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p. 207: Call for Papers for the 2003 Annual Convention in Boston

CONTENTS

FROM THE EDITOR
Behavior Therapy and Social Issues 205
George Ronan

SPECIAL SERIES: BT IN CORRECTIONAL SETTINGS
Behavior Therapy in Correctional Settings: Examples from the Georgia Department of Corrections 208
James F. DeGroot

Token Economics and Incentive Programs: Behavioral Improvement in Mental Health Inmates Housed in State Prisons 208
Carole R. Seegert

Utility of an Intensive Behavior Therapy Unit in a Maximum Security Female Prison 211
Christy Daniel, Javel Jackson, and John Watkins

Screening Inmates for Suicide Using Static Risk Factors 212
Greg Cox

Outcome Research With High-Risk Inmates 215
Javel Jackson

Assessing Inmate Satisfaction With Mental Health Services 217
Thomas J. Spudic

BEHAVIORAL ASSESSMENT
Computers and Behavioral Assessment: 6 Years Later 219
David C. S. Richard and Ken Bobicz

PRESIDENT'S MESSAGE
The Association for Behavioral and Cognitive Therapies: An Idea Whose Time Has Come 225
Jacqueline B. Persons

AT AABT
Reno Revisited 226
Ann M. Steffen

Run for an AABT Elected Office, Now! 226
Sue C. Jacobs, Patricia Long, and Maureen Sullivan

CLASSIFIEDS 231

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 *the Behavior Therapist* 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.

From the Editor

Behavior Therapy and Social Issues

George Ronan, *Central Michigan University*

Holiday greetings to AABT members in this first issue of the new year. Bear with me as I take the opportunity to share with you some changes you will be seeing in *tBT*, beginning with this issue. First of all, let me introduce my new Editorial Assistant, Jennifer Slezak. I am glad to have Jen on board, and am confident that she will do a bang-up job of assisting me with your submissions and coordinating the work of the associate editors. Speaking of whom, I have a couple of more introductions to make. Kelly McClure, Ph.D., is the new Associate Editor for the Student Forum column. Kelly will be accepting manuscripts geared toward student interests and related topics, so if you have a submission in this area, she is the person you will work with. Send correspondence to Kelly McClure, Ph.D., Student Forum, The Children's Hospital of Philadelphia, 3535 Market Street, Room 1485, Philadelphia, PA 19104 (phone: 215.590.0953; e-mail: mcclure@email.chop.edu). Another new face on the editorial staff of *tBT* is Tamara Penix Sbraga, Ph.D. Tamara has accepted the position of Associate Editor for a new *tBT* column, Institutional Settings. I know we have a number of AABT members who work in developmental disability residences, prisons, state hospitals, and various and sundry institutional settings. I hope those of you who work and/or research in an institutional environment will use the new column to keep the rest of us abreast of what is happening in such settings. You can contact Tamara via snail mail: Tamara Penix Sbraga, Ph.D., Institutional Settings, Department of Psychology, Central Michigan University, Mt. Pleasant, MI 48859 (phone: 989.774.6282; e-mail: sbrag1tp@cmich.edu). So, let's give a big

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welcome (and lots of submissions!) to our new *tBT* staff. In addition, I extend my warmest thanks to everyone who has helped make *tBT* happen and to the members whose contributions make this a fine AABT publication.

Now that I have addressed the business end of *tBT*, I want to devote the remainder of my column to an underemphasized area of research and practice for behavior therapists: behavior therapy in criminal justice settings. Why do I believe that behavior therapists need to increase their awareness/activity in forensic environments? Well, for one thing, the criminally incarcerated, a fast-growing population, could benefit from behavior change interventions. The statistics tell us that since 1972 the percentage of people incarcerated in the United States has increased over 400% (Sabol, 1999) and the U.S. now has the dubious distinction of imprisoning a larger percentage of its citizens than any other nation (Walmsley, 2000).

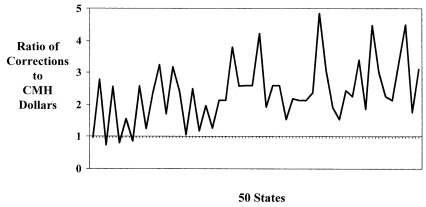

FIG. 1. State Dollars Devoted to Corrections Divided by State Dollars Devoted to Community Mental Health

As shown in Figure 1, over 90% of the states allot more funds to corrections than to community mental health centers (Lutterman & Hogan, 2000; U.S. Department of Justice, 2000). For another thing, there seems to be a need for psychological intervention. Estimates suggest that approximately 16% of the prison population has serious mental illness (Ditton, 1999). Others have found an inverse relationship between community mental health service utilization (Pandiani & Simon, 2002) and number of prison beds (Figure 2). Finally, the concept of relapse prevention appears to be particularly relevant to the prison population. National re-offense rates are notoriously difficult to calculate because of the variability of operational definitions used to identify recidivism. Most evidence suggests that the frequency and cost of re-offense is quite high. Behavior therapists could clearly have a field day here!

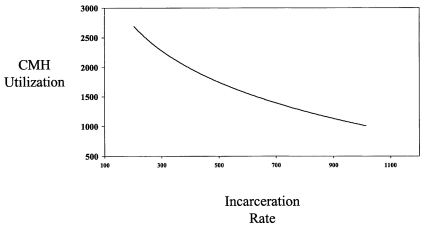

FIG. 2. Relationship Between Community Mental Health Utilization and Incarceration Rates (per 100,000) for 14 States

Problems within correctional facilities in terms of rehabilitation and problems post-release are major social issues, and those with training in behavior therapy have the expertise to make a difference. Thus, I am launching the new year with a *tBT* issue devoted to the topic of behavior therapy and the criminal justice system. The following contributions are from various members of the Behavior Therapy and Research in Criminal Justice Settings SIG. The articles highlight what behavior therapists have been doing in their work with the Georgia Department of Corrections. I hope that the special series will stimulate additional research and discussion on what I consider to be an incredibly important social issue. In fact, I would be very pleased to see a big crowd at the Criminal Justice SIG meeting in November at AABT's 37th Convention in Boston.

Speaking of which, don't forget that the submission deadline for presentations for the next AABT convention is in March (see p. 155). I hope that I will see many of you at the AABT convention in November. And don't forget to bring a friend. *Happy New Year!*

References

Ditton, P. (July, 1999). *Mental health and treatment of inmates and probationers.* Retrieved December 5, 2002, from http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf

Lutterman, T., & Hogan, M. (2000). State Mental Health Agency controlled expenditures and revenues for mental health services, FY 1981 to FY 1997. In R. W. Manderscheid & M. J. Henderson (Eds.), *Mental Health, U.S., 2000.* Retrieved from www.mentalhealth.org/publications/allpubs/SMA01-3537/chapter16.asp

Pandiani, J., & Simon, M. (2002). *Mental health and corrections utilization rates* (Vermont Mental Health Performance Indicator Project). Retrieved December 5, 2002, from http://www.state.vt.us/dmh/Data/PIPs/2002/pip030102.pdf

Sabol, W. (May, 1999). *Crime control and common sense assumptions underlying the expansion of the prison population.* Washington, DC: The Urban Institute Press.

U.S. Department of Justice. (2000). *Sourcebook of criminal justice statistics.* Retrieved December 5, 2002, from http://www.albany.edu/sourcebook/

Walmsley, R. (July, 2000). World prison population list (UK Home Office Research, Development and Statistics Directory). Retrieved from http://www.homeoffice.gov.uk/rds/rf2000.html

AABT

Call for Papers

Mechanisms of Action of Effective Treatment

37th Annual Convention

November 20–23, 2003, Boston

DEBRA A. HOPE, PROGRAM CHAIR

We know that cognitive-behavioral therapies provide effective treatment for many disorders and problems. Unfortunately, we know disappointingly little about the mechanisms of action of the therapies. Understanding these mechanisms is essential to our efforts to strengthen available therapies, develop new and more effective therapies, tailor the evidence-based protocols to the unique needs of each patient, manage noncompliance and other obstacles to implementing the therapies, and understand and overcome treatment failure when it occurs. Therefore, the theme of the 2003 Annual Convention is "Mechanisms of Action of Effective Treatment."

We will give special priority to submissions that address mechanisms of action of cognitive-behavioral therapies, including studies of:

- the therapeutic processes that contribute to better and worse outcomes, including within- and between-session "micro-outcomes";
- the psychopathological processes that interact with intervention strategies and affect outcome; and
- client variables, such as culture, ethnicity, gender, age, and sexual orientation, that moderate and mediate the effectiveness of cognitive-behavioral interventions.

Submissions may be in the form of symposia, roundtables, panel discussions, or posters.

ELECTRONIC SUBMISSIONS

This year submissions for symposia, clinical roundtables, panel discussions and posters will be made electronically via the AABT Web site. The submission link will be active after February 1, 2003 at www.aabt.org. The format for submissions will be similar to last year and full instructions will appear on the Web site.

The deadline for submission of symposia, clinical roundtables, panel discussions, and posters is March 3, 2003.

Special Series

Behavior Therapy in Correctional Settings: Examples From the Georgia Department of Corrections

James F. DeGroot, *Georgia Department of Corrections*

The provision of mental health services to incarcerated populations is a relatively recent development. Historically, mentally ill inmates were treated by general practice physicians or placed in isolation/segregation until their behavior improved. With most recent statistics from the Department of Justice revealing that 16% of all prison inmates are mentally ill, it is imperative that effective treatments be developed and implemented. The National Alliance for the Mentally Ill has begun to call attention to the unique problems experienced by mentally ill inmates. The Department of Justice is focusing on this population by creating mental health courts and prison diversion programs for the mentally ill.

Unfortunately, most research focusing on effective technologies for treating prison inmates occurred before the 1980s. At a time when more mentally ill are in prison than ever before, there is little recent research on empirically supported treatments for them. As might be expected, the lack of research on effective behavioral interventions for prison inmates is multiply determined. The intense use of psychotropic medications resulted in a boon for psychiatry and a shadowing of nonpharmacological treatment (and correctional staff at least appreciate, and sometimes need, a quick fix for inmate mental health problems). Another issue is that prison populations create some difficulties. For instance, most mentally ill inmates also meet criteria for substance abuse and personality disorders. Failure to look only at the criminal aspect and not include addictive behaviors and personality issues can result in poor outcome when working with this disenfranchised population. Issues such as education are also pertinent. For example, 40% of the inmates in Georgia have less than a sixth-grade reading ability, 44% have less than a sixth-grade spelling ability, and 62% have less than a sixth-grade arithmetic ability. These demographic characteristics associated with prison populations often require making significant adjustments to existing protocols to accommodate special and specific needs. Also, a significant percentage of our inmates have chronic medical problems (e.g., HIV, TB, and hepatitis) that create challenges for even the most well-informed behavior therapists. These problems exist within the currently prevalent punishment-versus-rehabilitation model in most prison settings. This model can create significant barriers to the development and delivery of empirically supported interventions to mentally ill inmates.

In spite of its proven efficacy and cost-effectiveness, it is rare to see cognitive behavior therapy (CBT) used to treat inmates with mental health problems. We have attempted to implement behavior therapy and CBT into our treatment for Georgia inmates. This special series highlights some initial work conducted within the Georgia Department of Corrections. We intervene at several levels. A common treatment target in prison settings is decreasing the disproportionate number of disciplinary infractions obtained by mentally ill inmates. The consequence of prison infractions is punishment (isolation/ segregation). Carole Seegert presents descriptions, outcomes, and problems in several behavioral interventions. Christy Daniel and John Watkins present efforts by psychologists designed to decrease the number of disciplinary infractions through use of an intensive behavior therapy unit. Greg Cox presents initial development of a screening device to identify inmates at risk. Javel Jackson discusses the development and implementation of an intervention to decrease self-injurious behaviors. Finally, Tom Spudic addresses assessment of inmate satisfaction with mental health services.

This series provides a glimpse into some of the rewards and difficulties for behaviorally oriented clinicians working in correctional settings. If these articles help activate additional research and dialogue, and promote further attempts at valid behavioral interventions, they have accomplished their goal. ✍

Token Economics and Incentive Programs: Behavioral Improvement in Mental Health Inmates Housed in State Prisons

Carole R. Seegert, *MHM Correctional Services, Georgia Department of Corrections*

The use of a token economy to modify behavior has a long history as an operant procedure for maintaining or increasing desirable responses and decreasing undesirable behaviors. The essential feature of a token economy is the giving or taking away of behaviorally contingent tokens (or points) that can be exchanged for rewards (Westen, 1999). Token economies have been used in a variety of institutional settings such as psychiatric hospitals (e.g., McMonagle & Sultana, 2001) and schools (e.g., Myles, Moran, Ormsbee, & Downing, 1992). This article describes lessons learned from employing a similar operant procedure, incentive programming, to modify the behaviors of state correctional inmates classified as in need of mental health services.

Incentive programming is a variation of a token economy that provides direct rewards for targeted behavior change. Within the Georgia Department of Corrections, incentive programming has been used to increase positive behaviors such as treatment participation, personal hygiene, and appropriate social/psychological functioning. Reward-based treatment interventions have also been used to reduce problematic behaviors associated with disciplinary infractions and intentional self-injury. Inmate characteristics such as gender and contextual factors (e.g., what is permitted and available at specific institutions) are used to identify potential reinforcers.

