panic attacks.

The secondary purpose of the present paper is to use the CEO theory as an illustration of a maxim widely accepted in so many cognitive explanations of clinical phenomena. The maxim is formally stated here as an axiom, namely, that *a creative rearrangement of names yields meaning in cognitive systems* (ACRONYMICS). The heuristic value of acronymics, so clearly illustrated in the literature of the postrevolutionary years of clinical-cognitive theorizing, is commonly understood among researchers and clinicians. However, this article is the first to

present a formal statement of the axiom in the literature that marks the advancement of clinical cognitive psychology. Clinical reports and papers are sure to follow.

### The Theory


The catastrophic misinterpretation in panic is a consequence of a deranged cognitive editing operator (CEO). The derangement is a psychopathological outcome of cognitive imbalance that occurs when stress disrupts the mind-body flow system (MBFS). If this imbalance causes sufficiently acute and severe disruptions in the MBFS, the cognitive organizational board (COB) reduces cognitive remuneration (CR) thereby inducing cognitive dissonance (CD). The reduction in cognitive remuneration diminishes the cognitive belief system (CBS) of the CEO. The result of this diminution initially causes relatively small-scale catastrophic misinterpretations by the CEO which in turn trigger a reevaluation of the CEO's cognitive processing decision-making stability by the cognitive assessment division (CAD) of the COB. A negative assessment results in a proportional reduction in the cognitive remuneration to the CEO which in turn induces greater cognitive dissonance in the CEO

and thus an increase in the magnitude of subsequent catastrophic misinterpretations thereby creating a vicious cycle. As the momentum of the cycle increases the ultimate result is a deranged CEO. This is the critical point at which an otherwise normal bodily sensation will be catastrophically misinterpreted and a panic attack will occur.

### Treatment

Treatment for panic follows logically from the proposed theory. Since disruptions in the mind-body flow system are part of everyday living, the deranged CEO's cognitive belief system must be restructured to accommodate reduced cognitive remuneration from the COB. In so doing, the intensity of misinterpretations of normal bodily sensations will be reduced, low evaluations from the cognitive assessment division will be obviated, and harmony will replace cognitive dissonance. Normal bodily sensations will continue (painful though they may be) but misinterpretations will not be catastrophized by the remediated cognitively correct CEO and, therefore, panic attacks will not be reported. Furthermore, the cognitive restructuring procedure derived from the theory will be more efficacious than other procedures because the psychotherapist assumes the role of the Governing Organizational Director. To paraphrase a leading catastrophic-misinterpretation cogitator: "It's all in the head."

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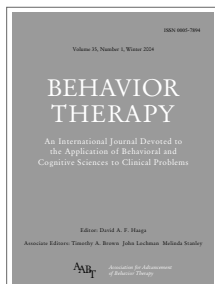
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## New Conference on Innovations in Trauma Research Methods (CITRM) Invites Program Input

Lynda A. King and Daniel W. King, *National Center for PTSD and Boston University*

A new yearly Conference on Innovations in Trauma Research Methods (CITRM) recently was funded by the National Institute of Mental Health, with supplementary support provided by the Department of Veterans Affairs, National Center for Posttraumatic Stress Disorder. The purposes of CITRM are to enhance the training of novice researchers, particularly underrepresented minority researchers; develop creative solutions to design and analysis issues; enhance diffusion of innovative research methods and designs from other disciplines; and explore ethical dilemmas and possible solutions in trauma research. The authors of the grant application and Executive Planning Committee for CITRM are: Lynda King and Daniel King (both from the National Center for PTSD and Boston University), Jeffrey Sonis (University of North Carolina Medical School), and Elisa Triffleman (The Public Health Institute, Oakland, CA, and Yale University School of Medicine).

With the endorsement of AABT's leadership, the first CITRM meeting is scheduled for November 17–18, 2004, in New Orleans, just prior to the 2004 AABT conference and at the same conference site. Its theme will be "Methodological Issues in Addressing Mass Disaster and Terrorism." CITRM activities will be directed toward researchers at all levels. The conference will include an Advanced Design and Methods Workshop, a Statistics Workshop, a Manuscript Preparation Workshop, and an Ethics Workshop. There will be formal and informal networking opportunities and a yearly Career Issues Panel for novice researchers.

CITRM will aim for a high degree of interaction among presenters and participants over a 2-day period in a small, cohesive setting. In this regard, the conference will offer two special features: a Methodological Think Tank and a Dissection of Innovative Studies sessions. For the Methodological Think Tank, an invited researcher will present an important

and thorny research dilemma to a panel of experts in design and quantitative methods, who, with audience participation, will then brainstorm and make recommendations. For the Dissection of Innovative Studies session, a methodologically innovative, published study will be selected, and its chief author will be invited to speak at CITRM on how the investigators dealt with the study's methodological hurdles and arrived at their innovative solution.

