

# the Behavior Therapist

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### SPECIAL SERIES

## Is It Time for AABT to Change Its Name?

Martin M. Antony, *AABT Representative-at-Large, Anxiety Treatment and Research Centre, St. Joseph's Healthcare, Psychiatry and Behavioural Neurosciences, McMaster University*

At the November 2002 meeting of AABT's Board of Directors, there was a brief discussion regarding the possibility of changing the name of AABT. There was enough support for the idea that the Board thought it would be useful to involve AABT members in a discussion regarding the possibility of a name change. As a first step toward introducing the issue to members, AABT President Jacqueline B. Persons published in the January 2003 issue of *the Behavior Therapist* a column advocating that AABT members consider changing the name of the organization to the Association for Behavioral and Cognitive Therapies.

Since that time, Jackie Persons's column has generated much discussion and debate. Dozens of e-mails on both sides of the issue were posted to the AABT listserv throughout the early part of this year. Reactions to the possibility of changing AABT's name were strong, ranging from members applauding the suggestion to members voicing strong opinions that the name not change. Some members suggested other possible names, as well. The listserv discussion was very useful (my own views on the issue shifted a number of times as a result of members' postings). However, many AABT members are not members of the listserv, and therefore have not had an opportunity to participate in the discussion. So, the Board suggested that I (in my role as Representative-at-

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Large) organize some further discussion on  
this issue for possible publication in *tBT*. In  
an effort to keep the debate as fair as possi-  
ble, we decided that an equal number of  
statements, from members of similar  
stature, be presented on both sides of the  
issue. In the end we decided to invite two  
student members and two former AABT  
presidents to participate in this debate. Our  
thinking was that former presidents would  
have a strong knowledge of the inner work-  
ings of AABT, as well as an appreciation of  
AABT's history. On the other hand, stu-  
dent members have to live with any deci-  
sion that is made, perhaps for much longer  
than the rest of us. Obtaining student per-  
spectives on a possible name change there-  
fore seemed particularly important.

As you read these statements, keep in  
mind that this is not the first time a name  
change has been suggested. In fact,  
*Association for Advancement of Behavior  
Therapy* is not the original name that AABT  
held when it was founded in 1966. The  
original name of AABT was *Association for  
Advancement of Behavioral Therapies*. It was  
actually a letter to Cyril Franks (AABT's  
founding president), written by G. Terence  
Wilson and Ian Evans (at the time, students  
at the University of Witwatersrand in  
Johannesburg, South Africa), that led to  
AABT's current name (Wilson & Evans,  
1967). It is noteworthy that both of the in-  
dividuals who argue against adding "cogni-  
tive" to AABT's name in the current issue  
of *tBT* suggest instead that AABT go back  
to the name it started with some 37 years  
ago.

This is also not the first time that there  
has been discussion about adding "cogni-  
tive" to AABT's name. In fact, in a vote  
during the early 1990s, members narrowly  
defeated a motion to do just that. More  
than 65% of members participated in the  
vote (a very high response rate), with 51%

voting to retain the name AABT, and 48%  
voting to add "cognitive" to the name.

As a member of AABT's Board, I want  
to reassure members about the process by  
which decisions regarding a name change  
will be made. The initial stages will con-  
tinue to involve discussion and feedback by  
members regarding the issue. If there is  
considerable support for such a change, the  
next stage would be to have a formal vote  
by members, perhaps several months later.  
In the end, it is the members who will make  
the decision. In the meantime, I encourage  
you to participate in the discussion and de-  
bate through postings on the AABT list-  
serve, Letters to the Editor of *the Behavior  
Therapist*, and relevant venues at the AABT  
convention.

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Behavior therapy and not the behavior thera-  
pies. *Newsletter of the Association for the  
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✍

### INSTRUCTIONS FOR AUTHORS

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

■ **Feature articles** that are approximately 16 double-  
spaced manuscript pages may be submitted. ■ **Brief ar-  
ticles**, approximately 6 to 12 double-spaced  
manuscript pages, are preferred. ■ **Feature articles**  
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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  
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## Let AABT Grow to Fit Its Already Large Label

Steven C. Hayes, *University of Nevada*

Going beyond the obvious issues of expense and market confusion, the proposed name change seems poorly timed, for two reasons. First, the traditional “cognitive / behavioral” distinction is becoming less important, not more, within the behavior therapy tradition as broadly conceived. The old battles and distinctions are just not worth emphasizing anymore. Normally, that might argue for a longer list of terms, but the second reason implies staying put for the time being: Changes outside of our tradition make this specific name change undesirable because of its narrowing connotations.

If we mean “cognitive” and “behavioral” in the sense of specific content domains that refer to different aspects of psychological functioning, then obviously we need both terms. Everyone within the behavior therapy tradition would agree with that. If that is the point of the name change, however, perhaps the list should be considerably longer. It should include “socio” and “bio,” for example, and maybe “spiritual,” and of course “emotive.” If we mean underlying theory and approach, we might benefit by both. There are good cognitive theories of overt action and good behavioral theories of cognition. But if that is the point of the name change, we again need still more, since the empirical clinical wing that AABT represents incorporates constructivist theories, developmental theories, and so on. Furthermore, the newest forms of behavior therapy from within both behavioral and cognitive wings are becoming more alike. New “cognitive” approaches such as Mindfulness-Based Cognitive Therapy share a stronger resemblance to the new “behavioral” approaches such as Dialectical Behavior Therapy or Acceptance and Commitment Therapy and vice versa than either do to their home traditions. No one is quite sure how this rise of new-wave behavior therapies will all shake out but it seems better to wait and see than to change a long-established name.

In the years since AABT’s founding, the word “behavioral” has become far broader than it once was. We need to recognize the simple fact that “behavioral” in the culture at large has come to refer to the entire domain of human psychosocial functioning. For example, insurance companies, federal

agencies, providers, and others now accept the term “behavioral health” to mean the fields of mental health, substance abuse, and the psychological aspects of physical disease. That covers everything currently in AABT, as well as allied areas that we want to attract. The fields of psychiatry, psychology, and so on are all “behavioral sciences.” The federal government has its “decade of behavior” and in the hands of the federal funders “behavior therapy” is as broad as behavioral science itself. For example, the joint program announcement of the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) on “behavior therapies development” (PA NUMBER: PA-03-066) says,

This program announcement (PA) reaffirms NIDA’s and NIAAA’s continued and ongoing commitment to major programs of research on behavioral therapies. The term “behavioral therapies” is used here in a broad sense and includes various forms of psychotherapy, behavior therapy, cognitive therapy, family therapy, couples and marital therapy, group therapy, skills training, counseling, and other rehabilitative therapies.

The same process has occurred within psychology. For example, the American Psychological Association (APA) and the American Board of Behavioral Psychology (ABBP) both use the term “behavioral psychology” to recognize a broader specialty that includes more specific traditions such as behavior analysis or cognitive therapy. A person getting ABBP certification in cognitive therapy does so through the program in behavioral psychology. When APA Council recognized that our field was a specialty (at the behest of a combined proposal from all of the major U.S. associations representing cognitive therapy, cognitive behavior therapy, behavior therapy, and behavior analysis . . . including AABT), it placed all of the more specific traditions under the umbrella “behavioral psychology.”

AABT itself has become broader and broader over the years. In essence, it now covers all empirical clinical intervention to a degree. AABT can’t use “psychological” anywhere in its name because it is multidisciplinary. The term for that multidisciplinary domain has become “behavioral.” This

all happened after AABT was named, but it is good for us and positions us for growth. All we have to do is to define the “behavioral therapies” much as has been done already by the federal government—to refer to empirical psychosocial approaches. Seen in that way, the word “cognitive” may narrow opportunities for a broader group self-definition just when we are positioned to claim the entire mantle of clinical interventions focused on human functioning.

All behavior therapists, cognitive therapists, behavior analysts, and cognitive behavior therapists in the United States are already well aware of AABT. Changing the name will be unlikely to attract new members from within those groups. But there are many in behavioral health who do not see AABT as their main group if they see it at all. They would be even less likely to see it that way if the name changes. This name change will narrow the market focus and growth potential of AABT, with no real market benefit other than warm, muscley feelings on the part of some. That is too high a cost.

If we want to change our name, a better choice would be to change it to something that really pushes the accelerator down on this fortuitous link (e.g., the *Association for Advancement of Behavioral Health* or some such. Indeed, the name that was the runner-up when AABT was originally named now seems very apt: the *Association for the Advancement of the Behavioral Therapies*). Another reasonable choice is to change the name but focus it on empirical clinical approaches. That might also broaden our market in a good way, but perhaps not as much as leaving it alone and broadening or embracing the changes in language that have occurred outside of our group.

Ideally, AABT would have a name that does not confuse or mislead and that properly balances inclusivity and specificity both in the eyes of members and interested non-members. Superficially, expanding the name in the manner proposed seems more inclusive, but in the present context it could have the exact opposite effect. The name change is not really important, especially in the short term. In the longer term, however, it runs the risk of ossifying and narrowing what should be left flexible and broad—at least until we see more clearly where these rapid changes are headed. This specific proposed name change is the wrong step taken at the wrong time for the wrong reason. It is not worth the expense or risk. ✍

## “A Rose by Any Other Name” Versus “A Boy Named Sue”

Arthur M. Nezu, *Drexel University*

My enigmatic title represents opposite perspectives regarding the possibility of changing the name of AABT. On one hand, as Shakespeare aptly posited, it is the substance of an entity that counts, rather than the name we call it. On the other hand, according to Johnny Cash’s melodious retort, a name, in fact, *does* shape one’s substance.

Let me be direct—I am very much for our name to be changed to the *Association for Behavioral and Cognitive Therapies*. This declaration is not without some nostalgic reluctance—I have been a member of this august and pioneering association for close to a quarter of a century. I have served in many capacities on behalf of this organization, most notably as its president from 1999 to 2000. I am very fond and proud of what it has been, what it is now, and where it is going. Change at times is hard, especially if we cannot understand why something needs to be changed. Allow me to give my perspective.

Let’s take a close look at our current name, *Association for Advancement of Behavior Therapy*. As I understand history, the logic used by AABT’s founding parents behind incorporating the term “advancement” was to create the desired perception by members of other orientations and philosophies that behavior therapy was inexorably linked to a scientific perspective. Hence, to foster such a persona, they borrowed part of the title from another august organization: *American Association for Advancement of Science*. Therefore, by including that term, AABT’s initial name both *denoted* members’ stake in promoting a behavioral approach, as well as *connoted* their embracing of a worldview that promulgated the use of scientific principles.

Is this connotation still relevant? I believe that the simple fact that our organization exists suggests that we are in favor of advancing our work; otherwise, we would not exist. Dropping this part of our name does not indicate that our fervor for seeing our discipline advance has waned. We will always support “advancement.” However, I do not think we need that part of our name any longer. Historically, it has served us well, but now I think it is redundant.

Let’s focus on the second part of our name—“behavior therapy.” What is behavior therapy? To borrow another quote from Shakespeare, “that’s the rub”—because, in part, how we define behavior therapy would seem to sway one to be in support of or against a name change. I have previously defined behavior therapy as “an experimental-clinical framework [that] incorporates a broad definition of behavior [including] overt actions, internal cognitive phenomena, and the experience of affect or emotions. These components range in complexity from molecular (i.e., lower-level) events (e.g., smoking a cigarette, hyperventilation, a critical comment in a dyadic interaction) to molar (i.e., higher-level) pluralistic and multidimensional constructs (e.g., complex social skills, solving a difficult calculus problem, major depressive disorder)” (Nezu, Nezu, Friedman, & Haynes, 1997, pp. 368-369).

This definition, by default, suggests that “behavior therapy” should be the overarching umbrella term that includes intervention strategies that have their conceptual roots in associative learning theory, operant learning theory, social learning theory, as well as experimental cognitive psychology. As previous chair of the Behavioral Psychology Specialty Council, current president of the American Board of Behavioral Psychology, previous member of the Council of Specialties in Professional Psychology, current member of the Board of Directors of the American Academy of Behavioral Psychology, and member of the original task force responsible for obtaining formal recognition of behavioral psychology as a specialty by the American Psychological Association, I am intimately familiar with the notion that the term “behavioral” functions as an all-encompassing label. For example, psychologists interested in applying for a diplomate in behavioral psychology from the American Board of Professional Psychology are able to do so by demonstrating competence in any (or all) of the following four subareas of “behavioral psychology”: behavior therapy, cognitive therapy, cognitive-behavior therapy, and applied behavior analysis. Given this, it would seem to make more sense that I should be in favor of retaining our current

name to be consistent with these other organizations.