A major influence on the effectiveness of incentive programming is the level of sophistication and the philosophy of prison administrators. Even cost-effective incentive programs are often viewed with suspicion and judged to be antithetical to the "tough-on-crime" approach. A prison administrator who is philosophically opposed to rewarding inmates often translates into a refusal to support incentive programming, whereas the active support of a warden can result in obtaining the resources necessary to implement a highly

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successful program. In addition to administrative support, involving front-line correctional staff members is critical to successful programming. In settings where the correctional staff are supportive it is sometimes difficult to determine whether targeted behavior change resulted from the positive influence of supportive correctional officers or the actual incentive.

The projects described below reflect small-scale efforts by behaviorally oriented clinicians to provide effective treatment for mental health inmates. A major threat to the internal validity of time-series designs involves a main effect of history; the use of a control group is the best approach for addressing this problem. Unfortunately, large case loads coupled with a lack of support staff rarely allows for such a comparison. The behavior therapists involved in these projects are aware of design limitations and the cases listed below are anecdotal and designed to highlight relevant factors.

Increasing the Personal Hygiene of Male Inmates Diagnosed With Schizophrenia

Beef sticks and coffee packets were used to promote good personal hygiene (e.g., showering 3 times per week) of a male inmate diagnosed with schizophrenia. Crackers, on the other hand, proved less effective as an incentive because inmates could easily obtain them in other ways (e.g., from the inmate store). As all behaviorally oriented clinicians know, the power of a reinforcer is diminished by its ready availability by means other than engaging in the targeted behavior.

Decreasing Disciplinary Reports for Male Inmates With Serious Mental Illness in a Maximum Security Prison

Personal staff congratulations and hot dogs with condiments were used to decrease the number of disciplinary reports (DRs) received by seriously mentally ill inmates residing on a supportive living unit (SLU) or in lock-down status. An SLU is a residential treatment unit for those whose functioning is so sufficiently impaired by mental illness that they need more intensive clinical services and shelter from the general population. These inmates generally have mobility on their unit and interact with peers. Inmates in lock-down status are housed in small cells, often alone, for purposes of administrative punishment or personal protection. This program had only limited success in decreasing rule infractions because it required inmates to be DR free for 3 months to earn their reward. A 90-day interval is excessively long, particularly for individuals oriented to short-term gratification. The greatest value of the project may have been its humanizing effect in the unpleasant environment of a high-security institution. The staff reported that inmates were very responsive to the positive attention they received. Another benefit, though unanticipated, was that some indigent inmates who routinely traded sex for prison store items like cigarettes and pastries traded their hot dogs instead.

Decreasing Self-Mutilation in Male Inmates

Ice cream sandwiches were used to motivate male inmates with histories of self-mutilation to participate in group therapy and remain injury free. Each week, patients were provided with an ice cream sandwich if they attended the treatment group and had not harmed themselves during the previous week. Participants received two ice cream sandwiches if none of the group members had engaged in self-harm. This promoted a social support system that rewarded inmates for not self-mutilating. The importance of conducting idiographic assessments was brought home when one man cut himself shortly after a group meeting in which he had enjoyed two ice cream sandwiches. When asked the reasons for the self-injurious behavior, he stated, "I don't do happiness." Although the overall reduction in self-mutilation was clinically significant, the program was derailed when a prison administrator discovered that the psychologist leading the group was purchasing the ice cream sandwiches with her own money. This violated the prison rule against giving gifts to inmates and continuing her practice would have jeopardized her job.

Decreasing Disciplinary Reports for Female Inmates on a Mental Health Unit

Music, games, and "sock hops" were used to reinforce females on a mental health unit for decreasing the number of disciplinary infractions. The women earned points for good behavior, which they could exchange for pleasurable social experiences like games that were provided by the activity therapist during special sessions. Data showed an initial decrease in disciplinary reports; however, personnel changes resulted in inconsistent implementation of the program and diminished efficacy.

Male Mental Health Inmates on an SLU

Videos and boom-box music were used to reinforce good dorm inspections and to decrease the number of disciplinary infractions on an SLU of 25 male residents. A point system was developed whereby the unit was given 5 points each month, earned additional points for good dorm inspections, and lost points for each disciplinary report received by any resident. The unit could watch a video if at least 1 point was left at the end of the month. An interrupted time-series design demonstrated a dramatic decrease in the number of disciplinary reports for the 5-month period after implementing the program. The prison administrators became concerned about copyright violations and halted the use of videotaped movies as reinforcers. Lawyers for the Department of Corrections clarified that showing videos to small groups of inmates without charging admission fees was legal. Nonetheless, concerned about how and which movies might be selected, prison administrators remained wary of this practice. Videos were a potent reinforcer and, when eliminated, disciplinary infractions increased. Access to boom-box music (of inmate choice) was enjoyed by the inmates but was not sufficient to motivate changes in behavior.

Psychotic Male Inmate

Permitting carefully scheduled phone calls to family members dramatically improved the behavior of a psychotic male inmate when used as reinforcement for not "pestering" his counselors. This pestering took the form of repeated, annoying requests for extra privileges (primarily to make phone calls to family members) and repeated requests to be transferred to a facility closer to home. More serious problem behaviors such as spreading feces over the walls of his cell, eating feces, and making repeated threats to harm himself resulted in frequent short-term placements on a Crisis Stabilization Unit.

As a first step, the behavior therapist met with the inmate and planned the incentive program. The inmate agreed to the schedule and the rewards. He understood that the required period of appropriate behavior would be lengthened incrementally. Phone calls were initially granted after 2 days of not nagging his counselor, with increments increasing to 1 week, 2 weeks, and 1 month. The inmate evinced greater self-control as the time required to receive the incentive increased. He refrained from nagging his counselor and engaging in inappropriate activity with fecal matter. Threats of self-harm ceased for the 6 months necessary to earn transfer to a prison closer to his home.

Summary

For a variety of reasons, the outlined projects were short-term. It is not known if the effects persist over time or decay. Erosion of the programs was often related to institutional interference, lack of funding, and personnel changes that resulted in diminished staff time and/or motivation. Because the inmate population is mobile, inmates are often released or transferred with little or no notice provided to the mental health staff. Thus, treatment may be interrupted and follow-up difficult or impossible. Limited ability to manage contingencies and dependency on staff members who, understandably, prefer efficiency to methodological rigor also presents challenges to correctional research. Even though prison is a self-contained environment, a limited ability to control contingencies can compromise treatment effects. Too frequently in prison settings, there is an uneasy and sometimes adversarial relationship between treatment and institutional personnel. Neither behavior therapists nor other mental health clinicians manage correctional facilities and, for obvious reasons, security needs have priority over mental health programming. Because clinicians typically must defer to wardens and captains, behavior therapists are likely to have the greatest chance of succeeding when they are sensitive to the language and perspectives of their institutional colleagues. With this in mind, proposals for new incentive programs may find a more receptive audience if they are presented as *behavior management* or *behavioral control* approaches rather than the more clinical terms of *behavior therapy*, *incentive programs*, or *behavior modification*.

References

McMonagle, T., & Sultana, A. (2001). Token economy for schizophrenia. *The Cochrane Library, 3*.

Myles, B. S., Moran, M. R., Ormsbee, C. I., & Downing, J. A. (1992). Guidelines for establishing and maintaining token economies. *Intervention in School and Clinic, 27*, 164-169.

Westen, D. (1999). *Psychology: Mind, brain, and culture*. New York: John Wiley & Sons. ✍

Utility of an Intensive Behavior Therapy Unit in a Maximum Security Female Prison

Christy Daniel, Javel Jackson, and John Watkins, Georgia Department of Corrections

In many ways prisons are used to house people who have not been able to behave in accordance with societal conceptualizations of individual rights and responsibilities. An intensive behavior therapy unit (IBTU) is for people who have not been able to adjust to prison-based rules regarding individual rights and responsibilities. More specifically, the IBTU is designed for MH/MR (mental health/mental retardation) inmates who are unable to perform in a less restrictive environment. The unit provides programs, security, and individual behavioral plans in a controlled atmosphere. Criteria for admission include behaviors that are disturbing to the general prison community, long-standing problematic behaviors that are resistant to normal, ward-based interventions, and demonstrated inability to participate appropriately in the usual activities offered by the institution. Customary treatment services and disciplinary procedures are exhausted before an inmate is placed in IBTU.

This article describes an IBTU located in a maximum-security female prison. A key component of this IBTU is a weekly incentive program that monitors personal hygiene and grooming, sanitation, and socialization activities. Appropriate compliance with these activities is recorded on a daily checklist and incentives are distributed based on performance. On admission to the IBTU, inmates are on room restriction and closely supervised when out of their rooms. Inmates on this level are allowed one phone call per month and 1 hour of recreation between Monday and Friday; no visitation or store privileges are allowed. Because behavior change often requires time for the consolidation of new skills, a period of behavioral stability is required. Advancement to the next level requires at least 3 weeks. After promotion to the next level, inmates are restricted to the unit, awarded 15

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minutes of telephone time, and receive 2 hours of television privileges. Inmates are quickly demoted to a lower level of privileges if inappropriate behaviors reemerge. A significant period of stability in behavioral change is required prior to the inmate being integrated back into the general prison population. Below, we present two cases to illustrate how the IBTU functions.

Case of Julia

Julia was transferred to the IBTU because she refused to attend to her personal hygiene, eat, or maintain her room at institutional standards. This was her first incarceration and there was no documented mental health diagnosis. She was extremely hostile and aggressive toward staff and other inmates. Julia's weight dropped 20 pounds in 6 weeks. A subsequent mental health evaluation resulted in a diagnosis of psychosis and an inability to care for herself. She was transferred to a crisis stabilization unit and placed on Prolixin. The next day she was admitted to the IBTU and provided with information about what she could expect to gain from participating in the program. Slowly over the next several weeks she began to participate in groups, demonstrate prosocial behavior, and take an active interest in the program. The incentive program was effective for increasing personal hygiene and prosocial behaviors. Within 3 months Julia was discharged from the IBTU and since her release she has complied with the rules and regulations of the institution.

Case of Jane

Jane underwent treatment in a mental hospital the year preceding her incarceration. The hospital reported little success in altering her behavior and described her as extremely self-injurious. She would throw herself down stairs and cut her face and throat with glass. She also would swallow elongated objects such as antennas, pens, spoons, and toothbrushes. Following surgeries to remove these items, she would reopen the wounds and remove her sutures. Jane was admitted to the IBTU and placed on camera observation to monitor the self-injurious behavior. Behavioral interventions included modeling, cueing her to articulate her needs, and systematically ignoring negative attention-seeking behaviors. Positive behaviors were rewarded with verbal praise, special activities like watching television, and weekly incentives. When her negative attention-seeking and self-injurious behaviors subsided for 3 months she was allowed to have her lights turned off at night and camera observation was terminated. After 10 months Jane was discharged to a less restrictive ward and no further incidents of self-injurious behavior were recorded.

Supportive Data

The goal of IBTU is to promote prosocial behavior and extinguish problematic behavior. The hope is that through the consistent application of external reward the inmate will eventually come to experience intrinsic motivation to behave in an appropriate manner. Pilot data are presented below. The goal was to asses the effectiveness of the program by contrasting the number of disciplinary reports received 90 days before IBTU admission with the number of disciplinary reports received 90 days after discharge from the IBTU. The sample consisted of 39 inmates, with average age of 28 and an average 6-month length of stay on the IBTU. Discharge from the IBTU was based upon a variety of factors, including the clinical judgment of the coordinator and other consultants for the unit (i.e., behavior therapists and psychiatrists).

A significant chi-square ($\chi^2 = 27.52$, $p < .05$) suggests that the number of inmates that the coordinator and consultants rated as significantly improved was greater than chance. A paired sample t test further revealed a significant difference between the number of disciplinary reports inmates received during the 3 months prior to admission to the IBTU ($M = 8.72$, $SD = 7.39$) and 3 months after release from the IBTU ($M = 4.00$, $SD = 4.34$). The lack of a significant relationship between disciplinary reports received prior to and after participating in the IBTU ($r = .19$, $p = .26$) suggests behavior change did occur between the periods sampled.

Discussion

The purpose of this paper was to briefly describe an IBTU and to present pilot data that assessed the efficacy of the program. The coordinator and consultants rated a greater number of inmates as improved than would be expected by chance. In addition, the contrast between disciplinary reports 3 months before versus 3 months after treatment was significant. We were unable to evaluate mechanisms related to the change and inmates demonstrated considerable variability in response to the program. For instance, indigent inmates in the general prison population do not have the ability to purchase items in the store; modifying their behavior in accordance with the IBTU guidelines allowed them to receive items they normally could not access. On the other hand, nonindigent inmates typically had some family support and social contacts, and this may have helped motivate behavior change. A follow-up study is evaluating the efficacy of the program and employs a comparison group composed of inmates with a comparable number of disciplinary reports who are not admitted to the IBTU.

Screening Inmates for Suicide Using Static Risk Factors

Greg Cox, *Georgia Department of Corrections*

Behavior therapists working in criminal justice settings are commonly called upon to identify inmates at risk for suicide and to implement interventions that will decrease the probability of suicide. This is a rather daunting task. A project currently under way involves the development of an assessment device to identify at-risk inmates in need of suicide prevention services. Clinical files for 35 inmates who had committed suicide over a 5-year period were reviewed to identify common characteristics. A wide variety of data were reviewed and five face-valid areas served to organize the search. The ultimate goal was to develop a screening instrument for selection of inmates most at risk of suicide.

