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International Scene

The Way We Were, the Way We Are: Cultural Evolution of Cognitive Therapy

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This article explores the cultural evolution of cognitive therapy from a modernist and postmodernist perspective. It is the main assumption of this article that cognitive therapy, along with psychology and psychotherapy, is deeply influenced by the particular cultural framework or zeitgeist. Each cultural moment will have some influence on several interrelated important issues of cognitive therapy, such as the cognitive technology defended, the roles therapists and patients play, and the specific kind of therapeutic relationship recommended. It is hoped that a cultural understanding of cognitive therapy will provide a description of how cognitive therapy has reached its present state and help us to anticipate future developments.

The Cultural Framework

Culture is composed of several main elements (Giner, 1969, p. 77): (a) cognitive elements that correspond to our knowledge; (b) ideology composed of beliefs; (c) values; (d) norms, which rule and frame the values; (e) signs implying language as the most important symbolic network; and finally (f) nonnormative behavioral ways, for instance, one's particular personal style.

It seems easy to translate all of the above into our conceptualization of psychotherapy; that is, any psychotherapeutic system offers us knowledge about psychopathology and mental health, human beings, and so forth, representing a specific ideology, prescribing what should or should not be done (the specific interventions, rules, and

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techniques), and it is a kind of work both for patient and therapist structured and framed by language. Finally, we practice psychotherapy with a particular behavioral style.

Let's assume that cognitive therapy is a changing scientific discipline, reflecting a particular cultural and historical moment. In this sense, each historical and cultural moment is characterized by different attitudes, values, worries and needs, representing a specific epistemology and ontology. The human being is a social and cultural product.

Each therapeutic approach is embedded in a cultural context. As psychotherapists, we inherit, and equally construe, a particular point of view about the human beings we work with. This reflects how we behave as active participants. Its combination produces or develops into a specific therapeutic context. Some assumptions inform this cultural analysis:

1. Cognitive therapy is a relevant psychotherapeutic model, which has evolved in different approaches. However, we could assume that cognitive therapy is practiced nowadays through three main models with different aims, definitions (Clark, 1995; Hollon & Beck, 1994), and metaphors (Meichenbaum, 1995): restructuring, cognitive-behavioral, and constructionist/constructivist models.

2. We could establish three main cognitive therapy phases (Caro, 1995, 1997). The first one is called "cognitive therapy is in the air," the second phase is "the cognitive establishment," and the phase we are living in now is "a happy cognitive world."

3. We will use two labels for this cultural analysis: modernism and postmodernism. We will focus on the modernist antecedents of cognitive therapy as the cognitive model originated in this epistemological and cultural background, while its development is better understood from a postmodern paradigm.[1]

4. Although differences and commonalities among cognitive models will require another paper, our assumption here is that restructuring and cognitive-behavioral models seem to be closer to a modernist perspective, while constructionist/narrative models seem to be closer to a postmodern one (Caro, 1995, 1997).

Modernist Antecedents of Cognitive Therapy

As a human system, psychology corresponds to modernity. As Kvale (1992) pointed out, psychology was founded on a conception of individual subjects who have internal *souls*—later to be characterized as internal psychic apparatuses. In the center of the modernist perspective lies the heady and optimistic romance with foundation and essence (Gergen, 1992). Modernism adds to the artists' and writers' accomplishments the development of psychology, understood as the internalization of the grand narratives (Parry, 1993). In this sense, psychology and the main psychotherapeutic systems appeared with the aim of being a grand narrative based on science. So, from its very beginning, psychology tried to be a scientific discipline. All psychological disciplines are a consequence and extraordinary examples of some of the main modernist characteristics (see, for instance, Gergen, 1992; Kvale, 1992; Parry, 1993). However, as Parry (p. 441) pointed out, psychology also contributed to the development of modernity: "psychotherapy also shares a great deal of responsibility, for the singularity of focus on the inner person and his or her personal satisfaction almost as life's summum bonum."

So the individual was the consequence of modernity. The individual does not emerge only through psychology. Modernism gave us a culture of personality, about the self (Lipovetsky, 1983), which is reflected in the works of Joyce, Proust, Faulkner, Baudelaire, Van Gogh, Matisse, and Picasso. They exemplify the fragmenting soul of the artist, mirroring the inner world of the artist. The writers challenged and sought to subvert a society that had gained the world but was losing its souls in the process. They portrayed their inner torment and uncertainty, expressed symbolically, metaphorically, and, as in Joyce and Proust, minutely (Parry, 1993).

The concept of madness originated in this period (E. Ibáñez, 1993). Modern psychology had considered the self as healthy or alienated. Psychology argued that the self could be isolated, observed, diagnosed and improved (Gottschalk, 2000). Following the Enlightenment, it was assumed that any individual has an inner space, full of rational abilities, sensible enough for observing and capable of making conscious elections (Gergen, 2000a).

[1] This is a tentative classification useful for exploring the cultural evolution of cognitive therapy. As all classifications, it neglects many important issues and possibilities.

However, modernity showed a deep gap between two cultures: popular and elite. The diagnoses of the modern psyche and its times by the artists and writers of modernism have remained impenetrable to the general population, which prefers popular culture (Parry, 1993). The development of psychological and other scientific disciplines produced incredible technological advances, which contributed to the gap between the experts and the lay people.

The First Phase of Cognitive Therapy: Cognitive Therapy Is in the Air (mid-1950s to 1980)

Although some historical reviews have shown the ancient antecedents of cognitive therapy (see for instance, Beck, Rush, Shaw, & Emery, 1979; Dryden & Ellis, 1988; Ellis, 1962), the first cognitive works began at the middle of last century, with the first cognitive therapy works of Ellis (1958) and Beck (1963, 1964). It includes the first main study on efficacy (Rush, Beck, Kovacs, & Hollon, 1977) and it finishes, from our point of view, in 1980 with the first within-the-model criticisms of cognitive therapy from Mahoney (1980). At that time, cognitive-behavioral models, such as the work in problem-solving from D'Zurilla and Goldfried (1971) and of Meichenbaum (1977) in the stress inoculation training, were developed.

The First Phase of Cognitive Therapy From a Cultural Perspective

The first phase of cognitive therapy is an example of some of the main modernist characteristics: an identifiable subject matter, the belief in the theory and the development of the cognitive model as a grand narrative. In this respect, the application of the empirical method and the consideration of research as a progressive matter were of great influence. Also, rationalism is a core issue here.

Although there is some controversy (see, for instance, Beck, 1984; Ellis, 1984, 1985; Kovacs & Beck, 1978), we can describe restructuring and cognitive-behavioral models as rationalist models. Rationalism (in Mahoney, 1991, p. 38) bases knowledge and knowing in reason and formal, logical thought, while senses are illusory and inferior to reason. The rationalist point of view implies a specific conceptualization of human beings and, accordingly, a specific definition of the scientific role. This scientific role reflects the gap between the expert and the lay culture. This could be exemplified in the kind of therapeutic relationship and in the aims of science.

The modernist person. Cognitive therapy developed the Cartesian dictum *I think, therefore I am*. Human beings know through rational processes. Any failure in these processes can "cause us some problems." The modernist person, according to cognitive, as well as behavioral and psychodynamic, models, is represented as a mechanism that needs to be fixed from time to time (McLeod, 1997). From this mechanistic point of view a great importance is given to rationality, control and risk canceling.