On the contrary—if I had the opportunity, I would change the names of these other professional entities, simply in order to prevent having to constantly and consistently explain that “behavior therapy” is the term used in these contexts as an umbrella label. As current chair of the World Congress of Behavioural and Cognitive Therapies (WCBCT), I am also familiar with the names of similar organizations around the world. Although not all of them use both “behavioral” and “cognitive” in their names, it is the collective agreement by scores of individual organizations around the world to come together under a name that incorporates both elements (i.e., WCBCT). This includes AABT.

It is especially for this reason that I advocate a name change—to be perceived by future potential members as being more *inclusive* than *exclusive*. I believe the name Association for Behavioral and Cognitive Therapies does just that. It suggests that integration is more intellectually profitable than being a separatist.


However, is this simply caving in to political correctness? Or is it conceptually and practically more representative of reality? While pondering this name change, I was simultaneously putting the finishing touches on a text regarding cognitive-behavioral case formulation and treatment planning (Nezu, Nezu, & Lombardo, in press). In writing this book, my colleagues, Christine and Elizabeth, and I delved into the empirical and clinical literature regarding a range of treatment targets and interventions concerning common disorders seen in outpatient settings. Without exception, each disorder or problem was characterized by *both* behavioral and cognitive explanatory constructs, as well as interventions that emanated from such conceptualizations. Moreover, the synergy between such treatment strategies was found to increase treatment efficacy, not hinder it.

In sum, this new name would connote inclusion and synergy. This change is not to curry favor for the sake of political correctness, but because the proposed new name actually represents reality. So, is it Shakespeare or Johnny Cash? If I had to spend an afternoon listening to a Shakespearean soliloquy or Johnny Cash’s groveling voice, I would have to cast my vote for the bard. But with regard to the name change, Cash’s perspective gets my endorsement!

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## References

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## Call for **Workshop Submissions**

Suggestions for Workshops are welcomed. A 250-word abstract and a CV for each presenter must accompany any suggestions. Please send workshop suggestions to: Lizabeth Roemer, Ph.D., Dept. of Psychology, University of Massachusetts at Boston, 100 Morrissey Blvd., Boston, MA 02125. Lizabeth.Roemer@umb.edu **DEADLINE:** February 1, 2004

AABT's 38th Annual Convention — Nov. 18-21, 2004 — New Orleans

## Naming the Change of AABT: Implications for Recruitment and Treatment Utilization

Todd A. Smitherman, *Auburn University*

In a recent issue of *the Behavior Therapist*, AABT President Jacqueline Persons (2003) supported the idea that our organization change its name to the Association for Behavioral and Cognitive Therapies. In the time since, AABT members have actively discussed, on the AABT listserv and amongst themselves, a possible name change. The November 2003 convention in Boston will undoubtedly serve as another venue whereby a name change can be discussed, both formally and informally, by a large number of AABT members. Changing the name of our organization is not a trivial act. The implications of a name change are large for the future of what is currently known as AABT, and changing the name appears to hold promise for increasing AABT membership, popularizing treatment strategies, and describing the makeup of our organization more accurately.

When I joined AABT as a student member 3 years ago, I was a first-year graduate student with only limited exposure to behavioral and cognitive therapies. To me, AABT was largely identified with various forms of behaviorism, and I had some initial reservations about becoming part of an organization built on a theoretical focus that most psychologists believed was narrow, superficial, or otherwise inadequate. I aligned myself with AABT but was to a large extent unfamiliar with what AABT encompassed. It was not until later, after I had joined AABT, learned more about behavioral approaches, and further developed my own theoretical identity that I realized that my initial conceptions about AABT were wrong. Not only were there radical behaviorists and neobehaviorists in AABT, but there were also cognitive therapists, func-

tional analytic therapists, and even therapists who adopted mindfulness and acceptance-based approaches as integral parts of their clinical work.

By no means are these latter approaches in opposition to the goals of behavior therapy; in fact, they fit quite nicely within the behavior therapist's focus on reducing symptomatic and functional impairment via short-term, directive interventions. One might even argue that a name change is not needed, because "behavior therapy" now embodies many varied approaches. The problem, though, is that much of the general public and even a significant portion of those in our profession do not appreciate the multifaceted nature of contemporary behavior therapy. Potentially, changing the name of AABT would help attract more clients as well as members, particularly well-educated clients and prospective members who are cognitively oriented. The benefit of a name change for recruiting interested student members would also be noteworthy, assuming that there are many other students who, like myself, initially thought of behavior therapy as ignoring cognitive and other factors that historically have been outside the purview of behaviorism.

Changing the name of AABT might also yield benefits in terms of broadened treatment credibility. AABT members have a history of developing and espousing treatments that have been shown in relatively well-designed research to be effective for alleviating human suffering. Concern with efficacy has, in fact, been the feature of behavior therapy that has contributed to its acceptance by managed care companies and by psychologists who value empiricism. Cognitive-behavioral therapies have cer-

tainly garnered a substantial amount of empirical support in treating people who manifest a variety of conditions. This being the case, it now seems appropriate to highlight their demonstrable efficacy by changing the name of AABT so as to reflect the incorporation of cognitive strategies.

Radical behaviorists and others might argue, and rightfully so, that cognitive activity is a form of behavior and thus there is no need to isolate cognitive approaches explicitly. We must guard against taking this argument too far, however, because we run the risk of making "behavior" a catchall term devoid of significant meaning. Virtually all approaches to psychological treatment are intended to promote behavior change at some level, but we do not include many of them under the behavior therapy rubric. Many factors have contributed to the categorization of certain treatment strategies as behavioral, as well as to the incorporation of cognitive techniques within the realm of behavior therapy. Suffice it to say that the incorporation of cognitive techniques into behavior therapy was in large part influenced by the theoretical pluralism of neobehaviorism, the zeitgeist surrounding the "cognitive revolution," factors related to the theoretical orientations of the developers of treatment models, and the nature and goals of the interventions espoused. The cumulative effect of such factors placed cognition and cognitive techniques cheek by jowl with behavior therapy, adding force to the behavior therapy movement at a time when its momentum seemed to be declining. Incorporating the term "cognitive" into our name would reflect our acknowledgment of these historical processes as well as the embodiment of cognitive approaches within behavior therapy.

Finally, changing the name of AABT would more accurately reflect the interests and clinical activities of our current membership. The influence of cognition surrounds our organization in all facets but its name. The subtitle of *Behavior Therapy* reads, "An International Journal Devoted to

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*continued from p. 366*

the Application of Behavioral and Cognitive Sciences to Clinical Problems.” The title of our most recent journal, *Cognitive and Behavioral Practice*, likewise reflects the shift of our organizational frame of reference. Our membership is comprised of many professionals who think of themselves as cognitively oriented. Therefore, changing the name of AABT is not merely about changing the name; it is about naming the change that AABT has undergone in recent years.

**Reference**

Persons, J. B. (2003). The Association for Behavioral and Cognitive Therapies: An idea whose time has come. *the Behavior Therapist*, 26, 225. ✍

*2004 Call for Nominations*

The first phase of AABT’s 2004 election process is under way: the nomination of qualified full members for the positions of President-Elect (2004-2005) and Representative-at-Large (2006-2009).

**Every Nomination Counts!** Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 2, 2004, will be counted.**

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

**NOMINATE** the Next Candidates for AABT Office

*I nominate*  
the following individuals  
for the positions indicated:

PRESIDENT-ELECT (2004–2005)  
\_\_\_\_\_  
\_\_\_\_\_

REPRESENTATIVE-AT-LARGE (2006–2009)  
\_\_\_\_\_  
\_\_\_\_\_

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## Would an AABT by Just Any Other Name Smell as Sweet?

Brandon A. Gaudiano, *Drexel University*

I am a doctoral student in a clinical psychology program rooted in the scientist-practitioner tradition who identifies himself as a behaviorally oriented clinician and researcher. A student member of AABT since 1999, I noted with considerable interest the announcement that a vote would be taken to determine if the name of this organization should be changed. After listening to the thoughts of fellow students and notable AABT members on this subject, I have come to the conclusion that changing the name of AABT might be beneficial. As some have argued, the current name may sound old-fashioned to some and an update could help to encourage new membership. However, I disagree with the suggestion that AABT should adopt the proposed Association for Behavioral and Cognitive Therapies (or some such variation on this theme). Instead, I suggest that a different name be considered—Association for Advancement of Behavior Therapies.

It is understandable that many would argue that the name be changed to include the word “cognitive” in the title. Many current members of AABT, as well as many prospective and student members, would likely identify themselves as cognitive-behavioral in their orientation. Therefore, adding “cognitive” to the title might well attract new members. Gaining new members, and retaining old ones, is of critical importance to the long-term viability of the organization.

However, more than marketing should be considered in the decision to change the organization’s name. What has always attracted me to AABT is that it not only promotes the advancement of behavior therapy and assessment, but that it is also, at its heart, a scientific organization. With the current disappointing state of affairs within the American Psychological Association, where science often is given short shrift in the service of guild interests, AABT has been an organization where scientific practitioners could find a satisfying home. The organization always has made its aim the advancement of the science of behavior therapy, and I would argue that any change that would undermine the integrity of this tradition would be ill-advisable. Here are two points to consider.

1. *What makes cognitive interventions effective?* First, let me be clear that my comments are in no way meant to demean the significant advancements brought about by cognitive therapists within AABT and the larger professional community. The proposals of neobehaviorists such as Bandura, Beck, Ellis, Meichenbaum, and others helped bring about a paradigm shift within the field. Classic behavior therapy was forever altered so that maladaptive cognitions and emotions were as legitimate a focus of treatment as overt behaviors. However, in recent years, while the empirical support for studying and targeting cognitions and emotions continues to receive substantial support, the use of strictly cognitive interventions (i.e., techniques where the theorized mechanism of action is the direct modification of cognitions through verbal means) divorced from their behavioral underpinnings has not continued to receive substantial support. Although beyond the scope of the current discussion, some notable examples are studies by Jacobson and colleagues (1996), McLean and colleagues (2001), and Borkovec, Newman, Pincus, and Lytle (2003) on cognitive behavior therapy for major depression, obsessive-compulsive disorder, and generalized anxiety disorder, respectively. These studies failed to demonstrate the incremental efficacy of cognitive strategies above and beyond more traditionally behavioral ones. Although currently the data can still best be described as preliminary and suggestive on the matter, further research on this topic will be of fundamental importance to the field in the foreseeable future.

2. *“Cognitive therapy” is a behavioral intervention.* There exists no empirically supported “cognitive therapy” that does not rely heavily on basic behavior therapy principles and techniques. For example, Beck’s cognitive therapy for depression (Beck, Rush, Shaw, & Emery, 1979) includes behavioral activation and “behavioral experiments” that have been shown to be fundamental to the effectiveness of the treatment. In other words, cognitive therapy is a brand of behavior therapy. Therefore, making a false distinction between behavioral and cognitive therapies in the title of the organization would only fos-

ter this misconception (especially in the minds of new members), and may further divide members who identify themselves more with one tradition than the other.

At this point, some may conclude that the organization’s name should be changed to include “cognitive behavior therapy” in the title. However, now I will present two reasons why the term “behavior therapies” is preferable.

1. *Where do the newer behavior therapies fit in?* Hayes (in press) argues that a “third wave” of behavior therapy is on its way, and can be witnessed in interventions such as Dialectical Behavior Therapy (DBT; Linehan, 1993) and Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999). Although these interventions build upon classic behavioral or cognitive-behavioral approaches, they also appear to go beyond those traditions in their emphases on acceptance, mindfulness, and contextualism. These third-wave behavior therapies are amassing a growing body of empirical and popular support with AABT members, although it remains to be seen whether they ultimately will deserve this distinction. This then begs the question: In the near future, will the organization require yet another name change? The Association of Behavioral-, Cognitive-, and Mindfulness-Based Therapies?

2. *The behavioral glue remains.* Several broad classifications can be made at the level of technique: behavior therapy (e.g., in vivo exposure for specific phobias), applied behavior analysis (e.g., behavior modification techniques for pervasive developmental disorders), cognitive behavior therapy (e.g., behavioral activation and cognitive restructuring for depression), and mindfulness/acceptance-based behavior therapy (e.g., DBT for borderline personality disorder). How different these approaches are in mechanisms of action is an empirical question that requires much more research. However, the unquestionable link between these approaches is that they all are solidly rooted in a classic behavior therapy.

In conclusion, a change that would include adding “cognitive therapies” to the title would not only fail to be parsimonious based on current research, but would promote the questionable dichotomy between “cognitive therapy” and “behavior therapy.” The name change would further be complicated by the newer behavior therapies, such as ACT and DBT, that do not fall neatly into old categories, at least theoretically. Therefore, changing the name of the organization to Association for Advancement of Behavior Therapies (still AABT) might

help to promote a renewed discourse between these various types and flavors of behavior therapy, which currently are all being housed comfortably within the organization. Instead of reinforcing the artificial distinctions between cognitive and behavioral traditions, this proposed name change would help us recognize our common foundation, continue to highlight and promote behavior therapy to the public, and most accurately reflect the scientific state of affairs within the field.

