

# the Behavior Therapist

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### Open Forum

## Cognitive-Behavioral Couple's Treatment for Posttraumatic Stress Disorder

Candice M. Monson, Karen A. Guthrie, and Susan Stevens, *White River Junction VA Regional Office and Medical Center*

Cognitive-behavioral theory and technique has been relatively underutilized in treating individuals with posttraumatic stress disorder (PTSD) within a couple's therapy context. This is despite the clinically recognized and empirically established association between PTSD and intimate relationship problems (e.g., Beckham, Lytle, & Feldman, 1996; Byrne & Riggs, 1996; Carroll, Rueger, Foy, & Donahoe, 1985; Jordan et al., 1992). Although existing cognitive-behavioral treatments for PTSD are extremely beneficial for some clients (Rothbaum, Meadows, Resick, & Foy, 2000, for review), there are limitations to these existing treatments, including problems in delivery (i.e., attrition rates as high as 50% in some samples) and outcomes (e.g., variable success in treating avoidance/numbing symptoms; 25% to 60% still meet diagnostic criteria for PTSD at the end of treatment and at follow-up periods; see Zayfert, Becker, & Gillock, 2002, for discussion). Moreover, these treatments have not been specifically designed to address the complex interplay of intimate relationships and PTSD. In an effort to extend our treatment repertoire for PTSD, we developed a Cognitive-Behavioral Couple's Treatment (CBCT) for PTSD that addresses cognitive and behavioral mechanisms thought to contribute to both PTSD and intimate relationship discord. This article provides an overview of the treatment protocol.

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This approach evolved out of our work  
with veterans suffering from military-  
related PTSD—primarily men suffering  
from combat-related trauma—within the  
Family IMPACT (Family Integration in the  
Management, Prevention, Assessment, and  
Counseling of Trauma) Project at the White  
River Junction VA Regional Office and  
Medical Center, Mental Health/Behavioral  
Science Service and National Center for  
PTSD, Executive Division. However, the  
interpersonal problems of men and women  
suffering from PTSD caused by the expo-  
sure to a wide variety of stressors appear to  
be remarkably similar to those suffering  
from combat-related trauma (e.g.,  
Herman, 1992; Neumann, Houskamp,  
Pollock, & Briere, 1996). In brief, individu-  
als with PTSD report greater frequency and  
severity of intimate relationship dysfunc-  
tion, including intimate aggression. PTSD  
is also associated with a higher rate of sepa-  
rations and divorce. The avoidance/numb-  
ing cluster of PTSD has been implicated in  
relationship discord and intimacy prob-  
lems, and there is some evidence of an asso-  
ciation between hyperarousal symptoms  
and the perpetration of physical and psy-  
chological aggression in male veterans.  
Most of the empirical research that has been  
conducted with the significant others of  
traumatized individuals has consisted of fe-  
male partners of male combat veterans.  
These partners report a wide range of men-  
tal health and relationship problems that  
have been found to be associated with their  
partner's PTSD symptomatology. Despite  
the similarity of these relationship issues  
caused by various forms of trauma, there are  
also symptoms unique to specific types of  
trauma.

## Previous Studies of Conjoint Therapy for PTSD

The identification of intimate relation-  
ship problems associated with PTSD and  
discussion of the role of traumatized indi-  
viduals' partners in trauma treatment (e.g.,  
Byrne & Riggs, 1996; Carroll et al., 1985;  
Erickson, 1989; Figley, 1988, 1989;  
Johnson, Feldman, & Lubin, 1995; Johnson  
& Williams-Keeler, 1998; Matsakis, 1994;  
Riggs, 2000; Riggs, Byrne, Weathers, &  
Litz, 1998; Tarrier, Sommerfield, & Pil-  
grim, 1999) has not necessarily translated  
into treatment research efforts. To our  
knowledge, there have been only two con-  
trolled and two uncontrolled studies that  
have investigated conjoint treatment for  
PTSD. Treatments employed in these stud-  
ies consisted of generic forms of behavioral  
couple's/family therapy (i.e., no specific  
focus on PTSD-related issues).

## Randomized Clinical Trials

In a dissertation study of group behav-  
ioral couple's therapy compared to wait list,  
Sweany (1987) found a significant decrease  
in self-reported PTSD symptoms for those  
in treatment compared to the control con-  
dition. Furthermore, there were trends for  
improvements in relationship satisfaction  
and the veteran's depression. Also using a  
veteran sample, Glynn et al. (1999) com-  
pared individual exposure therapy alone to  
individual exposure therapy followed by be-  
havioral family therapy (BFT; 89% were  
conjugal partners) to a wait-list control  
group. They found significant improve-  
ments in the positive symptoms of PTSD  
(i.e., reexperiencing and hyperarousal) for  
both active treatments compared to the  
control group, but no differences between  
the two active treatments. There were no  
significant improvements found in the neg-  
ative symptoms of PTSD (i.e., avoidance

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The Association for Advancement of Behavior  
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and numbing) across the three conditions. It should be noted that there was a high dropout rate in the BFT condition (i.e., 35%), which the authors attributed to the delay prior to receiving BFT and the fragility of these veterans' relationships. Experiences with exposure therapy may also explain this attrition, given the study's sequential design.

### *Uncontrolled Trials*

Two uncontrolled treatment studies of conjoint therapy have been reported. Using group behavioral couple's therapy with combat veterans, Cahoon (1984) found statistically significant improvements in PTSD symptoms and coping ability (as rated by the group leaders; effect sizes .47 and .72, respectively). While the veterans reported nonsignificant improvements in emotional and problem-solving communication (effect sizes .18 and .41, respectively), the veterans' female significant others reported significant improvements in marital distress and problem-solving communication (effect sizes .34 and .56, respectively). Rabin and Nardi (1991) also provided a cognitive-behavioral group couple's treatment with Israeli combat veterans and their wives, which included psychoeducation about PTSD. Minimal objective outcome data are provided from this study; however, 68% of the traumatized men and their wives reported relationship improvements. However, this study did not show a decrease in the veterans' PTSD symptoms.

### **CBCT for PTSD**

CBCT<sup>1</sup> has received widespread validation for treatment of couple's distress and dysfunction (see Christensen & Heavey, 1999, for review), and has been extended and empirically tested in the treatment of individuals suffering from a variety of clinical problems. With regard to depression, domestic violence, alcohol and drug dependence/abuse, and agoraphobia, CBCT has been found to be equally or more efficacious than individual or group therapy in treating the primary clinical problem. Moreover, CBCT has a variety of additional benefits, including increased relationship satisfaction, decreased intimate aggression, less time separated, fewer divorces, more efficient treatment (i.e., greater gains, quicker), less attrition from treatment, and

treatment-related cost savings (e.g., Arrindell & Emmelkamp, 1986; Daiuto, Baucom, Epstein, & Dutton, 1998, for meta-analysis regarding agoraphobia; Fals-Stewart, Birchler, & O'Farrell, 1996; Jacobson, Dobson, Fruzzetti, Schmalings, & Salusky, 1991; McCrady, Stout, Noel, Abrams, & Nelson, 1991; O'Farrell et al., 1996; O'Leary & Beach, 1990; O'Leary, Heyman, & Neidig, 1999).

Taking into account the devastating and largely untreated relationship problems associated with PTSD, some preliminary evidence supporting the efficacy of behavioral couple's therapy for PTSD, and the established efficacy of CBCT for a variety of other individual problems, we have developed a cognitive-behavioral couple's treatment specific to PTSD. The treatment is grounded in cognitive-behavioral conceptualizations of intimate relationship discord and PTSD.

### *Cognitive and Behavioral Mechanisms*

Behavioral conceptualizations have been offered to explain intimate relationship discord and PTSD, respectively. In the case of intimate relationship discord, nonreinforcing, conflictual, and/or abusive behavior and communication are considered to cause and maintain couple distress and are primary targets for intervention (Jacobson & Margolin, 1979). Mowrer's (1960) two-factor explanation of conditioned fears has been used to explain the development and maintenance of PTSD symptoms (e.g., Foa & Kozak, 1991; Keane, Zimering, & Caddell, 1985). Classical conditioning processes are postulated to explain the origins of the anxiety response, while operant conditioning processes explain its maintenance (i.e., negative reinforcement of fear through behavioral avoidance). Experiential avoidance, or avoidance of private experiences (e.g., feelings, memories, behavioral predispositions, thoughts; Hayes & Gifford, 1997, for review) construed to be negative, is a particular form of avoidance that has recently been implicated in the development and maintenance of PTSD (Boesch, Koss, Figueredo, & Coan, 2001). Behavioral interventions for PTSD are aimed at exposure to traumatic memories and trauma-related cues, with the goal of anxiety habituation. While the trauma exposure may differ with regard to the dimensions of exposure type

(i.e., imaginal versus in vivo), exposure length (i.e., short versus long), and arousal level during exposure (low versus high), they share the common feature of having patients confront their fears, and are generically referred to as "exposure" treatments for PTSD (Foa & Rothbaum, 1998).

Cognitive constructs have been incorporated into these behavioral conceptualizations of PTSD and relationship dysfunction. Selective attention to negative events, distress-maintaining attributions, unrealistic and/or unshared expectancies, conflicting assumptions, and differing standards have been found to be associated with intimate relationship discord (Baucom, Epstein, & Rankin, 1995). Similarly, information (Lang, 1977) and emotion (e.g., Foa & Kozak, 1991) processing theories have been used to explain the processes through which traumatic memories and associated affects are stored, maintained, and targeted in treatment. Schemas, or cognitive structures of meaning, have also been used to explain how trauma affects a person's belief system and the adjustments (i.e., schema accommodation and assimilation) necessary to reconcile the traumatic event with existing beliefs and expectations and to process associated emotions (e.g., Resick & Schnicke, 1993). Cognitive interventions consist of challenging irrational and/or dysfunctional thoughts and beliefs related to intimate relationship discord or PTSD.

