AABT

ISSN 0278-8403
Volume 26, No. 3, Spring 2003

the Behavior Therapist

CONTENTS

SPECIAL SERIES: INSIDER PERSPECTIVES ON THE FUNDING REVIEW PROCESS

Looking Inside the Black Box: Insider Perspectives on the Funding Review Process 253
Steven R. H. Beach

NIMH Funding: Understanding the Mechanisms 254
Philip C. Kendall and Meredith E. Coles

Hints for Writing a NIMH Grant Proposal 258
Dianne L. Chambless

Protecting Patient Safety in Clinical Research 261
Steven D. Hollon

CLINICAL FORUM

The Virtual Therapist: Behavior Therapy in a Digital Age 265
Kenneth P. Bobicz and David C. S. Richard

BOOK REVIEWS

Sherman, C. (2001). *How to Go to Therapy* 270
Reviewed by Frank M. Dattilio

Klingemann et al. (2001). *Promoting Self-Change From Problem Substance Use: Practical Implications for Policy, Prevention and Treatment* 271
Reviewed by Ronald M. Kadden

AT AABT

Welcome, New Members! 272

You Can Help AABT Grow 273
Michael Petronko

Minutes of the Annual Meeting of Members 274

CLASSIFIEDS 277

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.

— Research-Training Link

SPECIAL SERIES

Looking Inside the Black Box: Insider Perspectives on the Funding Review Process

Steven R. H. Beach, *University of Georgia*

When junior academics within AABT think about career advancement, it is increasingly common for them to think about gaining some type of extramural support for their research. But for those attempting funding for the first time, applying for support can be a daunting task. There are many different types of funding mechanisms and many different agencies ready to support the research that is of interest to AABT's membership. This diversity is good because it provides a variety of avenues for successful grant applications. At the same time, this diversity can arouse anxiety among junior academics who may be less seasoned in the funding process. To address the needs and concerns of this important group within AABT, the Committee for Research Agenda of AABT sponsored two panel discussions on research funding at the 35th annual convention of the association.

The first panel was comprised of program officers from major funding agencies: Lisa Onken representing the National Institute on Drug Abuse (NIDA), Bob Heinssen representing the National Institute of Mental Health (NIMH), and Ileana Arias representing the Center for Disease Control (CDC). The program officers presented information about funding mechanisms, points of contact with funding agencies, and, most importantly, encourage-

the Behavior Therapist

Published by the Association for Advancement of Behavior Therapy
305 Seventh Avenue - 16th Floor
New York, NY 10001-6008
(212) 647-1890/Fax: (212) 647-1865
www.aabt.org

Subscription information: *the Behavior Therapist* is published in 8 issues per year. It is provided free to AABT members. Nonmember subscriptions are available at $38.00 per year (+$17.00 surface postage or +$32.00 airmail postage outside USA).

Change of address: 6 to 8 weeks are required for address changes. Send both old and new addresses to the AABT office.

ment to contact and communicate with program officers to receive help in the process of grant writing. A central theme of the presentations was that federal agencies are very interested in facilitating the development of new investigators and that program officials are ready to help those applying for funding.

The second panel was comprised of three experienced members of NIH review panels: Dianne Chambless, Steve Hollon, and Phil Kendall. These three long-time AABT leaders provided an insider's look at the various mechanisms of support, what happens to grants after they are submitted, the criteria by which they are reviewed, and numerous tips about how to maximize the fundability of treatment grant proposals. Several overarching themes were evident across the presentations. First, there are many sources of support and many types of support (see especially the article by Kendall and Coles, p. 254). So, there is likely to be a type of support that fits your circumstances. Second, the criteria by which proposals are evaluated can be articulated in clear language that provides guidance to those submitting proposals, and the most important individual characteristic predictive of funding is persistence, with revisions being necessary for funding in most cases (see especially Chambless, p. 258). Finally, for treatment research, the grant process does not stop with initial approval, so it behooves aspiring clinical researchers to understand the mechanisms involved in patient protection and the very issues that need to be dealt with to ensure patient safety (see Hollon, p. 261). This special section of *tBT* is meant to summarize the presentations of Drs. Chambless, Hollon, and Kendall and so to disseminate more broadly this important information to aspiring clinical scientists in AABT. In the pages that follow, these three experienced reviewers provide a wealth of information in a brief and useful format.

NIMH Funding: Understanding the Mechanisms

Philip C. Kendall and Meredith E. Coles, *Temple University*

The National Institute of Mental Health (NIMH) provides a variety of mechanisms to secure funding for mental health research. Although it is pleasing that there are many funding sources available, identifying the proper funding mechanism can be a demanding task. This article provides a quick overview of the main funding mechanisms of interest to cognitive-behavioral researchers and offers some observations and suggestions. Additional information, including application materials, due dates, and detailed information about the various funding mechanisms, is available on the Web (start at www.nih.gov and click on the link for "Grants and Funding Opportunities"). Another useful Web page is the Grants Office of Extramural Research home page (http://grants.nih.gov/grants/oer.htm).

In this article we discuss five major types of funding mechanisms. We highlight the purpose of the mechanisms, the eligibility criteria, the basic review criteria that are used for evaluating proposals, and information about expenses covered by the mechanism. Observations and suggestions that are intended to be helpful to applicants are laced throughout.

RO1s: Investigator-Initiated Research Projects

RO1s represent the broadest funding mechanism. It is the mechanism for investigator-initiated research grants and therefore the most common. The nature of RO1 projects varies widely, from basic psychopathology research to large-scale randomized clinical trials. Also, because of the broad nature of this mechanism, specific information regarding the purpose of RO1s is difficult to secure. However, a few useful resources may contribute to a better understanding of RO1s. First, information about the form used to prepare an RO1 submission, the PHS 398, is available and includes a helpful instruction book for preparing submissions, sample forms, and a downloadable version (http:\\grants.nih.gov\grants\funding\phs398\phs398.html). Another useful resource is CRISP (Computer Retrieval of Information on Scientific Projects), a searchable database of biomedical research. CRISP allows you to sort by various characteristics, such as funding mechanism, to get a sense of what types of questions are addressed with a given funding mechanism or topic area, to get a sense of current research in a particular

SEPI 2003 in New York City
19th Annual Conference
May 2-4, 2003
The Westin New York At Times Square

The Society for the Exploration of Psychotherapy Integration (SEPI) is an international organization that promotes communication and integration across differing approaches to psychotherapy. SEPI provides a collaborative and open community for clinicians and scholars who recognize the limitations of single school perspectives and who are interested in learning alternative ways of working with patients and thinking about clinical phenomena.

CONFERENCE THEME:

A Dialogue on Difference

• 10 Workshops • 18 Symposia • 2 Plenaries • 17 Dialogues • 6 Panels • 23 Papers
Research Consultations

The aim of this conference is to establish an open dialogue that emphasizes the exploration of differences among a variety of perspectives on theory and technique. In addition, there will be presentations on age, cultural, racial, religious, socioeconomic, sexual and gender differences, as well as differences between individual versus couples, family, and group psychotherapies. By creating a forum for a frank discussion of differences, the hope is to establish a richer, more nuanced, shared understanding of the psychotherapy process, including clarifying where apparent differences may obscure clinically important common ground.

Registration information and the complete conference program is available at our website at

www.cyberpsych.org/sepi/

If you have any further questions, contact Dr. Peter Costello at *costello@adelphi.edu.*

area. You can access CRISP at http://crisp.cit.nih.gov/.

Applications for RO1s are reviewed with consideration of their ability to advance the understanding of biological systems, improve the control of disease, and enhance health. Within the mental health arena, a better understanding of a disorder or a proposal that could improve the treatment of a disorder fulfills this aspect of the evaluation. RO1 applications are evaluated on the following criteria: (a) significance of the project, (b) approach/methods proposed, (c) innovation, (d) credentials of the investigator, and (e) scientific environment for the work. The bar is set high, as these projects are typically large in scope and expense. Reviewers also examine the appropriateness of the proposed budget and the adequacy of plans to include a diverse sample (genders, children and adolescents, and minorities).

An applicant seeking support from the RO1 mechanism should have had relevant experience in the research arena. Having conducted and reported on studies similar to those proposed and having gathered pilot data that inform the study and its methods are examples of this valued experience. But, as you may have guessed, experience is not sufficient. Rather, each of the criteria is considered and an impressive application is one that achieves high marks on all five criteria. Although we offer a few observations about the process, one fact remains: The key to a successful research grant application is a first-rate proposal (e.g., quality methods).

Significance has to do with the public health relevance of the work—tying the proposal to an important concern in the mental health field and showing that the work has relevance to a pressing need. Keep in mind that members of the community are a part of the review process and they often want to see that the research has direct public health relevance. The review of the section called "approach" is the one that involves the science of the proposal. Make every effort to propose the best study, not the easiest to do. In this section, an incomplete assessment plan, an inchoate intervention, or an unsound data analytic strategy will be identified and potentially seen as a sufficient detraction from the proposal. Conduct and report power analyses, provide information about the psychometrics of the scales being proposed, and be clear and compelling in the rationales used to justify important procedural decisions. Consider the various methods that could be followed, and provide a rationale for the methods that are chosen.

Although innovation is a good thing, innovation alone will not carry the proposal forward—a good approach (e.g., methods, analysis plan) will. The investigator and the scientific environment are criteria in the sense that it is important that reviewers can be confident that the principal investigator (PI) can do the work and that the setting for the work is supportive. Past research publication and pilot work help to document the qualifications of the PI and letters of support can buttress the commitment of the research environment. Institutions without prior publication on the topic are not penalized, whereas a PI without some prior research experience may be questioned.

The budget is not the central issue in the evaluation of an RO1 application. True, the budget entries need to be justified, and there are limits that require approval before submission, but the general rule is that the budget should reflect what it would take to conduct the needed and proper study. Reviewers evaluate the budget, and may make some suggestions about it, but this is done after the scientific merit of the proposal has been determined.

"F" Awards: Individual National Research Service Awards (F30, F31, and F32)

(For additional information see http://grants.nih.gov/training/nrsa.htm#fellowships.)

The purpose of the F awards is to help ensure that highly trained scientists will be available in adequate numbers and in appropriate research areas to carry out the nation's biomedical and behavioral research agenda. These awards seek to facilitate the training of those applicants judged to have the potential to become productive, independent investigators. There are three types: F30 Individual Predoctoral awards for M.D./Ph.D. Fellowships; F31 Predoctoral Fellows; and F32 Individual Postdoctoral Fellows.

To be eligible, the applicant must be a citizen or a noncitizen national of the United States or have been lawfully admitted for permanent residence at the time of award. All applicants must have a baccalaureate degree. F30 applicants must be enrolled in an M.D./Ph.D. program at an approved medical school, accepted in a related scientific Ph.D. program, and supervised by a mentor in that scientific discipline. F31 applicants must be enrolled in a program leading to a research doctorate (e.g., Ph.D. or D.Sc.) or a combined clinical and research degree (M.D./Ph.D.). F31 awards support research training applied toward preparation of a dissertation and do not support study leading to the professional degrees (e.g., M.D., D.O., Psy.D.). F32 applicants must have already received their advanced degree from an accredited domestic or foreign institution. In all cases a sponsoring institution with adequate staff and facilities for training must be identified.

When considering the criteria used to review applications it's worthwhile to remember the goal of the fellowships—they are designed to train future generations of outstanding scientists committed to pursuing careers in mental health sciences research. Therefore, it is not surprising that the review of F30 and F31 applications focuses on the applicant, the research training plan, the sponsor, and the institutional environment/commitment. Review of F32 applications focuses on the candidate, the sponsor/training environment, the research proposal, and the training potential. A track record of research is quite helpful, as is the plan to work with an established research mentor. The training plan should be specific to the training goals and well integrated within the overall application.

All three F's provide a stipend that is determined based on the funding institute and funding mechanism (years postdoctoral in the case of F32). Awards also provide yearly research allowances/institutional allowances (F30 up to $2,000, F31 up to $2,500, and F32 up to $4,000). These funds are intended to defray costs of expenses such as research supplies, equipment, and travel to scientific meetings. Further, awards provide payment of tuition/fees/health insurance (100% of the cost of up to $2,000 for F30 and up to $3,000 for F31/F32, and 60% of costs above these thresholds).

Small Grant Applications (R03)

(For additional information see http://grants.nih.gov/grants/guide/pa-files/PAR-99-140.html.)

The small grants program provides research support of up to $50,000 per year (direct costs) for up to 2 years for new research projects in areas of relevance. These short-term awards are intended to fund investigations of specific, focused research questions. New investigators may use these grants to generate data for future research grants and more experienced investigators may use these grants to fund new research directions or develop new methodology.

Applications can be submitted by domestic organizations both nonprofit and for-profit and public and private. Examples include universities, colleges, hospitals, and laboratories.

Individuals supported by National Research Service Awards traineeships and/or fellowships are not eligible.

Applications are reviewed with consideration of their ability to advance the understanding of biological systems, improve the control of disease, and

enhance health. Like RO1s, small grant applications are evaluated on the following criteria: (a) significance of the project, (b) approach/methods proposed, (c) innovation, (d) credentials of the investigator, and (e) scientific environment for the work. In other words, studies are evaluated on their public health relevance, the scientific merit of the proposal, the qualifications of the investigator, and the scientific environment for the study. Reviewers also examine the appropriateness of the proposed budget and the adequacy of plans to include a diverse sample (genders, children and adolescents, and minorities). Finally, it is worth noting that while small grant awards are evaluated on the same criteria as R01's, the larger scope and expense of RO1s typically translates to higher review standards.

Support from RO3s may be requested for up to 2 years at $50,000 per year in direct costs, plus facilities and administrative (F&A) costs. Budget requests are submitted using the "Modular Grant" procedures. Small grants are not renewable.

"K" Awards: Career Development Awards (K01, K02, K05, K08, K23, and K24)

(For additional information see http://grants.nih.gov/training/careerdevelopmentawards.htm.)

Various institutes within NIMH, with the unifying goal of career development, sponsor K awards. These awards vary greatly in the level of experience of the trainee, the number of years of funding provided, and the percent effort required of the recipient. Many of the programs are intended to facilitate the career development of scientists, and to allow for increasing independence. Awards are available for both new and seasoned researchers. For example, the K01, Mentored Research Scientist Development Award, supports career development in a new area of research for a period of 3 to 5 years. Similarly, the K02, Independent Scientist Award, is aimed at developing the career of the funded scientist. Awards for more established researchers are also available such as the K05, Senior Scientist Award, which provides funding for up to 5 years and is intended for scientists with a sustained record of high productivity. Awards are also available for researchers with a clinical focus. For example, the K23, Mentored Patient-Oriented Research Career Development Award, supports the career development of investigators who have made a commitment to focus their research endeavors on patient-oriented research. Finally, awards are also available for institutions to improve the quality of training in clinical research. The K30, Clinical Research Curriculum Awards, are intended to support the development of didactic programs in clinical research at institutions that do not already have such programs, or to improve the quality of existing clinical research didactic programs.

"T" Awards: Training Grants (T32 and T35)

(For additional information see http://grants.nih.gov/training/nrsa.htm#inst.)

Institutional Research Training Grants (T32) are awarded to eligible institutions with the goal of enhancing research training (improvements to existing training programs or the development of new programs). Such training is intended for both pre- and postdoctoral trainees in the fields of behavioral, biomedical, and clinical research. The overarching goal of these grants is to ensure that a diverse and highly trained work force is available to assume leadership roles.

Short-term Institutional Research Training Grants (T35) are available with similar goals to the T32 mechanism, but are intended to support intensive, short-term research training experiences for students in health professional schools during the summer. T35 training programs must be in either basic or clinical aspects of the health-related sciences and should provide sufficient training to enable trainees to have thorough exposure to the principles underlying the conduct of research.

Closing Remarks

The Web provides easy access to the lengthy descriptions of the various mechanisms, and we provided Web addresses to ease your journey. But the materials are dense in "government speak" and probably will require sifting to find the specific information that you seek. What may be helpful to someone unfamiliar with an application is to examine the application of someone who has submitted previously. Also, NIMH staff can be contacted and they are quite helpful in directing you to the proper mechanism for your proposal.

Hints for Writing a NIMH Grant Proposal

Dianne L. Chambless, *University of North Carolina at Chapel Hill*

Getting funding to do your research is desirable for several reasons: Much research is impossible to do without significant external funding; you may provide financial support for graduate students and for yourself; and your institution may consider external funding to be important in evaluations for promotion, tenure, and merit pay raises. Given all these benefits, why isn't everyone doing it? Writing an application is effortful, and the payoff is uncertain. Depending on the funding year, 15% to 20% of applications to the National Institute of Mental Health (NIMH) programs with which I'm familiar may be funded. Also, the process itself may seem daunting, perhaps accessible only to those gifted in what's known as grantsmanship, and passed down from successful mentors to their acolytes.

