

# *the* Behavior Therapist

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## CLINICAL TRAINING

### **Training in Integrated Behavioral Health Care: Dipping a Toe or Diving In**

*Ana J. Bridges, Timothy A. Cavell,  
Carlos A. Ojeda, Samantha J. Gregus,  
Debbie Gomez,  
University of Arkansas*

IT IS ESTIMATED that one out of four individuals in the United States meets criteria for a psychiatric disorder (Kessler & Wang, 2008), but only one-third of those individuals actually receives mental health treatment (Kessler et al., 2005). Most patients with mental health concerns are treated by a primary care physician, and this pattern is especially strong among underserved patient populations, including members of ethnic/racial minority groups and families living in rural areas (Kessler et al.). Mental health care problems are also linked to physical health problems in a reciprocal fashion (World Health Organization, 2004).

Health care reform efforts in the U.S. over the past decade were designed to broaden health care coverage and increase patient access to needed services, thereby reducing health disparities among Americans. Numerous efforts to repeal the Patient Protection and Affordable Care Act (111-148) have been unsuccessful and it appears the law will remain in effect for the foreseeable future. An important feature of health care reform is the integration of primary medicine and behavioral health into a collaborative, interdisciplinary-based team model of service delivery and changes in how health care services are reimbursed, with a greater focus on health promotion, disease prevention, and

[continued on p. 171]

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ABCT

# Election Results



**Bruce Chorpita, Ph.D.**

President-Elect, 2017–2018



**Risa B. Weisberg, Ph.D.**

Representative-at-Large, 2017–2020  
and liaison to Membership Issues

All three bylaw changes were approved: Mission Statement, Purposes, and changes to our membership categories.

The membership has voted to revise our mission statement to read:

*The Association for Behavioral and Cognitive Therapies is a multidisciplinary organization committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through behavioral, cognitive, and biological evidence-based principles.*

While ABCT's name and identity will ensure that we maintain our core focus on Behavioral and Cognitive Therapies, the Board hopes that our slightly revised mission statement will encourage further exploration and collaboration in a broader range of range of mental health areas, including biological mechanisms of behavioral and cognitive therapies. In this way, we seek to foster a welcoming and innovative environment for a range of researchers and clinicians who are passionate about advancing empirically effective cognitive and behavioral treatments. We are excited about the opportunities that lie ahead. Please join us in congratulating our new leaders Bruce and Risa.

## INSTRUCTIONS for AUTHORS

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

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

**Submissions must be accompanied by a Copyright Transfer Form** (which can be downloaded on our website: <http://www.abct.org/Journals/?m=mJournal&fa=TB T>): *submissions will not be reviewed without a copyright transfer form.* Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Kate Wolitzky-Taylor, Ph.D., at [KBTaylor@mednet.ucla.edu](mailto:KBTaylor@mednet.ucla.edu). Please include the phrase *tBT submission* and the author's last name (e.g., *tBT Submission - Smith et al.*) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

addressing the behavioral components of health. The integrated behavioral health care (IBHC) model represents a paradigm shift for health service psychology, one that requires new roles, different skills, and expanded competencies (McDaniel et al., 2014). To keep pace with these changes in health care delivery, doctoral programs in psychology may want to provide students with some level of IBHC training. In this article, we present a framework to guide programs seeking to add or expand IBHC training, with a particular focus on primary care psychology or what is called primary care behavioral health (Robinson & Reiter, 2006). Although many models of integrated care exist (e.g., Peek, 2013), the primary care behavioral health model is particularly novel for psychologists because of significant practice shifts away from traditional models of care, as we detail below. Because doctoral programs will vary in their readiness for or investment in IBHC training, this framework offers multiple options rather than a single standard. Guided by this framework, programs interested in the IBHC model can choose to dip a toe or dive in to training.

### Rationale for Integrated Care

The lifetime prevalence of mental health problems ranges from 12% to 47.4% of the population (Kazdin & Blase, 2011). In any given year, approximately 25% of the population is in need of mental health services (Kazdin & Blase). However, the majority of these individuals do not receive appropriate care. Reasons include a shortage of mental health professionals, a lack of health insurance coverage, limited access to care, and stigma associated with seeking therapy. The unmet need for mental health services is greatest in underserved, ethnic minority populations (Kessler et al., 2005).

In this country, most individuals with mental health problems are treated by primary care physicians (PCPs) and not mental health specialists (McDaniel et al., 2014; Regier et al., 1993). Depression is the third most common reason for a PCP visit (Uniform Data System, 2007) and many patients suffer chronic medical conditions (e.g., chronic pain, hypertension, diabetes) that are frequently comorbid with behavioral health risk factors, such as smoking or obesity (Bodenheimer, Chen, & Bennett, 2009). Unfortunately, less than 50% of patients with depression are correctly diagnosed by PCPs (Fernandez et al., 2010), and PCPs typically lack the training needed to treat psychosocial concerns and have

little time to address significant barriers that arise when chronic disease regimens demand fundamental change in a patient's lifestyle (Robinson & Reiter, 2006). PCPs are prone to prescribing action-oriented interventions, even though the majority of patients are not ready to change or have never contemplated change (Prochaska, DiClemente, & Norcross, 1992). PCPs also prescribe the majority of psychotropic medications, which introduces additional health care costs and widens further the gap between patients who can afford to be treated and those who cannot (Regier et al., 1993).

Calls for increased collaboration among health care professionals began in the medical field, although early efforts to promote interprofessional training did not include psychology (Interprofessional Education Collaborative Expert Panel, 2011). More recently, however, the role of psychologists on the health care team has been recognized by numerous health professionals. For instance, a recent editorial in the *Journal of the American Medical Association* notes the benefits, both financially and ethically, of providing mental health care for primary-care patients in an integrated fashion (Schwenk, 2016). The Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Health and Human Services/Health Resources and Services Administration (HRSA) actively promote integrated behavioral health care, maintaining a resource-rich website ([www.integration.samhsa.gov](http://www.integration.samhsa.gov)) and many federal funding opportunities in health care service delivery focus on combining physical and behavioral/mental health care.

The American Psychological Association (APA) has been a strong advocate for patient-centered care and IBHC service delivery (APA, Presidential Task Force on Integrated Health Care for an Aging Population, 2008). As APA President, Suzanne Bennett Johnson (2012) argued that integrated, patient-centered care that blends medical and mental health services can provide better and more cost-effective care, greater access, less stigma, and greater patient satisfaction than traditional forms of health care delivery. To ensure that psychologists are not left out of these trends in health care reform, APA has called for a redefinition of psychology as a health service profession (vs. a mental health care profession) and for integrating professional psychology into primary health-care settings (Belar, 2012; Johnson, 2012).

### The IBHC Model

Integrated behavioral health care (IBHC) is a health care delivery model in which diverse health professionals, including mental health professionals, actively work together to target patient health care needs (O'Donohue, Cummings, Cucciare, Runyan, & Cummings, 2006). While many models of mental and physical health collaboration exist (for a review, see Blount, 1998), the IBHC model strives for the highest level of integration where all a patient's needs are addressed in one medical home by a diverse team of health professionals who can deliver needed care in a single, collaborative system rather than having health professionals work in silos. This integration means team members meet regularly to coordinate patient care, medical records are housed in one location and shared by all health care team members, and services are delivered at the time a need is addressed rather than in some distant future. This integration is theorized to not only reduce lag time between when needs are identified and appropriate services are received, but also to reduce the stigma and increase the acceptability of behavioral health care interventions.

Psychologists who work in IBHC settings find this model requires a change in the way behavioral health care interventions are delivered so that the pace and patient flow match that of primary care (Robinson & Reiter, 2006). This is often in stark contrast to the traditional method of service delivery that comprises individual sessions, typically of a 50-minute or 1-hour duration and typically lasting for many weeks or months. The mental health professional is introduced to the patient by the primary care provider as Behavioral Health Consultant (BHC), a member of the patient's health care team who specializes in behavior change. Then, the BHC and other members of the health care team (e.g., primary care provider, nurses, nutritionists, case managers, and other allied health professionals) focus on providing early interventions for patients with lifestyle- and stress-related disorders and chronic illness. Although the primary care manager (e.g., physician) remains in charge of the treatment plan, BHCs do not operate solely as consultants—they also provide brief interventions, behavioral health assessments, and follow-ups (usually within a month) with primary care managers on health-related issues and care (Dobmeyer, Rowan, Etherage, & Wilson, 2003).



BHC professionals' repertoire of clinical strategies address issues related to teaching prevention techniques, early recognition of problems, or working with diverse populations (e.g., patients with limited English proficiency). In addition, assessment interventions are adapted to conditions in primary care settings (approximately 5–10 minutes) instead of long sessions (e.g., at least an hour) in mental health settings. In IBHC settings, empirical interventions are often educational and directive (e.g., problem-solving advice, pamphlets), emphasizing prevention strategies (e.g., self-monitoring), and built around structures that support skills, such as long-term change, self-management, and self-efficacy (Robinson & Reiter, 2006). Taken together, the IBHC paradigm shift challenges psychology professionals to provide interventions that address mental health concerns while functioning as full members of a health care team.

### Efforts to Promote IBHC Training

To the extent that psychology is indeed facing a paradigm shift toward integrated health care delivery (Johnson, 2012), training at the predoctoral, internship, and postdoctoral levels will need to keep pace (Larkin, Bridges, Fields, & Vogel, 2016). Rozensky (2012) has argued that the future of psychological care depends on efforts to prepare current trainees in competencies needed to work in an integrated, interprofessional environment. The HRSA Graduate Psychology Education (GPE) program, the only federal program that funds psychology education and training, has an explicit focus on preparing psychologists to provide integrated health care to underserved populations. Thus, GPE-funded training programs often place psychology trainees in federally qualified health centers (FQHCs) that require delivery of mental health and substance abuse services along with primary medical care.

Data gathered by APA in 2015 show that a growing number of programs are training students to practice in primary care settings (<http://www.apa.org/ed/graduate/primary-care-psychology.aspx>). This webpage lists doctoral, internship, and postdoctoral programs that offer education or training in primary care psychology. Each of these programs trains students to provide psychological services in primary care settings to patients and families with both physical and mental health problems; many also provide training in consul-

tation and/or assessment in primary care settings. Some programs specifically identify as providing trainees with experience in integrated care.

APA's list is noteworthy in that the total number of programs is rather small. Of the 307 APA-accredited clinical and counseling psychology doctoral training programs currently in the U.S., only 29 (9.4%) identify as providing training in primary care psychology (<http://www.apa.org/ed/accreditation/programs/>). Doctoral programs on this list are further categorized according to whether training involves (a) exposure (a training opportunity limited in extent and intensity; e.g., 1–2 courses), (b) experience (somewhere between exposure and emphasis; e.g., 1–2 courses, a practicum), (c) emphasis (in-depth opportunities to learn about the primary care specialty area; e.g., numerous courses and 2 practica), or (d) a major area of study (intense and highly involved training that includes multiple years of didactics, clinical training, and research in primary care). None of the doctoral programs indicated primary care psychology as a major area of study and only 7 indicated an emphasis in this specialty area. Perhaps most striking is how these numbers compare to training emphases found in internship settings. A search of the 461 U.S.-based APA-accredited predoctoral internship programs listed in the online directory of the Association of Psychology Postdoctoral and Internship Centers (APPIC) revealed that 42% of internship programs provide training in primary care. Specifically, 102 (22%) programs had a major rotation in primary care and an additional 94 (20%) programs had minor rotations in primary care. It appears that despite increased demands for psychologists to work in primary care settings, doctoral training programs have been slow to expand the focus of training to include IBHC or primary care psychology.

Many practical limitations to incorporating IBHC training into doctoral programs can create significant barriers, even for programs highly motivated to move in this direction. These may include a lack of (a) access to partnering primary care sites; (b) faculty with knowledge or expertise in this area; (c) space in the training curriculum to include additional courses, clinical experiences, or other training activities; (d) funds to support training activities specific to IBHC; and (e) partnering health programs (e.g., nursing, public health, medicine, social work) for interdisciplinary training. Without these resources, programs will be limited by how much they

can incorporate IBHC training into their curricula; however, even when these resources are in abundance, programs may not be certain of which ones to prioritize or how to approach such a training shift. However, even absent a primary care partner, McDaniel, Belar, Schroeder, Hargrove, and Freeman (2002) noted that exposure to interdisciplinary health care teams in other health care settings is beneficial for doctoral students who eventually may practice or train in primary care. Below we describe how we went from no exposure or training in IBHC to incorporating it as a major training focus of our doctoral program.

### Example of IBHC Training for Doctoral Students at the University of Arkansas

Psychology training programs cannot be all things to all students and decisions about training emphases are typically a function of current training faculty, available funding, and potential clinical training settings. There can be significant, practical constraints to changing or expanding a program's training model, from that which is functional and familiar to that which is currently trending. Even programs with strong interest in IBHC training will by necessity have to weigh the costs and benefits of such a move.

In our own program at the University of Arkansas, we began with no faculty with IBHC expertise and no courses that covered content relevant to IBHC. However, when we were approached by a local primary care clinic and asked to design a program for the clinic that would allow their patients to have better access to mental health services, a willing faculty member whose research focused on reducing health disparities and access to mental health care (the first author) eagerly agreed to assist. To begin, we researched different models of collaboration between primary care and specialty mental health care. The first author and members of the primary care team also attended a conference on collaborative care to learn more about what options were available. After this, we settled on the primary care behavioral health model of integrated behavioral health care (Robinson & Reiter, 2006). As we moved towards the design and implementation of the program, we sought consultation from other experts who had already developed well-functioning programs to guide us. We also sought funding (from service-based grants to research and training grants) to

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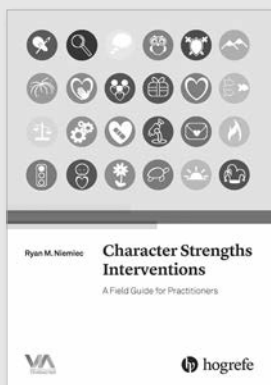
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help provide funds for the infrastructure and initial start-up costs.