*Interplay of intimate relationship discord and PTSD.* Similar cognitive and behavioral mechanisms are postulated to underlie PTSD and relationship discord, and can interact to maintain or exacerbate both problem areas. If successfully targeted in treatment, this reciprocal association holds potential to ameliorate both PTSD and intimate relationship dysfunction.

In CBCT for PTSD, avoidance is considered to be a primary behavioral mechanism contributing to PTSD and intimate relationship problems, and is consequently targeted early on and throughout treatment. This notion is supported by empirical research that has revealed an association between the avoidance/numbing PTSD symptom cluster and diminished relationship satisfaction and intimacy. In this research, numbing symptoms were especially problematic to relationship functioning (Riggs et al., 1998). Likewise, the avoidance of affective expression and sharing in intimate relationships has long been associated with diminished relationship satisfaction and intimacy in couples in general (see Gottman & Levenson, 1986, for review).

<sup>1</sup>For this review, we use CBCT to describe the treatments to date that have been expanded to treat people suffering from a variety of individual problems. However, CBCT is part of a larger class of conjoint interventions with varying emphases and interventions. These treatments are also referred to in the literature as behavioral couple's therapy, behavioral marital therapy, behavioral conjoint therapy, and integrative behavioral couple therapy.

Monitoring for the various means by which an individual or couple may exhibit avoidance is considered integral to successful treatment. Avoidance may consist of more traditionally considered behavioral avoidance of trauma-related cues and reminders. However, this avoidance may be generalized to include experiential avoidance, as well as avoidance of certain individual or couple's issues. Experiential avoidance is considered to frustrate intimacy because of the diminished ability for affective expression and communication. "Avoiding avoidance" is accomplished through psychoeducation and the couple's development of conflict management and communication skills that can be used to discuss and manage increasingly distressing issues previously avoided. The discussion of these topics, including trauma-related thoughts, feelings, and behaviors, provides opportunities to directly address the issues contributing to PTSD. Moreover, specific emphasis is paid to emotion identification, sharing, and reflection in couple's communication, and the value of emotion expression and tolerance in individual and couple functioning is underscored. Conflict-management skills building is also postulated to improve management of PTSD hyperarousal symptoms such as anger and irritability, which have been found to be associated with intimate aggression perpetration (Savarese, Suvak, King, & King, 2001).

CBCT for PTSD is not considered to be an exposure treatment: Individuals are not confronted with specific traumatic experiences with the goal of anxiety habituation. Rather, consistent with cognitive conceptualizations of PTSD, individuals are encouraged to focus on the various emotions surrounding their memories and reminders of the event(s), as well as the meaning of the event(s) for the here-and-now. Thus, we argue that relaying the specific details is less important than fully experiencing, expressing, and processing the emotions attached to them. In this cognitive vein, similar cognitive structural (i.e., schemas), content (i.e., irrational and/or dysfunctional thoughts, beliefs, standards, assumptions, attributions), and process (i.e., accommodation, assimilation) variables have been used to explain the development and maintenance of intimate relationship discord and PTSD.

McCann and Pearlman's (1990) work, also incorporated into Cognitive Processing Therapy (CPT; Resick & Schnicke, 1993), provides cognitive content relevant to PTSD and intimate relationships that is

specifically targeted for cognitive intervention. They outline five areas of functioning frequently affected by traumatic experiences: safety, trust, power/control, esteem, and intimacy. Consistent with CPT, thoughts and beliefs held across these areas are explored and challenged as they relate to the self and other, with the goal of schema accommodation and emotional processing. These themes, including their interpersonal focus, fit nicely with the conjoint therapy frame.

### *Treatment Format*

Routine pre- and posttreatment assessments are highly encouraged, regardless of whether the treatment is delivered in a research protocol or in nonresearch practice. Prior to initiating treatment, we provide clients with feedback about their PTSD symptoms, relationship functioning, and associated psychological issues. This feedback is used as an aid to psychoeducation and in treatment goal setting, and supports the goal-oriented focus of treatment. In our experience, couples have been eager to receive their assessment results, and these results have enhanced treatment delivery. We use both self-report (PTSD Checklist; Weathers, Litz, Herman, Huska, & Keane, 1993) and interview (Clinician-Administered PTSD Scale for *DSM-IV*; Blake et al., 1990) methods for assessing PTSD. Relationship variables assessed include relationship satisfaction (Dyadic Adjustment Scale; Spanier, 1976), intimate aggression (Conflict Tactics Scale-Second Edition; Straus, Hamby, McCoy, & Sugarman, 1996), communication skills (10-minute communication sample about a moderately distressing topic for behavioral coding), and adult attachment (Experiences in Close Relationships; Brennan, Clark, & Shaver, 1998). Depression (Beck Depression Inventory; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961), anxiety (State-Trait Anxiety Inventory; Spielberger & Lushene, 1989), and affective control (Affective Control Scale; Berg, Shapiro, Chambless, Ahrens, 1998) are associated features assessed.

CBCT for PTSD consists of 15 weekly sessions comprising three primary treatment phases: (a) treatment orientation, psychoeducation about PTSD and its related intimate relationship problems, and safety building; (b) communication skills training; and (c) cognitive interventions. Each 75-minute session begins with an overview of what is to be accomplished in the session, and includes didactic information to convey to clients and skills for them to practice in

the session. Out-of-session assignments conclude each of the sessions (see Table 1).

The first three sessions of the treatment are focused on orienting the couple to treatment, psychoeducation about PTSD, relationships and avoidance, and establishing safety within the couple and the therapeutic relationship. The first session outlines treatment expectations and presents the phase-oriented, here-and-now, goal-oriented, and time-limited nature of the treatment. We candidly discuss the issue of trauma disclosure and solicit possible concerns, desires, and prohibitions from each member of the couple about this issue (see Special Considerations section for more discussion). The expectation and rationale for out-of-session assignments (we are careful to use the word "assignment" as opposed to "homework" based on feedback from our clients) are also provided in this session. Treatment goals are mutually developed, and each member of the couple signs a treatment contract containing these goals and the above treatment expectations. Session 1 also emphasizes the importance of increasing positive couple behavior while decreasing negative couple behavior. This leads to the first out-of-session assignment: daily attention to their partner's positive behavior.

Session 2 is devoted to understanding PTSD as an anxiety disorder as well as introducing a cognitive-behavioral conceptualization of PTSD. Couples receive information about hallmark PTSD symptoms and associated problems, for example, the maintenance of PTSD through avoidance strategies such as experiential avoidance. We also explore the hypothesized deleterious role of experiential avoidance in intimate relationships (i.e., avoidance and/or numbing symptoms) and its manifestation in the specific couple's relationship. The notion of habituation is presented to provide a rationale to support the couple in discussing uncomfortable and distressing topics. The third session is spent exploring the existence of very negative behavior (e.g., intimate aggression, threats to leave the relationship, ongoing infidelity), and developing conflict-management skills (e.g., timeouts).

*Communication skills training.* Sessions 4 through 8 focus on traditional communication skills building (e.g., listening/paraphrasing; assertiveness, emotional versus problem-solving communication; emotion identification, sharing, and reflection) using increasingly distressing topics (low to moderate range) based on the couple's current difficulties. In the fourth session, the couple



views their pretreatment communication sample with the therapist. This supports the rationale for communication skills training and allows the couple to observe their communication from a more objective perspective. The couple is asked to audiotape 5 to 10 minutes of communication each week in their home setting during this treatment phase, utilizing the communication skills they are building. These audiotapes are reviewed with the couple in the next session to troubleshoot and to provide positive feedback to the couple.

**Cognitive interventions.** In the final phase of treatment, the couple more deeply consolidates their knowledge about PTSD and intimate relationships using their newly developed skills to address the effect of trauma on themselves and their relationship. Session 9 introduces the influence of trauma on how people perceive the world, themselves, and others, and the role of dysfunctional thoughts and beliefs in maintaining distress. The five themes outlined by McCann and Pearlman (1990) presented above (i.e., safety, trust, power/control, intimacy, and esteem) are introduced over five sessions and used as communication topics for the couple's out-of-session practice. The couple is encouraged to draw upon their communication skills and to assume a posture of curiosity as they nonjudgmentally explore and gently mutually challenge or support their thoughts and beliefs held in these areas. Each session concludes with an out-of-session assignment to discuss the identified area presented in that session over the subsequent week, audiotaping at least one of the communications for review at the next session.

The final session is spent reviewing and reinforcing gains made in therapy and anticipating future challenges.

### Special Considerations

We recently completed an open trial of CBCT for PTSD to fine-tune the treatment manual (available from the first author), train therapists, and provide initial evidence regarding its safety, tolerability, and efficacy. From this initial, and other's, work, we offer up the following considerations.

#### *Dually Traumatized Couples*

Dually traumatized couples may be more the rule than the exception. This is especially likely when working with couples wherein the initially referred patient has a female partner because of the two-to-one prevalence of PTSD in women versus men (e.g., Kessler, Sonnega, Bromet, Hughes, &

Nelson, 1995). In addition, previous research suggests that people who have a psychological disorder are more likely to marry or cohabit with people who also have a psychological disorder (Du Fort, Kovess, & Boivin, 1994). The partner may have experienced primary traumatization prior to or during their intimate relationship as a result of family-of-origin violence, exposure to domestic violence perpetrated by their partner with PTSD or previous partner, sexual assault, or some other type of trauma. In addition, a number of authors have discussed vicarious or secondary traumatization of these partners as a result of strong emotional connections with the trauma victim (e.g., Figley, 1989; Nelson & Wright, 1996; Rosenheck & Nathan, 1985). Thus, we assume, and it has been the case thus far in our work, that partners are likely to present with PTSD and/or some other type of psychological problem.