The purpose of this article is to give you some of that insider information and thus perhaps the necessary encouragement to write applications and obtain funding for your work. Keep three caveats in mind: First, my experience is limited to the review process for NIMH study sections (now called initial review groups or IRGs) for psychotherapy and other intervention research. Second, much of what I will say is based on my perception and, as such, may well be wrong. Third, with each new head of the NIH, review processes are changed, and IRGs are constituted and reconstituted. Some of what I have to say here may only pertain until the next, seemingly inevitable, reorganization. Kendall and Coles (see p. 254) have described a variety of mechanisms for funding. I will focus on the most common, the R01. The R01 may be a single application from one institution or a coordinated group of applications from investigators at two or more institutions applying to conduct multisite research (for the latter, see http://grants.nih.gov/grants/guide/pa-files/PAR-98-107.html). The separate R10 mechanism for multisite grants no longer exists, but, using the multisite R01, the principal investigator (PI) at each institution is credited with being a PI. This can be important for career advancement in that institutions give more credit to the person serving as PI than to those in co-PI roles.

Review Criteria

Reviewers follow broad formal guidelines provided by NIMH, and, over time, IRGs also develop informal criteria by which they interpret the specific applications of these guidelines. The formal criteria are significance, the approach, innovation, the investigator, the environment, and the adequacy of the plans for inclusion of children, women, and ethnic minorities, and for monitoring the safety of research participants and the integrity of the data.

Significance

Applications are judged on the basis of the scientific significance of the work and the public health significance. A relatively recent change at NIMH is that public participants are now included on IRGs. This step was taken, in large part, to have mental health consumers' (e.g., clinicians, state mental health administrators, patients, or their families) voices heard in evaluations of significance. One powerful NIMH administrator commented to the committee that he was tired of elegant applications that proposed new studies of well-studied phenomena; rather, he wanted research on understudied areas or on applications of research to real-world settings (i.e., what is called *effectiveness research*; see NIMH's document "Bridging Science and Service," available at http://www.nimh.nih.gov/publist/nih4353.cfm). It seems to me that IRG members differ in how much they adhere to this instruction and that your chances of being funded for theoretically meaningful work without strong immediate public health significance will vary unpredictably according to the reviewers to whom you are assigned. Nonetheless, one of your reviewers will be a public participant who will be instructed to evaluate the grant by that criterion. It behooves you to make as strong and clear a case as you can for the significance of your proposed research. The disease model of mental health problems predominates, and it can be difficult to get funding from NIMH if you deviate from that. If you're interested in positive psychology, you would do well to apply to private foundations instead.

Note that the IRG does not have the last word on your chances of funding. Technically, the IRG simply provides advice to the overall NIMH council and to program officers (the people who hand out the money and supervise your administration of the work). Program officers are sensitive to the priorities of the institute and are free to go out of order of the IRG's priority scores to fund proposals they think are significant to the mission of the NIMH. In practice, they are unlikely to deviate wildly from the IRG's recommendations, or IRGs would revolt. Nonetheless, it is easier to get funding in an area the program office thinks is highly significant, for example, research on children or severe mental illness. When NIMH particularly wants to stimulate research in a given area, officials may issue a program announcement (PA), encouraging researchers to write particular types of applications. The researcher indicates on the front page of the grant application whether the application is in response to a program announcement, in which case the reviewers will look at the criteria specified by the announcement before conducting their review. It is worthwhile to check for program announcements that might pertain to your research (go to http://grants2.nih.gov/grants/guide/index.html).

Approach

This is the heart of the proposal and of its review. No matter how important your research question is, if you don't do well here, you won't get funded. Steve Hollon and I have elsewhere described the elements we think are crucial for good psychotherapy research (Chambless & Hollon, 1998). In part, we gleaned these ideas from our experience on IRGs. These points are too lengthy to repeat in detail here, but I will include them briefly in my description of the issues you should consider.

Here are questions to ask yourself: Are the conceptual and empirical bases of your proposed research clear, and do they make a compelling argument for your research as the next logical step? Does your proposed methodology follow logically from your hypotheses and test them adequately? Do you have pilot work that indicates you can do what you say you will do and that it is reasonable to think it will pay off? The reviewers will be looking to see that you have clear and reasonable inclusion and exclusion criteria for your sample, that you use reliable and valid measures (when possible, include measures that are the gold standards in the field), that you have manuals for your intervention protocols as well as measures of treatment integrity and, perhaps, ratings for therapist competence. Reviewers will examine your design. Have you ruled out important threats to internal and construct validity and made it clear how you

did this? It would be reasonable to think that, with the focus on effectiveness research, IRGs would consider quasi-experimental designs to be appropriate for funding. I have yet to see this happen, although advances in quasi-experimentation permit a high level of internal validity in such a design (see Shadish, Cook, & Campbell, 2002). So far, the IRG on which I serve seems only to be comfortable with the standard randomized controlled trial, even in effectiveness research and certainly in efficacy research.

An important change in recent years is the increased emphasis on statistical issues. In my IRG, each grant will be assigned a statistician as a reviewer. That person may know little about the substance of your area and will be primarily examining the data analysis and perhaps other areas of methodology. The statisticians look for a detailed, sophisticated approach to data analysis and are more favorable toward applications that include a statistician among the key personnel. Make clear your statistician's expertise in the types of analysis you plan to use if it is not apparent from his or her publications. Include power analyses and describe the basis for these analyses, and make clear links between the statistical analyses and the research hypotheses.

Finally, you need a good implementation plan. Include a time line for the proposal. For example, how long will you spend training raters and therapists before you begin to see the first real participants? How will you decide the therapists are competent at the proposed treatment? How will you determine interrater reliability of interview data? How will you recruit subjects? Who will take responsibility for what in the project? Have your manuals and rating scales been pilot tested? Where multisite applications are involved, a special section on coordination between sites is required. Spell out how decisions will be made, which site will be responsible for what tasks, how cross-site consistency will be ensured, and so on.

Innovation

Applications deemed to be innovative get better priority scores, other things being equal. There are a number of different ways you can prepare an innovative application. One important approach is to conduct research with an understudied population, such as children, the aged, those with severe mental illness, or those living in rural areas. In short, go where others aren't. If your research could be carried out in the arena of alcohol or substance abuse or health problems, you have a real advantage. Funding is easier to obtain at the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) than at NIMH and at the various institutes for physical health problems. A second type of innovation is the study of effectiveness, the benefits of treatment in real-world settings. If you've been working with a treatment shown to be efficacious in tightly controlled settings, consider testing this therapy in primary care settings or community agencies.

NIMH would also like to see research on cost-effectiveness included in effectiveness studies. Incorporate such analyses only if you have the relevant expertise or can find a collaborator who does. The IRG includes health economists who will look at your proposal almost entirely through those eyes. At this point, it seems that no cost-effective analyses would be better than ones that are not state-of-the-art. Of course, new treatments for problems that have proved refractory to available therapies or treatments for problems that have not often been the subject of controlled treatment research constitute another kind of innovation, as do new methodological approaches, such as applications of emerging technologies.

Investigator

Funding an application requires faith in the research team's ability to complete the research in a high-quality fashion. The reviewers use the quality of the proposal to do this, but they also consider the investigators themselves. Here the biosketch is useful for demonstrating prior research in the area of your proposal as well as your general productivity, and the reviewers may be influenced by what they know of your overall scientific reputation. In the body of the application, you can describe your training and experience for the proposed tasks and demonstrate with pilot work that you can carry out the proposed research. Does this work to the dis-

advantage of less experienced investigators? It certainly may.

There are several ways to get around this. First, NIMH wishes to encourage new investigators, and you are invited to indicate on the application face page if you are such a person (e.g., someone relatively new to the field who has not previously had an R01). In such cases, the IRG is asked to consider the potential of the investigator more than the past track record and to expect less extensive preliminary research. Second, you can include more experienced co-investigators or consultants to shore up the IRG's confidence, as well as to help you conduct an excellent project. Third, start small. Build up your track record by completing a smaller project that heads you in the direction you want to go but without such high stakes. Kendall and Coles (see p. 254) describe the R03 small grant mechanism, which is, in part, intended for new investigators.

Environment

You can be a wonderful investigator with a great idea, but if the IRG doubts that you can carry out the research in the proposed setting, you're sunk. When you describe the environment, indicate all the resources (programs, space, equipment, and people) available to you at your institution and at any other sites where you plan to conduct your research. In particular, document that the patient flow is adequate to fill the cells of your trial. If you will interface with other agencies, for example, for recruitment, then include supporting letters in which the responsible individuals at those agencies indicate their agreement to participate.

Human Subjects

The recent deaths of participants in medical research trials have increased the intensity of NIH's focus on safety of human subjects in all treatment research. Reviewers are expected to downgrade your priority score if they have significant questions about the safety of your procedures and whether you have sufficiently protected the welfare of your participants. The human subjects section and the safety-monitoring plan will come in for close scrutiny. The public participants are asked to comment on these aspects of your application in their reviews, and they will also weigh in on the burden to participants of taking part in your study. More than ever, you will be expected to describe when you would decide to remove participants from a trial for their welfare, how you provide emergency coverage, and how you will handle adverse events. All personnel who have contact with human participants or their identifiable data are required to have a certificate of training in ethics. Large-scale studies and multisite studies require that the researcher establish a formal board, including people who are not project personnel, to monitor the safety of human subjects.

Inclusion of Women, Minorities, and Children

You are now required to include sections describing your plans for inclusion of women, minorities, and children (defined as subjects less than 21 years old) in your research. Do not make light of these sections or omit them. This is NIH's way of trying to get researchers to increase the amount of available data on these subgroups. Few psychotherapy researchers have trouble including women in their studies; this is more of an issue for health or medical researchers, who have often omitted women from their samples.

If you study geriatric problems, your rationale for omission of children is clear. Otherwise, you need to include them or have a good reason why you're not going to do so (for example, if the intervention you plan to use is not developmentally appropriate for children).

Indicating that you will include minorities insofar as they apply to your project and that you hope to match the demographics of your geographic area no longer suffices. Rather, you need to describe the ethnic makeup of your facility's clientele and, if this provides insufficient minority representation (as it often will), you need to develop a specific plan for recruitment of minorities.

Data and Safety Monitoring Plan

The importance and some of the features of the safety-monitoring plan have already been described in the human subjects section. Often overlooked is the requirement for a data-monitoring plan. For large-scale and multisite grants, this comes under the review of the Data and Safety Monitoring Board, which Steve Hollon (see p. 261) will describe. Otherwise, the PI and perhaps the project statistician may serve this role. You should provide your plan to ensure accuracy of data entry, back-up routines, and checks to further verify the validity of the data. For multisite projects, indicate how data will be transmitted from one site to another.

Overall Strategies

Write a Good Proposal

Allow yourself time to prepare your proposal carefully and to have one or more colleagues read it over, preferably one colleague who is in your specific field and one who is not. The reviewers will judge you by your written proposal, especially if you are a new investigator about whom they know little else. They are likely to conclude that an inconsistent, sloppy, or poorly written proposal means that you are an inconsistent, sloppy, poor investigator.

Discuss and Defend All Important Decisions

There is often more than one way of doing something, and someone will disagree with whatever you do in these cases. For example, you may choose to control for therapist characteristics by crossing therapists with condition (i.e., having each therapist provide each treatment that is being compared with another). Some people will think this is a fine idea. Others will worry that your therapists will not be able to keep the treatment conditions distinct, or that they will have an allegiance to one treatment over another. What to do? Demonstrate that you understand the potential problems and have thought about why you've decided to do it the way you have. Back yourself up with data, if possible. For example, if you choose to cross therapists with condition, then show that in pilot work your integrity measures indicated that therapists maintained the boundaries between treatments (presuming this is the case).

Obtain Feasibility Data

Before you start a large-scale project, demonstrate that the procedures you are planning to use can be carried out. For example, say you want to train therapists in the community to conduct a particular kind of treatment. You need to show that you can get these therapists involved in the project and that your training plan and materials are adequate to the job. Again, this means you'll likely need a pilot study. It is highly unlikely that you will be funded to carry out a full-scale intervention study unless you have conducted such pilot research, resulting in the development of fully elaborated treatment manuals, integrity measures, and competence ratings, and providing estimates of effect size for your power analyses. This pilot research may involve 2 to 3 years of work. A special funding mechanism, the R21, exists to enable you to carry out such research before you submit an application for an R01 (see program announcement at http://grants2.nih.gov/grants/guide/pa-files/PA-99-134.html).

Persist

Be prepared to be rejected and to bounce back. Resilience will serve you well in obtaining a grant, just as it does in

getting published. You will receive the comments of at least several reviewers on your application, and you may get a summary of the discussion of the IRG meeting as well. (To save IRG time, applications that the assigned reviewers find to be in the lower 50% of priority scores are not discussed at the meeting. Thus, you will not receive a summary if your application falls in this category, called unscored.) Consider the critiques carefully and decide whether you think your project is basically a sound one, or can become so with additional work. If the message is at all encouraging, plan to revise and resubmit the application, perhaps after doing additional pilot work to address the IRG's concerns. Don't assume that, if your application was unscored, the IRG is saying it is without merit. That is often not the case; you need to read the critiques (called pink sheets because in the old days they were printed on pink paper). Program officers often attend the IRG meetings as observers and can provide you with additional feedback about the reaction of the group to your work, thus helping you decide whether and how to resubmit. Please do not contact members of the IRG. We are not allowed to talk with you about the content of the meeting or about our thoughts concerning your application. For a resubmission, you will get additional introductory pages to specify your response to the IRG's critique, in particular, what changes you've made. If you believe the IRG was flat-out wrong about some point, then think of a respectful way to explain why your original plan was the best approach. Make sure you go through the application and carry any changes throughout. Don't waste a resubmission with hasty work. NIMH will only consider two resubmissions now of a given project: Three strikes and you're out.

Summary

The process may seem daunting, and indeed it is hard work. However, writing an application almost always sharpens your thinking about your work, and you may shape the introduction to a journal article or the bulk of a book chapter from your background and significance section. You will often get a very careful reading of your ideas with valuable feedback you couldn't buy from experts in your field. The reinforcement schedule is intermittent, but the rewards are potent when they come.

References

Chambless, D. L., & Hollon, S. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7-18.

Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental design for generalized causal inference*. New York: Houghton Mifflin.

Protecting Patient Safety in Clinical Research

Steven D. Hollon, *Vanderbilt University*

There are several additional steps that must be mastered before a grant can be funded. To varying extents, each involves considerations that balance patient welfare against the expected scientific value of the project. These include (a) being approved for funding by council, which often conducts its own review of the risks and benefits to the participants involved in clinical research; (b) oversight by committees charged with monitoring the ongoing conduct of the trial; and (c) obtaining permission to conduct the research from local committees charged with protecting subject welfare. Each is discussed in turn.

Human Subjects Research Council Workgroups

Even after a grant receives a potentially fundable priority score, it is not guaranteed funding from the National Institute of Mental Health (NIMH). Recommendations from NIMH Institutional Review Groups (IRGs) are advisory only and subject to the discretion of council. Although council does not depart all that often from recommended rankings, it does have the power to do so. Moreover, certain kinds of studies receive an additional round of review from a standing committee composed of council members called the Human Subjects Research Council Workgroup (HSRCW). In particular, studies that conduct biological challenge tests or that withdraw responsive patients from medications are subject to this additional level of review before they can be approved for funding.

Our experience with a recent proposal is illustrative. What we proposed to do was a study in which patients would be randomly assigned to either medication alone or the combination of medication plus cognitive therapy and treated first to remission (1 month symptom-free) and then continued in treatment until the point of recovery (6 months without relapse). At that point, cognitive therapy would be phased out for all patients in combined treatment and recovered patients would be randomized a second time to either medication maintenance or medication withdrawal and followed over the next 3 years to ascertain the frequency of recurrence. We hypothesized that either prior exposure to cognitive therapy or staying on maintenance medication would protect patients from recurrence (the onset of wholly new episodes).

The problem with this protocol is that we already know that patients withdrawn from medication are put at elevated risk for recurrence. What we do not know is whether prior exposure to cognitive therapy will reduce that risk, and if it does, how the magnitude of that preventive effect compares to the benefits of keeping patients on maintenance medication, the current treatment standard. We know that not everyone who is taken off medication will have a recurrence (we can expect that about half will) and that some patients who stay on medication will have a recurrence nonetheless (about one in five). We also know that some patients take themselves off maintenance medications against medical advice. Nonetheless, we know that we are putting patients at risk by asking them to stop taking medications. The HRSCW wanted to ensure that adequate safeguards were in place to protect patient welfare and that prospective participants would be fully informed as to the risks involved in participating in the research.