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## Governing the AABT

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



I have recently become convinced that AABT would benefit from strengthening its governance system, and I'd like to share my thinking here.

The AABT is governed by a seven-member board consisting of the president, president-elect, past president, secretary-treasurer, and three representatives-at-large. The board is responsible to the members for the health and well-being of the organization. The day-to-day operations of the organization are handled by our staff, led by our long-time executive director, Mary Jane Eimer. Many members serve as editors of our newsletter, journals, and Web site, and as coordinators, committee chairs, and committee members; they too play key roles in our day-to-day operations.

A strong governance system is essential to the smooth functioning of a complex organization like the AABT. A good governance system clearly specifies the roles and duties of staff, officers, and members, and also specifies how they relate to one another. It provides a clear chain of command and tight accountability. The result is a stronger, more effective organization. In the case of the AABT, where members are busy professionals with many obligations and staff are themselves pulled in many directions, it is particularly important to have an efficient governance mechanism.

The governance initiative I describe below builds on the work of many who preceded me. Art Nezu, during his presidential term, initiated efforts to clarify and strengthen our committee structure, and he pushed the activity level of board members

up a notch by instituting monthly board meetings, which have been invaluable. During their presidential terms, Marsha Linehan and Rick Heimberg stepped forward to take hands-on and active leadership roles, as did our current secretary-treasurer, Alan Gross, and his predecessor, Ron Drabman.

The AABT's board and staff (including M. J. Eimer and her two senior staff members, Mary Ellen Brown and David Teisler) have recently begun tackling governance issues in the board meetings. We are currently in the beginning stages of what I hope will be a sustained effort to strengthen our governance system. We have all read a book about policy-based governance written by John Carver (*Boards That Make a Difference*), and we are examining whether Carver's model of policy-based governance is a good fit for the AABT.

A policy-based governance system relies on four types of policies: ends, executive limitations, board-staff relationship, and governance policies. Ends policies describe what difference the organization strives to make in the world. *Executive limitations* policies focus on what means will be used to reach the ends; these policies describe principles of prudence and ethics (e.g., not spending money we don't have) that staff and members must follow as they try to accomplish the ends. *Board-staff relations* policies clarify the roles of board and staff and how they relate to one another. For example, Carver suggests setting the policy that the board speaks to the staff with one voice (versus individual board members setting policy for the staff). *Board governance* policies describe the roles and duties of board members. The goal of policy-based governance is an effective organization in which the lines

of communication, authority, and responsibility are clearly drawn and implemented.

The board has appointed a governance subcommittee to draft some policies for the full board to review, and we have hired an expert in policy-based governance (Vance Yoshida, based in San Francisco) to guide us. We recently carried out a survey of members to give input to the board as it develops ends policies.

My hope is that a stronger governance structure will provide more direction to all of us, members and staff alike, who are committed and work hard for the AABT, so that our efforts and energy are focused and productive. It will produce a stronger organization that does an even better job of meeting members' needs than we do now, and an organization that can continue to play a leadership role in the process of disseminating cognitive-behavior therapy to the professional community and the larger world.

Let me conclude by saying good-bye. My presidential term is nearly over. It has been my privilege to serve the AABT. I would like to thank the staff and the members, particularly M. J. Eimer and my fellow board members, who have worked so patiently with me during my term. If my successors find that the governance efforts I describe here are consistent with their goals, I hope to be able to continue to contribute in that arena.

Finally, I'd like to give particular thanks to several members who, working closely with the staff, made truly outstanding contributions to the AABT in recent months: Debra Hope and David DiLillo developed and implemented a mechanism to process electronic submissions to the 2003 convention, Lynn Marcinko and her students and colleagues have established and maintain a listserv for the AABT, and Bruce Gale has taken on the challenge of serving as the first editor of the AABT's Web site.

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NOVEMBER 20-23

# Behavioral Intervention for Enhancing Instructional Control in Preschool

Assegdetch HaileMariam, *Eastern Illinois University*

Attention is fundamental to the acquisition of new behavior. Before learning occurs parents and teachers need a child's attention (Perry, Cohen, & DeCarlo, 1995). They must make sure that the child is attending to the instruction and that the instruction serves as an easily discriminable cue for a particular response (Schreibman, Koegel, Charlop, & Eigel, 1990). It appears that children who develop good attention skills early may be better prepared for instruction than those who lack attention skills (McEachin & Lovaas, 1993; Olley, Robbins, & Morelli-Robbins, 1993).

Based on the aforementioned, the primary purpose of this case study was to teach the participant basic attending skills using Lovaas's (1981) "Getting Ready to Learn" program so that speech and language skills could be taught. The child in this case study was a preschooler who was referred for evaluation because of language and speech delay. A secondary goal was to demonstrate and stress the importance of a problem-focused and data-based practice for addressing the needs of children, without labeling.

Some of the most promising work for shaping children's behaviors has been conducted by Lovaas. Although it is beyond the scope of this paper to fully present Lovaas's treatment program, it suffices to say that it begins early, is highly structured and behavioral, and closely engages parents (Olley, Robbins, & Morelli-Robbins, 1993). A guiding principle is that the effective management of environmental contingencies, based on the principles and procedures of applied behavior analysis, often results in acquisition of new behaviors (Laski, Charlop, & Schreibman, 1988). Lovaas's interventions are based on operant conditioning principles such as shaping, chaining, discrimination training, and contingency management. Empirical validation has been provided by a number of investigators over the past 20 years (e.g., Newsom & Rincover, 1989; Smith & Lovaas, 1998).

## Method

### Instruments

Current functioning was assessed using both behavioral observation and a broad assessment of adaptive, communication, and

cognitive functioning. Specifically, the Vineland Adaptive Behavior Scales, the Ordinal Scale of Psychological Development, the Cognitive Abilities Scale, and the Battelle Development Inventory were employed. A physical examination, including vision and hearing test, was completed to rule out any physical causes. A reinforcement survey was also completed.

### Procedure

A single-subject A-B design was used. The natural frequency of the behavior under study was first assessed in baseline (A). Then, in the B phase, treatment was introduced. Follow-up data were collected 3 months after termination.

### Intervention

Using Lovaas's "Getting Ready to Learn" program, a two-phase intervention was implemented—"Sit Down" and "Look at Me." To reduce visual distraction, the intervention took place in a fairly uncluttered room; to minimize fatigue, frequent breaks were given; and to increase generalization, the speech therapist and the child's mother were trained and they actively participated as trainers.

**Phase I—Sit Down.** The trainer instructed the child to "sit down" for blocks of 10 trials, three times a session. Failure to respond within 3 to 5 seconds following the trainer's instructions was defined as no response. The intervention was introduced after a stable baseline was established. First, the trainer placed a child-sized chair behind the child, then gave the command to sit down, physically prompting the child into the chair. This was immediately followed by food reward. Second, the trainer asked the child to stand up and physically lifted the child to a standing position. The command to "sit down" was then repeated. The physical prompt was gradually faded so that the child accomplished the act of sitting down and standing up independently. Three 40-minute sessions were used.

**Phase II—Look at Me.** This program consisted of six 40-minute weekly sessions and required slow and gradual shaping. Reinforcers needed to be varied to avoid satiation. After baseline data collection was completed, shaping began at the child's visual field: The trainer held the reinforcer where the child could see it and instructed, "Look at me" every 5 to 10 seconds. Then, any visual approximation was rewarded. Gradually, reinforcers were held at the eye level of the trainer while giving the command to "look at me." Eventually, the child

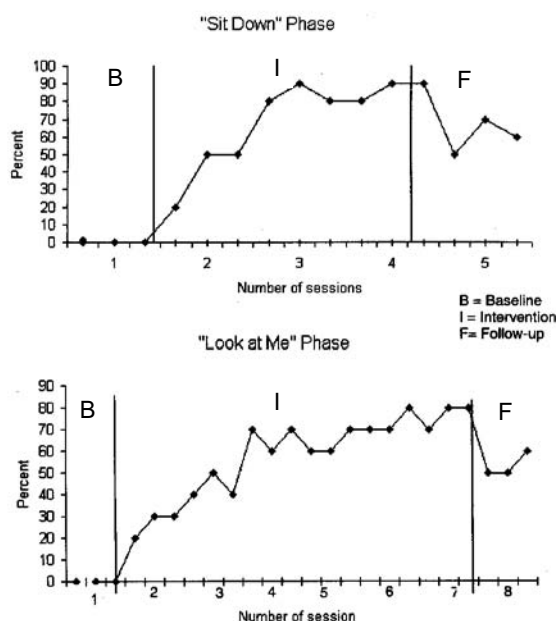


Figure 1. Comparison data for instructional control, sitting, and looking.

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had to look the trainer in the eye within 2 seconds after the command was given and for at least 1 second. Failure to look within the 2-second interval resulted in the trainer's looking away for about 5 seconds. Finally, reinforcers were spaced out (delayed), longer eye contact (e.g., 1, 2, and 3 seconds) was required, and more verbal rewards, such as "Good looking," were given.

### Results

The psychoeducational assessment of this client revealed low-average cognitive skills and below-average communication and social skills. The child's health, including hearing and vision, was within the normal range, and food (e.g., candies) was found to be an effective reinforcer. Baseline data were compared to intervention data. As Figure 1 illustrates, the participant showed better instructional control as the result of intervention. She sat down and got up when instructed, and maintained eye contact when told, "Look at me."

Phase I—Sit Down data indicated 70% improvement in sitting down compared to 0% during baseline. At Phase II—Look at Me, there was a 58% improvement in eye contact compared to 0% during baseline. During follow-up, 3 months after termination, she appeared to maintain the skills. She sat down and maintained eye contact 60% and 53% of the time, respectively. Results were also supported by informal observations. Her parents and school staff reported that the child was more compliant and initiated and maintained more eye contact. As expected, the skills generalized.

### Discussion

A 3-year-old child who presented poor attending skills learned to "sit down" and "look at," using Lovaas's "Getting Ready to Learn" program. A single-case A-B design was used. Results indicated that compared to baseline (0%) the child was under better instructional control for learning. The slightly lower level of compliance at follow-up suggested that continued intervention is needed to maintain as well as enhance instructional control.

The child in this case had not been diagnosed with autism; however, behavior observations led to the presumption that Lovaas's (1981) program would be effective for addressing the presenting problems. The child moved aimlessly from one thing to another, failed to follow directions, and she did not orient or look at a speaker when spoken to. Thus, the major problem interfering with the child's language develop-

ment, as well as the development of other skills, appeared to be lack of instructional controls: lack of sustained attention as evidenced by the absence of eye contact and compliance. In other words, the child was not willing to follow instructions, nor would she imitate. This seemed to be a problem because children learn either through direct instruction or by imitation (Schunk, 1991).

Lovaas's "Getting Ready to Learn" program was successfully used for teaching instructional control. The intervention closely paralleled four of Smith and Lovaas's (1998) approaches for improving intervention outcomes:

1. The intervention was based on operant conditioning principles such as shaping.
2. Instead of focusing on a central problem (labeling), the intervention aimed at alleviating behavior problems: Lack of compliance and attention were targeted.
3. To promote generalization, significant persons in the life of the child (parent and teacher) were involved, across settings (home and school).
4. The intervention was provided during the preschool years, before the child fell far behind her typically developing peers. (pp. 68-69)

Moreover, the study demonstrated and stressed that a problem-focused and data-based approach, using a single-subject A-B design, is an effective technique for addressing and monitoring the needs of this child. Labeling does not often contribute to the development of an intervention, whereas a focus on linking assessment to intervention has clear utility.

Although the long-term benefits of early intervention and parent training, in this case, remain to be seen, the study accomplished its goal of preparing this child for speech and language skills. In sum, the objective of teaching the speech and language skills was possible because of the child's newly acquired attending skills as a result of behavioral intervention provided by school psychological services.

The concern about an uncontrolled case study is applicable here and is a major limitation. Employing an ABAB single-subject design (baseline, intervention, second baseline-withdrawal of treatment, and intervention) would have demonstrated the direct effect of the intervention and should be considered for future research.

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## Open Forum

# Using E-Mail to Facilitate Compliance to Reprint Requests for Convention Poster Presenters: The Poster Police Are Back

Daniel J. Moran, *MidAmerican Psychological Institute*, and Mark Terjesen, *St. John's University*

The Bylaws of the Association for Advancement of Behavior Therapy (2003) state that one of the purposes of the organization is to "serve as a resource and information center for matters related to behavior therapy." The annual convention is considered an information center for its members, and last year 2,122 out of 3,520 members attended the convention in Reno. These scientist-practitioners had numerous opportunities to learn the latest information about cognitive and behavioral therapy. One vehicle of disseminating new information at the conference is the poster session.