The treatment principles and interventions of CBCT for PTSD are considered to be sufficiently broad and flexible to meet the challenges of couples with their respective psychopathology. Evidence to support this assertion is that all of the female partners in our study had trauma histories and/or clinical levels of depression, anxiety, and/or PTSD symptoms. Therapists should anticipate possible reactions to disclosures and distressing topics, monitor for any changes in risk factors (e.g., suicidality, aggression, substance abuse) for both members of the couple, and stress the importance of emotional and physical safety throughout therapy.

#### *Trauma Disclosure*

Another important point to highlight about the treatment is that we explicitly discuss with the couple that there is no requirement that either of them disclose specific information about their trauma history. In general, we encourage clients to talk about their trauma histories as they relate to here-and-now thoughts and feelings; we discourage in-depth, gory, and/or gratuitous retellings of their experiences. We have adopted this approach to avoid possible vicarious traumatization of partners and based on clinical trials supporting the efficacy of cognitively focused approaches to PTSD treatment (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Resick, Nishith, Weaver, Astin, & Feuer, in press; Tarrier et al., 1999). Even if clients do not share details of their traumatic experiences, beliefs and emotions linked to their traumas are likely to be evoked, which provides op-

portunities for habituation, schema accommodation, emotional processing, and greater mastery and tolerance of these emotions.

#### *Type of Trauma*

As noted in the introduction, military-related trauma is clearly not the only form of trauma exposure that leads to significant interpersonal difficulties. By their very nature, interpersonal traumas appear likely to lead to intimate relationship problems and may be particularly well suited for CBCT. For example, Follette and Pistorello (1995) outlined various problems found in couples in which the woman was a victim of childhood sexual assault; they also suggest the use of interventions to address experiential avoidance. Some specific problems related to sexual assault/abuse may include retriggering of traumatic memories and sensations, dissociation, or flashbacks during the couple's sexual relations; hyper- or hyposexuality; problems with libido; or general negative attitudes about sex. Revictimization is clearly of concern with victims of interpersonal violence (e.g., Messman-Moore & Long, 2000) and is an issue that should be specifically assessed and addressed within the conjoint context (i.e., history of, or current emotional, physical, or sexual abuse within the relationship).

### Summary

Our challenge in advancing PTSD treatment is to offer innovative stand-alone or adjunctive treatments for those individuals who have not responded or fully benefited from available empirically validated treatments. Given the established interpersonal costs of PTSD and proven efficacy of conjoint therapy for other individual problems, we believe that CBCT for PTSD holds promise as an efficient and efficacious treatment for individuals and their loved ones with PTSD.

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Table 1  
CBCT for PTSD Session Overview

|   |   |
|---|---|
| Pretreatment Session: Treatment Summary and Informed Consent Procedures |   |
| Pretreatment Session: Self-Report, CAPS, and Behavioral Assessments     |   |
| Pretreatment Session: Review of Assessment Results                      |   |
| Session 1   | <b>Introduction of Treatment Model, Frame, and Contract</b><br><i>Out-of-session assignment:</i> session overview<br>treatment contract<br>common reactions to trauma<br>Catch Your Partner Doing Something Nice I<br>impact statements                       |
| Session 2   | <b>Psychoeducation About PTSD, Relationships, and Avoidance</b><br><i>Out-of-session assignment:</i> PTSD and avoidance handout<br>Catch Your Partner Doing Something Nice II   |
| Session 3   | <b>Safety Building</b><br><i>Out-of-session assignment:</i> steps to an effective time-out  |
| Session 4   | <b>Introduction of Communication Skills Training</b><br><i>Out-of-session assignment:</i> common communication problems handout<br>Dirty Fighter's Instruction Manual handout   |
| Session 5   | <b>Listening and Paraphrasing</b><br><i>Out-of-session assignment:</i> communication practice-listening/paraphrasing<br>communication reviews   |
| Session 6   | <b>Assertive Speaking</b><br><i>Out-of-session assignment:</i> assertiveness definitions and barriers<br>assertiveness table<br>making assertive requests and refusals<br>communication practice-assertive speaking<br>communication reviews                  |
| Session 7   | <b>Communication Channels</b><br><i>Out-of-session assignment:</i> communication channels hand-out<br>communication practice-communication channels<br>communication reviews  |
| Session 8   | <b>Identification, Sharing, and Reflection of Feelings</b><br><i>Out-of-session assignment:</i> Feeling Faces handout<br>daily expression and reflection of feelings<br>communication practice-feelings<br>communication reviews<br>treatment contract review |
| Session 9   | <b>Cognitive Overview*</b><br><i>Out-of-session assignment:</i> stuck-points handout<br>problematic-thinking handout<br>thinking about trauma and relationships handout<br>safety-issues handout  |
| Session 10  | <b>Safety Issues</b><br><i>Out-of-session assignment:</i> communication practice-safety<br>communication reviews<br>trust issues handout  |
| Session 11  | <b>Trust Issues</b><br><i>Out-of-session assignment:</i> communication practice: trust<br>communication reviews<br>power and control issues handout   |
| Session 12  | <b>Power and Control Issues</b><br><i>Out-of-session assignment:</i> communication practice-power and control<br>communication reviews<br>intimacy issues handout   |
| Session 13  | <b>Intimacy Issues</b><br><i>Out-of-session assignment:</i> communication practice-intimacy<br>communication reviews<br>esteem issues handout<br>A Compliment a Day   |
| Session 14  | <b>Esteem Issues</b><br><i>Out-of-session assignment:</i> communication practice-esteem<br>communication reviews<br>impact statements ii<br>review of treatment gains   |
| Session 15 Review and Reinforcement of Gains                            |   |
| Posttreatment Sessions: Self-report, CAPS, and Behavioral Assessments   |   |
| *Midtreatment Assessment - PTSD Checklist and Dyadic Adjustment Scale   |   |

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### Open Forum

## Rational Animals: Behavior Therapy's Focus on Knowledge and the Understanding of Human Behavior

William O'Donohue, *University of Nevada, Reno*

I was trained as a cognitive-behavioral clinical psychologist with an emphasis on research. My training was not too atypical. There has been a trend over at least the last three decades for many of the top doctoral programs to have a similar emphasis. This trend looks like it will continue. My thesis—my epiphany—is that the orientation associated with this training is problematic. This training produced what I think may be most aptly described as an applied epistemologist—i.e., someone who has excellent critical abilities regarding knowledge claims—but it produced a very limited psychologist, someone who is skilled at understanding why people behave as they do. Let me explain.

I was trained—well trained, I think—to hear knowledge claims and to evaluate the evidence and logic associated with these. If someone (a colleague or even a client) said that Person X was depressed, I was well trained to evaluate and criticize the quality of this claim, for example, by evaluating the psychometrics of the assessment data, by the degree of independent, convergent sources of information, and even to evaluate to what extent the construct of depression made sense, all in an effort to determine to

what level this inference was warranted. Similarly, if a colleague wanted to use a particular therapy, I was well trained to evaluate the quality of the outcome research to determine if some bar of acceptability was passed. In fact, much of my “growth” after graduate school was learning how to be even better at evaluating these claims. I learned about additional topics such as clinical significance, social validity, meta-analysis, path analyses—how to evaluate knowledge claims with even more tools and at times even higher standards. I could even apply these generic critical skills to topics outside of psychology—the arguments for abortion or against school prayer. This is why I say I became what philosophers often call a critical rationalist; my focus was honing skills to critically evaluate beliefs and knowledge claims. I wasn't unique (although I did have a somewhat unique path as I studied philosophy and philosophy of science for 4 years at the graduate level). My colleagues also had these skills and this orientation.

This worldview—seeing humans as epistemic agents—has deep roots in Western civilization. The ancient Greeks defined humans as “rational animals” and a

key goal was to “know thyself.” Notice the terms “rational” and “know” (but don't forget the term “animal”!). The Enlightenment and the rise of science emphasized refinements and more emphasis upon more careful analysis of knowledge claims. Indeed, certain kinds of defects in rationality came to be the essence of defining madness, insanity, or abnormality (Beck, Rush, Shaw, & Emery, 1979; Ellis & Grieger, 1977; but especially see Sass, 1992). With this orientation, the epistemic emphasis in psychology followed: Look to defects in rationality to understand abnormal behavior and its cures.

But what happened to “the animal”? Taking a closer look at the Greeks and other thinkers, we see that they had a very large and important role for our animal, arational natures (see O'Donohue & Lloyd, 2003). Reason battled against the arational “passions.” Even the medievals saw this battle, reason fought against the Seven Deadly Sins: lust, gluttony, sloth, greed, etc. Much later in intellectual history, Nietzsche's dialectic involving the clean, orderly, rational Apollonian versus the chaotic, passionate, carnal Dionysian also superbly captured this contrast. What place do “the passions”—lust, aggression, and greed—and the Dionysian have in contemporary psychology, particularly contemporary cognitive behavior therapy? They seem to be in the shadows, influencing the well-illuminated rationality. Why aren't they examined in the bright light?

My claim is that this epistemic emphasis (it can even be called rationalistic machoism) moved me away from being a better psychologist. When I listened to people or had interactions, I listened to their knowl-

edge claims (and even evaluated my knowledge claims about their knowledge claims) and evaluated the extent to which these were warranted. This was literally “my experience.” I did not attend to the arational (e.g., the emotional motivations associated with the claim) or fully understand the arational and thus I missed much of what was actually happening. I missed, to be blunt, that people are much more than epistemic agents.