The process went through several iterations of review and response and required several months to resolve. Although we had considerable experience conducting long-term follow-ups on remitted patients following medication withdrawal and had been through a complete and thorough review by our local human subjects committee, we found the process to be as helpful as it was intense. Two specific suggestions from the HRSCW were particularly helpful. First, they recommended that we secure informed consent again

just prior to the second randomization and possible medication withdrawal. Their thinking was that symptomatic patients might feel pressed at the beginning of the trial to agree to subsequent medication withdrawal in return for treatment for their current distress. Once recovered, those same patients could make their decision with less of a sense of personal desperation. Second, the HRSCW recommended that we secure permission at the outset of the trial to establish a relationship with a close family member or friend that we could contact in the event that we lost touch with a patient during the follow-up. This recommendation was based on the recognition that some patients become withdrawn and hopeless following a recurrence. Although patients have a right to withdraw from a protocol at any point, the HRSCW wanted us to be sure that such patients did not misconstrue the consequences of medication withdrawal as an indication that their depressions could not be treated.

In their oversight capacity, the HRSCW had the opportunity to review numerous similar proposals and was familiar with the most up-to-date strategies for protecting the welfare of patients while pursuing questions of science. In that respect, the review process served an educational function that improved the integrity of the final design. Rather than being just a burden or a threat (it did involve considerable effort and raised concerns about the eventual funding of the project), the additional level of review led to important modifications in the implementation of the design that enhanced the quality of the protections for the patients.

Data and Safety Monitoring Boards

One of the additional safeguards that we built into our trial was ongoing review by an independent Data Safety and Monitoring Board (DSMB). In recent years the National Institute of Health (NIH) has begun to mandate the formation of DSMBs to safeguard human research participants, oversee interim analyses, and determine whether trials need to be modified or terminated. DSMBs are designed to monitor clinical trials on an ongoing basis. They do not replace local committees set up to monitor participant safety, but rather provide additional oversight on an ongoing basis for studies that have already been approved. The purpose of this process is to assess scientific integrity and patient safety issues and to ensure the ethical conduct of clinical research involving human subjects.

The composition of the DSMB is determined by the investigator in consultation with the funding agency, but typically includes experts in clinical trial design and treatment issues, biostatistics and data management, research ethics, and patient advocacy. For example, for the multisite comparison of cognitive therapy and maintenance medications in the long-term prevention of recurrence in depression previously described, our research team put together a DSMB composed of a research psychiatrist, a research psychologist, a biostatistician, an ethicist, and a lay representative active in patient advocacy. None of the DSMB members was employed by any of the participating institutions taking part in the grant. Monies were built into the grant to support the activities of the DSMB. In order to defray costs and reduce the burden to the participants, all members were drawn from other institutions in the same large metropolitan area so that the board could meet without having to travel out of town.

DSMBs typically are asked to meet to review the protocol prior to study initiation and again on a regular basis throughout the conduct of the trial. We plan to have our DSMB meet on a semiannual basis while patients are being screened for the study, although meeting frequency likely will be cut back during later stages of the trial and could be increased at any time at the discretion of the board. The DSMB will be asked to review information relevant to patient safety and response on an ongoing basis to determine if any study procedures should be altered or stopped because of evidence of benefit or harm to participants that can be attributed to the treatments under evaluation. Specific responsibilities include:

- to review and approve, disapprove, or modify study protocol or consent documents to assure both scientific integrity and adherence to human subject protection policies;
- to monitor adverse events to determine whether changes are needed in study protocol or consent forms to ensure the safety of participants;
- to monitor data regarding efficacy (typically in a semi-blinded fashion) on an ongoing basis to determine whether the trial should be continued;
- to monitor data management activities and review data relevant to quality control; and
- to determine on a regular basis whether a given project should be continued, suspended (pending further information), or stopped, depending on how it was doing with respect to protecting patient safety and whether it had met (or could meet) its scientific objectives).

I recently served on an in-house DSMB that monitored progress in a number of clinical trials supported by contracts from the NIMH. Before a project could be initiated, we reviewed all aspects of the study protocol and consent documents and voted on approval, disapproval, or deferral for revision and reconsideration for each of several ongoing clinical trials. The DSMB had the power and responsibility to request changes in study protocols and consent documents at any time and could recommend continuation, suspension (pending further information), or stopping with respect to ongoing trials. When unexpected adverse events were encountered, we could require that appropriate actions be taken, such as introducing new monitoring tests, altering inclusion or exclusion criteria, or recommending changes in the consent documents. Serious adverse events (suicide attempts or serious side effects) were reported to the board on an ongoing fashion. Typically, this was accomplished by reporting directly to the chair, who then had the discretion to pass the information on to the rest of the members and, if necessary, convene a meeting of the full board either via phone or in person.

Most protocols now specify stopping rules, conditions under which the study should be terminated. Typically, these involve indications that differences between treatment groups are both statistically and clinically significant and that nothing more would be learned by continuing to deny effective treatment to study participants. For example, a major cardiology trial was terminated early when it became clear that taking an aspirin a day greatly reduced risk for heart attacks (Steering Committee of the Physicians' Health Study Research Group, 1988). Most protocols now specify stopping rules that come into effect if interim analyses show that group differences are either greater than expected or that effects are so small that there is no chance of detecting differences even if the study were completed.

Monitoring adverse events sometimes uncovers problems that were not anticipated. Another recent trial found that certain medications that blocked sodium channels had precisely the desired effect predicted on the basis of theory and clinical experience in terms of suppressing cardiac arrhythmias. Unfortunately, these medications also had the effect of increasing mortality following myocardial infarction for reasons that had not been anticipated and that had gone unnoticed in clinical practice (Epstein et al., 1993). In fact, the rationale behind the use of these medications was so compelling and their beneficial effect on the specific problem they were intended to correct was so evident in everyday practice that it had been hard to secure permission to do the study and to convince practitioners to take part.

Institutional Review Board

By congressional mandate, all studies involving human subjects must be reviewed by Institutional Review Boards (IRBs) to ensure that participants' rights and welfare are adequately protected. These boards were instituted in response to several studies that sacrificed patient welfare in the service of scientific inquiry. In the spirit of the Geneva Convention and the Helsinki accord, it is generally accepted that there must be limits to what someone can be asked to do (or what can be done to them) in the name of science. Central to this process are the notions of informed consent (that people have a right to decide for themselves what risks they are willing to take) and freedom from coercion (that people must have the right to refuse participation without penalty or repercussions).

Most investigators are familiar with the operation of IRBs and many have served on these boards themselves, so I will not describe their inner workings. What I do want to share are several of my own experiences dealing with these boards. Given that much of my work involves the treatment of depressed and suicidal patients, I often work with high-risk patients who are sometimes put at risk by virtue of taking part in controlled research designs. My goal is to make treatment better, but that cannot be achieved without sometimes putting some patients at risk, if for no other reason than that not everyone can get the most effective treatment if contrasts are to be drawn between different treatments.

Rather than viewing the IRB as an obstacle to doing the kinds of studies that I want to do, I consider it to be a valuable resource in conducting my research in an ethical and conscientious fashion. The first principle to which I subscribe is that I should not be the sole arbiter of what I do; I want my protocols and consent procedures to be scrutinized by others who stand to gain no benefit from the studies I conduct. Moreover, I want at least some of those others to be as different from me as possible. I very much like the notion that my projects are reviewed by ethicists and patient advocates as well as other scientists. If something goes wrong (as things sometimes do go wrong with the kinds of patients that we treat), I want to be sure that we exercised due diligence in designing our trial and that we were not blinded to our patients' needs by our interest in the process of discovery.

Over the course of my career, I have compared novel treatments to established standards, randomly assigned patients to pill-placebos, and withdrawn patients from effective interventions, all in the service of learning what works and why. I think the work is important, but I am keenly aware that each person we treat is someone's parent or child or spouse or friend. I have never had a protocol denied

AABT — 8TH ANNUAL

Awards and Recognition

Presented at the 36th Annual Convention in Reno

Lifetime Achievement Leonard Krasner, Ph.D.

Outstanding Clinician Marvin Goldfried, Ph.D.

Outstanding Service to AABT
Barry S. Lubetkin, Ph.D.,
and Steven T. Fishman, Ph.D.

Outstanding Training Program Psychology Internship and Postdoctoral Programs at Wilford Hall Medical Center, *Robert K. Klepac, Ph.D., Director of Psychology Training,* and *Alan L. Peterson, Ph.D., Director of Postdoctoral Training*

Distinguished Friend to Behavior Therapy
Anne Fletcher, for her book *Sober for Good*

Virginia Roswell Dissertation Award
Sudie Back, M.A., for "Alcohol Dependence and PTSD: Differences in Clinical Presentation and Response to Cognitive-Behavioral Substance Use Therapy by Order of Onset"

President's New Researcher Allison Harvey, Ph.D., for "A Cognitive Model of Insomnia"

Jellinek Memorial Award Mark B. Sobell, Ph.D.

Anxiety Disorders Association of America Career Development
Jennifer Hudson, Ph.D., Jan Mohlman, Ph.D., Nnamdi Pole, Ph.D., Christine Purdon, Ph.D.

Tribute to Lizette Peterson

Elsie Ramos Student Poster Award Recipients

- Nicole K. Y. Tang, "The Role of Pre-Sleep Cognitive Activity and Pre-Sleep Anxiety in Distorted Perception of Sleep in Insomnia"
- Ulrike Buhlmann, "Interpretive Biases for Ambiguous Information in Body Dysmorphic Disorder: A Text Comprehension Study"
- Eric A. Storch, "The Relationship of Peer Victimization to Social Anxiety and Loneliness in Adolescent Females"

In Recognition of Your Valued Efforts and Service in Response to Sept. 11, 2001

Anne Marie Albano, Ph.D., Stephen Becker, Ed.D., Connie Best, Ph.D., Andreas Bollinger, Ph.D., David Bricker, Ph.D., Deborah Brief, Ph.D., Elissa Brown, Ph.D., Todd Buckley, Ph.D., Dominic Candido, Ph.D., Marylene Cloitre, Ph.D., Thomas Demaria, Ph.D., Sherry Falsetti, Ph.D., Edna Foa, Ph.D., Richard Gallagher, Ph.D., Vicki Gluhoski, Ph.D., Steven Gordon, Ph.D., Robin Gurwitch, Ph.D., Danny Kaloupek, Ph.D., Terence Keane, Ph.D., Dean Kilpatrick, Ph.D., Amy Krain, M.A., Annette La Greca, Ph.D., Brett Litz, Ph.D., Barry Lubetkin, Ph.D., Bruce Mansbridge, Ph.D., Lata McGinn, Ph.D., Douglas Mennin, Ph.D., Kim Mueser, Ph.D., Pallavi Nishith, Ph.D., Christine Padesky, Ph.D., Alan Peterson, Ph.D., Patricia Resick, Ph.D., Heidi Resnick, Ph.D., Josef Ruzek, Ph.D., Kathleen Sexton-Radek, Ph.D., Christine Scher, Ph.D., Jillian Shipherd, Ph.D., Mark Sisti, Ph.D., Judith Tutin, Ph.D., Robyn Walser, Ph.D., Norman Weissberg, Ph.D., Susan Westover, Ph.D.

or even modified in a major fashion, but I have often had to work closely with my local IRB to ensure that what we were proposing to do met every reasonable standard.

We lost two patients to suicide in an earlier project (Hollon et al., 1992). One was a woman who should not have been put on medication (she was at high risk for suicide because of severe and chronic pain but hid this from us at intake to gain access to medications). The other was a woman who had responded well to medication but made a suicide attempt on impulse following an argument with her boyfriend. In each case there were mitigating circumstances that undermined safeguards built into the protocol and each was fully reviewed by persons independent of the study. We lost two more patients to suicide in our most recent project, one after being withdrawn from protocol in order to provide more flexible treatment in response to his growing sense of hopelessness and the other after learning that his estranged wife had become involved with another man. After this second suicide, our local IRB called us in to show cause why the project should not be suspended. In particular, they were concerned about withholding treatment from depressed and suicidal patients, since our study included a pill-placebo control. What we were able to show was that both of the completed suicides (and the majority of the other serious adverse events we had encountered in the study) had occurred in patients who were receiving active medication and were being closely followed by an experienced research psychiatrist. In each case, the level of care being provided met or exceeded what these patients would have received if they had been treated in the community outside of the context of a clinical trial. There was a brief pause, and then someone asked from across the room, "Do you think you should be putting depressed and suicidal patients on medications?"

We made no further changes in the protocol, but only because it was already rich in protections, at least the equal of what patients would have received if they were being treated in conventional clinical practice. In fact, what we try to do is to limit the length of time that patients must be kept in control conditions and provide extended treatment afterwards, combined with intensive ongoing monitoring and independent review of patient progress. When we do become aware that a patient is moving into risk, we have that patient seen by an independent clinician who can withdraw the patient from the trial and mandate whatever treatment appears to be clinically indicated. Such procedures are becoming routine in clinical research and there is evidence that when carefully done such participation does not put even suicidal patients at undue risk (Khan, Warner, & Brown, 2000). Not including such patients in our trials would prevent our ever learning better ways to treat them, a concern addressed in a recent NIMH report on issues to consider in conducting research with suicidal patients (Pearson, Stanley, King, & Fisher, 2001).

Conclusions

The bottom line is that outside scrutiny is good for everyone concerned. External review not only serves to protect our patients, but also protects us as investigators. Given that we do not yet know how best to treat our patients, particularly those at greatest risk, it is important to have outside input on what we do and how we do it. The various monitoring boards can serve both as a check on our judgment and as a resource for disseminating the latest thinking on how best to protect the welfare and safety of the patients in our trials.

References

Epstein, A. E., Hallstrom, A. P., Rogers, W. J., Liebson, P. R., Seals, A. A., Anderson, J. L., Cohen, J. D., Capone, R. J., & Wyse, D. G. (1993). Mortality following ventricular arrhythmia suppression by encainide, flecainide, and moricizine after myocardial infarction. The original design concept of the Cardiac Arrhythmia Suppression Trial (CAST). *JAMA, 270*, 2451-2455.

Hollon, S. D., DeRubeis, R. J., Evans, M. D., Wiemer, M. J., Garvey, M. J., Grove, W. M., & Tuason, V. B. (1992). Cognitive therapy and pharmacotherapy for depression: Singly and in combination. *Archives of General Psychiatry, 49*, 774-781.

Khan, A., Warner, .H. A., & Brown, W. A. (2000). Symptom reduction and suicide risk in patients treated with placebo in antidepressant clinical trials: An analysis of the food and drug administration database. *Archives of General Psychiatry, 57*, 311-317.

Pearson, J. L., Stanley, B., King, C., & Fisher, C. (2001). Issues to consider in intervention research with persons at high risk for suicidality. Retrieved January 28, 2003, from: http://www.nimh.nih.gov/research/highrisksuicide/cfm

Steering Committee of the Physicians' Health Study Research Group. (1988). Preliminary report: Findings from the aspirin component of the ongoing physicians' health study. *New England Journal of Medicine, 318*, 262-264.

Last year's winners are listed on p. 263

Call

for Award Nominations

9th Annual AABT Awards

- Distinguished/Outstanding Contribution by an Individual for Educational/Training Activities
- Outstanding Training Program
- Virginia A. Roswell Student Dissertation Award
- Career/Lifetime Achievement
- Distinguished Friend to Behavior Therapy
- Outstanding Service to AABT

Nominate your colleagues! For award/program description and nomination guidelines, please refer to the Winter 2002 *tBT*, p. 188, or go to www.aabt.org and click on "Nominate Your Colleagues."

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

DEADLINE: **TUESDAY, APRIL 1, 2003**

The Virtual Therapist: Behavior Therapy in a Digital Age

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

Within the last 20 years, the information revolution spawned by the desktop computer has transformed American society more swiftly than, and just as dramatically as, its industrial counterpart. Whereas the industrial revolution is often considered to have started with Newcomen's steam engine in 1712 and ended with the Wright brothers' successful flight at Kitty Hawk in 1903, the microchip and desktop computer have exerted their effect on Western society in a mere 25 years. Today, we settle for nothing less than instantaneous information and communication. Computer terms and language are so commonplace in our culture that we no longer consciously recognize the roots of information-age colloquialisms. We talk about needing "downtime" to relax, working the "bugs out" in a project, or sending a package via "snail mail."

Since the first desktop computer was marketed over 2 decades ago, psychologists and behavior therapists have been developing software programs that incorporate the computer into science and practice. Initially, desktop computers supplanted large mainframe computers and, for better or worse, greatly accelerated statistical data analyses. Word processing programs spelled the doom of a legion of typists who made their living on typewriting-impaired doctoral students. And, in the clinical arena, researchers began to explore the new age of digital processing and pondered the computer's potential for therapeutic purposes. Within the last 10 years, the number of computer-based intervention programs has mushroomed (see Bloom, 1992; and Marks, Shaw, & Parkin, 1998, for comprehensive reviews).

