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PRESIDENT'S MESSAGE

Birds of a Feather

Jonathan S. Abramowitz, *University of North Carolina–Chapel Hill*

FEBRUARY WITNESSED THE LOSS of two great men who were "birds of a feather" as far as I'm concerned. Most people might not make the connection between Cyril Franks, Ph.D., and Coach Dean Smith, but as a psychologist and a University of North Carolina (UNC) basketball fan, the parallels are very clear. Both have much more in common than meets the eye. Both were trailblazers—guys who took a stand when they saw things they didn't like in the world. Guys who were courageous enough to butt heads with the status quo. And guys who will forever be remembered as pioneers and leaders in their respective fields.

Dr. Franks (whose obituary appears on page 107 of this issue) was one of a small group of behaviorally oriented psychologists who founded ABCT (then called the Association for Advancement of Behavior Therapy or "AABT"). He was the ring leader and became our association's first president. That was in 1966, when behavior therapy was still very much a fledgling enterprise. It was considered an "extreme," "radical," and even "harmful" approach compared to the dominant Freudian psychoanalytic therapy of the time. And the idea of psychologists—nonphysicians—delivering interventions to the mentally ill was loathed by the psychiatric community. But Dr. Franks was a visionary. Driven by his convictions, he threw down the gauntlet at psychoanalysis and called it out for its lack of a scientific foundation. He knew that the growing body of research on how people learn to behave and respond

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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.
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emotionally would give rise to more efficacious therapies. And he was not afraid to stand up for an evidence-based approach. Dr. Franks also founded (and was the first editor of) *Behavior Therapy* as AABT's flagship journal. And they needed that journal to disseminate their work since journal editors of the day typically rejected papers on behavioral treatments. Dr. Franks was a game changer. The movement he led was revolutionary in 1966, but look at us now. ABCT and the importance of science in psychological practice are his rich legacy. His efforts made it possible for us to take for granted who we are professionally in 2015.

Dean E. Smith was a different sort of game changer; and I'm not talking about his success on the basketball court. Sure, he led the UNC men's team from 1961 to 1997 and was one of the winningest college coaches. But he was also a pioneer outside the lines. He was a civil rights pioneer who stood up for many causes that were unpopular in the south in the 1950s and 60s. In 1959—a year before the famous Woolworth sit-ins in Greensboro—Coach Smith (then just an assistant coach) integrated a notoriously "whites only" restaurant in Chapel Hill, NC, by sitting down to eat with a black theology student. He was also a visionary, helping to integrate college athletics by breaking the color barrier at UNC and recruiting Charlie Scott as the first African-American scholarship basketball player there. Like Dr. Franks, Coach Smith was also driven by the courage of his convictions. Unafraid to ruffle feathers, he stood up for many causes often unpopular in southern states like North Carolina: gay rights, opposition to the death penalty, and abuses of the justice system. He would sometimes take his teams to practice at local prisons as a form of entertainment for the inmates. This also taught his students important lessons—an important part of Coach Smith's legacy. Recognizing these off-the-court efforts, President Obama in 2013 awarded Coach Smith the Presidential Medal of Freedom.

I never knew Dr. Franks or Coach Smith, but their convictions and actions speak for themselves. They risked their careers and reputations to do what they thought was right. They were true leaders with real vision and authentic courage. It is likely that in life, Cyril Franks and Dean Smith did not cross paths. But they were birds of a feather. Whether helping to launch a "radical" scientific field of psychotherapy or integrating a southern town in the 1950s, we can learn much from these men's lives. They were a part of different worlds, yet both left their field of expertise a better place than how they found it.

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SCIENCE FORUM

A Meta-Analysis of CBT Components for Anxiety Disorders

Thomas G. Adams, *Yale University School of Medicine* and *University of Arkansas*

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SOCIETAL CONCERNS OVER ACCOUNTABILITY and cost-effectiveness of mental health services has kindled interest in the empirical determination of the clinical efficacy of psychosocial treatments. As a result, several research groups have identified specific treatments for specific disorders (Chambless et al., 1996; Chambless et al., 1998). Based on these kinds of findings, some treatments have become increasingly structured and prescriptive. The purpose of the approach is to target specific disorders (diagnoses) or components of treatments and thus identify and use efficacious treatments of choice (Chambless et al., 1998).

Evaluating the impact of psychosocial treatments is commonly accomplished by examining a large number of efficacy and/or effectiveness studies simultaneously using meta-analytic methods (Eysenck, 1994; Kazrin, Durac, & Agteros, 1979). The earliest meta-analysis of psychotherapy (Smith & Glass, 1977) documented evidence for the efficacy of most psychotherapies, and provided evidence that cognitive-behavioral therapy (CBT) had the largest effect size among them. Subsequent meta-analyses of CBT addressed specific disorders including panic disorder (PD; Gould, Otto, & Pollack, 1995), generalized anxiety disorder (GAD; Siev & Chambless, 2007), posttraumatic stress disorder (PTSD; Bradley, Greene, Russ, Dutra, & Westen, 2005; Ehlers et al., 2010; Van Etten & Taylor, 1998), specific phobia (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008), social phobia (Gould, Buckminster, Pollack, Otto, & Yap, 1997), and obsessive-compulsive disorder (OCD; Rosa-Alcazar, Sanchez-Meca, Gomez-Conesa, & Marin-Martinez, 2008). Several meta-analyses demonstrate the efficacy of CBT among the anxiety disorders (Eysenck, 1994; Hofmann & Smits, 2008; Norton & Price, 2007) and mood disorders (Cuijpers, Smit, Bohlmeijer, Hollon, & Andersson, 2010; Cuijpers, van Straten, Bohlmeijer, Hollon, & Andresson, 2010). Other analyses show the superior efficacy of CBT relative to nonspecific treatment factors (Bowers & Clum, 1988; Eysenck, 1994; Hofmann & Smits, 2008), other specific forms of psychotherapy (Eysenck, 1994; Tolin, 2010), and when anxiety disorders are comorbid with other disorders (Olatunji, Cisler, & Tolin, 2010).

Recent qualitative analyses addressing the efficacy of CBT components have generated debate regarding the necessity of directly modifying cognitive processes in anxiety or depressive disorders directly (Hofmann, 2008; Longmore & Worrell, 2007), and the notion that exposure alone is responsible for the efficacy of CBT for anxiety disorders (McMillan & Lee, 2010). Recent meta-analyses (e.g., Hofmann & Smitts, 2008) showing that the relative effect size of exposure alone is roughly equivalent to the combination of exposure

and cognitive therapy indirectly support this notion.

These findings are important for content-specific treatments such as CBT because without directly addressing treatment content and mechanisms, only limited conclusions can be made about why a treatment is efficacious. That is, if a treatment intervention has met the specific and efficacious criteria, it can be concluded only that: "the therapy contained some (as yet unknown) active ingredients that caused some degree of change (beyond the change caused by factors common to all forms of psychotherapy, or placebo conditions, or chance) and this was true for a particular problem, clients, setting, methods, therapists, and means of assessment" (Borkovec & Castonguay, 1998, p. 137).

Component-controlled efficacy designs help us identify mechanisms of change. Such designs permit us to document the causative agents of change by sorting the characteristic (specific) from the incidental (nonspecific) factors that contribute to therapeutic efficacy ("what about it works?"). The experimental analysis of treatment efficacy using component-controlled designs represents a strong-inference approach to research by pitting competing predictions based on theories of treatment mechanisms and related procedural content within and across treatments against one another (Borkovec & Bauer, 1982; Platt, 1964). Strong inference is perhaps the most rigorous approach we have to rapidly improve treatment efficacy, effectiveness, and efficiency.

To our knowledge, an analysis of component-controlled efficacy studies has been conducted only at the level of the individual studies, and in a qualitative analysis of CBT for GAD (Lohr, Olatunji, Parker, & DeMaio, 2005). Thus, we conducted a literature search for component-controlled CBT-based efficacy studies for anxiety disorders and submitted their results to a meta-analysis to determine the relative contributions of the behavioral and cognitive components.

Method

We used several search strategies to identify all available randomized, component-controlled CBT outcome studies for anxiety disorders. We began by reviewing published qualitative reviews of behavior therapy and CBT since Kazdin and Wilcoxon (1976). These included Foa, Cahill, and Pontoski (2004), Butler, Chapman, Forman, and Beck (2006), Longmore and Worrell (2007), and McMillan and Lee (2010). We also reviewed the meta-analyses listed in the Introduction. Next, two independent internet searches were conducted on PsycINFO. The first was a simultaneous search using the search terms: random*, beh*, cog*, and ther*. The second was a series of independent searches using the search terms: generalized anxiety, GAD, obsessive compulsive, OCD, post traumatic, PTSD, phobia, social

Table 1. Behavioral and Cognitive Treatment Content of Component-Controlled Studies Included in Meta-Analyses

Behavioral Content					
In vivo exposure	Imaginal exposure	Relaxation	Self-controlled desensitization	Respiratory control	Functional analysis
Emmelkamp & Beens (1991)	Bryant et al. (2003)	Barlow et al. (1989)	Borkovec et al. (2002)	White et al. (1992)	White et al. (1992)
Foa et al. (1999)	Foa et al. (1999)	Barlow et al. (1992)			
Foa et al. (2005)	Foa et al. (2005)	Borkovec et al. (2002)			
Hope et al. (1995)	Marks et al. (1998)	Craske et al. (1991)			
Koch et al. (2004)	White et al. (1992)	White et al. (1992)			
Marks et al. (1998)					
Mattick & Peters (1988)					
Mattick et al. (1989)					
Raes et al. (2011)					
Szymanski & O'Donohue (1995)					
Vogel et al. (2004)					

