

# the Behavior Therapist

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### President's Message

## Strategic Plan and Special Election

*Patricia Resick, University of Missouri, St. Louis*



One of the core responsibilities of the AABT Board is to ensure that the organization remains responsive to the membership and achieves its mission. Accordingly, AABT has a tradition of regular strategic planning meetings, held every 3 years, to focus our attention on current issues of the organization and our planning efforts. On April 2-4, 2004, the Board of Directors, along with coordinators, a representative of past presidents (Gerald Davison), and AABT staff, met at the central office in New York City for a strategic planning meeting. The purposes of the meeting were to: (1) take stock of where we are as an organization, (2) assess our strengths and weaknesses, (3) predict upcoming opportunities for and threats to the organization, and (4) determine our overarching goals for the next 3 years. We then evaluated our current activities with respect to how well they are addressing these goals and made suggestions for other activities that should be undertaken. We also recognized that as an organization, we cannot continue to add new projects and activities without substantial growth to the organization or without eliminating other activities. In the end, we compromised and identified initiatives for growth, the addition of new high-priority activities, and marked certain other activities to deemphasize at the current time.

As an organization, AABT is comprised of five major divisions: Governance; Publications; Membership; Convention and Continuing Education;

### instructions for authors

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

■ **Feature articles** that are approximately 16 double-spaced manuscript pages may be submitted. ■ **Brief articles**, approximately 6 to 12 double-spaced manuscript pages, are preferred. ■ **Feature articles and brief articles** should be accompanied by a 75- to 100-word abstract. ■ **Letters to the Editor** may be used to respond to articles published in the *Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Please contact the Editor or any of the Associate Editors for guidance prior to submitting series, special issues, or other unique formats. All submissions should be in triplicate and formatted according to the *Publication Manual of the American Psychological Association, 5th edition*. Prior to publication, authors will be asked to provide a 3.5" diskette containing a file copy of the final version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of published materials shall be assigned exclusively to the Association for Advancement of Behavior Therapy. **Please submit materials** to the attention of the Editor: George F. Ronan, Ph.D., Department of Psychology, Central Michigan University, Mount Pleasant, MI 48859.

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All items published in *the Behavior Therapist*,  
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tion of our readers, and publication does not  
imply endorsement by the Association.

and Academic and Professional Issues. The  
Governance division is comprised of the  
Board of Directors (President, Past-  
President, President-Elect, Secretary Treas-  
urer, and three Representatives-at-Large),  
who are elected by the AABT membership.  
Coordinators are appointed from the mem-  
bership by the Board to oversee each of the  
remaining four divisions. All of the stand-  
ing and ad hoc committees fall under one of  
the five divisions. To facilitate the strategic  
planning agenda, the Board developed a list  
of goals and activities relevant to each divi-  
sion. The Board is now asking the coordina-  
tors of each division to consider our new  
strategic goals with their constituent com-  
mittees and to submit plans for how they  
intend to pursue the goals and suggested  
strategies. Please see the strategic plan docu-  
ment at the end of this article for details on  
the planning process.

Our strategic planning meeting also in-  
cluded a discussion of the ways in which  
AABT defines itself, including our mission  
statement. After discussing the achieve-  
ments of AABT over time and the current  
status of the field, we decided to propose a  
change in our mission statement. This  
change reflects the emergence of greater di-  
versity in scientific approaches to clinical  
science and treatment over the past decade  
and represented in our organization. A  
change in the mission statement requires  
ratification by the membership. Accord-  
ingly, along with several other important is-  
sues, we will be asking the membership to  
vote on this new mission statement this fall  
in a special election. Both the old and newly  
proposed mission statements are listed in  
the strategic plan. Concurrently, we mod-  
ified the list of purposes for the organization  
and will also be asking for a vote of the  
members regarding these modifications.

Following more discussion and debate,  
the Board has proposed that the four highest  
priority goals for the immediate future are:

1. Provide a professional home/commu-  
nity to our members.
2. Be the voice of Cognitive Behavior  
Therapy/ Empirically Supported Treat-  
ments (CBT/EST) through outreach, edu-  
cation, journals, etc.
3. Improve our governance structure.
4. Continue to improve the use of tech-  
nology for the organization (e.g., ex-  
panded Web-based capabilities).

The first goal is obvious and most basic  
to the survival and health of our organiza-  
tion, but needs to be attended to in a very  
proactive way. There are many other com-

peting organizations that can garner the at-  
tention and loyalty of our members. We  
want this organization to continue to be the  
high-quality professional home it has been  
for many people for decades, and to con-  
tinue to welcome new members.

The most controversial goal was the sec-  
ond, to be the voice of cognitive behavioral  
treatment and champion of empirically  
supported treatments. This goal is contro-  
versial because some members believe we  
should be a smaller mentor- or program-  
based organization (the apprenticeship  
model). Others believe that for the vitality  
and stability of the organization, we must  
grow, train, and accommodate new mem-  
bers, perhaps from more diverse disciplines  
than we currently represent (please see my  
column in the January *tBT*, p. 3, for a more  
complete discussion of these issues). There  
was some concern expressed that if AABT  
does not step up to the plate and become  
the voice for CBT, then other organizations  
will soon fill that void. This would be par-  
ticularly ironic given that the most notable  
researchers and clinicians in the cognitive  
behavioral field have been founders and  
leaders of AABT and the original mission  
was to advance CBT. However, because of  
the limited scope projected to the public  
and the scientific community by the name  
Association for Advancement of Behavior  
Therapy, there are restricted opportunities  
to be recognized as the leader in evidence-  
based assessment and treatment of psycho-  
logical problems. To that end, we concluded  
that it was time to change our public per-  
sona and to propose changing the name of  
the organization. The possible name change  
has been publicly discussed and debated in  
the organization's listserve, at the conven-  
tion, and in *tBT* for well over a year. We will  
be placing this recommendation on the bal-  
lot for your consideration and vote as well.  
The Board is recommending that the name  
of our organization be changed to:

## Association for Behavioral and Cognitive Therapies (ABCT)

*Advancing Research and Empirically  
Supported Practice*

The third goal, to improve our gover-  
nance structure, is well under way but  
needs more work and attention to com-  
plete. Jackie Persons began this process dur-  
ing her tenure as President and has  
continued as the chair of the Ad Hoc  
Governance Committee. The committee is  
developing a policy-based form of gover-  
nance in which the Board of Directors will  
set policy and will develop operational goals

but will be less involved in the day-to-day management of the organization. We are working to establish policies and procedures for the Board, the Executive Director, and for nonelected coordinators, chairs, committee members, and editors who are actively involved in the governance of the organization. We are establishing both policies and procedures for clarifying communication channels, grievance concerns, and management of problems in the organization. The ad hoc committee hopes to have its work completed before the end of the year, but it is possible that the committee will need to continue beyond that time.

The last goal, to continue to improve technology, has been a particular focus over the last year. The central office staff have been working to improve the organization's Web site, to bring the journals on-line by 2005, and to increase the ease of on-line membership renewal, submissions and registrations for the conference, and the purchasing of products. These efforts appear to be paying off. For example, after rather stagnant growth that characterized our organization for a number of years, convention attendance and membership are beginning to increase, most likely because of on-line access.

One last item, which will be placed on the ballot for your consideration, is a recommendation to remove the committee structure from the by-laws. A survey of other organizations indicates that it is not standard practice to place the organizational chart, and particularly the committee structure, in the by-laws. The organizational chart could be a free-standing document. It was proposed in the strategic planning meeting, and voted on in a subsequent Board meeting, to remove the committee structure from the by-laws so that minor changes in the organization (the addition, reorganization, or elimination of committees) would not have to be voted on by the entire membership, but could be handled at the Board level. Our current practice is to include by-laws changes with the election ballot every spring. Removing the committee structure from the by-laws would allow proposed changes to proceed without having to wait up to a year for votes, or by working as ad hoc committees. This would eliminate the need for the entire membership to vote on housekeeping types of issues. Of course, major issues such as the name change and all other by-laws changes would continue to be voted on by the entire membership.

Please be on the lookout for your ballot on these issues in the fall. The strategic

plan, along with the SWOT (strengths, weaknesses, opportunities, threats) can also be found on AABT's Web site. If you have any feedback regarding specific components of the strategic plan, please contact the appropriate coordinator for that division. They are listed in the strategic planning document and their e-mail addresses are listed below and on the AABT Web page ([www.aabt.org](http://www.aabt.org)) under "Who We Are." The Board and I hope to see you at the annual conference in November in New Orleans, where the results of this ballot will be announced.

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AABT's strategic plan appears on  
pp. 116-117.

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# AABT's Strategic Plan

THE STRATEGIC PLANNING meeting was held April 2-4, 2004, in New York City at the central office of AABT. In attendance were Patricia A. Resick, President; Jacqueline Persons, Immediate Past President; J. Gayle Beck, President-Elect; Alan M. Gross, Secretary-Treasurer; Anne Marie Albano, Martin Antony, and Michael Otto, Representatives-at-Large; Ann Steffen, Convention and Education Issues Coordinator; Judith Favell, Publications Committee Coordinator; Gerald C. Davison, representative of the Past Presidents; Mary Jane Eimer, Executive Director; Mary Ellen Brown, Director of Administration and Convention Manager; and David Teisler, Director of Publications.

## A. MISSION STATEMENT

*AABT's current mission statement:*

The Association for Advancement of Behavior Therapy is a professional, interdisciplinary organization which is concerned with the application of behavioral and cognitive sciences to understanding human behavior, developing interventions to enhance the human condition, and promoting the appropriating utilization of these interventions.

*Proposed mission statement:*

The Association for Advancement of Behavior Therapy is an interdisciplinary organization committed to the advancement of a scientific approach to the understanding and amelioration of problems of the human condition. These aims are achieved through the investigation and application of behavioral, cognitive, and other evidence-based principles to assessment, prevention, and treatment.

## B. PURPOSES

*AABT's current purposes:*

While primarily an interest group, AABT is also active in:

1. Encouraging the development of the conceptual and scientific basis of the behavioral therapies as an empirical approach to applied problems;
2. Facilitating the appropriate utilization and growth of behavior therapy as a professional activity;
3. Serving as a resource and information center for matters related to behavior therapy.

*AABT's proposed purposes are to:*

1. Encourage the development, study, and dissemination of scientific approaches to behavioral health.
2. Promote the utilization, expansion, and dissemination of behavioral, cognitive, and other empirically derived practices.
3. Facilitate professional development, interaction, and networking among members.

## C. HIGH-PRIORITY GOALS OVER THE NEXT FEW YEARS

1. Provide a professional home/community to our members.

2. Be the voice of CBT/EST (i.e., outreach, education, journals).
3. Improve our governance structure.
4. Continue to improve technology.

## D. ACTIVITIES THAT CURRENTLY ADDRESS THESE GOALS AND SUGGESTIONS TO ADDRESS EACH OF THESE GOALS

In order to begin to prioritize goals and establish strategies, we listed all current activities and then rated which activities are mandated (necessary to the organization) listed below as (1), which activities are highly desirable (2), and which activities were deemed lower priority (3) at the current time. We then placed these activities under the goals we have chosen. We then generated suggestions to further meet these overarching goals.