The marriage of computers to behavior therapy has a number of implications. First, researchers have long recognized that computer-assisted or computer-delivered interventions could make clinical services more cost-effective. In addition, many software programs bridge the gap between clinical sessions by providing relevant homework assignments (e.g. Dolezal-Wood, Belar, & Snibbe, 1998). Internet-based behavioral interventions could be used to help underserved populations in areas that do not have adequate psychological and social services. Researchers are only now beginning to explore these possibilities.

Although many behavior therapists welcome the development of software to assist therapeutic efforts, many consider the computer an unnecessary intrusion. One frequent criticism has been that clients will feel dehumanized by computer interactions. Research, however, has generally not supported this conclusion. In fact, many researchers have concluded the opposite—that the computer may create a sense of independence and foster behavioral disclosure. Most clients report interactions with computerized treatment interventions to be a positive experience because of their simplicity (Dolezal-Wood et al., 1998) and convenience.

Because the number of programs developed in recent years greatly exceeds the capacity of any one review to provide comprehensive coverage, we will focus on studies that best illustrate the ways in which the computer is being used in behavior therapy. Given the rate at which the field is progressing, it would not be unreasonable to assume this review may be outdated before it ever goes to press.

A Sampling of Applications

Expert Systems

An expert system is a software program that implements one or more decision rules when a threshold criterion has been passed. The decision rules are often derived from expert opinion and are part of an integrated decision tree that takes into account values on multiple variables simultaneously. The end product of an expert system is usually a report or a practice recommendation. Thus, two key elements in an expert system are a message library that contains all the possible messages that can be generated by the system and an algorithm designed to access a knowledge base to select the best messages from the message library according to a priori decision rules (de Vries & Brug, 1999). Expert systems are modeled on human problem-solving strategies in that they are responsive to changing, dynamic systems featuring multiple interacting variables. They differ from human experts in that decision rules are reliably applied according to explicit, predetermined criteria. Expert systems have been utilized extensively in medicine and engineering.

Expert systems can be useful in behavior therapy because reliably executed decision rules responsive to the characteristics of an individual case can encourage personally tailored behavioral interventions. For example, Velicer and Prochaska (1999) developed a smoking-cessation expert system that analyzed mail and telephone interview assessment data collected at 3-month intervals and then produced a detailed 3- to 4-page report that included individualized recommendations for each participant. Results from four studies found that the expert system was up to twice as effective as self-help manuals. Overall point prevalence rates of smoking cessation ranged from 22% to 26% at the end of each study, rates that are close to those achieved by intensive and costly clinic-based interventions. The researchers concluded that expert systems provide a less costly alternative to standard treatment with close to equivalent abstinence rates.

Coulson (2000) reported the development of an expert system designed to help staff manage vocally disruptive behaviors in patients with dementia. The system helps clinicians identify possible environmental stimuli that might explain sudden changes in a patient's behavior, recommends assessments for signs of pain and discomfort, and helps clinicians determine whether emotional factors such as loneliness, sadness, or boredom may explain vocal outbursts. While no empirical data have been published regarding the use of the system, it provides an example of how expert systems might be integrated into daily clinical activities.

Expert systems are becoming increasingly accessible to the public as the Internet gains popularity. Several recent reports describe the use of expert systems to help individuals address alcohol problems (Humphreys & Klaw, 2001), sexual dysfunction (Ochs & Binik, 2000), and substance abuse prevention in teens (Skinner, Maley, Smith, Chirrey, & Morrison, 2001). Controlled studies on the effect of on-line expert systems in modifying behavior have yet to be conducted.

Virtual Reality

Virtual reality (VR) programs create an interactive and immersive environment by using sophisticated programming techniques that integrate user motions with a three-dimensional video display. Hardware for VR programs often includes stereoscopic goggles and headphones that enhance visual and auditory fields. Motor movements are detected by motion sen-

sors placed on a person's head and hands, although other parts of the body may be monitored as well. The sensors communicate with the software, allowing the computer to refresh the virtual environment in real time. The net effect is to produce a realistic or semirealistic interactive virtual environment. While sophisticated hardware is often used with VR programs, many applications have been developed that do not require a head-mounted display. These programs are useful in situations where such equipment is not feasible, as with physically disabled children (see Stanton, Foreman, & Wilson, 1998).

Not surprisingly, VR programs have been developed that conduct exposure therapy. Becker and North (1998) described the development of the VRT-2002, a VR system that can be run off a Pentium desktop computer and includes treatment protocols for agoraphobia, acrophobia, fear of flying, fear of public speaking, obsessive-compulsive disorder, and attention-deficit disorder. Other desktop programs that include a VR component have been developed to treat spider phobia (Carlin, Hoffman, & Weghorst, 1997; Gilroy, Kirkby, Daniels, Menzies, & Montgomery, 2000), claustrophobia (Botella, Baños, Villa, Perpiñá, & García-Palacios, 2000), pain from second- and third-degree burns (Hoffman, 1998), dental fear (Coldwell et al., 1998), obsessive-compulsive symptoms (Clark, Kirkby, Daniels & Marks, 1998; Kirkby et al., 2000), fear of flying and driving (Wiederhold & Wiederhold, 1999), anxiety and panic (Newman, Kenardy, Herman, & Taylor, 1997; White, Jones, & McGarry, 2000), and agoraphobia (Coble, North, & North, 1995).

The use of VR technology to treat fear of heights (acrophobia) has generated significant interest. In fact, one of the first efforts to integrate VR into the behavioral treatment of any disorder was reported by Rothbaum and colleagues in 1995. In their study, 20 undergraduates screened for fear of heights (12 men, 8 women) completed seven individual VR exposure sessions. Participants stood on a 4-by-4-foot platform with railings (to increase perceived sense of height) and interacted with the virtual environment using a head-mounted display and motion-sensitive right-hand glove. The virtual environments included a footbridge at 7, 50, and 80 meters above water, 4 outdoor balconies with railings that were on different floors (i.e., ground, 2nd, 10th, and 20th), and a glass elevator that rose 49 floors. All measures of anxiety, avoidance, and distress showed significant decreases from pretreatment assessment to the posttreatment assessment in the 8th week. These changes were not observed in an 8-participant wait-list control group. The VR exposure treatment also appeared to have an emboldening effect on many participants as 7 of the 10 participants in the VR exposure condition voluntarily exposed themselves to height situations between treatment sessions even though they were asked not to do so. While the number of participants was small and no extended follow-up measures were completed (e.g., at 90 days or more posttreatment), Rothbaum et al. (1995) provided the first controlled study of VR exposure treatment.

A few years later, Emmelkamp, Bruynzeel, Drost, and van der Mast (2001) compared a VR exposure program to an exposure in vivo condition using 10 individuals diagnosed with acrophobia. Participants received two sessions of VR exposure therapy followed by two sessions of in vivo exposure. The VR exposure treatment utilized a head-mounted display that supported stereographic projection. The virtual environments included a diving tower at a swimming pool and a tower building with an elevator. Patients rated their anxiety levels using a standard Subjective Units of Distress (SUDS) 0-to-8 scale. Heart rate was also monitored and displayed for the clinician during the session on a computer monitor. Activities in the virtual environment were increased in difficulty contingent on SUDS and heart rate reductions. During the in vivo condition, activities included climbing the fire escape of a 5-story building, walking on the balconies of an 18-story building while looking at the ground, and walking on the roof of a 5-story building while looking at the ground. Results indicated that both the in vivo and VR conditions led to significant improvement in anxiety as measured by the Acrophobia Questionnaire. In addition, there were no significant differences on any of the measures when comparing the in vivo and VR conditions. There was some indication that the VR condition may have had a greater effect on participants' avoidance of feared situations (as measured by the avoidance subscale of the Acrophobia Questionnaire). The researchers concluded that the VR condition was "at least as effective as exposure in vivo on anxiety and avoidance as measured by the AQ, and even more effective on attitudes toward heights" (p. 338).

While VR programs have largely investigated the treatment of fears, other applications have been reported as well. For example, Stanton et al. (1998) reported the use of a VR program to train spatial skills in children with mobility impairments. Using a desktop VR system without a head-mounted display, they created a virtual environment that replicated a special education school. Over three training sessions, seven physically disabled children explored the virtual school in a free play condition and in a specific task condition (e.g., they were asked to find an object or room in the virtual environment or to take a direct route from one room to another). To assess whether the learning in the virtual environment generalized to the natural environment, the children were taken to the school, asked a series of questions, and then asked to identify room locations on a prepared map. Afterward, they were required to lead researchers on routes that were either familiar to them from the VR environment or novel and not practiced in the VR environment. Stanton and colleagues found that the children demonstrated good transfer of spatial relationships and were more accurate in their answers on the room identification task than untrained undergraduate controls. In fact, the researchers described the childrens' error rates as "remarkably low" (p. 226) and attributed their comprehension of the school environment to the prior VR training.

VR exposure therapy has the potential to dramatically change the way clinicians conduct exposure therapy. First, the clinician is offered greater control of the exposure experience in VR than in vivo. VR environments can be custom designed and the intensity of the experience can be closely calibrated to the client's behavioral and emotional responses. The clinician can control the dimensions and features of the feared stimulus and when the stimulus is presented. Of equal importance is the fact that the sessions can be conducted in the clinician's office rather than at a remote site, a convenience that has many practical implications. Beyond the degree of control afforded behavior therapists by VR environments, some researchers have also pointed out that clients may be more willing to interact with virtual environments than to confront feared stimuli in vivo. One group of researchers recently found that 81% to 89% of individuals with spider phobia preferred VR exposure therapy to in vivo exposure (Garcia-Palacios, Hoffman, Kwong See, Tsai, & Botella, 2001).

How persons react to VR exposure, and the degree to which they benefit from it, is likely mediated by both intrinsic factors and the extent to which the program can realistically simulate anxiety-eliciting stimuli. For example, Wiederhold and Wiederhold (1999) concluded that most highly phobic individuals become highly immersed in VR environments and display subjective and objective signs of arousal almost immediately. SUDS reports in reaction to the VR environment by these persons are typically high and decrease with repeated sessions, as one might expect in exposure therapy. The researchers believe that the ability to

immerse oneself in a VR environment may be related to the person's hypnotizability and his or her ability to "fill in the pieces" of the virtual environment that are incomplete in the computer display (p. 167). They reported several anecdotal statements suggesting most phobic clients are able to suspend their disbelief and interact with the VR environment effectively. One client reported that a VR flying simulation, while cartoonish, helped ease her fears on an actual flight because of the practice she gained in session with her breathing exercises. Thus, VR interventions may have (a) a proximal effect of extinguishing fears during treatment and (b) a delayed, and more subtle, effect of reducing in vivo anxiety because of the learning that occurs during VR training.

The current literature, however, is incomplete in its treatment of VR exposure programs. Most studies are either case studies or include small samples (samples of 5 to 20 participants are not uncommon) with inconclusive or absent follow-up data. It is the rare study that compares VR exposure to its in vivo cousin or other treatment modalities. Treatment outcome is often measured using questionnaires rather than by observing more meaningful behavioral activities that assess criterion-related validity (e.g., Carlin et al., 1997, assessed a woman's attitudes toward spiders before and after VR exposure therapy but did not observe her actual approach behavior). Questions regarding how long treatment effects are sustained, which clients are most likely to benefit from VR therapy, which variables may influence treatment outcome, and which behaviors are most effectively treated using VR programs remain.

The Internet

While the first major milestone of the information age was the development of the microchip and the subsequent development of the desktop computer, the rise of the Internet ingrained computers into the American lifestyle. Numerous mental health professionals now provide psychological services over the Internet using a variety of venues: e-mail, chat rooms, Web sites, video conferencing, and so forth. One group of researchers estimated the annual growth rate of the industry to be around 55% (Zabinski et al., 2001). Somewhat ominously, Maheu and Gordon (2000) found in a survey of Internet-based mental health care providers that three-quarters of their respondents offered services to clients even if the client lived in a state other than where the clinician was licensed or registered. Fully 18% considered their services to be "therapy" or "counseling" (p. 485) and 41% indicated that their clientele was composed of individuals diagnosed with a mood, anxiety, sexual, or adjustment disorder. While we will focus mainly on reporting novel Internet-based behavior therapies, the reader should be aware that ethical issues surrounding the use of the Internet for therapeutic purposes are the subject of active debate and have been discussed in several recent articles (see Barak, 1999; Humphreys, Winzelberg, & Klaw, 2000; King & Moreggi, 1998; Manhal-Baugus, 2001).

In a pilot study examining the utility of using an Internet chat room to deliver cognitive-behavior therapy for women with an eating disorder, Zabinski and colleagues (2001) developed a 7-week on-line educational program for four university women with weight and shape concerns. The chat room was set up on a public site (yahoo.com) and the group treatment consisted of weekly readings, chat discussions led by a moderator, and summaries of each chat discussion. Homework was assigned between sessions. While results were difficult to interpret given the small sample size and the qualitative nature of the data, the researchers concluded that most indices of eating behavior showed improvement over the 7 weeks. Participants also reported being satisfied with the chat room venue.

In many ways, using an Internet chat room for group therapy is convenient for both the clinician and the client. Sessions can take place at any time and participants can attend the group from the comfort of their homes. Some degree of anonymity is achieved since group participants need not meet face to face and can use pseudonyms or "handles" instead of their real names. However, a significant problem for Internet-delivered services to overcome involves confidentiality. Zabinski and colleagues (2001) reported that their chat site on Yahoo was "secure and private" (p. 136) but also warned participants that "no guarantee could be made with regard to confidentiality" (p. 132). While the site may have been reasonably secure from hackers and outside agencies, Zabinski and colleagues appeared to overlook the fact that the chat room was hosted on a server owned by a commercial company. As such, all interactions among participants were likely monitored, or could be monitored, by Yahoo employees.

Several other issues besides confidentiality need to be addressed. Clients may have differing skill levels and experience with Internet chat, and their comfort level with the venue will likely influence their performance and disclosure (but see Lange, van de Ven, Schrieken, & Emmelkamp, 2000, who concluded that prior experience with the Internet is not related to therapeutic improvement). Slow typing speed may constrain the ability of an individual to participate in an on-line discussion. Computers may occasionally crash or on-line connections may be lost. Clients may be distracted by events that a clinician cannot observe. Relatedly, the clinician can not observe important nonverbal behavior. The credibility of the mental health professional managing the chat room, and the chat room participants, can not be assumed, and some critics have suggested that chat room forums could place female clients at risk for exploitation (Finn & Banach, 2000). Perhaps the strongest criticism of on-line chat rooms is that the clinician is not available to directly manage a crisis should it occur. Since members of an online chat room can be virtually anywhere in the country, there is little in the way of a safety net should a participant develop significant emotional problems while on-line.

Chat rooms, however, are just one venue available via the Internet. The Internet also lends itself to the delivery of self-help programs that may involve minimal therapist-client contact. Some researchers have developed Web sites that provide Web-based treatment modules that users can proceed through at their own pace. For example, Carlbring and colleagues (2001) developed a six-module, Web-based treatment protocol for panic disorder. The modules included didactics about panic, training in breathing retraining, interoceptive exposure, and in vivo exposure, discussion of maladaptive thought patterns (e.g., catastrophic thinking), and a lesson on relapse prevention. When participants completed a module, they e-mailed the program staff with responses to a competency quiz. If the participant passed the quiz, he or she received a password that allowed them to proceed to the next module. Frequently used measures of anxiety and depression all showed significant within-group treatment effects from pre- to posttreatment. Behaviorally, participants reported significant declines in the frequency, duration, and intensity of full-blown panic attacks after completing the modules. The pattern of results held when participants were compared to a wait-list control group: The participants who completed the Internet modules showed significantly better scores on all measures at posttreatment and reported significantly fewer full-blown panic attacks.

Lange, van de Ven, Schrieken, and Emmelkamp (2001) recently reported the results of an Internet-based intervention for 13 individuals with symptoms of posttraumatic stress. A Web site was set up that guided participants through three

phases of treatment: (1) narrative writing in the form of essays entered into Web page text fields; (2) cognitive reappraisal of the traumatic event by writing "encouraging advice for a hypothetical friend who has experienced the same traumatic event" (p. 80); and (3) a sharing and farewell ritual in which participants wrote a letter to a family member, friend, or themselves about the traumatic event. Trained clinicians communicated with individuals via e-mail and encouraged their participation. Within-group results showed significant reductions in intrusion and avoidance symptoms as measured by the Impact of Events Scale (IES). Measures of depression, anxiety, somatization, sleeping problems, hostility, fatigue, and anger showed similarly large reductions in severity. When comparing participants in the Internet condition with waitlist controls, treatment effect sizes across measures were large (d = .60 and higher) and provided convergent evidence of therapeutic gains. One should note, however, that all of the dependent measures in the study were self-report measures and only one measure used was specifically designed to measure symptoms of posttraumatic stress (i.e., the IES).