A first step along the path can be the realization that people have some of the beliefs and make some of the knowledge claims they do for other than rational, evidential reasons. To be sure, some folks make these claims because they fairly simply and dispassionately want to know, want to inquire, and want to debate in the Grand Conversation. But, at times, are there other motivations? Are some people making knowledge claims partly because they desire attention/recognition? Because they seek power? Because they have aggressive drives (e.g., Can criticism be aggressive?) Or do they make claims (perhaps at a low frequency and very qualified, and very “conservative”) because they fear being exposed as an imposter—as stupid or ignorant? Are their claims doctrinaire because they need the security of group membership? Finally, are their arguments and evidence for their claims slippery and shoddy because of psychopathic tendencies? I have recently learned it is useful to look at the *psychology of the person* making the claims—their fears, motivations, and needs instead of simply focusing on the claim and its supporting argument. This is not an invitation to make ad hominem arguments—i.e., invalid criticisms of reasoning that refer to some characteristics of the person making the argument. It is a move away from the simplistic notion that the only motivation for a person to make Claim X is that they are (perhaps) in an epistemic position to do so. And I believe it is a move toward one of the ultimate aims of both the scholar and the therapist: to be persuasive. Being persuasive involves understanding the psychology of the person as well as the evidential basis for the claim.

But this still does not go far enough. The lesson I am claiming worth knowing is not, “When people make knowledge claims, understand the person making the claim” (although this is part of it). What I am saying is more like, “Understand people. Their knowledge claim-making component (i.e., what philosophers call their *epistemic agency*) is only a part—sometimes only a small part—of such understanding.”

I believe I’ve made this error for four principle reasons, three of which are common to many of the readers and one of which is somewhat unique. Psychology training has emphasized research methodology. In some ways research methodology is our core. Research methods are, in essence, applied epistemology. Their focus is on gaining knowledge and putting knowledge claims to the test. One can see how this core can lead to the basic orientation I have described. Second, I was trained as a cognitive-behavior therapist. Behavior therapists tend to be hard-nosed, research-oriented folks—again, oriented to claims and evidence. Cognitive therapy, on the other hand, is applied epistemology—evaluating beliefs that lead to problems and teaching better belief formation (O’Donohue & Vass, 1996). Third, I wonder if this orientation comes from a personal need, perhaps widely shared, to see life as orderly, rational, and knowable, and that the arational and irrational (to use Gellner’s felicitous phrase, the “cunning of unreason”) is disturbing and anxiety provoking.

The unique reason (and this is more of a hopefully somewhat interesting side line) is that during my training as a philosopher I learned much about the philosophy of science of Karl Popper and the neo-Popperians (e.g., Lakatos and Bartley). Popper’s ontology (on what there is) asserts the existence of three worlds. Each world consists of different kinds of existences. World 1 consists of all physical objects. World 2 of all psychological events, including actual beliefs, thoughts, and emotions, experienced by real people. World 3 contains intellectual products: arguments, books, claims, and evidence. World 3 objects can be evaluated without reference to real people. Pythagoras’ theorem can be evaluated without any reference to Pythagoras the person. My purpose here is not to argue for the soundness of this ontology but rather to point out how this disposed me to forget the psychology involved in all of this. I lived in World 3 and largely ignored World 2.

What are my positive proposals?

1. See people as (arational and rational) *psychological* entities (i.e., with motivations, fears, and guilt), not only as epistemic entities. The question becomes, *What are the most useful noncognitive constructs to fill out this picture?*

2. Develop a research agenda into the rational/arational model of human behavior, perhaps even drawing on other traditions within psychology that have seen this. The goal is to provide useful assessments

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and therapies that take into account these factors.

There are three (interrelated) general arguments against this “warmer” approach: (a) The ontic argument: These entities just don’t exist. These constructs associated with the arational are in a similar state to poltergeists and devils. If one talks about these, then one is talking about nothing. (b) The epistemic argument: Even if they exist, we can’t know them. This is an epistemic bar/detection-measurement issue (ontology and epistemology are interconnected and thus so are 1 and 2. (c) Even if they exist and they can be known, they aren’t useful in the description, prediction, and control of human behavior. Let me briefly examine each of these issues.

### They Don’t Exist

This is phenomenologically false. We know directly that we have experiences such as felt motives, fears, guilt, needs, fantasies, conflicts. We directly experience our animal/emotional/instinctual/Dionysian natures (at least part of this). We don’t perhaps know all of it, may perhaps have unrecognized components of this, and may need a good taxonomy to organize it, but to any reasonably observant person this claim is obviously false.

Second, science is ultimately pragmatic, and if talk of these constructs results in better outcomes, then this conceptualization wins and these entities are construed as “existing” (see Quine’s 1980 work on what exists—bound variables in the best scientific theories).

### We Can’t Measure These Reliably and Validly

Basically we won’t know until we try. Some progress has been made, but this argument is too general. If we look at the total number of constructs psychologists of all persuasions use and the actual evidence that they can measure these well, we’d find that the vast majority of constructs are not measured well. Some of the hard scientific psychology folks have similar problems (show me a person’s “reinforcement history”). Second, some progress has been made in measuring these constructs. Admittedly more work needs to be done. This does not mean I think something like the Rorschach is what is needed. But it is an argument to understand and attempt to assess that rational but still cognitive and emotional forces influence human behavior. This argument is basically an epistemic one:

The issue is that they cannot be known. Let me spend a bit of time on a meta-issue.

### *Epistemic Bars, What Constitutes Knowledge, and What Might Need to Be in Our Net*

This is a direct relationship between what epistemic criteria we hold and what gets into our net. The philosophy of René Descartes shows this lesson clearly. Descartes wanted to make sure he did not hold a false belief and so he set the epistemic bar very high. Basically he said that a claim could not count as knowledge unless it was “clear and distinct” and “indubitable”—literally not capable of being doubted. He even used an “evil genius” as a heuristic to operationalize the second criterion.

This evil genius was omnipotent and intent on doing all in his power to deceive poor Descartes. Thus, for example, Descartes concluded that none of his sensory data could count as knowledge because the evil genius could simply be tricking his senses. The only belief that passed both criteria was “I think.” (Deception, Descartes pointed out, implied a thinking entity being deceived.) From “I think” Descartes argued that “I exist” could be indubitably inferred. And that was about it. This epistemological bar admitted only Descartes’ cogito, “I think, therefore I exist.”

Descartes was in a pickle. He didn’t want to stop there. Solipsism isn’t all that interesting, particularly in the historical context of the early Enlightenment. Descartes admitted other beliefs, such as the existence of the world through an (invalid) ontological argument for the existence of God. (Basically this argument goes, “I have a thought of God, a perfect being. The only way I can have a thought of such a perfect being is for such a perfect being to actually exist because only a perfect being can cause the thought of its existence.”) Because this perfect being is all good, he does not want to deceive, and therefore Descartes could believe in the veridicalness of his senses and consequently the existence of the world.

Descartes’ epistemic bar is too high. Not enough passes to say much of interest about the world. Bars, obviously, can be too low—and as a field we’ve paid a lot of attention to this problem. But have we paid insufficient attention to the other problem? Have we been too concerned with epistemology and set our epistemic bar too high? Is there a dialectic here—between epistemic standards and admitting the “right stuff” of what it takes to understand humans? Note also

that this happens commonly in the sciences. If astronomy were held to an experimental bar (that is, astronomers had to manipulate independent variables before they could make a knowledge claim), astronomers would be able to make only a small fraction of their current knowledge claims.

Let me ask my new style question: How much have we ignored the irrational and arational because of our needs (associated with being a researcher and intellectual) to see the world in dispassionate, rational terms?

What is it to see a person as a complex psychological entity rather than simply as an epistemic agent? These are the kinds of entities I think might need more attention. Here’s a quick list:

- arational needs (e.g., sex and aggression; recognized and unrecognized)
- ambivalence
- core interpersonal styles and conflict patterns
- image of self
- secrets and shame
- implicit agendas
- narcissistic and power drives
- developmental blocks/issues
- blind spots (motivated and unmotivated), and the processes that create these

The person with these constructs is seen as an epistemic agent but also as a needy, emotional, somewhat confused, somewhat ambivalent, somewhat deceptive, somewhat fearful, somewhat proud, somewhat aggressive, somewhat ashamed, somewhat harmed by past difficulties individual constructing façades to self and others to hide some of these irrationalities and embarrassments. And of course there are huge individual differences in the valences and magnitudes of each of these dimensions. This, I think, is a more interesting and fruitful conceptualization of human behavior. A human being is seen as much more than an epistemic agent. How do we balance epistemic standards and not make the Cartesian mistake to gain some of the content of these, while at the same time not becoming careless epistemically?

We can have reasonable epistemic standards and still adopt this basic view of a person. After all, even the behavioral position sees arational mechanisms as its two major determinants of human behavior. The “contingencies of survival” are not rational, they simply determine the probability of surviving and reproducing. The same thing is true about the “contingencies of reinforcement,” except the stuff acted on is behavior instead

of people (or gene pools). Some of the above-listed entities can be translated into other systems' vernaculars.

We have two orthogonal dimensions: humans as rational agents versus arational beings. We also have epistemic standards (say, high or low) to know these. Note that a comfortable place for some people—and still a more broad view—is high epistemic standards applied to understanding the arational elements of human behavior. The highest risk and scariest category is lower (although still “acceptable”) standards applied to the arational.