For the modernists (see Parry, 1993) a person does not know his/her own mind and needs help from psychological experts to understand and change him/herself. From this perspective, human beings are both object and subject of study. In cognitive terms, this means that they are objects, as the cognitive work focuses on all the "cognitive production" of an individual (and the corresponding feelings) in terms of cognitive

events, processes and structures, and subjects as patients are active agents for their cognitive change. This distinction between object and subject implies:

1. Human knowledge could be studied and analyzed.
2. The cause of psychological problems is erroneous knowledge.
3. This erroneous knowledge could be isolated, measured and modified.
4. We should follow human rational mechanisms as guidelines for modifying knowledge.
5. Knowledge could be objective, free of values.

Obviously the rationalists have never neglected the relevance of feelings and emotions (see Beck, 1985), but if we look closer at the cognitive work in these first-phase models we could conclude that the perceived problem lies in intensity and negativity of emotion and affect. In this sense, reason is the tool to get the desired therapeutic change.

The modernist scientist. For Cushman (1992), industrialization, urbanization and secularization renewed the interest in the physical world, the humanities, science, commerce and rationality. And the person became more mobile, less constrained by tradition and religion, less confined by role, and less predictable. As Foucault (1975) explained, this self became isolated, less communal and more individualistic, more confused about what is good or bad. Self-consciousness developed, creating individuals who were able to observe themselves, reflect upon their nature, think about what they hide or manifest, and speculate about their real being and identity. A narrative emerged (implicit at the first formulations of cognitive therapy) which separated the body from the soul, the subject from the object, and reason from emotion.

The Panopticum was the metaphorical example offered by Foucault. The Panopticum, a prison designed by Bentham in the 18th century, had the aim of increasing in the prisoners the following: the tolerance to be observed, the tendency and capability to observe themselves, the pressure for being "normals," the tendency to practice self-observation and conscious behavioral change. The Panopticum was the perfect symbol for a new social order. But how could we have access to the private domain?

The cure technology. All cognitive therapy works with rational individuals, encouraging rational attitudes, helping the individuals observe, control and regulate themselves. As examples, we have Socratic dialogue, REBT, hypothesis testing, and the analysis of faulty reasoning. Cognitive therapy, for instance, implies the identification of thoughts and feelings and, thereafter, the modification of negative thoughts through techniques such as guided discovery, Socratic questioning, behavioral experiments or behavioral strategies for solving problems (Wills & Sanders, 1997). In Nezu's approach on problem-solving therapy (an example of a cognitive-behavioral model), the therapeutic procedure encompasses problem orientation, problem definition and formulation, generation of alternatives, decision making, solution-implementation and verification (A. M. Nezu, Nezu, & Perri, 1989; C. M. Nezu, Nezu, & Houts, 1993). Again, we see rational questioning where patients are subjects and agents of their treatment who detach themselves from problems in order to apply what they are learning in therapy.

The cognitive therapist at the first phase. The connection among the modernist scientist, the person conceptualization, and the cognitive therapist in this first phase is the lynchpin for describing therapist characteristics and optimum therapist effectiveness (see, for instance, Beal & DiGiuseppe, 1998; Bernard, 1991; Liese & Alford, 1998). According to Newman (1998) a cognitive therapist practicing Beck's model should formulate and test hypotheses; develop a patient's hope and coping skills; listen and communicate; use systematic problem solving; and establish and reevaluate therapeutic aims.

The Cognitive Therapy Scale (Young & Beck, 1980) establishes the training and supervision guidelines within this model. Among other things, a "good" cognitive therapist should be able to use the guided discovery to explore problems and help patients to reach their own conclusions. Also, therapists should be able to review the homework assigned and properly design it for the next session. The aim of this homework is to help patients to adopt a new and different perspective (that is, cognitive change), testing hypotheses, experiencing new behaviors, and so on.

Although there are commonalities between Beck's and Ellis' models (Dryden, 1984; Kuehlwein, 1993), the differences in therapeutic roles are quite relevant. In an REBT framework, Grieger (1991, p. 35) described his therapeutic role:

> . . . I practice RET in an energetic, active, directive way; I see my therapeutic role as being more of a teacher and coach than a doctor; I attempt to blanket my clients with emotive and behavioral as well as cognitive techniques; I see cognitive dis-

putation as the major tool of change; and, assuming that people will inevitably slip back to their former pathologies unless they continue to work on themselves the rest of their lives, I emphasize the importance of their learning both the theory and the techniques of RET for future use so that they do not have to rely on me in the future.

Briefly, then, modernists "portrayed individuals as human beings who, by implication, could not have been expected to know their own mind, who were essentially left having to seek out and rely on experts in psychological and mythological interpretation in order to understand themselves, not to mention change" (Parry, 1993, p. 433).

So, cognitive therapy inherited a modernist background,[2] which also influenced its tendency to become a grand narrative, showing its scientific validity, and believing in its contribution to human well-being. At its core, there is a particular kind of human who looks eagerly to be guided in discovering processes and who fits perfectly with the therapist.

The therapeutic relationship. Therefore, with such kind of scientists, persons, and aims, little wonder that cognitive therapists influenced by this inherited modernist zeitgeist, defended a therapeutic relationship where the therapist should be a scientist who guides; the patient should become a scientist who analyzes, observes, and changes; and reason is emphasized over emotion.

When cognitive therapy began, most of its basic issues came from a modernist epistemology that defends a rationalist point of view; splits, rationalizes, and follows the science in relations with clients; aimed for a grand therapeutic approach toward understanding the person; and aimed to be recognized as a relevant and distinctive scientific therapeutic approach, favoring a methodology that came from science and looked for an external legitimacy.

Toward Postmodernity

Cognitive therapy has evolved toward postmodernity with the constructionist and narrative approaches. Timidly, at the end of this first phase, the evolutionary constructionist models criticized the primacy of reason over emotion and favored a radical turn, with different roles for the person and the scientist.

Modernism vs. Postmodernism

Western society has changed. At the beginning of the 21st century we are facing different worlds, cultures, and people (see Rychlak, 2003, for a review). The postmodern culture certifies the death of the subject. The individual is no longer at the center of the universe; instead, it is decentered. The modernist self died (Jameson, 1984), and instead we have saturated and fragmented (Gergen, 1991), empty (Lipovetsky, 1983), or narcissistic selves (Lasch, 1978). We have examples of the postmodern culture throughout the arts, architecture, and the movies. Lyon (1994) described postmodernity using the film *Blade Runner*'s urban decadence, abandoned buildings, crowded markets, pervasive trash, and an unending drizzle. "Replicants" want to become humans and dream about a mother from one photograph. *Blade Runner* pictures postmodernity as it questions reality itself. As Lyon says, postmodernity enlarges or exag-

[2] Clark, Beck, and Alford stated (1999, p. 62): "cognitive therapy adopts a realist and modernist epistemology as opposed to an antirealist and postmodern perspective." It could be said differently, but not clearer.

gerates some of the modernist characteristics, while criticizing others.