1. Provide a professional home/community to our members.

*Currently address:*

- Convention (1)
- BT, tBT, C&BP (1)
- Clinical Assessment Series (3)
- Fact Sheets (3)
- Awards and recognition program (2)
- Ease of membership renewals, convention registration (1)
- On-line publication purchasing, Bookselling (3)
- SIGs (1)
- Listserve (3)
- Membership Directory (1)
- Find a Therapist (2)
- Surveys (3)
- Archives videos (2)
- International affiliates (3)
- Reduced membership rate for the young professionals (1)

*Suggestions:*

- Increase retention of our members and of those who attended our conference
- Work to increase our membership numbers and diversity
- More activities aimed at students and young members to feed and mentor them and keep them in our group
- Establish a gallery of post-convention photos and post it on the Web page
- Make tBT more newsy

2. Be the voice of CBT/ESP (outreach, education, journals, etc.)

*Currently address:*

- BT, C&BP, tBT (1)
- Clinical Assessment Series (3)
- Fact Sheets (3)
- Find a Therapist (2)
- Public education (e.g., talk at conference, Web site, etc.) (3)
- Clinical Grand Rounds videos (3)
- Professional education for nonmember mental health professionals (3)

# AABT's Strategic Plan

## *Suggestions:*

- Propose that the membership vote on a name change to:  
*Association for Behavioral and Cognitive Therapies (ABCT)*  
*Advancing Research and Empirically Supported Practice*
- More actively promote the training offerings done by our members
- Develop collaborative relationships with other organizations we support to get them to support us too
- Bring the journals on-line
- Improve the Web site
- Explore hiring a Development Officer/Marketing Manager
- More outreach to media: press releases, relationships with journalists
- Alert mechanism for misrepresentations of behavior therapy
- Proactive advocacy (e.g., Guidelines Coalition)
- CBT self-help books (reviews)
- Bookselling catalog
- Work to increase our membership numbers and diversity

## 3. Improve our governance structure.

### *Currently address:*

- AHC on Governance (1)
- Finance Committee (1)

## 4. Continue to improve technology.

### *Currently address:*

- Revisions to the Web site (1)
- On-line convention submissions, registration (1)

### *Suggestions:*

- Hire a Web site consultant
- Continue to improve on-line membership renewal/publication purchases
- On-line convention registration
- Current/vital/user friendly

## **E. STRATEGIC ACTION PROGRAMS:**

### **By organizational structure**

#### **1. Publications**

- Get the journals on-line
- Get the newsletter to be more newsworthy
- Improve the citation impact of *BT*
- Improve the Web site
- Finish the outstanding Archives tapes
- Support the Public Education and Media Dissemination Committee (create Rapid Response network and Media and Community Connections efforts)

### *Deprioritize:*

- Clinical Assessment Series
- Slow down on Clinical Grand Rounds Videos
- Fact Sheets

#### **2. Membership**

- Continue to refine use of technology to facilitate joining, renewing, etc.

- Work to retain current members and those who attend our convention
- Recruit new members from groups that share our values and support our mission
- Work to improve our culture and make it more supportive to new members and those who attend our convention (e.g., this year the ISTSS people who may attend the workshops)

#### **3. Convention and CE**

- Continue to refine access to the convention (on-line submission and registration and post more information about the program on-line)
- Improve access to information about AABT members engaged in CE training
- Continue to provide high-level technology to presenters (LCDs)
- Work to improve our culture and make it more supportive to new members and those who attend our convention (e.g., this year the ISTSS people who may attend the workshops)

#### **4. Academic and Professional Issues**

- Remind Committee on Research Agenda of its stated description in by-laws and ask them to increase their activities in their high-priority areas
- We endorse the current activities of Academic Training (focus on Council on Behavioral Specialties and APA Council of Specialties)
- Increase visibility of all these committees in the newsletter and on the Web page
- Awards and Recognition: consider expanding awards, perhaps giving awards for good treatment manuals, books, self-help books, or a Mentoring award or an award to a journalist or media representative

#### **5. Governance**

- Improve lines of communication and procedures for problem-solving
- Clarify roles and responsibilities
- Establish systems for assuring compliance and accountability
- Periodically review the organization's structure and functioning (e.g., at the Strategic Planning meeting)
- Write the policies

## Strategies for Increasing Client Completion of Treatment Assignments

John M. Malouff and Nicola S. Schutte, *University of New England*

Behavior therapists often give clients important assignments to do outside therapy sessions, such as recording information about each binge-eating episode, carrying out in vivo exposure, or applying time-out in specific circumstances. Unfortunately, clients fail to perform the assignments roughly half the time (see Detweiler & Whisman, 1999; Spiegler & Guevremont, 2003).

Various psychotherapists have suggested strategies for increasing treatment homework adherence (e.g., Addis & Jacobson, 2000; Coon & Gallagher-Thompson, 2002; Cox, Tisdale, & Culbert, 1988; Detweiler & Whisman, 1999; Kazantzis & Lampropoulos, 2002; Larabee, 1988; Openshaw, 1998; Spiegler & Guevremont, 2003; Startup & Edmunds, 1994; and Tomkins, 2002). However, no one has ever published a comprehensive list of strategies that psychotherapists can use to increase the chances of client adherence to treatment assignments. The main purpose of this article is to fill the void. Ancillary purposes include providing information about the efficacy of adherence methods, providing a model from which one could possibly derive novel adherence strategies, and providing suggestions for how to choose among the identified strategies.

### Evidence of Efficacy

There have been no published studies that used experimental methods to test the efficacy of individual adherence-enhancement strategies with psychotherapy clients. A study by Cox et al. (1988) found that adherence increased when therapists gave psycho-medical assignments in writing as well as orally. Other experimental studies have found evidence that certain procedures increased adherence to medical recommendations in a specific sample of patients. These procedures include encouraging self-monitoring of assignment completion, providing prompts, modeling of required behavior, using a contingency contract, and reinforcement of assignment completion (Spiegler & Guevremont, 2003). For a more complete review of research on the efficacy of methods of increasing adherence to assignments

given by health care providers, see Burke and Ockene (2001).

### Model of Adherence

Strategies for increasing treatment assignment adherence can be classified according to the following model of the elements of home assignment adherence. One may be able to use the model to derive novel strategies. This model postulates that for assignment adherence to occur, the client must:

- Understand what to do and how, where, and when to do it;
- Have the ability (the needed intelligence, memory, and self-control) to complete the assignment;
- Have self-efficacy—think that he or she can do the assignment (see Bandura, 1997; Bouchard, Bastien, & Morin, 2003);
- Have sufficient motivation to do the assignment to outweigh factors such as inertia, time pressure, and stressors that compete with assignment completion;
- Have the opportunity to do the assignment (e.g., needed cooperation from a partner for sexual assignments or the right situation for assertion assignments);
- Remember to do the assignment.

### Sources of Strategies to Increase Adherence

Most of the following ideas come from the published suggestions of experts. Additionally, we derived a few of the ideas from cognitive learning theory (Bandura, 1986), a few from typical cognitive behavioral therapy procedures, and a few from professional experience. The strategies are organized in order of when a therapist might use them during the progression of therapy.

### Strategies to Increase Adherence

Relevant adherence model elements are in *italic*.

1. During the first session with the client mention that home assignments are com-

mon in behavior therapy and explain their importance (Coon & Gallagher-Thompson, 2002; *motivation*).

2. Establish and maintain rapport by treating the client with warmth, empathy, and genuineness and by frequently paraphrasing what the client says (Openshaw, 1998; *motivation*).

3. To the extent feasible, collaborate with the client in assigning home tasks (Startup & Edmunds, 1994; *understand, ability, self-efficacy, motivation, opportunity*).

4. Assess whether the client is able to complete the assignment (e.g., whether the person can read required forms or written instructions and remember the assignment and whether the person will have the opportunity to do the assignment; *ability, opportunity*).

5. Assess (using open-ended questions) whether the client is willing to complete the assignment (Larabee, 1988; *motivation*).

6. To the extent feasible, give assignments that (a) relate closely to the client's own therapy goals; (b) relate closely to the goal pursued in the current session, (c) suit the interests or habits of the client, which might include such activities as writing, collecting things, reading, watching TV, or acting; and (d) are reinforcing or that tend to lead to natural reinforcement for the client (Coon & Gallagher-Thompson, 2002; Detweiler & Whisman, 1999; Openshaw, 1998; *self-efficacy, motivation*).

7. Praise the client for doing something analogous to completing an assignment, such as setting an initial appointment, and point out the similarity (related to ideas of Openshaw, 1998; *self-efficacy, motivation*).

8. Explain how completing the assignment will help the client and ask what potential benefits he or she sees in completing the assignment (Larabee, 1988; Startup & Edmunds, 1994; *motivation*).

9. With less motivated or able clients, such as children, or with clients whose assignments require the cooperation of someone else (e.g., a sexual partner), include in sessions relevant third persons who are willing and able to help and apply these assignment adherence methods to those third persons (Detweiler & Whisman, 1999; *ability, motivation, opportunity*).

10. Using simple words, make the assignment clear, concrete, and specific (Tomkins, 2002; *understand*).

11. Call the assignment an "assignment," "task," "mission," or something other than "homework" (Coon & Gallagher-Thompson, 2002; *motivation*).

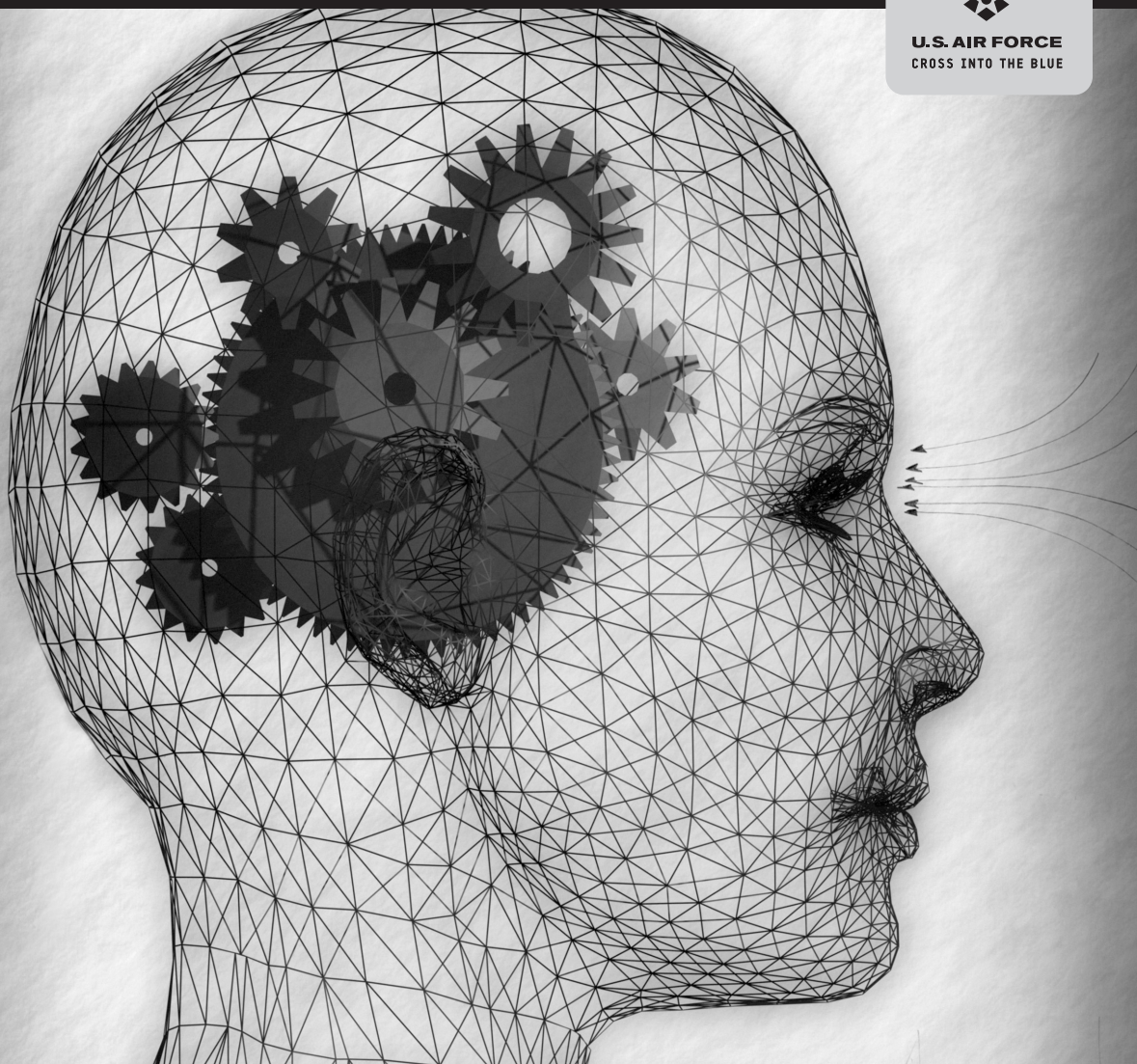
12. Make the assignment realistic for the client—not too difficult, time-consuming,



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or unappealing (Detweiler & Whisman, 1999; *ability, self-efficacy, motivation*).