Cognitive Content			
Cognitive reappraisal	Cognitive restructuring	Cognitive therapy	Rational restructuring
Koch et al. (2004)	Barlow et al. (1989)	Borkovec et al.(2002)	Emmelkamp & Beens (1991)
Raes et al. (2011)	Barlow et al. (1992)	Hope et al. (1995)	Vogel et al. (2004)
	Bryant et al. (2003)	White et al. (1992)	
	Craske et al. (1991)		
	Foa et al. (1999)		
	Foa et al. (2005)		
	Marks et al. (1998)		
	Mattick & Peters (1988)		
	Mattick et al. (1989)		
	Szymanski & O'Donohue (1995)		

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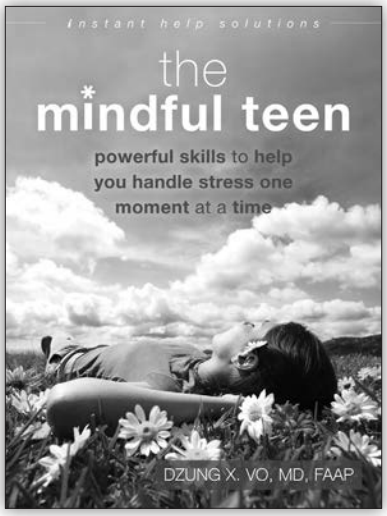

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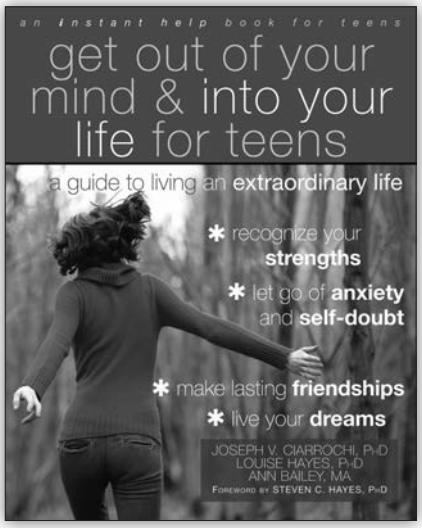

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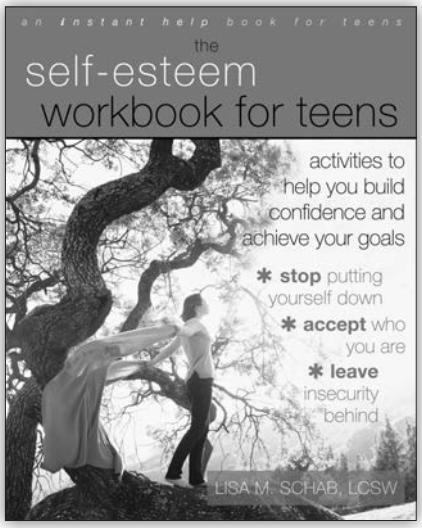

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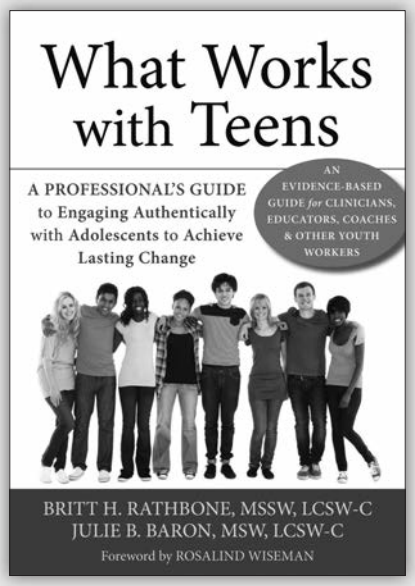

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anxiety disorder, SAD, panic agoraphobia, acute stress disorder, component, dismantling.

Only randomized, component-controlled, CBT outcome studies for anxiety disorders were included in the data analysis. This required that the study (a) used random group assignment, (b) included a variant of behavior therapy as a treatment condition, and (c) contained a CBT comparison condition. Moreover, to qualify as a dismantling (component-controlled) design, the same content of the behavioral condition was included in the cognitive-behavioral condition.

Inclusions and exclusions were made by independent examination by TGA and JML. The aforementioned identification procedures initially yielded 725 candidate studies. Examination of previously published qualitative and quantitative reviews and the on-line search yielded 46 studies based on the title, abstract, and keywords. Twenty-nine studies were excluded for the following reasons: (a) no dismantling design (N = 11); (b) no diagnostic classification of participants (N = 3); (c) inadequate data reporting (N = 5); (d) medication confound (N = 3); (e) reanalysis of previously published data (N= 6); or (f) no behavior therapy (BT) condition (N = 1). A Table and Figure representing the excluded studies can be obtained from the corresponding author.

Sixteen data sets (17 peer-reviewed publications) were included in the meta-analysis. We combined the data sets from Barlow, Craske, Cerny, and Klosko (1989) and Craske, Brown, and Barlow (1991) to produce a data set providing for pretreatment to posttreatment, and pretreatment to follow-up comparisons. PTSD was treated in four studies, GAD was treated in three studies, OCD was treated in three studies, panic disorder was treated in two studies, social anxiety disorder was treated in three studies, and specific phobia was treated in three studies. The aforementioned studies are marked with an asterisk in the Reference section.

The behavioral content was characterized as exposure therapy (ET: in vivo or imaginal), self-control desensitization, relaxation, respiratory control, functional analysis, modeling and role-playing, and behavioral activation. The cognitive content was characterized as cognitive restructuring, cognitive reappraisal, cognitive therapy, and rational restructuring. Table 1 presents the content of treatments in the included studies as described by the authors of the studies.

Dependent variables were selected in a manner similar to that of Hofmann and Smits (2008). Measures were included if the authors of the efficacy studies identified them as primary measures and if the measure was a reliable and valid index of the symptoms being treated. A measure was excluded if it was secondary or incidental to the disorder being treated (e.g., Global Improvement in the treatment of PTSD [Marks, Lovell, Noshrivani, Livanou, & Thrasher, 1998]), if it was a reliable and valid measure of another disorder (e.g., Beck Depression Inventory administered in the treatment of an anxiety disorder [Borkovec, Newman, Lytle, & Pincus, 2002; Foa et al., 2005]), or if means and standard deviations were not reported or made available following e-mail requests from the primary author. Two authors (TGA and JML) made these decisions collaboratively where discussion and consensus served to resolve disagreement. In Marks et al.'s (1998) treatment of PTSD, the authors labeled eight dependent variables as primary. Direct inspection, however, revealed that seven were not primary measures of PTSD, leaving only a Clinician-Administered PTSD Scale (CAPS) score as a primary measure. The data matrix was composed of 16 pre-post comparisons and 14 pre-first follow-up comparisons. Barlow, Rapee, and Brown (1992) and Szymanski and O'Donohue (1995) did not conduct follow-up assessments. The mean length of time from posttreatment to first follow-up was 18.29 weeks (range: 4–36 weeks).

Analytic Strategy

All statistical analyses used Biostat Comprehensive Meta-Analysis version in a manner consistent with Tolin (2010, 2014). The reported means, standard deviations (SDs), and sample size representing pretreatment, posttreatment, and first follow-up measures (when available) within each study condition served as the raw data. Effect sizes (Cohen's d) for BT and CBT were standardized with combined posttreatment and follow-up SDs. Individual effect sizes were calculated to measure differences in change (pre to post and pre to first follow-up) between each treatment condition within each study collapsed across all included measures. The magnitude and direction of pretreatment to posttreatment effect sizes varied substantially within and across studies. Inspection of Table 2 shows that BT and CBT were both highly efficacious treatments (both Cohen's d-values = 1.23).

To examine differences between effect size estimates between BT and CBT, effect sizes were collapsed within conditions and contrasted to test the overall differences from pre- to posttreatment. Mixed-effects between-group heterogeneity (Q) was calculated where the random effects model was used. The Q-statistic is a studentized range statistic. It is used for multiple significance testing across a number of means. The analysis showed there was no statistically significant difference between the conditions ($Q_{between}$ = 0.004, p = .947). There were very few studies within individual diagnostic categories (range = 1–4) and comparisons within specific categories should be interpreted with great caution. The PTSD category had the most studies (N = 4), and although BT was slightly more efficacious than CBT, there was no statistically significant difference between the conditions ($Q_{between}$ = 0.082, p = .775).

The pretreatment to first follow-up effect sizes of both BT and CBT were slightly larger than those calculated from pretreatment to posttreatment (see Tables 2 and 3). To examine differences between effect size estimates between BT and CBT, effect sizes were collapsed within conditions and contrasted to test the overall differences from pretreatment to first follow-up. Mixed-effects between-group heterogeneity (Q) was calculated where the random effects model was used. The comparisons of BT and CBT closely paralleled those from pre- to posttreatment (see Table 3). There was no statistically significant difference in the efficacy of BT relative to CBT within the entire sample ($Q_{between}$ = 0.194, p = .659), or within all PTSD studies ($Q_{between}$ = 0.608, p = .436).

Two power analyses tested the requisite sample size to detect statistical significance given the observed differences in effect size between BT and CBT from pretreatment to posttreatment and from pretreatment to first follow-up. Power was set at .80 and alpha was set at .05 for both analyses. Given the observed difference in effect size between BT and CBT from pretreatment to posttreatment (d = -.009), a minimum number of 96,902 participants would be required to detect a statistically significant difference. Given the difference in effect sizes between BT and CBT from pretreatment to first follow-up (d = -.066), a minimum of 88,676 participants would be required to detect a statistically significant difference.