Means of Suicide

Tatarelli, Mancinelli, Taggi, and Polidori (1999) found hanging and gas inhalation to be the most frequently occurring methods of suicide in an Italian sample of incarcerated individuals. Several studies of nonincarcerated offenders have found drug overdose to be the most frequent method of suicide (Kullgren, Tengstrom, & Grann, 1998; Saarinen, Lehtonen, & Lonnqvist, 1999). For the sample described here, the method used was recorded for 32 inmates. Ninety-one percent died by hanging and 9% died from an overdose. Detailed information was available in 23 of the hanging

TABLE 1
DIAGNOSES FOR SUCCESSFUL SUICIDES

Diagnosis	Number	Percent
Personality disorders	17	63
Depression-related disorders	13	48
Psychosis-related disorders	11	41
Anxiety disorders	5	19
Bipolar disorders	5	19
Schizoaffective disorder	5	19
Organic disorders	3	11
Sexual disorders	1	4
Malingering	1	4
Mental retardation	1	4
Sexual disorders	1	4

TABLE 2
PROPOSED SCREENING ITEMS TO EVALUATE RISK OF SELF-INJURY AND SUICIDE

	Response Format
•Low-Risk Items	
Diagnosis of severe depression	Absent = 0; Present = 1
Diagnosis of substance abuse	Absent = 0; Present = 1
Diagnosis of schizophrenia	Absent = 0; Present = 1
Psychiatric treatment prior to incarceration	Absent = 0; Present = 1
History of self-injurious behaviors	Absent = 0; Present = 1
•Medium-Risk Items	
Chronic medical condition	Absent = 0; Present = 2
More than three episodes of self-injury	Absent = 0; Present = 2
History of suicidal ideation	Absent = 0; Present = 2
Recent significant losses	Absent = 0; Present = 2
Suicide by a first-degree relative	Absent = 0; Present = 2
•High-Risk Items	
Attempted or made reference to hanging or overdose	Absent = 0; Present = 3
Past self-injury that was nearly lethal and required medical attention	Absent = 0; Present = 3
Verbalize intention to kill self	Absent = 0; Present = 3
History of command hallucination or delusions involving self-harm	Absent = 0; Present = 3

cases: 87% used a sheet or blanket and 13% used strings from a laundry bag or shoes. One of the overdose cases used Tylenol, one Doxepin, and one Elavil. In general, these results are similar to what has been reported in other correctional settings. Although many forms of self-injurious behavior (e.g., cutting, head banging, ingestion of foreign objects or substances) indicate suicidality and require direct clinical oversight and review, hanging and drug overdose are the most strongly related to completed suicide.

Past Episodes of Self-Injury

Some have differentiated self-injurious behaviors based on motivational differences between inmates who self-harm because they wish to die versus inmates who self-harm to escape a situation (Apter et al., 1995). Others suggest that self-harm behaviors follow a continuum of parasuicides to completed suicides (Evans, Albers, Macari, & Mason, 1996). Base-rate data show that the rate of suicidal ideation is greater than the rate of suicide attempts, which, in turn, is greater than the rate of completed suicides. For instance, estimates for the rate of parasuicidal gestures within prison settings have ranged from 1,380 per 100,000 inmates to 3,760 per 100,000 inmates. Depending on the prison setting, rates of completed suicides are much lower. Clinically meaningful differences are likely to exist among inmates who report thoughts of killing themselves, inmates with a history of a single suicide attempt, inmates with a history of multiple suicide attempts, and inmates who complete suicide (see Ivanoff, Jang, & Smyth, 1996; Joiner, Walker, Rudd, & Jobes, 1999). Nevertheless, 86% of the inmates in our sample had previous episodes of self-injurious behavior.

Psychiatric Diagnosis

Efforts to discriminate among motivational factors related to self-harm revealed some interesting differences in psychiatric diagnoses. For example, Fulwiler, Forbes, Santangelo, and Folstein (1997) found that prisoners who injured themselves without intending to die (a wish to escape a situation) demonstrated fewer diagnoses of depression and dysthymia than inmates who attempted suicide (a wish to die). Conversely, suicide attempters obtained fewer diagnoses of childhood hyperactivity and antisocial, aggressive, and impulsive personality traits than those who used self-injury as an avoidance strategy. Depression has often been reported as the most frequent diagnosis carried by inmates who complete suicide (54%: Fulwiler et al., 1997; 69%: Saarinen et al., 1999; 62%: Tatarelli et al., 1999).

For our sample, information on psychiatric diagnosis was available for 33 of the 35 inmates who had completed suicide. The number of diagnoses per inmate ranged from 0 to 5, with an average of 2.25 per inmate. Eighty-one percent carried at least one psychiatric diagnosis. Table 1 lists the psychiatric diagnoses for this sample. It is striking that 41% of this sample was diagnosed with a psychotic disorder, a number that would have been higher except that psychosis data related to schizoaffective diagnosis were not available. Research has estimated the prevalence of psychotic disorders among inmates who suicide to range from 8.6% to 20% (Saarinen et al., 1999; Tatarelli et al., 1999).

The preponderance of personality disorders (63%) and psychotic diagnoses found in our sample of individuals who completed suicide is consistent with the Kullgren et al. (1998) finding relating a personality disorder diagnosis to suicide risk. Indeed, Kullgren and colleagues found a standardized mortality ratio among personality-disordered offenders about 12 times that of the general population of offenders.

Although Fulwiler et al. (1997) found a bipolar disorder diagnosis in 33% of a sample of inmates who committed suicide, only 19% of our sample carried that diagnosis. Moreover, rates of depression were somewhat less in this sample than what has been previously reported (e.g., 53%: Fulwiler et al.; 61% to 62%: Tatarelli et al., 1999).

History of Psychiatric Treatment Prior to Incarceration

Psychiatric history appears to be the most consistent correlate of suicide among prison inmates. Inmates with documented psychiatric histories were eight times more likely to commit parasuicide during incarceration than those without such histories (Ivanoff et al., 1996). Twenty-two of 26 inmates (85%) for whom such information was available had received psychiatric treatment prior to incarceration. Of these, 12 records indicated psychiatric hospitalization prior to incarceration.

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Presence of Chronic Medical or Neurological Condition

The presence of a chronic illness has also been related to suicide in prison inmates. Tatarelli et al. (1999) found that 66.7% of inmates who committed suicide were HIV-positive. A second study using a different sample found 36% tested positive for HIV (Tatarelli et al.). Eighty-four percent of the inmates in the current sample had either a neurological or a chronic illness. Sixty-nine percent were diagnosed with one or more of the following: HIV, diabetes, prostate disorder, hyperthyroid, pituitary tumor, lupus, gastric disease, asthma, hypertension, or migraines. Fifty-eight percent were diagnosed with neurological disorders like closed head injury, closed seizure disorder, post-encephalic parkinsonianism.

Implications

Items were developed based on the chart reviews (Table 1). Weights were assigned based on the perceived importance of each item (Table 2). Greater weights were assigned based on either strong evidence relating the factor to suicidality or clinical evidence of the importance of that item for predicting suicidality.

We are interested in refining this instrument and look forward to the possibility of cross-validation using other state prison systems. The hope is that working together we can more effectively begin to identify inmates most in need of the scarce resources currently available.

References

Apter, A., Gothele, D., Orbach, I., Weizman, R., Ratzoni, G., Hareven, D., & Tyano, S. (1995). Correlation of suicidal and violent behavior in different diagnostic categories in hospitalized adolescent patients. *Journal of the American Academy of Child Adolescent Psychiatry, 34*, 912-918.

Biggar, K., & Neal, D. (1996). Caring for the suicidal in custody: Developing a multidisciplinary approach. *Omega, 33*, 207-213.

Evans, W., Albers, E., Macari, D., & Mason, A. (1996). Suicide ideation, attempts, and abuse among incarcerated gang and non-gang delinquents. *Child and Adolescent Social Work Journal, 13*, 115-126.

Fulwiler, C., Forbes, C., Santangelo S. I., & Folstein, M. (1997). Self-mutilation and suicide attempt: Distinguishing features in prisoners. *Journal of the American Academy of Psychiatry Law, 25*, 69-77.

Ivanoff, A., Jang, S. J., & Smyth, N. J. (1996). Clinical risk factors associated with parasuicide in prison. *International Journal of Offender Therapy and Comparative Criminology, 40*, 135-146.

Joiner, T. E., Walker, R. L., Rudd, M. D., & Jobes, D. A. (1999). Scientizing and routinizing the assessment of suicidality in outpatient practice. *Professional Psychology: Research and Practice, 30*, 447-453.

Kullgren, G., Tengstrom, A., & Grann, M. (1998). Suicide among personality-disordered offenders: A follow-up study of 1,943 male criminal offenders. *Social Psychiatry and Psychiatric Epidemiology, 33*, 102-106.

Saarinen, P. I., Lehtonen, J., & Lonnqvist, J. (1999). Suicide risk in schizophrenia: An analysis of 17 consecutive suicides. *Schizophrenia Bulletin, 25*, 533-542.

Tatarelli, R., Mancinelli, I., Taggi, F., & Polidori, G. (1999). Suicide in Italian prisons in 1996 and 1997: A descriptive epidemiological study. *International Journal of Offender Therapy and Comparative Criminology, 43*, 438-447.

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Outcome Research With High-Risk Inmates

Javel Jackson, *Georgia Department of Corrections*

Behavior therapists working in prison settings are often asked to identify factors that increase the probability that an inmate will attempt suicide. The low base rate for suicide makes the identification of reliable predictors difficult. For instance, the Georgia Department of Corrections houses approximately 40,000 inmates and, since records have been kept, the annual suicide rate has varied from 1 to 12 per year. Nonetheless, inmate suicide can have an enormous impact on the inmate's family members and friends, as well as other inmates and the correctional staff. Therefore, developing programs that decrease the number of parasuicides and suicides remains an important goal.

This paper describes a suicide prevention program that was developed after two female inmates in the same facility killed themselves within a 2-week period. The program employs a psychoeducational approach and treatment is administered in a group format. The goal is to train inmates in coping skills that can be used to deal with stressful situations. After inmates complete the initial program they can be assigned to a long-term therapeutic group that was designed to provide inmates with a support system to help them cope with suicide-related thoughts, feelings, and impulses. Coping skills learned in the first groups are reinforced and serve as the basis for the support system. Because the initial program was favorably received by inmates and staff, a pilot study was conducted as the program was exported to additional facilities within the Georgia Department of Corrections.

Method

Participants

Participants were screened using a device developed from a review of the empirical literature (see Cox, 2002, in this issue). Inmates with high scores and who were clinically considered a high risk for suicide were selected to participate in the suicide prevention group. Inmates were strongly encouraged to participate, but participation was voluntary and inmates could decline participation after a waiver was signed. The number of participants in each group ranged from 6 to 14. A wait list was established whenever a large number of inmates met the threshold for potential participation. When possible, inmates on the wait list participated in a support group until program openings arose.

Materials

The group followed a treatment protocol developed by Ellis and Newman (1996). The protocol employed cognitive therapy techniques to decrease the urge to suicide. The Reasons for Living Inventory (Linehan, Goodstein, Nielsen, & Chiles, 1983) was used to measure changes in attitude.

Procedure

Training sessions were implemented to encourage treatment fidelity across groups and prison settings. All group leaders participated in approximately 4 hours of training that involved reviewing the treatment materials and the format for delivering the protocol. Whenever a support group was available for wait-listed inmates, they also completed pre- and posttreatment measures. Although approximately 21 facilities participated in the initial training, only 4 facilities agreed to collect pre- and posttreatment measures. These 4 settings received additional training that included mock group sessions.

TABLE 1
DESCRIPTIVE INFORMATION

Facility	% White	Age Range	% Transferred or Released During Treatment	% Completed
Facility 1 (n = 12)	66	19–53	58	42
Facility 2 (n = 6)	50	27–51	50	50
Total	61	19–53	61	44

Results

Although four settings had agreed to collect pre- and posttreatment data, problems related to the copying and administration of the materials (e.g., leaving out questions or questionnaires) resulted in data being available from only two facilities. Table 1 provides descriptive information from the participants.

Means and standard deviations are presented in Table 2. Results were analyzed using paired samples t-test.

For Prison 1, significant pre- to postreatment differences emerged for the Survival and Coping Beliefs subscale and the Fear of Social Disgrace subscale of the Reasons for Living Inventory.

Discussion

The overall goal for the program was to increase participants' desires to live, decrease participants' level of suicide risk, and, ultimately, save lives within the Georgia State Prison system. The results of this project highlight some of the difficulties of developing empirical support for treatments conducted within such a setting. For instance, 21 facilities initially demonstrated an interest in a suicide prevention program, but only 4 facilities agreed to collect data to determine the effectiveness of the program. Moreover, problems with data collection resulted in the data from only 2 programs being available for analysis. Discussion with the facilitator (of Prison 2) mentioned that the group was not conducted as the training had suggested. While it would be easy to criticize the facilities or personnel involved, my belief is that these problems stem from the priorities that are operating in most state prison systems. The institutional goals include containing and securing the incarcerated. In many facilities there is a lack of space for programming because the physical plant has been designed to secure prisoners, not to promote programming. Therefore, weekly groups may not always occur if the space is not available. Furthermore, a group may miss its designated meeting time because of conflicts with the standard institutional schedule, such as count clearing (which is required for the accountability of all inmates) or the administration of medication that must occur during specified times. Moreover, because many departments (medical, security, various work details, etc.) are vying for an inmate's time, requiring inmates to arrive in a designated place on time may be difficult. In addition, in this study, 61% of those who began the program were transferred or released before they were able to complete the group. Inmates transfer for various reasons, including pos-

TABLE 2
MEANS AND STANDARD DEVIATIONS FOR THE REASONS FOR LIVING SCALE

	SCB		RF		CC		FS		FSD		MO	
Prison	pre	post	pre	post	pre	post	pre	post	pre	post	pre	post
P1												
M	4.25	4.97*	4.74	5.02	3.80	4.91	3.48	3.82	2.60	4.06*	3.90	4.20
SD	2.08	1.26	1.75	1.40	2.39	1.92	2.30	1.82	1.76	1.66	2.17	2.01
P2												
M	3.36	4.06	4.80	4.76	3.22	4.55	4.04	3.75	4.22	3.22	3.66	4.00
SD	1.90	1.63	1.72	1.54	2.43	2.12	2.03	1.40	4.56	1.92	2.10	1.65
Total												
M	4.02	4.63	4.76	4.92	3.58	4.76	3.69	3.80	3.20	3.75	3.81	4.12
SD	2.03	1.47	1.72	1.45	2.37	1.97	2.20	1.67	1.84	1.77	2.11	1.86

Note. SCB = Survival and Coping Beliefs, RF = Responsibility to Family, CC = Child Concerns, FS = Fear of Suicide, FSD = Fear of Social Disgrace, MO = Moral Objections
*Significant pre- to posttreatment change ($p < .05$).

itive transfer to a facility closer to the inmate's home or for training at a facility that offers a particular vocational program. Those released may have served their maximum time or may have been released on parole. All of the abovementioned reasons make it quite difficult for facilitators to conduct groups in a standard manner and for any inmate to complete a group.