13. Start small, if necessary, with the first assignment and gradually increase, as needed, the time requirements or difficulty of the assignments (Detweiler & Whisman, 1999; *self-efficacy, motivation*).

14. Encourage self-monitoring of assignment completion (Spiegler & Guevremont, 2003; *motivation*).

15. Encourage self-reinforcement of assignment completion (Coon & Gallagher-Thompson, 2002; *motivation*).

16. Teach the client through instruction, modeling, rehearsal, and feedback any needed skills (Tomkins, 2002; *ability, self-efficacy*).

17. Start in session if the assignment is new or hard (Tomkins, 2002; *ability, self-efficacy*).

18. Give the assignment in writing as well as orally (Cox et al., 1988; *ability, remember*).

19. Provide any helpful forms (*ability, motivation, remember*).

20. Make the goal explicit; the goal is usually to carry out the assignment (not to achieve some outcome such as feeling not depressed or obtaining a requested raise) (Tomkins, 2002; *self-efficacy, motivation*).

21. Explore when and where the client will do the assignment and in doing so have the client describe what he or she will do (to confirm understanding of the task and assess opportunity) (related to suggestions of Coon & Gallagher-Thompson, 2002; *understand, ability, self-efficacy, opportunity, remember*).

22. Suggest choosing logical, easily remembered times to complete the assignment, if possible right before some regular, high-frequency, pleasant activity, e.g., right before eating supper (Coon & Gallagher-Thompson, 2002; *motivation, remember*).

23. If you yourself have done something similar to the assignment and benefited, mention that (related to modeling and vicarious reinforcement as described by Bandura, 1986; *self-efficacy, motivation, remember*).

24. Tell the client, orally or in writing, about similar (anonymous) clients who carried out a similar assignment and benefited; alternative: give the client anonymous written comments of clients who completed similar assignments and benefited (related to modeling and vicarious reinforcement as described by Bandura, 1986; *understand, self-efficacy, motivation, remember*).

25. Explore ways that the client can use stimulus control methods to prompt completion of the assignment—e.g., posted re-

mindings, notes in an appointment book, computer reminders (Coon & Gallagher-Thompson, 2002; *remember*).

26. Discuss with the client the possible value of asking a family member or other person to (a) join in the task (Detweiler & Whisman, 1999) or (b) simply to remind him or her of the assignment (*motivation, remember*).

27. If necessary, create a signed contingency contract with a promised reinforcer for assignment completion when you make the assignment (Spiegler & Guevremont, 2003; *motivation*).

28. Explore what might prevent the client from completing the assignment and use problem-solving methods (e.g., Malouff, 2002) to prevent possible obstacles (Startup & Edmunds, 1994; *understand, ability, self-efficacy, motivation, remember, opportunity*).

29. Ask the client to indicate how confident he or she feels about completing the assignment (e.g., on a scale of 0%–100%) and explore the answer (Tomkins, 2002; *self-efficacy*).

30. If the client lacks self-efficacy regarding completing the assignment, ask the client to describe a challenging assignment—e.g., academic or job-related—that he or she has completed at some time and explore what assignment-completion methods the person used that he or she could use now (Detweiler & Whisman, 1999; *self-efficacy*).

31. Tell the client that you will ask about the assignment at your next meeting (*motivation*).

32. If necessary, go to the home or other relevant setting of the client and provide support, structure, and prompts regarding the assignment (*understand, ability, self-efficacy, motivation, remember*).

33. Ask the client to provide you with daily results via phone messages or e-mail. Alternatives: (a) contact the client soon after giving the first assignment to ask how it is going (Coon & Gallagher-Thompson, 2002) or (b) ask the client to call or e-mail you right away if problems arise (*understand, ability, self-efficacy, motivation, remember*).

34. Go over the assignment first thing on the day of the next session, discuss any benefits that completing the assignment brought to the client, and ask about and explore solutions for any problems that occurred (Coon & Gallagher-Thompson, 2002; *understand, ability, self-efficacy, motivation, remember, opportunity*).

35. Reinforce powerfully and as soon as possible, e.g., with praise, completion of the assignment (Tomkins, 2002; *motivation*).

36. Use shaping if needed: At first, reinforce even approximate completion and gradually raise the standard for reinforcement (Kazantzis & Lampropoulos, 2002; *motivation*).

37. If members of a group receive assignments to complete, praise in front of group the ones who complete the assignment (related to vicarious reinforcement as described by Bandura, 1986; *self-efficacy, motivation*).

38. If the assignment is not completed, show curiosity while exploring what happened and what could be done differently in the future (Tomkins, 2002; *understand, ability, self-efficacy, motivation, opportunity, remember*).

39. If showing curiosity doesn't work, ask the client to switch roles with you for a moment and deal with the issue of completing assignments (Detweiler & Whisman, 1999; *understand, ability, self-efficacy, motivation, remember*).

40. If reversing roles doesn't work, ask the client open-ended questions about how his or her life will improve in the absence of assignment completion (Detweiler & Whisman, 1999; *motivation*).

### Choosing Among Strategies to Increase Adherence

In choosing strategies, therapists might: (a) consider which of the six adherence model elements the client or group of clients may be lacking, (b) consider the likely effect of a specific strategy with a particular client or group of clients and also the amount of therapist time required by the strategy, and (c) use the strategies that fit the needs of the client and the time limitations of the therapist.


### Conclusion

Trying to increase the chances of a client completing assignments is worth a good deal of effort when the assignments play an important role in the therapy. Carefully selecting and applying a set of strategies suggested by experts or derived from well-supported theories is a sensible, systematic method for attaining adherence.

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## Schizophrenia: Some Recent Advances and Implications for Behavioral Intervention

Robin McKinney, *Western Michigan University*, and Scott Fiedler, *Eastern Michigan University*

Schizophrenia remains one of the most debilitating of mental illnesses. Current medical investigations are exploring the role of the negative symptoms of schizophrenia and their long-term impact upon those afflicted with schizophrenia. There is a growing body of literature suggesting that the negative symptoms, primarily lack of motivation, cognitive deficits, and social withdrawal, may be more debilitating than other symptoms of the illness. New medications are being developed to address these aspects of schizophrenia. Behavioral scientists are currently exploring how behavioral interventions can be expanded to also address the negative symptoms of schizophrenia. This article addresses strengths and limits of behavioral interventions and gives some suggestions for enhancing behavioral interventions with schizophrenic populations.

### Recent Pharmacological Developments

No effective pharmacological treatment for schizophrenia existed until 1953, when chlorpromazine (Thorazine) was developed. Neuroleptics such as Thorazine were able to reduce the positive symptoms of the disease—delusions and hallucinations—by inhibiting the activity of dopamine, a key neurotransmitter involved in neural functioning (Javitt & Coyle, 2004). It was not until 1989, when the first “atypical antipsychotic,” Clozaril, was introduced, that the negative symptoms of schizophrenia (i.e., lack of emotion, flat affect, and social isolation) were able to be alleviated by psychotropic medication. Although many other atypical antipsychotics are now available, many afflicted with schizophrenia still display negative symptoms of the illness. As a result, they are unable to live fully productive and independent lives (Collier, 2003; Goff & Coyle, 2001).

Until the 1990s, dopamine was generally thought to be the only neurotransmitter involved in the development of schizophrenia. The first generation of antipsychotics, or typical antipsychotics, is

known to block dopamine D2 receptors and decrease the positive symptoms of some patients with schizophrenia (Javitt & Coyle, 2004). Individuals displaying more of the negative symptoms did not fit the dopamine hypothesis. This led some researchers to modify the dopamine hypothesis. Namely, it was suggested that those with negative symptomatology may have deficits in dopamine functioning in other regions of the brain. As Javitt and Coyle note, there are mainly dopamine D1 receptors in the frontal lobe of the brain (2004). Although the typical antipsychotics may have blocked the D2 dopamine receptors in the brain regions responsible for the positive symptoms of schizophrenia for patients that display these symptoms, the frontal lobe dopamine receptors may have been blocked in patients with the negative symptoms, causing more cognitive difficulties than previously existed for these individuals (Javitt & Coyle, 2004). Similarly, high-dose glycine was found to be effective in the reduction of the negative symptoms of schizophrenia (Coyle & Tsai, 2004; Heresco-Levey et al., 1999; Javitt et al., 1999).

Stimulators of D1 dopamine receptor are under investigation for use with Parkinson's patients. One such example is the compound ABT-431 currently being developed by Abbot Laboratories. Although large-scale clinical trials have not yet been conducted with ABT-431 for use in improving cognition in schizophrenic patients with negative symptoms, this is an area that hopefully will be explored in the near future.

In addition to the antipsychotics that were developed in the 1960s, there was another important compound created during this decade that may prove crucial to the understanding of schizophrenia. This compound is PCP (phencyclidine). PCP, or angel dust, is known to cause symptoms that resemble schizophrenia by negatively influencing the functioning of glutamate, another important neurotransmitter. Specifically, PCP interferes with the functioning of glutamate by blocking a type of

glutamate receptor known as the N-methyl-D-aspartate (NMDA) receptor (Javitt & Zukin, 1991). By controlling the release of dopamine, the NMDA-type glutamate receptor is integral to neural processes that include brain development, learning, and memory (Javitt & Coyle, 2004). Several companies are targeting NMDA receptors in this novel area of research. By regulating neural receptors and transmitters, it may be possible to address both negative and positive symptoms of schizophrenia through pharmacological means (Javitt & Coyle, 2004).

Nicotinic receptors are another potential pharmacological target for schizophrenia. As many mental health clinicians are aware, smoking is very prevalent among the schizophrenic population. Nicotine can be an important facilitator in controlling dopamine and glutamine neurotransmission (Dalack, Healy, & Meador-Woodruff, 1998). There are countless health concerns for those with schizophrenia and are cigarette smokers. A compound that could target the same nicotine receptors that are impacted by smoking could have far-reaching health benefits for the 0.2% to 2.0% of the United States population that suffers from schizophrenia (prevalence rates courtesy of American Psychiatric Association, 2000).