### They Are Not Scientifically Useful

There is an important distinction to make in this claim. First is the case in which they have been tried and found to be not useful. The second is the case in which they have largely been untried and the issue is that we really don't know how useful they will prove to be. My claim is that we are in

the second case, not the first. And then it can be useful (depending perhaps on what individual researchers see as most plausible) to place bets on these horses.

### Conclusion

Let me close by saying there is no doubt that this is somewhat controversial. Please don't counterargue by using a slippery slope argument—that is, “If we lower our epistemic standard, then we accept all kinds of gobbledygook.” This is a red herring. One can lower epistemic standards (and I could argue we actually do this in our day-to-day lives to function). We don't have to become dogmatists or irrationalists, we just need to titrate to let into our nets some interesting and potentially useful constructs. We need to have epistemic standards that connect with and illuminate our problems. If astronomers had epistemic standards that allowed beliefs to be counted as knowledge only if these beliefs were evaluated by ex-

perimental evidence, we'd know nothing about the planets.

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### Open Forum

## Epicurus: The First Rational-Emotive Therapist

Steven Reiss, *The Ohio State University*

Epicurus (341–270 B.C.E.) was a Greek philosopher who advocated ideas similar to those embraced in rational-emotive theory (Ellis, 1962; Lazarus, 1971). His history shows the extraordinary appeal of the rational-emotive approach. For 700 years Epicurus' teachings were popular among Greeks, Romans, barbarians, Syrians, Jews, Egyptians, Africans, and Gaulists (Inwood & Gerson, 1994; Russell, 1977). Followers wore his likeness on rings and created statues in his honor. His most eminent disciple was Lucretius (99–55 B.C.E.), the great Roman poet.

Epicurus is one of history's most influential hedonists. Hedonists hold that the road to a good life comes from maximizing pleasure and minimizing pain. This may seem straightforward, but there are problems with hedonism that are not immediately apparent. The advice to maximize positive feelings leads to a lifestyle of pleasure seeking, but pleasure seeking often increases risk of future pain and suffering. Feasting, for example, increases the risk of indigestion. Thrill seeking is fun but dan-

gerous. Alcohol consumption feels good at first but leads to hangover. Nearly every hedonist of historical significance advocated that it is more important to minimize pain and suffering than to maximize pleasure. Epicurus was no exception: He taught that the pain of indigestion outweighs the pleasures of a feast.

Epicurus' philosophy is not what psychologists think it is. Although remembered for advocating the pleasure-seeking philosophy of “eat, drink, and be merry,” Epicurus actually advocated the opposite, advising only to eat what was necessary because one does not want indigestion, to drink as little as possible because one does not want hangover, and to keep the merriment to a minimum to avoid exhaustion. He was no connoisseur of gourmet food, and he did not have a highly refined sense of taste. The man for whom the word “epicure” was coined taught that a meal of barley cakes and water will taste good when you are sufficiently hungry.

Epicurus thought that the best strategy in life is to minimize anxiety and pain. He

was quoted as having said that we should do everything for the sake of being neither in pain nor in fear. He believed that the absence of pain and anxiety was an essential element of the good life. For example, he advised his followers to keep romance to a minimum. Although sex is enjoyable, many relationships deteriorate toward disillusionment, argument, and boredom. How can a person maintain a tranquil lifestyle going through the frustrations of love? Romance is often not worth it because “the things which produce certain pleasures bring troubles many times greater than the pleasures.”

How could a resident of the ancient world reduce worry and stress when war, famine, disease, and economic depressions were common? According to Epicurus, the key to reducing worry is to control our thoughts. People need to embrace the following four beliefs (“points of rational emphasis”):

God does not judge us.

Death is not unpleasant.

What is good is easy to get.

What is terrible is easy to endure.

We will consider each of these points separately.

1. Epicurus taught that the fear of divine judgment is irrational. Because God is a state of bliss—a state of maximum possible happiness—he will not interrupt the bliss to pay attention to us. Since He is not paying attention, God will not bother to judge us after we die. Once we embrace this rational

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analysis of divinity, we will stop worrying about the afterlife.

2. Because we will not experience anxiety and pain after we die, we should neither worry nor fear death. "Death is nothing to us," Epicurus taught. "For what has been dissolved has no sensory experience, and what has no sensory experience is nothing to us" (Hutchinson, 1994, p. 7).

3. We can avoid worrying about money by embracing a simple and inexpensive lifestyle. Only if we desire more than what is necessary to sustain life do we risk disappointment. Rather than strive to be wealthy, which is difficult to do, we should lower our expectations, which is easy to do. After our expectations are adjusted, the basic necessities will bring as much joy to us as luxury brings to the wealthy.

4. We can endure any tragedy and minimize pain by controlling how we think. It is best to be optimistic, expecting that any pain in our lives will be brief, bearable, and not intense. We should not exaggerate any tragedy in our mind (do not catastrophize). We should focus on the positive aspects of experience and forget the negative aspects. When faced with inescapable disaster, we can minimize the pain and suffering by remaining calm. Worry and emotional distress only make the experience more unpleasant than it already is. Dying is less painful if one does not whimper about it. (Epicurus allowed, however, that even people who embrace his philosophy moan and groan when being tortured on the rack.)

Epicurus' ideas, and the basic assumptions of rational-emotive theory, are similar in a number of significant ways. Both schools hold that cognitions are the key to controlling emotions. Whereas Epicurus taught people to reduce stress and worry by changing their beliefs, expectations, and interpretations, rational-emotive theorists hold that changing irrational ideas is the key to improvement in anxiety and stress disorders (Ellis, 1962; Lazarus, 1973). Under both approaches, the ultimate reason to embrace cognitions is to reduce anxiety and worry or improve symptoms of psychopathology. The alternative idea—that we should embrace cognitions based on their validity, not based on how they make us feel—was deemphasized in the works of both Epicurean and rational-emotive theorists.

In certain key respects, Epicurus was history's first influential rational-emotive theorist. His focus, not unlike that of a rational-emotive therapist, was to make people worry less and feel better. His technique was to change cognitions by arguing ratio-

nally. In his system, a "rational" person embraces stress-reducing thoughts and rejects stress-enhancing thoughts. Arguing that believing in a nonjudgmental God is a less stressful idea than believing in a judgmental god, Epicurus concluded that the rational person should embrace the nonjudgmental deity.

The extraordinary appeal of Epicurus' ideas had much to do with the promise of control over the emotional consequences of life in an unpredictable, violent, and chaotic world. Although we cannot control events, we have the potential to control our emotional reaction to those events and the consequences of events for our personal happiness. During the Hellenistic period of history, there was little individuals could do to control their fate. Wars and natural disasters were common, resulting in famine. Diseases were poorly understood and medicine was primitive. Poverty was a reality; there were no government safety nets.

In a frightening and uncontrollable world, Epicurus' philosophy offered people a measure of control. The key to happiness is our feelings, our feelings are determined by our interpretations of events (not so much the events themselves), and we can control how we interpret things.

In conclusion, Epicurus expressed ideas similar to those that underlie rational-emotive theory. His work had extraordinary appeal, partially because it offered people a measure of control in an unpredictable world. The conclusion that Epicurean philosophy and rational-emotive theory are similar does not have implications for the validity of rational-emotive theory, but it does provide an interesting context for rational-emotive theory. These ideas had a 700-year run the last time they surfaced, and I suspect they will remain a focus of psychology for quite some time.

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# Call

## for Award Nominations

## 10th Annual AABT Awards

*This is an open call to the AABT membership to provide nominations for the following awards, to be presented at the 2004 Convention in New Orleans.*

### **Distinguished/Outstanding Contribution by an Individual for Research Activities**

On a rotating annual basis, one of the following three types of distinguished contributions by an individual member of AABT will be recognized at the Annual Convention: research, clinical, or educational/training. For 2004, we seek nominations from AABT members concerning outstanding research contributions. Eligible candidates for this award should be members of AABT in good standing who have provided significant contributions to the literature advancing our knowledge of behavior therapy. Applications should include a letter of nomination, at least three letters of support, and a curriculum vitae of the nominee. Please send an e-mail version as well as a hard copy of all nomination material to the program chair at the address below, plus, send 1 duplicate copy of your submission to AABT, Outstanding Research Award, 305 Seventh Ave., New York, NY 10001. Past recipients of this award are Alan E. Kazdin in 1998 and David H. Barlow in 2001.

### **Outstanding Training Program**

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

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

### **Virginia A. Roswell Student Dissertation Award**

This award will be given to a student based upon his or her approved doctoral dissertation proposal. The research should be relevant to behavior therapy. Accompanying this honor will

be a \$1,000 award to be used in support of research (e.g., pay participants, purchase testing equipment) and/or to facilitate travel to the AABT convention. Eligible candidates for this award should be student members, have already had their dissertation proposal approved, and be investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor should send a letter of nomination and provide a 3- to 5-page summary of the proposal. Anything longer than 3 to 5 pages will not be considered. The summary should minimally include a brief introduction to the area of research, methodological design, and a description of the participants. Please send an e-mail version as well as a hard copy of all materials to the program chair at the address below, plus, send 1 duplicate copy of your submission to AABT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001.

Three additional awards will be presented annually.