Because of the profusion of data and new techniques promoted during these poster sessions, authors usually offer reprints of their poster. These reprints are useful in many ways. The plethora of disparate information seems difficult for an attendee to retain for later use, and it would be cumbersome to take notes at these events. The poster session is usually not conducive for learning, given that it is often noisy, and reading colorful, large-font text posted on a corkboard is certainly different from reading a journal in a library. In addition, reprints can be brought away from the convention and shared with fellow staff and faculty. It is most convenient for the author and the audience to have the poster reprints at the presentation site. Oftentimes, when reprints are not made available on-site, or

when they are depleted by interested research consumers, the presenter solicits addresses on a mailing list, implying a commitment to send the reprints after the conference. Unfortunately, Danyko and McKay (1994) found a disappointing 49% return rate for poster presenters at the 1993 AABT convention.

In an effort to improve return rates, Moran (1995) manipulated response cost for the randomly selected poster presenters at the 1994 AABT convention in San Diego by giving self-addressed stamped envelopes (SASE) to half of the subject pool, while the other half received the author's home address on the mailing list that the presenter provided. Individual antecedent social attention was also manipulated in the investigation. For half of the subject pool, the experimenter either introduced himself and spoke with the presenter about the poster for over 3 minutes, or did not speak to the presenter at all. Chi-square analysis indicated no significant difference based on the four combined conditions. The return rate was 45% for those given social attention and a written address (typical response

cost), and 50% for those not talked to and given a SASE (reduced response cost). The return rates for the groups given attention and a SASE, and not given social attention or a SASE, were 60%. It did not matter if the response cost was reduced, nor if interest was shown in the research. The average return rate in this study was 54%, approximately replicating the coin-flip chances of receiving a reprint calculated by Danyko and McKay (1994).

The fact that interested poster session attendees have about a 50-50 chance of receiving poster reprints is not in line with the scientist-practitioner model that AABT promotes. The present investigation tests if requesting reprints to be sent to an e-mail address might increase return rate. Electronic mail is ubiquitous in academe and clinical settings, and because most of the posters will be generated on a computer, the transfer of information is simple. If an e-mail account is already established, then the mass mailing of the information is practically free. Requesting and delivering electronic reprints is simple, inexpensive, and hypothesized to increase the return rate.

## Method

At the 2002 36th annual AABT convention held in Reno, reprint requests were made to 60 poster presenters who were soliciting contact information for reprints. These requests were only made during 7 of the 14 poster sessions because scheduling conflicts prevented every session to be sampled. Using the convention guide, posters were randomly selected from these sessions prior to the conference. No posters were included if the presenters were colleagues of the authors. If there were multiple posters

TABLE 1: Total Reprints Requested and Received

Category	Requested	Received
Request reprint sent to e-mail	30	18 (60%)
Request reprint sent to postal mail	30	10 (33%)

by the same presenters, only one poster was included to maintain independent data points. If the randomly selected posters provided reprints at the session or violated the inclusion criteria, then the next higher numbered poster without reprints available on-site was included in the study. These flexible criteria were required in order to gather enough data for this field study, thus, strict randomization could not be maintained, which is a limitation to the study.

A 1-x-2 5/8-inch white ink-jet label was placed on each selected poster's mailing list. The labels were placed on the mailing lists during the last 20 minutes of the poster session, and this delay was necessary to increase the number of subjects for the pool, as many presenters have usually distributed their handouts by that time. One group of labels read, PLEASE E-MAIL A REPRINT TO: DANIEL J. MORAN, PH.D., and the e-mail address was on the next line. The other group of labels read, PLEASE MAIL A REPRINT TO: and included the first author's name and full academic address. The same font size and color were used on all the labels.

Address condition (e-mail or postal mail) was randomly assigned. The two conditions were analyzed by chi-square. Data collection ceased 4 months after the last day of the convention. This deadline, also used by Danyko and McKay (1994) and Moran (1995), seemed to allow the presenters adequate time to respond.

### Results

Thirty requests were made of both categories, and the data were based on the actual return rates in each category. More requests were planned in order to increase statistical power, but there were very few presenters without ample reprints. A total of 18 replies were received by e-mail, and 10 replies were received by postal mail. There was no significant difference between requesting methods,  $\chi^2 = 2.285, p > .05, ns$ . The percentage return rate of all requests was 60% for e-mail and 33% for postal mail, and out of all reprint requests combined, the average return rate was 46%. Although these data suggest no significant difference between the two methods, the small sample size decreased power, and similar percentage rates with a larger sample size would indicate a difference, and implies a slightly better chance of compliance if one makes e-mail requests rather than postal mail requests. Although the small sample size negatively impacted this study, it is actually encouraging that so few poster presenters were without reprints. Fortunately

for 2002 AABT convention attendees, there were plenty of reprints available at the poster sites.

An unplanned but important observation was made during data collection at the poster sessions. While making requests for reprints, the investigators noticed a number of posters were inexplicably absent at the sessions. During the three poster sessions surveyed, 18 of the 188 (9.6%) scheduled posters were not displayed. Even more alarming was that only 1 of the 18 missing posters was officially withdrawn in the convention addendum.

### Discussion

The total return rate for reprint requests remains low despite creative ways of increasing request compliance. Although the return rates were not higher than chance when using mailing labels, one recommendation from this research is that it is practical to bring a 30-label ink-jet sheet with your e-mail and postal mail address printed on it. This makes it easier for you to put the address on the mailing list in a manner that is quicker than writing it, and more secure than giving a business card. It may not increase your coin-flip chances of receiving a reprint, but it will save you time at the poster session. Putting both types of mail addresses on the label might allow greater flexibility of compliance for the poster presenter.

Although the authors were not initially investigating whether scheduled poster presentations were displayed or not, the glaring absence of posters prompted an ad-hoc investigation. Unfortunately, 9% of the posters slated for exhibit were not shown, nor were they officially withdrawn. These data are taken from the last 2 days of the conference, and might be inflated, as some presenters may not be able to attend the last day of the conference. However, when submitting an abstract for a poster presentation, the instructions clearly state that the authors are responsible for making sure the presentation is made.

It seems that the most simple and courteous method of disseminating poster information, apart from actually showing up to the poster session, is to provide the reprints at the convention. Because providing reprints may not be within the presenter's budget, authors might consider reducing costs by condensing the margins and font size when they create the reprint documents, and to use single spacing on both sides of the sheet of paper. Desktop publishing technology has made it possible to cre-

ate information-rich documents for a very small cost, and if the authors truly believe their work is important to disseminate, then the small price of providing reprints is indeed a small price to pay for promotion.

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## ADAA Announces Its 2004 Awards Program Call for Applications

Applications available online at:

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### Career Development Award

**Deadline: Monday, December 22, 2003**

This award includes: a travel stipend to attend the ADAA Annual Conference and the invitation only ADAA Scientific Satellite Meeting in March 2004, in Miami, Florida and a second meeting of choice—either the American College of Neuropsychopharmacology (ACNP) or the Association for Advancement of Behavior Therapy (AABT).

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This award includes: a \$30,000 grant to assist young investigators in making the transition from junior faculty to independent researcher of anxiety disorders; a travel stipend to attend the ADAA Annual Conference and the invitation only ADAA Scientific Satellite Meeting in March 2004, in Miami, Florida; a one-year ADAA membership.

For more information on the ADAA Awards, contact Stephanie Seeger, Program Manager, at (240) 485-1025 or at [sseeger@adaa.org](mailto:sseeger@adaa.org).

## Invitation for Contributions to a New International Project: Toward a Common Language of Psychotherapy Procedures

Psychotherapists often use different terms to describe similar therapy procedures and the same terms to describe different procedures. To reduce this confusion and improve scientific communication and research, the Association for Advancement of Behavior Therapy (AABT) and the European Association for Behavioural and Cognitive Therapies (EABCT) set up a task force to evolve a common language of psychotherapy procedures. The AABT members are Marvin Goldfried, Michelle Newman, and George Stricker. The European members of the task force—Stefania Borgo (Italy), Isaac Marks (UK), and Lucio Sibilio (Italy), and a co-opted member, Kathleen Moore, Australian Psychological Society—met twice to start the process, and suggested the following aim and way to proceed.

### Aim

To evolve a dictionary of psychotherapy procedures used by psychotherapists of different perspectives in order to encourage shared use of the same terms for given procedures. The project will *not* lead to an encyclopedia or textbook or theoretical exposition of psychotherapies.

### Principles

- concise descriptions of a comprehensive set of psychotherapy procedures in simple language as free from theoretical assumptions as possible, each with a brief case example and note about its first known use;
- therapists from different perspectives to agree on each description;
- cross-referencing of different terms describing similar therapy procedures;
- revision of dictionary to occur regularly (perhaps every 3 years);
- all interested therapists invited to contribute brief definitions and case examples (up to 450 words) of psychotherapy procedures (*not* theories).

The dictionary will acknowledge contributors of the definitions and case examples it publishes.

**Target Audience:** All psychotherapy and other mental and allied health practitioners, researchers, and students.

This dictionary will describe what psychotherapists *do* in practice (procedures), not why they do it (principles, processes, mechanisms, assumptions). In describing terms that describe psychotherapy it can be difficult to separate procedures from principles, processes, and so forth. The dictionary will use the most practical term available, though some terms embed both procedure and principle inextricably.

The third small meeting will be in London, November 27-28, 2003, to which AABT task force and other would-be contributors are invited. Those seeking further information on this and on the template structure and samples for developing submissions should contact Dr. Isaac Marks: 43 Dulwich Common, London SE217EU, UK; phone: +44 (0)208) 693 6611; e-mail: i.marks@iop.kcl.ac.uk.

### Structure for Submissions

(*maximum lines in 12-pitch*):

- Definition (4)
- Elements (13)
- Related procedures (2)
- Application (1)
- First known use/references (3)
- Case illustration (40)

First round of 30 (out of 400+) terms for which submissions are invited: anger management/control; anxiety/stress management; attentional training; behavioral experiment; breathing retraining; challenging; contracting; contingency management; couple therapy; diary keeping; family work; family therapy; goal/target setting; grief therapy/guided mourning; marital therapy; problem-solving; guided mourning; homework; interpersonal therapy; modeling; motivational interviewing; panic control/management; paradoxical intention; parent training; reframing/relabeling; rehearsal; relaxation/autogenic training; role-play; self-instruction training; well-being therapy.

### TEMPLATE EXAMPLE

*Terms in italics appear separately in the dictionary*

#### ASSERTIVENESS (ASSERTIVE, ASSERTION) TRAINING (AT)

**DEFINITION:** A form of *social skills training* to carry out culturally/context-appropriate assertive behaviors that the client lacks, e.g., initiating, continuing and/or stopping social contact; responding to requests, demands and/or annoying behaviors; expressing feelings; exercising own rights while respecting other people's rights.

**ELEMENTS:** Targets the behavioral, cognitive, and emotive components of assertion, e.g., what to say, how to say it, tone, and body language. Involves *role-play, modeling, feedback of videotaped practice, homework* of increasingly difficult social tasks, praise of progress (*reinforcement, reward, contingency management*). Includes:

- *Problem solving* by helping clients to: define their problem social behavior and break it down into manageable bits to be learned one by one; find alternative (adaptive) forms of social interaction; *self-observe to achieve perspective (distancing)*.
- *Exposure* to feared social situations and *behavioral experiments* to challenge the negative thoughts, self-talk and imagery evoked by those situations.
- *Rehearsal* of new social behavior in the treatment session and in homework in imagination and in real life (involves *exposure and behavioral experiments* if behavior/situations are feared), followed by *reward*.
- *Cognitive restructuring* to change socially maladaptive thoughts to more adaptive ones.

**RELATED PROCEDURES:** AT is a form of *social skills training* to remedy *social skills deficits* (not excesses as in *anger management*) and of *rational emotive therapy* in its education in personal rights.

**APPLICATION:** Taught individually or in small groups in clinical, work, school, or other settings.

**FIRST USE:** Salter, A. (1949). *Conditioned Reflex Therapy*. New York: Capricorn Books. Salter used assertiveness training to describe

how to increase clients' social skills and reduce social anxiety.

### Brief Case Illustration of AT (350 words)

Pat had long feared and avoided eating with people, and had always been shy and reserved, with a limited social life. With her therapist she set medium-term targets of eating a meal with three other friends and also at her boyfriend's home with his family (*goal setting*). She described a detailed imagined scene of having a meal with her boyfriend (*imaginal [fantasy] exposure*) and the therapist prompted Pat's flow of talk when she flagged (*guided fantasy/imagery*). She then actually had a meal with her boyfriend (*live [real, in vivo] exposure*). Pat also *role-played* asserting herself appropriately. In "playlets" her therapist pretended to be a shop assistant and Pat acted the part of a customer returning defective goods. This was recorded on *videotape* and played back to her (*feedback*). She was taught what to say as a disgruntled customer (*assertion*), and they played the same parts again and switched roles with Pat as the salesperson (*reverse role-play*). They also role-played asking directions in the street from a stranger and refusing to carry out an unreasonable request from a colleague. The therapist first *modeled* what to do and then asked Pat to do the same thing (*rehearsal*). Pat then lunched with an acquaintance (*live [real, in vivo] exposure*).