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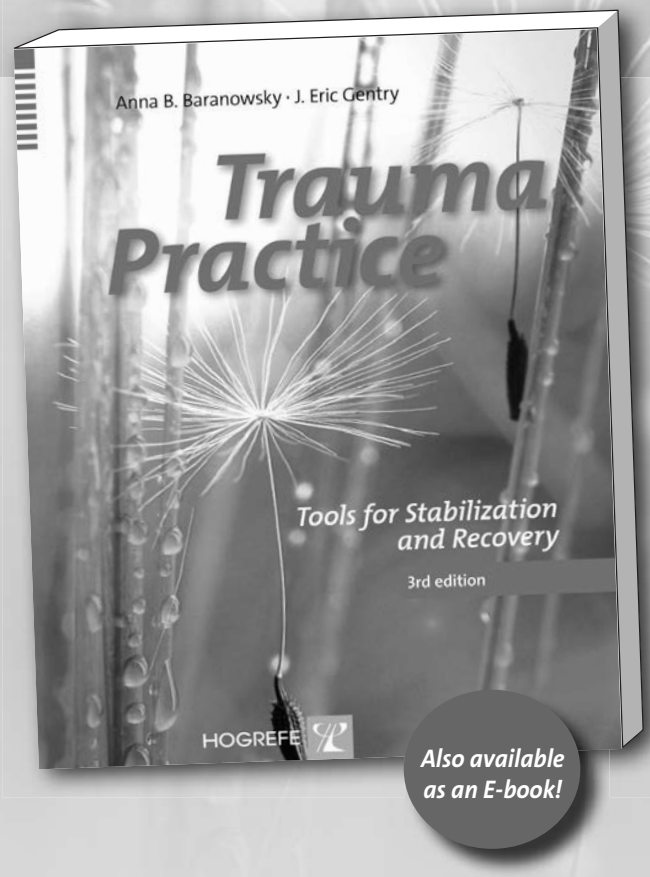

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Discussion

The apparent zeitgeist within clinical psychology has it that CBT for anxiety disorders is superior to its constituent components. The outcomes we describe here are at odds with this idea. The present statistical analysis detected strong effect sizes for both CBT and BT administrations that are comparable to those reported in other meta-analyses (e.g., Eysenck, 1994; Hofmann & Smits, 2008; Tolin, 2010). The analysis also indicated that the addition of cognitive content to behavioral content did not produce a statistically significant increase in effect size. Moreover, examination of effects for specific disorders (Tables 2 and 3), particularly PTSD, indicates little benefit in adding cognitive content to each disorder for which component-controlled studies were conducted. This apparent absence of incremental efficacy of cognitive content to behavioral interventions is inconsistent with the historical development of CBT (Dobson, Beamish, & Taylor, 1992) and with CBT models of the change process (Smits, Rosenfeld, McDonald, & Telch, 2006; Tang, DeRubeis, Beberman, & Pham, 2005), but is nonetheless consistent with previous reviews (Deacon & Abramowitz, 2004; Norton & Price, 2007).

There are several factors to consider in understanding these null results. The first is the possibility that the meta-analysis was underpowered and that the apparent null results represent a Type II error of inference. Though this is a possibility, the power analysis reported above indicates that at traditional levels of statistical significance, a large number of research participants would be required to reject the null hypothesis. It is also possible that studies selected on the basis of the dismantling criteria represent a lower dosage of cognitive content relative to behavioral content. We selected only those studies that clearly indicated in their Methods section that cognitive content provided in the CBT condition was specifically added to the behavioral content. Perhaps a more appropriate comparison would include studies where the CBT content contained equal dosages of BT and CT content, and where CBT was compared to BT content and to CT content. In our sample of studies included in the meta-analysis only nine studies used that method (Barlow et al., 1992; Barlow et al., 1989; Borkovec et al., 2002; Craske et al., 1991; Foa et al., 1999; Marks et al., 1989; Mattick, Peters, & Clark, 1989; Szymanski & O'Donohue, 1995; White, Keenan & Brooks, 1992). Examination of the effect sizes for these studies, however, reveals no indication that CBT resulted in greater effect sizes than BT (summaries of the effect sizes for each study are available upon request from the corresponding author).

The apparent absence of incremental efficacy of cognitive content over and above behavioral content does not clarify the mechanisms underpinning the efficacy of behavioral content. Examination of Table 1 shows eight different behavioral procedures described in the 17 data sets. The most frequently used procedure is in vivo exposure, followed by imaginal exposure, and relaxation training. In vivo and imaginal exposure were both used in Foa et al. (1999), Foa et al. (2005), and Marks et al. (1998), while White et al. (1992) used a combination of imaginal exposure, relaxation, respiratory control, and functional analysis. The remaining studies used a single other behavioral procedure. Thus, we cannot specify the mechanisms that produced effects of these sizes. On the other hand, the design and procedures of these studies indirectly indicates that there are a number of different behavioral proce-

Table 2. Pretreatment to Posttreatment Effects of CBT Compared to Nested BT Component(s)

	Cohen's d	LL	UL	*p*	Q_{within}	$Q_{between}$
All Anxiety Disorders (17 studies, 34 groups)						0.004, $p = .947$
BT	1.234	1.042	1.426	< .001	37.839, $p = .002$	
CBT	1.225	1.036	1.414	< .001	31.796, $p = .011$	
PTSD (4 studies, 8 groups)						0.082, $p = .775$
BT	1.739	1.348	2.13	< .001	16.423, $p = .001$	
CBT	1.661	1.286	2.035	< .001	8.596, $p = .035$	
Social Phobia (4 studies, 8 groups)						0.704, $p = .401$
BT	0.863	0.531	1.195	< .001	1.914, $p = .590$	
CBT	1.066	0.727	1.404	< .001	3.156, $p = .368$	
Specific Phobia (3 studies, 6 groups)						0.184, $p = .668$
BT	1.723	0.979	2.466	< .001	1.562, $p = .458$	
CBT	1.512	0.906	2.119	< .001	1.194, $p = .550$	
GAD (3 studies, 6 groups)						0.69, $p = .406$
BT	1.266	0.596	1.937	< .001	4.25, $p = .119$	
CBT	1.054	0.16	1.947	= .021	8.05, p = .018	
OCD (2 studies, 4 groups)						0.000, $p = .992$
BT	1.092	0.527	1.657	< .001	0.159, $p = .690$	
CBT	1.088	0.457	1.719	0.001	1.075, $p = .300$	
Panic (1 study, 2 groups)						0.340, $p = .560$
BT	1.493	0.343	2.643	= 0.011	0.000, $p = 1.00$	
CBT	1.054	0.125	1.982	= 0.026	0.000, $p = 1.00$	

LL = Lower Limit of 95% Confidence Interval; UL = Upper Limit of 95% Confidence Interval

dures that can be considered when implementing treatment strategy and technique.

It is possible that changes in cognitive phenomena (e.g., negative thinking) are responsible for clinical effects of both cognitive and behavioral interventions (Hofmann, 2008; Smits et al., 2006; Tang et al., 2005). Hofmann (2004) conducted a component analysis of CBT for social phobia and, using mediational analyses, concluded that the comparable change in CBT and BT groups were correlated with and caused by changes in dysfunctional cognitions. Some studies have also demonstrated that cognitive changes temporally preceded—a critical factor when making causal inferences (Kraemer, Wilson, Fairburn, & Agras, 2002)—and mediated manifest symptom reductions following cognitive modifications (Smits et al., 2006: Teachman, Marker, & Clerkin, 2010). Mediational analyses, while informative, do not speak to whether it is necessary to directly target cognitive mechanisms to reduce clinical symptoms. Perhaps the most famous study to address this issue is that of Jacobson and colleagues (1996), who showed that behavioral activation for depression reduced negative thinking, dysfunctional attributional styles, and depressive symptoms as much as cognitive therapy and full-scale CBT. Findings such as these suggest that cognitive processes change following behavior therapy and do not need to be directly modified (i.e., with cognitive therapy) in all circumstances.

There are several implications of comparing multicomponent CBT protocols with single-component—or, at the very least, lesser-components—BT protocols we would like to consider. We assert that, if comparable outcomes can be obtained with a simpler protocol, we should administer the simplest, least expensive, and the most easily tolerated protocol. Clients incur costs for the benefits they receive. Clients invest time, money, and themselves in the interventions that we offer. The simpler, least expensive, more parsimonious, and perhaps more elegant protocols necessarily reduce at least the time and resources that clients must invest in the treatment process. Moreover, those who provide services also incur costs. Implementing multicomponent protocols requires training in each component, the clinical integration of the components, and delivery of those components with fidelity. Rather than being a Jack-or-Jill-of-All-Trades, the service provider improves efficiency and perhaps effectiveness by being Master-or-Matron-of-the-Demonstrated-Tried-and-True.

Similar concerns about strategy and tactics may be brought to bear on the training and development of clinical skills. Institutions incur costs for the benefit of society; those costs should be considered when promoting protocols for application and training. Obviously, training is a resource-intensive process. There are institutional costs associated with each model or protocol promoted for training and application. Service provision teams can control institutional costs by training team members to apply unified, parsimonious protocols. Moreover, training team members might function more efficiently if training permitted personnel and protocols to be interchangeable.