The concept of providing a suicide program for prison inmates seems reasonable and inmates tagged as high risk for suicide rate the program as helpful. Therefore, the effort to develop an effective protocol that is sensitive to contextual factors will continue. The hope is that further refinements will result in a program that increases the inmate's ability to cope with stressors and decreases the propensity to seek out a permanent solution to temporary problems.

References

Cox, G. (2002). Screening inmates for suicide. *the Behavior Therapist, 26*, 160-162.

Ellis, T. E., & Newman, C. F. (1996). *Choosing to live: How to defeat suicide through cognitive therapy*. Oakland, CA: New Harbinger Publications.

Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: The Reasons for Living Inventory. *Journal of Consulting and Clinical Psychology, 51*, 276-286.

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Assessing Inmate Satisfaction With Mental Health Services

Thomas J. Spudic, *Georgia Department of Corrections*

An inherent tension exists between providing mental health services and societal goals for incarceration. Prisons separate and punish criminal offenders; rehabilitation is either not a goal or is viewed as a secondary function. Although case law disagrees, some correctional staff and prison administrators challenge the basic tenets of providing any mental health treatment for criminals. This tension between the goals of punishment versus rehabilitation is prevalent within most state-funded correctional facilities and creates special challenges for behavior therapists who are typically trained to assess the effectiveness or quality of the services they provide.

In typical business settings the amount of money people are willing to pay for products or services has served as a rough estimate of quality. Using such an analysis in correctional settings is problematic because there is no overlap between those who receive services (inmates) and those who pay the bill (the public). Those appointed to oversee the functioning of the state prison system (governors or commissioners) are typically motivated to minimize the cost to the public while adhering to the technical standards required to avoid legal liabilities. Thus, behavior therapists often find themselves defining the customer as some combination of the inmates, the correctional staff, the warden, the public, and the commissioner or governor. Given the different perspectives and contingencies that are operative for each of these stakeholders, it is common for each constituent to voice disagreement about what constitutes high-quality mental health services. Nevertheless, defining what constitutes effective correctional mental health services remains an important first step for behaviorally oriented clinicians, trained to focus on evaluating the effectiveness of the services they provide.

The concept of quality is more easily connected to a product as opposed to less tangible entities like mental health treatments (Ishikawa, 1985; Morita, 1986). Even in industry, however, quality is rarely defined as a simple adherence to "standards." It is quite possible, for example, to create a technically superior product that no one would want to buy because of excessive complexity, cost, or poor marketing. Although the concept of quality may include adherence to technical standards, application of the concept contains a strong component of consumer satisfaction. This article reviews the results of a consumer satisfaction questionnaire that was administered to inmates housed, over a 2-year period, in the mental health units of a state prison.

The questionnaires asked mental health inmates to rate (on a 5-point Likert scale) the helpfulness of their counselors, medications, mental health groups, and other mental health staff. They were also asked to rate the clarity of explanations they were provided regarding their diagnoses and treatment plans, as well as their level of involvement in treatment planning. Additional questions assessed the responsiveness of staff, level of unit activity, staff interest/awareness of their mental health needs, overall quality of mental health services, and a self-rating about whether they take "full advantage" of available services.

The data provided in Table 1 report the results of the questionnaires, with the identity of the units disguised. It is helpful to compare the ratings of mental health services both across units and across time. No test of significance was performed, and indeed the results must be interpreted in context. For example, a counselor who takes a tough stand on disciplinary "lock-downs" or recommends a unit shakedown for drugs may not be rated as helpful or effective. Psychotic patients may not view being on medication as helpful or effective. Drug-seeking patient inmates may not view limit setting as helpful. In short, effective mental health treatment with this population is not solely a reflection of inmate/patient satisfaction. Effective treatment—good treatment for this population—may actually at times lead to customer dissatisfaction! Results that are well above or below average—or which change dramatically over time—are flags for discussion.

Despite the limitations, these data provide a somewhat objective and anonymous measure of services as perceived by inmates. The numbers generally coincided with anecdotal comments by inmates, and provided some quantitative basis on which to assess progress. The overall rating across units of 3.2 on a scale of 5 indicated both an overall rating of "good," and shows continued room for improvement. Ratings that fell below 3 on certain units served to focus discussions about what changes could be made (Table 2).

It should be noted that any such ratings of services by inmates could serve as political dynamite. Inmates can be litigious and there is always the possibility of information about quality of services being turned into a lawsuit. On the other side, some staff may literally believe that prison is not to be "enjoyed" and that the opinions of inmates are irrelevant. Moreover, staff may view ratings of their performance not as useful tools for clinical supervision but as weapons to undermine their own positions. Those individuals may not be reassured by supervisors' comments that this is only one measure of quality—and an imperfect one at that.

Despite the problems with inmate surveys, the ultimate consumer of mental health services in prison remains the mental health inmate. Assessing the quality or cost-effectiveness of mental health services requires information from the recipients of the services. Inmate surveys can provide valuable information about the relative strengths and weaknesses of the mental health program. They are one component of continuous quality improvement and

TABLE 1
QUESTIONS AND MEAN RATINGS

Question	Mean Rating
My mental health counselor is helpful.	3.5
My mental health group is helpful.	3.4
My mental health–related medication is helpful.	3.2
Other mental health staff help me when my counselor is not available.	3.2
My diagnosis has been explained in a way that I can understand.	3.2
My treatment plan has been explained in a way that I can understand.	3.2
Options for my treatment goals were included in my treatment plan.	2.9
The mental health staff attends to me when I am having a difficult time.	3.3
The mental health staff are aware of my problems and are interested in helping.	3.8
I take full advantage of mental health services by attending all groups, working on problems, and regularly taking mental health–related medication.	3.5
My overall rating of the mental health services at this facility is:	3.2

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TABLE 2
MEAN SATISFACTION RATINGS

		Prison Ward						
Rated Mental Health Service	*N*	A	B	C	D	E	F	G
Counselor	47	3.5	3.7	3.7	4.1	4.1	2.5	2.5
Medication	45	2.9	3.9	3.2	3.0	3.8	3.1	2.7
Group treatment	47	3.2	3.9	3.1	3.5	3.7	3.2	3.3
Other mental health staff	47	3.3	3.7	3.3	3.3	3.1	3.3	3.5
Explanation of diagnosis	47	3.0	3.2	3.4	2.9	3.2	3.7	3.0
Explanation of mental health treatment	47	2.9	3.2	3.4	3.3	3.0	3.1	3.0
Explanation of treatment options	44	2.6	3.2	3.4	3.0	2.8	2.6	3.0
Responsiveness of mental health staff	45	3.0	3.4	3.2	4.0	3.6	3.0	3.0
Overall quality of mental health services	43	3.2	3.3	3.2	3.0	3.0	3.0	3.0
Awareness and interest of mental health staff	.44		3.7	4.0				
Utilization of available services	43		3.9	3.2				

the data can be used to trace changes over time, across counselors, and across units. Because of the possible misuses of the findings within a given setting, survey results must be used cautiously. Adding staff self-ratings and having staff rate the quality of supervisors may be ways to help reduce negative staff reactions. Finally, ratings of satisfaction from our other "consumers"—correctional staff, wardens, the governor, and the public—must also be considered if we are to continue to serve this population.

References

Ishikawa, K. (1985). *What is total quality control? The Japanese way*. Englewood Cliffs, NJ: Prentice-Hall.

Morita, A. (1986). *Made in Japan: Akio Morita and Sony*. New York: Dutton.

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Computers and Behavioral Assessment: 6 Years Later

David C. S. Richard and Ken Bobicz, *Eastern Michigan University*

Six years ago, the first author and a colleague published a paper in *the Behavior Therapist* detailing the emerging role of the computer in behavioral assessment (Richard & Mayo, 1997). Much has changed since then and computer applications have increasingly gained a place in behavioral assessment, behavior analysis, and behavior therapy. This paper is the first in a two-part series exploring the many ways computer technology can be, and has been, incorporated in the clinical activities of behavior therapists and behavior analysts. The paper starts by identifying the benefits associated with using computers in behavioral assessment as well as some common criticisms. We then discuss specific applications across a variety of behavior assessment methods, with a focus on behavioral observation, behavioral interviews, self-monitoring, and the use of computerized simulations in training contexts. In the next issue of *the Behavior Therapist*, we will extend our analysis to the use of computers and virtual reality technology in behavior therapy.

Several critical indicators suggest that computer technology has sparked considerable interest among clinicians. One way to measure the direction of a field is to examine dissertation topics, which reflect the research interests of psychology's next generation. To that end, we entered the key words *computerized*, *assessment* or *testing*, and *dissertation* into the PsycINFO database on October 18, 2001. The returned list included 541 citations. Figure 1 shows a positively accelerating increase in dissertations in computerized assessment over the last 20 years. Indeed, the number of dissertations in the past 5 years is only slightly smaller than the number of dissertations from the previous 15 years combined. We then repeated the search without restricting the search to dissertations. The returned list included 5,887 references, 1,612 (27.38%) of which have been published since 1997. Thus, close to a third of the literature in computerized assessment has been published in the last 4 to 5 years.

The advantages of using computers in clinical practice have been recognized for some time. Benefits include increased cost-effectiveness of assessment (Lockshin & Harrison, 1991), faster collection and analysis of data (Hallfors, Khatapoush, Kadushin, Watson, & Saxe, 2000), increased accuracy in participant self-report (Evans & Miller, 1969), identification of important clinical problems that are routinely missed by clinicians (Angle, Johnsen, Grebenkemper, & Ellinwood, 1979), and strengthening the relationship between assessment and treatment (Kratochwill, Doll, & Dickson, 1991).

Critics have objected to the use of computers for several reasons. Critics contend that computerized assessment is impersonal and may disengage clients from the therapeutic process. While most clients and practitioners respond favorably to computerized assessment and interviewing, some do not. Several factors (e.g., sex, age, education level, computer experience, diagnostic status, sensitivity of information) may affect client acceptance of computerized assessment (see Farrell, Cuseo-Ott, & Fenerty, 1988; Lucas, Mullin, Luna, & McInroy, 1977; Petrie & Abell, 1994; Skinner & Allen, 1983). Pragmatically, many clinicians may not have the time to learn how to use assessment software or otherwise lack computer experience and acumen (Farrell, 1989). In addition, clinicians who do not conduct thorough psychological and behavioral assessments to begin with are not likely to appreciate the benefits of computerized assessment. In terms of treatment utility, there is little if any evidence that computerized assessment positively influences client treatment outcome.

From a behavioral perspective, most assessment software does not incorporate important behavioral principles and methods. First, most diagnostic programs assess behavior topography rather than function and behavioral covariance with maintaining variables. Thus, the same conceptual problems evident in many clinician-administered structured interviews also plague computerized diagnostic interviews. Second, most computerized assessment programs do not provide routines by which clinical data may be analyzed over multiple observation points (e.g., interrupted time series analysis). There have been, however, some noteworthy exceptions (see Farrell, 1999a; Sandman, Touchette, Ly, Marion, & Bruinsma, 2000). Additionally, no programs exist to date that automate integration of behavioral assessment data with clinical case formulation models.

Computers and Behavioral Assessment

In the last few years, there has been a rapid increase in the number and type of software programs developed for behavioral assessors and behavior therapists. The programs cross all methods of behavioral assessment and have become increasingly sophisticated in their capabilities. We present here some of the more recent and innovative programs available to clinicians and researchers.

Behavioral Observation

Behavioral observation is an important behavioral assessment method, especially when the goal of assessment is to identify contingencies controlling behavior or measure rates of behavior (Haynes & O'Brien, 2000). Observation may be conducted in the client's natural environment (e.g., in the client's home or work setting) or in analogue settings (e.g., observing

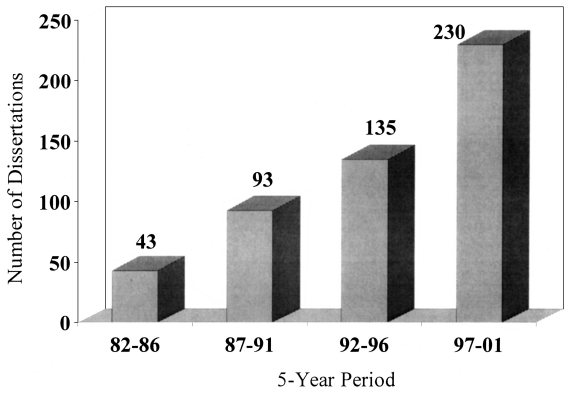

FIG. 1. Dissertations in Computerized Assessment and Testing: The Last 20 Years

behavior at a clinic through a one-way mirror).