Our program benefited from GPE funding that allowed us to expand both coursework and clinical experiences related to IBHC training. For instance, one of us (first author) developed a semester-long course in integrated care and evidence-based psychology practice. The course introduces students to key topics in IBHC, including application of evidence-based clinical services to the primary care setting, behavioral health issues that complicate management of chronic diseases, biological bases of psychiatric conditions, and use of informatics for clinical decision-making (see Spring, 2007; Walker & London, 2007). We also infused instruction in medical consultation into our graduate course in consultation and supervision (taught by the second author). Perhaps the most salient aspect of IBHC training for our students is a clinical clerkship at a local FQHC that provides integrated care to low-income, often minority patients. Each year, a limited number of graduate student clinicians have the opportunity to learn firsthand about providing behavioral health services to primary care patients. Approximately two-thirds of patient contacts are unscheduled, warm handoffs by medical providers, while the remaining third are follow-up sessions with patients for whom a single session was insufficient to address their acute behavioral needs. Apart from these formal training activities, our program regularly invites community leaders and nationally recognized scholars, including internship directors, to our campus to give colloquia on behavioral health topics. We have also made efforts to expose undergraduate students to psychology's role in health service delivery. We have given modest fellowship awards to undergraduate students who show promise in research and professional development in the area of primary care and health psychology. More recently, we developed an undergraduate course in interprofessional approaches to health care service. We have continued expanding our partnerships (e.g., school-based health clinic, university health center), to infuse IBHC-related content into additional clinical clerkships, to develop interprofessional courses at the graduate level, and to hire new faculty with expertise in team-based approaches to care.

### The IBHC Training Matrix

Knowing how other programs structure IBHC training is useful but lacks sufficient

information to guide those programs that are unsure of the level of investment needed. To help guide programs looking to expand in this direction, we offer the IBHC Training Matrix. We drew from existing program models and our own experience with IBHC training to develop this guiding framework. We make the assumption that programs will differ in the degree to which IBHC training is currently a valued or prominent training goal. For some programs, giving students a cursory overview or an introductory exposure to the IBHC model will suffice; other programs might be inclined to restructure their program model and begin providing extensive IBHC training that includes rich and varied opportunities across multiple domains (research, didactics, and clinical practice). To be useful across a wide range of programs, our training matrix describes three levels of training depth or program investment. At each level, we provide examples for how programs can address four different training domains: (a) program culture or identity, (b) preparatory steps and needed infrastructure, (c) focal training goals, and (d) sample training activities (Table 1). This matrix and its three levels are merely heuristic, designed to help programs work through decisions about a move toward IBHC training. More important, each level represents its own end point as it relates to a program's training model; there is no implication in our three levels that programs should eventually move toward the highest level of investment. Programs could also elect to invest in one domain of IBHC training (e.g., didactics) while maintaining status quo with other training domains (e.g., research and practicum). This framework is also not meant to be prescriptive or comprehensive. Programs need not implement all identified training components and we suspect there are many other valuable training components missing from our matrix. Finally, our suggestions for training activities are only meant to illustrate what might be consistent with that level of program investment. With those caveats in place, we begin discussion of the training matrix at the modest level of program investment.

#### Modest Investment

Level I, the most basic level, provides opportunities for students to become exposed to IBHC without the training program having to undergo a dramatic shift in its identity or training mission. In fact, this level may involve only one faculty member who has interest in increasing students'

training in IBHC; other faculty can continue to provide instruction as usual with minimal interruption in the program's training mission. Training at this level does assume, however, that other faculty members are supportive of efforts to expose students to IBHC. It would be difficult for a program to move forward if core faculty saw little value in IBHC training or considered it antithetical to the program's philosophy or approach to evidence-based clinical psychology. Level I is comparable to the exposure many clinical psychology training programs provide students in fields such as forensic or health psychology when there is no formal training track or area of emphasis within the program. Programs can simply introduce students to the IBHC model, offering it as one approach among several by which clinical psychologists can deliver their services. An important benefit of this training level is that it requires relatively little change in infrastructure and only modest support from the broader program or department (e.g., funds to bring in colloquium speakers, support efforts to make minor modifications to course content).

Although Level I provides minimal exposure to IBHC, it is important to recognize that even this level of exposure can be enormously beneficial to trainees. Predoctoral internship training directors and directors of IBHC in primary care settings often lament the lack of knowledge mental health professionals have about this model and many are excited at the possibility of training students or recent graduates who have some familiarity with the basic tenets of IBHC (e.g., Perez, August 2012, personal communication; Shuler, September 2012, personal communication). As internship slots and job opportunities continue to expand to include more opportunities for IBHC, even minimal exposure could provide a valued benefit to trainees, one that sets them apart in the eyes of training selection committees.

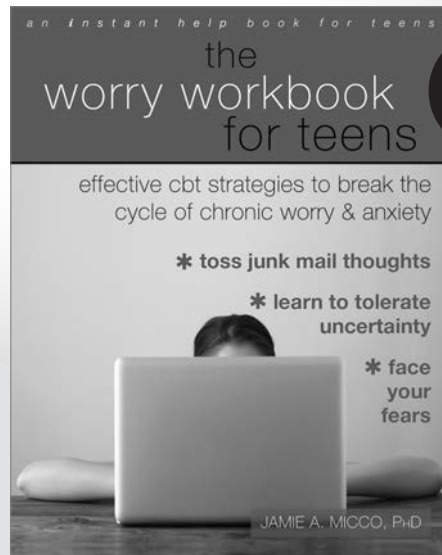
#### Moderate Investment: Enhancing Depth

Level II, the intermediate level of investment, moves IBHC training to a more central position within the program. No longer is it peripheral to the program's training mission but instead is a bona-fide training component that a significant number of students will seek. Programs may elect to have an area of emphasis in IBHC (i.e., not quite a formal track, which would be more

[Continued on p. 178]



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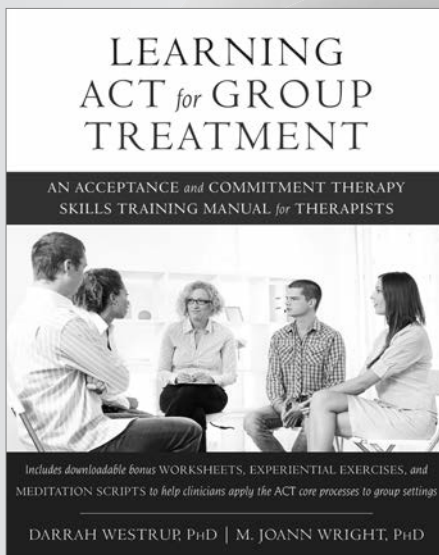
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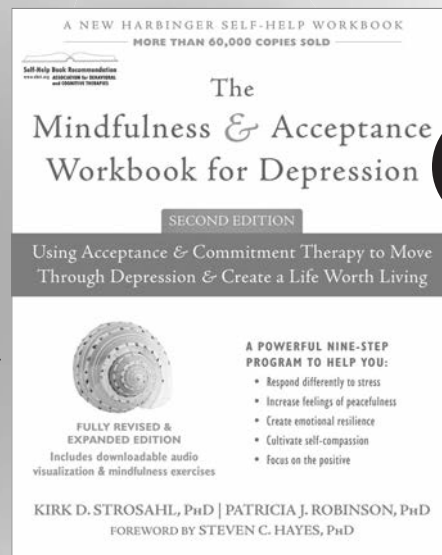
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**Table 1.** Program Culture, Infrastructure, Training Goals, and Training Activities by Level of Investment

Culture/Identity	Preparation & Infrastructure	Training Goals	Sample Training Activities
<i>Level I: Modest Investment</i>			
<ul style="list-style-type: none"> <li>• Program faculty comfortable with and committed to its current (non-IBHC) training model</li> <li>• Faculty cautious but open to IBHC-related training “trials”</li> <li>• Students involved in IBHC training are exclusively advisees of faculty who champion IBHC</li> </ul>	<p><b>Preparation</b></p> <ul style="list-style-type: none"> <li>• At least one faculty member with prior training in IBHC or a strong interest in learning the IBHC model</li> <li>• At least one faculty member willing to champion and launch IBHC training</li> <li>• Locate nearby community health centers (CHCs) and build relationship with CHC directors</li> </ul> <p><b>Infrastructure</b></p> <ul style="list-style-type: none"> <li>• Existing curriculum allows for the pursuit of optional training experiences (e.g., IBHC) if minimally disruptive to program advancement</li> <li>• Faculty free to include IBHC-relevant material into existing courses</li> <li>• Costs associated with IBHC training impact minimally on participating faculty and students and the program as a whole</li> </ul>	<ul style="list-style-type: none"> <li>• Introduction to IBHC model and supporting research literature</li> <li>• Exposure to IBHC practice settings</li> </ul>	<p><b>Didactics</b></p> <ul style="list-style-type: none"> <li>• Supplementing existing courses with IBHC-relevant content (e.g., psychotherapy, clinical science, biological bases of human behavior)</li> <li>• Invited talks or colloquia by IBHC scholars or practitioners (such as a DCT at an IBHC internship site)</li> </ul> <p><b>Clinical</b></p> <ul style="list-style-type: none"> <li>• Shadowing opportunities at a primary care clinic</li> </ul> <p><b>Research</b></p> <ul style="list-style-type: none"> <li>• Reading some primary research, attending a conference talk, conducting a literature review on IBHC</li> </ul>
<i>Level II: Moderate Investment</i>			
<ul style="list-style-type: none"> <li>• IBHC considered a visible and viable training option in the program</li> <li>• Broad faculty acceptance of and support for IBHC training options</li> <li>• Faculty involved in IBHC training are mainly IBHC champions</li> <li>• Strong student interest in IBHC training, especially among advisees of IBHC champions</li> <li>• IBHC champions conduct or oversee IBHC-related research projects</li> </ul>	<p><b>Preparation</b></p> <ul style="list-style-type: none"> <li>• At least one faculty member who obtains specialty training in IBHC, possibly leading to certification</li> <li>• Seek IBHC-related practicum opportunities, perhaps with local CHCs</li> <li>• Cultivate opportunities to partner with local FQHC in pursuing grant funds for IBHC</li> </ul> <p><b>Infrastructure</b></p> <ul style="list-style-type: none"> <li>• Strong working alliance with local CHC</li> <li>• Training curriculum allows for IBHC-focused seminar</li> <li>• Faculty member willing/able to offer IBHC seminar</li> </ul>	<ul style="list-style-type: none"> <li>• Working knowledge of IBHC model and supporting research literature</li> <li>• Exposure to IBHC-related clinical experiences</li> <li>• Emerging identity as IBHC service provider</li> </ul>	<p><b>Didactics</b></p> <ul style="list-style-type: none"> <li>• Dedicated course to IBHC for clinical psychology students</li> </ul> <p><b>Clinical</b></p> <ul style="list-style-type: none"> <li>• Some clinical experience in IBHC service provision through an externship/practicum of moderate duration</li> </ul> <p><b>Research</b></p> <ul style="list-style-type: none"> <li>• Some data collection and smaller projects occurring at primary care clinics</li> <li>• Secondary data analyses of publicly available data sets with health and mental health variables</li> </ul>

[Table continued on p. 177]