Interventions delivered via Web sites are most likely to emphasize treatments that have a large educational component while deemphasizing real-time chatting. As such, these approaches often can be described as interactive forms of bibliotherapy. Client-therapist contact is minimal and, potentially, may not occur at all. Of course, because the user will never actually meet the person who designed the Web site, there is no guarantee that the site was constructed by a person proficient in behavioral or cognitive-behavioral interventions. Additionally, the issue of confidentiality remains: It would not be especially difficult for an unscrupulous Web site developer to ask probing personal questions under the guise of treatment necessity.

Overall, research on the utility of the Internet as a means of delivering psychological and behavioral services is in its infancy. No study to date has compared Internet-based treatment modules with standard behavioral or cognitive-behavioral intervention protocols for any disorder. Beyond issues of treatment effectiveness and the sometimes high level of attrition experienced in these studies (see Stroem, Pettersson, & Andersson, 2000), significant ethical and practical issues need to be addressed.

Handheld Computers

Within the last few years, researchers have reported the development of behavioral intervention software programs designed for handheld computers. The programs address a range of behavioral problems and vary in their sophistication. In many cases, clients interact with the handheld computer using a stylus to select response options on the computer's pressure-sensitive screen.

Handheld computers are easily programmable using any of several commercial software tools. They allow for rapid and effortless recording of behavior as it occurs and can be operated inconspicuously in most environments. Thus, it is not surprising that handheld computers have been used both as a means of collecting self-monitoring data (i.e., ecological momentary assessment) and as a way of walking clients through simple exposure and symptom control exercises (Newman, Consoli, & Taylor, 1996).

For example, Newman, Kenardy, Herman, and Barr Taylor (1997) developed a four-session cognitive-behavioral intervention for individuals with panic disorder using a Casio PB-1000 handheld computer. The program included a diary mode and a therapy mode. The diary mode was controlled by the computer and prompted participants to rate their anxiety four times per day at predetermined intervals. The therapy mode could be activated by the patient at any time and included breathing retraining exercises and a series of on-line statements designed to help clients objectively reassess their fears if they were experiencing a panic attack. The researchers then compared a 12-session individual cognitive-behavior therapy (CBT) regimen to the handheld intervention version using nine participants diagnosed with panic disorder. Results showed no significant differences between the individual CBT condition and the handheld condition on anxiety and panic reduction across several measures. Significant main effects were found for time on all measures, suggesting detectable clinical improvement for both treatments (46% of patients in the individual CBT condition and 35% of patients in the handheld condition showed clinically significant improvement on follow-up measures).

Handheld computers and monitoring devices have also been used as a way of training new behaviors while assessing psychophysiological change in response to treatment. For example, Meuret, Wilhelm, and Roth (2001) used a handheld capnometry device with four panic disordered patients to measure changes in exhaled gas during treatment and home-training exercises. The capnometer, which samples exhaled gas through a nasal cannula, was used in conjunction with an audiotaped tone sequence that trained participants in proper breathing patterns. Participants synchronized their breathing to the ascending and descending tones on the audiotape and observed the effect of their breathing on arterial PCO2 by reading the capnometer display. Data were downloaded on a weekly basis to the treatment team's computer where data could be graphed and analyzed. Patients rated the treatment as "very credible" (p. 594) and scores on all psychological and physiological measures of panic, anxiety, and depression improved from pre- to posttreatment. All patients were symptom-free by the end of treatment.

Conclusions

This two-part series on computers and behavioral assessment/therapy was initially conceived of as a follow-up to an article one of us wrote for *the Behavior Therapist* 6 years ago (see Richard & Mayo, 1997). Since then, the field has grown tremendously. In addition to the programs described above, researchers have developed programs that facilitate cognitive-behavioral treatment with disabled children (Fitzgerald & Werner, 1996), deliver behavior therapy for obsessive-compulsive symptoms (Baer & Greist, 1997; Kirkby et al., 2000), and train parents in effective parenting strategies (Kacir & Gordon, 1999; MacKenzie & Hilgedick, 1999).

Despite these advances, several issues must be addressed. First, long-term treatment outcome studies need to be conducted. Initial results suggest that computer-based behavioral interventions may lead to clinically significant change in many clients, but for how long and for which clients with what disorders? While researchers have focused on anxiety disorders, applications for individuals diagnosed with other disorders (e.g., the mood disorders, schizophrenia) have not been developed. Ethical issues as they relate to treatment must also be systematically addressed.

Second, independent evaluations of the software programs are lacking. Because the field is in its infancy, it may be too much to expect a strong record of replicated results. However, computer-based interventions should be subjected to the same rigorous standards as any empirically validated treatment if they are to be accepted by mainstream clinicians and behavior therapists. Programmatic research emphasizing both single-subject and group designs should be conducted. Relatedly, researchers have yet to design any deconstruction or dismantling studies that attempt to identify the active elements of these novel interventions.

Computer-based behavioral interventions could be enhanced by the use of digitized video and other multimedia elements. Taking advantage of multimedia is a promising avenue for several reasons.

First, video clips provide an ideal way to model behavior for clients. For example, breathing retraining could be demonstrated in a video clip for a patient with panic disorder. PTSD patients could observe fragments of an imaginal exposure therapy session prior to engaging in the treatment themselves. Second, multimedia programs can incorporate many characteristics previously reserved for the VR domain. For example, individuals working on improving their social skills could view a digitized video of a social gathering and then select from several possible behavioral choices presented by the computer. Contingent automated feedback could reference major therapeutic points covered in previous training modules. Third, multimedia can be useful in both behavioral assessment and treatment. Video clips could be used to test whether behaviors learned by a client in a training environment are likely to transfer to natural social contexts. For example, a participant might complete an Internet-based parent training module and then view a video clip showing an adult engaging in ineffective parenting strategies with a child. A short quiz at the end of the video clip could assess both the degree to which the participant comprehended the major points of the training and his or her ability to apply the training to a staged social situation.

Lest we dismiss the emerging role of computers in behavior therapy as a passing fad, keep in mind that the total estimated costs for all participants to use the Internet-based panic disorder treatment reported by Carlbring et al. (2001) were around $1,000. In a world where healthcare dollars are shrinking, any treatment that can cost-effectively improve patients' quality of life while maintaining high ethical and professional standards should be considered as more than a fad. The question, of course, is how fast the cart can catch up with the horse. If we are to believe Maheu and Gordon's (2000) survey data, many clinicians are taking advantage of computer and Internet technology without fully considering the professional consequences and implications of their actions.

References

Baer, L., & Greist, J. H. (1997). An interactive computer-administered self-assessment and self-help program for behavior therapy. *Journal of Clinical Psychiatry, 58*, 23-28.

Barak, A. (1999). Psychological applications on the internet: A discipline on the threshold of a new millennium. *Applied and Preventive Psychology, 8*, 231-245.

Becker, D., & North, M. M. (1998). The virtual reality therapy system: VRT-2002. *CyberPsychology & Behavior, 1*, 401-403.

Bloom, B. L. (1992). Computer-assisted psychological intervention: A review and commentary. *Clinical Psychology Review, 12*, 169-197.

Carlbring, P., Westling, B. E., Ljungstrand, P., Ekselius, L., & Andersson, G. (2001). Treatment of panic disorder via the Internet: A randomized trial of a self-help program. *Behavior Therapy, 32*, 751-765.

Carlin, A. S., Hoffman, H. G., & Weghorst, S. (1997). Virtual reality and tactile augmentation in the treatment of spider phobia: A case report. *Behavior Research and Therapy, 35*, 153-158.

Clark, A., Kirkby, K. C., Daniels, B. A., & Marks, I. M. (1998). A pilot study of computer-aided vicarious exposure for obsessive-compulsive disorder. *Australian and New Zealand Journal of Psychiatry, 32*, 268-275.

Coble, J. R., North, M. M., & North, S. M. (1995). Effectiveness of virtual reality environment desensitization in the treatment of agoraphobia. *International Journal of Virtual Reality, 1*, 25-34.

Coldwell, S. E., Getz, T., Milgrom, P., Prall, C. W., Spadlfora, A., & Ramsay (1998). CARL: A labVIEW 3 computer program for conducting exposure therapy for the treatment of dental injection fear. *Behaviour Research and Therapy, 36*, 429-441.

Coulson, J. S. (2000). Shhhh: An expert system for the management of clients with vocally disruptive behaviors in dementia. *Educational Gerontology, 26*, 401-408.

de Vries, H., & Brug, J. (1999). Computer-tailored interventions motivating people to adopt health promoting behaviors: Introduction to a new approach. *Patient Counseling and Education, 36*, 99-105.

Dolezal-Wood, S., Belar, C. D., & Snibbe (1998). A comparison of computer-assisted psychotherapy and cognitive-behavioral therapy in groups. *Journal of Clinical Psychology in Medical Settings, 5*, 103-118.

Emmelkamp, P. M. G., Bruynzeel, M., Drost, L., & Vand der Mast, C. A. P. G. (2001). Virtual Reality treatment in acrophobia: A comparison with exposure in vivo. *CyberPsychology & Behavior, 4*, 335-339.

Finn, J., & Banach, M. (2000). Victimization online: The downside of seeking human services for women on the Internet. *CyberPsychology & Behavior, 3*, 785-796.

Fitzgerald, G. E., & Werner, J. G. (1996). The use of the computer to support cognitive-behavioral interventions for students with behavioral disorders. *Journal of Computing in Childhood Education, 7*, 127-148.

Gilroy, L. J., Kirkby, K. C., Daniels, B. A., Menzies, R. G., & Montgomery, I. M. (2000). Controlled comparison of computer-aided vicarious exposure versus live exposure in the treatment of spider phobia. *Behavior Therapy, 31*, 733-744.

Hoffman, H. (1998). Virtual reality: A new tool for interdisciplinary psychology research. *CyberPsychology & Behavior, 1*, 195-200.

Humphreys, K., & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing Internet-based services expand access to assistance for alcohol problems? A study of the Moderation Management self-help/mutual aid organization. *Journal of Studies on Alcohol, 62*, 528-532.

Humphreys, K., Winzelberg, A., & Klaw, E. (2000). Psychologists' ethical responsibilities in the Internet-based groups: Issues, strategies, and a call for dialogue. *Professional Psychology: Research and Practice, 31*, 493-496.

Kacir, C. D., & Gordon, D. A. (1999). Parenting adolescents wisely: The effectiveness of an interactive videodisk parent training program in Appalachia. *Child and Family Behavior Therapy, 21*, 1-21.

King, S. A., & Moreggi, D. (1998). Internet therapy and self-help groups: The pros and cons. In J. Gackenbach (Ed.), *Psychology and the Internet: Intrapersonal, interpersonal, and transpersonal implications*. San Diego, CA: Academic Press.

Kirkby, K. C., Berrios, G. E., Daniels, B. A., Menzies, R. G., Clark, A., & Romano, A. (2000). Process-outcome analysis in computer-aided treatment of obsessive-compulsive disorder. *Comprehensive Psychiatry, 41*, 259-265.

MacKenzie, E. P., & Hilgedick, J. M. (1999). The computer-assisted parenting program (CAPP): The use of a computerized behavioral parent training program as an educational tool. *Child and Family Behavior Therapy, 21*, 484-489.

Maheu, M. M., & Gordon, B. L. (2000). Counseling and therapy on the Internet. *Professional Psychology: Research and Practice, 31*, 484-489.

Manhal-Baugus, M. (2001). E-therapy: Practical, ethical, and legal issues. *CyberPsychology and Behavior, 4*, 551-563.

Marks, I., Shaw, S., & Parkin, R. (1998). Computer-aided treatments of mental health problems. *Clinical Psychology: Science and Practice, 5*, 151-170.

Newman, M. G., Consoli, A. J., & Taylor, C. B. (1999). A palmtop computer program for the treatment of generalized anxiety disorder. *Behavior Modification, 23*, 597-619.

Newman, M. G., Kenardy, J., Herman, S., & Taylor, C. B. (1996). The use of hand-held computers as an adjunct to cognitive-behavior therapy. *Computers in Human Behavior, 12*, 135-143.

Newman, M. G., Kenardy, J., Herman, S., & Taylor, C. B. (1997). Comparison of palmtop-computer-assisted brief cognitive-behavioral treatment to cognitive-behavioral treatment for panic disorder. *Journal of Consulting and Clinical Psychology, 65*, 178-183.

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.

Rothbaum, B. O., Hodges, L. F., Kooper, R., Opdyke, D., Willford, J. S., & North, M. (1995). Effectiveness of computer-generated (virtual reality) graded exposure in the treatment of acrophobia. *American Journal of Psychiatry, 152*, 626-628.

Skinner, H., Maley, O., Smith, L., Chirrey, S., & Morrison, M. (2001). New frontiers: Using the Internet to engage teens in substance abuse prevention and treatment. In P. M. Monti & S. M. Colby (Eds.), *Adolescents, alcohol, and substance abuse: Reaching teens through brief interventions* (pp. 297-318). New York: The Guilford Press.

Stanton, D., Foreman, N., & Wilson, P. N. (1998). Uses of virtual reality in clinical training: Developing the spatial skills of children with mobility impairments. In G. Riva & B. K. Wiederhold (Eds.), *Virtual environments in clinical psychology and neuroscience: Methods and techniques in advanced patient-therapist interaction* (pp. 219-232). Amsterdam: IOS Press.

Stroem, L., Pettersson, R., & Andersson, G. (2000). A controlled trial of self-help treatment of recurrent headache conducted via the Internet. *Journal of Consulting and Clinical Psychology, 68*, 722-727.

Velicer, W. F., & Prochaska, J. O. (1999). An expert system intervention for smoking cessation. *Patient Education and Counseling, 36*, 119-129.

White, J., Jones, R., & McGarry, E. (2000). Cognitive behavioural computer therapy for the anxiety: A pilot study. *Journal of Mental Health, 9*, 505-516.

Wiederhold, B. K., & Wiederhold, M. D. (1999). Clinical observations during virtual reality therapy for specific phobias. *CyberPsychology and Behavior, 2*, 161-168.

Zabinski, M. F., Wilfley, D. W., Pung, M. A., Winzelberg, A. J., Eldredge, K., & Taylor, C. B. (2001), An interactive Internet-based intervention for women at risk of eating disorders: A pilot study. *International Journal of Eating Disorders, 30*, 129-137.

Book Review

Sherman, C. (2001). *How to Go to Therapy: Making the Most of Professional Help*. New York: Random House, $15.00, pp. 177.

Reviewed by Frank M. Dattilio, *Harvard Medical School* and *University of Pennsylvania School of Medicine*

The idea of a layperson writing about any aspect of psychology tends to make most mental health professionals very uneasy. This is especially true when the nontherapist is offering advice on finding the right type of therapy, given that our field has so often been inaccurately portrayed.

This new release by Carl Sherman is different. *How to Go to Therapy* provides concise, up-to-date information for the layperson seeking therapy. Divided into 14 chapters, the book addresses the broad spectrum of relevant issues, from evaluating therapists' education and training to who can benefit from what type of treatment to defining psychotherapy. The author thoughtfully explores the often ignored truth that "the best credentials and training don't always equate to the best treatment for you." Good advice is also offered on both how to verify a therapist's credentials, including using on-line resources, and what specifics should be considered when making a final choice of a therapist.

A good general education (in a jargon-free style) is offered on what to expect in therapy; parameters of therapists' behavior, appropriate and inappropriate; length and duration of treatment; and the identification of realistic therapeutic goals. Sherman discusses psychology research that supports the notion that most, if not all, therapies achieve similar results, and the most visible among them are presented: psychoanalytic and psychodynamic, cognitive-behavior, humanistic, group, couple and family, psychopharmacologic, and many of the postmodern theories on psychotherapy (interpersonal, EMDR, solutions-focused therapy, and computer therapy, to name a few). The author's thinking is solid and the perspective is laid out in a manner that is easy to read and comprehend.

Additional areas of focus include a chapter on "staying on track" in treatment, discerning whether or not you are making progress, and ethical red flags that should alert consumers to unethical and unorthodox behaviors on the part of so-called "mental health experts." These sections are especially important for consumers who are not necessarily well-versed in therapy. Options in paying for therapy, the role of managed care, and how the entire process of psychotherapy works are addressed as well.

The last chapter does a nice job of describing how therapy comes to a close and considering whether or not termination should be a mutual decision between therapist and client, in addition to explaining what occurs at termination and follow-up. Guidelines are provided for identifying psychological problem areas and includes labeling and diagnosis, as well as a synopsis of some of the more common types of disorders. The appendix contains a Web site resource directory with more than 30 different sites for locating a therapist.

Of the many different modalities of psychotherapy discussed in this text, cognitive-behavioral therapists are most frequently quoted. Aaron T. Beck, Albert Ellis, Judith Beck, Jacqueline B. Persons, Robert Leahy, Frank M. Dattilio, James Pretzer, Francine Shapiro, and Myrna Weissman are among those cited extensively.