Computer programs that facilitate behavior observation and coding have been widely used in a variety of ways. For example, Bowie and Mountain (1993) used portable computers to observe and code the behavior of patients with dementia. They found these patients spent approximately only 19.4% of their days engaged in constructive behaviors (i.e., self-care, social engagement, and receiving care). A majority of their waking days were spent doing "nothing at all" (p. 862).

Kaiser et al. (2000) used the KIDTALKER software system to code videotaped verbal interactions between children and adults. KIDTALKER includes a number of software components that permit transcript entry, code entry, and additional analyses of behavioral dimensions, linguistic characteristics, word roots, and data reliability.

Kahng and Iwata (2000) inventoried and described 15 real-time observational software programs.[1] While the programs vary in their sophistication, all permit calculation of descriptive statistics and rudimentary behavioral statistics (e.g., rate, interval percentages, and interval trials). Some programs include routines to perform time-based lag sequential analyses, or calculation of conditional probabilities and item response statistics. Many can produce instantaneous charts and graphs. The programs span a wide array of operating platforms with programs available for MS Windows, Apple computers, and hand-held computers. Data collected using hand-held computers can be downloaded to a desktop computer for additional processing. While some programs are free, most involve some cost, the maximum being $1,750 for the Observer program (Noldus, 1991). Since Kahng and Iwata's reviews, additional programs have been developed and reported in the literature (e.g., Mendo, Argilaga, & Rivera, 2000).

Behavioral Interviews

Behavioral interviews differ from more traditional clinical interviews in their emphasis on assessing functional relationships. One of the most sophisticated examples of a computerized behaviorally based interview is the Computerized Assessment System for Psychotherapy Evaluation and Research (CASPER) program (see Farrell, 1999a, 1999b; Farrell, Camplair, & McCullough, 1987; Farrell & McCullough, 1989; Farrell & McCullough-Vaillant, 1996). CASPER includes a branching computer algorithm designed to identify client presenting problems, generate a list of identified problems, assess client functioning, identify areas requiring additional assessment, and assist with treatment planning. In addition, CASPER includes routines to track patient functioning across sessions and measure treatment outcome. Version 3 of the interview includes 121 items covering a wide array of cognitive and behavioral domains.

Skinner and his colleagues have reported research on a computerized assessment of lifestyle behaviors (the Computerized Lifestyle Assessment or CLA; Skinner & Allen, 1983; Stein & Skinner, 1998). Items in the interview assess a wide variety of domains, including substance use, health-maintaining practices, and activities likely to prevent health problems, social issues, and emotional well-being. The interview takes 20 to 30 minutes to complete and generates a printed report on lifestyle strengths and weaknesses.

A common complaint directed at computerized assessment is that the process is dehumanizing and that clients will be put off by the computer interview. For the most part, this prediction has not been borne out in the empirical literature. For example, Petrie and Abell (1994) administered a computerized interview to 150 consecutive patients who had either attempted suicide or were admitted to the hospital for a drug overdose. When asked whether they would have preferred to give their personal information to a physician or the computer, 52.3% indicated they would prefer the computer while 17.4% indicated they would prefer a doctor. Approximately one third, 30.2%, indicated no preference. Individuals with lower measured levels of self-esteem and greater suicidal ideation showed a greater preference for the computer interview. Other researchers have found similar results (see Greist et al., 1987; Plutchik & Karasu, 1991; Richard, 1999). Behavioral interviews like CASPER and the CLA have also been positively received by patients.

Another issue relevant to computer interviewing includes the equivalence of information gathered by computers and human interviewers. Equivalence is a multidimensional construct that can refer to a variety of interview and data dimensions (e.g., equivalence of mean scores for the same instrument administered in different formats, participant reactions, and inferences drawn from interpretive reports) and can be affected by a potentially endless number of factors (Richard & Haynes, 2000). In general, it should not be assumed that norms for established interviews and tests are applicable to computerized versions.

Several researchers have concluded that the perceived anonymity of a computer interview makes it more likely that participants will be more accurate in reporting sensitive or potentially embarrassing information. Lucas et al. (1977) found that clients reported greater alcohol consumption to a computer than to a human interviewer. Others, however, have not found that computers elicit a different response pattern than human interviewers (Skinner & Allen, 1983).

Self-Monitoring

Self-monitoring involves "systematically observing and recording aspects of one's own behavior and internal and external environmental events thought to be functionally related to that behavior" (Cone, 1999, p. 411). Self-monitoring is a frequently used behavioral assessment method and was extensively reviewed in a special section of *Psychological Assessment* 4 years ago (see Volume 11, Number 4). Technological advances have led to increasingly sophisticated self-monitoring strategies and researchers have been quick to take advantage of these developments.

A growing literature has emerged around the use of portable or hand-held computers and personal organizers to self-monitor behavior in the natural environment. The term *ecological momentary assessment* (EMA; Stone & Shiffman, 1994) has been used to describe this approach. The instrument of choice for EMA recording is the hand-held or palmtop computer. Hand-held computers are easy to use, convenient, and protect clients' privacy when data are entered unobtrusively. Data collection via hand-held computers can take advantage of the computer's alarm functions to signal recording intervals, the computer's clock function to schedule response input, the computer's memory to log recording sessions and store data, and tailored item administration for item branching contingent on a participant's responses. Many researchers have argued that assessment using hand-held computers minimizes participant recall errors, reduces hindsight bias, and may produce data that are more ecologically valid (Fahrenberg & Wientjes, 2000; Shiffman, 2000).

Jamison et al. (1998) found that patients with chronic low back pain were 89.9% compliant in entering daily monitoring data to a palmtop computer. Affleck et al. (1998) used a Psion Organizor II to collect data randomly 3 times per day from 50 female patients with fibromyalgia. Participants were prompted to interact with the computer by an audible beep. Interview questions were presented one at a time and data were uploaded from the hand-held device

[1] Kahng and Iwata (2000) include a comprehensive table featuring properties of the software they reviewed and contact information for the software publishers.

periodically through the study. The researchers found that hindrance of social and interpersonal goal achievement was associated with greater pain and fatigue. In addition to collecting psychological and behavioral data, several researchers have extended hand-held computer technology to ambulatory monitoring of physiological response modes during rehabilitative treatment (see especially Fahrenberg & Myrtek, 1996; Fahrenberg, 1996).

An important issue in behavioral assessment is the degree to which retrospective self-report is congruent with actual behavior in the environment. Most clinicians, of course, rely on retrospective self-report as a means of assessing a client's behavioral problems, coping skills, and so forth. Research by Schwartz, Neale, Marco, Shiffman, and Stone (1999), however, suggests that retrospective self-reports may not yield accurate estimates of coping responses. In their study, 96 participants monitored stressful events and coping behaviors for 48 hours using a hand-held computer that assessed their responses every 40 minutes on average. They found that a coping style questionnaire administered prior to the self-monitoring component poorly predicted participants' actual coping style. They concluded that the relationship between self-reported coping styles and actual coping behaviors was "much too weak to justify using the former as a proxy for the latter" (p. 367). Their conclusions have some obvious implications for all clinicians who assume that self-report data may be a reasonably accurate representation of actual behavior.

Along these lines, Whalen, Jamner, Henker, and Delfino (2001) used palmtop devices to assess self-reported smoking behavior and symptoms of aggression and depression in 170 teenage students. They found that male and female adolescents scoring high on measures of depression and externalizing behaviors had an elevated risk of actual smoking, smoking urges, and alcohol intake. Girls were 43 times more likely to smoke if both depression and delinquency symptoms were present. The researchers reported correlations of .60 or less between various self-report questionnaires and data collected via the palmtop (e.g., smoking urges). Thus, a significant amount of unique information was provided by using the palmtop for momentary assessment.

Whether EMA will become a routine self-monitoring strategy in clinical practice depends on a number of factors. The cost of hand-held computers used to be a significant obstacle. However, within the last year the price of a low-end personal digital assistant that could be used for self-monitoring has dropped to a little over $100. Despite the falling costs of the technology, other issues remain. Because EMA places significant task demands on both participants and researchers, clients must react favorably to the hand-held computer and perceive the benefits of the assessment (Fahrenberg & Wientjes, 2000). While some researchers have found that many clients react favorably to hand-held assessment (Drummond et al., 1995; Fahrenberg & Myrtek, 1996; Tiplady, Crompton, & Brackenridge, 1995), participant reactions are likely contingent upon software features, sampling demands, assessment conditions, the types of problems targeted, the quality of participant training, and other participant characteristics. Some researchers have found that computer and hand-held versions of paper-and-pencil instruments may negatively affect participant mood and, in so doing, influence a client's self-report (see Schulenberg & Yutrzenka, 1999; Tseng, Tiplady, McLeod, & Wright, 1998). Understanding the conditions that promote acceptance of EMA and the effect computer and hand-held interfaces have on participant responses, especially mood ratings, is an important line of research.

Other issues include the need for programs written in a style that adequately generalizes to apply to a variety of behavior problems with a minimum of programming effort on the part of the clinician.[2] In addition, software that efficiently analyzes data and provides meaningful data analysis (e.g., graphing and statistics) needs to be developed. Methodologically, issues of incremental validity need to be addressed. Hand-held assessment is fairly labor intensive for the client and the investigator. Research should be undertaken to investigate the effect of varying recording frequencies for different types of behavior problems. EMA can utilize interval-contingent (i.e., recording at regular intervals), event-contingent (i.e., recording after an event occurs), and signal-contingent sampling methodologies (i.e., recording in response to an external cue). The appropriateness of using hand-held computers to self-monitor behavior will depend, minimally, on the behavioral dimensions of the target problem (Shiffman, 2000).

Training Simulations

Behavioral researchers have also been developing computerized simulations for the training of behavioral assessors. For example, Blasko, Kazmerski, Corty, and Kallgren (1998) reported the development of courseware that teaches naturalistic observation techniques. The Courseware for Observational Research (COR) is a multimedia software program that teaches students how to conduct a behavioral assessment, make observations, and test hypotheses. The software includes a module (five lessons) that teaches the fundamentals of observational coding and provides digitized video clips for coding practice. The software can be presented via an overhead projector and students can code behavior on recording sheets included with the software. Additional software provided is designed for laboratory use and homework assignments. Video clips are presented in real time and behavioral coding is performed using the software's intuitive interface. The software runs on Windows-based systems. Initial student reactions to the program have been very favorable.

Training programs have been developed that address assessment, case formulation, and treatment with specific disorders. Desrochers, Clemmons, Grady, and Justice (2000) reported an evaluation of the Simulations in Developmental Disabilities (SIDDS; Desrochers & Hile, 1993) multimedia instructional software designed for undergraduates studying applied behavior analysis. Specifically, the software helps students learn how to define client behavior, select assessments, interpret graphed data of client behavior, develop functional hypotheses about the causes of client behavior problem(s), and generate a treatment plan. The software includes help options, an on-screen notepad, hypertext-linked terms, video clips of clients, and other features to facilitate learning. Student skill acquisition is measured using simulated clinical cases that include graphed assessment data. The authors found that students rated the SIDDS software as a useful training tool. In addition, there was some evidence that students who used the SIDDs system developed superior assessment and treatment skills compared to students who did not use the system.

Issues and Directions

Continued integration of computer technology into behavioral assessment is contingent upon the training of behavioral assessors. The surge in publications and dissertations involving computerized assessment has not resulted in a corresponding training emphasis in computer applications. Given the growth of interest

[2] It is worth noting that there are several software programs available on the market that can be used for hand-held computer program development. Some programs, like AppForge Professional Edition, are relatively expensive at over $600.00. Microsoft, on the other hand, provides a version of Visual Basic at no cost through its corporate Web site.

in applying computer technology to behavioral assessment, graduate clinical faculty should consider reorienting their behavioral assessment courses to incorporate coverage of technological developments. For example, a behavioral assessment course that does not address the use of hand-held computers and EMA strategies will be overlooking a rapidly expanding literature base. In addition, computer simulations have the potential to greatly enhance students' understanding of behavioral assessment and behavior therapy. Lambert (1989) noted that simulations foster application of conceptually challenging material, create a common experiential base among students, and orient students to complex behavioral assessment and therapy processes.

Doctoral training programs may also want to consider developing elective or required courses in applied computer programming in conjunction with a behavioral assessment course. For example, a behavioral assessment course could include training in low-level programming of a hand-held computer (e.g., the basics of data acquisition, storage, and graphic display). The purpose of the course would be to develop in graduate students the skills they would need to take advantage of technology in future clinical contexts.

We have every reason to expect that innovative computer applications in behavioral assessment will continue to be developed in the coming years. Behavior assessors and therapists will benefit from increasingly affordable computer hardware and a greater selection of powerful software programs. Whether practitioners take full advantage of available software will be primarily contingent upon the training and orientation of the practitioner.

References

Affleck, G., Tennen, H., Urrows, S., Higgins, P., Abeles, M., Hall, C., Karoly, & Newton, C. (1998). Fibromyalgia and women's pursuit of personal goals: A daily process analysis. *Health Psychology, 17*, 40-47.

Angle, H. V., Johnsen, T., Grebenkemper, N. S., & Ellinwood, E. H. (1979). Computer interview support for clinicians. *Professional Psychology, 10*, 49-57.

Blasko, D. G., Kazmerski, V. A., Corty, E. W., & Kallgren, C. A. (1998). Courseware for observational research (COR): A new approach to teaching naturalistic observation. *Behavior Research Methods, Instruments, and Computers, 30*, 217-222.