Also implicated in the glutamate hypothesis are the metabotropic-type of glutamate receptors (mGlu). The mGlu receptors may be of possible therapeutic value, as they are involved in the release of glutamate and assist in controlling the neural activity of the NMDA-type glutamate receptors (Moghaddam, 2004).

The cost of developing new pharmaceutical products is immense, considering the research and development that is undertaken in this effort. However, for an illness such as schizophrenia, even modest improvements in pharmaceuticals can have a major effect on an individual's ability to perform activities of daily living (ADLs). For those with schizophrenia who do not show a complete alleviation of all symptoms with psychotropic intervention, future advances in treatment options will hopefully enable these individuals to live productive lives. However, it is unknown when future drug therapies will become available, as most of the pharmaceuticals that were mentioned are in the early stages of clinical trials. Also, psychotropic medications are useful in rapid reduction of psychotic symptoms but do not cause spontaneous remission of psychotic symptoms. Consequently, there remains a need for psychotherapeutic

interventions addressing the positive, negative, and cognitive symptoms of schizophrenia and their impact on social functioning.

### **Psychotherapeutic Implications of Pharmacological Advances**

Although pharmaceuticals are helpful in rapid reduction of the positive symptoms of schizophrenia, behavioral interventions remain necessary for long-term treatment of negative and cognitive symptoms of schizophrenia. As suggested by Todman (2003), much of what has been attempted in psychotherapy with schizophrenic individuals has been based on reducing the positive symptoms of schizophrenia. This concern has been raised by numerous researchers on schizophrenia (Ahmed & Boisvert, 2003; Javits & Coyle, 2004; Wang, Demler, & Kessler, 2002; and others). As might be expected, the emphasis on positive symptoms of schizophrenia has led to the development and refinement of treatment modalities that are most effective in reducing the positive symptoms of schizophrenia. Moreover, the emphasis on positive symptoms has fostered the perception that those afflicted with schizophrenia are a homogeneous group. Recent studies illustrate that considerable heterogeneity exists (Benton & Schroeder, 1990). Patients with a preponderance of negative symptoms have been

the most treatment refractory and require more financial and clinical resources than those with positive symptoms (Peralta et al., 2000). In addition, those with more negative symptoms of schizophrenia are at greater risk of social isolation and often lack personal resources to successfully cope with the illness (Kopelowicz et al., 1997).

### **Interpersonal Factors**

One approach for reducing the positive symptoms of schizophrenia has involved the use of psychotropic medications in conjunction with social skills training and other forms of community support. Reviews on the efficacy of social skills training and reduction of the symptoms of schizophrenia have reported that variability in the length, content, and breadth of material covered has made it difficult to determine whether or not these programs evidence long-term impact upon participants or differential utility (Benton & Schroeder, 1990). Nonetheless, internalization of program content does appear related to symptom severity. That is, level of impairment covaried with degree of internalization and generalization of treatment gains across settings. Inadequate diagnostic information on participants has made it difficult to determine if the programs were equally effective for those with positive symptoms as for

those with negative symptoms of schizophrenia. Further investigation of group composition and content of training programs is necessary to determine efficacy and appropriateness of social skills training for those with schizophrenia.

The focus of many social skills training programs has been to reduce social isolation, increase coping skills, contain positive symptoms of schizophrenia, and enhance medication compliance (Ahmed & Boisvert, 2003). Although these strategies have been somewhat successful in reducing positive symptoms of schizophrenia, they have been less effective in addressing long-term cognitive impairments or the negative symptoms associated with schizophrenia (Wallace, 1998). Our current understanding of the positive and negative symptoms of schizophrenia does have implications for using social skills training with schizophrenic populations (Tollefson & Sanger, 1997). For instance, negative symptoms, in comparison to positive symptoms, might be more predictive of difficulty engaging in treatment. Lack of motivation, social withdrawal, and lethargy are chronic deficits associated with the negative symptoms of schizophrenia and these might affect willingness to participate (Todman, 2003). Including motivational strategies when treating negative symptoms might help to

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address the typical reluctance and disinterest in engaging in the treatment process. Moreover, those experiencing negative symptoms may require more environmental stimulation than those with positive symptoms (Todman, 2003). This is contrary to the notion that stress and stimulation may precipitate an acute exacerbation of symptoms. Indeed, boredom has been linked to development of maladaptive behaviors across clinical and nonclinical populations but very little has been written on boredom and schizophrenia. Boredom can be conceptualized as a natural consequence for those who experience negative symptoms of schizophrenia and it might be that boredom can result in the exacerbation of positive symptoms of schizophrenia. Unfortunately, none of the major instruments used to assess psychotic conditions address boredom. Inclusion of boredom as a diagnostic feature may facilitate successful intervention and retention of treatment gains (Todman, 2003).

Motivation also affects the establishment and maintenance of stable interpersonal relationships. Those with negative symptoms of schizophrenia demonstrate difficulty in the workplace and in the general interpersonal arena (Peralta et al., 2000). Individuals with negative symptoms are more likely to have estranged familial relationships and fewer social supports than their counterparts with positive symptoms of schizophrenia (Clinton et al., 1998). We suggest a need exists for social skills interventions with schizophrenia to more directly address negative symptoms and their impact upon social support systems and interpersonal relationships.

Finally, for those with positive symptoms, short-term social-skills training may be adequate for addressing interpersonal interactions and reduction of social isolation (Wallace, 1998). However, for those experiencing negative symptoms, short-term models may be less effective. Negative symptoms of schizophrenia are more persistent and resistant to treatment and require sustained, long-term intervention. Social skill acquisition with this population is often a painstaking and tedious process (Tollefson & Sanger, 1997). Although shrinking community resources have reinforced short-term treatments (Wang, Demler, & Kessler, 2002), these treatments might be less efficacious for managing negative symptoms of schizophrenia.

### Long-Term Cognitive Deficits

Cognitive deficits associated with schizophrenia are receiving increased attention by the medical and psychotherapy professions. As with interpersonal factors, much of what is known about cognitive deficits and schizophrenia is related to positive symptoms. Psychotropic medications have been effective with rapid reduction of positive symptoms of schizophrenia but less effective in addressing the more insidious cognitive deficits in those afflicted with schizophrenia (Ahmed & Boisvert, 2003). Specific areas targeted for cognitive intervention are problem solving, coping skills, social perception, and treatment compliance. Enhancing treatment compliance, such as adherence to medication regimens, might be easier for those with positive symptoms of schizophrenia. These individuals may more readily comprehend the relationship between positive symptom reduction and medication compliance (Tollefson & Sanger, 1997). In contrast, those with negative and cognitive symptoms may see less relevance between medication compliance and symptom reduction because negative and cognitive symptoms typically are less responsive to medication (Todman, 2003). Therefore, cognitive training surrounding medication issues may need modification to address the slower response of cognitive and negative symptoms to psychotropic medication (Davalos, Green, & Rial, 2002).

Likewise, training in coping skills useful for enhancing motivation and treatment engagement might prove useful (Todman, 2003). As previously noted, the onset and course of negative symptoms of schizophrenia can be insidious compared to the rapid appearance and remission of positive symptoms of schizophrenia. The lack of motivation associated with negative and long-term cognitive symptoms of schizophrenia can lead to premature withdrawal from cognitive interventions. Despite the length of time necessary to impact negative symptoms of schizophrenia, it may be worthwhile to provide long-term intervention for those with cognitive deficits (Davalos et al., 2002). Unfortunately, long-term intervention has grown increasingly difficult as community resources for those with serious mental illness continue to diminish (Wang et al., 2002).

Social interactions may also be impaired by cognitive deficits found in some schizophrenics. Understanding and responding to social cues are a prerequisite to developing adaptive social skills. Those who fail to ac-

quire perceptual skills consistent with adequate social functioning are at heightened risk of social and occupational isolation and failure. For those with cognitive impairments, cognitive intervention must be of significant length, intensity, and interest to facilitate retention (Ahmed & Boisvert, 2003). For the most severely impaired, information-processing may be compromised, necessitating revision of cognitive materials to an elemental level. Abstraction may be limited and, as such, pairing of cognitive materials with meaningful life context is of great importance (Todman, 2003). To generalize cognitive treatment content beyond the treatment setting requires repetition and rehearsal, implying long-term intervention (Davalos et al., 2002).

### Implications for Assessing Outcomes

Conceptualizations of treatment success have focused most often on the extent to which positive symptoms associated with schizophrenia have been reduced (Ahmed & Boisvert, 2003). There is a growing body of literature suggesting that the absence or presence of negative symptoms and long-term cognitive deficits might affect quality of life to at least the same degree as the presence of positive symptoms. It has been further argued that negative and cognitive symptoms of schizophrenia may be more insidious and persistent than positive symptoms of schizophrenia, thereby necessitating more sensitive assessment and intervention than positive symptoms (Benton & Schroeder, 1990). Psychotropic medications have been effective in rapid reduction of positive symptoms and less so for negative and cognitive symptoms of schizophrenia.

Obtaining a varied sample of schizophrenic patients to study has also proven elusive. It has been estimated that a considerable portion of the most seriously impaired schizophrenics remain homeless and/or are otherwise unavailable for study (Wang et al., 2002). Many of the neediest have little access to treatment and evaluation of treatment efficacy for the most severely impaired is limited. Furthermore, when group methodologies have been undertaken, diagnostic information addressing criteria for inclusion in group treatment is often sketchy. Some researchers have mixed schizophrenics with other psychiatric populations within the same study (Ahmed & Boisvert, 2003). Likewise, little distinction is made between those with primarily positive symptoms and those with primarily negative and cognitive symptoms within outcome studies. It has been demonstrated

that differing intervention strategies are required depending upon the etiology of presenting symptomatology.

Treatment follow-up studies have also been adversely affected by the emphasis on the positive symptoms of schizophrenia in the outcome literature. Schizophrenics with few cognitive deficits and negative symptoms of the illness may participate in treatment and follow-up studies more often than those with significant cognitive impairments and negative symptoms. Those with few negative symptoms and cognitive impairments tend to maintain stable housing, employment, and enjoy a greater degree of success than those with more severe impairments. Thus, success rates may be biased and inflated in favor of those schizophrenics who experience primarily positive symptoms (Wang et al., 2002).

### Conclusion

Pharmacological advances in the treatment of schizophrenia are on the horizon. Of particular interest to researchers are the negative and cognitive symptoms of schizophrenia. The next generation of psychotropic medications is being developed with the intention of addressing the positive and negative symptoms of schizophrenia. Similarly, behavioral scientists are exploring intervention strategies consistent with medical advances. Several issues arise in the expansion of behavioral interventions with schizophrenia. First, how we conceptually and operationally define symptomatology will undoubtedly influence intervention development. As noted in the above discussion, poorly defined terms have adversely affected our understanding of schizophrenia and delivery of services to those suffering from schizophrenia.

Secondly, research efforts on the efficacy of behavioral interventions have been hampered by methodological flaws. Researchers have, at times, approached schizophrenics as a homogeneous group. Current data suggest that there is much diversity with the schizophrenic population and these diverse groups may require different treatment strategies. Furthermore, those schizopren-

ics with predominantly negative symptoms may require more intensive, long-term intervention than those schizophrenics with primarily positive symptoms. To determine the validity of treatment interventions, additional investigation is warranted.