Table 1, Continued

Culture/Identity	Preparation & Infrastructure	Training Goals	Sample Training Activities
	<p><i>[Level II, continued]</i></p> <ul style="list-style-type: none"> <li>• Program support for IBHC-related clinical practicum</li> <li>• Faculty member willing/able to supervise IBHC practicum</li> <li>• Students participate in IBHC-related seminars and practica</li> <li>• Active recruitment of students with interest in IBHC training</li> </ul>		
<i>Level III: Major Investment</i>			
<ul style="list-style-type: none"> <li>• Program identifies as IBHC-focused training model</li> <li>• IBHC training is codified in program's training goals</li> <li>• Program has national reputation as IBHC training program</li> <li>• Majority of faculty identify as IBHC-related professionals</li> </ul>	<ul style="list-style-type: none"> <li>• Majority of faculty and students involved in IBHC training activities</li> <li>• Majority of faculty and students participate in IBHC-related research</li> <li>• Faculty actively involved in IBHC-related journal submission review process</li> <li>• External funds support IBHC training or research</li> <li>• Established, stable relationships with IBHC clinical training sites</li> <li>• Multiple IBHC clinical training sites</li> <li>• Paid clerkships offering IBHC-related clinical training</li> <li>• Vertical teams used to increment IBHC-related clinical training for students at different levels</li> <li>• Didactic training addressing role of inter-professionalism in IBHC</li> <li>• Students actively engaged in interprofessional clinical work</li> <li>• Faculty retreat to discuss model implementation and training goals</li> </ul>	<ul style="list-style-type: none"> <li>• Strong foundation in the IBHC model and its supporting research literature</li> <li>• At least one year of clinical training in an IBHC setting</li> <li>• Strong identification with IBHC service delivery model</li> <li>• Theses and dissertation projects are IBHC-related</li> <li>• Students seek and obtain IBHC-focused clinical internships</li> </ul>	<p><b>Didactics</b></p> <ul style="list-style-type: none"> <li>• A sequence of courses, specialized curricula, and inter-professional training opportunities (e.g., courses that include nursing and psychology trainees as well as courses offered by other professionals)</li> </ul> <p><b>Clinical</b></p> <ul style="list-style-type: none"> <li>• Clinical experience in multiple (2+) primary care clinics (OB-GYN, family practice, pediatrics, internal medicine). Vertical team models of supervision—more senior students with 1+ years of clinical experience providing supervision of more junior clinicians. Expectations that students will complete IBHC-related internships.</li> </ul> <p><b>Research</b></p> <ul style="list-style-type: none"> <li>• Clinical trials in IBHC, program evaluation, multi-method, multi-informant projects that make use of electronic medical records, BHC data, provider data, and patient data. Publications and conference presentations.</li> </ul>

in line with Level III) that includes (a) a clinical practicum team or an externship opportunity that involves work in a primary care setting, (b) a full semester course in IBHC, and (c) opportunities to conduct IBHC-related research projects that are modest in scale. Trainees at this level not only acquire greater knowledge about IBHC, but also gain experience in providing clinical services to primary care patients. Research projects may be small-scale studies conducted in integrated primary-care sites, or may make use of publicly available data sets and data repositories (see [www.apa.org/research/responsible/data-links.aspx](http://www.apa.org/research/responsible/data-links.aspx) for a list of such resources). The program's culture and identity will necessarily need to shift from passive acceptance to a more active integration of IBHC training. Ideally, at least two faculty members will be actively involved in IBHC training efforts; one may be a liaison or administrative contact for the primary care training site and one or more may be involved in clinical supervision and didactic training. With increased emphasis in IBHC training, there's a concomitant need for increased resources from the program or academic department. At this level of investment, programs will need to dedicate some training funds specifically to support IBHC-area students or work with primary care sites to generate stipends that can be used to fund students enrolled in clinical externships that offer IBHC training. Affiliated faculty members can also pursue grants (e.g., GPE) to help provide funds for IBHC-focused training. An established relationship with a primary care site is critical at this level, as is a supervising psychologist who is trained in and identifies with the IBHC model. Because trainees in primary care settings tend to see many patients in a given week, supervision can be more time intensive and is best when it combines traditional supervisory meetings (group and/or individual) with real-time shadowing of interns on a regular basis. Supervising faculty can request departmental, college, or university support (e.g., reduced demands for other service- or training-related activities) for their efforts to provide instructional time away from campus. Programs operating at Level II would benefit from including information about their IBHC training on their websites, in program brochures, or in other materials used to advertise to applicants the unique training opportunities available. Programs at this level can also benefit from more focused and intentional connections

with internship sites that provide training in the IBHC model.

### **Major Investment: Enhancing Depth and Breadth**

Finally, at a Level III, the program has fully committed to having IBHC training as a major focus area or track. At this level, most faculty members are involved in IBHC-related training and research and the program has specifically identified itself as one that specializes in IBHC. Students are provided with an explicit set of sequenced training activities related to IBHC, including a series of dedicated courses and multiple clinical experiences in primary care settings. In line with the inter-professional nature of IBHC, some of these activities should include training alongside allied health professions, such as nursing, pharmacy, medicine, or social work. Psychology trainees might take courses offered in these other health disciplines or psychology faculty might team teach IBHC-related courses to health care trainees. Students at this level of training are involved in research projects, including theses or dissertations that address various issues within IBHC, including efficacy and effectiveness of IBHC interventions, cost-effectiveness research, and program evaluation. At the conclusion of doctoral training, students would be expected to pursue IBHC-related internships and continue their professional development as emerging leaders in the field of primary care psychology.

Once a program has identified the appropriate level of IBHC training and investment, it is critical to engage in a programmatic "self-study." This will help programs gauge the degree to which they have resources needed for the chosen level of training and will facilitate efforts to identify specific areas needed for expansion. The self-study may be guided by the recently developed IBHC competencies articulated by McDaniel and colleagues (2014). A survey of training experiences, course curricula, clinical expertise, knowledge and content domains of students, supervisor appraisals, and even outside expert consultants can help provide programs with feedback about the degree to which the program is adequately covering IBHC competencies. A road map for how the program can shift towards IBHC training is thus one outcome of a self-study. This road map will not only articulate *what* changes need to be made by the program, but also *who* is responsible for each component and set time lines for *when* the proposed changes might take place. The initial

self-study could be repeated at a later time point as a way to note programmatic progress towards IBHC-related training goals.

### **Conclusions**

Our goal in writing this paper was to help training faculty move forward on an issue that appears to be increasingly important for students they are currently training and will be training in the future. McDaniel and colleagues (2014) have argued that to compete in the changing climate of U.S. health care, psychologists must be health service providers whose work is not limited to mental health specialization. Nowhere is this more evident than in the recent funding for and increased focus on psychologists' role within integrated behavioral health care. Doctoral training faculty can survive being "late adopters" in the IBHC marketplace, but their students will be aided and grateful for training that prepares them for newer roles in health service delivery. Doctoral psychology training programs will vary in their eagerness to incorporate IBHC-related training activities, but even programs ready to add some level of IBHC training might lack useful information to begin a shift in that direction. Offered here is a conceptual framework that can be used to guide programs considering a shift, however slight, toward IBHC training. Described are potential pathways that programs can use when making minimal, moderate, or major investments in IBHC training. At each level of investment, programs have a range of options across key program domains (i.e., identity, infrastructure, goals, training activities) and can even stagger newer training efforts across these domains. We believe this framework can be useful to a range of programs, including those wary of any kind change toward IBHC training. IBHC training is an important and accessible goal for all psychology training programs (McDaniel et al.), and the training matrix presented here is one guide in making that investment.

### **References**

- American Psychological Association [APA], Presidential Task Force on Integrated Health Care for an Aging Population (2008). *Blueprint for change: Achieving integrated health care for an aging population*. Washington, DC: American Psychological Association.
- Belar, C. D. (2012). Reflections on the future: Psychology as a health profession. *Professional Psychology: Research and*

- Practice*, 43(6), 545-550. doi: 10.1037/a0029633
- Blount, A. (1998). *Integrated primary care: The future of medical and mental health collaboration*. New York: Norton.
- Bodenheimer, T., Chen, E., & Bennett, H. D. (2009). Confronting the growing burden of chronic disease: Can the U.S. health care workforce do their job? *Health Affairs*, 28, 64-74. doi: 10.1377/hlthaff.28.1.64
- Dobmeyer, A., Rowan, A., Etherage, J., & Wilson, R. (2003). Training psychology interns in primary behavioral care. *Professional Psychology*, 34, 586-594. doi: 10.1037/0735-7028.34.6.586
- Fernandez, A., Pinto-Meza, A., Bellón, J. A., Roura-Porch, P., Jaro, J. M., Autonell, J., ... Serrano-Blanco, A. (2010). Is major depression adequately diagnosed and treated by general practitioners? Results from an epidemiological study. *General Hospital Psychiatry*, 32, 201-209. doi: 10.1016/j.genhosppsych.2009.11.015
- Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington, DC: Interprofessional Education Collaborative.
- Johnson, S. B. (2012). Psychology's paradigm shift. Can psychology successfully transition from a mental health to a health profession? *APA Monitor*, 43, 5.
- Kazdin, A. E., & Blase, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives of Psychological Science*, 6, 21-37. doi: 10.1177/1745691610393527
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593-602. doi: 10.1001/archpsych.82.6.593
- Kessler, R. C., & Wang, P. S. (2008). The descriptive epidemiology of commonly occurring mental disorders in the United States. *Annual Review of Public Health*, 29, 115-129. doi: 10.1146/annurev.publhealth.29.020907.090847
- Larkin, K. T., Bridges, A. J., Fields, S. A., & Vogel, M. E. (2016). Acquiring competencies in integrated behavioral health care in doctoral, internship, and post-doctoral programs. *Training and Education in Professional Psychology*, 10, 14-23. doi: 10.1037/tep0000099
- McDaniel, S. H., Belar, C. D., Schroeder, C., Hargrove, D. S., & Freeman, E. L. (2002). A training curriculum for professional psychologists in primary care. *Professional Psychology: Research and Practice*, 33, 65-72. doi: 10.1037/0735-7028.33.1.65
- McDaniel, S. H., Grus, C. L., Cubic, B. A., Hunter, C. L., Kearney, L. K. ... Johnson, S. B. (2014). Competencies for psychology practice in primary care. *American Psychologist*, 69, 409-429. doi: 10.1037/a0036072
- O'Donohue, W., Cummings, N., Cucciare, M., Rumyan, C., & Cummings, J. (2006). *Integrated behavioral health care. A guide to effective intervention*. Amherst, NY: Humanity Books.
- Peek, C. J. (2013). Integrated behavioral health and primary care: A common language. In M. R. Talen & A. B. Valeras (Eds.), *Integrated behavioral health in primary care: Evaluating the evidence, identifying the essentials* (pp. 9 - 31). New York: Springer.
- Prochaska, J. O., DiClemente, C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive



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- behaviors. *American Psychologist*, 47, 1102-1114. doi: 10.1037/0003-066x.47.9.1102
- Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system: Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50, 85-94. doi: 10.1001/archpsyc.1993.01820140007001
- Robinson, P. J., & Reiter, J. T. (2006). *Behavioral consultation and primary care: A guide to integrating services*. New York: Springer.
- Rozenzky, R. H. (2012). Health care reform: Preparing the psychology workforce. *Journal of Clinical Psychology in Medical Settings*, 19, 5-11. doi: 10.1007/s10880-011-9287-7
- Schwenk, T. L. (2016). Integrated behavioral and primary care: What is the real cost? *Journal of the American Medical Association*, 316, 822-823. doi: 10.1001/jama.2016.11031
- Uniform Data System (UDS). (2007). *The Health Center Program: National Aggregate Data*. Retrieved April 2, 2009, from <http://bphc.hrsa.gov/uds/>
- Walker, B. B., & London, S. (2007). Novel tools and resources for evidence-based practice in psychology. *Journal of Clinical Psychology*, 63, 633-642. doi: 10.1002/jclp.20377
- World Health Organization. (2004). *Promoting mental health: Concepts, emerging evidence, practice: Summary report*. Geneva, Switzerland: Author.

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## You Mean I Have to Talk About Feelings? One CBT Therapist's Experience With Interpersonal Psychotherapy

Ari Lowell and John C. Markowitz, *Columbia University Medical Center, New York State Psychiatric Institute*

*"I don't know why she said that to me. I guess she's right, I am stupid, a loser, I don't do anything right." My patient, a heavyset man in his late 40s, sighs deeply, crossing his legs and looking down at the floor. Although the session has been plodding and slow so far, my CBT-honed instincts kick into high-gear. A distortion! A cognitive distortion! Eagerly I lean forward, ready to challenge the errant thought. And then I remember: I'm doing Interpersonal Psychotherapy now. What would an IPT therapist do? I squeeze my chair's armrests to steady myself and take a breath.*

*"How did you feel when she said that to you?" I ask.*

*"How did I what?"*

*"How did you feel?"*

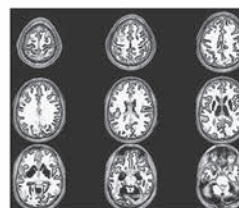
In graduate school, I was immediately drawn to cognitive behavioral therapy (CBT). And indeed, why not? CBT holds great appeal for any young, inexperienced therapist eager to enter the world of psychotherapy. To myself and many of my classmates, the concept of therapy was something ephemeral and mysterious, powerful and yet subtle, holding great promise, yet carrying a risk of causing great

harm if administered incorrectly. To this mindset, CBT was an obvious choice: it's hard to beat a highly structured, inherently logical mental health treatment, complete with a veritable avalanche of "how-to" treatment manuals, research evidence, training programs, and experienced supervisors. It seemed as though CBT works well for practically everything (Butler, Chapman, Forman, & Beck, 2006). So why try anything else?

Yet, CBT has its limitations. As Dr. Michelle Craske (2016) noted in her presidential address at ABCT's Annual Convention, despite CBT's extremely impressive history, about 20% of patients don't get better. Some argue that CBT's claim of superiority to other forms of therapy, particularly psychodynamic psychotherapy, is greatly overblown (Baardseth et al., 2013; Shedler, 2010). But even without wading more deeply into the sludge of the CBT versus psychodynamic psychotherapy debate, there is certainly evidence that CBT does not work for everyone.

I have been a fairly gung-ho CBT therapist. In my career, I have focused on the treatment of veterans and their families,

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and have used CBT effectively for the treatment of depression, generalized anxiety disorder, panic disorder, and PTSD. For the latter, I have been an adherent of such approaches as Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), and I have repeatedly been impressed by the capacity of patients to improve using these highly structured treatment recipes.

But I have also encountered patients who just don't seem to improve, for many reasons. For some, it's about the homework, and having difficulty resolving avoidance sufficiently to complete exposure exercises, a well-known challenge in CBT-oriented treatment (Cowan et al., 2007; Decker et al., 2016; LeBeau, Davies, Culver, & Craske, 2013). For others, I have wondered if it may be an issue of being overly cerebral; i.e., patients who can intellectually or philosophically grasp the concepts and behaviorally complete the exercises, but who seem detached from the actual emotional process of therapy and who struggle to engage in a meaningful way. Still others seem to just suffer without any clear reason as to why they're not getting better; no matter how much effort and work I or these patients put into treatment, they don't seem to be able to pull themselves out of their respective holes. CBT has tools for handling these situations, of course, such as identifying barriers to treatment and navigating around them, addressing distortions related to the treatment process, etc. But sometimes these strategies inexplicably fail. All too often in these situations we fall back on an old standby, the dirty secret of failed psychotherapy: blame the patient (Gunderman, 2000). "They don't want to get better." "They're not really trying." "They can't be helped." "I did everything I could think of." The comforting phrases we tell ourselves to absolve ourselves of guilt or maybe the secret fear that we're not doing a particularly good job.