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

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

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

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

**DEADLINE FOR ALL NOMINATIONS:**

**THURSDAY, APRIL 1, 2004**

**Salter, Andrew (1949; 2002—50th-anniversary printing)**  
***Conditioned Reflex Therapy: The Direct Approach to the***  
***Reconstruction of Personality***

Gretna, LA: Wellness Institute. (232 pp., ISBN 1-58741-048-6)

Reviewed by Alan E. Kazdin, *Yale University School of Medicine*

Andrew Salter (1914–1996) was a clinical psychologist in private practice who made enormous contributions to behavior therapy. *Conditioned Reflex Therapy*, only one of his books, was first published in 1949. The book was reissued to celebrate the 50th anniversary of its publication. With some minor condensation, the book retains the richness, innovativeness, and wisdom of the original. In addition, the reissued version includes a foreword by Gerald Davison and an extended introduction by William Salter, a psychologist and one of Andrew Salter's two sons.

Leaving aside the historical significance of the work, the book stands on its own as an excellent account of a novel set of behavioral treatments applicable to diverse disorders. The book is remarkably engaging, clinically astute, and of great practical value. However, it is the historical significance that deserves special attention. This facet requires comment on the context and time in which the book was published and how the book and Salter's work contributed directly to and anticipated much of contemporary behavior therapy. I highlight the context as a way to convey why we are indebted to Salter. At the same time, for many who knew him, I shall convey as well some of those features that made him a most unforgettable person in one's life.

Salter received his undergraduate degree in 1937 (New York University). Among his many interests was hypnosis. He drew upon the work of the learning theorist Clark Hull, who had provided a learning-based interpretation of hypnosis. This view relied on classical conditioning in which speech became conditioned stimuli that evoked reactions in clients. Salter expanded on this concept and developed techniques of auto-hypnosis as a self-control technique (Salter, 1941, 1944).

Salter continued his private practice and developed therapy techniques based explicitly on conditioning. The treatment, called

conditioned reflex therapy, drew directly from the writings of Sechenov, Pavlov, and Bechterev, but other learning theorists and researchers as well. The reader may recall that Sechenov, sometimes referred to as "the father of Russian physiology," discussed and experimentally investigated "reflexes of the brain" (i.e., inhibition and excitation in animal research). Pavlov and Bechterev were directly influenced by this work and in many ways continued the conceptual view and research focus begun by Sechenov. Pavlov elaborated on the notions of excitation, inhibition, and disinhibition, conveyed that they were processes within the brain, and could explain maladaptive (and other) behavior. Salter drew on these concepts explicitly. He believed that excessive inhibition in particular was responsible for maladjustment, and that the task was to achieve a balance between inhibition and excitation. In most cases, the task of the therapist was to increase excitation. Concretely, this meant encouraging expression of emotions and positive actions in everyday life. Expression of emotion was not based on a cathartic view. Rather, action in everyday life and expression of how one feels and thinks were critical.

Salter noted that the words of the therapist served as conditioned stimuli and could influence the client's nervous system in ways to encourage behavior change. The behavior changes would influence the nervous system further, and this in turn would foster further behavior change. This is certainly an early version of bidirectional changes and reciprocal causality. However, the key to the contribution was in viewing maladjustment and therapy from the standpoint of learning and then generating and applying concrete techniques for therapy. Salter made the case with unequivocal clarity: "Maladjustment is malconditioning, and psychotherapy is reconditioning" (Salter, 1949, p. 316).

Context Highlights

Permit me to merely identify a few points to situate Salter's work and to convey why the writings and this book in particular constitute formidable contributions. The context includes early stirrings of behavior therapy, conceived at the time as application of learning theory and research to treatment. It is useful to highlight the historical time line with familiar points merely. I have discussed a broader set of influences elsewhere (Kazdin, 1978).

The context within psychology more generally in the early 1900s was the burgeoning influence of learning theory and research. Psychology was moving to more objective methods of study than had been emphasized (e.g., away from introspection as a method of study and mentalistic descriptions and interpretations). Learning theory and research and comparative psychology developed in earnest, as evident in the first few decades of the 1900s in the works of Thorndike, Guthrie, Hull, Skinner, and others. Watson's (1919) formalization of the movement of behaviorism at this time emphasized both objective methods of research (conditioning paradigms) and the importance of the work of Pavlov and Bechterev. Conditioning methods and models were viewed as general ways of moving psychology forward. For example, in 1915, Watson's presidential address at the American Psychological Association was titled, "The Place of the Conditioned Reflex in Psychology."

Conditioning was evident in research and in the air but not much in therapy. Watson and his case studies to induce fear in Little Albert (Watson & Rayner, 1920) and to eliminate fear in Peter (Jones, 1924a) were influential in advancing a behaviorist view of psychology in general and in the context of psychopathology and psychotherapy more specifically. Jones, who was one of Watson's students and involved in the case of Peter, completed a dissertation that compared several methods of treating fear in children, and that study alone pioneered many innovations (e.g., demonstration of graduated exposure and modeling as effective therapy techniques; Jones, 1924b).

Isolated outcroppings of conditioning-based treatments emerged in which learning research was drawn on directly to explain existing treatments or to develop new treatments. For example, in 1938, Mowrer and Mowrer described the bell-and-pad method for controlling enuresis. The method was developed already but the Mowrers cast this as classical conditioning.

The fact that the procedure was effective added empirical frosting to the cake. In the late 1930s and early 1940s, aversion therapy was used as a treatment for voluntarily hospitalized individuals (Shadel Sanatorium, Washington) who abused alcohol, in a treatment referred to as conditioned reflex therapy (Voegtlin, Lemere, & Broz, 1940). This work drew directly from Russian research on conditioning to develop aversive reactions to alcohol. Treatment was evaluated in several reports encompassing over 4,000 patients and follow-up evaluation up to 13 years after treatment. This work was sophisticated (e.g., evaluation of abstinence, comparisons of multiple treatments, study of moderators) and exerted its own influence on behavior therapy.

The examples illustrate a few of many largely independent efforts to apply conditioning concepts for therapeutic ends. I note they are independent in the sense that the innovators did not draw on each other, usually did not know of each other's work, and were not wildly interested in beginning a larger movement of behavior therapy. Salter is a key figure in this history. In 1949, Salter developed conditioned reflex therapy, quite separate from the use of the term associated with the treatment developed of individuals with alcohol abuse in the program mentioned previously. Salter applied conditioning much more broadly to therapy and therapeutic problems than had been the case previously.

At the time of Salter's book, other important writings helped launch the movement toward learning-based therapies. From the 1930s through the 1950s, several authors provided accounts of "normal" and abnormal behavior, personality, and psychotherapy in terms of learning (e.g., Masserman, 1943; Mowrer, 1950). The best known of these is the book *Personality and Psychotherapy: An Analysis in Terms of Learning, Thinking, and Culture*, by Dollard and Miller (1950). This book provided a comprehensive theory of behavior and united learning, psychopathology, and psychotherapy. Of special note, psychoanalytic concepts related to symptom formation, conflict, transference, and others were explained in terms of learning concepts.

Treatises on learning, psychopathology, and therapy provided the groundwork for many later developments. However, they left open a great need, namely, to move from the concepts of conditioning to new treatment that could be used in clinical work. Salter explained therapy in learning terms too but also made the next critical next step, i.e., development of treatment

techniques that could be used in the context of therapy. A few years later, Wolpe (1958) made a similar leap in the development of systematic desensitization.

The beginning of behavior therapy included many writings on conditioning and their application to treatment. A related but distinguishable genre was a literature critically evaluating the prevailing conceptualization of psychopathology and its treatment (e.g., psychiatric diagnosis, medical models). Key writers whose names are familiar within behavior therapy (e.g., Eysenck, Rachman) criticized the substance, methods, unscientific nature, and plausibility of psychoanalysis, the dominant model at the time. Salter contributed to this genre as well with his inimitable vitality and style. For example, in lamenting the unscientific nature of key psychoanalytic concepts, he noted, "It is as easy to nail a custard pie to the wall as to pin down the Freudian speculations about the 'death instinct' and 'aggression'" (Salter, 1962, p. 8; first published in 1952). Salter criticized the role of insight as a basis of therapeutic change and continued his persuasive style in making the case by noting that "insight is not necessarily accompanied by important symptom improvement. Often individuals with insight might as well be saying, 'My dentist is marvelous. My teeth still ache but I know all about my roots and root canals. I can even read my own X-rays. . . . Really, you should try my dentist.'" (1962, p. 146). In this book, *The Case Against Psychoanalysis*, Salter drew heavily on quotes of Freud and the writings of others to make the case and to help set a context from which new therapies emerged.

As behavior therapy developed, there was a move away from criticizing psychoanalysis and traditional models of psychopathology and therapy in general. By the mid-1960s behavior therapy was developing its own literature that included conceptual views, scores of case studies, and the beginnings of an empirical literature that could stand on its own (Bandura, 1969; Krasner & Ullmann, 1965; Ullmann & Krasner, 1965). The task remained to specify the treatments and to conduct research to evaluate their effects and generality across problem domains and populations.

#### Conditioned Reflex Therapy and Salter's Contributions

Salter's leap from learning theory and research to treatments for clinical practice was novel and groundbreaking. He drew on a broad range of learning theorists and their

findings to explain the emergence of maladaptive behavior and the treatment process. He made a critical distinction often neglected today, namely, between a theory about the onset of a problem (e.g., etiology) and a theory of change (how treatment works). They may or may not be related. For example, Salter noted that "finding and exploring the situations that have caused the psychological difficulty does nothing to facilitate the cure" (1949, p. 38). For practical purposes, "how the individual 'gets that way' is of little therapeutic importance" (p. 143). Actually, in any given instance, how a person developed the problem might be important. Even so, Salter's views underscore the critical task of developing a theory of therapeutic change, generating techniques that follow from that, and then applying and testing the techniques in laboratory and treatment contexts. These were novel views.