Finally, despite advances in medical technology, there is a need for behavioral intervention to address cognitive and negative effects of schizophrenia. Medications are helpful in stabilizing and maintaining symptom reduction. However, behavioral interventions remain necessary in assisting those afflicted with schizophrenia to attain their maximum level of independence.

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## Conference on Innovations in Trauma Research Methods (CITRM): November 17–18, 2004, New Orleans

Lynda A. King and Daniel W. King, *National Center for PTSD and Boston University*, Jeffrey Sonis, *University of North Carolina School of Medicine*, and Elisa Triffleman, *The Public Health Institute and Yale University School of Medicine*

The inaugural Conference on Innovations in Trauma Research Methods (CITRM) will be held on November 17–18, 2004. CITRM is scheduled contiguously with the 2004 meetings of the Association for Advancement of Behavior Therapy (AABT, November 18–21) and the International Society for Traumatic Stress Studies (ISTSS, November 14–17), all in New Orleans, LA. CITRM is the only conference to focus specifically on research methods, as opposed to content, in the area of psychological trauma. Specifically, CITRM's objectives are to strengthen the methodological rigor of research on psychological trauma, develop approaches to design, measurement, and analysis issues unique to trauma research, enhance diffusion of creative research methods from other disciplines, supplement and enhance the training of novice researchers, and consider ethical dilemmas and possible resolutions in research on psychological trauma.

CITRM is designed to be a small conference, where attendees are encouraged to participate, interact, and contribute freely during formal sessions and in an informal fashion during times set aside for networking and conversation. Although not designed to teach the rudiments of scientific practice, many of the sessions are workshops, to allow participants opportunities to raise questions and have "hands-on" experience with methodological approaches. The conference agenda is intended to appeal to the interests of researchers at all levels (from novice researchers to experienced scientists). The theme for CITRM 2004 is "Methodological Issues in Addressing Mass Disaster and Terrorism." Yet, the methods-oriented sessions that comprise CITRM will speak to issues faced by researchers across all types of trauma. Therefore, attendance by researchers from the full spectrum of subspecialties is invited.

Fran Norris, Research Associate, Executive Division of the National Center for Posttraumatic Stress Disorder, and Research Professor, Department of Psychiatry, Dartmouth Medical School, will deliver the keynote address. Norris has published over 100 articles and chapters and has been the recipient of a number of grants for research, research education, and professional development from the National Institute of Mental Health. Her interests include the epidemiology of posttraumatic stress, cross-cultural studies, the mobilization and deterioration of social support after disasters, and systems issues in providing disaster mental health services. Her disaster studies have focused on such events as floods in Appalachia, Hurricanes Hugo and Andrew in the United States, and Hurricane Paulina and the 1999 floods and mudslides in Mexico. She was the lead author of a comprehensive review of the literature on disasters published in two parts in 2002 and was the lead investigator on two case studies that examined lessons learned from mental health systems' responses to the Oklahoma City bombing and the World Trade Center disaster. Norris will speak on the topic of innovations and future directions in disaster research.

Four CITRM workshops will emphasize design, statistics, and/or measurement: First, Dalene Stangl, Professor and Director of the Institute of Statistics and Decision Sciences, Duke University, will present "A Primer on Bayesian Statistical Methods." She will explain what a Bayesian approach involves, the differences between the hypothesis testing (frequentist) and Bayesian approaches, and examples that illustrate how the results and conclusions might be different using frequentist vs. Bayesian approaches. The presentation will contain few formulas and will be accessible to researchers at all levels of expertise. Daniel King and Lynda King, National Center for PTSD and Boston University, will overview

"New Longitudinal Methods for Trauma Research," particularly those derived from random effects regression models. Again, the presentation is intended to be more conceptual and accessible to researchers with a basic knowledge of bivariate and multiple regression. Ichiro Kawachi, Professor of Social Epidemiology and Director of the Harvard Center for Society and Health, Harvard School of Public Health, will discuss strategies for operationalizing group-level or community-level characteristics that may predict posttrauma outcomes. His workshop is titled "Measuring and Modeling the Social and Geographic Context of Trauma." Finally, Frank Weathers, Associate Professor of Psychology, Auburn University, will direct a measurement workshop aimed at understanding key issues in the assessment of trauma exposure and their implications for psychometric techniques. Presenters will supply attendees with documentation of further resources on the topics.

Several CITRM sessions are dedicated to research career concerns. Jayne Thorson will lead a workshop titled "Having the Time of Your Life: Time Management for Busy People." Thorson is the Assistant Dean and Director of Faculty Affairs at the University of Michigan Medical School and a well-regarded speaker on career development. Karestan Koenen, National Center for PTSD and Boston University Schools of Medicine and Public Health, will moderate a panel discussion on the topic "Advancing Your Trauma Research Career: Providence, Pearls, Pratfalls, and Pitfalls." The panel will feature five successful researchers drawn from different academic, government, and private sector settings. A "Paths to Publication" workshop and a "Meet the Experts" lunch are also planned.

CITRM's ethics workshop is titled "Ethical Decision-Making in Designing Disaster Research." Although important ethical principles must be addressed in planning any research project on the psychosocial effects of trauma, the unique aspects of disasters raise special ethical issues. The Ethics Workshop will address recruitment, confidentiality, the informed consent process, burdens on research participants, and working with Institutional Review Boards (IRBs), in the context of disaster and terrorism. The workshop will be presented by Joan Sieber, a psychologist and Professor Emerita, California State University/Hayward. Sieber has specialized in empirical research on questions of research ethics. She is the author of eight books and numerous other publications, including software



and encyclopedia entries, on ethical problem-solving in social and behavioral research.

Additional information about these and other special program features are posted at the CITRM Web site. Please visit <http://www.citrm.org>. Attendance is limited; early registration is encouraged.

CITRM also provides travel stipends for members of underrepresented groups. Stipends are available to both underrepresented novice and experienced researchers

who—through their research, teaching, or clinical activities—have demonstrated professional and scientific interest in the field of traumatic stress or closely allied areas of inquiry. “Underrepresented groups” are defined as members of U.S. minority racial and ethnic groups, the physically challenged, and researchers from Third World nations. Details on the application process and application forms may be accessed at <http://www.citrm.org>.

CITRM's location will be the Hilton Garden Inn New Orleans Convention Center, approximately one-third mile from the Hilton New Orleans Riverside, the site for the AABT and ISTSS meetings. The conference is funded by grants from the National Institute of Mental Health and U.S. Department of Veterans Affairs, National Center for PTSD; administrative support is provided by the Boston Veterans Affairs Research Institute, Inc. ✍

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## Book Review

### Frost, R. O., & Steketee, G. (Eds.). (2002). *Cognitive Approaches to Obsessions and Compulsions: Theory, Assessment, and Treatment*. New York: Pergamon Press.

James D'Alessandro and Benjamin Banister, *University of Hartford*, and David F. Tolin, *The Institute of Living and University of Connecticut School of Medicine*

Surveys of patients with obsessive-compulsive disorder (OCD) and practitioners who treat them (Freiheit, Vye, Swan, & Cady, 2004; Goisman et al., 1993) reveal that cognitive therapy is much more widely used than is exposure and response prevention, despite the stronger evidence base for the latter treatment. Until recently, cognitive therapists treating OCD have had to operate without a clear cognitive model of OCD, unlike those treating (for example) panic disorder, in which a cognitive model has been present for some time (e.g., Clark, 1986) and has led directly to the development of effective treatment (e.g., Barlow & Craske, 2000).

*Cognitive Approaches to Obsessions and Compulsions: Theory, Assessment, and Treatment* represents the most formidable attempt to date to assemble a comprehensive cognitive model of OCD for researchers and clinicians. This edited volume is a culmination of the work of the Obsessive Compulsive Cognitions Working Group, an international assembly of leading OCD researchers who have identified specific domains of dysfunctional beliefs (Obsessive Compulsive Cognitions Working Group, 1997) and have developed self-report measures designed to assess such beliefs (Obsessive Compulsive Cognitions Working Group, 2001, 2003).

After an introductory chapter by Taylor providing the theoretical underpinnings of the cognitive model and an overview of the book, the first section of the book provides a well-written overview of the six main cognitive domains underlying the pathogenesis of OCD. These include Importance of Thoughts (believing one's thoughts to be important, dangerous, etc.), the Need to Control Thoughts (believing that complete control over one's mental processes is both possible and desirable), Responsibility (an inflated sense that one is responsible for preventing harm), Overestimation of Threat (a general tendency to believe that negative outcomes are highly likely), Intolerance of Uncertainty (a belief that absolute certainty is necessary), and Perfectionism (an inability to tolerate mistakes or imperfection). In general, these chapters are well written, clear, and concise, and are ideal for graduate level training and coursework. They are also likely to be clinically useful, providing the reader with an understanding of the thought process and consequential compulsive behaviors in OCD. Some of the discussions of assessment strategies may be a bit dense for some readers, and the chapters might benefit from additional case descriptions to illustrate their points.

The book's second section discusses strategies for measuring cognition in OCD. The first chapter, by Taylor and colleagues,

describes the development and validation of the Obsessive Beliefs Questionnaire (OBQ; Obsessive Compulsive Cognitions Working Group, 2001), a self-report measure designed to assess the six cognitive domains described above. The six domains of maladaptive cognitions measured by the OBQ are the subject of a chapter by Riskind and colleagues, who discuss experimental psychopathology approaches to measuring cognition. This chapter also highlights some of the methodological problems present in previous OCD research. Amir and Kozak then present an information-processing model that describes OCD in terms of biases in attention, memory, and interpretation of thoughts, and links putative biological and psychological underpinnings of OCD. Neziroglu and Stevens provide information on the construct of insight in OCD, presenting ways to assess level of insight and to utilize this understanding in early treatment sessions. In general, the second section of the book is rich with data, making it perhaps a bit dense for a clinical audience but certainly a thought-provoking read for students and researchers.

The book's third section addresses the “obsessive-compulsive spectrum” of disorders. Although not all researchers agree that these disorders are related to OCD, it was nevertheless informative to read a discussion of possible cognitive links among the various disorders. In this section, OCD is compared and contrasted with body dysmorphic disorder, eating disorders, depression, and schizophrenia. An additional chapter by Kyrios and colleagues discusses the phenomenon of compulsive hoarding. Clinical readers will find this section of the book useful in thinking about their own patients; additional case material would have been a welcome addition.

The fourth section of the book reviews cognitive findings in select populations diagnosed with OCD. Many of these chapters identify gaps in current knowledge and opportunities for future research. Cognitive

features of OCD are discussed as they pertain to children, older adults, groups with subclinical OCD symptoms, individuals with treatment-resistant OCD, and individuals from other cultures. In each of these cases, the authors discuss how OCD and its associated cognitions appear in that population, and review implications for treatment.

The fifth and final section of the book discusses the effect of treatment. Emmelkamp and colleagues and Bouvard discuss data showing that the cognitive domains tapped by the OBQ appear to improve following exposure and response prevention. Whittal and McLean describe their group CBT protocol, with specific interventions targeting the maladaptive beliefs described in the first section of the book. Intriguingly, their data show that this cognitively based treatment was less effective than was group exposure and response prevention—in fact, group exposure and response prevention appeared to have a greater impact on cognitions than did the cognitive intervention, suggesting that behavioral change may be an effective means of changing cognitions (although, as the authors note, the group format may have attenuated the results of the cognitive intervention more than those of exposure and response prevention). Simos concludes the treatment section with a chapter on the effects of medications, and it is only here that the theme of the book is interrupted. Simos's chapter, although very well written, seems out of place. There is minimal discussion of cognitions, other than parsing out the "obsessions" scores of OCD measures as an estimate of cognitions. This seems like a step backward, rather than forward, from an otherwise coherent and compelling theme in the book.