An alternative explanation for lack of improvement may be that CBT was just not a good fit for these patients. Yet, I was hesitant to accept this idea. I often felt as though there weren't any good alternatives to CBT, perhaps because my training had been CBT-focused to the near total exclusion of other approaches. I imagine this view may be shared by many others of my generation of therapists, especially as CBT has become the best disseminated evidence-based mode of therapy in graduate psychology and other training programs (Weissman et al., 2006).

Enter IPT.

*The patient is crying softly. I consciously resist the urge to hand him a tissue, instead allowing him—and reminding myself—to sit with the emotions in the room. After a few moments, he wipes his eyes and tries to shift us away.*

*"Well, the truth is that she is right, what she's saying about me."*

*"Wait, hold on there for just a moment, let's stay with those feelings for a little bit. You told me just a moment ago that when your wife was speaking to you this way, you were feeling sad, and dismissed, and lonely, and upset. Do you think these feelings make sense? Is it okay to feel this way?"*

I first encountered IPT at Columbia University Medical Center/New York State Psychiatric Institute while working with Dr. Yuval Neria, director of the PTSD Research and Treatment Program, and Dr. John Markowitz, a leading psychotherapy researcher. Dr. Markowitz had conducted research using IPT for PTSD, and showed that IPT might do better than PE for a subset of patients with PTSD and comorbid depression (Markowitz, 2016; Markowitz et al., 2015). To a CBT therapist like me, experienced in PE and CPT, the concept of treating PTSD with IPT, which does not include exposure, sounded ludicrous. But I've always prided myself on being open-minded and flexible, and invested in learning anything that will help me be a better therapist. So, I skeptically but gamely agreed to attempt IPT.

IPT was difficult for me to learn. Although the concepts are relatively simple, and some of the core principles share commonality with CBT, it is truly a very different form of treatment, having its roots more in attachment theory and psychodynamic psychotherapy than anything else. IPT was originally developed in the 1970s by Dr. Gerald Klerman and Dr. Myrna Weissman as part of a study of amitriptyline for depression. IPT emphasized what was then a novel concept: depression is a medical illness that is not the patient's fault, and it can be improved through socially oriented interventions (Klerman, Weissman, Rounsaville, & Chevron, 1984; Markowitz & Weissman, 2012).

IPT has three basic principles: (a) whatever may have "caused" a depressive episode or other mental health disorder, it occurs in an interpersonal context and tends to involve disruption of important

attachments and social roles; (b) social support protects against psychopathology; and (c) working on changing social functioning in the "here and now" improves symptoms. To accomplish symptom improvement, IPT focuses on affective (rather than cognitive) understanding and engagement (i.e., embracing and expressing emotions as an important part of living: negative affects like anger are not harmful and provide important information about interpersonal conflict), bolstering social engagement and support, and enabling the patient to make proactive, effective interpersonal choices. IPT therapists never assign homework, but do encourage patients to "live dangerously" (i.e., experiment while in treatment in trying things differently to see what happens). IPT's time-limited approach subtly encourages movement and action. IPT is an active treatment in which the therapist works to keep the patient engaged emotionally.

IPT has three phases. In the first phase (roughly three sessions), the therapist gathers an interpersonal inventory, a sort of history of the patient's past and particularly present relationships, and the patient's patterns in those relationships. After conducting a thorough assessment, the therapist delivers a clear diagnosis. The patient is assigned the "sick role," and as with any medical condition, the patient is told that it's harder to function when not feeling well. The therapist explains that the patient's condition is no fault of the patient's own, and that the condition is treatable. Finally, the therapist gives the patient a formulation. The formulation links the patient's condition either to a role transition, in which there was a significant life change (or in the case of PTSD, onset of a significant condition); a role dispute, in which the patient's symptoms link to the onset of a fundamental personal disagreement and conflict with another person; unresolved grief, if the patient never fully processed the death of someone important; or if none of the above apply, the therapist may opt for an interpersonal deficit, an unfortunately named grouping that is intended for those who do not fit well into the other categories (Weissman, Markowitz, & Klerman, 2007).

In the second phase of treatment, the therapist begins each session by asking, "How have things been since we last met?" The patient responds by reporting how he or she is feeling, or what has happened recently. The therapist helps the patient connect mood to life circumstances, commenting that it makes sense that the patient

feels worse when bad things happen, and better when good things happen. In discussing incidents, the therapist asks:

*What happened?  
What did you feel?  
Did your feelings make sense?  
And what happened next?*

The goal of these questions is to help the patient recognize what the patient may be feeling, understand why the patient may be feeling this way, and allow the patient to experience and express this emotion. The therapist then moves to the next question: What are your options in this kind of situation? What would be helpful? Often, the IPT therapist will role-play scenarios with the patient to help the patient arrive at a satisfactory interpersonal choice that validates and honors the patient's feelings.

In the third and final phase, the therapist helps prepare for termination, and as in other forms of therapy, discusses what worked and what didn't, bolsters a sense of independence and competence, and

acknowledges that separation can be "bittersweet." The therapist attempts to relieve guilt and self-blame if the treatment was not fully successful, and explores other options with the patient as warranted.

*"Okay. We've established that you were feeling sad, and angry, and that these feelings made sense; in fact, most people would probably feel as you did if spoken to the way that you were. So what happened next? What did you do?"*

*"I didn't do anything. I mean, I apologized. I said I was sorry."*

*"You apologized?"*

*"Yeah." He pauses. "I know, stupid, right? I don't know what to do."*

*"Well, what are your options?"*

To even a casual observer, there are many noticeable differences between IPT and CBT, which are also readily visible on standardized adherence scales (Hill, O'Grady, & Elkin, 1992; Markowitz, Spiel-

man, Scarvalone, & Perry, 2000; see Table 1). Besides the structural issues of, for example, homework or agenda-setting, IPT generally targets emotions, whereas CBT primarily targets cognitions, viewing emotions as more of an outcome or measurement variable. Furthermore, IPT focuses on emotions within interpersonal contexts and exploration of interpersonal effectiveness with other human beings, rather than on a patient's internal, cognitive dysfunctions. Which is not to say that cognitive distortions or misperceptions are never addressed in IPT; but they are not a primary focus and are certainly no sine qua non.

This was hard to wrap my head around when I first started conducting IPT for depression and PTSD. No homework assignments? No discussion of trauma? No direct addressing of avoidance? We're just supposed to talk about feelings?

"Yes," I learned. The key difference between IPT and exposure treatments for



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PTSD is that exposure treatments target reminders of and the narrative of the traumatic event itself, whereas IPT targets the interpersonal sequelae of trauma—that is, withdrawal and isolation, distrust of others, “interpersonal hypervigilance,” impaired social and marital functioning (Markowitz, 2016).

I have had many uncomfortable moments while conducting IPT. Focusing on feelings rather than thoughts has meant having to be more in touch and present with my own feelings, including feelings of pain and discomfort, when my natural empathy connected me to my patient’s experiences. I have learned to be less quick to hand tissues to patients, and more willing to sit back and allow feelings just to be.

It has also been hard to resist “fixing” patients’ thoughts. When I hear a distorted cognition, I always want to change it, shape it, correct it, challenge it—something! In IPT, though, pulling the patient away from feelings is actually counterproductive. It distracts from the primary task of understanding, labeling, and accepting an emotion, and being willing to generate ways to honor and act on that feeling in an effective, interpersonally savvy way.

In somehow enduring and overcoming these and other challenges, however, I have made a startling discovery: IPT works! While this outcome is of no surprise to those already familiar with IPT’s considerable research support (Cuijpers et al., 2011; Negt et al., 2016), it has been eye-opening to see how patients get better simply by focusing on feelings and using them to explore how to interact with others in different, more effective ways. I have also found, anecdotally, that patients with PTSD gain perspective on their traumatic experiences and memories even without addressing them directly. They learn to identify the feelings that arise from trauma-related symptoms, such as intrusive

thoughts or startle reflex, and seek appropriate support for these feelings, rather than pull away from others and remain isolated and alone, burying or hiding their feelings. I have been impressed as patients, who at the onset of treatment appeared timid, depressed, and avoidant, become confident, mature individuals with the skills to successfully navigate their interpersonal environments.

I have also been surprised by IPT’s effects on me as a therapist: I have gradually noticed that I have become more patient, more comfortable with emotions, and better able to support patients in finding their own solutions to problems (although I’m sure Dr. Markowitz would say, correctly, that I still have plenty of room to grow). I find myself doing less mental juggling during IPT sessions in terms of what skills to focus on and what the patient needs to learn, and being more in the moment, allowing the process of therapy simply to be. And, I will admit, it has been incredibly freeing to get away from homework, and from endless, awkward discussions of why a patient didn’t complete a particular assignment. I look forward to my IPT sessions, and find myself immensely enjoying the sense of adventure that comes with not knowing what has happened in the past week, what emotions have been stirred up, and learning what patients have attempted on their own.

I have no intention of abandoning CBT, and continue to regularly use CBT treatments, including PE. There are unquestionable advantages to exposure-based and other CBT approaches for PTSD, depression, anxiety, and other problems, and much proven success. However, as no treatment works for all patients, it is extremely comforting to know that IPT is available for patients who don’t seem to be a good “fit” for CBT, who don’t seem to be

getting better, or who may especially benefit from an affect- or interpersonally focused treatment. As a therapist, I am grateful for how IPT has broadened my perspective, and I encourage other CBT therapists to give it a try as well.

References

Baardseth, T. P., Goldberg, S. B., Pace, B. T., Wislocki, A. P., Frost, N. D., Siddiqui, J. R., ... Wampold, B. E. (2013). Cognitive-behavioral therapy versus other therapies: Redux. *Clinical Psychology Review, 33*(3), 395–405. <https://doi.org/10.1016/j.cpr.2013.01.004>

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26*(1), 17–31. <https://doi.org/10.1016/j.cpr.2005.07.003>

Cowan, M. J., Freedland, K. E., Burg, M. M., Saab, P. G., Youngblood, M. E., Cornell, C. E., ... ENRICHD Investigators. (2007). Predictors of Treatment Response for Depression and Inadequate Social Support – The ENRICHD Randomized Clinical Trial. *Psychotherapy and Psychosomatics, 77*(1), 27–37. <https://doi.org/10.1159/000110057>

Craske, M.G. (2016, October 29). *Honoring the past, envisioning the future*. Presidential address presented at the Annual Convention of the Association for Behavioral and Cognitive Therapies, New York, NY.

Cuijpers, P., Geraedts, A. S., van Oppen, P., Andersson, G., Markowitz, J. C., & van Straten, A. (2011). Interpersonal psychotherapy for depression: A meta-analysis. *American Journal of Psychiatry, 168*(6), 581–592. <https://doi.org/10.1176/appi.ajp.2010.10101411>

Decker, S. E., Kiluk, B. D., Frankforter, T., Babuscio, T., Nich, C., & Carroll, K. M. (2016). Just showing up is not enough: Homework adherence and outcome in cognitive-behavioral therapy for cocaine dependence. *Journal of Consulting and Clinical Psychology, 84*(10), 907–912. <https://doi.org/10.1037/ccp0000126>

Gunderman, R. (2000). Illness as failure. Blaming patients. *The Hastings Center Report, 30*(4), 7–11. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/10971886>

Hill, C. E., O’Grady, K. E., & Elkin, I. (1992). Applying the Collaborative Study Psychotherapy Rating Scale to rate therapist adherence in cognitive-behavior therapy, interpersonal therapy, and clinical management. *Journal of Consulting and Clinical Psychology, 60*(1), 73–9. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/1556289>

Table 1. Similarities and Differences Between CBT and IPT

Category	CBT	IPT
Goal	Correct distorted thinking	Improve interpersonal functioning
Target of interventions	Cognitions and behaviors	Emotions (and interpersonal behaviors)
Focus	Diagnosis-, present-focused	Diagnosis-, present-focused
Use of homework	Yes	No
Time-limited	Usually	Yes



- Klerman, G. L., Weissman, M. M., Rounsaville, B., & Chevron, E. S. (1984). *Interpersonal psychotherapy of depression*. New York: Basic Books.
- LeBeau, R. T., Davies, C. D., Culver, N. C., & Craske, M. G. (2013). Homework compliance counts in cognitive-behavioral therapy. *Cognitive Behaviour Therapy*, 42(3), 171–179. <https://doi.org/10.1080/16506073.2013.763286>
- Markowitz, J. C. (2016). *Interpersonal psychotherapy for posttraumatic stress disorder*. New York: Oxford University Press.
- Markowitz, J. C., Petkova, E., Neria, Y., Van Meter, P. E., Zhao, Y., Hembree, E., ... Marshall, R. D. (2015). Is exposure necessary? A randomized clinical trial of interpersonal psychotherapy for PTSD. *American Journal of Psychiatry*, 172(5), 430–440. <https://doi.org/10.1176/appi.ajp.2014.14070908>
- Markowitz, J. C., Spielman, L. A., Scarvalone, P. A., & Perry, S. W. (2000). Psychotherapy adherence of therapists treating HIV-positive patients with depressive symptoms. *Journal of Psychotherapy Practice and Research*, 9(2), 75–80. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/10793126>
- Markowitz, J. C., & Weissman, M. M. (2012). Interpersonal psychotherapy: Past, present and future. *Clinical Psychology & Psychotherapy*, 19(2), 99–105. <https://doi.org/10.1002/cpp.1774>
- Negt, P., Brakemeier, E.-L., Michalak, J., Winter, L., Bleich, S., & Kahl, K. G. (2016). The treatment of chronic depression with cognitive behavioral analysis system of psychotherapy: A systematic review and meta-analysis of randomized-controlled clinical trials. *Brain and Behavior*, 6(8). <https://doi.org/10.1002/brb3.486>
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, 65(2), 98–109. <https://doi.org/10.1037/a0018378>
- Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2007). *Clinician's Quick Guide to Interpersonal Psychotherapy*. New York: Oxford University Press. <https://doi.org/10.1093/med:psych/9780195309416.001.0001>
- Weissman, M. M., Verdelli, H., Gameroff, M. J., Bledsoe, S. E., Betts, K., Mufson, L., ... P, C.-C. (2006). National survey of psychotherapy training in psychiatry, psychology, and social work. *Archives of General Psychiatry*, 63(8), 925. <https://doi.org/10.1001/archpsyc.63.8.925>
- ...