The choice of treatment content and the implementation of related procedures are determined not only by data regarding efficacy, but also by treatment effectiveness

(Davison, 2000). Matters of effectiveness are those that address the idiosyncrasies of the individual client and the special circumstances of the clinical condition, the social circumstances of their functioning, and the resources that can be brought to bear in improving psychological function (Paul, 1969, p. 44). Although randomized controlled group design research can tell us little about the effectiveness of treatment for a single individual, scientifically informed clinical judgment can help determine which treatment component should be implemented for that single individual (Rosen & Davison, 2003), and in what tactical order or combination. Procedures that are more basic, more easily learned and implemented, better understood by the client, and of lower intensity will likely be less expensive for the client, the therapist, and the agency sponsoring treatment. Indeed, Cougle (2012) has identified parsimony, ease, and efficiency as essential features of quality therapy. The present study, much like nearly all quantitative reviews that preceded it, has failed to provide evidence that it is necessary to add direct cognitive modification strategies to behavioral procedures to effectively treat disordered anxiety. Parsimonious behavioral interventions for disordered anxiety are as efficacious as multicomponential cognitive-behavioral interventions. As such, basic behavioral procedures like exposure and relaxation should be given equal consideration as full-fledged CBT when treating disordered anxiety.

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Table 3. Pretreatment to First Follow-up Effects of CBT Compared to Nested BT Component(s)

	Cohen's d	LL	UL	*p*	Q_{within}	$Q_{between}$
All Anxiety Disorders (14 studies, 28 groups)						0.194, $p = .659$
BT	1.594	1.39	1.799	< .001	58.542, $p < .001$	
CBT	1.66	1.449	1.871	< .001	26.634, $p = .014$	
PTSD (4 studies, 8 groups)						0.608, $p = .436$
BT	2.126	1.768	2.48	< .001	33.296, $p < .001$	
CBT	1.927	1.576	2.277	< .001	12.974, $p = .005$	
Social Phobia (3 studies, 6 groups)						1.596, $p = .207$
BT	1.182	0.727	1.637	< .001	0.252, $p = .882$	
CBT	1.618	1.117	2.12	< .001	3.329, $p = .189$	
Specific Phobia (2 studies, 4 groups)						0.302, $p = .582$
BT	1.964	1.292	2.636	< .001	0.088, $p = .767$	
CBT	1.699	1.037	2.362	< .001	2.268, $p = .132$	
GAD (2 studies, 4 groups)						0.78, $p = .379$
BT	1.707	1.231	2.182	< .001	1.28, $p = .257$	
CBT	1.408	0.945	1.871	< .001	3.52, $p = .061$	
OCD (2 studies, 4 groups)						1.235, $p = .266$
BT	0.899	0.356	1.442	= 0.001	0.737, $p = .391$	
CBT	1.367	0.746	1.988	< .001	0.172, $p = .678$	
Panic (1 study, 2 groups)						1.01, $p = .315$
BT	0.736	-0.15	1.623	= 0.104	0.000, $p = 1.00$	
CBT	1.469	0.348	2.589	= 0.01	0.000, $p = 1.00$	

LL = Lower Limit of 95% Confidence Interval; UL = Upper Limit of 95% Confidence Interval

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Brief Cognitive Therapy for Schizophrenia Interventions for the Therapeutic Milieu

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IN AN ARTICLE PREVIOUSLY PUBLISHED in this journal, Riggs, Stirman, and Beck (2012) presented a model for training community mental health agencies in cognitive therapy (CT) for schizophrenia. Specifically, this paper included details of the training that pertains to the therapeutic milieu, a setting in which the majority of people with psychosis receive their treatment, with a particular focus on building empathy and learning to "work within the delusional belief system." This current paper now provides more information regarding specific brief interventions from the CT for schizophrenia model that can be used in the milieu setting. These interventions, included within the original training (Riggs et al., 2012), have subsequently been used by this writer and by many of her colleagues and trainees on inpatient units to much success.

In the U.S., large numbers of individuals with psychotic disorders receive psychological treatment solely through milieu-based interventions: inpatient units; day-programs; partial hospital programs; assertive community treatment; psychosocial club house; and many more. Many of these programs provide only group therapy, many are staffed solely by paraprofessionals, with few psychologists or Ph.D.-level clinicians, and very rarely are staff trained in evidence-based psychological therapies. While certainly there is evidence that "supportive therapy" can be very helpful for this population, a more rigorous, evidence-based treatment, CT for schizophrenia (Mueser & Glynn, 2014; Pilling et al., 2002), has been and can be applied to milieu settings. Here, as part of the ongoing dissemination effort, we would like to describe some key interventions that can be delivered in milieu settings.

Brief Therapeutic Conversations

The most important mindset to consider in the provision of treatment for psychosis in milieu settings is that every conversation has very powerful therapeutic value. Interventions do not just happen in groups, treatment team meetings, or an individual staff member's office, but rather every interaction has the potential for contributing to the maintenance of psychosis, or the facilitation of its improvement. When a person comes to the nursing station and asks for a cup of juice, there is opportunity for engagement and empathy; when a person paces in the hallway, talking out loud to their voices, there is an opportunity for engagement, assessment of voices, and facilitation of coping strategies; when a person walks up to a staff member and spontaneously elaborates on their delusional belief systems, there is an opportunity to work within this system to engage, assess, and intervene. CT for schizophrenia is subtly different from standard CT (Riggs et al., 2012). As a staff member I can challenge a person's beliefs or tell them not to listen to their voices, and, by invalidating their emotional experience or pushing them to find more evidence to support their beliefs, in 5 minutes contribute to the perpetuation of their psychosis. Or in about the same amount of time I can provide a therapeutic interaction that does the opposite.

This not only provides access to a therapeutic environment that actually works, but it also reduces staff burnout by increasing sense of efficacy and competence. Helping so-called nonclinical staff to realize the clinical utility of their 5-minute conversations is an important part of CT for the milieu training. This utility is threefold: facilitating engagement; gaining useful information about the person's psychotic experience (which they often withhold from clinical staff due to fears of longer detention, treatment, etc.); and enhancing and reinforcing other specific clinical interventions initiated on a different shift, with a primary therapist, or in a group (to be described in more detail below).

Coping Skills Enhancement

Helping people to identify and utilize strategies to manage their distressing experiences has long been a part of cognitive therapy. Even for those not trained in CT for schizophrenia, specific skills for dealing with voices or other hallucinations have been an important focus of good practice in treating serious mental illness. These strategies can be broken down into several categories: physiological strategies such as relaxation; cognitive strategies such as self-instruction or attentional switching; behavioral strategies such as increasing or decreasing activity; sensory strategies such as listening to music (Breier & Strauss, 1983; Tarrier, 1992).

Unfortunately, coping skills enhancement rarely goes beyond "do you listen to headphones when the voices are bad?" We can do so much more than this. On initial discussion, a useful starting point begins by asking what coping skills a person has attempted to utilize in the past and to what effect. Next comes ranking strategies in order of effectiveness and troubleshooting for roadblocks, and considering whether existing strategies can be refined, or whether new ones might be added. Then perhaps the most crucial part of the process is to make a plan, have the person carry it out, get feedback, and adjust. All of us at one time or another are guilty of having suggested a strategy for homework and then never checking in with the person about it. It is important to remember that the success is in the feedback and adjustment, not in the prescription. Nelson (2005) suggests some helpful questions that may aid in the process (see Box 1).

Chadwick, Birchwood, and Trower (1996) suggest that the first and most important step in coping skills enhancement is to congratulate the person on what a great job they have been doing so far in surviving the distress incurred by the psychotic experience for so long. Much like in motivational interviewing (Rollnick & Miller, 1995), it is important to empower the person first by affirming their strengths. Fowler, Garety, and Kuipers (1995) depict these strategies as those that help to "self-regulate distressing psychotic symptomatology" (p. 106). That is, they are more than just distraction techniques, but actually important in reducing psychotic experiences. They stress the importance of determining the antecedent to the psychotic experience first as a means to selecting the most likely effective strategy. For example, if the person notices that their voices are preceded by a failure in a certain task and a reduction in self-esteem, the coping strategy offered is going to be different than for those preceded by the sun going down in the evening and an increase in anxiety.

The most effective way to utilize coping skills enhancement in the therapeutic milieu setting is to have the primary clinician meet with the person individually or in group for assessment that informs an action plan. This can then be detailed on a coping card that the person carries with them and can be referred to by other milieu staff throughout the day or night. For example, "When the voices say really mean things over and over sometimes it's because I'm anxious or stressed. If this happens I can take my stress ball from the cabinet and play with it for a while or listen to soothing music or talk to a member of staff about what's stressing me out." However, if this detailed assessment work is not possible, coping strategies can also be referred to on an ad hoc basis by all staff throughout the milieu. For example, "I can see the voices are pretty bad right now. What do you think might help: some relaxing music; the point-look-name-game; or maybe we could just walk and talk for a bit?" Then successes should be shared with the rest of the team, including nonclinical staff, during team meeting or equivalent.

Relaxation and Sensory Modulation

Most therapeutic milieu settings have access to materials and staff trained to facilitate relaxation and/or sensory modulation. Distressing psychotic experiences often happen at times of either heightened or diminished arousal. Deep breathing techniques, progressive muscle relaxation, and guided imagery can all be used to reduce arousal. In addition to anxiety, other intense emotions can also be a trigger for psychosis. Putting together a specific music playlist to lift a person's mood, help them relax, or help them be more focused and energized can all be helpful in dealing with specific experiences. If a person is experiencing a particular sensory hallucination, helping them to focus on a different sensory experience can also be grounding.