One of the major strengths of this book is its use of commentary chapters by experts in the field. David A. Clark, Steven Taylor, Martin Antony, Alec Pollard, Jose Yaryura-Tobias, and Paul Emmelkamp each serve as a discussant to synthesize a group of chapters. Thus, reading the book is not unlike attending a series of symposia, in which a group of individual presenters is followed by a discussant who pulls the information together and suggests directions for further study. The book as a whole is exceptionally well written and organized, and will be an invaluable resource to researchers, clinicians, and graduate students interested in understanding OCD from a cognitive perspective.

The book's primary weakness comes not from the writing, but rather from the limitations of the cognitive model itself (which,

as the Editors note, is a work in progress). For a cognitive model of OCD to be truly comprehensive, it is necessary to demonstrate that the cognitive domains are relevant to all (or at least most) variations of OCD symptoms, i.e., the cognitions do not apply only to a small subset of OCD patients. It can be argued that OCD is a more heterogeneous disorder (encompassing diverse symptoms such as washing, hoarding, scrupulosity, etc.) than is, say, panic disorder, making it more difficult to define OCD in terms of distinct cognitions. Most likely, different maladaptive beliefs are associated with different OCD symptoms, and it is hard to understand how any specific belief content would be associated with OCD in all its forms. For example, it is difficult to imagine (without stretching the definitions) how an OCD patient with contamination fears would be characterized as having a pathological need to control their thoughts.

A related issue is whether the cognitive model presented in this book is specific to OCD, rather than to anxiety in general (i.e., the cognitions show something that is unique to OCD beyond the effects of anxiety, negative affectivity). This concern is not limited to cognitive theory; it could certainly be argued that behavioral theories also do not explain well why an individual develops OCD rather than some other anxiety disorder. However, it would be useful to understand whether the maladaptive beliefs presented here are characteristic of OCD in particular, or whether they reflect the thinking processes of anxious people in general. Clark notes in a commentary chapter that a claim of specificity has not been made for most of these domains, with the possible exception of Responsibility. The initial validation studies of the OBQ did not sample enough anxious control participants to answer this question. As Taylor and colleagues discuss in their chapter, a larger study of OCD patients and anxious controls found that the OBQ scales were as strongly correlated with measures of anxiety, depression, and worry as they were with OCD symptoms; furthermore, three of the domains (Intolerance of Uncertainty, Overestimation of Threat, Perfectionism) did not discriminate people with OCD from anxious controls, suggesting that they may not be unique to OCD.

Finally, a cognitive model of OCD must demonstrate clinical utility. For example, use of the model should yield results that are superior to those of treatments that do not share the same conceptual framework. Studies addressing this specific issue are sparse; however, the group treatment data

described by Whittal and McLean seem to argue Rachman's (1997, p. 19) point that "...negative cognitions can decline after a direct attack or after an indirect attack." *Cognitive Approaches to Obsessions and Compulsions: Theory, Assessment, and Treatment* describes the cognitive model well, highlights the thinking of several leading experts, and should be considered a must-read for those interested in understanding OCD theory. Full acceptance of a cognitive model of OCD, however, awaits additional empirical testing.

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## Infidelity as a Cause of PTSD: "Much Overlooked" or Overdiagnosed? A Response to Dattilio (2004)

Candice M. Monson, Susan P. Stevens, and Paula P. Schnurr, *National Center for Posttraumatic Stress Disorder, Executive Division, White River Junction, VT, and Dartmouth Medical School*

In a comment on our recently published overview of cognitive-behavioral couple's treatment for posttraumatic stress disorder (CBCT for PTSD; Monson, Guthrie, & Stevens, 2003), Dattilio (2004) raised the concern that we had "omitted one of the most important and most difficult circumstances resulting in PTSD in couples: the trauma caused by extramarital affairs (EMA)" (p. 76). Our aims are to consider the issue of defining infidelity as a stressor precipitating PTSD and to address the role of infidelity within the context of our treatment. We use the word "infidelity," versus "extramarital affairs," to denote sexually unfaithful acts committed in any intimate relationship, regardless of marital status or sexual orientation.

Infidelity is a prevalent and pernicious problem for individuals, couples, families, and society in general. There is no doubt that the partner of an unfaithful individual can describe their experience as "traumatic," and that they may experience significant distress. However, infidelity does not meet the definition of a traumatic stressor for a PTSD diagnosis according to the *Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR; APA, 2000)*.

The *DSM-IV-TR* indicates that a person has been exposed to a traumatic event if he or she "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (p. 427), and responded with "intense fear, helplessness, or horror" (p. 428). Examples of traumatic events include combat, violent personal assault, disasters, accidents, and learning about the sudden, unexpected death of a family member or close friend.

Drawing from Glass's (2003) work, Dattilio (2004) writes, "many of the symptoms that follow the knowledge of infidelity may *mimic* [emphasis added] symptoms that are found with individuals who are exposed to a wide variety of stressors, such as

combat-related trauma or disaster situations" (pp. 76-77). Indeed, it seems wholly probable that partners of those having affairs might report fear, helplessness, and even horror, in reaction to disclosure or discovery of their partner's infidelity. Infidelity might even cause symptoms that resemble symptoms of PTSD, just as other psychosocial stressors can cause these types of PTSD-like symptoms. However, one has to stretch to describe most cases of infidelity as a threat to one's physical integrity or life, as required for a *DSM-IV-TR* PTSD diagnosis. Should a diagnosis of PTSD be given to an individual who is having distress because of suddenly and unexpectedly losing their job? Is it appropriate to give a diagnosis of PTSD to a husband who unexpectedly discovers that his wife is seeking a divorce and custody of their children? The ultimate question is whether these types of stressors reliably cause a reaction that is consistent with the phenomenology, symptom constellation, and biological findings of PTSD.

The available evidence indicates that the answer to this question is "no." In fact, this was one of the primary questions addressed in the *DSM-IV* field trials (Kilpatrick et al., 1998). The prevalence and phenomenology of symptoms caused by stressors excluded in previous editions of the *DSM* (e.g., marital conflict, job-related stress, simple bereavement) were investigated to determine if they produced PTSD. These stressors, by themselves, did not reliably yield a constellation of symptoms similar to those observed in individuals who experienced life-threatening and injury-producing situations. The *DSM-IV* (APA, 1994) stressor criteria were consequently not expanded to include such stressors. Moreover, there is substantial evidence that there are unique biological and psychological findings associated with PTSD versus other mental health conditions and stress reactions (Friedman, Charney, & Deutch, 1995). Until Dattilio (2004) or others can provide psychological and biological data to indicate otherwise,

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there is no reason to conclude that infidelity is a PTSD-inducing stressor.

Turning our attention to the implications of infidelity for CBCT for PTSD, we appreciate Dattilio (2004) highlighting an important contextual factor to be taken into account in the delivery of any couple's treatment. We do not agree, however, with his statement that "In most PTSD cases, one spouse becomes the healer, but in cases of infidelity, the spouse without PTSD is the offender" (p. 78). CBCT for PTSD is inherently systemic in nature, and our treatment is not designed in theory or practice to include an "Identified Patient" and partner "healer." We consider there to be multiple, reciprocally related individual and relationship factors that cause and maintain problems in both PTSD and relationship functioning, and usually in both members of the couple (see Monson, Stevens, & Schnurr, in press, for more elaborated theoretical discussion). Expanding on the latter point, we note in our original *tBT* article that comorbid partner psychopathology is the rule rather than the exception. Thus, couple's interactions and both partner's thoughts, feelings, and behaviors are targeted in treatment.

Building on the bi-directional association between relationship distress and PTSD, and acknowledging the high rates of mental health disorders in both partners, CBCT for PTSD was not designed to be a partner-coaching or partner-facilitated treatment for PTSD. It is a disorder-specific couple's treatment designed to treat PTSD and relationship problems concurrently, in order to reduce relapse and facilitate further gains in both areas (see Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998, for discussion of different forms of couple's treatment). CBCT for PTSD was developed to have sufficient flexibility to address the myriad of couples' presentations in which one or both members of the couple has PTSD or other psychological problems.

Perhaps the most credible evidence of this couple's treatment approach is that the male veterans and their wives in our pilot study reported significant improvements in their individual symptomatology and relationship functioning (Monson, Schnurr, Stevens, & Guthrie, 2004; Monson et al., in press). Moreover, two of the seven couples had a history of unaddressed infidelity within the past 2 years, and over half of them had a history of experiencing infidelity in a previous intimate relationship. The infidelity-related issues were included as therapeutic content, and the cognitive themes introduced in the latter stage of CBCT for

PTSD (e.g., trust, power/control, intimacy) were well suited to the beliefs and feelings that developed in response to the infidelities.

Dattilio (2004) expresses concern that our focus on the emotions surrounding the memories, reminders and meaning of the traumatic events for the here and now "appears to contradict the specific work that is done in treating PTSD with couples when infidelity is the issue" (p. 77). He appears to have concern that we do not address the memories and reminders of events that trigger negative emotions. It is important that we disabuse him or other readers of the notion that we avoid traumatic material, as that would run in direct opposition to our cognitive-behavioral conceptualization of the role of avoidance in maintaining PTSD and relationship problems.

The important point to be made is that CBCT for PTSD does not involve partner-witnessed imaginal exposure entailing fine-grained descriptions of the traumatic events and related sensory experiences, thoughts, and feelings. This is to prevent possible secondary traumatization of the partners. Expanding this to infidelity, we assume that Dattilio, like us, would not be a proponent of graphic disclosures by the unfaithful partner about his or her affairs. However, we would certainly not collude in the avoidance of the unfaithful partner or the emotions and thoughts that surround the infidelity.

After improving the couple's communication skills, CBCT for PTSD focuses on modifying thoughts and beliefs held by both partners that maintain PTSD and relationship problems. These cognitions are related to the meaning that one makes about traumatic events and relationship interactions. Similarly, Dattilio (Dattilio & Padesky, 1990) notes in his book on cognitive therapy for couples that "The important task for a therapist when an affair is revealed is to discover the meaning this other relationship has for the individual having the affair and for the primary relationship" (p. 86). Thus, we are not entirely clear how our approach is inconsistent with other couple treatments that address infidelity.

Our comments are in no way meant to minimize the effects of infidelity. Infidelity, in and of itself, can lead to substantial individual and relationship distress that merits our best treatment efforts. Moreover, infidelity can contribute to the development or exacerbation of a variety of mental health diagnoses, including PTSD. In his conclusion, Dattilio (2004) intimates that political

issues might prevent the field from considering infidelity as a source of PTSD and from approving treatment plans that are equivalent in intensity and duration to any other treatment for PTSD. Undoubtedly, political forces are at play in the field. However, we question the management of these political issues by assigning a PTSD diagnosis to those with infidelity-related reactions. Doing so ignores the empirical evidence about the precipitants of PTSD and runs the risk of trivializing those who have biological and psychological responses consistent with the diagnosis of PTSD. Instead, we argue for greater research and educational efforts that educate insurance companies and government sponsored healthcare programs about the longer-term value of appropriate mental health treatment for its consumers. These efforts might diminish the tendency toward overdiagnosis and overreliance on medications as the frontline treatment. As researchers and therapists for couples, we are especially compelled to join in these efforts, given the lack of, or limited, funding for our interventions. Perhaps such advocacy would ultimately elevate the perceived gravity of relationship stressors, including infidelity, for the patients we treat.