Pat now joined five other socially phobic patients for a day-long group session (*social skills training*). The therapist outlined the program. They played contact party games to encourage mixing, like having one of their number break out of a circle made by the others and, without using hands, transfer an orange held under the neck to another patient. These warm-up exercises led into *role-play* of increasingly difficult social situations (*exposure*). Toward evening the group split into subgroups to shop for ingredients for a meal to cook together (*social skills training, confidence building*). They chatted to one another and then ate together. After initial unease they enjoyed themselves and planned to meet one another after the group's conclusion. Pat had further sessions with the therapist alone. By 6-month follow-up she was dining regularly with her fiancé and his family and in selected restaurants with him and occasionally with a larger group of friends. ✍

## News of the SIGs

Ronald Fudge, *Chair, Special Interest Groups*

Hello to all of the Special Interest Groups of AABT. As the new chair of the AABT SIGs, I would like to take a few moments to introduce myself to you, and to begin what I hope will be a mutually beneficial dialogue. As chair of the African Americans in Behavior Therapy SIG, I'm well acquainted with the structure and functioning of SIGs, and having served in that capacity for the past 15 years, I've witnessed the growth of the SIGs into what can only be described as a significant part of AABT. The SIGs allow those who share a specialized interest the opportunity to exchange ideas, research, and clinical points of view. In turn they provide input to AABT as referral sources, subject experts, and forums for unique perspectives.

I believe that most members of AABT will readily admit that the contributions of the SIGs provide AABT with the breadth and scope of a much larger organization. Those who have ever attended a SIG cocktail hour understand what a unique learning experience the SIGs provide.

As the SIG committee chair, I plan to continue supporting the efforts of established and future SIGs in maintaining their exemplary contributions to the mission of AABT. I would like to devote my time as chair to fostering collaborative efforts between SIGs, and to foster better communication between AABT and the SIGs.

I look forward to meeting the SIG chairs during the upcoming conference, and will make the ultimate conference sacrifice: the 8:00 A.M. (Saturday) SIG leaders meeting.

• **Child Maltreatment and Family Violence (CMFV) SIG.** This newly formed SIG will be meeting at AABT's Annual Convention in Boston. The CMFV SIG welcomes all AABT attendees with clinical or research interests in child physical and sexual abuse, neglect, psychological abuse, marital and courtship violence, and related topics, to exchange ideas about current research and clinical issues in these areas. In addition to fostering professional relationships, this group seeks to (a) promote research and empirically based interventions addressing the many facets of child maltreatment and family violence; (b) facilitate the dissemination of research findings to help professionals address the needs of those

affected by child maltreatment and family violence; and (c) increase professional and societal awareness of issues related to maltreatment and violence.

For more information about the CMFV SIG, contact David DiLillo at [ddilillo2@unlnotes.unl.edu](mailto:ddilillo2@unlnotes.unl.edu); University of Nebraska-Lincoln, Dept. of Psychology, 238 Burnett Hall, Lincoln, NE 68588-0308; tel.: 402-472-3297. If you are interested in joining this SIG, please provide him with your contact information and AABT membership status, and plan to attend their SIG meeting in Boston, Saturday, 2:30 to 3:30 P.M., in the MIT room.

• **Mindfulness and Acceptance SIG.** The Mindfulness and Acceptance SIG has also been formed. The goals of this SIG are (a) to provide a forum to members for the development and dissemination of a behavioral science infused with mindfulness and acceptance techniques—including the discussion of current controversies and limitations of current research and directions for future research in these areas; (b) to provide information for training in mindfulness and acceptance schemes; (c) to foster collaboration and free exchange among researchers and clinicians; and (d) to create opportunities for members to network with colleagues who share these interests.

For more information about the Mindfulness and Acceptance SIG, contact David Fresco at [fresco@kent.edu](mailto:fresco@kent.edu); Dept. of Psychology, Kent State University, 315-A Kent Hall, PO Box 5190, Kent, OH 44242-0001. If interested, please provide your contact information and AABT membership status and plan to attend their meeting at the convention: Saturday, 1:30 to 2:30 P.M., in the Falmouth room.

• **SIG Events at the Boston Convention.** The annual SIG Exposition and Cocktail Party will be held at 6:30 on Friday evening, November 21, at the Boston Marriott Copley Place. This reception is an excellent opportunity to network, view the latest research, and learn about the activities of AABT's SIGs. The posters to be presented will appear in the program addendum. Other convention activities for the SIGs include the annual meetings of the individual SIGs, as well as the SIG leader meeting. ✍

## Some Reactions to Robert Kohlenberg's Article

Arnold A. Lazarus, *Rutgers University*

**D**r. Kohlenberg's (2003) article, "AABT: On the Precipice of Becoming Dysfunctional?" contains several provocative issues that I would like to discuss. There are three specific components that I will address: (a) historical antecedents; (b) accepting negative feelings rather than ameliorating them; and (c) rejection of transference.

### The Antecedents

I was privileged to be in on the ground floor, having not only introduced the terms "behavior therapy" and "behavior therapist" into the literature (Lazarus, 1958), but also serving as AABT's third president, from 1968 to 1969. In my book *Behavior Therapy and Beyond* (Lazarus, 1971) I had argued for the addition of "cognitive restructuring" to the behavioral repertoire, but this was met with strong opposition. It took about 10 years before the need to add cognitive interventions to standard behavioral methods became widely recognized (see Goldfried & Davison, 1994; Lazarus, 2001).

Thus, it is historically inaccurate for Kohlenberg to state that Ullmann and Krasner (1965) "specifically defined CBT as an approach that dismissed the medical model . . ." (p. 285). In fact, Ullmann and Krasner did not even consider themselves "behavior therapists" (let alone "cognitive-behavior therapists"), but espoused a strict form of *behavior modification*. CBT did not exist in 1965, and for both Ullmann and Krasner, cognitive processes fell under the rubric of Skinnerian verbal behavior, "wherein no matter how highly symbolic or idiosyncratic, the focus of modification is behavior" (p. 1).

### Acceptance Rather Than Amelioration

Kohlenberg argues that "true" human nature, accurately described by Freud and embraced by psychoanalysts, points to an essential morbidity—that it is difficult for humans to be happy. Preposterously, he asserts that "CBT rejects the notion that the human condition might entail suffering" (p. 285) and contends that CBT should em-

phasize the acceptance of negative feelings. He doesn't recognize the issue of context. We attempt to modify *exaggerated* and *irrational* emotional states—not all suffering or all negative emotional reactions. It is true that in the early years of behavior therapy we were overly optimistic about the possibilities for therapeutic change. Most of us had been schooled in psychodynamic thinking wherein tepid results often followed protracted treatment. Thus, when we began applying methods of systematic desensitization, in vivo exposure, assertiveness training and the like, and found these procedures remarkably robust in overcoming various phobias and other anxiety disorders, certain forms of depression, stress-related phenomena, sexual dysfunction, and a wide range of untoward habits and maladies, the pendulum swung to a position of overoptimism. In time, careful outcome studies highlighted our limitations and gave us a better sense of where and when we were genuinely effective and ineffective.

Nevertheless, I do not understand why Kohlenberg takes me to task for having commented that "The control or absence of unpleasant emotions coupled with an increase in positive feeling is a most worthy goal" (p. 285). Is this not generally the goal of therapy—to assist our clients to feel better and to function more adaptively? Recently, I ended therapy with a woman who had been referred to me for the treatment of an agitated depression. We met eight times over a period of 3 months before her "unpleasant emotions" (agitation and depression) subsided and were replaced by, dare I say, *joie de vivre*. She is not manic; nor is she free from other problematic issues, but now she seems capable of coping with them. Freud's mandate of transforming neurotic misery into normal suffering seems to have been satisfied. Nevertheless, when acceptance rather than change is the therapeutic outcome, the control of certain unpleasant emotions and an increase in positive feelings may ensue. Would this be considered inappropriate?

In his section on the overrejection of "transference," Kohlenberg asserts that CBT practitioners "rarely attend to clinically relevant behavior" (p. 286). Perhaps he is saying that he dislikes the *way* that most CBT practitioners attend to clinical behavior. We are given no operational definition of what Kohlenberg considers clinically relevant behavior and are therefore confronted with a statement that on its face is meaningless. For example, would any competent therapist misunderstand and not address, in session, hostile behavior from a somewhat belligerent youth who has problems with authority? Would any well-schooled CBT practitioner find it farfetched to point out to a client that she appears to react to her therapist in the same way that she views her abusive husband, and then use in-session cues to deal with the problem? Be that as it may, to refer to this as "transference" takes us very wide of the observation that clients may have distorted perceptions of the therapist that seem to rest on reenactments with significant others.

To borrow and use the murky term "transference" (on which many vague and complex psychoanalytic tomes have been written) leads to obfuscation. Perhaps it behooves us to find a different term that describes peoples' penchant to generalize and project onto one another accurate as well as distorted attributes and feelings that stem from past experiences. Perhaps instead of "transference" (with its many surplus meanings and untestable intrapsychic baggage) we could simply refer to the "transfer of feelings." I feel sure that Kohlenberg will agree that our quest should be to demystify our therapeutic endeavors.

As a final point, I want to stress that whereas psychodynamic practitioners advocate maintaining strict boundaries between clients and therapists, which are woven into their theories, CBT practitioners have no theoretical reasons to subscribe to these prohibitions. It is widely known that close rapport, a good working alliance, and other facets of the client-therapist relationship are often a *sine qua non* for effective outcomes. Thus, with selected clients, it is judicious and strongly advisable to cross certain boundaries, and if this is not done, ruptures in the therapeutic relationship may result (see Lazarus & Zur, 2002). Kohlenberg calls for more innovative treatments. I submit that the greater flexibility I am talking about vis-à-vis boundary crossings (as opposed to boundary violations) opens up many new vistas.

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### ACKNOWLEDGMENT

I am most grateful to Allen Fay for his critique of my initial draft. ✍

## Letter to the Editor

# AABT, Human Misery, and Transference: A Response to Arnold Lazarus

Robert J. Kohlenberg, *University of Washington*

I am not in an enviable position in attempting to address Dr. Lazarus's (2003) critique of my paper. I personally feel deeply indebted to him for his courage and creativity, which played a central role in establishing CBT (cognitive behavior therapy—the meaning of which I will address below) and AABT. Yet, it was the historical context for this courage and creativity that I believe has, some 40 years later, and in spite of Lazarus's intentions, led to some inadvertent and unforeseen side effects that currently do not serve us well. My original paper was intended to help CBT capitalize on the advances made by Lazarus and others over the years while simultaneously bringing attention to potential problems. In this commentary, I will try to show how Lazarus's response to my paper seems to illustrate both sides of my argument. On the one hand, he describes the foundations of what made behavior therapy succeed. We would not have advanced this far without the foundation built by him and other AABT pioneers. On the other hand, I believe his comments also corroborate my concerns that this foundation unintentionally leads to some thinking that threatens to hamper our progress. My hope is that our dialogue will facilitate us in continuing to evolve.

In a nutshell, my thesis is that our founding fathers by necessity rejected the dominant psychoanalytic model, but inadvertently threw out the baby with the bath water. The rejection of psychoanalytic theory was justified on empirical and theoretical grounds and, most importantly, it was

part of a counterattack needed to establish the legitimacy of our alternative view. The problem is that in denouncing the psychoanalytic model, we have disregarded some of its clinical insights. The negative effects of what we have overlooked recently have become apparent—an underacknowledgment of the intrinsic nature of human suffering as well as a relative lack of using the therapeutic relationship in ways that bear resemblance to how analysts dealt with "transference."

### Do CBT Therapists Acknowledge Human Suffering?

Lazarus said that I "preposterously" assert that "CBT rejects the notion that the human condition might entail suffering." This "rejection" hypothesis lies at the core of my concern, and I used it to refer to two different but related phenomena.

First, there is the rejection that I contend occurred early in our history and refers to the eschewing of Freud's *inevitability* of suffering that results from simply being human. I argued that this rejection served a valuable function in developing behavior therapy including the early "overly optimistic [view] about the possibilities for therapeutic change" (p. 380) acknowledged by Lazarus. Now, let me correct any misunderstandings that may have arisen out of my references to Freud. I did not say that Freud's theory was correct. I did say that his clinical observations about the pervasiveness of suffering might have merit and that current-day CBT was lacking because it didn't have the theoretical foundation to ac-

count for such a notion. My point was that the human experience of suffering was so important to Freud that he made it a cornerstone of his theory. With a few notable exceptions, CBT theories, postulates, and therapies do not posit that suffering is intrinsic to being human. In contrast, Hayes, Strosahl, and Wilson (1999) do take suffering seriously enough to say it is *intrinsic* to being human, and base its origins on a behavioral analysis of verbal behavior and the acquisition of language. This same issue is now being addressed in other acceptance-based interventions that are being introduced into CBT (Linehan, 1993; Marlatt, 2002; Teasdale et al., 2000). Nevertheless, it was rejected by our founders and not included in the initial creation of the infrastructure of behavior therapy.