Bowie, P., & Mountain, G. (1993). Using direct observation to record behaviour of long-stay patients with dementia. *International Journal of Geriatric Psychiatry, 8*, 857-864.

Cone, J. D. (1999). Introduction to the special section on self-monitoring: A major assessment method in clinical psychology. *Psychological Assessment, 11*, 411-414.

Desrochers, M. N., Clemmons, T., Grady, M., & Justice, B. (2000). An evaluation of Simulations in Developmental Disabilities (SIDD): Instructional software that provides practice in behavioral assessment and treatment decisions. *Journal of Technology in Human Services, 17*, 15-27.

Desrochers, M. N., & Hile, M. G. (1993). SIDDS: Simulation in developmental disabilities. *Behavior Research, Methods, Instruments, and Computers, 25*, 308-313.

Drummond, H. E., Ghosh, S., Ferguson, A., Brackenridge, D., & Tiplady, B. (1995). Electronic quality of life questionnaires: A comparison of pen-based electronic questionnaires with conventional paper in a gastrointestinal study. *Quality of Life Research, 4*, 2-7.

Evans, W. M., & Miller, J. R. (1969). Differential effects on response bias of computer vs. conventional administration of a social science questionnaire. *Behavioral Science, 14*, 216-227.

Fahrenberg, J. (1996). Ambulatory assessment: Issues and perspectives. In J. Fahrenberg & M. Myrtek (Eds.), *Ambulatory assessment: Computer-assisted psychological and psychophysiological methods in monitoring and field studies* (pp. 3-20). Kirkland, WA: Hogrefe & Huber.

Fahrenberg, J., & Myrtek, M. (Eds.). (1996). *Ambulatory assessment: Computer-assisted psychological and psychophysiological methods in monitoring and field studies*. Kirkland, WA: Hogrefe & Huber.

Fahrenberg, J., & Wientjes, C. J. E. (2000). Recording methods in applied environments. In R. W. Backs & W. Boucsein (Eds.), *Engineering psychophysiology: Issues and applications* (pp. 111-136). Mahwah, NJ: Lawrence Erlbaum.

Farrell, A. D. (1989). Impact of computers on professional practice: A survey of current practices and attitudes. *Professional Psychology: Research and Practice, 20*, 172-178.

Farrell, A. D. (1999a). Development and evaluation of problem frequency scales from Version 3 of the Computerized Assessment System for Psychotherapy Evaluation and Research (CASPER). *Journal of Clinical Psychology, 55*, 447-464.

Farrell, A. D. (1999b). Evaluation of the Computerized Assessment System for Psychotherapy Evaluation and Research (CASPER) as a measure of treatment effectiveness in an outpatient training clinic. *Psychological Assessment, 11*, 345-358.

Farrell, A. D., Camplair, P. S., & McCullough, L. (1987). Identification of target complaints by computer interview: Evaluation of the Computerized Assessment System for Psychotherapy Evaluation and Research. *Journal of Consulting and Clinical Psychology, 55*, 691-700.

Farrell, A. D., Cuseo-Ott, L., & Fenerty, M. (1988). Development and evaluation of a scale for measuring practitioners' attitudes toward computer applications. *Computers in Human Behavior, 4*, 207-220.

Farrell, A. D., & McCullough, L. (1989). *User's manual for the Computerized Assessment System for Psychotherapy Evaluation and Research*. Unpublished manuscript.

Farrell, A. D., & McCullough-Vaillant, L. (1996). Computerized Assessment System for Psychotherapy Evaluation and Research (CASPER): Development and current status. In M. J. Miller, K. W. Hammond, & M. M. Hile (Eds.), *Mental health computing* (pp. 34-53). New York: Springer.

Greist, J. H., Klein, M. H., Erdman, H. P., Bires, J. K., Bass, S. M., Machtinger, P. E., & Dresger, D. G. (1987). Comparison of computer and interviewer administered versions of the Diagnostic Interview Schedule. *Hospital and Community Psychiatry, 38*, 1304-1311.

Hallfors, D., Khatapoush, S., Kadushin, C., Watson, K., & Saxe, L. (2000). A comparison of paper versus computer-assisted self-interview for school alcohol, tobacco, and other drug surveys. *Evaluation and Program Planning, 23*, 149-155.

Haynes, S. N., & O'Brien, W. H. (2000). *Principles and practice of behavioral assessment*. New York: Kluwer Academic/Plenum.

Jamison, R. N., Raymond, S. A., Levine, J. G., Slawsby, E. A., Nedeljkovic, Srdjan, S., & Katz, N. P. (2001). Electronic diaries for monitoring chronic pain: One year validation study. *Pain, 91*, 277-285.

Kahng, S. W., & Iwata, B. A. (2000). Computer systems for collecting real-time observational data. In T. Thompson, D. Felce, & F. J. Symons (Eds.), *Behavioral observation: Technology and applications in developmental disabilities* (pp. 35-45). Baltimore, MD: Brookes Publishing.

Kaiser, A. P., Tapp, J., Solomon, N. A., Delaney, E. M., Ezell, S. S., Hester, P. P., & Hancock, T. B. (2000). Observing complex adult-child interactions: Computer-supported coding, analysis, and graphing. In T. Thompson, D. Felce, & F. J. Symons (Eds.), *Behavioral observation: Technology and applications in developmental disabilities* (pp. 177-192). Baltimore, MD: Brookes Publishing.

Kratochwill, T. R., Doll, E. J., & Dickson, W. P. (1991). Use of computer technology in behavioral assessments. In T. B. Gutkin & S. L. Wise (Eds.), *The computer and the deci-*

sion-making process (pp. 125-154). Hillsdale, NJ: Lawrence Erlbaum.

Lambert, M. E. (1989). Using computer simulations in behavior therapy training. *Computers in Human Services, 5*(3/4), 1-12.

Lockshin, S. B., & Harrison, K. (1991). Computer-assisted assessment of psychological problems. In A. Alastair & S. Bendall (Eds.), *Microcomputers and clinical psychology: Issues, applications and future development* (pp. 47-63). New York: John Wiley and Sons.

Lucas, R. W., Mullin, P. J., Luna, C. B. X., & McInroy, D. C. (1977). Psychiatrists and a computer as interrogators of patients with alcohol-related illnesses: A comparison. *British Journal of Psychiatry, 131*, 160-167.

Mendo, A. H., Argilaga, M. T. A., & Rivera, M. A. B. (2000). Software for recording observational files. *Behavior Research Methods, Instruments, and Computers, 32*, 436-445.

Noldus, L. P. J. J. (1991). The Observer: A software system for collection and analysis of observational data. *Behavior Research Methods, Instruments, and Computers, 23*, 415-429.

Petrie, K., & Abell, W. (1994). Responses of parasuicides to a computerized interview. *Computers in Human Behavior, 10*, 415-418.

Plutchik, R., & Karasu, T. B. (1991). Computers in psychotherapy: An overview. *Computers in Human Behavior, 7*, 33-44.

Richard, D. C. S. (1999). *Development and psychometric evaluation of the Computerized PTSD Scale*. Unpublished dissertation, University of Hawaii.

Richard, D. C. S., & Haynes, S. N. (2000). Computerized psychological assessment. In W. E. Craighead & C. B. Nemeroff (Eds.), *The Corsini encyclopedia of psychology and behavioral science* (3rd ed., pp. 339-341). New York: John Wiley and Sons.

Richard, D. C. S., & Mayo, S. (1997). Computers in the 21st century: Challenge to behavioral assessment and behavior therapy. *the Behavior Therapist, 20*, 186-190.

Sandman, C. A., Touchette, P. E., Ly, J., Marion, S. D., & Bruinsma, Y. E. M. (2000). Computer-assisted assessment of treatment effects among individuals with developmental disabilities. In T. Thompson, D. Felce, & F. J. Symons (Eds.), *Behavioral Observation: Technology and applications in developmental disabilities* (pp. 271-293). Baltimore, MD: Brookes Publishing.

Schulenberg, S. S., & Yutrzenka, B. A. (1999). The equivalence of computerized and paper-and-pencil psychological instruments: Implications for measures of negative affect. *Behavior Research, Methods, Instruments, and Computers, 31*, 315-321.

Schwartz, J. E., Neale, J., Marco, C., Shiffman, S. S., & Stone, A. A. (1999). Does trait coping exist? A momentary assessment approach to the evaluation of traits. *Journal of Social and Personality Psychology, 77*, 360-369.

Shiffman, S. (2000). Real-time self-report of momentary states in the natural environment: Computerized ecological momentary assessment. In A. A. Stone, J. S. Turkkan, C. A. Bachrach, J. B. Jobe, H. S. Kurtzman, & V. S. Cain (Eds.), *The science of self-report: Implications for research and practice*. Mahwah, NJ: Lawrence Erlbaum.

Skinner, H. A., & Allen, B. A. (1983). Does the computer make a difference? Computerized versus face-to-face versus self-report assessment of alcohol, drug, and tobacco use. *Journal of Consulting and Clinical Psychology, 51*, 267-275.

Stein, S. J., & Skinner, H. A. (1998). Why computerized life-style assessment is good for business. In S. Klarreich (Ed.), *Handbook of organizational health psychology: Programs to make the workplace healthier* (pp. 35-41). Madison, CT: Psychosocial Press/ International Universities Press.

Stone, A., & Shiffman, S. (1994). Ecological momentary assessment (EMA) in behavioral medicine. *Annals of Behavioral Medicine, 16*, 199-202.

Tiplady, B., Crompton, G. K., & Brackenridge, D. (1995). Electronic diaries for asthma. *British Medical Journal, 310*, 1469.

Tseng, H. M., Tiplady, B., McLeod, H., & Wright, P. (1998). Computer anxiety: A comparison of pen-based personal digital assistants, conventional computer, and paper assessment of mood and performance. *British Journal of Psychology, 89*, 599-610.

Whalen, C. K., Jamner, L. D., Henker, B., & Delfino, R. J. (2001). Smoking and moods in adolescents with depressive and aggressive dispositions: Evidence from surveys and electronic diaries. *Health Psychology, 20*, 99-111.

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Eligible papers must (a) be authored by an individual with five years or less posttraining experience (e.g., post-Ph.D. or postresidency); and (b) have been published in the last two years or currently be in press. Submissions can consist of one's own or any eligible candidate's paper. Papers will be judged by a review committee consisting of Jacqueline B. Persons, Ph.D.; Richard G. Heimberg, Ph.D., AABT's immediate Past-President; and Patricia Resick, Ph.D., the AABT President-Elect. Submissions must be **received by Monday, August 18, 2003,** and must include four copies of both the paper and the author's vita. Send submissions to: AABT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.

⌘ Virginia A. Roswell Student Dissertation Award

This award will be given to a student based upon his or her approved doctoral dissertation proposal. Their research should be relevant to behavior therapy. Accompanying this honor will be a $1,000 award to be used in support of research (e.g., pay subjects, purchase testing equipment, reimburse photocopying cost) and/or to facilitate travel to the AABT convention. Eligible candidates for this award should be student members, have already had their dissertation proposal approved, and be investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor should make nominations and only a 3- to 5-page summary of the proposal should be submitted (anything longer will not be considered). The 3- to 5-page summary, together with a letter of support from the student's dissertation chair, should be sent with nominations for the Student Dissertation Award. Please send an e-mail version as well as a hard copy of your nomination to the program chair at the address below, *plus* send 1 duplicate copy of your submission to AABT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001. The deadline for submission is Tuesday, April 1, 2003.

⌘ Elsie Ramos Memorial Student Poster Awards

These awards will be given to three student poster presenters (student first authors only), member or nonmember, at AABT's 37th Annual Convention in Boston, November 20 to 23, 2003. The winners will each receive a 2003 AABT Student Membership, a 1-year subscription to an AABT journal of their choice, and a complimentary general registration at AABT's 2004 Annual Convention in New Orleans. To be eligible, students must complete the submission for this year's AABT convention by **March 3, 2003.** The proposal must then pass AABT's peer review process. AABT's Awards and Recognition Committee will judge all student posters. Please see page 153 for submission information.

The Association for Behavioral and Cognitive Therapies: An Idea Whose Time Has Come

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

AABT members will soon receive a ballot on which they can vote to change the name of our association to the Association for Behavioral and Cognitive Therapies or to retain our current name. Our bylaws state that the name of the association can be changed if a simple majority of the membership endorses the new name. When we voted on this question 10 years ago, the name change proposal was narrowly defeated: 51% of responders voted to retain our current name and 49% voted to change it.

My own view is that it is now time to change our name to reflect the enduring influence of the cognitive revolution on our field. Cognitions have arrived and they are here to stay. I am reminded of the cartoon in which a youthful-looking elderly woman says brightly to her husband, "70 is the new 50!" Analogously, "Cognitive is the new behavioral." In fact, a name change to include cognitions is happening just in time—just as new ideas and therapies step forward and deserve recognition: dialectical behavior therapy, acceptance and commitment therapy, mindfulness meditation, functional analytic psychotherapy, the cognitive behavioral analysis system of psychotherapy, and multisystemic therapy, among others. All of these new ideas and therapies fit under the umbrella of the proposed new name at the same time that they hint at the day when yet another name for our association may be needed.

Back to the present. The proposed new name, with its plural "therapies," has the advantage that it encompasses a multiplicity of therapies united by the notion that all are based on theories about behavior and cognitions and on ideas about how to change them to alleviate suffering. Not stated but perhaps even more central to our identity is the high value we place on demonstrating the effectiveness of our methods in randomized controlled trials and other controlled studies.