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## SCIENCE FORUM

## Protecting the Scientific Lexical Canon

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WORDS MATTER IN SCIENTIFIC PRACTICE. They matter because they can facilitate or hamper clear communication among scientists about phenomena, which are often complex. They also matter because they impact the clarity of communication between scientists and the lay public. Words, if properly formulated, afford economical communication and enable the successful pursuit of scientific goals such as accurate interpretation of findings and facilitation of procedural replication (Chiesa, 1994).

Scientific communities construct their vocabularies with various considerations in mind. First, they consider “entymological sanctions” (Skinner, 1957), which is to say they try to avoid the use of words that already have meaning for many people. For example, when Skinner labeled his conceptual analysis of language, he chose the term “verbal behavior” rather than “language” because the latter already had meaning that differed from his view of the phenomena. Similarly, he often contrived novel words free from preexisting meaning to label his

foundational concepts (e.g., tact, mand, intraverbal, etc.).

Rather than construct new words, some scientists approach this difficulty by attempting to clearly define their novel use of existing terms. This is problematic, however, because despite careful attention to definitional matters, many people will still confuse the new use of the term with its preexisting use. A well-known example of this is the long-standing and widespread confusion surrounding the term “negative reinforcement.” Scientists of behavior use this term with precision; they use it when making reference to a process wherein environmental events that immediately follow a behavior, and which involve the termination of an aversive condition, lead to an increased probability of that behavior in similar conditions. In other words, this refers to a process that leads to an increase in behavior. Yet many laypeople, and even many professionals, use this term to refer to environmental events that lead to a decreased probability of responding. There is an existing term for this type of behav-

ioral decrease process: punishment. Clarification regarding the precise behavioral definition of this term has been attempted many times, but with little effect.

Scientists refine their concepts over time. For example, reinforcement, one of the most fundamental concepts in behavior analysis, is currently the subject of some debate. The dominant view has been that reinforcement involves the strengthening of behavior, though other theories dispute this (e.g., Davison & Nevin, 1999). Scientific communities are slow to modify their foundational concepts, but always remain open to modification if conceptual and empirical analyses reveal more effective specification.

Words impact scientific behavior when they influence the ways scientists view their subject matter, the manner in which they make interpretations, and the ways that terminology affects conceptual understanding. As such, scientific communities attend to the controlling effects their words have on their behavior (Chiesa, 1994).

Finally, scientific communities take substantial measures to protect their precise subject-specific terminological use. They accomplish this through the arrangement of contingencies that socialize junior members in terminological precision and weaken or prevent subsequent terminological drift.

The effectiveness of arranging such contingencies differs across scientific communities. Behavioral scientists have gener-

ally been less effective than other sciences in this regard, perhaps because their terminologies overlap more frequently with lay terminology than do those of other sciences. Consequently, behavioral scientists must be even more steadfast in protecting terminological precision with respect to their lexicon.

Concerns about terminological use in psychology, in both research and applied contexts, is not new (e.g., Miller & Pollock, 1994; Stanovich, 2012). A number of authors have noted the difficulty that psychological scientists have in using the same term for different constructs as well as referring to the same constructs with different labels (Block, 1995; Markon, 2009). One striking example is the documented use of 15 different terms to refer to the “false consensus effect” (Miller & Pederson, 1999). Further, a recent paper discussed the imprecise use of 50 psychological and psychiatric terms (Lilienfeld et al., 2015), including their identification and examples of their misuse. Words are important tools in a scientist’s armamentarium and, clearly, confusion is minimized when each word is restricted to a single meaning.

The field of applied behavior analysis (ABA) has also recognized this problem and has been more proactive than other areas of behavioral science at protecting its own lexical canon. For example, applied behavior analysts dedicate a section in one of their primary journals, *The Behavior Analyst*, to this specific issue. The section, “On Terms,” focuses on one technical term at a time and, as of 2016, there are more than 36 of these articles. The authors of the section clarify technical terms with definitions and descriptions of proper terminological use (Carr & Briggs, 2011).

Recently in the CBT community, there has been some interest in clarifying important terms. For example, Sauer-Zavala et al. (2017) clarified differing uses of the term “transdiagnostic,” specifying their consequences and offering guidance on how to engender consensus around the term. In contrast, others have stipulated lack of precision as “middle terms” to avoid the misperception of precision before supporting data (Hayes, Strosahl, & Wilson, 2012).

Verbal behavior evolves and over time words accumulate additional meaning. This occurs naturally in everyday language; scientific verbal communities are not immune to the phenomenon. So if scientific communities are going to retain the important benefits of precise and reliable

terminological use, they must attend to their language practices.

Unfortunately, significant terminological imprecision and drift is present in the CBT community. In this paper three key examples are noted and described, followed by suggestions for enhancing the community’s language practices. Two related issues involve the precise use of scientific terms among the lay public and across scientific disciplines, but these are not addressed here.

### Current Examples of Terminological Imprecision

Many examples of imprecise and drifting terminological use in the CBT community are available, but due to space limitations only three are presented. Terms were selected from three different categories: (a) a clinical decision-making process, (b) a clinical procedure, and (c) a method of inference considered foundational to scientific practice. Within each example the precise scientific term is noted, examples of its misuse described, and examples of negative consequences of the imprecision specified.

#### Example 1: “Evidence-Based”

“Evidence-based” is a descriptor primarily intended to modify the term “practice,” as in evidence-based practice. However, it is often used incorrectly, for reasons discussed below, to modify the noun “treatment,” (i.e., evidence-based treatment). This misuse appears to be a consequence of verbal drift.

Adding to the confusion, numerous technical definitions have been presented in the literature. Fortunately, most converge on common considerations and the key commonalities are captured by the definition of evidence-based practice (EBP) offered by the American Psychological Association: “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2005, p. 5). When one examines this definition one discovers that evidence-based practice involves the integration of three distinct components during clinical decision-making: (a) the best available research evidence, (b) one’s clinical expertise, and (c) the patient characteristics, culture, and preferences. The definition does not spec-

ify that one component be weighted more heavily than another, as they are all considered to be of equal value.<sup>1</sup>

Another difficulty is the use of differing terms to refer to evidence-based practice. A nonexhaustive list of examples includes: “evidence-informed practice,” “*the* evidence based approach” (emphasis added), “evidence-based practices” (italics mine), “evidence-based protocol,” and “empirically supported treatment.” These terms are often used as synonyms. They are also frequently used to solely mean a treatment or a list of treatments with scientific support. EBP, however, does not refer to a list of treatments, but rather a model for professional decision-making. In contrast, the term “empirically supported treatments” is derived from a movement involved in developing evidentiary standards and disseminating lists of interventions meeting those standards (Chambless & Hollon, 1998). The ability to identify and deliver scientifically supported interventions is an important element of evidence-based practice, but it only represents one third of the evidence-based-practice decision-making process (i.e., best available research, but not clinical expertise or client culture and preferences). Finally, since “empirically supported treatment” is already an established term for referencing a psychological treatment meeting specific evidentiary standards, it is unnecessary and confusing to make use of additional terms (e.g., “evidence-based treatment”) to refer to the same thing. Moreover, because differing classification systems for determining what satisfies the designation “evidence-based” exist, each with their own unique evaluation criteria (e.g., California evidence-based clearinghouse, SAMHSA’s NREPP, National Association of Public Child Welfare Administrators), the term evidence-based treatment (EBT) is not precise.

The terminological difficulties do not end with communication problems; the confusion also frustrates dissemination efforts. Many consumers have learned to seek out treatments with the designation “evidence-based,” but they have done so without awareness that this is only one component of evidence-based practice, albeit an important one. Certain practitioners, including those who do not operate from an EBP framework, have come to use that term because it produces business.

<sup>1</sup>However, some recent recommendations are for differential weighting in favor of the empirically supported treatment component (e.g., Lilienfeld, Ritschel, Lynn, & Latzman, in press; Tolin, McKay, Forman, Klonsky, & Thombs, 2015).

The use of the term serves a marketing function, and for it to function as intended, the meaning of the term must be protected. It is, of course, a common pseudoscientific tactic to use terms that sound scientific to gain credibility, despite referring to something else (Ruscio, 2002).

In sum, the negative consequences produced by these confusions include the emphasis of one component of EBP (i.e., treatment) rather than the appreciation of all three elements (i.e., treatment, clinical expertise, and client characteristics/preferences) and the inappropriate controlling effects on consumer behavior through the misappropriation of the term. An additional consequence is that it impedes clinician pursuit of evidence-based practice when they dislike the concept based on inaccurate information (e.g., “I don’t like evidence-based treatments because they are rigid and neglect the client’s values”).

#### *Example 2: “Functional Analysis”*

Functional assessment is an approach to the assessment of problem behavior focused on identifying environmental events thought to maintain those behaviors. The primary goal with this type of assessment is the identification of environmental contexts that immediately precede problem behavior (antecedents) and events that immediately follow the behavior (consequences). Functional analysis (FA) is a specific type of functional assessment procedure, which involves the use of the experimental method. The experimental procedure renders it distinct from the other two methods of functional assessment—indirect and observational—in that it affords the analyst the ability to specify causal relationships between environmental events and problem behavior. In essence, FA allows the clinician to experimentally determine the function of the target behavior, which then allows him or her to design an effective intervention.

FA is precisely defined by the community that created the procedure (i.e., applied behavior analysis), and that verbal community has academic and journalistic contingencies in place to protect its meaning. The FA procedure is well-articulated, supported by several decades of research and discussed in more than 2,000 chapters and articles. The discrimination between FA and other functional assessment procedures is crucial because the literature is clear that they differ in effectiveness. For example, it is well established that indirect functional assessment methods are generally ineffective at identifying maintaining

consequences relative to functional analyses (Hall, 2005; Hurl, Wightman, Haynes & Virues-Ortega, 2016; Lerman & Iwata, 1993; Mace & Lalli, 1991; Piazza et al., 2003; St. Peter et al., 2005; Thompson & Iwata, 2007). Because FA involves experimental procedures it is the only functional assessment method that can identify a functional relation (i.e., a “causal” relationship). For this reason, FA is considered the gold-standard functional assessment procedure.

Although the CBT community makes use of functional assessment procedures, they often refer to those procedures incorrectly. In fact, the CBT literature is replete with examples of the misuse of this term. Given the frequency with which this term is misused, a comprehensive listing of examples is not possible. In general, when one reads descriptions of procedures labeled as functional analyses in the CBT literature one typically does not discover reports of functional analyses, but rather indirect functional assessment procedures. That is, these depictions do not describe an experimental method for determining the function of client behavior, which is the key definitional element of this procedure. Notably, this terminological misuse is readily found in popular CBT texts and chapters written by prominent scholars in the field (e.g., Dimidjian, Martell, Herman-Dunn and Hubley, 2014; Kaplan & Harvey, 2014; Martell, Addis, & Jacobson, 2001; McCrady, 2014; Payne, Ellard, Farchione, Fairholme, & Barlow, 2014). Referring to indirect functional assessment methods as FAs is roughly analogous to referring to correlational procedures as experimental procedures. This is problematic because doing so suggests a causal relation can be revealed when only associative relationships have the possibility of discovery. Furthermore, many indirect functional assessment methods, as previously noted, are poor at accurately identifying correlations (see previous citation). These methods typically involve interviewing clients about these relationships, which is problematic because most clients are not trained observers, do not possess the tools to improve accuracy, and must rely on their recall.

Another example of improper usage is found in McCrady (2014) in a section on FA that describes the method as “. . . assessment techniques . . . used to identify antecedents to drinking” (p. 548). Functional assessment methods are primarily interested in consequent events (although the entire four-term contingency is appreciated), not just immediately antecedent

conditions that set the occasion for behavior that produces certain consequent events. Additionally, in describing their assessment approach one finds this language: “. . . use a functional analytic framework, in which the drinking response (R) is elicited by . . .” (p. 538). Although we are addressing misuse of the descriptions of FA as a procedure, we’ve discovered another example of terminological misuse along the way. There is a well-established difference between elicited and evoked behavior, and the meaning of these terms are quite precise. Elicited is used to refer to respondent behavior, whereas evoked is used to denote operant behavior. Drinking, the focus of this chapter, is evoked, not elicited, behavior.

