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# *the* Behavior Therapist

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*President's Message*

## The Problem of Stigma in Mental Health: A Role for CBT in Its Alleviation

**Dean McKay,** ***Fordham University***

We are all well aware that mental health problems are associated with considerable societal stigma. One of the primary aims for practitioners is to alleviate symptoms and foster improved functioning and quality of life. The reduction of stigma, particularly self-directed stigma that individuals suffering from mental illness might experience, may not be the first thing to occur to providers as a target of treatment. Cognitive-behavior therapy (CBT) is uniquely situated to reduce stigma given that our models of psychopathology focus on (a) learning experiences and cognitive processes as functional components of symptom manifestation and (b) the development of specific behavioral approaches to alleviate symptoms and suffering. It is therefore interesting that CBT is not presently center stage among policymakers and investigators in the movement to alleviate stigma.

Reducing stigma associated with psychiatric illness has been a serious challenge for the mental health professions. With the full-throated embrace of the biomedical model of mental illness adopted by the NIMH and the American Psychiatric Association, it has been hypothesized that the stigma of mental illness would be reduced (Haslam, 2011). The expected mechanism has been that with biological explanations of disease, there would be less societal stigma in a

[continued on p. 107]

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ABCT

# Election Results

**Michelle G. Craske**, Ph.D.
President-Elect, 2014–2015

**Keith S. Dobson**, Ph.D.
Representative-at-Large, 2014–2017

In our recent election, ABCT members also passed two bylaws proposals:

1. A proposed revision of Bylaws Article III: a Fellows member category
2. A proposed revision of Bylaws Article II: an updated Mission Statement

## 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** (a form is printed on p. 35 of the February 2011 issue of *tBT*, or download a form from our website): *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 at **bdeacon@uow.edu.au.** 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.

way similar to the lack of stigma of having the common cold or requiring a root canal. It has been suggested that biological explanations may reduce blame for individuals with mental illness (i.e., Lebowitz, 2014). This finding has been quite mixed, and in any event may increase perceptions of dangerousness and unpredictability (Kvaale, Gottdiener, & Haslam, 2013). In short, without careful scrutiny, the biological-based psychiatric illness hypothesis seems on solid ground until one considers the following: most of recorded human history, major psychological theories, and empirical research evaluating the role of biological (versus environmentally based) explanations of mental illness.

### A Brief Primer on Stigma Through the Ages

Many established biologically based illnesses have prompted feelings of stigma in unaffected members of the population. Some are particularly well documented, such as leprosy (now known as Hansen's disease), which is caused by a specific bacterium, and its onset is associated with consuming dirty water and poor diet, in conjunction with a specific biological disposition. Documented cases date back to the early Egyptians. Prompting the development of so-called "Leper colonies" to isolate the afflicted, we witness one of histories earliest forms of societal stigma. Being afflicted with Hansen's disease was treated as a crime in the 19th century, leading to exile to islands in Hawaii (see McMenamin, 2011, for a historical account) and it continues to be a disease with considerable stigma in areas where the disease is still common (Luka, 2010). Tuberculosis has likewise been a heavily stigmatized medical condition, and continues to be so today (Barel, Karki, & Newell, 2007). These conditions are ones with now established medical tests that reliably assess for their presence, and there also exist treatments to alleviate the diseases. Both diseases mentioned are the source of stigma due to mistaken perceptions of means of contraction, associations with cleanliness, and curability.

In the realm of mental illness stigma is likewise well known and prominent. Schizophrenia has long been the source of stigma, and evidence suggests that ascribing biological explanations for the disorder exacerbates the perception of dangerousness of individuals with the disorder (Corrigan & Watson, 2004[1]). And in general, when mental illness is ascribed to biological causes, the perception is that they are less curable, more disabling, and more likely associated with self-directed harm (Lam, Salkovskis, & Warwick, 2005).

To be fair, the biological approach to defining and understanding mental illness has benefits, namely in reducing blame and improving treatment access for psychiatric illness, so long as that treatment is biological in nature. And that is exactly the point I wish to advance: that the scale has tilted in a direction that so strongly favors the biological explanations that the public may have a reduced appreciation for the value of psychological methods of alleviating psychopathology. Accordingly, reliance solely on biomedical explanations for understanding mental illness necessarily oversimplifies the problem by ignoring the larger social and environmental contexts for the development of psychopathology.

### Accounting for Stigma

There is a vast literature depicting the theories that account for the development of stigma. One area that I would like to focus on concerns the interrelated connections between purity (lack of illness) versus the factors controlling dissemination of disease. At a basic level, Rozin and Fallon (1987) describe the Law of Contagion as a factor that leads to avoidance when it is perceived that a disease or contaminant might be transmitted through otherwise innocuous means. To illustrate, in the early days of the AIDS epidemic, it was not uncommon to hear of avoidance of affected individuals due to misperceptions and ignorance of the condition out of a concern the disease could be contracted from incidental contact (Herek, 1999). In a twist on this issue, there are documented cases of individuals with contamination-fear obsessive-compulsive disorder driven by excessive fear of contracting AIDS from sources that could not possibly be associated with transmission (i.e., visiting hospitals, swimming in public pools where affected individuals might also swim, etc.; i.e., Bruce & Stevens, 1992).