The film shows a new organizational order that centers around knowledge instead of work and capital. Knowledge has become a business. Genetic engineering makes human simulacrum possible. The replicants exist in a world that has conquered time and space. In the future Los Angeles, different cultures coexist. Third-world persons are part of the postindustrial proletariat; women and minorities are no longer "other," giving postmodernity its societal referents. Postmodern individuals live in a great consumer society, where everything is a show and public image is the only important thing (Bruckner, 2000).

From the elitist and modernist culture we have evolved into eclecticism, where anything goes. From the essential and basic lines, from the efficient, pragmatic layout of mass and space, postmodern art emphasizes the aesthetic over the functional (Rosenau, 1992). Finally, from the critical, anti–middle class and innovative modernist vanguard we see art where everything goes, being oneself is all, and where art objects are not the objects themselves, but their commercial facsimiles, as Warhol's works showed.

The Second Phase: Cognitive Therapy Establishment (1981 to 1991)

In the second phase of the cognitive therapy evolution, from 1981 to 1991, restructuring and cognitive-behavioral models increase their relevance and applicability. We see the popularization of cognitive therapy through all kinds of psychopathologies and a profusion of handbooks and self-help books. Publications such as Mahoney's (1991) *Human Change Processes* and Guidano's (1991) *The Self in Process* exemplify a different cognitive therapy perspective and a scientific turning point (see Guidano, 1987; Guidano & Liotti, 1983; Mahoney, 1988; and Safran & Segal, 1990). The postmodern culture was described (Habermas, 1981; Huyssen, 1981, 1984; Jameson, 1984) and reviewed (Pinillos, 1997; Simons & Billig, 1994). Gergen (1991) published one of the best introductions to postmodernity in psychology, *The Saturated Self*, at the end of this second phase.

The Second Phase of Cognitive Therapy From a Cultural Perspective

The postmodern turn in cognitive therapy promotes a constructionist point of view. It recommends a change in the scientist role, eliminating the split between the professional and lay culture, making everybody an expert.

The postmodern person. In psychology, postmodernity questions the conscious, logical and coherent subject. Postmodernity certifies the death of the modernist subject as a rational, unified, self-organized person, considering it instead as multiple, contradictory, and largely irrational (Rosenau, 1992). The old concept of "individual" no longer exists (Gergen, 1991). Even in an extreme behavioral zeitgeist, psychology defended some degree of behavioral consistency and the existence of an "ego," which integrated the behaviors and psychological processes of a given person (E. Ibáñez, 1993). In postmodernity the self is seen as a constraining cultural imperative, as a product of power/knowledge relationships framed in language games and ideology, a conversational resource, a story that we tell ourselves and others, a moment-by-moment construction embedded in a set of ongoing relationships (Gergen, 2000a; Gottschalk, 2000).

Postmodern selves are saturated, fragmented, empty. Contrary to the modern person, "boundedness, coherence, and consistency are impossible and irrelevant characteristics of the self" (Lyddon & Weill, 1997, p. 77). As Gergen said (Lyddon & Weill, 1997, p. 78), "We communicate, therefore I am."

Is the subject dead in cognitive therapy? The main issue is that in a therapeutic context the subject, the patient, is "real and necessary." As Kristeva said, How can we make therapy without a subject? (Rosenau, 1992). What kind of subject is behind postmodern cognitive therapy? Although there is no agreement in postmodern psychological theories about the self (Gergen, 2002), from a strict clinical perspective, therapists face a human who changes but maintains some degree of consistency. It seems that constructionist and narrative cognitive models, which were introduced in the second phase and developed in the third phase, were specially devised for dealing with this saturated or fragmented self (see Mahoney, 1993).

Recently, Neimeyer and Raskin (2001, p. 396) established five main varieties of constructivism: psychotherapy as a "personal science," as a "developmental reconstruction," as a "radical questioning," as "narrative reauthoring," and as "discursive critique." Humans in a constructivist perspective are better described by a narrative than a rationalist view because persons look for a coherent story, a story "they know to be true in their lives" (Russell, 1991, p. 244).

This quest for coherence (Guidano, 1991) is embedded in William James' *I–Me* distinction. "I" refers to the self as subject, to the inmediate experience of oneself, while the "Me" refers to the self as object, that is the self that emerges as a result of abstractly self-referring the ongoing experience (see Guidano, p. 7). The existential crisis arises when "Me" does not recognize "I," that is, when we are unable integrate our experiences. If the problems of patients are considered as texts and patients are readers construing multiple meanings, postmodern therapists will assume that the stories a patient tells in therapy are constructed narratives, an inseparable mixture of construction and event. These accounts must be judged in terms of narrative rather than historical truth (Burr & Butt, 2000).

Although in a constructionist/narrative perspective "the objective is not anymore to substitute thoughts and emotions but to allow the possibility of expanding and actualizing multiple worldviews, meanings and emotional experiences" (Gonçalves, 1997a, p. 106), it is also true that postmodern therapy implies a subject who is able to give sense and coherence to the stories. Guidano (1987, 1991) explains the development of the person through self-organization, which structures our identity and the consequent feelings of unity and historical continuity. The maintenance of this identity is a core aim for all of us (Guidano, 1987). Guidano, in his 1991 work, keeps this principle as the basic one for preserving the identity and integrity of the human system. Mahoney (1991) assumes a similar point of view: ". . . the self is a complex and dynamic metaphor for the unique and spontaneous self-organizing processes that are each person in his or her step-by-step, moment-to-moment becoming" (p. 224).

The "self" in this postmodern cognitive zeitgeist could be a metaphor, but it has some basic functions. A narrative and constructionist therapy still needs a human being who observes, reflects, and thinks. So, the narrative or constructionist therapist demands patients to focus on their selves and in all kinds of self-related problems. Guidano (1991) described self-observation as the basic therapeutic tool. Throughout it the patient is able to observe his/her inmediate experience and understand his/her personal meaning organization, in an ongoing reconstruction of significant events.

Does it mean that both kind of cognitive practices, modern and postmodern, are defending the same kind of human being?

Quite the contrary, but we could establish some parallels. Both modernist and postmodern cognitive therapies need a human being who is able to observe him/herself, is able to understand the meaning attached to things, knows a little bit more about him/herself, and changes what is advised in the quest for a "better" functioning. Nevertheless, two main differences arise.

Modernist and postmodern practices involve a different kind of human being. The modernist, through insight and reflection, helps patients to become masters of their own ships (Burr & Butt, 2000). A rational self is the aim. A specifically postmodern psychology helps patients to be more intelligible to themselves and produce self-narratives that allow them to live at peace with themselves (Burr & Butt).

Modernist and postmodern practices give a different treatment to patients' constructions. The modernist practice helps patients to make a more perfect and valid theory of reality, one that fits nicely with data. Postmodernists treat patients' narratives as local, without larger meaning, but only a little piece in a chain of meanings.

Therefore, the aim of the therapy is different. As Hare-Mustin and Marecek (1988) said, modern psychology has long emphasized that what the client says in therapy is only a narrative, a story, never a real representation of any actual experience. Postmodernists will agree. But while the modern therapist's role might be helping clients to sort things out, get below the surface, and achieve a more adequate understanding of reality, the postmodern therapist has no such aim. There is no true reality out there to be discovered. Therefore, the postmodern therapist merely "disrupts the frame of reference" and "manipulates meanings" by referring to marginalized subtexts, to alternative interpretations; meanwhile, the therapist "changes the clients' meanings" (Hare-Mustin & Marecek).