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## AABT's 38TH ANNUAL CONVENTION November 18–21, 2004

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## Convention 2004

# AABT in the Big Easy, Again

Persephanie Silverthorn, *Local Events Coordinator*

**AABT** comes to New Orleans for the second time in 4 years for its 38th Annual Convention. Those of you who were here for the 2000 convention remember our beautiful and vibrant city, but for those of you who have not been here or have not been here since the last convention, here are some interesting facts about New Orleans.

### Tips for Travelers

([http://www.neworleanscvb.com/new\\_site/visitor/vistips.cfm](http://www.neworleanscvb.com/new_site/visitor/vistips.cfm))

Before you leave home, pack an umbrella, comfortable shoes, and a camera. Showers can arrive unexpectedly, and you want to make sure you are not caught by surprise. And you'll need a camera immediately.

The convention bureau recommends that you buy a VisiTour pass. Available in one-day or three-day denominations, the pass allows unlimited on-and-off privileges for the streetcars and buses. Great for exploring!

The CVB also recommends that you take a round-trip sightseeing tour on the St. Charles Avenue Streetcar. "It's a great way to get an overview of the Garden District, Uptown, and the University areas of town, and you'll be aboard a movable historic landmark. It's the oldest continuously operating street railway system in the world!"

### Weather (based on 2000 U.S. Census Data)

In November:

Average High: 71

Average Low: 50

Average Precipitation: 4.5 inches

Annual precipitation: 61 inches

Annual number of clear days, no clouds: 109

### Alcohol Laws

The drinking age in New Orleans is 21. Alcohol can be purchased on Sunday and in local beverage stores and supermarkets. There are no closing laws on how late a bar can stay open. Alcohol may be consumed in the streets of the French Quarter, but only in unbreakable containers.

### Airport Information ([www.flymsy.com](http://www.flymsy.com))

**Taxis:** A cab ride costs \$28.00 from the airport to the Central Business District (CBD) for one or two persons and \$12.00 (per passenger) for three or more passengers. Pick-up is on the lower level, outside the baggage claim area. There may be an additional charge for extra baggage.

**Airport Shuttle:** Shuttle service is available from the airport to the hotels in the CBD for \$13.00 (per person, one-way), \$26.00 (per person, round-trip), or \$24.00 (per person, round-trip for two or more people when purchased at the airport). Three bags per person. Call 1-866-596-2699 or (504) 522-3500 for more details or to make a reservation. Advance reservations are required 48 hours prior to travel for all ADA accessible transfers. Please call well enough in advance for the specially equipped shuttle to be reserved. For group reservations of 10 or more people please dial 1-888-432-7651. Ticket booths are located on the lower level in the baggage claim area.

### Activities visited while in New Orleans

- French Quarter
- Riverfront
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- D-Day Museum
- Ride a Streetcar
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#### **Mardi Gras Information:**

2000 Mardi Gras Total Visitors: 6,135,890  
 Tourists staying in hotels: 985,890  
 Day Trippers/or staying with friends: 2,240,000  
 Overall Spending: \$1,056,124,885

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The Canal streetcar route takes riders on a historic tour of New Orleans. The route starts on the Riverfront at the French Market, the country's oldest public marketplace. The line then turns onto Canal Street in the heart of the city's Central Business District, bordering the famous French Quarter. The Canal line moves from the CBD to Mid-City, one of New Orleans' most popular neighborhoods, to end at City Park Avenue and the historic city cemeteries.

A spur along North Carrollton Avenue connects the line from City Park at Beauregard Circle to Canal Street. City Park visitors can enjoy more than 1,500 acres of recreation space, botanical gardens and family activities. The Canal Streetcar stops across from the New Orleans Museum of Art, and just blocks from the Fairgrounds.

#### **Geography**

- New Orleans covers 4,190 square miles and sits 90 miles north from the mouth of the Mississippi River.
- New Orleans city proper, shaped like a crescent (thus the nickname the Crescent City), is surrounded by water:
- The Mississippi River at Canal Street has a width of 2200 feet, a bankside depth of 30-60 feet and a mid-stream depth of 100-180 feet.
- Lake Pontchartrain, connecting with the Gulf of Mexico, covers an area of 621 square miles. The Causeway connects the south shore to the north shore and spans almost 24 miles, making it the world's longest over-water highway bridge. The Causeway opened in 1956 with a total cost of \$51 million. A second bridge runs parallel to the first. The toll fee is \$3 paid only on the north shore of the bridge.
- New Orleans is below sea level. Depending on what part of town you are in, you can be from 5-10 feet below sea level. Generally speaking, the closer you are to the river, the higher the elevation.
- The Historic French Quarter was laid out in a grid pattern in 1721 and measures six blocks by 13 blocks. It is considered one of America's greatest clusters of authentic Spanish, colonial, and antebellum structures. Even today it is a vibrant neighborhood filled with residences and business establishments.
- New Orleans restaurants are considered some of the best in the world, and there should be no trouble finding one in any area of the city. There are 3,068 restaurants in the New Orleans Metropolitan area.

#### **New Orleans Population**

Population of the metropolitan area:  
 1,337,726.  
 Population within city limits: 484,674  
 Male: 46.85%

Female: 53.15%  
 Median age: 33.1 years

#### **Finance and Economics:**

Cost of Living (100 = national average): 73  
 Sales Tax Rate: 9%  
 Unemployment rate (1998 most recent data): 4%

#### **Real Estate**

Home purchase cost (average 2000 sq.ft. home): \$162,000  
 Property Tax (average 2000 sq.ft. home): \$2,755  
 Electricity cost (average 2000 sq.ft. home): \$53

#### **Education**

High School graduation rate: 68%  
 Bachelor's Degree rate (% of population): 22%  
 The major universities include: Tulane, Loyola, Xavier, Dillard, the University of New Orleans, and Southern University of New Orleans.

#### **Quality of life**

Air pollution (U.S. average = 100): 77  
 Population density (people per sq.mi): 2,711

#### **Visitor Information**

([www.neworleanscvb.com](http://www.neworleanscvb.com))

The Top 10 States of origin of all New Orleans Visitors include: California, Texas, Florida, Illinois, Louisiana, Georgia, New York, Connecticut, Pennsylvania, Ohio

Number of Hotel Rooms: 33,022  
 Number of Limousines: 200  
 Number of Taxis: 1,600  
 Number of Rental Car Agencies: 12 (with a fleet of 9,000)

#### **More from the CVB**


*For a delightful introduction to Old Man River, take the ferry at the foot of Canal Street across the water to Algiers on the West Bank.*

*Brush up on New Orleansese. For example, in the local lingo we catch the streetcar on the "neutral ground" (elsewhere called a median). And "dressed" - when ordering a sandwich - does not mean formal attire, it means your sandwich comes with "the works." And, in the Crescent City, we're very big on "lagniappe" (pronounced lan-yap) which means "a little something extra."*

*Go with the flow. Directions here follow the river. "Upriver" is uptown, "downriver" is downtown, "lakeside" is toward Lake Pontchartrain, and "riverside" is toward the Mississippi River. The Central Business District and the French Quarter are downriver/downtown.*

*If you're driving into the city, remember that the French Quarter exit off of I-10 is the Vieux Carre- exit 235B.*

*Explore the 24-hour Farmers Market. In the early morning hours, you'll see some of the city's most famous folks shopping for produce.*

For more information, contact Persephanie Silverthorn at [psilver@uno.edu](mailto:psilver@uno.edu). 



# Welcome to New Orleans

As part of the local host committee, we would like to welcome you to New Orleans, Louisiana (or NOLA as it is often called). Here is a guide to New Orleans for the novice or for those who are always looking for a new place to try.

Here are our soon-to-be-patented UNO-NOLA tour packages.

## TOUR 1. How to Live Like a Tourist (But Still Have Fun)

- ✓ Stay in the French Quarter at night. Mainly Bourbon St. Period.
- ✓ Sing Karaoke at Cat's Meow (cover after 10)
- ✓ Dance onstage at Razzoo's (if you're female)
- ✓ Have a Hurricane at Pat O'Brien's (St. Peter)
- ✓ Have a Hand Grenade at Tropical Isle (at the walk-up window)
- ✓ Eat breakfast at Mother's (Poydras)
- ✓ Have beignets and coffee at Café Du Monde (Decatur)
- ✓ Eat at Port of Call (Esplanade)

## TOUR 2. NOLA as a Starving Student/Postdoc

- ✓ Eat at Café Maspero (best cost:quality:quantity ratio in NOLA, in my opinion)
- ✓ Drink at Razzoo's (3 for 1 drinks that are BIG and really affordable)
- ✓ Dance at Oz (cover charge)
- ✓ Go to any of the following student-recommended bars
  - DBA (Marigny)
  - Check Point Charley (Esplanade & Decatur)
  - Molly's at the Market (Decatur & French Market)
- ✓ When you get hungry in between dancing and drinking, go to Dante's Pizza or Ali Baba's (next to each other on St. Peter)
- ✓ Go dancing at the Dungeon (open after midnight)
- ✓ Eat at Mona Lisa (Royal). Might be a little expensive, but worth it to eat at an unknown place.

## TOUR 3. I Wrote a Textbook so I Can Afford to Eat Well

- ✓ Eat at any of the following restaurants:
  - Galatoires
  - Antoinies
  - Irene's
  - K-Paul's Kitchen
  - Commander's Palace
- ✓ Drink at Whisky Blue (in the W on Poydras, across from Mother's)
- ✓ Dance at 735 or Halo (designed for the NYC crowd. Note that 735 is under new management and now upscale.)
- ✓ Drink at the Columns
- ✓ Have brunch at Palace Café

## TOUR 4. I Will Leave the French Quarter and I'm Not Afraid to Admit it

- ✓ Eat at Jacques Imo (Oak & Carrollton)
- ✓ Drink at Cooter Browns (Carrollton & St. Charles)
- ✓ Go to the Warehouse District and visit any of the following bars:
  - Howling Wolf (S. Peters)
  - Red Eye (S. Peters)
  - Polynesian Joe's (Magazine)
  - Lucy's
  - The Mermaid
- ✓ Go to the Fauberg Marigny and drink at DBA, eat at Old Dog New Trick, eat at Café Brazil, listen to jazz at Snug Harbor, or stop at any of the cool places in the Marigny
- ✓ Eat at Jacques Imo, oh, wait, we mentioned that. Oh well, eat there again. It's that good.
- ✓ Drink at the Maple Leaf Bar, next to Jacques
- ✓ Go to the Rock-N-Bowl (Carrollton)
- ✓ Have breakfast at Camilla Grill or Trolley Stop Café (Carrollton at St. Charles)

## TOUR 5. I Saw the Mellow/Funky Side of NOLA

- ✓ Drink at any of the following mellow places:
  - O'Flaherty's Irish Pub (Toulouse)
  - Johnny White's (St. Peter)
  - Jean Lafitte's Blacksmith Shop (Bourbon)
- ✓ Drink at any of the following funky places:
  - The Mermaid (Warehouse District)
  - The Shim Sham (Toulouse)
  - The Matador (Esplanade & Decatur)
- ✓ Go to any of the following Gay Bars:
  - Oz (great dancing)
  - Bourbon Pub
  - Good Friends
  - Kim's (more female)

## TOUR 6. I Brought the Kids/Family Fun for All

- ✓ Go to the Aquarium of the Americas (expensive but fun, Canal & Iberville)
- ✓ Go to the Zoo at Audubon Park
- ✓ Go to the Children's Museum (my favorite, Julia)
- ✓ Go to Audubon Park (St. Charles)
- ✓ Go to City Park and check out the Storyland area
- ✓ Take the trolley up St. Charles and see the beautiful houses
- ✓ If you must take the stroller to Bourbon St., please only do so during the day!