The examples of misuse provided are not meant to suggest that these authors are guilty of terminological malpractice. Rather, they are provided to illustrate that all scientists, including senior ones, are equally susceptible to verbal drift, and to demonstrate the nature of the digression. Importantly, “functional analysis” provides a nice example of terminological use that has experienced drift to incorrect usage that is so substantial within a particular community (e.g., the CBT community) that its improper use appears to be the rule rather than the exception. Scientific communities should only modify the meaning of their terms when empirically or philosophically justified. That is, there must be some usefulness in relation to the meaning modification. Scientists should not modify their terms solely because the community has digressed so substantially that most members are using the terms improperly.

To understand functional assessment, one must understand the meaning of the term “function.” It has two definitions. The first involves the effect produced by the behavior. This is akin to asking, “What is the function of the heart?” The answer: to pump blood.

The second involves the question, “What is the effect of environmental events on behavior?” This question asks whether the consequences function as a reinforcer or a punisher. Questions such as, “What is the function of the behavior?” are not the questions that are answered by functional analysis. Indirect and observational functional assessment methods, as described in the above referenced manuscripts, can provide evidence about the types of environmental events produced by the behavior (e.g., the behavior produces attention, escape, access, etc.). However, clinicians need answers to a different question,



namely, Which of the produced consequences is functioning as a reinforcer for the behavior of interest? In other words, not all the consequences produced by a behavior are maintaining that behavior. A behavior might produce both attention and escape. A good FA might reveal that escape is the reinforcer, not attention. Some refer to the former as an establishing function and the latter a partial function (Marsh, 2013). This can only be determined through an FA, not the indirect functional assessment methods described in the above-referenced literature.

It's worth noting that the term "functional analysis" itself is at odds with ordinary usage. What generally is meant by the term is an analysis of function, or function analysis. For the analysis to be functional, it must lead to something else, like effective treatment (see Hineline, 1980; Hineline & Groeling, 2011).

These examples of terminological confusion impede communication between the CBT community and the ABA community, and they hide the relative strengths and weaknesses of each functional assessment method from the CBT community.

### Example 3: "Generalization"

Generalization is used in several ways within psychology and related disciplines. For example, the term is used to label the phenomenon known as response and stimulus generalization, as well as the generality of experimental findings. The latter use of the term is our focus here and for the sake of clarity we will use Johnson and Pennypacker's (2009) robust definition of this type of generality, which is: "The meaningfulness of experimental interpretations under circumstances different from those that generated the data" (p. 341). When one asserts that a set of experimental results is high in generality, one is indicating that generalization from those findings to novel individuals and conditions is reasonable.<sup>2</sup>

The misuse of this term is perhaps the most concerning of the three examples provided because it directly impacts the methods emphasized for scientific discovery. Examples of misuse of this term are readily found in the CBT literature, and are captured by the following quote found in a popular research methods text. The authors assert, "Perhaps the greatest limitation of [single case research designs],

however, is in their restricted ability to generalize beyond the individuals studied" (Nock, Janis, & Wedig, 2007; p. 203). Curiously, this sentence was written in the context of the authors' encouragement of readers to make use of single case research designs (SCRDs). They noted that use of these designs by clinical researchers has declined substantially in recent years, except within a restricted range of circumstances. They observed that SCRd use has largely been confined to use as a complementary research strategy to between-groups randomized controlled trials (RCTs), to examination of novel treatment approaches and to the preliminary examination of interventions in advance of embarking on an RCT. They apparently endorse the migration of this research practice pattern to these restricted circumstances largely because of their perspective regarding SCRds and generality, which they seemingly view as limited, relative to group designs. There are several types of generality, but these authors do not specify the type of generality to which they refer, leading to communication that lacks precision. One might infer they are referring to generality in an actuarial sense. If that is their intention, then they are correct in noting SCRds are restricted in that regard or, more precisely, in their ability to permit inferences about population parameters relative to between-groups designs. However, their expressed concerns regarding SCRds and generality involve several unarticulated assumptions worth examining. Most notably we might ask whether: (a) The type of generality they emphasize is the *only* form of generality important to psychotherapists? (b) This kind of generality is the *most* important and relevant type of generality to psychotherapists? and (c) The SCRds are robust at producing other types of generalizable data, and if so, how important and relevant those data are to psychotherapists? We examine the answers to these questions below.

As noted, there are many subtypes of generality and they are fully detailed and articulated by Johnson and Pennypacker (2009) as well as Branch and Pennypacker (2013), so they will only be mentioned briefly here. For example, there is generality of variables; procedures and processes; and generality across participants, response classes, settings, and species. In

addition, generality can be conveyed with an actuarial depiction or with a description at the individual level. The ability to discriminate between types of generality and between actuarial and individual levels of examination is crucial because such discriminated behavior reveals different types of research activity produces different types of information and deeper understanding of the methods necessary to produce each kind. Indeed, some authors suggest the research concerns within the overall field of psychology, of which CBT is a part, can and should be conceptualized into two distinct approaches—one concerned with individual behavioral processes and one concerned with actuarial science—but that the dominance of group-based methods have masked this distinction (see Branch & Pennypacker, 2013, for a full discussion of this point).

Group designs, which produce actuarial accounts, have their own limitations with respect to generality when considering how they are executed in actual practice, and these limitations are frequently underappreciated. Although they examine generality across participants, they do not, for example, typically examine generality across therapists or settings (Barlow & Hersen, 1984). This puts them in a position of silence on these relevant matters of generality. An additional concern about the generality of group-based data involves randomization. It is well known that an important ingredient in the ability to generalize from those data is random participant selection. However, while random assignment may occur during these experiments, random selection is seldom, if ever, achieved (Areán & Kraemer, 2013). Failing such randomization in a between-groups comparison compromises the kinds of generalization possible. Furthermore, even if perfectly randomized, group mean results provide no direct implication about generality across individuals. This is because, at best, sample means permit inferences about where a population mean might be, but they are silent with respect to what happens to any individual (see Penston, 2005, and Williams, 2010, for additional discussion of group mean inadequacies in the context of RCTs).

A more substantial concern is the apparent misunderstanding or undervaluing of the most relevant type of generality to a psychotherapist and how that type of generality is achieved. Psychotherapists work with individuals; therefore, a primary aim of the psychotherapy researcher is to be able to produce data with generality at

<sup>2</sup>Generality, generalization, and generalizability are interchangeable in this paper. The differing usage is solely reflective of their use as different parts of speech. The important discriminations for the reader are found across the different types of generality.



an individual participant level (sometimes called individual subject validity). If one applies Johnson and Pennypacker's (2009) definition of generality, it is unclear how drawing a sample from a population, making inferences about that population (actually, population parameters) on the basis of the drawn sample, and then making inferences back to individual cases, is accomplished. In fact, it is impossible unless data from individuals are examined, one by one. Recognizing this concern, some journal editors are now specifically requiring the simultaneous reporting of all individual data when reporting the results of randomized controlled trials (Hanley, 2017). An additional impediment to generality occurs when, or if, a representative sample is achieved. A representative sample, by definition, is heterogeneous with respect to participant characteristics and those variations frustrate generality back to an individual (Barlow & Hersen, 1984). Between-groups designs were constructed for a different subject matter, which involve actuarial questions, and they are robust with respect to that subject matter. However, their usefulness for psychotherapy, where individual subject validity is most pertinent, is overstated unless the goal of therapy is to improve the average behavior of a group of clients. To be clear, actuarial methods do produce data that are useful to mental health professionals and so should not be discarded. However, their limitations with respect to individual subject validity should be recognized. More crucially, the importance and relevance of individual subject validity, along with the advantages of SCRDS in this regard, should be fully understood. Ideally, this different understanding would produce a different scientific practice pattern.<sup>3</sup>

Scores of example difficulties with generalizing from actuarial data to individuals can be given, but only one is provided here. Several studies have identified risk factors for suicidal behavior, which include demographics such as race, age, marital status, and so on (Chiles & Strosahl, 2008). Generally, these factors identify high-risk groups, and while group membership points to elevated risk, most members of such groups will not die by suicide. Furthermore, the predictive validity of group membership with respect to completed suicide may be expressed over a long time horizon (i.e.,

decades). A clinician working with an individual client, however, is tasked with trying to determine an appropriate course of action with respect to an individual client and over a shorter time frame (i.e., hours or days). These data offer little use in this context.

Replication is at the heart of individual subject validity. Once a causal relation is identified, attempts at replication can vary key parameters. Through many replication attempts, noting where the causal relation survives and where it does not, scientists discover the domain of generality (Lykken, 1968; Sidman, 1960, Chps 3-4). SCRDS emphasize replication. For example, assume a single participant in a basic ABA design where a treatment effect is revealed. At least two replications of the causal relation are immediately apparent, once during the B phase and a second during the withdrawal phase. In most studies each phase (e.g., baseline and treatment) involves a series of observations and each of those observations is also an attempt at replication. Extending the example further with three participants, as is typical with SCRDS studies, one would observe at least six replications of the causal relation when considering the B and A phases for each participant. In contrast, a between-groups RCT contains a replicability ceiling, in that it can only demonstrate an effect once per experiment.

Group designs involve the aggregation of data into group means. The process of averaging masks individual differences and thus substantially frustrates the ability to generalize group-based findings to the individual level. Moreover, it is common to use meta-analytic procedures to summarize many experiments by combining these averages, further camouflaging individual values. In contrast, evaluating effects on many different individuals, as one would do with SCRDS, enhances generality by presenting it directly.

In essence, when one speaks of generality, regardless of the type of generality, one is speaking of the parameters necessary to produce certain outcomes. Systematic variation in a group design if it failed to replicate would not make clear the reasons for the failure of replication. An SCRDS, on the other hand, would. Indeed, psychology is currently experiencing a "replication crisis" (Open Science Collaboration, 2015), which

may be due in part to the overreliance on group designs.

The example of generality illustrates how one's understanding of a term impacts scientific practice. Since generality of experimental findings is an important objective of research activity, if one believes that group-based designs are more likely to produce this result, one would be more likely to design these types of experiments to the exclusion of SCRDS.

### Protecting Our Lexical Canon

A first step in remedying these difficulties is the recognition of the importance of scientific vocabularies as well as the resolve to defend them. While these are necessary conditions for safeguarding this important aspect of scientific practice, they are not sufficient because they are antecedent interventions, and as such, can only set the occasion for behavior. Because consequent events are usually necessary to maintain behavior, the cognitive and behavioral verbal community must ensure its participants contact reinforcement for appropriate terminological use.

Here are some additional recommendations:

1. *Design graduate and other training with fluent terminological performance in mind.* This is necessary because students do not acquire fluent terminological repertoires by mere reading of definitions. Empirically supported instructional methods such as precision teaching (Kubina & Yurich, 2012), which is designed to bring performance to fluent levels, should be used.

2. *Construct journal guidelines that specify that appropriate and precise use of terms are required.* One set of guidelines, Uniformed Requirements for Manuscripts Submitted to Biomedical Journals (ICMJE, 1997), adhered to by over 500 journals (Bhopal, Rankin, & Bennett, 2000), provides an example of an initial attempt to outline requirements for precise terminological use, although within a limited range of vocabulary. For example, one of their guidelines states that "The definition and relevance of race and ethnicity are ambiguous. Authors should be particularly careful about using these categories" (p. 311). While bringing attention to the issue of vague terminological use, the guidelines don't go far enough. It would be useful if the requirements for terminological clarity went beyond those terms to all of their discipline's terms, and if guidelines stronger

<sup>3</sup> See lecture by Neville Blampied, Ph.D., for a thorough discussion of these two experimental designs and generality: <https://www.youtube.com/watch?v=LcU6nhiTse4>.

than “be careful,” which itself is ambiguous, were provided.

3. *Engineer effective listserv practices.* Listservs, as verbal communities, will be more helpful if the members have been trained to discriminate between more and less useful talk, specifically during graduate training, and if that training has increased their verbal repertoire to fluent levels. Acquiring this discriminative repertoire will allow its members to shape more useful talk by new and junior members, as well as to maintain consequences for all members. Consider the method used by parents to teach their children to become speakers and listeners in their native language, and recall that some parents are more skilled teachers than others. The most effective parents are highly skilled speakers and listeners themselves (i.e., they talk usefully about their environments), interact frequently with their children, and those interactions primarily involve positive reinforcement relative to negative reinforcement or punishment. Interactions characterized primarily by negative reinforcement and punishment are likely to decrease the frequency of interactions once children learn how to escape and avoid them. Somewhat analogously, we need to engineer professional verbal communities to maintain useful speaking and writing as professionals transition from training to practice communities. The same variables apply. Members of the practice community must be trained as effective speakers and listeners. Properly trained speakers can provide models of, and instructions for, effective speaking and as listeners, they are able to reinforce such speaking. If properly trained, they will positively reinforce successful talk by prompting and shaping procedures. And if there are opportunities for frequent interaction between members of such a verbal community, they will maintain useful ways of talking about their practice.

4. *Routinely dedicate journal space to terms.* *The Behavior Analyst's* “On Terms” is a useful model. This practice affords conceptual development, emphasizes the importance of scientific word use, and assists with recalibrating terminological use among readers who’ve drifted.

Words are an important part of the behavioral scientist’s armamentarium and, as such, require active attention from the verbal community.