If individuals have difficulties narrating and framing their experiences, the new postmodern cognitive therapies help them develop alternative narratives and metaphors in their quest for sense. For instance, cognitive-narrative psychotherapy from Gonçalves (1997b) helps patients be good "readers" of their problems ("texts," in this context) through different and related therapeutic phases with the aim of giving sense and coherence to their lives and their problems translated into a prototype narrative. Guidano's (1991) moviola technique helps patients develop their self-observation processes, focusing on their problems as stories that should be construed and reconstrued. These aims require, obviously, a different kind of therapeutic relationship.

The Therapeutic Relationship in Postmodern Cognitive Therapies

As Rosenau (1992) stated, the postmodern reader is an actor-receiver, a participant observer, and an observing participant all at once. The therapist's role diminished and the client, through constructionist and narrative cognitive approaches, has a more relevant role.

"Because of his/her assumed superior position, the [modernist cognitive therapist]'s role is to educate, instill moral values, or enlighten the reader" (Rosenau, 1992, p. 27). The postmodern therapist comes to be an interpreter who claims no universal truth and has no prescription to offer (Rosenau, p. 31). Postmodern cognitive therapies give primacy to the client, who is helped to become the interpreter of the text, his life.

The typical postmodern cognitive style reflects a great collaboration between patients and therapists in terms of narratives or stories. As Gergen and Kaye (1992, p. 162) said, "When people seek psychotherapy they have a story to tell." Then, the development of meanings and alternative descriptions is the aim (Biever, de las Fuentes, Cashion, & Franklin, 1998).

These postmodern models do not assume the existence of an objective, external reality, and, consequently, the possibility of a valid and precise knowing. Instead of being a guide, the therapist is an escort in discovering more viable ways of knowing. The therapist does not play an authoritarian role; instead, the therapeutic relationship is characterized by a therapist-client epistemological balance (Joyce-Moniz, 1985).

The Third Phase of Cognitive Therapy: A Happy Cognitive World (1992 to the Present)

We are living in a "happy cognitive world." In the last decade of the 20th century and the beginning of the 21st we are experiencing a happy coexistence of the three main cognitive therapy metaphors—information processing, conditioning, and constructive narrative (see Meichenbaum, 1995, for a description).

In this third phase we could see the ongoing relevance of restructuring and cognitive-behavioral models and the remarkable presence of constructionist and narrative models as well as some clear postmodern traits.

The postmodern culture is a consumer culture. Everything is consumed, including statistics, truth, and knowledge. Post-

modern consumers are well informed, and are agents of technological advances. We see that psychology is a commodity. Lay people organize themselves around specific groups, which replace traditional experts. We are not referring to groups such as Alcoholics Anonymous, but about groups such as Hearing Voices Network, which challenges the reality of mental illnes and redefines hallucinations (see Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995).[3]

Western psychological practice is coherent with our postmodern world (Seoane, 1996); that is, authority arguments are "out" and our society feels more comfortable being able to choose between different little models (T. Ibáñez, 1993). This third phase exemplifies, according to Lipovetsky (1983), that we consume consciousness. Everybody surrenders to self-exploration by the most diverse means: Zen, group dynamics, yoga, meditation, energy liberation, and so on. Psychotherapy has become an integral element of our culture.

Our professional lives have been framed in constructs such as identity and "personal realization." Our everyday life has been transformed into a set of events that should be analyzed, understood, and controlled. Relationships, or their absence, are seen as the cause of private and social illnesses. Everything "causes" us stress. As a consequence, we experience the pathologization of our everyday life (Burr & Butt, 2000; Lipovetsky, 1983; Rose, 1989). So, psychology has developed itself into a tool and is able to attach a label to anything that stresses us or causes problems: PMS, post-holiday depression, or addictions to chocolat, sex, or the Internet. No doubt that cognitive therapy popularization and development is contributing to this, becoming part of the psychological collage. Assuming that we are living in a "happy cognitive world," we could state that cognitive therapy reflects a modernist-postmodernist collage. Cognitive therapists are able to choose among different ways of practicing (see Ellis, 1997).

A further example of this collage is seen in the scientific framework of cognitive therapy research (see Caro, 2002). Cognitive therapy shows examples of a verificationist, justificationist, and paradigmatic (based on the hypothetical-deductive method) modernist science (i.e., Lyddon & Jones, 2001), and examples of a postmodern scientific attitude: nonverificationist, nonjustificationist and narrative (based on hermeneutics; see, for instance, Gonçalves & Machado, 1999).

Cognitive therapy evolves toward eclecticism, one of the main elements of postmodernity. For instance, new cognitive therapy models use techniques from gestalt, other humanistic approaches, behavioral ones, etc. In this sense, they are more eclectic than integrative models,[4] culling techniques from other approaches, keeping the main theoretical differences between cognitive therapy and other therapeutic models.

Recent work shows this. Neimeyer and Feixas (1997) merge gestalt techniques with Kelly's role therapy, and Mahoney (1991) developed a wide constructivist therapeutic system using behavioral homework assignments, embodiment exercises, psychodrama, mirror time, stream of consciousness, and narrative techniques. Specific characteristics and limits between the cognitive therapy model and other models are beginning to disappear, and cognitive models reflect new demands upon psychology framed in a postmodern context.

Conclusion

If cognitive therapy keeps its distinctive or differential traits from other therapeutic models it could be a collage but never a pastiche. Cognitive therapy is a popular model. If cognitive therapy goes along with "the times," it could risk transforming itself into some kind of psychological fast food in its high degree of manualization and search for therapeutic recipes.

If a greater postmodernization occurs, cognitive therapy could lose its identity as a model that offers a different conceptualization of human problems in relation to meaning and knowing processes. This model developed a set of specific therapeutic techniques. If this a priori identity is lost, cognitive therapy could lose its unique flavor. Time will tell!

Cognitive therapy, through its three main models and through the two epistemologies that we have used in this paper, is giving different answers to the problem of human knowledge, the definition of human beings, our role as therapists. Our cognitive world, a happy one, is a diverse world. Patients enter into therapy with specific demands, problems and needs. Our responsibility as therapists is to be sensibly attuned to them.

We would like to assume that any theoretical or philosophical reflections could give us a sense of what is happening in the cognitive world. Maybe this will make cognitive therapy a complex and coherent model, with a differential identity.

Finally, modernity versus postmodernity should not be understood as a well-delimited dichotomy. We offer it here only as a useful axis to describe the evolution of cognitive therapy from a cultural perspective. It has helped us to frame our theoretical reflections upon cognitive therapy. As a classification it has left out many interesting issues and controversies in cognitive therapy, but we hope it has exemplified how a psychotherapeutic system could change along the sign of times.

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[3] In this sense, as Gergen (2000b) has said, the future of psychotherapy will overcome its traditional boundaries and style of practice.

[4] Following Norcross and Newman's (1992) distinction between integration and eclecticism, cognitive therapy could not be an integrative model; instead, it reflects an eclectic practice (Caro, 1995, 2003).