Second, I did imply that current-day CBT practice, as a result of this early rejection of psychoanalysis, subsequently lacks theory or procedures that systematically acknowledge human suffering, its origins, and implications for treatment. Without a theoretical basis or infrastructure to guide the CBT therapist as to the origins of "normal" human suffering and what to do about it, we are left with using common sense or clinical experience as to when the suffering is "irrational" or "exaggerated" and should be a target for elimination. Our current emphasis on treatment manuals and therapy adherence measurement is aimed at specifying relevant clinical procedures as opposed to depending on common sense. If not explicitly described in a manual, at worst some therapists may see no alternatives to dealing with negative emotions other than their elimination. This opens the possibility that some CBT therapists may go too far in attempting to eliminate negative emotional states and conversely not provide help for clients who are experiencing "inevitable" and "normal" suffering. I believe it was this second use of the term *rejection* that Lazarus refers to as "Preposterously [Kohlenberg asserts that] CBT rejects the notion that the human condition might entail suffering" (p.

380) and calls me to task for not recognizing that practicing CBT therapists would take context into account in deciding when to target unpleasant emotions. After rereading many of Lazarus's writings, I have every confidence in his ability to do this. But, I am not prepared to depend on the common sense and clinical experience of everyone else to do the same. Accordingly, Lazarus did not understand why I took him "to task" for saying that "the control or absence of unpleasant emotions coupled with an increase in positive feeling is a most worthy goal." On the one hand, I agree that this is a most worthy goal, one that I often try to help my clients achieve. On the other hand, I also am aware that the therapeutic pursuit of this goal can backfire and iatrogenically harm rather than help. Apparently this happens frequently enough that Hayes and colleagues (1999) found it necessary to develop a therapy specifically focused on undoing the iatrogenic effects of therapy aimed at decreasing negative feelings. My own opinion lies somewhere between Hayes et al. and Lazarus's positions. In that vein, I would prefer for Lazarus to have said, "This is one type of worthy goal, but sometimes its pursuit may cause more harm than good."

#### Transference and the CBT Therapist

Lazarus disputes my assertion that CBT practitioners rarely attend to in-session, here-and-now occurrences of the client's daily life problems in the context of the therapist-client relationship. I refer to these events as clinically relevant behaviors (CRB) that have been operationally defined elsewhere (Follette, Naugle, & Callaghan, 1996; Kohlenberg, Kanter, Bolling, & Parker, 2002; Kohlenberg & Tsai 1991). It should be pointed out that attending to CRB is distinguished from establishing a collaborative relationship or therapeutic alliance. An example of a therapist attending to CRB can be found in *Behavior Therapy and Beyond* (Lazarus, 1971) when Lazarus notices that a client is withdrawing from him during a therapy session. Lazarus then directly attends to this by (a) pointing it out to the client and (b) telling the client that "... I guess you are upsetting me because I want to help you and you are not giving me the chance" (p. 55). Although there are differences, Lazarus's response in this instance has much in common with the interventions called for by Kohlenberg and Tsai (1991). In fact, there are several examples in this book showing that Lazarus does attend to CRB. So, I will now include Lazarus

along with the other notable exceptions to my contention that CBT therapists rarely attend to CRB. I must admit that while I did note the importance of the therapeutic alliance and establishing a collaborative relationship when I first read his book some 30 years ago, I did not notice the CRB focus of Lazarus's work. This attests both to my own deficits as a therapist at that time as well as to the relative lack of discussion by Lazarus and others about how to discern when the client's daily life problems might arise within the therapist-client relationship, what to do when that happens, and why this presents a special therapeutic opportunity.

Nevertheless, based on available information, with the exception of Lazarus and others noted in Kohlenberg (2003), I still contend that CBT therapists rarely attend to CRBs. In part, this conclusion is based on data collected during a treatment development study (Kohlenberg et al., 2002) where we measured actual in-session therapist behavior of four CBT therapists and found that they rarely attended to CRB. These CBT therapists were all highly trained, experienced, and competent (as rated by an outside expert). To be sure, this was a limited sample, but there are few studies that actually measure these types of interventions (see below for others).

Two other facts also bolster my contention. First, the Collaborative Study Psychotherapy Rating Scale (CSPRS; Hollon et al., 1987), the gold standard for measuring Beck, Rush, Shaw, and Emery's (1979) CBT adherence, does not have any items that address content related to attending to CRB. Further, the CTS (Cognitive Therapy Scale; Dobson, Shaw, & Vallis, 1985), a measure used for assessing Beck CBT competence, likewise does not include items pertaining to attending to CRB. Together, these measures show that at the very least, attending to CRB is not important enough to be included in these frequently used measures that define adherent and competent CBT based on Beck et al.'s widely used approach. Further, the focus on CRB is not underscored as having any special significance in the CBT literature (exceptions are noted in Kohlenberg, 2003). Thus, it is not unreasonable to suggest that a therapist who reads the literature and whose training is guided by the CSPRS and CTS might not learn to notice and use CRB. Ultimately, it is of course an empirical question as to how much CBT therapists use an in-vivo focus. Our lab is currently collecting such data on a larger sample of CBT therapists to answer this question.

I do have a possible explanation as to why Lazarus assumes that CBT therapists attend to CRB. First, I want to point out that a focus on therapist-client issues during a therapy session is a necessary precursor to focusing on CRB—thus, an increase in focusing on such issues also indicates an increase in attending to CRB. According to an analysis of selected samples of therapy sessions of master cognitive therapists (Lazarus was one of the therapists studied), these experts focused on therapist-client issues on an average of 7% of the turns (Goldfried, Raue, & Castonguay, 1998). In comparison, only 2.1% of the turns focused on therapist-client issues when nonmaster CBT therapists were studied (Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997). Thus it is possible that Lazarus is generalizing from his personal experience to cognitive therapists in general or to those whom he personally trains. For comparison purposes, the CBT therapists who were given training in CRB awareness in our treatment development study (Kohlenberg et al., 2002) increased their focus on therapist-client issues from 3% to 15% of the turns (Kanter, Schildcrout, & Kohlenberg, 2002).

#### Other Issues

I agree with Lazarus that transference is a murky concept and has no place in behavior therapy. I used that term mainly to give the historical context for a lack of emphasis on the related behavioral concept of CRB. I also favor a learning-based account of why a CRB focus may be an especially important avenue for significant behavior change. In particular, general consensus exists that in-vivo CBT is more "powerful" (e.g., Goldfried, 1985). Although Lazarus reiterates this idea in his 1971 book, he limits the emphasis on using in-vivo methods to desensitization and does not extend this analysis to his focus on CRB.

I admit that I used the term CBT quite loosely and did not differentiate behavior therapy from behavior modification and cognitive behavior therapy or track terminology changes over the past 45 years. I do, however, believe that the foundation of today's CBT has common roots that include behavior modification and behavior therapy as evidenced by the fact that behavior modification is well represented in the first issue of *Behavior Therapy*.

Lazarus dismisses Ullman and Krasner's (1965) view that cognitive processes fall "under the rubric of Skinnerian verbal behavior." I believe Ullman and Krasner's view has merit and ultimately led to thera-

peutic acceptance and a focus on the client-therapist relationship, but this is a topic for another discussion. I do, however, enthusiastically agree with Lazarus that opening boundary crossings creates new vistas for innovation. In addition, boundary issues are fertile ground for the evocation of CRB and hence provide significant opportunities for behavior change.

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I appreciate Drs. Jonathan Kanter and Mavis Tsai's contributions to this manuscript. ✍

## Letter to the Editor

# CBT and Human Misery: Do We Really Need a New Infrastructure?

Arnold A. Lazarus, *Rutgers University and Center for Multimodal Psychological Services*

I thank Dr. Kohlenberg for his most gracious comments (2003; see pp. 381-383) about my contributions. There are still some questions that linger. Kohlenberg's two main criticisms are that in most CBT writings, there is "an underacknowledgment of the intrinsic nature of human suffering as well as a relative lack of using the therapeutic relationship in ways that bear resemblance to how analysts dealt with 'transference'" (p. 381). With regard to the first point, it seems to me that one need only read a newspaper or watch a newscast on television to appreciate the widespread, if not ubiquitous, extent of suffering. With our clients, this translates into a need to appreciate individual suffering for

which the importance of empathy has been widely stressed. As for the manner in which analysts deal with transference, the fact that we do not use the therapeutic relationship in ways that bear resemblance to their convoluted use of "transference" does not mean that CBT dismisses intratherapy interpersonal events.

Is it true that CBT lacks a "theoretical foundation to account for such a notion" (the importance of human suffering)? I think the last thing we need is yet another theory to add to the plethora of suppositions that assail our field. I recall earnest discussions that date back to my undergraduate years during which we concluded that the mainstay of suffering stems from

the awareness of our own mortality, which is, of course, *intrinsically* human. Kohlenberg asserts that the consummate significance of suffering "was rejected by our founders and not included in the initial creation of the infrastructure of behavior therapy." Certainly, psychoanalytic theories and most of their methods were rejected, especially the heavy reliance on free association and dream interpretation. But the existence and importance of human suffering was not rejected, although it may have been taken for granted and, at worst, somewhat neglected. Perhaps this neglect stemmed from a reluctance to emphasize the obvious—although Wolpe and I stated that "the *raison d'être* of psychotherapy is the presumption that it can overcome certain kinds of human suffering" (Wolpe & Lazarus, 1966, p. 20). Throughout the millennia, poets, philosophers, and innumerable authors have addressed the ubiquity of suffering. Kohlenberg's comment that "CBT theories, postulates and therapies do not posit that suffering is intrinsic to being human" seems to imply that if you don't keep underscoring this obvious fact, you do

not take suffering seriously. This is simply not so.

Kohlenberg emphasizes that “current-day CBT practice, as a result of this early rejection of psychoanalysis, subsequently lacks a theory or procedures that systematically acknowledge human suffering, its origins, and implications for treatment.” Surely we don’t have to resort to psychoanalytic reasoning to understand the vicissitudes of suffering. For example, Bandura’s (1986) social cognitive theory seems to provide an erudite social learning theory analysis of mood, pain, and depression. He shows how the preponderance of aversive stimuli intertwine physically and linguistically and become part of enactive learning and consciousness. Do we really need a clearer infrastructure to account for the origins of suffering, and is it always so difficult to determine when suffering is dysfunctional and a viable candidate for mitigation through CBT?

I can understand how and why overzealous therapeutic attempts to decrease negative feelings can result in iatrogenic harm, as Kohlenberg asserts. Is that a result of inexperience or incompetence on the part of some clinicians, as I would declare, or is it inherent in the philosophy and practice of CBT as Kohlenberg suggests? It may be an utter waste of the therapist’s time and the client’s money to try to change that which cannot be fixed, or it may be a normal and expected reaction. In addition, such efforts may mislead the client, raise false hopes, and result in the client’s personal feelings of failure and self-blame. As the well-known and very old Serenity Prayer states: “God, grant me serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference.” As physicians are apt to say when confronted by a condition for which there is no cure, “You’ll have to learn to live with it.” Kohlenberg might be correct in stressing the need for specific training in how and when to encourage acceptance, although the *acceptance-based and mindfulness approach*

that now seems to be in vogue is anything but new or unique as a way of achieving the objective. Nevertheless, let us beware of any proclivity to accept the unnecessary suffering of individual patients when we have the capacity to ameliorate their distress. Can a theory point the way to those precise units of suffering that are adaptive versus maladaptive? As Kohlenberg knows full well, there are qualitative, quantitative, and contextual aspects to suffering, and it is not necessarily desirable to lump them together, as he seems to do.

In deference to space limitations, I will address one final point—attending to clinically relevant behaviors (CRB) in the context of the therapist-client relationship. There are those who maintain that what transpires in the consulting room between therapist and client is a microcosm of all the client’s significant relationships—past and present. This view ignores the fact that *person-and-situation-specificity* makes every relationship unique. I have often treated aggressive bullies who revealed no untoward or offensive behaviors whatsoever in my office. (I only learned of this highly significant but carefully concealed obnoxious behavior from members of the clients’ network whom I had interviewed with permission.) On the other hand, clients with diagnosed borderline personality disorder are apt to toss nearly all their emotional baggage right in the therapist’s face, and it is inconceivable to me how any clinician could fail to deal with it there and then (Lazarus, 2000a).