## References

- American Psychological Association. (2005). *Policy statement on evidence-based practice in psychology*. Retrieved from <http://www.apa.org/practice/resources/evidence/evidence-basedstatement.pdf>
- Areán, P. A., & Kraemer, H. C. (2013). *High quality psychotherapy research: From conception to piloting to national trials*. New York: Oxford University Press.
- Barlow, D. H. (Ed.). (2014). *Clinical handbook of psychological disorders: A step-by-step treatment manual* (5th ed.). New York: The Guilford Press.
- Barlow, D. H., & Hersen, M. (1984). *Single case experimental designs*. Needham Heights, MA: Pergamon Press.
- Bhopal, R., Rankin, J., & Bennett, T. (2000). Editorial role in promoting valid use of concepts and terminology in race and ethnicity research. *Science Editor*, 23(3), 75-80.
- Block, J. (1995). A contrarian view of the five-factor approach to personality description. *Psychological Bulletin*, 117(2), 187-215.
- Branch, M. N. and Pennypacker, H. S. (2013). Generality and generalization of research findings. In G. J. Madden (Ed.), *APA Handbook of Behavior Analysis, Vol. 1* (pp. 151-175). Washington DC: APA Publications.
- Carr, J. E., & Briggs, A. M. (2011). A resource on behavioral terminology: An annotated bibliography of on terms articles in the behavior analyst. *The Behavior Analyst*, 34(1), 93-101.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66(1), 7.
- Chiesa, M. (1994). *Radical behaviorism: The philosophy and the science*. Sarasota, FL: Authors Cooperative.
- Chiles, J. A., & Strosahl, K. D. (2008). *Clinical manual for assessment and treatment of suicidal patients*. Washington, DC: American Psychiatric Publishing.
- Davison, M., & Nevin, J. A. (1999). Stimuli, reinforcers, and behavior: An integration. *Journal of the Experimental Analysis of Behavior*, 71(3), 439-482.
- Hall, S. S. (2005). Comparing descriptive, experimental and informant-based assessments of problem behaviors. *Research in Developmental Disabilities*, 26(6), 514-526.
- Hanley, G. P. (2017). Editor’s Note. *Journal of Applied Behavior Analysis*, 50, 3-7.
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and Commitment Therapy (ACT): The process and practice of mindful change* (2nd ed.). New York: The Guilford Press.
- Hineline, P. N. (1980). The language of behavior analysis: Its community, its functions, and its limitations. *Behaviorism*, 8(1), 67-86.
- Hineline, P.N, & Groeling, S.M. (2011). Behavior-analytic language and interventions for autism. In J.A. Mulick & E.A. Mayville (Eds.), *Behavioral foundations of effective autism treatment* (pp. 35-55). Cornwall-on-Hudson, NY: Sloan.
- Hurl, K., Wightman, J., Haynes, S. N., & Virues-Ortega, J. (2016). Does a pre-intervention functional assessment increase intervention effectiveness? A meta-analysis of within-subject interrupted time-series studies. *Clinical Psychology Review*, 47, 71-84.
- International Committee of Medical Journal Editors. (1997). Uniform requirements for manuscripts submitted to biomedical journals. *New England Journal of Medicine*, 336, 309-316.
- Johnston, J. M., & Pennypacker, H. S. (2009). *Strategies and tactics of behavioral research* (3rd ed.). New York: Routledge.
- Kaplan, K.A., & Harvey, A.G. (2014). Treatment of sleep disturbance. In Barlow, D.H. (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (pp. 640-669). New York, NY: The Guilford Press.
- Kubina, R. M., & Yurich, K. K. (2012). *Precision teaching book*. Lemont, PA: Greatness Achieved Publishing.
- Layng, T. J., Twyman, J. S., & Stikeleather, G. (2004). Engineering discovery learning: The contingency adduction of some precursors of textual responding in a beginning program. *The Analysis of Verbal Behavior*, 20, 99.
- Lerman, D. C., & Iwata, B. A. (1993). Descriptive and experimental analyses of variables maintaining self-injurious behavior. *Journal of Applied Behavior Analysis*, 26(3), 293-319.
- Lilienfeld, S.O., Ritschel, L.A., Lynn, S.J., & Lutzman, R.D. (in press). Evidence-Based Practice: Its insufficiently Appreciation Raison d’etre. In S. Dimidjian (Ed.), *Evidence-based therapy in action*. New York: Guilford.
- Lilienfeld, S. O., Sauvigné, K. C., Lynn, S. J., Cautin, R. L., Lutzman, R. D., & Waldman, I. D. (2015). Fifty psychological and psychiatric terms to avoid: A list of inaccurate, misleading, misused, ambiguous, and logically confused words and phrases. *Frontiers in Psychology*, 6.
- Lykken, D. T. (1968). Statistical significance in psychological research. *Psychological Bulletin*, 70, 151-159.
- Mace, F. C., & Lalli, J. S. (1991). Linking descriptive and experimental analyses in

- the treatment of bizarre speech. *Journal of Applied Behavior Analysis*, 24(3), 553-562.
- Markon, K. E. (2009). Hierarchies in the structure of personality traits. *Social and Personality Psychology Compass*, 3(5), 812-826.
- Marsh, W., (2013). *A functional analysis methodology for identifying motivating operations of behavior*. Presented at the 39th Annual Convention of the Association of Behavior Analysts International, Minneapolis Convention Center, Minneapolis, Minnesota.
- Martell, C. R., Addis, M. E., & Jacobson, N. S. (2001). *Depression in context: Strategies for guided action*. New York: WW Norton & Co.
- McCrary, B. S. (2014). Alcohol use disorders. In Barlow, D.H. (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (pp. 533-587). New York, NY: The Guilford Press.
- Miller, N., & Pedersen, W. C. (1999). Assessing process distinctiveness. *Psychological Inquiry*, 10(2), 150-156.
- Miller, N., & Pollock, V. E. (1994). Meta-analysis and some science-compromising problems of social psychology. *The Social Psychology of Science*, 230-261.
- Nock, M. K., Janis, I. B., & Wedig, M. M. (2007). Research designs. In A.M. Nezu & C.M. Nezu (Eds.), *Evidence-based outcome research: A practical guide to conducting randomized controlled trials for psychosocial interventions* (pp. 201-218). New York: Oxford University Press.
- Open Science Collaboration. (2015). Estimating the reproducibility of psychological science. *Science*, 349.
- Payne, L.A., Ellard, K.K., Farchione, T.J., Fairholme, C.P., & Barlow, D.H. (2014). Emotional disorders: A unified transdiagnostic protocol. In D.H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (pp. 237-274). New York, NY: The Guilford Press.
- Penston, J. (2005). Large-scale randomised trials—a misguided approach to clinical research. *Medical Hypotheses*, 64(3), 651-657.
- Piazza, C. C., Fisher, W. W., Brown, K. A., Shore, B. A., Patel, M. R., Katz, R. M., ... Blakely-Smith, A. (2003). Functional analysis of inappropriate mealtime behaviors. *Journal of applied behavior analysis*, 36(2), 187-204.
- Ruscio, J. (2002). *Clear thinking with psychology: Separating sense from nonsense*. Belmont, CA: Wadsworth Publishing.
- Sauer-Zavala, S., Gutner, C. A., Farchione, T. J., Boettcher, H. T., Bullis, J. R., & Barlow, D. H. (2016). Current definitions of “transdiagnostic” in treatment development: A search for consensus. *Behavior Therapy*, 48, 128-138.
- Sidman, M. (1960). *Tactics of scientific research: Evaluating experimental data in psychology*. New York: Basic Books.
- Skinner, B. F. (1957). *Verbal behavior*. Brattleboro, VT: Echo Point Books & Media.
- Stanovich, K. E. (2012). *How to think straight about psychology* (10th ed.). New York: Pearson.
- St. Peter, C. C., Vollmer, T. R., Bourret, J. C., Borrero, C. S., Sloman, K. N., & Rapp, J. T. (2005). On the role of attention in naturally occurring matching relations. *Journal of Applied Behavior Analysis*, 38(4), 429-443.
- Thompson, R. H., & Iwata, B. A. (2007). A comparison of outcomes from descriptive and functional analyses of problem behavior. *Journal of Applied Behavior Analysis*, 40(2), 333-338.
- Tolin, D. F., McKay, D., Forman, E. M., Klonsky, E. D., & Thombs, B. D. (2015). Empirically supported treatment: Recommendations for a new model. *Clinical Psychology: Science and Practice*, 22(4), 317-338.
- Williams, B. A. (2010). Perils of evidence-based medicine. *Perspectives in Biology and Medicine*, 53(1), 106-120.
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## BOOK REVIEW

# Doing CBT Will Help You Do CBT

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DAVID TOLIN'S NEW BOOK, *Doing CBT* (2016; Guilford Press), tries to be many things to many people, and succeeds ably in the attempt. The book's subtitle—*A Comprehensive Guide to Working With Behaviors, Thoughts, and Emotions*—captures the goal and central thesis of the book. Tolin intended to create a resource for both novice cognitive-behavioral therapy (CBT) learners and seasoned practitioners that would provide both practical advice and a rich understanding of the various approaches under the ever-broadening umbrella of modern CBT. His approach is described well in the preface, with no denying his use of personal opin-

ion throughout but promising to tell the reader when he is doing so. Further, the emphasis on theory-driven techniques and science-based conceptualizations is maintained without jargon, making the text easily digestible for clinicians of all backgrounds and experience levels.

The book opens with a four-chapter section titled “Why People Suffer” that lays out the CBT framework of interacting behaviors, cognitive processes, and emotions. These chapters are rich with theory and scientific grounding, and the reader is left with an understanding of how a CBT therapist approaches presenting problems. Importantly, Tolin does not focus on one

particular type of problem but rather how CBT strategies can be applied across a diverse array of symptoms and clients. The section closes with an explanation of how these processes might be integrated into useful case conceptualizations, complete with several case examples. These illustrations are helpful in providing concrete examples of effective CBT treatment planning that specifically targets a client's problem areas.

The second section of the book—“How Do We Help”—comprises the meat of the book. Several chapters lay out the major intervention strategies of modern CBT, including behavioral interventions like contingency management, behavioral activation, and exposure; cognitive interventions like cognitive restructuring, acceptance, and bias correction; and emotion regulation strategies like distress tolerance and emotion modulation. Each chapter is written in an accessible and readable style, sometimes funny or even poignant. Chapters feature break-out boxes that focus on



the science behind the approach (“The Science Behind It”) and common clinical challenges or misunderstandings (“Things That Might Bug You About This”). This section manages to be comprehensive and clear, with concise descriptions of intervention techniques without forgoing essential information. The reader is left with a good understanding of both the why and the how of each of the interventions covered.

The book concludes with three complete case examples that include assessment information, conceptualization, treatment plans, and progress of treatment, particularly helpful for novice therapists given that comprehensive case conceptualization is often difficult for less experienced clinicians. It also includes several helpful forms that can be used with clients, with unlimited reproducible downloads available to purchasers of the book. For example, one handout provides the blank version of Tolin’s “Meaty Conceptualization

Form” that he uses to illustrate CBT case formulation. They are a useful addition.

The strength of the book is its attempt to be comprehensive and integrative in introducing the reader to the varieties of modern CBT interventions. In its early history, behavior therapy was a principle-driven approach that was tailored to individual clients by the expertise of the behaviorist. As the field moved toward empirically supported treatments and prioritized writing and testing specific CBT protocols for specific disorders, the field of CBT seemed less like a single entity and more like a collection of loosely related cognitive-behavioral therapies, some more behavioral and some more cognitive. Books often include chapters on CBTs for specific disorders. Recently, the field has begun moving toward reunification of a principle-driven but flexible CBT (Barlow et al., 2010), and Tolin’s book is an important reflection of that important and badly needed reintegration. It is a perfect text-

book for courses introducing evidence-based CBT techniques to new therapists, and an excellent resource for professionals who want a resource for broadening and honing their skills.

### References

- Barlow, D. H., Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Allen, L. B., & May, J. T. E. (2010). *Unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide*. New York: Oxford University Press.
- Tolin, D. (2016). *Doing CBT: A comprehensive guide to working with behaviors, thoughts, and emotions*. New York: Guilford Press.

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### NEWS

## Trauma, Anxiety, and Depression in Iran: A Report From the 3rd International Anxiety Congress in Iran

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### International Scientific Committee of the International Anxiety Congress

THE SUBSTANTIAL UNMET mental health need and disparity in access to evidence-based treatment for mental health disorders in low- to middle-income countries (LMIC) is widely recognized (Demyttenaera et al., 2004). A particular barrier relates to imbalances in the ability to access and contribute to scientific mental health research (Joint Statement, 2004; Saxena, Paraje, Sharan, Karam, & Sadana, 2006). For example, Saxena and colleagues (2006) identified that high-income countries contributed 94% of the total authorships of mental health publications indexed in the ISI Web of Science database. Representa-

tion of LMIC-based individuals on the editorial boards of leading psychiatric journals is 3.5%, with one journal, *World Psychiatry*, accounting for nearly half of the editorial board members from LMICs (Pike, Min, Poku, Reed, & Saxena, 2017). Finally, access to current published mental health research in LMICs is limited, with most subscriptions to leading mental health journals coming from high-income countries (Joint Statement). While efforts such as the WHO Health InterNetwork Access to Research Initiative (<http://www.who.int/hinari/>; accessed February 16, 2017), which provides free or low-cost access to journals

for institutions in LMICs, are a valuable step to reduce barriers in knowledge sharing, scientific publications represent only one pathway for the dissemination of mental health knowledge.