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PARTICIPATE IN

The Professional Issues

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Election

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Debra A. Hope

At AABT

Update From the Professional Issues Committee

Simon A. Rego, *Professional Issues Committee Chair*

I recently took over as chair of the Professional Issues Committee from Lata McGinn. For those of you who have not heard of us, do not be alarmed! The Professional Issues Committee adopted a new mission statement just 3 years ago. In brief, our mission is to explore and enhance professional issues of interest to behavior therapists and cognitive behavior therapists, with an emphasis on: (a) ongoing communication with the membership in order to identify key professional issues and, (b) developing activities that serve the professional interests of the membership and behavior therapists in general.

Over the past 3 years we have, among other things, worked to establish ourselves within AABT, create a mission statement, and develop a presence on the AABT Web site (which can be reached via a link under the Resources section of the Web site). Having established ourselves within AABT, our goals currently include increasing the membership's awareness of the committee and providing information and resources that are relevant to members and practitioners. As such, I am writing to inform you that we will be posting a series of brief surveys on the AABT Web site in the coming weeks. I encourage each of you to take a few minutes to complete the survey(s) so that we may determine the best way to serve your needs.

I also invite you to consider serving as a member of the committee. The committee currently consists of seven members. We do most of our work over e-mail, and meet once per year at the AABT annual convention. If you have any interest in joining, please do not hesitate to contact me at Simon@Rego.ws. We are particularly interested in adding students, new professionals, and associate members to the committee.

Professional Issues Committee: *Timothy J. Bruce, Ph.D., Sussie Eshun, Ph.D., Vicki Gluhoski, Ph.D., Jonathan D. Huppert, Ph.D., Lata K. McGinn, Ph.D., Deborah Melamed* ✍

Research-Practice Link

Measuring Adherence in Behavior Therapy: Opportunities for Practice and Research

Craig Springer and Linda Reddy, *Fairleigh Dickinson University*

Researchers and practitioners alike have found that treatment adherence has a direct impact on the effectiveness of behavioral, cognitive-behavioral, and psychoeducational interventions (Schmidt & Woolaway-Bickel, 2000). A key proponent of many behaviorally oriented treatments involves training clients in techniques during sessions that can be implemented in natural settings such as the home, community, or school. Often clients are instructed to practice techniques between sessions in order to master the skill and ensure generalization to real-life settings and problems (Burns, Adams, & Anastopoulos, 1985).

For many years the field of medicine has acknowledged that lack of treatment adherence has specific and dire effects on treatment success. Some have even suggested that failure to adhere to prescribed treatment is one of the most important causes of treatment failure and preventable hospitalizations (Dunbar-Jacob, 1993). As a result, physicians have developed various methods for assessing (e.g., monitoring medication levels in clients' blood) and treating lack of adherence. These approaches are integrated into the early stages of medical school training; therefore, measuring and monitoring treatment adherence is a critical component of the standard of care among our physician colleagues. Although behaviorally oriented clinicians are aware of the importance of adherence on a theoretical level, data on between-session adherence are often not present in descriptions of research or practice. This is particularly the case when the intervention involves performing certain actions or cognitive exercises, as opposed to traditional self-monitoring techniques, which are more often documented. Failure to measure treatment adherence in behavioral interventions may be based on the assumption that individual differences, independent of the treatment, explain variable treatment outcomes. The assumption is that clients adequately and equally practiced the intervention between sessions. A more robust analysis would include data on between-session adherence when evaluating variability in treatment outcomes.

This article offers a brief overview of the research trends and benefits of measuring treatment adherence in clinical practice. We also outline possible barriers, solutions, and concerns related to the measurement of treatment adherence.

Research Trends

Only a handful of studies have examined the impact of treatment adherence on client outcomes (e.g., Burns et al., 1985). In general, engaging in between-session practice has been found to yield greater behavioral improvements than noncompliance with homework for the treatment of depression, anxiety, and sleep disorders (e.g., Burns & Nolen-Hoeksema, 1991; Chambers, 1992; Schmidt & Woolaway-Bickel, 2000). For instance, Persons, Burns, and Perloff (1988) found that clients who consistently completed homework as directed improved

three times more than those who were inconsistent or who did not comply with assigned homework. Because many behavioral interventions rely heavily on homework, and adherence seems to affect treatment, it makes sense for practitioners to include methods for assessing adherence.

Few studies have attempted to identify predictors of client adherence. Conoley, Padula, Payton, and Daniels (1994) found the match between client problems and therapist recommendations, the perceived difficulty of the treatment recommendations, and the degree to which treatment recommendation capitalized on client strengths all predicted treatment adherence. MacNaughton and Rodrigue (2001) examined predictors of parental adherence to recommendations for clinic-referred children. Parental adherence was predicted from severity of child behavior problems, ability to recall the recommendations, parental locus of control, satisfaction with the services provided, and perceived barriers to implementing treatment recommendations.

Benefits of Measuring Treatment Adherence

The measurement of treatment adherence enables practitioners to obtain more accurate measures of intervention effectiveness. Information on how clients implement components of treatment can also help to identify mechanisms responsible for behavior change. If improvements are not obtained, adherence data provide valuable information about whether undesired outcomes are a result of lack of adherence to the treatment or a lack of treatment efficacy. Strategies to improve adherence can be used when a lack of adherence is determined to be the cause, whereas modifying the interventions can be used when treatment adherence is not a factor. Monitoring and evaluating treatment adherence also can have a positive impact through motivating clients to more strictly adhere to the treatment regimen.

Barriers and Possible Solutions

Many factors contribute to lack of treatment adherence. For example, problems understanding the importance or utility of using between-session exercises can affect treatment adherence. Moreover, a lack of training in how to implement between-session assignments can negatively affect compliance. Similarly, difficulty determining when to implement a between-session exercise or the belief that the assignment requires more time to implement than one has available can result in noncompliance. Finally, congruence with a client's values can also influence treatment adherence.

Monitoring treatment adherence permits the identification of techniques employed and an exploration of factors related to adherence. If either a lack of motivation or a lack of understanding is found to be the cause of noncompliance, clients can be provided additional training, rationale, and background on implementing the skills necessary for success. The techniques can be retaught in more understandable terms while including concrete examples and modeling each step. Special attention can be focused on training clients on when and where to implement the techniques. For example, if parents use time-out with their children indiscriminately across contexts instead of using it only immediately following a behavior problem, the technique might no longer serve to help the child calm down. Teaching the timing and the contextual factors related to these skills might serve to bolster confidence and efficacy, which in turn might result in greater use of the technique. Timing difficulties can also require exploring client schedules to prescribe specific times and contexts for implementing the techniques. Developing treatment strategies and methods to monitor these strategies can also help to instill a sense of shared ownership in the treatment process.

Issues of Measurement

There are a number of ways to assess treatment adherence. One way of assessing adherence is through the use of direct observation, where a trained observer (e.g., spouse or friend) records treatment adherence for a given period of time in a real-life setting. Direct observation can serve as an objective and reliable method for assessing client use of assigned techniques, as well as provide a fidelity check on the implementation of the technique. A major drawback to the use of direct observation is that resources such as a trained independent are required. Indeed, the accuracy of using observational approaches is contingent on the clarity of target behaviors, the coding instruction, and the specified context observed. This method is also predicated on the assumption that the defined observation period is an accurate representation of the time periods in which the target behavior should normally be implemented. Moreover, the act of observing can be viewed as intrusive to some clients and influences emanating from reactivity should be considered.