When working with couples, it is usually easy and often extremely helpful to evoke veridical interspousal behaviors in the office that pertain to their problems, and to proceed with reparative role-playing. But perhaps Kohlenberg is correct that more CBT clinicians need to be reminded to spend some time examining in-office transactions with their clients so as to consolidate the relationship and point to issues that can be changed and those that need acceptance training. Certainly, my multimodal ap-

proach (Lazarus, 1997, 2000b), in which interpersonal relationships (in and outside the client-therapist alliance) receive ample attention, is by no means incompatible with the major tenets of CBT. Nevertheless, as I have stated in several writings, attention to phenomena of what are traditionally called “transference” and “countertransference” should take place only when there is reason to suspect that this process will facilitate therapeutic progress. Thus, treatment impasses may be caused by specific client-therapist interactions that need to be addressed, but when therapy is proceeding well, such a focus may truncate therapeutic progress. A skillful clinician always factors in the relationship but knows when to shift attention elsewhere.

After all is said and done, the quintessential outcome measure of psychotherapy is change.

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Again, I thank Allen Fay for incisively critiquing the initial draft of this paper. ✍

# Log-ins & Passwords

[www.aabt.org](http://www.aabt.org)

At AABT, all you need is a **log-in** and **password**, and you have entrée to various aspects of our new on-line system: renew your membership, update your records, register for the convention, and more. Each AABT member received a letter at the end of September describing the project. The letter included your individual **log-in** and **password**. Those of you for whom we have functioning email addresses also received the **log-in** and **password** electronically. Questions, comments? Write David Teisler at [teisler@aabt.org](mailto:teisler@aabt.org).

If you ever lose your **log-in** or **password**, retrieve it simply by entering your email (which must match the email in the database). Failing that, you can still get it by following the directions in the LOST YOUR PASSWORD? link at the bottom of the MEMBERSHIP DIRECTORY page. You may change either your **log-in** or **password** at any time. Follow the directions on your screen in the MEMBERSHIP DIRECTORY section. And, if you indicated that you take referrals, you are also posted on our website in the FIND A THERAPIST section, which is accessible to the general public.



## Doing Good by Doing Good

Arnold Holzman, *Behavioral Health Consultants, LLC, Hamden, CT*

The article by Derek and Sandra Hopko (2003), "Employee Assistance Programs: Opportunities for Behavior Therapists," that appeared in the summer issue of *the Behavior Therapist* was timely and worthwhile. Buried in their article was the very important point that Employee Assistance Programs (EAPs) are increasingly becoming the entry point by which many Americans are obtaining treatment. This is a result of a combination of factors including the obstacles created by managed care and the proliferation of employer-sponsored EAPs. The proliferation of EAPs is based on need and demonstrates that effective behavioral health consultation and treatment has real-life utility and value.

The growth of EAPs presents additional opportunities for behavior therapists not addressed in the article. In addition to training opportunities, clinical services, and research, behavioral therapists are ideally suited to provide direct contracting for EAPs. This is something we cannot do in managed care.

The vast majority of Americans are employed by small and mid-sized businesses that operate in local communities. The behavioral practitioner or group practice can contract directly with local employers and thereby serve as both contract holder and service provider. In so doing the behavioral practitioner can offer direct individual clinical

service and can also focus organizationally using his or her programmatic and analytical skills. Therefore, we can apply our skills on multiple levels and make a difference that is demonstrable at the larger level of analysis, including the bottom line (theirs and ours).

Contracting directly on a capitated or similar basis can allow the practitioner or group to practice to diversify services to include these and related programs. For example, in our practice, we offer evaluation, brief treatment, primary and secondary prevention, meditation, executive coaching, organizational development consultation, and skills-building programs, all via our EAP contracts. We have contracts with a large and growing number of companies in our region. Our services are sought after and valued, which is profoundly uplifting in the health-care marketplace in which we all practice. EAPs are a large, barely tapped market that is ideally suited to the creative skills and entrepreneurial interests of the behavioral practitioner.

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## Letter to the Editor

Esteban Cardemil, *Clark University*

It was with dismay that I read Kenneth D. Salzwedel's (2003) Letter to the Editor in which he argued that the name of AABT should not be changed to reflect the various theoretical perspectives already found in the organization's membership. While I believed that it matters little what we call ourselves, I was most unsettled by my sense that Salzwedel was advocating exclusionary and restrictive values.

Science advances and thrives through the interchange of diverse ideas. It is likely that AABT and the various behavioral journals to which Salzwedel (2003) refers have

expanded their scope to include cognitive therapy because of data demonstrating its efficacy and relevance. If Salzwedel believes that behavior therapy should be advanced ahead of cognitive therapy, he should make his points through data and science, not by excluding those who disagree with him. Any organization that attempts to ensure that its membership is comprised of only like-minded individuals ceases to be a scientific one.

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- Salzwedel, K. (2003). What's in a name? Everything! *the Behavior Therapist*, 26, 325. ✍

coming soon

## Cognitive and Behavioral Practice

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### EDITOR'S INVITATION: PRIMERS IN COGNITIVE AND BEHAVIORAL THERAPY

- Getting Back to the Basics: Primers in Cognitive and Behavioral Therapy (**Albano**)
- Treatment Contracting in Cognitive-Behavior Therapy (**Otto et al.**)

### REGULAR ARTICLES

- Cognitive-Behavioral Treatment for Pediatric Posttraumatic Stress Disorder: Protocol and Application in School and Community Settings (**Amaya-Jackson et al.**)
- Using Motivational Interviewing Techniques to Talk With Clients About Their Alcohol Use (**Sobell & Sobell**)
- Integrating Acceptance and Mindfulness Into Existing Cognitive-Behavioral Treatment for GAD: A Case Study (**Orsillo et al.**)
- Cognitive-Behavioral Treatment of Depression: A Three-Stage Model to Guide Treatment Planning (**Overholser**)
- Virtual Reality Exposure in the Treatment of Social Anxiety (**Anderson et al.**)
- Cognitive Behavioral Therapy for Schizophrenia: An Overview of Treatment (**Warman & Beck**)

### ISSUES IN DIVERSITY

- Student Perspectives on Training in Gay, Lesbian, and Bisexual Issues: A Survey of Behavioral Clinical Psychology Programs (**Anhalt et al.**)

### BOOK REVIEW

- M. M. Antony & D. H. Barlow (Eds.), *Handbook of Assessment and Treatment Planning for Psychological Disorders*. Reviewed by Emily M. Collinsworth and Scott R. Ross

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*We welcome them into the Association and appreciate their support.*

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*AABT welcomes its new members and appreciates those members who helped us grow. We will reinforce both with the AABT Lottery. Please check the convention program addendum for prize drawing times. You don't need to be there to win but it sure would be nice! Prizes include choice of journal, videotapes, and free membership in 2004!*

*Asterisks next to the names below indicate that these members were the source of 3 or more new members.*

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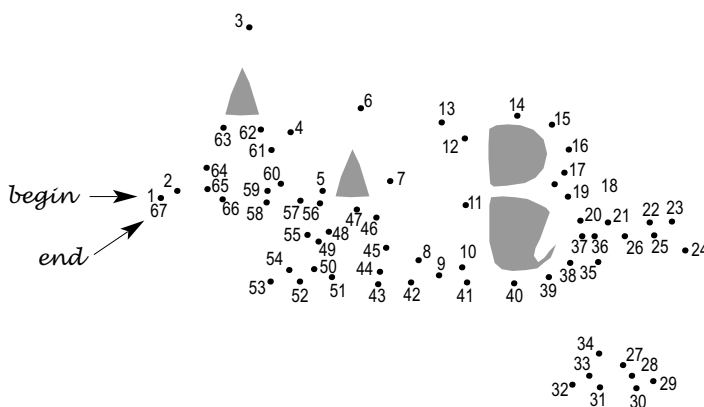
Christine Wilson  
 G. Terence Wilson  
 Lucene Wisniewski  
 Mary Wong  
 Douglas Woods  
 Eric Youngstrom  
 Claudia Zayfert  
 Janice Zemen  
 Richard Zinbarg

## 2003 Voluntary Contributors

The following members made generous voluntary financial contributions to AABT in 2003. AABT has used these funds to fuel its continuing growth by expanding its services and publications, and to further our goal of encouraging the practice, research and recognition of behavior therapy. We sincerely thank them for their generosity.

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## It Begins and Ends With AABT



*Stay Connected*

**Renew Your Membership**

Convention 2003

## The 37th Annual AABT Convention Travel Companion to Boston

Michael W. Otto, *Massachusetts General Hospital and Harvard Medical School*, and Donna B. Pincus, *Boston University, Local Arrangements Co-Chairs*

The 37th Annual AABT Convention is fast approaching, and it won't be long before the historic brownstones, public gardens, and beautiful tree-lined streets of Boston will surround us. What could be better than getting together with friends and colleagues in a vibrant, historic city, with great opportunities for fun? Before you begin packing your bags, read ahead for all the fast facts on getting to the city, including previews of party plans and conference highlights.

### Getting to Boston

With the Marriott Copley Place located in the heart of Boston's Back Bay, only 4 miles from Boston's Logan Airport, it won't be long after you land that you will be able to begin your exploration of the city. To assure that your trip here is as smooth as possible, we are providing traveling directions and details. Detailed driving instructions/maps can be obtained by calling the Marriott Copley Place directly (617) 236-5800 or by visiting their Web site ([www.marriott.com](http://www.marriott.com); choose Marriott Copley Place from the list). Boston's major airport is located across the harbor from the center of Boston's downtown area. To get to the conference hotel from the airport, you have several choices.

*By taxi.* Certainly the easiest choice; from each airport terminal, look for signs for cab/taxi lines. Cost is in the range of \$30 to get from the airport to the Marriott Copley Place Hotel. We recommend finding a fellow AABT conference attendee on your flight or in the airport and sharing the cost.

*By subway.* From the terminal, take the MASSPORT Shuttle Bus 22 from Terminals A or B, or MASSPORT Shuttle Bus 33 from Terminals C, D, or E. Get off at the subway "T" terminal, which is the Blue Line's "Airport" stop. Take the Blue Line inbound to the Government Center T stop; get off the Blue Line and, while staying underground, look for the Green Line platform. Take the Green Line outbound (any

"letter" train going outbound will get you there) to the Copley "T" stop. Exit to ground level, and walk toward Copley Square to Huntington Avenue. The hotel is located at 110 Huntington Avenue.

*By train.* Amtrak trains arrive at both South Station and Back Bay Station. The arrival of the new Acela speed train makes the trip only 3½ hours from New York. The MBTA also runs commuter trains on set schedules to points south, west, and north of Boston. The Copley Marriott is only a short walk from the Back Bay Train Station. It is a short cab ride from South Station.

### Driving to Boston Marriott Copley Place

The cost to self-park at the Marriott Copley Place is \$28 for 24 hours of self-parking and \$32 for valet parking. Remember that the Big Dig can sometimes cause traffic delays and detours. Up-to-the-minute traffic reports are available through [www.smarttraveler.com](http://www.smarttraveler.com). Remember that Boston is not the easiest city to drive in; there are many roadways in and around the city that are under construction or in repair, and many streets are one-way, which can make navigating difficult. Come with directions so that you find your way more easily!

From Logan Airport, follow signs for Boston/Summer Tunnel, and stay in the right lane through the Summer Tunnel. Take a right from the tunnel onto Storrow Drive. Take Copley Square/Back Bay Exit; turn right onto Beacon Street. Follow Beacon Street for 4 blocks and make a left onto Exeter Street. Continue on Exeter Street through 6 lights, which ends on Huntington Avenue. Make a right turn onto Huntington Ave and stay in the left lane. At the first light make a U-turn to the left and the main entrance of the hotel is on your right.

### Weather: What to Expect

The average temperature in the month of November is approximately 45 degrees

Fahrenheit. So pack your jackets and coats, as you will want to have them for walking around the city! Of course, it isn't unheard of to have a few snowflakes in November, though not typical. Let's hope for a crisp, fall weekend in New England!

### The Conference Hotel: What to Expect

For those who appreciate the feeling of getting away from it all and make conferences double as a long weekend getaway/vacation, the Boston Marriott Copley Place has all the right ingredients to make the trip feel like a break. The Boston Marriott Copley Place is located in the heart of the Back Bay, just steps from great shopping and restaurants. For those who didn't quite finish their poster or presentation, and didn't bring a laptop, the hotel has PC and printer available in their full business center. In addition, each room has high-speed Internet access. The hotel also has a fitness center and indoor pool, whirlpool and sauna. Besides 24-hour room service, there are also plenty of restaurants and lounges in the hotel, including Gourmeli's (Casual American cuisine), Champions (American Sports Bar), a Sushi Bar, and a Starbucks coffee (open all day!). In addition, the hotel happens to be connected by indoor walkways to the Copley mall, an upscale mall complete with a movie theatre and a Legal Seafood Restaurant, Cheesecake Factory Restaurant, and California Pizza Kitchen, among others. Although the hotel certainly has enough to keep everyone content, we encourage conference attendees to venture out and explore the restaurants and sights of Boston.