Voices

It is important to make the distinction here between strategies that help patients cope with voices and those that actually have the potential to diminish them in volume or intensity. Many people who hear voices learn to deal with their voices by listening to loud music, by answering back, or shouting profanities. At worst this serves to make them louder, and at best it just serves to drown them out. There are a number of strategies, however, that can bring immediate improvement in the voices. This in turn has the effect of increasing the person's sense of control, thereby working to change the belief that the voices are all powerful, and in turn breaking the cycle of maintenance (Chadwick & Birchwood, 1994). These include focusing or concentrating on the voices, subvocal speech, singing, humming, reading aloud or just talking to someone. In particular, a strategy that combines elements of these, and can be taught to people who hear voices as a very simple game, is described in Box 2. It is often referred to as "Look-Point-Name." The practice of these strategies can be made even more effective by having the person bring the voices on first by thinking about particular things that they commonly say (Fowler & Morley, 1989). In addition, people who hear voices can find relief from their distress by setting a particular, limited time of the day when they are going to interact with the voices.

Delusions

Delusions can be much more diverse and so it is harder to list specific strategies that might be helpful to a person without assessing the details of their belief system first. Certainly asking particular, interested questions, using your "natural curiosity" (Nelson, 2005), can be an intervention in itself, and all milieu staff can be taught to do this. Nelson lists specific questions that might be useful in this situation, stressing the importance of a neutral tone of voice (see Box 3). Further to using such questions, if a person's belief system includes elements of paranoia or suspiciousness, then stress reduction or relaxation (see above) would be indicated. Staff members can also help the person pick out an activity to focus on to reduce their preoccupation with ruminatory thoughts—for example, "I can see that you have a lot on your mind right now, which is causing you distress. Is there something else you might enjoy doing to take your mind off it? How about a game of checkers?"

For the many people who experience complex beliefs concerning being followed, having their life interfered with by a particular agency, "sabotage," or other concerns of this nature, it can be extremely validating and empowering to have this experience conceptualized as a form of "bullying."

Comments such as, "I am so sorry this is happening to you"; "This is really not acceptable"; and "I wish there was something I could do to stop this, but unfortunately I'm not really important enough in these circles" can be extremely supportive. In addition, urging the person not to let the bullies win, and supporting them to continue making steps towards achieving their goals anyway, can be very powerful. Clinicians often fear that engaging in the delusional content in this manner serves as colluding with it and therefore increases conviction in delusional beliefs; however, this assumption has not been borne out in clinical practice. Instead, these interventions can be strongly therapeutic for facilitating recovery.

Negative Symptoms

Over the years negative symptoms of psychosis have been a source of major difficulty for staff in therapeutic milieu settings. Traditionally seen as "treatment resistant" (i.e., persistent in the face of so-called therapeutic doses of antipsychotic medication), such symptoms as lack of energy, lack of motivation, and diminished affect contribute to the serious mental illness stereotype: the therapeutic milieu setting with large numbers of people sitting, staring blankly for the majority of the day. But we now have studies that support a cognitive therapy approach for the treatment of negative symptoms too (Grant, Huh, Perivoliotis, Stolar, & Beck, 2012; Perivoliotis, Grant, & Beck, in press) and these are extremely simple for all milieu staff to carry out.

Activity is the backbone of negative symptom treatment. According to the cognitive model of negative symptoms, people with negative symptoms experience diminished capacity to anticipate pleasure from previously enjoyed activities, as well as impaired reward learning when actually engaged in such activities. Coupled with the effects of cognitive limitations, aversive life experiences (e.g., failures in school, work, relationships), positive symptoms, and societal messages about schizophrenia and its prognosis, they come to believe that it is not worth engaging in productive or pleasurable activities and that they cannot enjoy or succeed in anything again (Perivoliotis, Grant, & Beck, in press). Supporting someone while they engage in activity, enhancing their enjoyment of it through praise and reward, and helping them to notice and build on the enjoyment and success they do experience helps to correct these maladaptive and recovery-interfering defeatist beliefs.

Determining an activity that a person used to like or enjoy, encouraging them to engage with it again, maybe bringing it to their bedside or to where they are, and providing ample praise when there is even a flicker of a smile or enjoyment. This could be described as the "cheerleader" intervention. This can be as simple as playing a game of cards or checkers, watching funny clips on youtube, listening to music, taking a walk together. In addition, staff members can have a person rate their anticipation of enjoyment or sense of achievement on a 0–10 scale before and then again after the activity, with much praise and reinforcement for even one point of difference.

Building upon this work would be activity monitoring/scheduling, again using ratings for enjoyment and sense of achievement, as well as closeness to other people. Many programs have a daily schedule and are keen for people to engage with it. Having someone monitor how their mood and experience changes as a result of different items in the program, and modifying their schedule the following week in order to capitalize on positive outcomes can be extremely powerful. Simply helping someone to eliminate or minimize unpleasurable activities (e.g., getting out of bed, showering, laundry) and maximize pleasurable ones (e.g., a favorite group, time in the gym, a favorite game or conversation with a particular staff member) in their daily schedule can also positively impact negative symptoms. This leads to goal setting, which again fits with the recovery-driven model that many agencies are now reorienting their programs to include. Here the key is assisting the person to break down every goal (however unrealistic) into tiny, daily achievable steps, and then having them celebrate the achievement of every single step along the way. By doing so the clinician is investing in a strategy that the person can continue to utilize postdischarge or graduation from the program, that can also be shared with their next provider(s) to facilitate continuity of care.

Coping Cards

Although many people have access to smart technology devices these days, traditional pen-and-paper coping cards still have strong value. In many therapeutic milieu settings phones or other devices may not be allowed, and in many neighborhoods it may not be prudent to pull out devices on the street. A simple flash card with hand-written items on the front and back can be taken almost anywhere and used easily to reorient someone during a time of distressing psychosis. Specific strategies that have been determined to be effective in specific moments can be briefly detailed, providing cues for a particular cognition, behavior, or technique. In addition, they help large teams of staff be able to know the specific interventions relevant to each individual: any staff member can simply say, "I can see you are having difficulty with your voices right now. Is there anything on your coping card (see Box 4) that I can help you with to feel better?" Coping cards can also be used for daily goals, and again facilitate the sharing of information between staff specific to each individual in the program.

Conclusion

CT for schizophrenia is an evidence-based therapy than can be utilized in the community mental health setting, and not just by those trained as licensed clinicians. Many of these strategies you might recognize as classic CT interventions, just applied in a more specialist way. It is critical to engage all staff on a milieu to consider how their interactions can impact the experience of psychosis, and to give them the tools to contribute to treatment through brief interventions and interactions. Not only does this facilitate faster and more lasting recovery for clients, it also empowers and validates staff, reducing burnout for those who arguably perform some of the most valuable roles in the treatment of mental illness in the U.S.

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Box 1

Questions for Coping Skills Enhancement

- Do you do anything when you feel like this? … or hear the voice?
- Is it worse in some places than others?
- Have you ever noticed anything special that helps at all when that happens?
- In what way does it make you feel better?
- Do you use it every time, or do you forget sometimes?
- Would it be helpful if you were to use it more often?

Note. Based on the principles of Nelson (2005), *Cognitive behavioral therapy with schizophrenia: A practice manual*. Cheltenham, UK: Stanley Thornes Ltd.

Box 2

Look-Point-Name Strategy for Voices

- Rate the loudness of the voices (0-10)
- Look at an object, point to it and name it out loud
- Keep going until you run out of objects
- Rate the loudness of the voices again (0-10)

Box 3

Questions to Ask When Talking With Someone About Their Delusional Beliefs

- Use your natural curiosity
  - o What happened?
  - o What lets you know that people are talking about you?
  - o Have you any idea what they are saying about you?
  - o How could you tell…?
- Importance of neutral tone of voice

Note. Based on the principles of Nelson (2005), *Cognitive behavioral therapy with schizophrenia: A practice manual*. Cheltenham, UK: Stanley Thornes Ltd.

Box 4

Sample Coping Card

When the voices are really bad I can:

1. Check my emotion and my thoughts to see what made them start
2. Do point-look-name
3. Remind myself that the voices don't know what they are talking about, "they are only 10% wise"
4. If I'm feeling stressed my soothing activities are:
   a. Drawing and art
   b. Writing in my journal
   c. Listening to music from the 80s
   d. Reading about animals on the internet

Professional Challenges Facing African American Psychologists: The Presence and Impact of Racial Microaggressions

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RACIAL DISCRIMINATION HAS EVOLVED to occur on a continuum ranging from constant yet covert experiences to very explicit and blatant hate crimes and assaults (Williams et al., 2014). Researchers argue that a modern form of racial mistreatment, termed *racial microaggressions*, is more subtle, frequent, and can include daily racial slights or insults directed towards racial minorities (Torres, Driscoll, & Burrow, 2010). Such mistreatment can be detected in nonverbal or verbal expression, can seem unintentional or intentional, and appear vague or specific, thereby generating a variety of experiences that place the responsibility on the racial minority to decipher whether a given experience was racially motivated or not (Torres et al., 2010). Within these interactions, there is variability regarding one's awareness of racial microaggressions as influenced by the individual's level of racial consciousness (Constantine & Sue, 2007; Helms, 1984). There are commonly three categories of such experiences: microassaults, microinsults, and microinvalidations. This paper will focus on the latter two categories (Sue et al., 2007).