Structured interviews are one of the most common and accepted ways of obtaining information from clients. Structured interviews can be used to assess treatment adherence by asking clients standard questions about their use of between-session exercises. Interviews can take place in person or over the telephone. Although structured interviewing is less intrusive than direct observation, there are also some concerns associated with this method. For instance, practitioner and client schedules typically limit the frequency at which information can be obtained. For example, practitioner and/or client schedules may vary due to situational factors and may limit scheduled appointments and interfere with data collection.

Self-report questionnaires are another method for obtaining information on treatment adherence. Self-report questionnaires are cost- and time-effective, do not necessarily require a trained professional, and responses can be objectively scored and quantified. In addition, questionnaires can be designed to be relatively unobtrusive and data collection can be conducted on a relatively frequent basis. While this method has some shortcomings (e.g., inconsistent responding), self-report questionnaires offer a highly practical and useful method for assessing treatment adherence (Reddy et al., 2004; Springer & Reddy, 2004).

Regardless of the methods used to measure treatment adherence, we recommend that specific information be obtained about the implementation of between-session assignments. For example, if a client with an anxiety disorder is trained to use progressive muscle relaxation, then information should be collected during each step of the exercise: (1) applied tension, (2) held it for X seconds, (3) released the tension, and (4) stayed relaxed for X seconds for each of the main muscle groups. The direct and indirect effects of deviating from the treatment regime can then be noted and corrections made.

Conclusion

Measuring treatment adherence in behavior therapy can increase outcome success through promoting meaningful changes in adaptive functioning (Reddy et al. 2004; Springer & Reddy, 2004). As outlined above, treatment adherence data offer an empirical framework for determining whether client outcome is due, in part, to treatment adherence and whether the treatment is a good fit. We argue that treatment adherence can be easily measured in prac-

tice and provide invaluable information to researchers, practitioners, and clients.

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Science Forum

Toward the Dissemination and Acceptance of Behavioral Interventions: Reporting Sample Characteristics

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Theoretical, philosophical, and methodological differences exist among the behavioral approaches and between other theoretical paradigms within psychology. The reporting of the sample's demographic makeup may be a classic example of such differences between orientations. Mainstream psychology has deemed the reporting of demographic variables important (American Psychological Association, 2001) and fundamental for purposes of research replication, generalizability, and external validity (American Psychological Association, 2003; Kazdin, 2003). Additionally, the federal government requires funding applications to specify and include a diverse participant population (Chambless, 2003). The APA Division 12 Task Force on Promotion and Dissemination of Psychological Procedures similarly has deemed it necessary to specify sample characteristics to have an intervention evaluated for its list of empirically supported interventions (Chambless et al., 1998).

Behavior analysis, by comparison, has a tradition of eschewing subject differences in favor of manipulable contingencies (Baer, Wolf, & Risley, 1968, 1987). For example, the focus of the *Journal of Applied Behavior Analysis* (*JABA*) is the application of principles of behavior to social problems while assessing if changes in behavior are the result of a particular behavioral process (Baer et al., 1968). Behavior analysts have traditionally argued against inclusion of these variables on the basis that they are irrelevant to the behavioral principles underlying these interventions.

Based on the above behavioral theoretical orientation and rationale, behaviorist/behavior analysts (*Behavior Therapy* and *JABA*) are hypothesized to report sample characteristics less frequently compared to a more mainstream psychology journal: *Journal of Consulting and Clinical Psychology* (*JCCP*). To assess for these differences, the complete volumes for several years of *JABA*, *Behavior Therapy* (*BT*), and *JCCP* were reviewed to examine the inclusion of basic sample characteristics (age, gender, and race/ethnicity).

Method

Five hundred and six experimental studies published from 1995 to 2000 in *BT* (n = 65), *JABA* (n = 259), and *JCCP* (n = 182) were reviewed. All studies utilizing experimental designs employed to assess the effect of an independent variable on behavior or reports of human behavior between these years were included. Published articles (both full and brief reports) related to human participants were evaluated. The list of reviewed articles and the coding manual with operational definitions of the variables are available from the first author.

Training Procedure for Coders

Training occurred during a 2-hour session that consisted of a comprehensive discussion of inclusion criteria and coded variables. Operational definitions were discussed in detail and potential coding problems were resolved. Following the initial training session, eight articles were coded, two dependently and six independently, to provide practice and verify consistent coding procedures.

A first-year graduate student and a bachelor's-level research assistant independently read the titles, abstracts, and Methods sections of all published articles to determine whether they met inclusion criteria. If inclusion criteria were met, the article was coded and entered into a database. A third coder, a second-year graduate student, read every fifth article to assess the reliability of the inclusion criteria and coded variables.

Interrater Reliability

For each variable, interrater reliability was calculated by taking the number of agreements, divided by the number of total ratings, and then multiplying it by 100.

Agreements for age, gender, and race/ethnicity were all acceptable at 95%, 95%, and 92% respectively. Interrater reliability for article selection yielded a 95% agreement.

Results and Discussion

To test whether journals differed on the reporting of age, gender, and race, three likelihood ratio χ^2 using SAS GENMOD were conducted, with an alpha level set at .017 (.05/3) to correct for multiple comparisons. The likelihood ratio χ^2 revealed significant dependence between the journals on age, $\chi^2 = 21.23, df = 2, p < .0001$, gender, $\chi^2 = 24.34$, $df = 2$, $p < .0001$, and race, $\chi^2 = 204.24$, $df = 2$, $p < .0001$. To further examine these findings, follow-up contrasts were conducted to examine journal differences (see Table 1).

Results showed that *JCCP* and *BT* authors regularly reported participant age and gender. *JABA* authors reported age and race data less frequently, although they still reported these variables in over 80% of the cases. Authors in all three journals reported participant race/ethnicity in less than 65% of the reports. However, *JABA* authors reported race/ethnicity dramatically less often relative to the other two journals, with *BT* authors also reporting significantly less often compared to *JCCP*.

As shown statistically and descriptively, behavioral journals tend to report race/ethnicity less frequently in comparison to *JCCP*, with *JABA* authors also reporting age and gender less regularly compared to the other journals. These differences may not be surprising given the orientations of the different journals, but they are very likely to lead to communication difficulties across the readers of the journals and between professionals of different orientations. This is more than theoretical significance: treatment research that does not report sample characteristics will be excluded from compilations of empirically validated psychological procedures. Given the increasing importance of these classifications in mainstream clinical psychology, this will affect both the adoption of the treatments and their potential societal benefits.

Behavioral researchers contend that background characteristics merely "mark" sample variation. Furthermore, the correlational nature with other variables has limited functional information associated with participants' behavior. Many behaviorists agree with this stance; however, the establishment of a cause-effect relationship can be established during an experiment/treatment should not render the finding insignificant, given that these variables may assist in understanding variability within the data. However, if age, gender, or race/ethnic differences are revealed after treatment, this variation may be partially due to differential reinforcement effectiveness. Moreover, even under circumstances where sample characteristics are not an analytic variable, this information allows readers and meta-analytic studies a more complete understanding of the sample (American Psychological Association, 2001).