CITRM's Executive Planning Committee invites nominations from the field regarding the content of the Methodological Think Tank and Dissection of Innovative Studies sessions. In particular, nominations for a design, statistics, or measurement dilemma to be the topic of the Methodological Think Tank and for a recently published innovative study to be the focus of the Dissection of Innovative Studies session, both preferably reflecting the theme of the 2004 conference, are being sought. Additional details on the nomination and selection process may be found at [www.citrm.org](http://www.citrm.org), along with further information on conference content, registration procedures, and available travel stipends. Any AABT member who has suggestions or wishes to be involved in conference planning may contact [lking@theworld.com](mailto:lking@theworld.com). ✍

## Moving Poster Dissemination Into the 21st Century

Andy Lopez-Williams, *University of Washington, Public Behavioral Health and Justice Policy Division*

In an article published in the October issue of *the Behavior Therapist*, Moran and Terjesen (2003) discussed the problems associated with dissemination of poster presentations at conferences. Based on several studies, they concluded that the "return rate for reprint request remains low despite creative ways of increasing request compliance," and thus, "the most simple and courteous method of disseminating poster information . . . is to provide the reprints at the convention" (p. 376). I disagree with this suggestion and believe that although it may be among the most simple, it is not the most effective. In fact, unless the presenter brings enough copies for everyone, this system is highly ineffective as noted by Moran and Terjesen (2003). Such suggestions fail to draw upon the widespread availability of computer and Internet technology and fail to place due responsibility on the conference attendee.

First, consider the issue of responsibility. As noted by Moran and Terjesen (2003), the rate of honored requests for reprints of conference posters was about 50%. I believe that the reason stems from the majority of responsibility for dissemination beyond the poster presentation being placed on presenters. It is likely that most presenters fail to comply with requests for reprints due to a lack of salient consequences. There are probably few, if any, immediate punishments for not honoring requests (although, one might get a nasty reminder via e-mail or postal mail), and the rewards of being a good citizen of the scientific community may not be potent enough to overcome hectic daily schedules and forgetful minds. By shifting the responsibility from the presenter alone to being shared between presenter and attendee, we will likely increase the rate of interested attendees receiving copies of poster presentations. Presenters can be responsible for providing access to their presentations, and consumers can be responsible for obtaining the information if they so choose. My system fosters this shared responsibility while overcoming the

potential limitations of providing paper copies by using current technology.

Beginning in 1999, I began uploading a copy of my conference presentation onto my Web page prior to attending the conference. During my presentation, I displayed the Internet address prominently on my poster and also provided labels with the Internet link address for conference attendees to take with them. Interestingly, many of my peers were outwardly amused and remarked that it would never work. However, following the first implementation of this system, it was clear to me that it was very effective. Many people were pleasantly surprised when I advised them that a copy could be downloaded from the Internet. Many people made comments expressing how innovative, simple, and convenient they found the system to be. There were a few who frowned on this system. When I informed one attendee that I did not supply paper copies but that he could download one from my Web page, he looked rather displeased and grumbled that he didn't have time for that. He didn't have time for that? Wasn't the information important to him? If he didn't have time to download it, how would he ever find the time to read it? In my opinion, had a paper copy been supplied to this person it would have likely gone unread—an outcome that I do not think is unique.

There are many benefits of my system for attendees and presenters. Presenters incur no extra workload than preparing paper copies and no costs (the cost is distributed among those who download the paper) and do not have to concern themselves with requests for reprints. Attendees are not prisoners of the coin-flip chances of having their reprints request honored; they become masters of their scientific knowledge destinies. Third, there are no extra papers to carry home for presenters or attendees. When attendees arrive home and are ready to read the information, they can simply download it.

This system may not be for everyone. There are those who may not have access to

the Internet, do not have a Web page, or lack the computer knowledge to implement this system. However, in today's technological atmosphere, these barriers are easily surmountable for those interested in implementing this system. I believe that this system has the potential to be much more effective than the current system advocated by Moran and Terjesen (2003), and can easily be extended to other conference presentations (e.g., symposia).

### References

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**POSTDOCTORAL POSITION IN COGNITIVE THERAPY.** Beginning August 2004. Commitment to the CBT model is essential. Applications will be accepted until a suitable candidate is found. Send a Vita, statement of experience and interest, and three letters of reference to Dr. Robert Leahy, Search Committee, American Institute for Cognitive Therapy, 136 East 57th St., Suite 1101, New York, NY 10022. [www.CognitiveTherapyNYC.com](http://www.CognitiveTherapyNYC.com) or email to [Leahy@CognitiveTherapyNYC.com](mailto:Leahy@CognitiveTherapyNYC.com).

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## 2004 Call for Nominations

The first phase of AABT's 2004 election process is under way: the nomination of qualified full members for the positions of President-Elect (2004-2005) and Representative-at-Large (2004-2007).

**Run for President-Elect or Representative-at-Large!** You can make a difference in the future of AABT. Nominate yourself and one of your colleagues. You must be a full member of AABT to be nominated. **Only those nomination forms bearing a signature and postmark on or before February 2, 2004, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to AABT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of AABT members in important policy decisions in the coming years. Contact the Nominations and Elections Chair for more information about serving AABT or to get more information on the positions. **Please complete, sign, and send this nomination form to Carrie Winterowd, Ph.D., Associate Professor, School of Applied Health and Educational Psychology, 434 Willard Hall, Oklahoma State University, Stillwater, OK 74078.**

## NOMINATE the Next Candidates for AABT Office

*I nominate*  
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*For descriptions of President-Elect and Representative-at-Large,  
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