Mental health conferences, which can more easily blend scientific dissemination (e.g., research symposia) with skill transfer strategies (e.g., training workshops or demonstrations), are an additional pathway. However, most of the leading mental health-oriented gatherings are localized in high-income countries due to both regional affiliations (e.g., American Psychiatric Association, British Psychological Society) and the infrastructural and economic challenges of LMICs to host large-scale international gatherings such as the World Congress of Behavioral and Cognitive Therapies. The economic burden on scientists and practitioners from LMICs to travel to and attend major conferences and congresses can be overwhelming, despite many organizing bodies providing scholarships or reduced registration rates for individuals from LMICs. As such, a “bring them to us” approach to mental health knowledge dissemination needs to be reconsidered in favor of a “bring us to them” framework. A recent example of the success of this strategy was the 3rd International Anxiety Congress in Tehran, Iran, held in November 2016.

One of the oldest continuous major civilizations, Iran has had a tumultuous his-

tory, recently including the coup supported by the United States of America and Great Britain in 1953; the Islamic Revolution, overthrow of Shah Mohammad Reza Pahlavi, and formation of the Islamic Republic of Iran in 1979; the Iran-Iraq war from 1980 to 1988; the U.S. and international economic sanctions and embargoes from 1979 to 2016; and uncertainty regarding the shorthanded approach by the new U.S. administration regarding travel restrictions and sanctions following the presidential election. Such political, military, and economic upheaval, in addition to high rates of road accidents and several natural disasters in the last decade, has had a significant impact on the mental health needs of Iran, in particular high rates of combat-related PTSD following the Iran-Iraq war.

Despite the clear need for effective evidence-based mental health care, the economic sanctions resulting from political conflicts between Iran and many Western governments have limited the ability of the Iranian mental health workforce to access contemporary mental health science and training in evidence-based mental health interventions. Similar concerns have been previously raised regarding access to medical supplies and pharmaceuticals as a result of the economic sanctions (Gorji, 2013), which have been partially alleviated by a report to the United Nations General Assembly and subsequent medical exemptions to the sanctions (Setayesh & Mackey, 2016). Scientific knowledge and practical therapeutic skills in treating mental health disorders in Iran, however, remains limited due to the aforementioned barriers to knowledge dissemination. Further, master's-level training in clinical psychology in Iranian universities began in the 1970s (with a subsequent period of interruption) and the Ph.D. in clinical psychology was developed in 2011 (Birashk, 2013). Legal regulation and registration of psychology and counseling practitioners was only initiated in 2004 (Khodayarifard, Rehm, & Khodayarifard, 2007). Although formal practitioner therapeutic orientation surveys have not been conducted, Iranian training programs in counseling and psychotherapy (Birashk) and psychiatry (Tavakoli, 2014) cover a broad range of non-evidence-based and evidence-based therapeutic approaches in their curricula. As a result, dissemination, training, and availability of efficacious evidence-based mental health treatments is limited despite high need, further widening the interna-

tional health care gaps between prosperous and developing nations.

In response, the Shefa Neuroscience Research Center of the Khatam Alambia Hospital, the governmental Foundation of Martyrs and Veterans Affairs, and the Iranian Center for Emergency Medical Services sponsored and organized the 3rd International Anxiety Congress at the Khatam Alambia Hospital in Tehran to bring Iranian scientists and mental health practitioners together with international experts from Australia, Germany, Switzerland, the U.K., and the U.S., to advance mental health knowledge and patient care. This congress was held in official cooperation with the Monash Institute of Cognitive and Clinical Neuroscience (Australia) and Basel University (Switzerland). Held over two consecutive days (November 23–24, 2016),<sup>1</sup> the international scholars at the 3rd International Anxiety Congress program addressed critical topics such as “Posttraumatic Stress Disorder and Substance Use Disorder” (Christi Cabrera—USA), “Review of Evidence-Based and Experimental Treatment of Posttraumatic Stress Disorder” (Markus Burgmer—Germany), “The Mechanistic Role of Sleep in Posttraumatic Stress Disorder” (Sean Drummond—Australia), “The Impact of Physical Activity on Posttraumatic Stress Disorder” (Simon Rosenbaum—Australia), “The Impact of Neuroscience in Understanding Posttraumatic Stress Disorder” (Markus Burgmer—Germany), “Cognitive Appraisals and Social Support in Predicting Children’s Posttraumatic Stress” (Caitlin Hitchcock—UK), “Recent Developments in the Treatment of Anxiety, Trauma, and Emotional Disorders” (Peter Norton—Australia), “Autobiographical Memory, Trauma, and the Development of Memory Interventions” (Caitlin Hitchcock—UK), “How Do Concepts of Evolutionary Psychology and Evolutionary Psychiatry Explain Anxiety Disorders?” (Serge Brand—Switzerland), “Social Cognition in Patients with Anxiety Disorders” (Dena Sadeghi Bahmani—Switzerland), “The Benefits of Increased Physical Activity and Higher Cardiorespiratory Fitness in People Living with Mental Health Disorders, with Specific Emphasis on Anxiety Disorders” (Philip Ward—Australia), and “Exposure Therapy’s Two Cultures: Anxiety-Reducing vs. Anxiety-

Increasing Treatment” (Brett Deacon—Australia), as well as a number of scientific presentations by Iranian mental health scientists and professionals.

Across the scientific presentations, several consistent themes were highlighted. First, and most central to the goals of the congress, was an overarching emphasis on the importance of utilizing evidence-based interventions and providing summaries of the empirical evidence supporting various interventions. The second theme revolved around identifying and targeting transdiagnostic mechanisms, particularly the presence of comorbid psychological diagnoses (e.g., anxiety and depression, trauma and substance use) or co-occurring psychological and physical concerns (e.g., sleep and PTSD, mental health and physical activity). Finally, many of the international and Iranian scholars spoke on the importance of adapting evidence-based interventions into the unique cultural, religious, and political contexts existing in Iran, including incorporating an Islamic worldview into treatment and specific combat-related PTSD factors commonly seen in veterans of the Iran-Iraq war.

Further, a series of practical training workshops were delivered, including “Relaxation and Imagery Techniques to Improve Sleep in Patients with Posttraumatic Stress Disorder and to Reduce Nightmares” (Serge Brand and Dena Sadeghi Bahmani—Switzerland), “The Role of Art Therapy (Music and Psychodrama) on Improvement of Anxiety in Children with Autism Spectrum Disorders” (Kaveh Moghaddam—Iran), “Cognitive Behavioral Therapy for Insomnia in Posttraumatic Stress Disorder” (Sean Drummond—Australia), and “Cognitive Behavioral Approaches for the Treatment of Trauma and Anxiety (Peter Norton & Brett Deacon—Australia). Consistent with the goals of the congress, the workshops were specifically selected and designed to facilitate the transfer of the scientific presentations into immediate clinical practice. Within the workshops, for example, attendees were provided direct instruction and practice with strategies for developing fear hierarchies for use in exposure therapy, alongside video and live demonstrations of in vivo exposures, imaginal trauma and worry scripting, and interoceptive exposure; demonstrations on the use of art and

<sup>1</sup>The full abstract book (available in English and Farsi) of the 3rd International Anxiety Congress is available at [http://shefayekhatam.ir/browse.php?a\\_id=993&slc\\_lang=en&sid=1&ftxt=1](http://shefayekhatam.ir/browse.php?a_id=993&slc_lang=en&sid=1&ftxt=1)

music in therapy with children; live practice with relaxation and imagery techniques; and practical guidelines for implementing evidence-based strategies for improving sleep in insomnia.

Beyond the expected educational and clinician training outcomes of the congress, an additional benefit arose after the organizing and funding bodies of the congress specifically solicited recommendations from the congress delegates on priorities for meeting the mental health needs of the aging Iranian population in general, and elderly veterans with PTSD in particular. Training of the patients and their families on age-related physiological changes, screening of somatic disorders, daily exercise, and specific evidence-based PTSD treatment programs for veterans were suggestions of congress for follow-up of these groups of patients. As a result of these recommendations, a new office was established within the Foundation of Martyrs and Veterans Affairs to follow up all recommendations and introduce their 1-year experience in the next congress in 2017.

While political tension and conflict between various nations will always exist, this does not supersede Principle 1 of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (United Nations General Assembly, 1991) that “all persons have the right to the best available mental health care.” It is hoped that the model and success of the 3rd International Anxiety Congress in Tehran, Iran will serve as a benchmark both to national governments and funding agencies, as well as scholars, treatment developers, and mental health practitioners, to work outside of the prevailing political climates in an effort to jointly work to increase dissemination and training in order to improve the quality of mental health for all persons regardless of nationality.

## References

- Birashk, B. (2013). Counseling and psychotherapy in Iran. In R. G. Moodley, U. P. Gielen, & R. Wu (Eds.), *Handbook of counselling and psychotherapy in an international context* (pp. 361-370). New York: Routledge.
- Demyttenaera, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J., . . . WHO Mental Health Survey Consortium. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Journal of*

*the American Medical Association*, 291, 2581-2590.

- Gorji, A. (2013). Health care: Medical supplies in Iran hit by sanctions. *Nature*, 495, 314.
- Joint Statement (2004). Galvanizing mental health research in low- and middle-income countries: Role of scientific journals. *Bulletin of the World Health Organization*, 82, 226-228.
- Khodayarifard, M., Rehm, L. P., & Khodayarifard, S. (2007). Psychotherapy in Iran: A case study of cognitive-behavioral family therapy for Mrs. A. *Journal of Clinical Psychology*, 63, 745-753.
- Pike, K., Min, S-H., Poku, O. B., Reed, G. M., & Saxena, A. (2017). A renewed call for international representation in editorial boards of international psychiatry journals. *World Psychiatry*, 16, 106-107.
- Saxena, S., Paraje, G., Sharan, P., Karam, G., & Sadana, R. (2006). The 10/90 divide in mental health research: Trends over a 10-year period. *British Journal of Psychiatry*, 188, 81-82.
- Setayesh, S. & Mackey, T. (2016). Addressing the impact of economic sanctions on Iranian drug shortages in the joint comprehensive plan of action: Promoting access to medicines and health diplomacy. *Global Health*, 12, 31.
- Tavakoli, S. (2014). The place of psychotherapy in contemporary psychiatry. *Iranian Journal of Psychiatry and Behavioral Sciences*, 8(4), 1-6.
- United Nations General Assembly. (1991). *General Assembly Resolution A/RES/46/119: The protection of persons with mental illness and the improvement of mental health care*. Geneva, Switzerland: World Health Organization.

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The International Scientific Committee was comprised of Dena Sadeghi Bahmani (University of Basel; Switzerland), Serge Brand, (University of Basel; Switzerland), Markus Burgmer (Universität Münster Hospital; Germany), Christi Cabrera (Private Practice; USA), Brett Deacon (Illawarra Anxiety Clinic; Australia), Sean P. A. Drummond (Monash University; Australia), Caitlin Hitchcock (MRC Cognition and Brain Sciences Unit; UK), Simon Rosenbaum (University of New South Wales; Australia), and Philip Ward (University of New South Wales; Australia).

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## NEWS

# Featured Award Recipient: Outstanding Service Award

Katherine J. W. Baucom, *Chair, Awards & Recognition Committee*



This month we are pleased to feature Patrick Kerr, Ph.D., recipient of the 2016 Outstanding Service Award. This award recognizes ABCT members who have made significant contributions to the organization as a whole.

Dr. Kerr is an Associate Professor of Behavioral Medicine and Psychiatry at West Virginia University's Health Sciences Center. Dr. Kerr joined ABCT as an undergraduate in 2001 and it quickly became his professional home. He joined the Listserve Committee as a postdoctoral fellow and moved into the position of Listserve Moderator in 2013 and Listserve Committee Chair in 2014, positions that he still holds today.

In his role as Listserve Committee Chair, Dr. Kerr has made it a priority to shape the list's policies and procedures on an ongoing basis in an effort to keep pace with the opportunities and vulnerabilities inherent in the ever-evolving frontier of communication technology. He also prioritized and successfully implemented a shift in listserv operation to an unscreened format, which now permits instantaneous, free-flowing conversations between members, including everything from rich discussions about fascinating cases to debates about mechanisms of change. This format shift also means staying constantly alert to potential side effects of the new format; he therefore continually monitors the list's traffic throughout each day to ensure that this avenue of communication functions optimally for our members. As Executive Director Mary Jane Eimer described, "He is quick to catch potential problems and handles them with grace and professionalism." ABCT and its members have benefited tremendously from Dr. Kerr's service. ■





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the next ABCT

# Webinar

JUNE 16, 2017

## Behavioral Treatment of Insomnia in Children: Beyond the Basics

[ **Candice Alfano**, *Ph.D., Associate Professor of Psychology and Director of the Sleep and Anxiety Center of Houston (SACH) at the University of Houston*

- 11:00 A.M. – 12:30 P.M. Eastern | 10:00 A.M. – 11:00 A.M. Central | 9:00 a.m. – 10:30 A.M. Mountain | 8:00 A.M. – 9:30 A.M. Pacific
- \$30 for members | \$45 for nonmembers

Adequate sleep is essential for all age groups, but sleep during childhood is particularly critical based on its temporal overlap with brain development and physical growth. In addition to sleep problems that persist into adulthood, insomnia in childhood is a potent risk factor for a wide range of negative outcomes including overweight/obesity, inattention, hyperactivity, learning problems, conduct problems, substance use, anxiety, and depression. Unfortunately, up to 70% of children in the U.S. age 10 and under experience a sleep problem several times per week. Effective, evidence-based treatments are available, but the number of providers with training in behavioral sleep interventions is limited. This webinar will provide a comprehensive overview of insomnia in children.

Following brief review of the essential role of sleep in childhood and specific factors that give rise to poor sleep, validated assessment tools that provide a comprehensive understanding of children's sleep problems will be discussed. Evidence-based treatment strategies will then be presented and discussed in the context of a case example.

Register at [www.abct.org](http://www.abct.org)

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