The authors argue that the editors of behaviorally oriented journals should mandate the inclusion of sample characteristics. The justifications for this are purely practical. First, the inclusion of these data, which is not burdensome, would make behavioral research more known across the field of psychology and would significantly increase the chance that these interventions will be identified as empirically supported treatments, thus reaching a greater number of clients. Second, the question of whether ethnicity and race is relevant to our understanding of clinical interventions is an empirical question. Inclusion of this information is advisable to allow direct examination of the variables that might ultimately explain behavior. As indicated by the American Psychological Association (2003), researchers are encouraged to treat ethnicity/race not as nuisance or control variables, but rather as a variable that might eventually explain behavior. In the current system, these communication differences influence psychologists from all areas of psychology by hindering the dissemination of information and advancements between orientations.

TABLE 1
Frequency and Percent of Studies Reporting Sample Characteristics by Journal

Sample Characteristics	*n*	%	*LR* χ^2
Age			
JCCP	179	98[1]	20.22[1**]
JABA	227	88[1,2]	
BT	62	95[2]	3.83[2*]
Gender			
JCCP	178	98[3]	20.99[3**]
JABA	223	86[3,4]	
BT	63	97[4]	7.55[4**]
Race/Ethnicity			
JCCP	113	62[5,7]	195.82[5**], 4.94[7*]
JABA	10	4[5,6]	
BT	30	46[6,7]	67.78[6**]

Note. The number of reviewed articles was 65 for *BT*, 259 for *JABA*, and 182 for *JCCP*. Values with the same superscripts were significantly different from each other on post hoc tests.
** $p < .007$, * $p < .05$.

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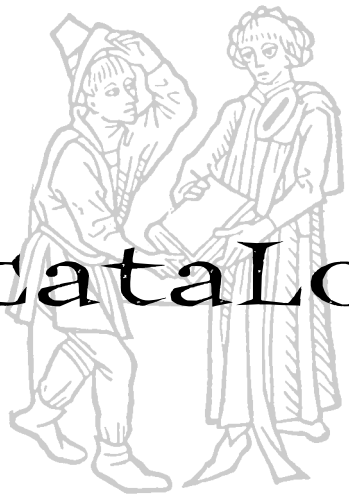

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THURSDAY, NOVEMBER 18, 9:00 A.M. – 5:00 P.M. **Earn 14 CE credits**

Beginning to intermediate level of familiarity with the material. This practical, interactive session is designed to teach the essentials of cognitive therapy and to help participants immediately start using what they have learned with "easier" patients and with patients with more challenging problems. The focus in the first part is on learning how to conceptualize patients according to a cognitive framework and how to use this conceptualization to plan treatment within and across sessions and to solve therapy-related problems. In the second part, participants will learn how to develop and maintain a strong therapeutic alliance, set goals, structure therapy sessions, orient treatment toward problem solving, design effective homework assignments, elicit homework compliance, and use standard strategies to modify dysfunctional thinking and behavior. In the third part, participants will learn how to design and implement advanced strategies to help patients modify their entrenched, global, dysfunctional beliefs about themselves, their worlds, and other people, including restructuring the meaning of early traumatic experience. Finally, Dr. Beck will discuss resources and steps participants can take to learn more about cognitive therapy. Dr. Beck will demonstrate role plays, provide group experiences in conceptualizing patients via worksheets, discuss participants' cases, show and discuss videos of therapy sessions, and encourage questions and discussion.

You will learn to:

- Conceptualize patients according to the cognitive model;
- Establish and maintain a strong therapeutic alliance;
- Structure therapy sessions effectively;
- Use a variety of cognitive and behavioral techniques; and
- Vary standard therapy for patients with challenging problems.

CIT 2

ANNE MARIE ALBANO | Columbia University

Cognitive Behavioral Treatment of Anxiety in Children and Adolescents: Moving Beyond the Basics

WEDNESDAY, NOVEMBER 17, 9:00 A.M. – 5:00 P.M. **Earn 7 CE credits**

Intermediate level of familiarity with the material. Anxiety disorders are among the most common conditions affecting children and adolescents. Estimates place the prevalence of anxiety disorders in youth to be greater than 10%. An individual anxiety disorder may occur alone, but more often anxiety disorders are associated with high comorbidity with each other and with other internalizing disorders such as depression. Childhood anxiety disorders cause significant impairment in school performance, family relationships, and social functioning.

This session will be focused on the current status of evidence-based cognitive behavioral treatments for anxiety disorders in youth. Participants will be provided an overview of the cognitive behavioral model of psychotherapy for the three most common and co-existing childhood anxiety disorders: separation anxiety disorder, social phobia, and generalized anxiety disorder. An overview of assessment methods for clinical practice will be presented. There will be a detailed presentation of the components of cognitive behavioral therapy for anxiety in youth, followed by a review of the foundations for empirical support for cognitive behavioral treatment for childhood anxiety. Involvement of parents in treatment, school issues, and considerations for combined treatment with medications will also be discussed.

You will learn:

- The psychopathology of anxiety in youth and its sequelae;
- Empirically supported methods of assessment, diagnosis, and treatment;
- The basic elements of the cognitive behavioral treatment programs for anxiety concerns, and when to apply these components in a comprehensive treatment plan;
- Optimal and innovative ways to involve parents and other family members in the recovery process.

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CIT 3

LINDA C. SOBELL | Nova Southeastern University

Using Motivational Interviewing With Substance Use and Comorbid Disorders

WEDNESDAY, NOVEMBER 17 9:00 A.M. – 5:00 P.M. **Earn 7 CE credits**

Beginner to intermediate level of familiarity with the material. This session will teach practitioners a variety of motivational and behavioral skills to work more effectively with their clients. Motivational Interviewing (MI), initially developed for dealing with resistive substance abusers, has been adapted to address other health behaviors and conditions (e.g., smoking, diet, physical activity, HIV screening, sexual behavior, diabetes control, gambling, and medical adherence). MI is not an entirely new intervention; rather, it is a collection of strategies and techniques from existing models of psychotherapy and behavior change. A key goal of MI is to assist individuals who are initially low in terms of readiness to change. The tone of the MI encounter is nonjudgmental, empathetic, and empowering. MI techniques and interventions will be demonstrated using short role-playing scenarios, videotape clinical vignettes, and case material. These techniques can be used to enhance clients' commitment to change. A variety of empirically based assessment instruments that are practical to use and have clinical value will be presented. Handouts of the major motivational materials and assessment instruments will be distributed.

You will learn:

- How to use motivational strategies and skills to enhance clients' commitment to change;
- How to use advice/feedback materials and assessment instruments in a motivationally enhancing manner; and
- How to use a decisional balance exercise to evaluate and promote readiness for change.

CIT 4

MARSHA LINEHAN & KATHRYN E. KORSLUND

University of Washington

The A, B, Zs of DBT: Dialectical Behavior Therapy Basics and Beyond

THURSDAY, NOVEMBER 18, 9:00 A.M. – 5:00 P.M. **Earn 7 CE credits**

All levels of familiarity with the material. Dialectical Behavior Therapy (DBT) is a comprehensive, principle-driven, cognitive-behavioral treatment for borderline personality disorder (BPD). Originally developed for the chronically suicidal individual, the treatment has been extended to nonsuicidal individuals engaging in other patterns of life-threatening or severely dysfunctional behavior. DBT is arguably the most researched treatment for BPD. To date, seven randomized controlled trials have shown DBT to be effective across a wide range of outcomes.