In treatment, Salter focused primarily on behavior as a way of achieving therapeutic change. "To change the way a person feels and thinks about himself, we must change the way he acts toward others" (Salter, 1949, p. 100). The reader familiar with early musings of cognitive therapy and cognitively based interpretations of therapy will recognize the position of later writers (e.g., Bandura, 1977), who noted that cognition is a key to sources of clinical problems and/or therapeutic change. However, one of the best ways to modify cognitions is through action.

Salter did not believe improvements would be gained if treatment were restricted to the therapist's office. Clients were instructed on how to perform in everyday life situations and were given extra-therapeutic tasks (i.e., homework assignments). In the treatment sessions, Salter used many adjunctive therapy techniques. For example, individuals who experienced anxiety learned to relax to reduce tension in stressful settings. They were trained to relax in therapy and to apply this skill to problematic situations in everyday life, a procedure very closely resembling what came to be known years later as *in vivo* desensitization. Similarly, imagery connected with positive experiences or events were evoked to overcome other problems. For example, calmness would be induced with pleasant imagery to overcome anxiety or insomnia or to foster desired behavior such as appropriate sexual functioning. These applications anticipated diverse forms of systematic desensitization as well as covert conditioning.

In Salter's *Conditioned Reflex Therapy*, several treatments are explicitly described and applied to many cases. I mentioned systematic desensitization and covert conditioning, but these cases illustrate other techniques as well, including self-control therapy and assertion training (later blending into social skills training). These treatments all played a part in behavior modification in the 1960s. Assertion training in particular deserves special mention because it is evident, without the term, quite explicitly in the book and did not take hold in research until 20 to 25 years later.

Salter's work was carried out in a very active private practice. With a baccalaureate degree and novel experience and credentials, he was grand-fathered officially as a clinical psychologist. He did not have the academic affiliations that may have given him an even more visible historical place that I believe he unequivocally deserves. One only has to brush the surface of his writings to find many treatments and insights that characterize early behavior therapy and contemporary cognitive behavior therapy. In terms of professional development, Salter organized the first conference on behavior modification in 1962 in collaboration with Wolpe and Reyna. The proceedings of this conference were later published in book form (Wolpe, Salter, & Reyna, 1964), a time that preceded the tsunami of books on behavior therapy that began in the 1970s.

Salter's clinical work was not just another private practice. He routinely treated well-placed figures from diverse areas of life including the arts and movies. This was not minor; many outside of academia were influenced by Salter and were vocal in his support. His ideas in various degrees of explicitness found their ways into movies and books outside of psychology because of the circles in which he provided treatment.

### The Person

The scholarship, merit, prescience, and insightfulness of Salter's ideas stand on their own and are critically important. Something must be said about the man and his character, although they can be readily separated from his intellectual contributions. To facilitate this, permit me to switch from referring to him as Salter to Andy.

Andy was perhaps the most unforgettable character I ever knew. I met and befriended Andy and Rhoda, his wife, in the mid-1970s; Andy was in his 60s at the time. He was a wonderful mix of boyish mischief and wisdom, plainly a young man

in the body of the older person. He was dynamic (although he would mock me gently for using a word that in mixed company might be interpreted as psychodynamic). He sparkled in a room, was warm, engaging, witty, and a raconteur without peer. He was the kind of person to whom we gravitated in a room. He was a constant performer but a willing audience. He and Rhoda invariably were together, and if there is another unforgettable character to compete with this title, she would be the other person. In ordinary social interaction, it is often said that the opposite of speaking is not listening but rather waiting to speak. This would be quite untrue of Andy and Rhoda. They had so much to say but listened, heard, and cared with equal intensity and focus. If one were on a debating team, an infinitely long voyage, or in need of comfort from a horrible personal loss, Andy and Rhoda would be the choice partners.

A facet of history that may be relatively superficial is to identify who was first in relation to an invention, device, or discovery. Scholars often debate these details but those of us who are merely lay persons in relation to the issue are relatively indifferent. For example, not many of us are concerned with the fact that Pavlov was not the first to discover classical conditioning any more than Columbus was the first to discover America. We love or at least respect Ivan and Chris because their contributions do not depend on whether they were first. Similarly, cognitive therapy has so many historical antecedents before contemporary work, including those by Salter, as to make any reader clinically depressed. These antecedents too do not distract from contemporary advances. Salter could arguably be credited with firsts on several fronts in behavior therapy, including a handful of techniques, a stable full of ideas, and a look toward the future about what treatment ought to be. He had, in my view, something much better than a positive posthumous crediting of his accomplishments, namely, a rather amazing family, a set of friends who loved and adored him, and patients who were grateful to him for having changed their lives. I expect that during his life the present was amply rewarded, even though I expect due credit was not provided fully in the domains I have highlighted here. It is a privilege to have the opportunity to mention some of his major accomplishments, even if only briefly here.

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Lyddon, W. J., & Jones, J. V., Jr. (2001). *Empirically Supported Cognitive Therapies: Current and Future Applications*

New York: Springer Publishing Company

Reviewed by Amy Przeworski and Michelle G. Newman, *The Pennsylvania State University*

Cognitive-behavioral therapy (CBT) is one of the most widely used and researched treatments for psychological disorders (Barlow, 1988; Chambless & Gillis, 1993; Zinbarg, Barlow, Brown, & Hertz, 1992). In fact, in the past 30 years well over 1,000 studies have examined the efficacy of CBT for psychological disorders.

William Lyddon and John V. Jones, Jr.'s *Empirically Supported Cognitive Therapies: Current and Future Applications* unites this wide body of research in a comprehensive yet concise review of the theory, empirical support, and implementation of cognitive and cognitive-behavioral therapies for psychological disorders. Each chapter in the book is devoted to a different psychological disorder and includes a description of the theory underlying the etiology and treatment of the disorder, a review of the empirical support for the treatment, and a case study that illustrates the implementation of the cognitive-behavioral techniques.

Chapter 1 introduces the debate surrounding empirically supported treatments. The chapter begins with a historical review of psychotherapy research, beginning with Eysenck's (1952) assertion that there is no evidence to support the effectiveness of psychotherapy. The chapter goes on to describe criticism of and support for the empirical evaluation of psychotherapy as well as the importance of disseminating such information to clinicians and students in training.

Chapter 2 provides a systematic review of empirically validated treatments for unipolar depression and includes a discussion of the process variables that have been examined as well as moderators, such as the working alliance, homework compliance, and therapist contact. The authors also describe mediators of change, such as hopelessness and the effect that specific treatment techniques can have on these variables. This chapter also demonstrates the evolution of the cognitive theory of de-

pression, starting with Beck's (1963) theory and ending with more contemporary theories emphasizing interpersonal schema and metacognition. Finally, the authors illustrate the implementation of cognitive therapy for depression in a complex case study of an individual with comorbid unipolar depression and personality disorders.

In chapter 3, the authors describe a new and innovative CBT approach for individuals with bipolar disorder. The treatment package helps clients to increase medication compliance, recognize patterns of mood fluctuation, decrease insomnia, and use cognitive restructuring to intervene on subsyndromal mood fluctuations. The chapter also describes the implementation of this cutting-edge treatment in a clinical setting and illustrates each step of the process using a case study of an individual with bipolar disorder and medication noncompliance.

Chapter 4 describes CBT for phobias, a well-documented and empirically validated treatment. The chapter provides step-by-step guidelines for the methods of treating phobias and a case study demonstrating the use of these guidelines.

Chapter 5 covers CBT for panic disorder and provides a well-documented table reviewing the empirical support for CBT in panic disorder. The chapter describes the implementation and efficacy of the core treatment components, psychoeducation, cognitive restructuring, relaxation, interoceptive exposure, and visualization as well as research examining the efficacy of these interventions. Finally, the case study illustrates these techniques as well as the importance of utilizing a variety of means of assessing outcome, including behavioral avoidance and cognitive change.

Chapter 6 approaches obsessive-compulsive disorder (OCD) from a purely cognitive perspective. It first cites research demonstrating that cognitive therapy is as efficacious as exposure and response prevention in the treatment of OCD. The authors

then describe the cognitive domains of OCD targeted in cognitive therapy, including overestimation of danger, intolerance of uncertainty, perfectionism, excessive responsibility, overimportance of thoughts, and the need to control thoughts. The case study describes an 8-week brief cognitive therapy which was effective in treating OCD despite the restricted number of therapy hours, further lending support for the efficacy of this intervention. Finally, the authors provide a detailed description of various assessment methods that were utilized in the case, including commonly used OCD measures such as the Yale-Brown Obsessive-Compulsive Scale (YBOCS; Goodman et al., 1989) and measures of overall disability and functional improvement.

Chapter 7 discusses the efficacy of CBT for PTSD and highlights the additive effect that comorbid disorders can have on impairment associated with PTSD. The chapter first reviews the treatment outcome research supporting the use of cognitive behavioral alternatives for PTSD treatment, such as cognitive processing therapy, prolonged exposure, and stress inoculation training. The authors then describe a new and innovative treatment called Multiple Channel Exposure Therapy (MCET; Falsetti & Resnick, 1997), which targets comorbid PTSD and panic disorder symptoms. The implementation of this treatment is illustrated through a complex case study of an individual with a primary diagnosis of PTSD resulting from multiple traumas, and a secondary diagnosis of panic disorder.

The final section of this book elaborates on new directions and developments in cognitive-behavioral treatments. These include interventions for such common but often underresearched difficulties as anger management and antisocial behaviors. For example, chapter 8 examines cognitive behavioral techniques for addressing problematic levels of anger. It reviews classic literature on the treatment of anger and illustrates these well-supported techniques through a description of therapy with an individual with road rage. The case study also highlights the importance of assessing physiological arousal, signs of physical tension, and cognitive and behavioral symptoms of anger when treating someone with anger management problems.