Clearly, this is a helpful book for both therapists and clients. Having said this, however, the book does contain a few slight inaccuracies. For instance, the author states that psychiatrists are the only mental health professionals permitted by law to prescribe medication. This is not entirely true. In many states, psychiatric nurse practitioners now have limited prescribing rights and can prescribe psychotropic medication independent of physicians. There are also some physician assistants who work in the psychiatric field who can independently prescribe medication.

Further, the author states that "while most psychologists possess doctoral degrees, in some states they can be licensed with master's degrees." This is no longer true as almost every state in the United States now requires a minimum of a doctoral degree for independent practice. Of those few states that do license master's-level practitioners, it is usually on a two-tiered level. These minor issues do not detract from what is, overall, a

well-balanced and extremely well-written text that maintains a no-nonsense style throughout. *How to Go to Therapy* is highly recommended as a primer for people who are seeking mental health treatment. Students of psychotherapy as well as practitioners who are looking for adjunctive resources for their clients should also find this book to be a very useful guide to the field of psychotherapy. ✍

Book Review

Klingemann, H., Sobell, L., Barker, J., Blomqvist, J., Cloud, W., Ellinstad, T., Finfgeld, D., Granfield, R., Hodgins, D., Hunt, G., Junker, C., Moggi, F., Peele, S., Smart, R., Sobell, M., and Tucker, J. (2001). *Promoting Self-Change From Problem Substance Use: Practical Implications for Policy, Prevention and Treatment.* Dordrecht, The Netherlands: Kluwer Academic Publishers

Reviewed by Ronald M. Kadden, *University of Connecticut School of Medicine*

Interest in "self-change" from substance use problems has been growing in the United States and Europe. Despite improvements in the effectiveness of treatments for alcohol and drug use disorders, the fact remains that large numbers of people resolve their substance use problems on their own, without any help from professionals or even from self-help groups. This is especially true among those with relatively low problem severity. Interest among professionals in understanding how people change their substance use on their own arises for two main reasons: first, as a source of information about naturally occurring change processes that might be useful for improving treatment, and second, as a means of promoting self-change in the context of prevention efforts. However, studying this phenomenon presents formidable challenges because many self-changers never come in contact with addictions treaters or researchers, making it very difficult to identify them and obtain information about their experiences in changing their behavior.

An international conference on recovery from alcohol, tobacco, and other drug problems without treatment was held in 1999 in Switzerland, bringing together researchers, treatment providers, and policymakers. The themes of the conference included natural recovery rates in various countries and cultures, life events research, implications for therapeutic interventions, gender and minority factors, theories of change, social context of change, and data analytic strategies. Participants in the conference, and a few others, contributed chapters that were edited by the first two authors and molded into the present volume, with the contributors listed as co-authors.

The first chapter provides an overview of the phenomenon of self-change, the current state of the art, why it is worth studying but has nevertheless been ignored for so long, and a review of major findings. One is impressed with how little is really known about a phenomenon that has considerable potential for enhancing understanding of the change process. Chapter 2 reviews frequently cited studies of self-change from alcohol and drug use, including some that were not specifically designed to study self-change but nevertheless provide supporting evidence. These classic studies demonstrate that there is not a single, uniform entity called "addiction," nor a single pathway out of it. Chapter 3 examines findings about self-change obtained by a variety of different sampling methods. Chapter 4 examines what is known about self-change among smokers and gamblers, and similarities/differences between them and self-changing alcohol and drug users.

Chapter 5 considers social factors that may influence self-change and includes a particularly interesting section on advertising aimed at moving people from the precontemplation and contemplation stages of change toward the action stage. Chapter 6 reviews what little is known about factors that influence the decision to change and the route that is taken to change. The chapter concludes by advocating a stepped-care approach to intervention, beginning at minimal intensity and proceeding to increasing levels of intervention if the less intense ones are not successful. Chapter 7 considers possible roles for health-care practitioners in expediting the change process, and Chapter 8 suggests avenues for motivating those who never enter formal treatment. Chapter 9 considers the role of environmental context, using "social capital" theory to examine factors that may affect the likelihood of making and maintaining change. Chapter 10 attempts to consider self-change from a cross-cultural perspective, but there is even less hard data on this than on the other topics, so it is more a summary of questions that need to be asked and an outline of challenges.

The final chapter summarizes the advice that was offered in the preceding chapters for policymakers, treatment providers, and researchers. This is followed by an appendix comprising a "toolbox" with a list of brief instruments that can be used to assess problem severity, triggers for addictive behavior, and readiness for change. Addiction self-change Web sites, addiction self-change books, articles, resource guides, and videos are also listed by country.

The book is filled with personal statements from people who changed their behavior on their own. Although they are entirely anecdotal, this touch is consistent with one of the overall themes of the book: that there is a lot to be learned from the experience of those who have tried to change on their own.

The final impression one is left with is how far we have to go. Although awareness of the phenomenon of self-change is not new, it has not been extensively studied, because the obstacles to doing so are formidable. The present volume provides a compendium of what is known and provides an agenda for future work in this area. Through its analysis of different aspects of the self-change phenomenon, it makes the obstacles to further study seem a bit less formidable and the tasks that lie ahead a bit more manageable. As a result, this little volume provides a useful starting point for investigating processes of self-change and for developing ways to foster greater awareness among the general population so that they may be able to resolve substance use problems on their own. ✍

Welcome, New Members!

• ASSOCIATE MEMBERS
Nicholas R. Forand, B.A.
Melody L. Keller, B.S.
Katie M. Klein, B.S.

• FULL MEMBERS
Nancy E. Addison, Ph.D.
Mona H. Allard, M.Ed.
Rosa M. Banos-Rivera, Ph.D.
Patricia E. Barry, M.D.
Helen M. Best, M.Ed.
Randi E. Bienstock, Psy.D.
Scott Blair-West, FRANZCP
Cristina Botella, Ph.D.
Linda R. Bright, M.S.W.
Elaine C. Brown, Ph.D.
Gary J. Bryson, Psy.D.
Maria L. Buckley, Ph.D.
Adrianne M. Camero-Sulak, Psy.D.
Kristina L. Campbell, Ph.D.
Deborah M. Capaldi, Ph.D.
Junwen Chen, Ph.D.
Yongrae Cho, Ph.D.
Mirabel Sarron Christine, M.D.
Dana B. Couch-Davis, Ed.D.
Steven L. Cranfill, M.B.A.
Carolina Cristi, Ph.D.
Garry Lopes Cunha, M.A.
David J. C. Dewulf, M.D.
Susan E. Dickens, M.A.
Anne C. Dobmeyer, Ph.D.
Linda W. Dutcher, Ph.D.
Sari H. Dworkin, Ph.D.
Jon E. Eggert, Ed.D.
Rosemary J. Erickson, M.S.W.
Sussie Eshun, Ph.D.
Peter G. Farvolden, Ph.D.
Mary G. Freitag, Psy.D.
Melissa D. Fulgieri, Psy.D.
Christine A. Gidycz, Ph.D.
Barbara A. Golden, Psy.D.
L. Robert Gore, Ph.D.
Kirsten L. Haman, Ph.D.
Kenneth E. Hart, Ph.D.
Chris R. Hayward, M.D.
Julie R. Hergenrather, Ph.D.
Richard J. Huddleston, Ph.D.
Joquetta P. Hutchens, MSSW
Connie J. Johnmeyer, Ph.D.
Kevin R. Kracke, Ph.D.
Tracy F. Kuo, Ph.D.
Steven J. Lash, Ph.D.
Dorene E. Loew, Ph.D.
Katharina Manassis, M.D.
James N. Marchman, Ph.D.
Greta M. Massetti, Ph.D.
Stephen R. McCutcheon, Ph.D.
Sandra L. Mendlowitz, Ph.D.
James R. Meyer, Ph.D.
Catherine R. Michas, Ph.D.
Terry L. Miller, M.S.
Christopher F. Mogan, M.A.
Richard A. Moody, Psy.D.
Donald B. Nadler, Ph.D.
Julie S. Nathan, Ph.D.
Rachel A. Nutter, M.S.W.
Lynn E. O'Connor, Ph.D.
David D. O'Grady, Ph.D.
Roberto Olivardia, Ph.D.
John D. Otis, Ph.D.
Kee Hwan Park, Ph.D.
George A. Parks, Ph.D.
Terri S. Parsons, MSSW
Timothy J. Petersen, Ph.D.
Patrice L. Pye, Ph.D.
Robert Reiser, Ph.D.
Melisa Rempfer, Ph.D.
Saul L. Rosenthal, Ph.D.
Joan C. Russo, Ph.D.
Debra L. Safer, M.D.
Caroline E. Sakai, Ph.D.
Saima Salman, M.Sc.
William A. Satterfield, Ph.D.
Pierre Savard, M.D.
Sharon F. Smith, M.S.W.
Helen D. Stevens, Ph.D.
David R. Strong, Ph.D.
Vicki L. Stubbings, Ph.D.
Nina S. Sugar, M.D.
Yoshihiko Tanno, Ph.D.
Jay C. Thomas, Ph.D.
Timothy R. Tumlin, Ph.D.
Alex W. Ursprung, Ph.D.
Wiljo J. P. J. Van Hout, Ph.D.
Tanya Vapnik, Ph.D.
Jonathan Von Breton, M.A.
Christine H. Walker, Psy.D.
Mark A. Watling, M.D.
Amy G. Weisman, Ph.D.
Carol A. Werlinich, Ph.D.
David W. Wetter, Ph.D.
William A. Wiener, Ph.D.
Gisela Wisung, Ph.D.
Hakan Wisung, Ph.D.
Lee C. Zlomke, Ph.D.

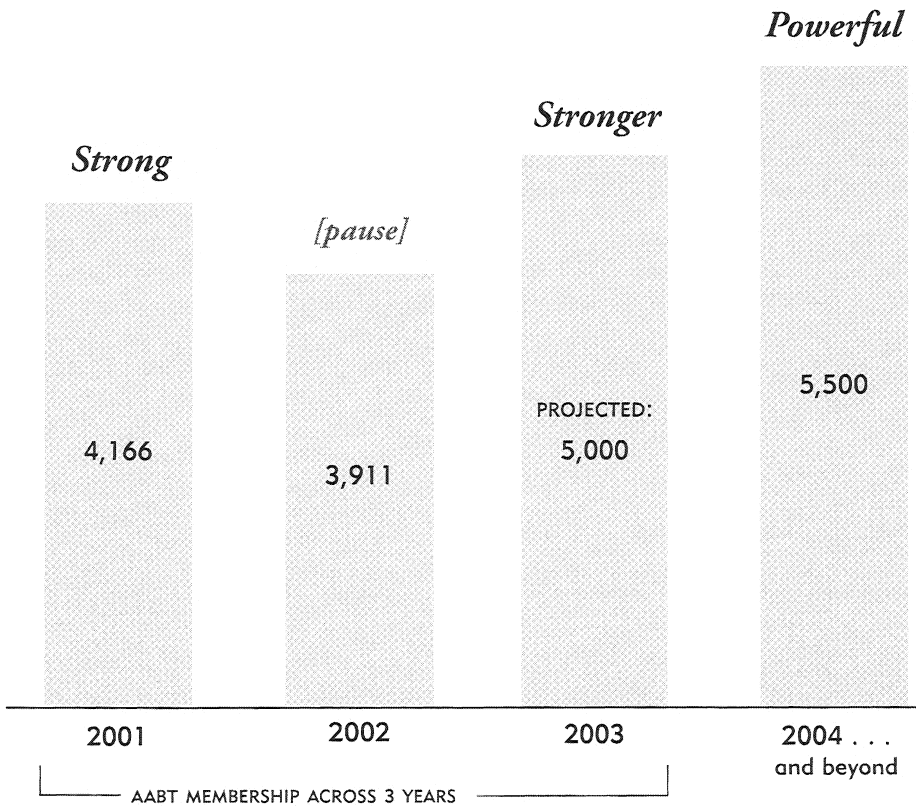
• STUDENT MEMBERS
Christina L. Abbott
Amy C. Abraham, M.S.
John Agee
Melissa D. Altman, M.A.
Lucia A. Angelini
Aleta G. Angelosante, M.A.
Michael F. Armey, B.A.
Jay A. Ashmore, M.A.
Natasha A. Bacchus, M.A.
Natalie G. Ballash, B.A.
Velma Barrios, B.A.
Brian R. Baucom, B.S.
Barbara D. Beach, M.S.
Courtney L. Beard
Evelyn S. Behar, M.S.
Annie E. Belcourt-Dittloff, B.A.
Anna E. Bergen
Allison L. Berger
Caroline Berthiaume, B.Sc.
Shelly R. Bird, B.A.
Richard T. Bloch
Kenneth P. Bobicz, B.S.
Michel F. Bonin, B.A.
Michele L. Borynski, B.A.
Kelly M. Brey, B.A.
Carrie A. Bronars, B.A.
Rashelle E. Broun, B.S.
Joshua D. Brown, M.S.
Jean E. Burger
Sarah E. Burlingame, M.S.
Stacey Colman Cahn, M.S.
Darren Calhoun
Jill K. Carey-Melton
Noelle E. Carlozzi, B.A.
Melissa Y. Carpentier, B.A.
Hillary L. Case, Ph.D.
Paula S. Cerveny, B.A.
Anthony L. Chambers, M.A.
Karen K. Chan
Robin R. L. Chang, B.A.
Ray W. Christner
Sophie M. Chulvick, B.A.
Caroline N. Coffield
Amy M. Cohn, B.A.
Trina A. Colburn
Jonathan S. Comer, B.A.
Robin L. Comerford
Kevin M. Connolly, B.S.
Lauren M. Conoscenti, M.A.
Annette M. Conway, Psy.D.
Kathleen Corcoran, M.A.
Michelle M. Cornette, Ph.D.
Joseph A. Costa, M.S.
Torrey A. Creed, MS.Ed.
Natasha Crewdson
Renee I. Culp
Vanessa L. D'Anna
Laura S. Dawkins, B.A.
Amisha L. Dean
Ronald M. Deguffroy, M.S.
Colin A. Depp, M.A.
Jeff C. Diebold, M.A.
Leilani, F. DiLiberto, M.A.
Jacqueline M. Dillon, B.S.
Carla A. DiSalvo, B.S.
Katherine M. Diskin, Ph.D.
Jeanne M. Dorland, M.A.
Paul D. Dukarm, M.A.
Dominique Dussault
Gareth R. Dutton, B.A.
Aileen M. Echiverri, B.A.
Teresa M. Edenfield, B.S.
Kristin R. Egemo
Angela L. W. Ehrlick, M.S.
Brian S. Eig
Lori R. Eisner, B.A.
Andrew G. Ekblad, B.S.
Lisa S. Elwood, B.A.
Shannon C. Erickson, M.S.
Leafar F. J. Espinoza, B.A.
Francisco J. Farach, Jr., B.A.
David B. Feldman, M.A.
Theresa H. Fesperman
Carlos Finlay, M.S.
Nicholas L. Finstrom
Kelly R. Fleming, Ed.S.
Cynthia Flynn, M.S.
Heather M. Foran, B.S.
Sarah E. Foster, B.A.
Abby H. Friedman
Janet M. Friedman
April Fritch, B.S.
Seiya Fukuda, M.S.
Cristi L. Gallagher
Marilyn Garcia, B.A.
Sarah M. Gasper, B.A.
Karli A. Ghering, B.S.
Christopher D. Goings, B.A.
Abby L. Goldstein, M.A.
Jennifer C. Goring, B.A.
Angela A. Gorman
Jennifer J. Grant, B.A.
Ernestine G. Green-Turner, B.S.
Jeffrey H. Greenberg
Farrah Greene, B.A.
Lisa B. Greene, B.A.
Joseph A. Greer, M.S.
Jeff C. Gregory, M.S.
Lezlee A. Greguson, B.A.
Tania E. E. Grunfeld
Max L. Gunther, B.A.
Maya E. Gupta, A.B.
Greg Hajcak, B.S.
Michelle Harada, B.A.
Ellen F. Harrington, B.A.
Julie F. Hasman
Lauren C. Haubert
Kisha M. Haye, M.A.
Lisa J. Heaton, M.S.
Jill M. Hedt, B.S.
Laura S. Hemmy, M.S.
Ellen S. Hendriksen, B.A.
Heather Hernandez
Melanie D. Hetzel, M.A.
Diana M. Higgins, B.A.
Michael B. Himle, B.S.
Jessica F. Hirsch
David E. Holden
Rachael A. Horton, B.A.
Michael J. Hosbach
Elisabeth A. Hudgens, B.S.
Megan E. Hughes, B.A.