Microinsults are subtle messages that demean and debase the racial heritage or identity of minorities. Such racial microaggressions can include a peer/colleague expressing skepticism regarding an African American's qualification for a prestigious position or their ability to obtain a renowned achievement (e.g., lighthearted jokes, making sure they are aware of less prestigious positions), which may unintentionally or intentionally communicate that African Americans only qualify for prestigious positions or awards through affirmative action or quota-based programs (Williams, Gooden, & Davis, 2012). Similarly, microinsults can be committed nonverbally by students, peers, colleagues, and supervisors. For example, a supervisor may frequently appear distracted when a Black[1] colleague is talking in a meeting or unintentionally appear to discredit their contributions to the meeting topic, which may communicate that the intellectual contributions of the racial minority are not important or valued (Sue et al., 2007). Additionally, microinsults can include the unintentional endorsement of both positive and negative stereotypes. For example, a peer may interact with a Black male exclusively to discuss recent sporting events. Within an academic environment, limitation of conversational content to sports may reinforce the idea the Black male solely possesses expertise in sports, despite having rich and varied domains of intellectual ability and interest. Moreover, this example becomes more nuanced if the Black male is not personally interested in sports, but must appear knowledgeable about sports to preserve the vitality of his social interactions with his non-Black colleagues. Importantly, this example demonstrates that (a) microaggressions do not necessarily encompass malicious intent towards racial minorities, and (b) seemingly innocent attempts to socially interact inadvertently incite unwanted social pressure.

Similar to microinsults, microinvalidations are covert messages that may result in the unconscious mistreatment of racial minorities. Sue and colleagues (2007) define this category of racial microaggressions as messages that "exclude, negate, or nullify the psychological feelings, or experiential reality of people of color" (p. 274). Commonly, microinvalidations include statements and/or broad social interactions that minimize the importance of one's racial/ethnic heritage. For example, though the apparent goal of statements such as "I don't see race or color when I talk to you" is to communicate acceptance and inclusion, such statements also have an underlying message that the racial minority's acceptance and inclusion is in spite of their physical appearance or racial/cultural experiences. Such statements devalue the minority's racial/ethnic heritage. Another example of microinvalidations can include the dismissal of a racial minority's belief that negative or uncomfortable life events may have resulted from racism (e.g., "Let's hope you weren't treated that way due to racism"). Extant literature has demonstrated that there are social costs for making causal attributions to discrimination, which include being rated less likeable, viewed as a complainer, and viewed as attempting to avoid personal responsibility (Garcia, Reser, Amo, Redersdorff, & Branscombe, 2005; Stangor, Swim, Van Allen, & Sechrist, 2002). Therefore, racial minorities must attempt to resolve dissonance between their personal reality of encountering race-based stressors and microinvalidations which communicate racism is not a valid explanation for their experiences.

Microaggressions in Academia/ Professional Settings

In an attempt to illustrate the impact of racial microaggressions on the daily experiences of Black psychologists in academia and other professional settings, we will utilize a conceptual model that is inspired by the stress-coping literature (Torres et al., 2010). Broadly, the model conceptualizes racial microaggression as a potentially stressful life event commonly experienced by Black psychologists which requires ongoing cognitive appraisal and coping to manage cognitive, emotional, environmental, and physiological consequences associated with such experiences. According to Folkman, Lazarus, Dunkel-Schetter, Delongis, and Gruen (1986), when negative life events are encountered, an individual engages in cognitive appraisal, which entails a determination of the potential threat and overall impact the life event can have to an individual's well-being. The individual engages in a primary appraisal (or the rating of how affecting or meaningful the event is) and a secondary appraisal (or the contemplation of the availability of resources to assuage the potential impacts of the stressor). For Black psychologists, there are a number of potentially stressful events within professional settings, such as

[1]The word Black is sometimes used interchangeably with the word African American. Use of the ethnic identifier African American is specific to Black people raised in America while Black is an all-inclusive word used to refer to people of African ancestry worldwide. The word White is used to indicate the European American ethnoracial group in America (Williams et al., 2012).

time management of various responsibilities spanning teaching, mentorship, clinical supervision, or publishing. However, microaggressions generate an added stress that minorities are required to manage. Extant literature has demonstrated that racial discrimination (which subsumes racial microaggression) is predictive of negative health outcomes beyond solely accounting for perceived life stress, thereby demonstrating the unique source of stress that racial microaggressions can have on Black psychologists (Clark et al., 1999; Pieterse, Todd, Neville, & Carter, 2012; Torres et al., 2010). As such, the amalgamation of the already taxing demands of one's professional setting with the race-based stress of microaggressions engenders a distinct experience for the Black psychologist.

Race-based stress may involve interactions with superiors, colleagues, administrative staff, and students (Pittman, 2010, 2012; Torres et al., 2010). Several studies investigating such experiences in graduate students and faculty have captured an array of racial microaggressions commonly encountered in this environment. Torres and colleagues assessed the experiences of Black individuals who had obtained or were in the process of obtaining a degree in various disciplines (i.e., physical sciences, health sciences, social sciences, arts, and humanities) and found three primary themes descriptive of their encounters with racial microaggressions. First, the theme of "assumptions of criminality/second-class citizen" described race-based negative experiences in which a Black individual was confronted as if he/she were doing something illegal or treated in a demeaning fashion. For example, a professor in this study reported that a distinct obstacle in the academic environment is "getting past peoples' expectations and perceptions of what it is to be a young Black man. . . . Once while working towards my master's I was told by a woman that worked at the university that I should not shave my head because I looked like a criminal and looked like other Black people" (Torres et al., p. 1085). This man's statement is characteristic of a microinvalidation in that it communicates there is something wrong with resembling other African Americans; it conveys that the standards of an academic setting require the abandonment of one's racial/ethnic heritage (e.g., African style of dress) to belong and be respected. Potentially more concerning is that this statement also labels Black men with shaved heads as criminal, communicating that if this Black scholar were to wear such a hair style, then he looks like a "thug." As a result of such messages, Black scholars may become hypervigilant of their image, which can come in the form of monitoring their style of speech, emotional expression, and style of dress. For example, a Black male scholar reported that he is "very cognizant" of how others may perceive him and attempts to avoid confirming pathological stereotypes often associated with being a Black male (Constantine, Smith, Redington, & Owens, 2008). Specifically, he acknowledges that by simply being a Black male, he "may be intimidating to some people," which translates into combating such perceptions by "dress[ing] in a certain way" and not saying "anything grammatically incorrect or anything that might perpetuate stereotypes about Black people" (Constantine et al., 2008, p. 353).

Additionally, a commonly endorsed microaggression included interactions that communicated an "underestimation of personal ability"—the encountering of messages regarding how others perceive a person's ability or capacity to succeed in a professional setting. This type of microaggression can be in the form of a microinsult or microinvalidation (e.g., feeling as if others in your department do not value your scholarly work, especially when it focuses on race/ethnic/gender issues; Constantine et al., 2008), and can foster a motivation to constantly prove one's ability. For example, a Black graduate student explained, "most of the time, I get the feeling that others do not feel that I belong. That the only reason I am there is to fill a quota. I have overheard comments about the concern for my lack of ability to perform as others. This is nothing new. When I finish this degree and get in the real world this mess will continue to exist" (Torres et al., 2010, p. 1085). This illustrates that racial microaggressions are a common and expected obstacle to be overcome as an individual continues to grow in their career.

Along these lines, Constantine et al. (2008) found a similar theme among African American scholars, which she described as "Alternating Feelings of Invisibility/Marginalization and Hypervisibility." Specifically, these participants perceived that they were invisible to the members of their department until cultural matters became a department priority (e.g., multicultural requirements for accreditations, minority recruitment). For example, Black faculty and students often become hypervisible when there is a need for someone to serve on race-related committees, to lead race/culture-related classes, and to attend race-related meetings. On the surface, the expectation for African American scholars to fulfill such responsibilities seems intuitive, especially if race or culture-related topics are a focus of their scholarly work. However, the disproportionate expectation for these individuals to fulfill these roles in addition to the typical demands of their academic work, can communicate that Black psychologists are solely valued as experts on "all things Black" (Pittman, 2012). Collectively, these findings describe that African American scholars can be confronted with contradictory messages that question, demean, and devalue their intellectual ability until moments where their expertise as a member of the Black community is a high priority. Such experiences can contribute to a sense of not belonging, isolation, and poor support.

Aside from comments inciting feelings of isolation or not belonging, there are often contextual dynamics (e.g., few African Americans in various professional settings) that also bolster a sense of cultural/racial isolation. For instance, a Black scholar reported that, "By being [one of] only a few of the minority or Black students in my program, I have had increasing paranoia over the years about people's perceptions of my academic performance. My anxiety and stress levels have hindered my performance in classes and in my research production" (Torres et al., 2010, p. 1086). This statement highlights how being a visible minority in a professional setting can create an added pressure to perform, which can come at the expense of one's emotional well-being. Moreover, aside from being the only "one" of your race or ethnicity within a department, institution, or even in the classroom, the theme of cultural/racial isolation can be exacerbated when Black scholars perceive that the racially homogeneous academic environment is unwelcoming or excludes their racial/ethnic heritage (Pittman, 2012).

Additionally, Black members of academia, especially faculty members, encounter racial microaggressions from their students; this experience has been tied to amplified emotional management demands (Harlow, 2003) both within the classroom and outside it. Black professors are also rated lower on student evaluations compared to White faculty, rated as less intelligent relative to White faculty, and

encounter a lack of respect from White students (Dipietro & Faye, 2005; Hamermesh & Parker, 2005; Rubin, 2001). In a recent article published in the *New York Times*, Dr. Carolotta Berry (2014), an African American professor, explained that "in class, I have my derivations questioned, lectures critiqued, grading regarded as too harsh or unfair and my expectations dismissed as too high or difficult." Moreover, she noted that, "I once had a student who would review notes with me that he had taken on my lecture, then offered tips on how I could improve." Her students' actions blatantly communicated she was not qualified to lead the course despite her doctoral-level training and 6 years of experience. Altogether, these accounts from qualitative research provide an illustration of race-based stressors that Black scholars may encounter within the academy. It should be noted that the summary of these experiences are not deemed universally applicable to all scholars, but should be considered a sampling of how such experiences can generate an added stress or even barriers for Black scholars.