On a fulcrum of dialectical philosophy, DBT blends interventions targeting behavior change (skills training, behavioral analysis, contingency management, exposure procedures, cognitive modification) with therapeutic strategies that foster acceptance (validation and mindfulness). Treatment is carried out across four modes of service delivery (individual psychotherapy, group skills training, as-needed telephone consultation, and a therapist consultation team) designed to enhance patient and therapist capabilities and motivation, generalize to the natural environment, and shape the environment in a manner that does not reinforce dysfunctional acts.

This session will present the philosophical principles that serve as the foundation for DBT and the specific strategies and techniques used in its application. It will cover the basics of DBT as well as more advanced topics. Clinical vignettes and videotape will be used to exemplify the therapy. Recent adaptations and outcome data will also be discussed.

You will learn:

- Empirical support for DBT's effectiveness;
- The biosocial theory of BPD; and
- Essential principles, structure, and strategies of DBT.

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POSTDOCTORAL FELLOWSHIP, WEIGHT AND EATING DISORDERS PROGRAM, UNIVERSITY OF PENNSYLVANIA (Anticipated start date July/August 1, 2003). A post-doctoral fellowship will be available at the Weight and Eating Disorders Program (WEDP), University of Pennsylvania. The candidate will participate in research concerning the growth and development of children born at high-risk and low-risk for obesity, who have been tracked for the past 10 years. The candidate will conduct a range of activities pertinent to this project, as well as other issues concerning the interplay of genetic and environmental influences on pediatric obesity. There will be opportunities for manuscript and grant writing, and to work with a collaborative group of investigators (including Drs. Albert Stunkard, Robert Berkowitz, Virginia Stallings, Myles Faith, and others at Penn and the Children's Hospital of Philadelphia). Research experience is desirable, although energy, initiative, and hard work are more important. Interested applicants should send cover letter, CV, (p)reprints, statement of research interests and names of three references including email addresses and telephone numbers to: Myles Faith, Ph.D., 3535 Market Street, 3rd Floor, Philadelphia, PA 19104, or mfaith@mail.med.upenn.edu.

BEHAVIORAL TECH RESEARCH, INC., SEATTLE invites applicants for a full time Research Scientist I position to coordinate and collaborate on two large NIH-funded grants to disseminate Dialectical Behavior Therapy (DBT). The ideal candidate will have a Doctoral Degree in clinical, social, or cognitive psychology, instructional design, or multi-media development; an interest in research regarding the use of information technology to disseminate evidence-based practices; and research and grant writing experience. Activities include managing various phases of research trials, managing a research organization, grant writing, mentoring undergraduate students, and supervising research assistants. This position offers a competitive compensation package, including health and vacation benefits. Salary is negotiable based on qualifications and experience. Organization founded by Marsha M. Linehan, Ph.D. Desired start date August 1, 2004. Forward letter of interest and curriculum vitae to: ldimeff@behavioraltechresearch.com.

BOSTON UNIVERSITY, POSTDOCTORAL FELLOW / RESEARCH ASSISTANT PROFESSOR IN CHILD ANXIETY AT THE CENTER FOR ANXIETY AND RELATED DISORDERS AT BOSTON UNIVERSITY. The Child and Adolescent Fear and Anxiety Treatment Program at Boston University is recruiting one post-doctoral fellow to join our Child Program at the Center for Anxiety and Related Disorders (CARD) at Boston University. CARD is a large, federally funded anxiety disorders center with an international reputation. Successful candidates will be involved in one or more NIMH and SAMHSA funded projects through our Child Program and will also have clinical responsibilities. Position will provide postdoctoral clinical hours and supervision necessary for licensure. After successful completion of the post-doctoral fellowship (Year 1), candidates will be eligible for a Research Assistant Professorship in the Department of Psychology at Boston University (Year 2). Supervision of clinical psychology doctoral students is expected along with teaching one course at the graduate level. Many opportunities exist for participating in ongoing collaborative research and scholarly writing. Applicants should have completed their Ph.D. by the start of employment. Competitive salary and fringe benefits. For additional information, email Donna Pincus, Ph.D. at dpincus@bu.edu. Send curriculum vitae, letter of interest, and three letters of recommendation to: Donna B. Pincus, Ph.D., Director, Child and Adolescent Fear and Anxiety Treatment Program, Center for Anxiety and Related Disorders at Boston University, 648 Beacon Street, 6th Floor, Boston, MA 02215-2015. Boston University is an Affirmative Action/Equal Opportunity Employer.

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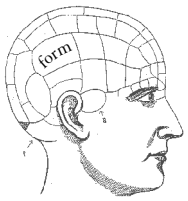

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ISSUE	DEADLINE
January	December 2
February	January 2
Spring	February 3
Summer I	March 3
Summer II	May 3
September	August 2
October	September 3
Winter	November 3

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Web Site

There was a special series on dialectical behavior therapy in *Cognitive and Behavioral Practice* 7 (issue 4) . . . Can I read the article abstracts?
www.aabt.org/publication/cbp/c&bp7.4.html

What are "ad hoc committees" and who serves on them?
www.aabt.org/Committee/committees.html#Ad_hoc_Committees

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www.aabt.org/publication/BT/bt_submission.html

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www.aabt.org/sigs/sigs.html

I need to learn about funding.
www.aabt.org/Resources%20for%20Researchers/resources.html

Who treats depression in Idaho?
aabt.org/members/Directory/Clinical_Directory_Results.cfm?DIRTYPE=Clinical

Who is AABT's Secretary-Treasurer?
www.aabt.org/Committee/committees.html#board

Can I fight with you on the listserve?
www.aabt.org/Listserve/listserve-rules.html

Hmm, I wonder if Arnold Lazarus has ever been interviewed by G. Terence Wilson?
aabt.org/members/source/Orders/index.cfm

Who handles permissions in the AABT central office?
www.aabt.org/staff

How do I set up and tear down my poster session?
www.aabt.org/Convention/convention%202004/forms/poster%20guidelines_2004.pdf

Clinical Grand Rounds

Experience 3 Master Clinicians Treating a Client With Anxiety and Depression

Clinical Grand Rounds, formerly known as World Rounds, has been a huge success since the introduction of this exciting format at the 2001 World Congress of Behavioral and Cognitive Therapies in Vancouver in 2001.

In Boston last November each World Rounds session was standing room only. In New Orleans these sessions, which are included in the general registration fee and need no ticket, will be presented in a larger ballroom. Arrive early to get a good seat!

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- CLINICAL GRAND ROUNDS 1
  Using Cognitive Behavioral Case Formulation
  Jacqueline B. Persons, San Francisco Bay Area Center for Cognitive Therapy
- CLINICAL GRAND ROUNDS 2
  Using Functional Analytic Psychotherapy
  Robert J. Kohlenberg, University of Washington
- CLINICAL GRAND ROUNDS 3
  Using an Integrated Psychotherapy Approach
  Marvin Goldfried, SUNY at Stony Brook
- CLINICAL GRAND ROUNDS 4: Review
  Comparing Three Treatment Approaches
  MODERATOR: Joanne Davila, SUNY at Stony Brook

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