Hillary R. Hunt, B.A.
Melissa K. Hunt, B.A.
Mark A. Ilgen, M.A.
Daniel H. Ingram, M.Ed.
Kate M. Iverson, B.A.
Srividya N. Iyer, M.A.
Adrian S. Janit, B.A.
Anne Marie Jefferson, Pharm.D.
Michelle T. Jesse, B.A.
Ayna B. Johansen, B.A.
Jill M. Johansson-Love, B.S.
Lynae A. Johnsen, B.A.
Brigitte M. Johnson
Lacque L. Jones
Robyn M. Jones, M.S.
Jana I. Joseph, B.A.
Abigail M. Judge, B.A.
Shoshana Y. Kahana, M.A.
Danielle M. Kalmanson, B.A.
Victoria H. Kaslow, M.A.
Jeffrey R. Kelly, Ed.S.
Kathleen E. Kendra
Darla E. Kendzor, B.A.
Cassian B. K. Kimhan, B.A.
James L. Klosky, M.S.
Lisa M. Kopp, B.A.
Linda S. Kranitz
Erica M. Krisztal
Marc I. Kruse, B.A.
Janice R. Kuo, B.A.
Heather R. LaChance, M.A.
Caleb W. Lack
Jodelle V. Landis, M.S.
Sean A. Lauderdale, Ph.D.
Tricia M. Leahey, B.A.
Lori J. Lennon
Hillary A. LeRoux
Eric M. Levander, M.D.
Brian R. Lim, M.A.
Noam Lindenboim, B.A.
Lori B. Listug-Lunde, M.A.
Samantha C. Litzinger, B.A.
Kristen A. Lowry, B.A.
Chad M. Lystad
Carol Mack
Laura Marie MacPherson, B.A.
Mariola Magovcevic, M.S.
Suzanne C. Main, B.S.
Kimberly A. Mallett, B.S.
Gloria G. Maramba, M.A.
Craig D. Marker, M.S.
Jaime L. Marmorato
Megan P. Martins
Anthony J. Mascola, M.D.
Shawn T. Mason, M.A.
Elise D. Massie
Jake B. Mathiason, B.S.
Aleta A. Mattaino
Victoria M. McKeever, Ph.D.
Bryce D. McLeod
Amori Y. Mikami, M.A.
Brian I. Miller, B.S.
Chris S. Miller
Sarah A. Miller, B.A.
Stacy L. Miller, B.S.
Matthew J. Mimiaga, B.S.
Arti R. Mithal
Theresa M. Molony
Scott R. Mooney, B.S.
Brie A. Moore, M.S.
Michael T. Moore
Rachel G. Morier, B.A.
Catherine E. Mosher
Susannah L. Mozley, Ph.D.
Brad J. Nakamura
Sidney D. Nau, Ph.D.
Elizabeth V. Naylor, B.A.
Christopher A. Neumann, M.S.
Robert M. Nichols
Heather M. Niemeier, M.A.
Reginald D. V. Nixon, Ph.D.
Nicole R. Nugent, M.A.
Julia E. Oppenheimer, B.A.
Karin L. Ovefelt, Ph.D.
Jennifer D. Pahl, M.S.W.
Heather T. Pane
Holly Parker, M.S.
Sarah J. Parker
Chad J. Parsons, B.A.
Nicole T. Passmore, B.A.
Candace L. Patterson
Heather C. Payne, B.A.
Ann Pearman
Adria N. Pearson, B.A.
Norma J. Perez, M.A.
Scott M. Pickett, B.A.
E. Brooke Pope, B.A.
Valerie Porr, M.A.
Katherine E. Presnell, M.A.

continued

You Can Help AABT Grow

Michael Petronko, *Membership Issues Coordinator*



Growth is not always linear. Growing is helping someone to accomplish their full potential, which is what AABT wants to do for you, and what you can do for a student or colleague. Let them know that you care about their professional and academic growth. Recommend AABT for its dedication to continuing education, behavioral tradition, sense of community, and relevant, state-of-the-art programs and scholarship. Formally sponsor just one student or colleague's membership this year and you help AABT get stronger and stronger. Encourage your colleagues and students to join the faculty and student body of AABT University!

AABT

Beverley J. Priest
Christina Psaros
Meredith A. Pung, M.A.
Holly J. Ramsawh, M.A.
Hannah E. Reese, B.A.
Kerry A. Renner, M.S.
W. Rusty Reynolds
Dana M. Rhule, B.A.
Reagan L. Rinderknecht
Sharon C. Risch, B.A.
Adrienne E. Robek
Denise K. Robeson
Kathleen M. Romanek, M.S.
Rachel H. R. Romm, M.A.
Michelle T. Roos, B.S.
Glenna S. Rousseau, B.S.
Joshua L. Ruberg, B.A.
Rebecca M. Rygwall, B.S.
Kimberly E. Sayer
Stephanie A. Scheck, B.A.
Tanya Schlam, M.A.
Heather M. Schloss, B.A.
Sabine P. Schmid, M.A.
Jessica R. Schultz, B.A.
Lisa A. Schwartz, M.S.
Asani H. Seawell, B.A.
Safet Seferovic, Dipl.Psych
Mia Sevier, M.A.
Erin S. Sheets, B.A.
Rachael L. Sheffield, B.S.
Chad E. Shenk, B.A.
G. Deacon Shoenberger, M.A.
Rebecca S. Siegel, B.A.
Evette L. Simmons, M.A.
Laura E. Simons, B.A.
Sonia Singh, M.A.
Traci E. Sitzer, M.S.
Alethea A. Smith
Joyce L. Smith, M.A.
Clint C. Stankiewicz, M.Ed.
Cheryl A. Stayer, B.A.
David P. Steinke
Jera Stewart, B.A.
Jill A. Stoddard, M.A.
Michael K. Suvak, B.S.
JoAnna L. Swafford
Margaret H. Swartz
Angela J. Sweeny, B.A.
Robyn J. Sysko
Nicole K. Y. Tang, B.Sc.
Stephen M. Timchack, M.S.
Stacy I. Trogner, M.S.
Carolyn I. Trojahn, Ph.D.
Tunde Turi-Markovic, B.S.
Jose D. Useda
Noreen J. Vail, B.S.
Kristine E. Van Doran
Edward M. Vega
Kelly L. Wadeson, Ph.D.
Christine M. Walling
Cortney S. Warren, B.A.
Deidre M. Waters, M.A.
Justin W. Weeks, B.A.
Janet L. Wells, M.A.
Chad T. Wetterneck, B.S.
Reo Wexner, B.A.
Heather A. Wheeler, M.A.
Ralph W. Whetstine, B.A.
Stephen P. Whiteside, Ph.D.
Laurie A. Wiggen, Psy.D.
Tamara C. Wilburn, B.A./B.S.
Mathew C. Williams, B.A.
Susan K. Williams
Kristen A. Woodberry, M.S.W.
Kristin Kahle Wrobleski, M.A.
Donna L. Yaure
Iftah Yovel, M.S.
Craig A. Yury, B.A.
Maha Zayed, B.A.
Kimberlee J. Zetocha
Jill M. Zlomke
Linda E. Zynda, B.A.

• NEW PROFESSIONALS

Mariah E. Coe, Ph.D.
Ata Ghaderi, Ph.D.
Marcie C. Goeke-Morey, Ph.D.
David M. Lischner, M.D.
Larissa N. Niec, Ph.D.
Nanci M. Pradas, Ph.D.
Daljit K. Sawhney, Ph.D.

• MEMBERS IN TRANSITION TO NEW PROFESSIONALS

Alice S. Alexander, Ph.D.
Wesley D. Allan, Ph.D.
Karla Anhalt, Ph.D.
Krista A. Barbour, Ph.D.
Christopher G. Beevers, Ph.D.
Lisa M. Blackwell, Ph.D.
Steven E. Bruce, Ph.D.
Jennifer L. Burden, Ph.D.
Esteban V. Cardemil, Ph.D.
Kathleen A. Carty, LICSW
Susan M. Chudzik, M.Sc.
Dennis R. Combs, Ph.D.
Amy M. Combs-Lane, Ph.D.
Daniel Deutsch, Ph.D.
Rebeca T. Dingfelder
David M. Direnfeld, Ph.D.
Diana M. Dorhofer, Ph.D.
Jonathan A. Dudek, Ph.D.
Barbara Elbl, M.A.
Kathleen A. Eldridge, Ph.D.
David B. Franklin, Ph.D.
Debra W. Fredericks, Ph.D.
Sharon M. Freeman, M.A., M.S.N.
Jackie K. Gollan, Ph.D.
John K. Grebe, Ph.D.
Robert P. Guillard, Psy.D.
Susan K. Heffelfinger, Ph.D.
Nina Heinrichs, Ph.D.
Tracy M. Jendritza, M.S.
Melissa Kalarchian, Ph.D.
Carolynn S. Kohn, Ph.D.
Shari R. Kohn, Ph.D.
Tommy Kot, Ph.D.
Joseph W. LaBrie, M.S.
Frederic Langlois, Ph.D.
J. Miles Lawrence, Psy.D.
Monique M. LeBlanc, Ph.D.
Jill T. Levitt, Ph.D.
Sarah F. Lewis, Ph.D.
Vicki A. Lumley, Ph.D.
Catherine P. MacLaren, MSW
Nicholas A. Maltby, Ph.D.
Maria C. Mancebo, Ph.D.
Wanda M. Mandell
Corby K. Martin, Ph.D.
Jessica Mass, M.A.
Ryan K. May, Ph.D.
Tanna M. Mellings, Ph.D.
Heather M. Nash, Ph.D.
April C. O'Grady, Ph.D.
James F. Paulson, Ph.D.
John E. Perez, Ph.D.
Donna M. Posluszny, Ph.D.
Dena C. Rabinowitz, Ph.D.
Simon A. Rego, Psy.D.
Raphael D. Rose, Ph.D.
Lou Sandler, Ph.D.
Tamara Penix Sbraga, Ph.D.
Jillian C. Shipherd, Ph.D.
Michael J. Stasio, M.A.
Jennifer L. Strauss, Ph.D.
Joseph J. Trunzo, Ph.D.
Jillon S. Vander Wal, Ph.D.
Kamilla L. Venner, Ph.D.
Brooke L. Whisenhunt, Ph.D.
Nathan L. Williams, Ph.D.
Karen B. Wood, Ph.D.
Theodore P. Wright, Ph.D.
M. Catherine Yeager, Ph.D.
Andrea R. Zuellig, Ph.D.
Michael J. Zvolensky, Ph.D.

Minutes of the Annual Meeting of Members

November 16, 2002, Reno, NV

I. Call to Order

The Annual Meeting of Members of the Association for Advancement of Behavior Therapy was called to order by President Richard Heimberg at 6:40 p.m. in the Carson 1 Room of the Reno Hilton Hotel, Reno, Nevada. Notice of this meeting was sent to all Full Members of AABT in August 2002 in the 36th Annual Convention Program Book.

II. Minutes

The Minutes from the November 17, 2001 Annual Meeting of Members held in Philadelphia, Pennsylvania, were accepted as distributed.

III. Service to the Organization

President Heimberg extended the gratitude of the Association to the following members who have been of service to AABT: Raymond DiGiuseppe, Ph.D., Representative-at-Large, 1999-2002; Gayle Y. Iwamasa, Ph.D., Coordinator of Academic and Professional Issues, 2000-2002; Melissa Hunt, Ph.D., Committee on Academic Training Chair, 2000-2002; Michael Pantalon, Ph.D., Committee on Awards and Recognition Chair, 1999-2002; Ann M. Steffen, Ph.D., Coordinator of Convention and Education Issues, 1999-2002; Raymond Tafrate, Ph.D., Continuing Education Issues Committee Chair, 1999-2002; Mark Terjesen, Ph.D., Institutes Committee Chair, 1999-2002; Andrea Seidner Burling, Ph.D., Special Interest Groups Committee Chair, 1999-2002; Mitchell L. Schare, Ph.D., 2002 Top Membership Recruiter; David J. Hansen, Ph.D., Committee

on Public Education and Media Dissemination, Committee Chair, 1999-2002; Kenneth J. Sher, Ph.D., Finance Committee Member, 1998-2001; Lynn Marcinko, Ph.D., and her students, Brittany Burchfield, M.A. and Marie K. Lee, M.A., for creating and hosting the AABT List Serve.

President Heimberg thanked the 2002 Program Chairperson and his committee members for putting together this year's outstanding convention program: Michael W. Otto, Ph.D., 2002 Program Committee Chair. The 2002 Program Committee Members: Anne Marie Albano, Drew A. Anderson, Gordon J.G. Asmundson, Sonja V. Batten, Steven R. H. Beach, Joaquin Borrego, Jr., Elizabeth V. Brestan, Elissa J. Brown, Steven E. Bruce, Cheryl Carmin, Corinne Cather, Marie B. Caulfield, Timothy A. Cavell, Thilo Deckersbach, Raymond DiGiuseppe, David DiLillo, Linda Dimeff, Greg Dubord, David M. Fresco, Robert A. Gould, Nancy S. Handmaker, Aude Henin, Stefan G. Hofmann, Debra A. Hope, Curtis C. Hsia, Heidi Inderbitzen-Nolan, Kelly Koerner, Kenneth L. Lichstein, Trish Long, Frank J. Marone, Robert J. McMahon, Daniel W. McNeil, John R. McQuaid Elizabeth Meadows, Douglas S. Mennin, Jan Mohlman, Tracy L. Morris, Amy E. Naugle, Fugen Neziroglu, Holly K. Orcutt, Susan M. Orsillo, Elyse R. Park, David Penn, Carolyn Pepper, Jacqueline B. Persons, Donna B. Pincus, Melissa A. Polusny, David Powers, Adam S. Radomsky, Noreen A. Reilly-Harrington, Lizabeth Roemer, Kelly J. Rohan, Steven A. Safren, Zindel Segal, Sandra T. Sigmon, Jillian C. Shipherd, Ann M. Steffen, Amy E. Street, Paul Stuve, Maureen A. Sullivan, Bethany A. Teachman, Giao Q. Tran, Amy W. Wagner, Robyn Walser, Maureen L. Whittal, Sabine Wilhelm, Carol A. Winett, Jose A. Yayura-Tobias, Michael J. Zvolensky.

The President thanked the 2002 Local Arrangements Committee Chair, Victoria M. Follette, Ph.D., along with Kathleen M. Palm and Alethea A.A. Smith, 2002 Local Arrangements Committee Chair Assistants.

IV. New Appointments

President Heimberg announced the new members to AABT's governing structure: Mark Terjesen, 2002-2005 Continuing Education Issues Committee Chair; Kristene Doyle, 2002-2005 Institutes Committee Chair; Debra Hope, 2003 Boston Program Chair; Michael W. Otto and Donna Pincus, 2003 Local Arrangements Co-Chairs; Patricia J. "Trish" Long, 2004 New Orleans Program Chair; Ronald Fudge, 2002-2005 Special Interest Groups Committee Chair; John Guthman, 2002-2005 Awards and Recognition Committee Chair; Kenneth Ruggiero, 2002-2005 Public Education and Media Dissemination Committee Chair; Karen Christoff, 2002-2005 Academic Training Committee Chair.

V. Coordinators' Reports

A. Academic and Professional Issues Committee

Michael W. Otto gave the report for the Academic and Professional Issues Committees in Coordinator Iwamasa's absence.

He reported that the Professional Issues Committee has been tackling several difficult issues over the past year. They have written a summary statement addressing advantages and disadvantages on the prescription privileges debate, centering on House Bill 170, which was passed earlier in the year in New Mexico. He commended the committee for handling this political issue in a nonpolitical way. To gather more information on this subject, they may conduct a survey on the Professional Issues website to see where the AABT members stand. He reported that the Committee on Research Agenda web page is expanding its resources for researchers, and members should be sure to visit the site.

The Academic Training Committee's project to increase the amount of CBT training in the education of medical students has been difficult, but is making some small progress in the Philadelphia area. He reported that the NIMH, having funded for years projects that provide information on treatments that really work, has found that their product is not adequately getting to the public or therapists. The program put out an announcement asking, "How do we get out what is known to work more often?"

Dr. Otto informed the membership of the wonderful Awards Ceremony presented during the Convention. Leonard Krasner received the AABT Lifetime Achievement Award; Marvin Goldfried received the Outstanding Clinician Award; Steven T. Fishman and Barry S. Lubetkin received the Outstanding Service to AABT Award; Robert Klepac, Director of Psychology Training and Alan Peterson, Director of Postdoctoral Training, received the Outstanding Training Program on behalf of Wilford Hall Medical Center/Lackland Air Force Base, San Antonio, Texas; the 2nd Annual Virginia A. Roswell Dissertation Award was presented to Sudie Back; Allison Harvey received the 2002 New Researcher Award. Nicole K. Y. Tang, Eric A. Stroch, and Ulrike Buhlmann received the Elsie Ramos Student Poster Award. Mark Sobell was presented the Jellinek Award for Outstanding Contribution to the field of Alcohol Research at our ceremony. The ADAA Career Development Travel Award Recipients, Jennifer Hudson, Jan Mohlman, Nnamdi Pole, and Christine Purdon, were recognized. We also acknowledged many AABT members for their professional contributions following the tragedy of September 11.