Another professional setting where African American psychologists may encounter racial microaggressions is within clinical practice. As a racial minority in the field of psychology, the odds of working with non-Black clients are relatively high; however, the majority of studies have only examined the presence of racial microaggressions within White therapist–Black client dyads (Bronstein, 1986; Comas-Diaz & Jacobsen, 1995; Jones & Seagull, 1977). Comas-Diaz and Jacobsen uniquely brought to light the power reversal seen in Black therapist–White client dyads in that the relationship is incongruent to the historical racial divisions of class and power in Western society. As a result, a Black therapist may encounter client mistrust, racial guilt or shame, hypercritical interactions (e.g., overemphasizing therapist mistakes), and even have their competency questioned by a non-Black client (Comas-Diaz & Jacobsen). Among the few studies describing how such race-based stressors might impact Black therapists, Kelly and Greene (2010) unearth microaggressions that may be unique to female African American therapists. The authors describe that clients might endorse gender-specific stereotypes, such as perceiving Black female therapists as characteristically nurturing and maternal (i.e., the "Mammy" stereotype), overly sexual and seductive (i.e., the "Jezebel" stereotype), or easily angered (i.e., the "Angry Black Woman/Sapphire" stereotype). The authors broadly explain how a client's endorsement of these stereotypes can result in subtle behaviors (e.g., seductive statements directed towards the therapist; client avoiding confrontation in therapy due to fear of therapist's excessive anger) that jeopardize rapport building and overall progression toward treatment goals.

Besides interactions with non-Black clients, Black therapists may also experience racial microaggressions when engaging in clinical supervision. Specifically, Constantine and Sue (2007) surveyed the experiences of Black supervisees and found several broad themes of microaggressions encountered within the supervisor-supervisee relationship. Such themes included microaggressions directed towards Black clients during the supervision period (i.e., communicating stereotypic assumptions about minority clients; heavily emphasizing clinical deficits rather than acknowledging clinical strengths; blaming the clients for their unfortunate circumstances that are rooted in oppression). For example, a Black supervisee recalled that her European American supervisor stated, "You shouldn't expect a lot of African American clients to be in touch with their feelings and do some real intrapsychic work. Sometimes you have to be more directive and problem-focused in dealing with Black people" (Constantine & Sue, p. 146). Also, racial microaggressions were directed towards the Black supervisee in the form of exhibiting stereotypic assumptions about the supervisee, such as making statements like "Don't be late for supervision" and noting that "I don't want [Black people's different time orientation] to turn into some kind of cultural thing" (Constantine & Sue, p. 146). Altogether, these statements illustrate how stereotypes about Black culture distort the quality of supervision as well as influence the rapport within supervisor-supervisee relationship. Such racial microaggressions resulted in feelings of frustration, anger, and occasionally led to the Black supervisees avoiding discussions of their Black clients as well as broader discussions of racial-cultural issues.

In summary, racial microaggression can impact Black psychologists across diverse professional settings, which most notably includes the academic and clinical arenas. In many of these encounters, it is often unclear that these experiences are attributable to racial biases, which requires the scholar to determine the most realistic cause of their experience. Such ambiguity can result in an array of emotional responses and contribute to stress within the academic environment. For example, Torres et al. (2010) found that racial microaggressions experienced in the academic setting were positively related to future perceived stress, which subsequently predicted depressive symptoms a year later. Also, Black psychologists may feel an added pressure to prove competence and experience anger, resentment, and anxiety following exposure to racial microaggressions (Comas-Dias & Jacobsen, 1995). More broadly, a preponderance of literature has conveyed that the severity, temporality, and chronicity of exposure to discrimination are associated with poor physical and psychological health outcomes across both genders and diverse ethnic groups (Pascoe & Richman, 2009). In particular, evidence supports the harmful effects of discrimination across a multitude of mental health outcomes (e.g., depression, anxiety, psychological distress, well-being; Clark et al., 1999; Paradies, 2006; Soto et al., 2011; Williams et al., 2003). Given its potentially harmful effects, it is imperative that Black psychologists are equipped with resources to manage the onset and emotional responses related to racial microaggressions.

Coping With Microaggressions in Academia

When confronted with stressful situations, an individual's emotional responses are often the impetus that initiates the coping process (i.e., the selection and implementation of coping strategies). When coping with racial microaggressions, the perceived availability and suitability of coping resources in one's environment can influence the overall appraisal of the event and the general perception of life stress (Clark et al., 1999; Lazarus & Folkman, 1984), which highlights the importance of having knowledge of accessible resources when confronted by race-based stress.

Torres and colleagues (2010) found that the relationship between racial microaggressions (i.e., the underestimation of personal ability) and perceived stress a year later was moderated by coping style. Although Torres and colleagues did not assess the specific coping strategies utilized to manage the stress associated with racial microaggressions, their findings suggest that certain coping strategies can serve as a buffer against racially stressful

events. As such, we provide a brief summary of the coping strategies implemented by African American psychologists to address race-based stress in academia. However, it is important to acknowledge that no singular coping strategy is thought to be universally effective for all African American scholars, nor is a sole strategy effective across all possible academic situations. To effectively navigate racial microaggressions in academia, one must consider individual goals, desired outcomes, available coping resources, and specific demands of the situation (Folkman & Moskowitz, 2004).

In terms of coping with microaggressions at one's academic institution or department, ethnic minority female faculty members provide several coping options intended to overcome an unsupportive and unfriendly environment within the department/institution (Thomas & Hollenhead, 2001). For instance, a faculty member described how exhausting and self-defeating such an environment can be and noted that she has observed "talented" scholars begin doubting their abilities. In turn, she recommended that Black scholars establish a social network (either within or beyond one's academic environment) that will allow them look objectively at their own work and provide a safe place for the personal reflection regarding one's talents and overall experiences. Moreover, she suggested that scholars utilize this social network "to tell [their] horror stories to one another so [they are] not afraid that it really is [their] problem" (Thomas & Hollenhead, 2001, p.171). In other words, seeking social support can become a source of objective feedback and validation to combat experiences within an unsupportive environment (Constantine et al., 2008). Black psychologists struggle with securing effective and supportive mentorship (Constantine et al., 2008), but the participants in the Thomas and Hollenhead study alluded to the "creative strategies" that African American students, faculty members, and even therapists must employ in order to manufacture the mentorship needed to pursue personal career goals and cope with the stress resulting from microaggressions. Specifically, it is recommended that Black psychologists seek mentorship from others outside of one's department, institution, or even beyond one's professional setting as needed. In summary, establishing a social network can provide an emotional outlet, validation and support, and mentorship in pursuit of career goals. Additional strategies include religious coping (e.g., prayer, church group), avoidance of perpetrators of racial microaggressions, and "choosing one's battles carefully" (e.g., selectively determining when to confront race-based stressors; Constantine et al., 2008).

Regarding coping with microaggressions in the classroom, Pittman (2010) utilized the responses from 16 African American, award-winning faculty to describe potential strategies for managing exposure to racial microaggression from students. Specifically, many of these Black scholars endorsed contemplating whether a student's openly expressed racial biases could be redirected into a positive teaching opportunity. This approach minimizes the one-on-one confrontation between the instructor-student and instead conveys a broader message about the implications of racial assumptions as it may relate to the course's material. Along these lines, these scholars generally supported the importance of providing students (especially those who exhibit racial biases towards stigmatized groups) with a safe space to challenge and encounter experiences that disconfirm their preconceived notions about African Americans. A specific strategy for facilitating a safe space is to utilize nonreactive questioning: for example, "Why do you believe that?" or "What enables you to know this about that person or group?" (Pittman, 2010). A similar recommendation was made for coping with racial microaggressions in a clinical setting. Particularly, Kelly and Greene (2010) note that the therapist should be sensitive to the emergence of racial microaggressions within the therapist-client relationship and, when deemed vital to the client's treatment goals, the authors recommend exploring the client's racial assumptions of the therapists and setting boundaries when appropriate (e.g., in response to a male client's seductive advances towards a Black therapist).

Finally, Pittman (2010) found that African American faculty members coped with microaggressions in the classroom by using both assertive actions to establish authority and through the use of anticipatory actions (e.g., discussing expectations for classroom discussions about race; presenting educational credentials at beginning of semester to challenge assumptions of not being qualified). Such coping strategies offer options for addressing the inappropriateness of classroom microaggressions without singling out the racial biases at the foundation of the racially microaggressive behavior (Pittman, 2010).

Conclusion

Racism in the form of racial microaggressions is commonplace and African American psychologists must navigate these experiences in nearly all professional domains. Such experiences are inherently stressful and anxiety producing and can lead to discouragement and feelings of isolation. The negative sequela of such events can be mitigated with proactive coping and judicious handling of select experiences. Nonetheless, additional energies are required to manage the problems that result from pervasive stereotypical beliefs about African Americans and their fitness as scholars and professionals. We need a cultural shift within our own ranks to celebrate African American scholars, not only as worthy fellow psychologists, but as fighters, survivors, and victors in the war against racism.