Another new direction, described in chapter 9, is the CBT of antisocial behaviors in children and adolescents. The chapter aims to integrate a cognitive model of antisocial behavior with a family systems model through the use of cognitive techniques tar-

getting not only problematic behaviors in the child or adolescent, but also the contributions of parents, peers, communities, and teachers. Consistent with this approach, the case study describes therapeutic techniques targeting both the child's delinquent behaviors and the parent's inconsistent and ineffective disciplinary strategies. The treatment also targets the parent's coercive and hostile interactive style.

Chapter 10 integrates a cognitive model of eating disorders and a feminist perspective that emphasizes the importance of societal and cultural contributions to eating disorders. This innovative approach is theorized to improve upon existing treatments for eating disorders by teaching clients to explore their own core beliefs, as well as implicit cultural and societal beliefs that are communicated through such media as advertisements. Similar to a family systems approach, this therapy aims to treat the client within the context of his or her environment in order to fully change the maladaptive core belief structure and prevent relapse. The chapter also provides client handouts that may be helpful in teaching clients to attend to personal reactions to advertising, identify cultural directives, and critique core cultural beliefs in advertising.

The final chapter of the book describes limitations of and future directions for psychotherapy research. The chapter highlights the importance of empirically supported treatments in ensuring that the psychotherapies administered to clients are sound. Nonetheless, it points to the need for a greater focus on ecological validity and psychotherapy effectiveness research in clinical settings.

This well-written and organized book is a fantastic resource for practitioners, teachers, and graduate students uniting 30-plus years worth of research into a single small volume. The book integrates empirical research with illustrations of the implementation of therapy techniques in clinical settings. Further, it includes complex case studies in which comorbid diagnoses, medication noncompliance, and maintaining contextual factors further complicate the implementation of the techniques. Thus, we recommend this book as a means to become acquainted with recent research and the application of empirically supported treatments.

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## Book Review

### Ellis, A. (2001). *New Directions for Rational Emotive Behavior Therapy: Overcoming Destructive Beliefs, Feelings, and Behaviors*

Amherst, NY: Prometheus Books

Reviewed by Mariola Magovcevic and Michael E. Addis, *Clark University*

The therapeutic techniques and concepts of rational emotive behavior therapy (REBT) have been highly influential in professional and lay circles for close to half a century. Since 1955, Albert Ellis has consistently developed the theory and techniques of what was first termed *rational therapy*, then later renamed *rational-emotive therapy*, and finally, in the early 90s, retitled *rational emotive behavior therapy*.

In his most recent book, Ellis provides an overview of the theoretical and practical development of REBT, discusses the newest theoretical developments, and provides

multiple examples of the application of REBT techniques in clinical practice. The book is divided into two parts; the first part mostly focuses on the theoretical premises of REBT, and the second part provides examples of the practical application of REBT in the treatment of multiple disorders.

Ellis begins by discussing the major theoretical premises of REBT, and develops his theory further by incorporating some aspects of postmodernist theory. Ellis not only clearly explains the relationship between activating events (A), irrational beliefs (B), and behavioral consequences (C), but also

develops the concept of irrational beliefs further by conceptualizing them as irrational *believing-emoting-behaving*. Viewing irrational believing as an ongoing action, which in itself incorporates both emotions and behaviors, makes salient one's constant interaction with the environment and in this way speaks to the way people create their own realities. This view, according to Ellis, together with the idea that people constantly make choices about their behavior, emotions, and beliefs, is the major argument for why REBT represents a constructivist approach. The importance of the interplay of beliefs, emotions, and behaviors in conceptualizing a client is clearly stressed throughout the book, and is one of the most salient factors in distinguishing REBT from other cognitive behavioral therapies. Ellis' major theoretical focus is on the importance of viewing people as creators of their own realities, as agents of their own behavioral, emotional, and cognitive disturbances, and as agents of their own change.

Ellis stresses his advocacy of a sociopolitical stance in therapy by comparing REBT to Rigazio-DiGilio, Ivey, and Locke's (1997; as cited in Ellis, 2001, pp. 51-58)

Theory of Developmental Counseling and Therapy (DCT) and Systematic Cognitive-Developmental Theory (SCDT). The humanistic aspects of REBT are highlighted by comparison to, among others, Carl Rogers' person-centered approach. The multimodal and comprehensive aspects of REBT are explained by describing REBT's application in brief, family, and group therapy, and the incorporating of behavioral, emotive, and cognitive techniques in the practice of REBT.

Although Ellis discusses his ideas in detail, and often provides case examples and therapy excerpts as illustrations of his ideas, the first part of the book can be difficult to follow at points. For example, some chapters cover similar complex theoretical concepts without providing the reader with a clear idea of how the ideas are distinct. For instance, Ellis in one chapter states that REBT is in essence a postmodernist theory, but in a later chapter compares the theoretical premises of REBT to Alfred Korzybski's theory of general semantics (as cited in Ellis, 2001, pp. 99-113). Ellis draws on both of these theories in his theoretical elaboration of REBT; yet, these two theories provide contradictory explanations of the human condition.

In the second part of the book, Ellis provides numerous examples of the application of REBT in the treatment of specific disorders and problems. Ellis discusses the appli-

cation of REBT in the treatment of depression, anxiety, low frustration tolerance, morbid jealousy, perfectionism, addictive behaviors, borderline personality disorder, obsessive-compulsive disorder, and post-traumatic stress disorder. The theoretical ideas discussed in the first part of the book are made concrete through case examples. The REBT techniques Ellis employs differ somewhat from techniques applied by other cognitive-behavioral practitioners. For instance, in addition to rational coping techniques common to many cognitive-behavioral therapies, Ellis favors the use of rational-emotive imagery and forceful taped disputing as emotive techniques, and shaming exercises as behavioral interventions.

A strength of the REBT techniques provided is that they are discussed clearly and in detail, and could be applied as useful tools even by those practitioners who do not necessarily adhere to the theory underlying the treatment. However, although there is a body of empirical support for the efficacy of REBT techniques (Engels, Granefski, & Diekstra, 1993), Ellis provides little empirical evidence for the efficacy of the therapeutic techniques he presents for many of the disorders and problems.

Ellis' directive and uncompromising clinical style is evident throughout the therapy excerpts. The directive style and the teacher-student quality of the therapeutic

relationship are clearly implicated in the theory underlying REBT. However, this style may not come naturally to many therapists and may be uncomfortable for some clients. For example, the song that Ellis cites as a technique to help clients not take themselves too seriously is entitled "I Wish I Were Not Crazy" and includes the following verse:

I could agree to really be less crazy,  
but I, alas, am just too goddamned  
lazy! (p. 180)

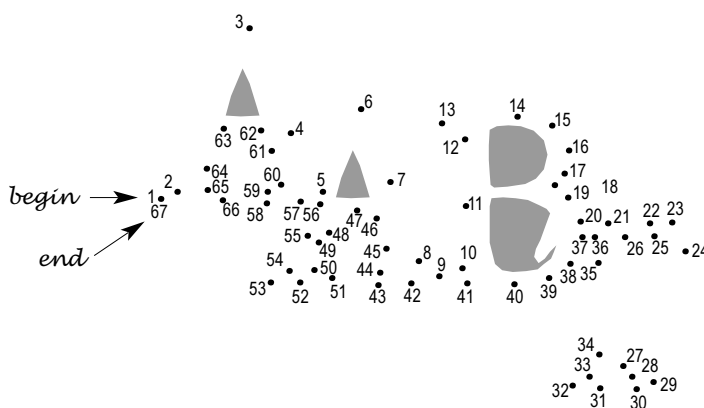
Ellis intends this book as a tool for both therapists and lay people. Although it may function well as a tool for facilitating therapists' application of REBT, its usefulness as a self-help book may be somewhat constrained. Many of the chapters are laden with psychological jargon and difficult theoretical concepts. These sections may be perceived as too intricate by some psychologically nonsavvy individuals who are looking for a concise and clear how-to guide in dealing with their life problems.

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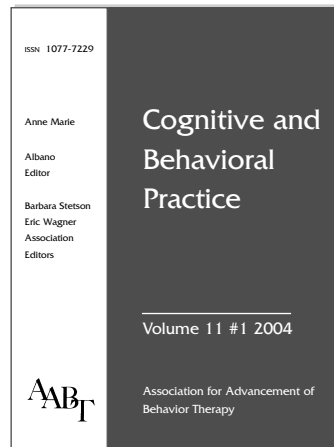
## Erratum

*tBT* 26(7), p. 338

Michel Hersen was a postdoctoral fellow at Yale from 1965 to 1966, *not* from 1965 to 1996.

## s u b • m i s s i o n s

Although Anne Marie Albano remains editor of the journal *Cognitive and Behavioral Practice* until the end of 2004, note this change:



Stefan Hofmann, incoming editor in 2005, is now accepting manuscripts. Please send all new submissions to Stefan Hofmann at this address:

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This individual serves as liaison to an AABT Coordinator, working to review, develop, and/or maintain activities that service and support the members of AABT in that respective area of the governing structure and serving as the "big picture" person to assist the coordinator in knowing who to keep informed of activities that have an effect on other areas of the governing structure.

The Representative-at-Large should be familiar with the AABT mission statement, bylaws, and the most recent strategic long-range planning report, and is expected to attend the annual fall Board of Directors meeting and monthly conference calls; maintain contact with the coordinator, and to serve as a facilitator if required to move projects and/or activities along; encourage members' involvement in AABT and encourage prospective members to join; and attend the annual convention, including all relevant meetings (i.e., with your coordinator and committee chairs).

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