I admit to some reluctance to moving forward with the proposed name change. The name change promises to bring into our association members who are drawn to and have learned some cognitive therapy but who would not describe themselves as behavior therapists and who may not have learned the skills of functional analysis, the principles of operant and Pavlovian conditioning, or the basics of social learning theory. This promise is good news and bad news. The bad news is that we will meet, at our convention, people who think partly like us but not completely like us, and attending our convention will be a bit less like returning to the womb and a bit more like— attending a professional meeting. The good news is that our association will grow and cognitive-behavior therapy will grow as they deserve to and must if we are to permeate and fundamentally influence the mainstream of routine clinical practice in a way that we have so far failed to do.

In concrete terms, I am concerned that the addition of the term "cognitive" to our name may lead to an erosion of our behavioral analytic membership. This would indeed be unfortunate, as the intellectual traditions and contributions of this part of our field and our membership are invaluable, and are likely to become even more so as therapists who call themselves cognitive but not behavioral enter our group. We will need to work harder to reach out to the behavior analysts. As a small step, we will invite the president of the Association for Behavior Analysis to attend our 2003 conference in Boston as our guest, and I encourage AABT members to consider attending ABA's conference, to be held in San Francisco May 23 to 27, 2003 (for more information, go to www.abainternational.org).

It is useful to ponder not just what the proposed new name adds, but also what it omits. The proposed new name omits the term "advancement of." The inclusion of this term in our original name reflects the fact that when AABT was founded in 1966, behavior therapy was the new kid on the block struggling for recognition and credibility in the field. The proposal to adopt a name that no longer includes the term "advancement" is partly an issue of length (the name Association for Advancement of Behavioral and Cognitive Therapies is too long), but also reflects the fact that in significant ways our field has advanced and is certainly no longer fighting for recognition and credibility. Just one index of our progress is the table of contents of the *Journal of Consulting and Clinical Psychology*, the premier scientific journal of clinical psychology. Nearly every article in the *JCCP* is about cognitive-behavior therapy, and all or nearly all of the editors of the *JCCP* have been cognitive-behavior therapists and members of AABT.

The name of our association is an important matter. I have expressed my own view and I encourage members to state theirs on these pages (submit articles to the editor, George Ronan, or as letters to the editor) or on our listserve, accessible via the front page of our Web site, located at www.aabt.org.

A lively debate on this topic is yet another of the many benefits of membership in this remarkable group. ✍

Renew your AABT membership today!

Reno Revisited

Ann M. Steffen, *Coordinator for Convention and Continuing Education Issues*

Dear AABT members:

Thanks to all of you who helped make the Reno Convention a success! This convention received very positive evaluations from attendees regarding the high quality of the program; it also had the highest attendance of any AABT convention held in the western part of the United States. For example, this year's total convention attendance was 2,122, compared to 1,955 participants in San Diego (in 1994) and 1,801 participants in San Francisco (in 1990). Why does attendance matter? We know that the convention is one of the primary ways that members stay connected to each other and to AABT. We also wanted to offer an affordable convention in the West that was reasonably priced for all of you who pay your own way.

Aside from generally complementing the program, attendees were very enthusiastic about a number of specific offerings, including the invited addresses, the Master Clinician and World Rounds series, and the many high-quality symposia. Others commented on the breadth of the program and the program's success in balancing basic science and practical applications. Not surprisingly, attendees also commented on the friendly and open atmosphere of the convention. We are proud of our ability to provide a venue for so many of our members to share new developments.

On the other hand, while reading over the general evaluation forms from the Reno convention, we saw a number of responses from attendees who thought the choice of venue was "bizarre." Many were unhappy with the amount of smoke in the hotel and the casino atmosphere. Some expressed dismay at the thought that we were supporting the gambling industry. Finding efficient air travel was a challenge for all. The available space of the Reno Hilton allowed us to offer a West Coast meeting at a truly low sleeping room rate, which helped us serve a large segment of our membership. The Hilton was also the only Reno hotel that could accommodate all our sessions. However, please be assured that we have heard you loud and clear; this venue or other casino locations are unlikely to be on our list of future sites!

In general, you should know that we are quite thoughtful about our choice of city and hotel, and there are a number of factors involved. One of the challenges of organizing our meeting is keeping it within one hotel. This is the most consistent request from the AABT membership regarding the convention. The number of meeting rooms needed for our complex mix of sessions as well as the number of sleeping rooms needed makes our Annual Convention fit into less than two dozen hotels in the U.S. and Canada. We then compete with other organizations so that we can offer the convention at approximately the same time each year, while rotating the location across different parts of the U.S. and Canada. We also continue to try to find inexpensive alternatives at least every few years.

On the convention evaluation forms, we also received some concerns and complaints about topic overlap. This is one of the hardest tasks for the program chair and for the central office staff. An enormous amount of time and effort is put toward scheduling and preventing overlap as much as is possible. Each year there are new challenges. We are optimistic that new technology may help us with this daunting goal.

We hope that, all in all, your Reno experience was positive and we apologize for those places where we didn't get it right. See you in Boston next year! ✍

Run for an AABT Elected Office Now!

Sue C. Jacobs, *Nominations and Elections Committee Chair*, and Patricia Long and Maureen Sullivan, *Nominations and Elections Committee Members*

Nominations for the 2003 elections are due soon—on or before February 1, with the actual elections taking place in April. On behalf of the membership of AABT, the Nominations and Elections Committee would like to urge every eligible full member to consider running for an elected office. In addition, we ask each one of you to nominate yourself or other qualified AABT members for the positions of President-Elect (2003–2004), Representative-at-Large (2003–2006), and Secretary-Treasurer (2004–2007). You can nominate more than one person for any of these offices. Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to AABT.

Why Should You Run for Elected Office?

Last year, Maria Testa, then AABT Nominations and Elections Chair, listed a number of reasons to run for elected office (*tBT*, October, 2001, p. 199). That article is worth reading again. This year, we decided to ask a number of relatively recent elected office holders about running for office and what they got out of serving AABT. Their words speak for themselves and provide multiple reasons for running for elected office, as well as some sense of the responsibilities of office.

President

The person elected as President-Elect (2003–2004) will serve as President (2004–2005) and Past President (2005–2006) and on the Board of Directors for 3 years. The Board meets once a year the Thursday of the convention and conducts monthly conference calls the other 11 months of the year. Toni Zeiss and Rick Heimberg talk about being AABT President. They and all the current officers welcome inquiries from you about running for and holding office; we have included e-mails to facilitate this process.

- Toni Zeiss
  Antonette.Zeiss@med.va.gov

  One of the most common remarks I hear at AABT is that it feels like members' "professional home." That doesn't happen by chance, or simply because we are like-minded professionals. It must be created and re-created, and those in governance at AABT have felt this responsibility keenly. I ran for office at AABT three times and won twice. I ran once, and won, as Representative-at-Large to the Board of Directors, after holding an appointive role on the Board as

Chair of Membership Activities. I ran twice for President, and won the second time I ran. I found it hard to put myself forward as a candidate, especially for President, and I was especially uncomfortable with asking for members' support and votes. Three things were most helpful for me in that process:

1. The warmth and collegiality I felt from others in AABT, whether they planned to vote for me or the person I ran against. There was no rancor or animosity in the campaign process.

2. Each time I ran, the emphasis, for me and the others running, was on the desire to serve AABT, not to achieve a career honor (although it certainly feels like an honor to hold office in AABT).

3. This brings me back to the opening. The family of AABT supports those who run for office, win or lose, and in turn, those who run for office should, I believe, hold warmly the idea that their responsibility is to participate in continuously re-creating the collegial environment that characterizes AABT.

- Rick Heimberg
  rheimber@nimbus.ocis.temple.edu

  I have just finished my term as President of AABT. The Reno convention was a whirlwind, and it will be remembered as one of the highlights of my professional career. As President, I had the opportunity to work with many of the leading figures in behavior therapy and to contribute to the organization and the discipline. We tackled issues as diverse as AABT's financial bottom line, the development of more and better member services (e.g., the new AABT listserve), the impact of September 11, and the New Mexico law on prescription privileges for psychologists. Although the issues are different from year to year, they are always thought-provoking, complex, and important to the future of behavior therapy. We need our best people to run for President (and other offices as well). I hope you will consider doing so.

Representative-at-Large (2003–2006)

Ray DiGiuseppe, who just completed his term as Representative-at-Large, and Victoria Follette, currently a Representative-at Large, speak about the rewards of this office.

- Victoria Follette
  vmf@unr.edu

  Being a Representative-at-Large is a fantastic opportunity to learn more about the day-to-day functioning of the organization, with input at the levels of both policy and procedure. Reps work closely with committee coordinators and the central office staff on a variety of issues, including membership, professional issues, conventions and media dissemination, to name just a few. Additionally, it is a great opportunity to form closer working relationships with individuals who are doing work that is on the cutting edge of our field.

- Ray DiGiuseppe
  digiuser@stjohns.edu

  As Representative-at-Large, I got to work with great people and a sense of satisfaction in molding the future of the association. The Representatives-at-Large have two major tasks on the AABT Board. The first is attending the Board meeting, and voting on all of the important business of the association. The Board votes on such issues as the choice of convention cities, the chairs of all active committees, all new initiatives and activities, and, most important of all, the budgets. The Board meets at the convention each year; some years they hold one other all-day board meeting in the Spring. The Board also holds monthly telephone conference call meetings. The second function of the Representatives is supervising the activities of one of the Coordinators and the committees that fall under that Coordinator. The Representative communicates to the Coordinator and the committees the goals of the Board. This link ensures that the committees are working toward the same goals as all of the other committees in the association. The Representative sets time lines for the various committees to complete their work and informs the Board of any difficulties the committees have in meeting their objectives.

Secretary-Treasurer (2004–2007)

The person elected Secretary-Treasurer will spend the year 2003–2004 in training and learning the functions of this office. We asked Barbara S. McCrady, who was Secretary-Treasurer a couple terms ago, and Alan M. Gross, the current Secretary-Treasurer, to discuss the office.

- Barbara S. McCrady
  bmccrady@rci.rutgers.edu

  As Secretary-Treasurer, I became knowledgeable about every aspect of AABT—everything from the cost of walkie-talkies at the convention to the publishing of *Behavior Therapy*. The position requires careful oversight of financial planning and decision making, as well as overall responsibility for the central office. As a member of the Executive Committee of the Board of Directors, the Secretary-Treasurer has a key role in long-term planning for AABT. I found that I had to use an interesting range of skills—knowledge of and attention to financial detail, organizational and administrative skills, and big-picture vision. I worked with great staff in the office, and many terrific colleagues in AABT. It's a position that requires some commitment of time, but is well worth the effort.

- Alan M. Gross
  pygross@olemiss.edu

  The finance committee has the continuing responsibilities of oversight of the financial condition of AABT, monitoring fiscal projections, making recommendations regarding personnel and capital equipment, making conservative investments of our reserve funds, and evaluating financial considerations related to ownership of the permanent headquarters space. The current finance committee meets twice yearly, and is in frequent e-mail contact among its members and with the central office, especially with M.J. The Treasurer also participates in monthly Board calls, as well as the annual Board meeting at the convention. I will also be preparing financial statements for your edification in a later issue of *tBT*.

  I enjoy being involved—I really like working with Board members and the central office staff—learning about the mechanics of the way the organization is run, being part of the leadership as they attempt to make the organization be responsive to the needs of its members. And you don't need to be an accountant to do this job.

How Do You Run for Office and Get Elected?

Again last year's *tBT* article by Maria Testa has many wonderful suggestions and we urge you to read it again (*tBT*, October, 2001, p. 199). There are a number of strategies that successful candidates have used in the past, including running a second and third time if not elected the first time. All the strategies include doing something(s) to increase visibility among AABT membership, such as being involved in appointed AABT positions, committees, and Special Interest Groups (SIGs); serving as an editor of an AABT publication; presenting at AABT conventions; and/or gaining visibility from journal articles and books.

Getting Nominated

The first step to getting elected is to get your name on the ballot. You will need to fill out and send in the nomination form that is included with your dues statement and also appears on the back page of this issue of *tBT*. Let your colleagues and friends know that you are interested in running for a particular office and ask them to also nominate you. Soliciting the support of SIGs to which you belong can be extremely helpful in getting nominated and later elected. You can also rent a mailing list of all AABT members and send a letter encouraging members to nominate and vote for you. The new AABT listserve may also be helpful in letting others know you would like to be nominated and elected.

Although there is no magic number of nominations that you need to get your name on the ballot, we encourage you to try to get at least 20 to 25 people to nominate you to indicate your seriousness in seeking election. However, only the nominees receiving the most nominations will actually get on the ballot, so we encourage you to solicit as many nominations as possible now. That will also increase your visibility for the actual election or the next election, if you don't get nominated this time.

Remember, you can nominate as many individuals as you like. But, the nominations must be signed and postmarked no later than February 1. Contact Sue C. Jacobs, Nominations and Elections Chair, in care of the AABT national office or at sjacobs@okstate.edu if you need more information about running. We look forward to talking to those of you who become nominated. Good luck!

AABT

Deadline: Feb. 15

Call for Web Editor

AABT is seeking candidates to serve on the Publications Committee as AABT's Web Editor. As the very idea is new, we hope that you can help in fleshing out the position, its responsibilities, and its duties. Below you will find a tentative job description that is clearly a work in progress, but should give you some idea of what we're looking for in a candidate.

To be considered, candidates should supply the Publications Committee with a vision statement, which, at a minimum, describes your vision of AABT's Web site and how you might best assist in moving us toward that vision. It is quite possible that your approach may include others who could assist you, much as associate editors do their editor. If this model appeals to you, you may wish to delineate those areas that others might oversee on your behalf and under your guidance.