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Introducing . . .

Linda M. Still, CMP, Director of Education and Meeting Services, *to the ABCT Central Office*

Where did you grow up?

I was born and raised in Camden, New Jersey, and have lived in New Jersey my entire life. My family moved to Lawnside, New Jersey, when I was in my late teens since this was the hometown where my father grew up. Lawnside has a long and rich African American history. The current name of Lawnside was coined in 1907 when the Pennsylvania and Reading Railroad built a station stop there.

What led you on the path of planning meetings/events?

I fell into this industry while working for Penn Mutual Life Insurance Company. I had the opportunity to learn about meeting and event planning when a position became available in the Marketing & Advertising Department. We did incentive trips for insurance agents and senior leadership. When my direct supervisor was preparing to retire, I was given the opportunity to take on the meeting planning portion of his job. He was a wonderful mentor who took the time to teach me the art of planning and executing incentive meetings which included contract negotiations, food and beverage, etc. I truly believe it was a very valuable foundation that fueled my desire for meeting, trade show, and event management. The profession has evolved over the years, and now there are many hospitality, hotel and meeting management courses/degrees offered today.

Can you tell us any high points of your career so far?

My career includes working for the National Association for Recording Merchandisers (now Music Business Association), the American Association for Cancer Research and the Juvenile Products Manufactures Association, just to name a few. I have been blessed to travel to most of the 50 states as well as international travel. Never in my wildest dreams did I ever think I would plan meetings and conferences in Amsterdam, Hong Kong, India, Israel, and Singapore. I led a team of my colleagues to plan a Rally for Medical Research in Washington, DC, for 10,000 attendees, and credited for many successful conventions in San Francisco, San Diego, Orlando, Washington, DC, Denver, and Chicago. I have planned conventions that included concerts by Phil Collins, Liza Minnelli, Seal, Rod Stewart, Dionne Warwick, N'Sync, KD Lang, Mandy Patinkin and many more. I worked for some amazing associations whose members inspire me to do better in my personal endeavors.

How to you measure the success of an event?

It depends on the event. Achieving the goals of the association, increasing attendances, presenting first-class educational content, no major mishaps at the venue, an overall high approval rating for the attendees.

What other interests do you have?

I love to read, work in the garden/yard, cook, go to the movies, and spend time with family and friends.

What inspires and/or motivates you?

People inspire me. Spending time at the beach/near water. I normally vacation with my extended family in Ocean City, New Jersey, every summer. This is where I re-energize and center myself.

What do you love most about planning an event?

I love creating a new experience for attendees. I love making people feel at home, make their experience easy and enjoyable. I love the element of surprise in the everyday event. If I can make the experience memorable, then I have achieved success. I also love collaborating with some amazing people throughout the planning process.

Do you have a secret skill?

Yes, but if I told you then it wouldn't be a secret any longer.

What's up with all the flowers in your office?

I have been in this industry for many years, and have made so many lasting friendships and partnerships with peers and vendor partners. I am overwhelmed with the outpouring on notes, flowers, and calls I received after joining ABCT. Meeting Management/Hospitality is a close community and we celebrate and support each other. I guess these flowers are my visible blessings.

Is there anything else we should know about you?

I love music, all genres. I also have a thing for Denzel Washington. Perhaps now that I am working at ABCT I should talk with someone. Hahaha!!!! ■

"I love the element of surprise in the everyday event. . . ."

OBITUARY

Cyril M. Franks, Ph.D.

G. Terence Wilson, R*utgers University*

CYRIL M. FRANKS, PH.D., DIED ON MONDAY, February 23, in Bloomington, Indiana. He was 91. Born in Neath, Wales, United Kingdom, Cyril completed his Ph.D. in Psychology at London University where his mentor and friend was the renowned Hans Eysenck at the Institute of Psychiatry. He then emigrated to the United States, living in Princeton, New Jersey, for 52 years before moving to Bloomington. From the late 1960s until his retirement in 1991 Cyril was a faculty member at Rutgers University and the Graduate School of Applied and Professional Psychology where he was not only active in both the Ph.D. and Psy.D. programs, but also served as Director of the Psychological Clinic. On the occasion of his retirement he established the annual Cyril M. Franks Award for Outstanding Psy.D. Dissertation. Cyril also served as program chairperson of the New Jersey Psychological Association and of the Pavlovian Society of North America. He was a Fellow in both the American Psychological Association and the British Psychological Society.

It would be difficult indeed to overstate the seminal and enduring influence Cyril had on the development of the field of behavior therapy. Cyril was a founding member and the first president of our organization that was originally established in 1966 under the name Association for Advancement of Behavioral Therapies (AABT). He also founded the organization's flagship journal *Behavior Therapy* and was the first editor of the AABT *Newsletter*. It is a little known fact that in choosing the original title of AABT, Cyril had as his model the British Association for the Advancement of Science. In short order Cyril then altered the title to the "Association for the Advancement of Behavior Therapy" in response to an article he accepted for publication in the *Newsletter* in 1967 (see History, ABCT website). Yet in 1969, in the Preface to his landmark edited volume *Behavior Therapy: Appraisal and Status*, Cyril voiced his misgivings over abandoning the plural form. With trademark eloquence Cyril wrote that "I am still not certain whether the use of the singular is justified since it assumes a unified body of knowledge and an underlying conceptual harmony which may be more in the nature of wishful thinking than an obtained objective at this time." Of course in 2005 another name change reclaimed the plural and added the cognitive.

Cyril was the author and editor of several hundred articles, book chapters, and professional texts. In addition to editing *Behavior Therapy*, he was also editor of *Child and Family Behavior Therapy*. He was prolific and very influential through his various publications. His 1969 edited volume, *Behavior Therapy: Appraisal and Status*, was a classic—massively important at the time. From 1973 to 1988 Cyril was the senior editor of the *Annual Review of Behavior Therapy: Theory and Practice*. I was fortunate to be a co-editor in the series. It was Cyril's good sense to understand that an edited volume, reprinting key journal articles with accompanying critical commentary, would greatly assist the dissemination of behavior therapy in those early days when access to the journals was limited in many countries outside of the U.S. and U.K. It was Cyril's custom, drawing upon his rich history of scholarship, to precede the preface in each volume with a pithy quotation about the nature of science. One of his favorites appears in Volume 4, 1976, from Sir William Osler: "To the [practitioner] particularly, a scientific discipline is an incalculable gift, which leavens his whole life, giving exactness to habits of thought and tempering the mind with that judicious faculty of distrust which can alone, amid the uncertainties of practice, make him wise. . . ."

No remembrance of Cyril could possibly be complete without celebrating his sense of humor—a quintessential British one. Cyril was a "character," replete with some engaging idiosyncracies. In a recent exchange of emails among past-presidents of our organization, it was both striking and moving to read how the many anecdotes and personal memories of Cyril fondly featured his infectious sense of humor and occasional offbeat action. Cyril influenced the field in so many ways, including his vision of the future, his encouragement of students and junior colleagues, and his shrewd appreciation of talent and fellow professionals. His 1969 edited volume, noted above, is a case in point. The list of authors of the various chapters was a timely and extraordinary collection of the best talent the field had to offer.

As cognitive behavior therapy is "thriving" as an ever-expanding and evidence-based intervention around the world, it is all too easy to forget the original contributions of Cyril and his fellow pioneers. Those founding figures encountered objections, rejection, and hostility. Yet they persevered, inspired subsequent generations, and helped lay the foundations for changing the world of mental health and its treatment. In 2016 in New York, ABCT will celebrate its 50th anniversary. It will be a fitting occasion to remember Cyril and honor his remarkable vision and numerous accomplishments.

Cyril is survived by his wife Violet, a distinguished clinical psychologist in her own right; his son Steven, his wife Karen and their children Julia of Coral Gables, Florida, Elisabeth, of Edinburgh, Scotland, and David of Bloomington; and his daughter Sharrin Franks Vernall and her two children Brendon Liam Miles and Emily Sage Vernall of Auckland, New Zealand. Donations may be made in his memory to the American Psychological Foundation, 750 First Street NE, Washington, DC 20002, or online at www.apaa.org/APF for the Cyril and Violet Franks research fund for stigma in mental illness.

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CBT Medical Educator Directory

Another indispensable resource from ABCT—an online directory of CBT educators who have agreed to be listed as potential resources to others involved in training physicians and allied health providers. In particular, the educators on this list have been involved in providing education in CBT and/or the theories underlying such interventions to medical and other allied health trainees at various levels. The listing is meant to connect teachers across institutions and allow for the sharing of resources.

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.

2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.

3. Training should take place or be affiliated with an academic training facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

Please note that this list is offered as a service to all who teach CBT to the medical community and is not exhaustive.

To Submit Your Name for Inclusion in the Medical Educator Directory

If you meet the above inclusion criteria and wish to be included on this list, please send the contact information that you would like included, along with a few sentences describing your experience with training physicians and/or allied health providers in CBT to Barbara Kamholz at barbara.kamholz2@va.gov and include "Medical Educator Directory" in the subject line.

Disclaimer

Time and availability to participate in such efforts may vary widely among the educators listed. It is up to the individuals seeking guidance to pick who they wish to contact and to evaluate the quality of the advice/guidance they receive. ABCT has not evaluated the quality of potential teaching materials and inclusion on this list does not imply endorsement by ABCT of any particular training program or professional. The individuals in this listing serve strictly in a volunteer capacity.

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—Cyril Franks & John Paul Brady
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REASON #12

"I must confess a shameful secret:
I love Chicago best in the cold."

— Erik Larson