Dr. Otto reminded everyone that the January issue of *the Behavior Therapist* will have a call for nominations for the 2003 Awards Program.

Reporting for the International Associates Committee, headed by Art Nezu, Dr. Otto said that the mission of this committee is to link therapists to the international community. The focus of this committee right now is the 2004 World Congress of Behavioral and Cognitive Therapies in Kobe, Japan. Information for the 2004 World Congress was available at the Information Booth area at the Reno convention as well as AABT's web site.

B. Convention and Education Issues

Ann Steffen, Coordinator, reported that the total number of registrants for the Reno convention was 2,102. This is a good turnout, despite some complaints from members regarding going West and difficult travel arrangements. She stated that this attests to the people advocating Reno. She also commended Michael Otto for putting on a marvelous program. She had heard many compliments from convention attendees regarding the wide range of program offerings and the scientific soundness of the meeting.

She was pleased to announce that Deb Hope will be spearheading the plans for the 2004 Boston Convention. She was also pleased to announce that Deb Hope and David DiLillo are implementing electronic submissions for the 2004 convention. Though there may be the usual snags that come with a new system, things are going smoothly. There is also wonderful involvement from the members for the Boston convention.

She reminded members that there is a Call for Papers, along with an invitation for people to suggest workshops, for the Boston Convention on the inside back cover of the Convention Program book.

C. Public Information Committees

Reporting for the Public Information Committee was Representative-at-Large Victoria Follette. She also commended Michael Otto and the Program Committee for heading up a fantastic convention this year.

She reported that the Public Information Committees have been restructured and assigned to new areas of our governing structure. The coordinator position is being eliminated, as it has become apparent to the Board that this position is no longer

required. The Committee on Public Education and Media Dissemination is being moved to the Publications Committee. Ken Ruggiero will be heading up this committee, and is looking at how we can get our publications and fact sheets seen by a wider audience.

This project includes more web accessibility for publications.

The Clinical Directory and Referral Committee, chaired by Brian Marx, is moving to the Membership Issues Committees. This group is working on more web-based activities to help the public find our members who offer clinical services. They hope to complete the production of a videotape to give consumers information on the advantages and benefits of behavior therapy. These changes require bylaw amendments, on which the membership can vote on in April 2003.

Dr. Follette has also been serving as the liaison to the Ad Hoc Committee on AABT's Response on Terrorism. This committee generated the call and review system to acknowledge AABT members who responded professionally to 9/11. They were honored during the Awards Ceremony. This group has worked with Project Liberty/LifeNet to get AABT members on provider panels so that they can provide services to those who have been affected by 9/11. They are also working to collaborate better with the Red Cross in the event of a future need.

D. Publications Committee

Reporting for the Publications Committee was David Teisler, Director of Publications, in Coordinator Arthur Freeman's absence. He announced that the Publications Committee is looking for a web editor. Anyone interested in assisting with this search should contact him immediately at the AABT Central Office. They would like to have this position filled by March 2003.

He reported that the three journals are all doing very well. Other great news is that the Archives and World Rounds videos are selling wonderfully. They are continuing to add to the series, including taping the World Rounds at the 2003 Reno Convention.

He extended thanks to the editors of the journals, who make the publications work so well.

E. Membership Issues

Reporting for the Membership Committees was Coordinator Mike Petronko. He reported that membership is less than 4,000, a big drop from previous years. Recognizing this as a trend, the committees initiated a major campaign to increase full membership to 5,000 by the end of the year 2003. He stated that there are some creative methods to achieving this goal, but that all members should look at why this is necessary. Is it just to generate money to increase our bottom line? Is it to make sure that behavior therapy gets out there to those who need it? He believes both are necessary, and that we can share in making this 5000-member goal happen.

The Special Interest Groups Program has been very active this past year. There are 29 active SIGs; 2 new in-formation SIGs, Child and Adolescent Anxiety and Neuropsychology and Rehabilitation; as well as a SIG, Behavioral Medicine, being revitalized. The SIG Guidelines were revised this year, and the majority of SIGs are already in compliance with the revised rules.

Student membership continues to increase. We had 949 renewed and 348 new student members.

The committees have formed a new category of membership for students who've become a new professional. They can have a 2-year transitional New Professional status that is less expensive than the Full and Associate status. This new category appears on our membership application and dues statement. It is another demonstration that AABT is here to assist new members of the field in their professional development.

A subcommittee for lost members has been formed. We know that members move, get married, sometimes change their last name, or take a leave of absence. This group is trying to reconnect with previous members and encourage them to renew. Let us know if you are interested in assisting.

The Nominations and Elections Committee has put forth the Call for Nominations. There are three positions for which they are seeking nominations: President-Elect, Representative-at-Large, and Secretary-Treasurer. The nominations form will appear in several issues of *tBT*, and a copy will be included in the annual dues renewal mailings. Dr. Petronko invited people to submit their name or that of a colleague and to vote when the ballots arrive in early April.

Returning to his theme of 5,000 in 2003, he informed the membership that everyone's participation is required to meet our goal. A lottery system was created to reward members' assistance and to acknowledge new members. At this point, the lottery winners were chosen and announced by Dr. Petronko. Those receiving a complimentary journal: Catherine Michas, Melanie Hope Jackson, Margaret Boyer, Karen Calhoun, Lester Wright, and Amy Wenzel; those receiving their choice of three archive or world round tapes: Denis Sukhodolsky, Christine Lemke, Richard Allen Moody, Lee Cohen, David Hansen, and Martin Antony; those receiving a complimentary membership in 2003: Safet Seferovic and Mitchell Schare.

During the Reno Convention, we accepted over 100 new members, which is quite remarkable. Dr. Petronko thanked all who sponsored individuals to join and talked up the virtues of AABT.

VI. Executive Director's Report

Mary Jane Eimer, Executive Director, reported that 2002 had been a year of change and refinement at the Central Office. AABT has expanded its website greatly, and new information is constantly being posted. AABT now has the capability for broadcast emails. The decision has been made that broadcast emails will be used only to inform members of new opportunities, pertinent information, or reminders of impending deadlines. Our email list will not be sold for commercial purposes. AABT now also has a list serve, thanks to Lynn Marcinko and her colleagues. This gives members the ability to communicate with each other.

The Executive Director reported the utility of face-to-face meetings with all the various committees during the Reno Convention. It has been exciting to participate in a number of discussions that will facilitate communication among like-minded people, add new services for the membership, and to see how ideas that we discussed years ago have come to fruition. An example is AABT's participation in forming the Behavioral Psychology Specialties Council that now provides input to the APA Council of Specialties. It has also been good to hear various committee members' input in the convention committee to ensure future success and see that all topics that are of special interest to our constituents are represented in next year's program.

This past year has been a difficult year in some ways because staff size was reduced, including the Executive Director's assistant, in an effort to reduce the budget.

The Executive Director extended a big thanks to Rick Heimberg and Alan Gross for their help with revisions to the internal operations. We have streamlined the financial reporting system and made adjustments to the governing structure. They went beyond the call of duty by coming to meetings at the central office as well as participating in many phone conferences.

She congratulated all of those members who have participated in the membership retention and recruitment efforts. It is wonderful seeing so many members wearing the "Ask Me" ribbons, giving information at the AABT booth, and answering questions at the registration area. She also thanked the wonderful staff at

the AABT Central Office: Mary Ellen Brown, Convention Manager and Director of Administration; Tonya Childers, Convention Registrar and Administrative Secretary; Patience Newman, Projects Manager; Rosemary Park, Convention Registrar and Membership Services Manager; Stephanie Schwartz, Managing Editor; Teresa Wimmer, Publications Secretary and Staff Liaison to the SIG Program; and David Teisler, Director of Publications.

VII. Finance Committee Report

Alan Gross, Secretary-Treasurer, reported that the Finance Committee had worked hard on improving the financial budgeting and reporting systems, and that the organization was now on very firm ground and ready to move forward in a positive direction. There had been serious concern about the fiscal health of the organization, and after the board implemented a number of the Finance Committee's recommendations, AABT ended with a surplus for the years 2001 and 2002. A few examples of these recommendations included eliminating the position of the Assistant to the Executive Director, putting a freeze on hiring a Membership/Marketing Manager, and eliminating the spring board and publications meetings. The Board now holds monthly conference calls instead. A projected surplus in the next three years is expected. The organization looks very fiscally healthy.

VIII. President's Report

Richard Heimberg reported how at the beginning of his presidency, there was a belief that the organization was having serious financial problems. He stressed how much work had gone on with the board officers and the Central Office staff to address this. The organization was conservative on spending money, making sacrifices and budget cuts; now, however, the organization can worry less and enjoy using the surplus to grow. His presidential priority had been about budget spreadsheets instead of membership issues.

He introduced the President for 2003, Dr. Jacqueline Persons, and said how pleased he is that she has this position.

Dr. Heimberg gave a big thanks to all the people involved in helping to bring the positive changes in the organization during his presidency. He thanked all the staff for their efforts and commented that he always had felt welcome when he visited the Central Office. He encouraged everyone to visit the Central Office, meet the staff, and see what they do. He announced that the organization now has a strong budget and can move forward on other issues.

IX. Transition of Officers

President Heimberg announced the new officers. The President-Elect is Patricia Resick. The Representative-at-Large is Martin Antony. The new President is Jacqueline Persons.

X. Comments from the Membership

He then turned the presidency and the meeting over to Jacqueline Persons. She asked if there were any comments from membership.

One member brought up the re-emergence of behavioral medicine in a Special Interest Group. He noted that AABT has always been a friendly organization for empirically oriented psychiatrists, in particular, physicians. He has become sensitized to the issues from the other side and feels that since we have some surplus funds we should offer CE credits for physician colleagues. This would be a tremendous opportunity for collaboration with empirically oriented physician colleagues. Although this involves cost, this endeavor would provide room for increase in membership and a synergy of the two fields. Dr. Persons agreed that this is a great idea, that the organization should investigate it.

XI. Adjournment

President Persons asked if there were any other comments from membership.

There being no other comments, the meeting was adjourned at 7:30 P.M.

Classifieds

Positions Available. $4.00 per line. Contact sschwartz@aabt.org for information about placing an ad.

Positions Available

POSTDOCTORAL OR STAFF POSITION IN COGNITIVE THERAPY. Beginning Summer or Fall of 2003. Commitment to the CBT model is essential. Applications will be accepted until a suitable candidate is found. Send a Vita, statement of experience and interest, and three letters of reference to Dr. Robert Leahy, Search Committee, American Institute for Cognitive Therapy, 136 East 57th St., Suite 1101, New York, NY 10022. www.CognitiveTherapyNYC.com or email to Leahy@CognitiveTherapyNYC.com

POSTDOCTORAL RESEARCH FELLOWSHIP IN SUBSTANCE ABUSE. Research fellowship position (2-3 yrs) is available in a stimulating and productive clinic. Participate in the develoment, conduct, and publication of studies on behavioral treatments for cigarette smoking among pregnant women and for cocaine dependence. Applicants must have completed doctoral training in psychology and have research experience. Individuals from disadvantaged groups are enouraged to apply. Competitive stipends. Send letter of interest, vita, and letters of reference to Stephen T. Higgins, Ph.D., University of Vermont, Dept. of Psychiatry, 38 Fletcher Place, Burlington, VT 05401-1419.

CLINICAL DIRECTOR, CENTER FOR ANXIETY AND RELATED DISORDERS AT BOSTON UNIVERSITY. Available in the Summer of 2003. This individual will have principal responsibility for clinical operations at the Center for Anxiety and Related Disorders (CARD). This will include working closely with the clinic administrator to ensure highest levels of patient care in this large teaching and research clinic with approximately 500 new admissions per year. Clinical supervision of doctoral students in clinical psychology and psychiatric residents, as well as teaching a graduate seminar on clinical issues, will comprise a major part of the duties. Participation in on-going research, while not discouraged, IS NOT part of the job description, nor is grant writing expected. The position requires experience with anxiety disorders and strong CBT skills and the ability to work collaboratively. Level of appointment will be at the clinical associate professor or above, although an individual with somewhat less experience may be considered. The compensation package will be $75,000 plus. Please send a vita and three letters of recommendation prior to April 1, 2003, to: David H. Barlow, Ph.D., Professor of Psychology & Director, Center for Anxiety and Related Disorders, Boston University, 648 Beacon Street, 6th Floor, Boston, MA 02215-2013.

SUMMER RESEARCH TRAINING IN CLINICAL PSYCHOLOGY FOR ETHNIC MINORITY STUDENTS. The University of Oregon Summer Research Training Program in Clinical Psychology is an internship that provides ethnic minority undergraduate students with training under the guidance of a faculty member. Funded in part by the National Institute of Mental Health, this year's 6-week mentorship will run from June 23 to August 1, 2003. The purpose of the program is to prepare students for graduate study in clinical psychology. In addition to learning about research with individual faculty mentors, students participate in a clinical research methods course and attend research presentations by other program faculty. Students write a paper on their research area and make presentations in a joint symposium at the end of the program. Participating students receive a tuition waiver, free on-campus room and

board, a research stipend of $2000 and 4 academic credits from the University of Oregon. Social activities including field trips will also be part of the experience. Candidates must be U.S. residents, have completed their junior year by July 2003 and submit a completed application by April 1, 2003. For more information visit our website at http://darkwing.uoregon.edu/~gnhall/summer/ or contact Dr. Gordon C. Nagayama Hall, University of Oregon, 1227 University of Oregon, Eugene OR 97403-1227, phone 541-346-4969, email gnhall@darkwing.uoregon.edu.

BEHAVIORAL PSYCHOLOGIST. Behavior Therapy Associates seeks cognitive-behavior therapist to join successful private practice on full-time basis. Strong background in assessment/treatment of full range of child and adolescent disorders required. Expertise in AD/HD desirable. Must have passion, combined with creativity, for self-marketing and desire to be free of managed care. Send resume: Steven B. Gordon, Ph.D., ABPP, Behavior Therapy Associates, P.A., 35 Clyde Rd., Suite 101, Somerset, NJ 08873. Call 732-873-1212.

RESEARCH PSYCHOLOGIST FOR THE RHODE ISLAND MIDAS PROJECT (MIDASproject.org). License or license-eligibility required. Diagnostic evaluations and 40-50% protected time for manuscript and grant writing. Email letter of interest and CV to Mzimmerman@Lifespan.org

BEHAVIORAL PSYCHOLOGIST. Multidisciplinary practice in suburban Philadelphia seeks licensed psychologist for full or part time. Must have strong training in CBT and desire to practice free of managed care. Fax vita to Margaret Sayers, Ph.D. 215/396-1886 ✍

Call for Candidates

EDITOR of *Behavior Therapy*

Candidates are sought for Editor-Elect of *Behavior Therapy*, volumes 37 to 40. The official term for the Editor is January 1, 2006, to December 31, 2009, but the Editor-Elect should be prepared to begin handling manuscripts at least 1 year prior.

Candidates should send a letter of intent and a copy of their CV to Arthur Freeman, Ed.D., Publications Coordinator, AABT, 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008 or via email to teisler@aabt.org

After an initial screening by the Publications Committee, successful candidates will be asked to prepare a vision letter in support of their candidacy. David Teisler, AABT's Director of Publications, will provide you with more details at the appropriate time. Letters of support or recommendation are discouraged. However, candidates should have secured the support of their institution.

Questions about the responsibilities and duties of the Editor or about the selection process can be directed to David Teisler at the above email address or by phone at (212) 647-1890.

Letters of intent MUST BE RECEIVED BY June 1, 2003. Vision letters will be required by October 1, 2003. The Editor will be selected at AABT's Board of Directors meeting in November.

1 1/2-hour tapes

WORLD ROUNDS

VIDEOTAPES

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.

COST PER TAPE

☐ Member: $ 55.00 ☐ Nonmember: $ 100.00 • Shipping & Handling: $5.00 • Overseas postage: $10.00

• *Buy the Whole Set: Take 10% off and pay no shipping* • **Please put a check mark next to the videotapes of your choice**

Total No. of Tapes _____ Total Amount Due $ _____

Name _____

Street _____ City _____

State/Province _____ ZIP _____

Please send check or money order payable to AABT drawn from a U.S. bank. Do not send cash.

☐Visa ☐MasterCard Expiration Date _____

Card No. _____ Signature _____

the Behavior Therapist

Association for Advancement of Behavior Therapy
305 Seventh Avenue, 16th Floor,
New York, NY 10001-6008

Tel: (212) 647-1890 Fax: (212) 647-1865
e-mail: publications@aabt.org
www.aabt.org

Address Service Requested

PRSRT STD
U.S. POSTAGE
PAID
Hanover, PA
Permit No. 4