Persephanie Silverthorn, *Local Arrangements Chair*

## Classifieds

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

### positions available

**COGNITIVE-BEHAVIORAL THERAPY (CBT) - THE UNIVERSITY OF CHICAGO.** The Department of Psychiatry is seeking a full-time psychologist to provide psychotherapeutic services. The candidate would provide direct clinical care to a mixed caseload, mainly those with mood and anxiety disorders. The position also entails a modest amount of supervision and teaching of psychology interns and psychiatry residents. The candidate should have a PhD and possess an Illinois license. Salary is commensurate with qualifications and experience.

Please send current c.v. and cover letter to Larry S. Goldman, MD, Director, Adult Psychiatry Section, Department of Psychiatry, 5841 S Maryland - MC3077, Chicago, Illinois, 60637, [l-goldman@uchicago.edu](mailto:l-goldman@uchicago.edu). The University of Chicago is an equal opportunity, affirmative action employer.

**EAST HILLS** - Newly renovated deluxe office space within a suite is available in a prestigious professional building. Four private offices, waiting room, valet parking. Prime location. Call Dr. Kerry Betensky for more information at 515-626-8353.

**COGNITIVE THERAPY TRAINING OPPORTUNITIES AT THE BECK INSTITUTE.** Please see our website for details: [www.beckinstitute.org](http://www.beckinstitute.org)

**FACULTY POSITION IN CLINICAL PSYCHOLOGY.** The Department of Psychology at the University of Arkansas invites applications for a tenure track position at the rank of Assistant Professor beginning August 2005 in the area of CLINICAL psychology. The successful applicant will be expected to conduct high quality, programmatic research that is competitive for extramural funding. Specific area of scholarship is open, but we prefer candidates whose research complements current program emphases in the study of interpersonal violence, anxiety disorders, and preventative interventions for high-risk children. We especially encourage applications from researchers who study under-

represented populations. The position involves both graduate and undergraduate instruction. Applicants must have a Ph.D. from an APA-accredited Clinical Psychology Program. Research and training in clinical psychology at the University of Arkansas is supported by a major endowment to the Department of Psychology and by graduate fellowships from the \$300 million Walton Foundation Endowment. The Fayetteville area is nestled in the foothills of the Ozark Mountains and offers a temperate climate, beautiful scenery, numerous recreational and cultural opportunities, excellent schools, and a nationally recognized and growing economy. Review of applications begins November 1, 2004 and will continue until the position is filled. Women and members of racial or ethnic minority groups are strongly encouraged to apply. Applicants should send a) a curriculum vitae, b) publication reprints, c) a statement of their research plans and teaching interests; they should also arrange for three letters of recommendation to be sent to Timothy A. Cavell, Chair, Clinical Search Committee, Department of Psychology, 216 Memorial Hall, University of Arkansas, Fayetteville, AR 72701. The University of Arkansas is an Equal Opportunity/Affirmative Action Institution. Questions regarding this position can be sent to [tcavell@uark.edu](mailto:tcavell@uark.edu). Visit our website at <http://www.uark.edu/depts/psyc/> for more information about the department.

**HUDSON RIVER REGIONAL PREDOCTORAL INTERNSHIP PROGRAM IN PROFESSIONAL PSYCHOLOGY, NEW YORK STATE OFFICE OF MENTAL HEALTH** offers full time predoctoral internship positions in professional psychology for 2005-2006 in its APA accredited program. Weekly seminars in a variety of clinical and professional areas supplement extensive supervision. Clinical assignments are to inpatient and community services programs at facilities of the New York State Office of Mental Health. Preference is given to students enrolled in APA-accredited clinical or counseling psychology programs. For further information and application materials, contact: Paul Margolies, Ph.D., Training Director, Hudson River Regional Psychology Internship Program, Hudson River Psychiatric Center, 10 Ross Circle, Poughkeepsie, New York, 12601-1078; e-mail: [hrrhjim@omh.state.ny.us](mailto:hrrhjim@omh.state.ny.us); phone: 845-483-3310.

**SEEKING THERAPISTS FOR ACADEMY OF THE SIERRAS.** Academy of the Sierras is the first year-round residential treatment program for adolescent obesity, and also a boarding

school located near Fresno, CA. We are seeking therapists (Masters level and above) experienced in CBT to work (full time or part time) with students ages 13-18 on weight and related issues. Please see [www.academyofthesierras.com](http://www.academyofthesierras.com) and e-mail CVs to Dan Kirschenbaum, Ph.D., Clinical Director, at [dkirschenbaum@healthylivingacademies.com](mailto:dkirschenbaum@healthylivingacademies.com).

**FACULTY POSITION IN CLINICAL PSYCHOLOGY, DEPARTMENT OF PSYCHOLOGY, TEXAS TECH UNIVERSITY.** The Clinical Psychology Doctoral Program (APA-accredited since 1972) at Texas Tech University invites applications for one tenure-track Assistant Professor position to begin Fall, 2005. Research area within clinical psychology is open. We are particularly interested in applicants who have strong programmatic research and who are able to supervise clinical practice for both child and adult clients and teach assessment courses. The position also requires effective undergraduate teaching and departmental service. Candidates from underrepresented groups are strongly encouraged to apply. Candidates must receive the Ph.D. from an APA-accredited Clinical Psychology program by August, 2005.

The Clinical Psychology program embraces a scientist-practitioner training model with strong mentorship of graduate students. The Department (see [www.psychology.ttu.edu](http://www.psychology.ttu.edu)) promotes a collegial environment among 27 full-time faculty and approximately 90 graduate students. Texas Tech University ([www.ttu.edu](http://www.ttu.edu)) is a research university with 28,000 students and numerous opportunities for collaborative work with nearby Health Sciences Center departments. Lubbock ([www.ci.lubbock.tx.us](http://www.ci.lubbock.tx.us)) has a pleasant year-round climate and relatively low cost of living.

Review of applicants begins October 20, 2004 and continues until the position is filled. Send cover letter, curriculum vita, up to three sample reprints, and three letters of recommendation to: Clinical Psychology Search Committee, Department of Psychology, Texas Tech University, Lubbock, TX 79409-2051. For electronic applications, see [www.psychology.ttu.edu](http://www.psychology.ttu.edu) then click on "News". Texas Tech University is an EEO/affirmative action institution and is responsive to the needs of dual career couples. Direct questions about this position to Lee Cohen, Ph.D. or Gregory Mumma, Ph.D., Co-Chairs, Clinical Search Committee, at 806-742-3711, ext. 236 or 246 (office phone), e-mail: [lee.cohen@ttu.edu](mailto:lee.cohen@ttu.edu) or [g.mumma@ttu.edu](mailto:g.mumma@ttu.edu) (e-mail).

## MEMBERS: *Review / Renew*

AABT

We have expanded listings for all members on our database. See board certifications, licensure, and more. We've also added fields in the "Find a Therapist" section of the web site. Now, folks looking for a therapist to treat specific disorders can get even more information.

So, when you renew, take a few minutes to review your record and ensure that it is correct and complete.

How? Go to our site: [www.aabt.org](http://www.aabt.org), and log on. Click on "renew" and get yourself all set for the coming membership year.

Click on the "membership directory" and see how you look. Want to add or change? Click on "update membership profile." Add or change from the various categories.

Questions, write or call David Teisler: [teisler@aabt.org](mailto:teisler@aabt.org) or 212.647.1890

# Register Early for AABT's 38th Annual Meeting in New Orleans

November 18–21, 2004

*Don't miss out on seminal talks by the field's most important investigators:*

## Patricia A. Resick

*Beyond Cognitive Processing: A Reconceptualization of Posttrauma Pathology*

## Gerald C. Davison

*ATSS: A Personal Journey from Fuzzy Pictures and Concerns About Bias to Controlled Free Association in Cognitive-Behavioral Assessment*

## Marvin R. Goldfried

*"Comorbid" Themes in the Career of a Behavior Therapist*

## Robert F. Krueger

*Comorbidity: Toward a Dimensional-Spectrum Model*

## Dean G. Kilpatrick

*Complex Exposure to Traumatic Events and Comorbid Mental Disorders Among Children, Adolescents, and Young Adults*

<b>General Registration</b>	<b>AABT MEMBER</b>	<b>NONMEMBER</b>	<b>AABT STUDENT MEMBER</b>	<b>STUDENT NONMEMBER</b>
Preregistration Received by Oct. 19	\$215	\$415	\$75	\$105
Current registration On-site	\$260	\$455	\$95	\$125
2-Day Clinical Training	\$250	\$300	\$150	\$170
1-Day Clinical Training	\$125	\$150	\$75	\$85
AMASS	\$85	\$100	\$85	\$100
5-Hour Institutes	\$90	\$130	\$75	\$90
Workshops	\$45	\$65	\$40	\$45
Master Clinician Seminar	\$55	\$75	\$45	\$55

ISTSS is the International Society for Traumatic Stress Studies. The society's annual convention will take place at the Hilton New Orleans Riverside immediately prior to AABT's meeting. For more information, visit [www.istss.org](http://www.istss.org)

# Clinical Grand Rounds

## *at AABT's Convention in New Orleans*

Three expert clinicians of different orientations will demonstrate a therapy session with the same "patient," followed by a review session in which the three clinicians and patient come together for discussion.

This will be an exciting opportunity to observe the experts at work, see how different approaches can be used to treat the

same problems, and discuss the strengths of each approach and the contexts in which each approach has advantages.

In keeping with the conference theme of comorbidity, the patient will present with comorbid symptoms of anxiety and depression. Register on-line at [www.aabt.org](http://www.aabt.org).

SESSION 1 Friday, 12:15 p.m. – 1:45 p.m. Grand Ballroom D

Using Cognitive Behavioral Case Formulation in Treating a Client With Anxiety and Depression

*Jacqueline B. Persons*, San Francisco Bay Area Center for Cognitive Therapy

SESSION 2 Friday, 2:30 p.m. – 4:00 p.m. Grand Ballroom D

Using Functional Analytic Psychotherapy When Treating a Client With Anxiety and Depression

*Robert J. Kohlenberg*, University of Washington

SESSION 3 Saturday, 9:00 a.m. – 10:30 a.m. Grand Ballroom D

Using an Integrated Psychotherapy Approach When Treating a Client With Anxiety and Depression

*Marvin Goldfried*, SUNY at Stony Brook

REVIEW Saturday, 1:15 p.m. – 2:45 p.m. Grand Ballroom D

Comparing Three Treatment Approaches

**AABT's 38<sup>TH</sup>**

— *annual* —

C O N V E N T I O N

November 18–21, 2004

 **NEW ORLEANS**

*Hilton Riverside Hotel*

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