### It's an Evening Together! And You Are Invited . . .

In the mood for an evening of conversation, beverages, billiards, and plates of fresh seafood? For those who arrive in Boston by Thursday, join us Thursday evening in Boston's new lounge/restaurant/entertainment complex, just a short walk from the conference hotel. We will be gathering in the King's and DeVille Lounge/Summer Shack, which are all interconnected and are located right across the street from the Sheraton Hotel, at 50 Dalton Street. In the Summer Shack, you can bring the whole gang to this classic, fun, brightly colored dining room, complete with lobster tank and clam shack "to go" window. The King's Lounge and DeVille Lounge are retro-designed watering holes complete with neon-lit 10-pin bowling alleys, billiards, and upbeat disco and funk music. Black

lights illuminate the rainbow-colored bowling balls. Kings is also home to DeVille Lounge, a 1960s-style lounge complete with all the retro details. King's/Deville and the Summer Shack are big enough to have something for everyone—so bring your companions and reunite with colleagues and fellow AABT friends on Thursday evening to kick off your Boston weekend!

To get to the party from the conference hotel, you can walk through the Boston Marriott Copley Place Hotel toward the Prudential Shopping Mall. While in the Prudential Mall, follow signs and walkways to the Sheraton Hotel. Go down the escalator to the hotel lobby. Across the street from the Sheraton Hotel is King's/Deville Lounge and the Summer Shack. For those driving to the party, parking is conveniently located right next door at the parking garage on Dalton Street.

### Don't Forget About *Shear Madness!*

For those who are interested in seeing Boston's longest-running comedy theatre production, we have reserved tickets for *Shear Madness*, a fun "whodunit," Boston-themed production. Reserve your ticket early; information about reserving a ticket will be forthcoming in the AABT program guide.

### Visit the Local Arrangements Desk

Need detailed information about hotels, restaurants, sights, tours, or theater? Come visit our Local Arrangements desk, located near the registration tables at the Marriott Hotel. We will have maps available, discount coupons to restaurants and attractions in the city, as well as sign-up sheets for dining with locals. Also, visit the Local Arrangements desk to get information about when to meet our Local Arrange-

ments guides for runs and walks on the Charles River Esplanade. All Local Arrangements volunteers will be wearing identifying ribbons on our nametags; feel free to ask any of us questions about what to do in Boston.

Finally, to get you ready for Boston, we leave you with a break from your work. Put down the grant proposals, manuscripts, progress notes, and other work for a few minutes, and try your skill at the crossword puzzle located on the back page. Try it now, or save it for the flight to Boston. The answer key is posted at [www.aabt.org](http://www.aabt.org). Use it as an opportunity to get on-line and register for the conference! For those who finish the crossword on the plane, come visit the Local Arrangements desk for a copy of the answer key. Enjoy, and we'll see you in Beantown!



*Crossword on back page.*

### Preconvention Soiree!

# YOU ARE INVITED

Thursday, November 20  
King's and DeVille Lounge  
50 Dalton Street

For those who arrive in Boston by Thursday, join us Thursday evening in Boston's new lounge/restaurant/entertainment complex, just a short walk from the conference hotel. We will be gathering in the King's and DeVille Lounge/Summer Shack, which are all interconnected and are located right across the street from the Sheraton Hotel, at 50 Dalton Street.



### Classifieds

Classified ads are charged at \$4.00 per line. Classified ads can be e-mailed directly to Stephanie Schwartz, Advertising Manager, at [sschwartz@aabt.org](mailto:sschwartz@aabt.org); otherwise, please fax or mail hard copy to AABT, 305 Seventh Ave., New York, NY 10001 (fax: 212-647-1865).

#### Positions Available

**ALLIED HEALTH PROVIDERS PC** is a multi-site group practice on Cape Cod. We are looking for licensed psychologists with 2 or more years post-license as a health-care provider, experienced with children/adolescents. We will use our group HMO contracts to facilitate credentialing on all our panels. Send resume, copy of license, graduate transcript, and recommendation letters to: AHP, 1074 Rte 6A W. Barnstable, MA 02668-1142. Tel.: 508-362-1180.

**BEHAVIORAL HEALTH CONSULTANT.** Seeking a clinical psychologist to be a team member in our Auburn primary care clinic providing consultation & behavioral health intervention. Exp. in behavioral health required. Bilingual in Spanish preferred. Send cover letter & resume to Community Health Centers of King County 403 E. Meeker St., Suite 300, Kent, WA 98030, fax (425) 277-1566 or [recruiting@chckc.org](mailto:recruiting@chckc.org) Job line: (253) 372-3662 EOE

**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.

**BEHAVIORAL PSYCHOLOGIST.** Multi-disciplinary 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.

**HUDSON RIVER REGIONAL PREDOCTORAL INTERNSHIP PROGRAM IN PROFESSIONAL PSYCHOLOGY, NEW YORK STATE OFFICE OF MENTAL HEALTH:** offers full time pre-doctoral internship positions in professional psychology for 2004-2005 in its APA accredited program. Weekly seminars in a variety of clinical and professional areas supplement extensive supervision. Clinical assignments are to inpatient and community services programs at facilities of the New York State Office of Mental Health. Preference is given to students enrolled in APA-accredited clinical or counseling psychology programs. For further information and application materials contact: Paul Margolies, Ph.D., Training Director, Hudson River Regional Psychology Internship Program, Hudson River Psychiatric Center, 10 Ross Circle, Poughkeepsie, New York, 12601-1078; e-mail [hrrhbjm@omh.state.ny.us](mailto:hrrhbjm@omh.state.ny.us); phone: (845) 483-3310.

**EXCELLENT OPPORTUNITY FOR A PART-TIME BEHAVIORAL PSYCHOLOGIST** to work in a well-established private practice. Applicants must have a doctorate in psychology and be on at least two major insurance panels (i.e., BC/BS, Tufts, Magellan, Harvard Pilgrim). Send resume to: Jacob Azerrad, Ph.D., P.O. Box 353, Lexington, MA 02420 or fax to 781-861-8637.

# AWARDS & RECOGNITION

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## Lifetime Achievement

*Gerald C. Davison, Ph.D.*, University of Southern California

## Outstanding Service to AABT

*Lizette Peterson-Homer, Ph.D.* (in memoriam)

*Richard J. Seime, Ph.D.*, Mayo Clinic

*Rosemary Park*, AABT

## Outstanding Educator

*Harold Leitenberg, Ph.D.*, University of Vermont

## Outstanding Training Program

University of Washington Clinical Ph.D. Program

*Robert J. Kohlenberg, Ph.D.*, Director of Clinical Training

## Distinguished Friend to Behavior Therapy

*John Allen, Ph.D., M.P.A.*, Chief of the Treatment Research  
Branch of the National Institute of Alcohol Abuse and Alcoholism

## 3rd Annual Virginia Roswell Dissertation

*Elizabeth M. Podniesinski, M.A.*, Boston University



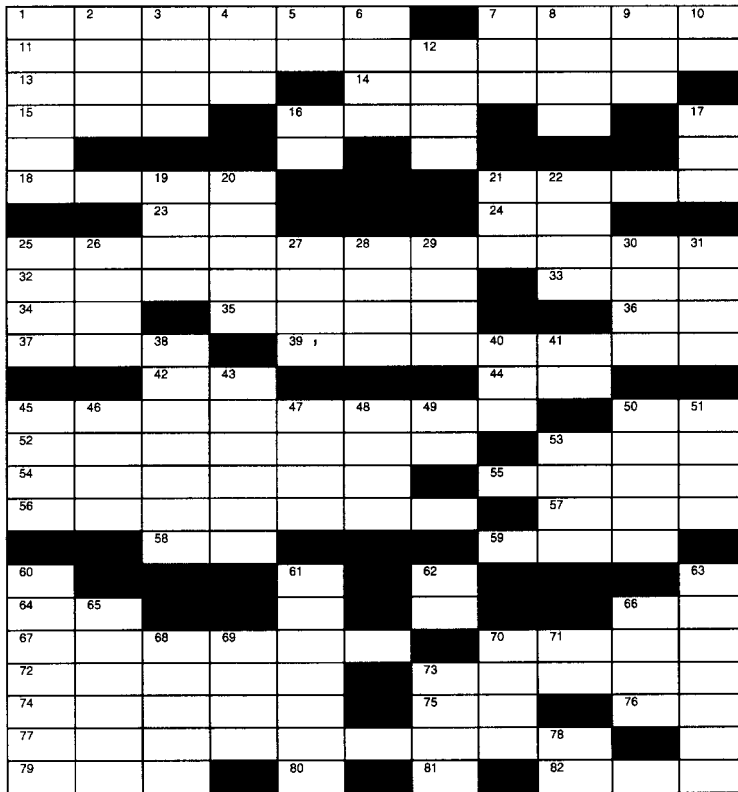
**When?** FRIDAY, NOVEMBER 21, 2003, 5:15–6:15 P.M.

**Where?** AABT'S ANNUAL MEETING AT THE BOSTON MARRIOTT COPLEY PLACE,  
GRAND BALLROOM A/B/C/D

# 37th Annual Convention *Travel Companion*



Boston, November 20-23, 2003



37. Apply your analytic skills to this org.  
 39. Program book disappointment  
 42. \_\_\_ Minnow  
 44. Below Canada (abbr.)  
 45. See 12 down  
 50. Not quite a PhD: \_\_\_D.  
 52. Heading eastward  
 53. Golf club  
 54. Division  
 55. 1776 Loyalist  
 56. See 12 down  
 57. Natural or noble \_\_\_  
 58. Follows your ABCs  
 59. \_\_\_ Angeles or Alamos, for example  
 64. Sale item: \_\_\_ is  
 66. Area prosecutor  
 67. A. T. Beck wears one  
 70. A \_\_\_ is born  
 72. Not fauna  
 73. Update of the law school exam?  
 74. Inferior organ donor? (to psychology)  
 75. Mass. General Hospital has one  
 76. Machine smarts  
 77. What a practiced speaker does with a question in a large room  
 79. Before (in rhyme)  
 80. Boston subway  
 81. \_\_\_-bone  
 82. Piece of a byte
9. Distress message  
 10. With "Live" it would make a TV show (abbr.)  
 12. See 11, 15, 25 across etc.  
 16. J \_\_\_  
 17. A CS is one  
 19. Green feeling  
 20. Produce lots of offspring  
 21. Overact  
 22. \_\_\_ Easy  
 25. Anxiety Org.  
 26. Dull  
 27. Relevant Consumer Org.  
 28. A Chowder favorite  
 29. Spirit  
 30. \_\_\_ ception (ouch!)  
 31. Car \_\_\_  
 38. Place to keep fireplace refuse? (you mean you don't have one?)  
 40. \_\_\_Town  
 41. \_\_\_ Elliot  
 43. Theme of 10 down  
 45. \_\_\_ in show  
 46. \_\_\_ and every time  
 47. Purchase air travel with this  
 48. Joined the army police  
 49. Start of monster (from a fairy tale?)  
 50. Eating disorder focused - Stewart \_\_\_  
 51. Boston coastal areas  
 53. \_\_\_ Stick  
 60. \$30 or so from Logan airport to the hotel  
 61. Nice Ronco product for an oxygen-deprived animal researcher?  
 62. Too much of no. 70 down  
 63. Conference hotel (minus 81 across)  
 65. Mending alloy  
 66. Valuable research product  
 68. Notable systematic desensitizer  
 69. Arborist's fancy  
 70. Popular psychiatric drug  
 71. Grad student job other than RA  
 73. Peter Pan's boys  
 78. Much more than a bad cough (abbr.)

## Crossword by Michael Otto

### ACROSS

1. Site of conference  
 7. Western religious rite  
 11. See 12 down  
 13. Your registration will do this  
 14. Barlow, Haaga, Penn, & Teisler  
 15. See 12 down  
 16. Needs a key or a collar  
 18. \_\_\_ St. Laurent  
 21. Program chair who brought e-submissions  
 23. Letters for size and significance, respectively  
 24. Speakers turned in this request  
 25. See 12 down  
 32. Plasterboard  
 33. Kanga's kid  
 34. 12-step program  
 35. 34-across in Santa Fe or Albuquerque  
 36. Firm (abbr.)

### DOWN

1. Movie starring Mickey Rourke  
 2. \_\_\_ Bucco  
 3. Evidence this was not done by Will Shortz  
 4. \_\_\_ Gun  
 5. With D, makes an anxiety disorder  
 6. Lisa Onken's group  
 7. I want my \_\_\_ (Dire Straits)  
 8. Classes for 76 across?

SOLUTION AT [WWW.AABT.ORG](http://WWW.AABT.ORG)

## *the Behavior Therapist*

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