No budget currently exists in this area. If you have specific recommendations that you would like implemented and already have a sense of their cost, you might want to include those costs.

We would also like you to explain why you judge yourself qualified to assist us. Although we will eventually want a CV, we don't envision that document giving us a clear sense of how you would contribute. You might also want to list any relevant contributions you've made in similar endeavors and, if relevant, include URLs or other clues that will lead us to them.

Please send all relevant information to me, in care of David Teisler, at teisler@aabt.org. **The deadline is February 15.** If you have any questions, you may contact him or me.

—Art Freeman,
Publications Coordinator

Job Description: Web Editor

The Web Editor sits ex officio on the Publications Committee. As an ex officio member, the Editor's counsel will be welcomed in all manners, but s/he is not given a vote.

The role of Web Editor is to guide the Publications Committee and staff in designing and implementing the best possible Web site given the Association's resources.

The exact responsibilities and duties remain to be determined, but among the possibilities are:

Advertising

✓Advise in developing guidelines

✓Arbitrate when advertisement and guidelines might be in conflict

✓Assist Director of Publications in determining pricing structures

✓Advise about advertising best practices

Navigation

✓Advise about constituents' approach

✓Advise about what's most important to various professional members

✓Advise in developing effective navigation

Content and Links

✓Advise in developing guidelines

✓Advise in developing editorial style guide

✓Serve as conduit through which requests are funneled

✓Interface with other areas (*BT*, *tBT*, *C&BP*, convention) to cull important material (exciting studies, new applications)

✓Interface with other existing and potential electronic services (membership directory, clinical directory, other directories)

✓Interact with others in AABT's governing structure in determining what goes on the Web and in what ways

Technical

✓Advise about other technological interfaces, developments, etc. This could include download speed, types of lines and hosting services used, optimizing software and line efficiencies.

Because this volunteer position doesn't exist, we envision candidates to assist us in expanding, reducing, or refining the definition and scope of the duties and responsibilities. We envision that it may change over time. We see the spot as requiring highly technical expertise, with vision, an ability to listen, ability to understand the goals and the resources available. For it to work, it must be collaborative. We do not envision the Web editor as fulfilling the duties of a copy editor, designer, or one who posts information.

Call

for Award Nominations

9th Annual AABT Awards

This is an open call to the AABT membership to provide nominations for the following awards, to be presented at the 2003 Convention in Boston.

Distinguished/Outstanding Contribution by an Individual for Educational/Training Activities

On a rotating annual basis, one of the following three types of distinguished contributions by an individual member of AABT will be recognized at the Annual Convention: **research, clinical,** or **educational/training.** For 2003, we seek nominations from the membership concerning outstanding contributions in the area of education/training. Eligible candidates for this award should be members of AABT in good standing who have provided significant contributions toward educating and training behavior therapists. Past recipients of this award are Gerald C. Davison in 1997 and Leo Reyna in 2000.

Outstanding Training Program

This award will be given to a training program (not an individual) that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Suggestions for outstanding educational/training programs should be accompanied by a brief summary of information in support of the nomination.

Please send an e-mail version as well as a hard copy of your nomination to the program chair at the address below, *plus*, send 1 duplicate copy of your submission to AABT, Outstanding Training Program Award, 305 Seventh Ave., New York, NY 10001. Past recipients of this award include University of Georgia's Clinical Psychology program; the Clinical Psychology Training Programs at Rutgers, the State University of New Jersey; the Clinical Psychology Training Program at West Virginia University; and the Psychology Internship and Postdoctoral Programs at Wilford Hall Medical Center.

Virginia A. Roswell Student Dissertation Award

This award will be given to a student based upon his or her approved doctoral dissertation proposal. Their research should be relevant to behavior therapy. Accompanying this honor will be a $1,000 award to be used in support of research (e.g., pay subjects, purchase testing equipment, reimburse photocopying cost) and/or to facilitate travel to the AABT convention. Eligible candidates for this award should be student members, have already had their dissertation proposal approved, and be investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor should make nominations and only a 3- to 5-page summary of the proposal should be submitted (anything longer will not be considered). The 3- to 5-page summary, together with a letter of support from the student's dissertation chair, should be sent with nominations for the Student Dissertation Award. Please send an e-mail version as well as a hard copy of your nomination to the program chair at the address below, *plus* send 1 duplicate copy of your submission to AABT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001.

Three additional awards will be presented annually. They include:

Career/Lifetime Achievement
Distinguished Friend to Behavior Therapy
Outstanding Service to AABT

Nominations for these awards are solicited from the members of AABT governance. (This award program does not replace those awards offered by certain segments within AABT such as the President's New Researcher Award, Elsie Ramos Student Poster Award, or those awards offered by individual SIGs. Attempts are made to avoid duplication in a given year.)

To make this a successful program, we need your help. Please e-mail and regular mail nominations to:

John C. Guthman, Ph.D.
Chair, Awards and Recognition Committee
131 Hofstra University
Hempstead, NY 11549
Tel.: 516-463-6791
e-mail: cccjcg@hofstra.edu

General suggestions about the annual AABT awards program are appreciated. Please forward your suggestions to AABT, 305 Seventh Ave., New York, NY 10001.

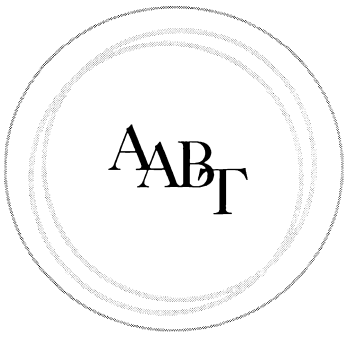
DEADLINE FOR ALL NOMINATIONS

TUESDAY, APRIL 1, 2003

1 1/2-hour tapes

WORLD ROUNDS

V I D E O T A P E S



These best-selling World Rounds videos feature internationally renowned clinicians demonstrating real techniques with simulated clients. It's an excellent opportunity to watch those who developed the techniques demonstrate those techniques.

☐ Acceptance and Commitment Therapy

Steven C. Hayes, *University of Nevada, Reno*

Emphasizing experience, ACT works exclusively through process rather than content to diffuse patterns of the mind. The ultimate goal: the realization that there is no ultimate goal.

In this refreshingly different video, Hayes works with Candace, a young woman with social phobia who views her anxiety as a problem. He encourages the client to deconstruct anxiety into a set of harmless individual symptoms and meaningless words. Through the use of metaphor and sensory exercises, Hayes guides Candace to a state of acceptance of her anxiety in social situations. He strives to help her disentangle from language and, instead, promote her true intentions by "watching the chatter" of her mind without doing anything about it.

☐ DBT for Suicidal Clients Meeting Criteria for Borderline Personality Disorder

Marsha M. Linehan, *University of Washington, Seattle*

"Suicide is always in the back of my mind." These are not words a therapist hopes to hear from a client. What happens next in the therapy session could influence your client's decision to live or die. Are you as prepared as you should be?

Marsha Linehan, master clinician and founder of Dialectical Behavior Therapy, demonstrates techniques used to persuade clients to refrain from harmful behaviors during the course of treatment. Linehan demonstrates successful negotiating and contracting for nonsuicidal behaviors, techniques to strengthen commitment to therapy, and emphasizes ways for therapists to treat clients with borderline personality disorder as humans rather than patients.

ADDITIONAL WORLD ROUNDS VIDEOS

- ☐ *Tammie Ronen* **Problem Behavior in Children and Adolescents**
- ☐ *Edna B. Foa* **Imaginal Exposure**
- ☐ *Art Freeman* **Personality Disorder**
- ☐ *Frank Dattilio* **CBT With a Couple**
- ☐ *Lars Goran-Öst* **One-Session Treatment of a Specific Phobia**
- ☐ *Ray DiGiuseppe* **Redirecting Anger Toward Self-Change**
- ☐ *E. Thomas Dowd* **Cognitive Hypnotherapy in Anxiety Management**

For a full list of all the videos available, including our historical Archives videos capturing such pioneers as Andy Salter, Joe Wolpe, and Alan Marlatt, visit us at* **www.aabt.org.

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☐**Visa** ☐**MasterCard** Expiration Date _____

Card No. _____ Signature _____

Classifieds

Positions Available. Fees are $4.00 per line, with a $15 minimum.

Address correspondence to:
Stephanie Schwartz, Advertising Manager, AABT, 305 Seventh Ave., New York, NY 10001; sschwartz@aabt.org

Positions Available

SUMMER FELLOWSHIPS IN COGNITIVE BEHAVIOR THERAPY AND REBT FOR FULL-TIME UNIVERSITY FACULTY. A limited number of 3-week fellowships for university and college faculty in psychology, psychiatry, counseling, or social work are being offered at the Albert Ellis Institute in July 2003. Featuring intensive practica in REBT, direct supervision of therapy sessions, special seminars, and co-leading a therapy group with Albert Ellis. Send reasons for wishing to participate and vita to Kristene Doyle, Albert Ellis Institute, 45 East 65th Street, New York, NY 10021; or fax at 212-249-3582; or e-mail at krisdoyle@msn.com. Proficiency in English is required. Deadline is March 1, 2003.

CLINICAL FELLOWSHIPS IN COGNITIVE BEHAVIOR THERAPY AND REBT: A limited number of part-time two-year postgraduate Fellowships are being offered at The Albert Ellis Institute beginning July 2003. Featuring supervision of individual, couples, and group therapy by Ray DiGiuseppe, Albert Ellis, and other senior staff. Training programs involve 16 hours a week. Candidates carry a diverse caseload of clients, co-lead therapy groups, participate in special seminars and ongoing clinical research, and co-lead public workshops. Send requests for applications to: Kristene Doyle, Albert Ellis Institute, 45 East 65th St., New York, NY 10021. All Fellowship candidates must be licensed, license-eligible psychologists, or hold an MSW degree. Deadline for applications is February 15, 2003.

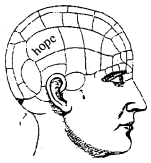
ASSISTANT or ASSOCIATE PROFESSOR (RESEARCH) Rhode Island Hospital/Brown Medical School. The Department of Medicine at Rhode Island Hospital, one of the affiliated hospitals of Brown Medical School, seeks a research faculty member beginning on or before September 1, 2003. This is a renewable, non-tenure track position. The successful candidate must quality for a faculty position at the rank of Assistant or Associate Professor (Research).

Applicants must have a doctoral degree in psychology, sociology or social work with research experience and interest in alcohol, drug abuse, mental health, and/or HIV disease. Primary responsibilities: the applicant will be expected to participate in Brown's funded research program working with a multidisciplinary group of substance abuse and HIV investigators whose studies include behavioral interventions, health services research and mental health research. The applicant is expected to develop an independent funded research program.

Interested applicants should forward a letter of application, an updated curriculum vitae along with three letters of reference to: Michael D. Stein, M.D., Division of General Internal Medicine, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903.

RESEARCH PSYCHOLOGIST for the Rhode Island MIDAS Project (MIDASproject.org). 40-50% protected time for manuscript and grant writing. Email letter of interest and CV to Mzimmerman @Lifespan.org

FACULTY POSITION AT JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE IN SUBSTANCE ABUSE RESEARCH. A new faculty position at Instructor, Assistant or Associate Professor level is available at JHUSOM. The candidate would be expected to establish a line of independent research in clinical pharmacology or substance abuse treatment research at JHUSOM, which offers a rich array of facilities and a stimulating environment to support independent research activities. In addition, candidate would collaborate with PI of the Mid Atlantic Node of the National Drug Abuse Clinical Trials Network (CTN) to develop and direct study concepts and to help set future research directions. The CTN is a new national treatment-research partnership that conducts multi-site effectiveness studies of empirically based treatments for drug abuse within community treatment programs. Position is suitable for a M.D. or Ph.D. with training and experience in substance abuse treatment and research. Academic rank and pay grade depends on experience. Candidates should send vita and letter of interest to: Maxine L. Stitzer, Ph.D., Professor of Psychiatry and Behavioral Sciences, Mid Atlantic Clinical Trials Network, Room 580, Mason F. Lord Building, 4940 Eastern Avenue, Baltimore, MD 21224.



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CLASSIFIEDS

Advertisements for positions available and positions wanted are charged at **$4.00 per line.** All other classified notices (books, pamphlets, commercial products, conferences, workshops, and general announcements) are charged at **$4.50 per line, $15 minimum**. Each line contains approximately 42 characters. Corrections or revisions in copy will not be accepted after the camera-ready deadline. Proofs are not supplied. Advertisers are invoiced after publication.

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Issue	Insertion Order Deadline
January	December 2
February	January 1
Spring	February 3
Summer I	March 3
Summer II	May 1
September	August 1
October	September 3
Winter	November 3

2003 Call for Nominations

AABT is pleased to announce that the first phase of its 2003 election process is under way: the nomination of qualified full members for the positions of President-Elect (2003-2004), Representative-at-Large (2003-2006), and Secretary-Treasurer (2004-2007).

Every Nomination Counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2003, will be counted.**

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

NOMINATE the Next Candidates for AABT Office

I NOMINATE THE FOLLOWING INDIVIDUALS FOR THE POSITIONS INDICATED:

PRESIDENT-ELECT (2003–2004)

_____

_____

REPRESENTATIVE-AT-LARGE (2003–2006)

_____

_____

SECRETARY-TREASURER* (2004–2007)

_____

_____

NAME (printed) _____

SIGNATURE (required) _____

* A description of the Secretary-Treasurer's responsibilities is located on p. 203 of the Winter issue

the Behavior Therapist

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