In a more general discussion of the controlling factors involved in stigma, the classic text by Douglas (1966) discusses how the perception of a lack of cleanliness contributes to an increased sense of potential harm. This is especially pronounced by contact with what she terms "primitive cultures,"[2] with primitiveness defined arbitrarily by the purportedly advanced groups. Contact with putative primitive cultures would be contaminating, violating the aforementioned Law of Contagion. In reference to mental illness specifically, Douglas states, "So long as they stay at home their peculiar behaviour is accepted. Once they have been formally classified as abnormal, the very same behaviour is counted intolerable" (p. 121). Accordingly, the same avoidance pattern emerges for mental illness as for the so-called "primitive cultures" that Douglas discusses.

Miller (1997) takes us a step further to the stigmatized individual, rather than group, when he depicts the conditions under which civility toward our fellow man may be lowered, when it is ascribed to provoking negative emotional reactions:

> This minimal demand of being civilly disattendable, however, is very hard to meet for certain people. Take the beautiful: we do not blame them for their lack of disattendability since they do not elicit our attention by disgust or alarm. They do, however, impose extra demands on our poise and tact, on our abilities to maintain decorum. There is a thin line between the looks of admiration these people have come to expect as their due and importunate gawking. On the other side are the stigmatized: the obese, the disabled, the deformed, the mentally ill, the grotesquely ugly, the criminal, or those who do not qualify for membership in the generous category of "normals." Stigma disrupts the conditions that make for uneventful disattendability. The stigmatized variously generate alarm, disgust, contempt, embarrassment, concern, pity, or fear. These emotions in turn confirm the stigmatized person as one who is properly stigmatized. (p. 199)

According to Miller, stigmatizing others is justified by the mere experience of a negative emotion in their presence, by their behaviors that fall outside our particular and potentially idiosyncratic definitions of the norm. He goes on to point to how our disgust reactions to the stigmatized individual further produce a moral reaction, and that this can infect even those of us who hold ourselves to higher standards, who believe

[1] Corrigan and Watson (2004) emphasize the need to integrate biological and psychosocial explanations of mental illness.

[2] Douglas (1966) relies on the term "primitive cultures" in light of its accepted use at the time of her writing. I have retained the term here purely for convenience and consistency with the context of the source material cited.

we are above stigmatizing others on such shallow and unwarranted grounds.

### Empirical Findings

Recent empirical papers paint a bleak picture for reducing stigma by relying on biological explanations. One study by Pescosolido et al. (2010) vividly highlights this issue. On the positive side, widespread views of mental illness as being the result of disease processes increases the support for providing biologically based services. However, on the negative side, their findings show that, over time, as biological explanations have been increasingly promoted, stigma has likewise increased for schizophrenia, depression, and alcohol dependence.

While support for increased services commensurate with biological explanations for mental illness is desirable, it can also be construed as inherently contradictory. In short, why change one's biology since it is by definition unchangeable, a point particularly relevant in the biases the public makes about genetic causes of illness (Dar-Nimrod & Heine, 2011). This negative effect is evident in experimental and naturalistic findings. For example, when individuals are given biological explanations for depression, they are more pessimistic about potential treatment outcome and lower expected benefit from psychosocial interventions (Deacon & Baird, 2009). Nonexperimental research has shown that mental health treatment providers also hold stigmatizing attitudes toward the very individuals they are treating (Avery et al., 2013). Further, communication of stigmatizing attitudes toward clients worsens treatment outcome. Yanos, Lysaker, and Roe (2010) showed that as individuals with schizophrenia-spectrum disorders embraced greater self-directed stigma (i.e., agreed with the stigmatizing sentiment about their condition), treatment was worse regardless of approach. In another evaluation with individuals with schizophrenia, Hsiung et al. (2010) found that self-directed stigma was significantly associated with poorer quality of life. Finally, at least in the case of depression, it has been found that the biological aspects of the condition are in fact malleable despite the prevailing sentiment that biology = fixed (Dar-Nimrod & Heine; Lebowitz, Ahn, & Nolen-Hoeksema, 2013).

Collectively these findings suggest that biological explanations may increase public support for providing biologically based services for mental health care (Pescodolido et al., 2010). On the other hand, biological explanations may worsen stigma, worsen perceived treatment outcome, diminish optimism for and engagement in psychosocial interventions; that stigma, when internalized, contributes to poorer quality of life and poorer treatment outcome; and may not alleviate self-blame. On this last note, Kemp, Lickel, and Deacon (2014) illustrate how biological explanations of depression failed to reduce self-blame and led individuals to view pharmacotherapy as a more credible therapeutic modality.

A detailed review of the literature on the impact of biological conceptualizations on individuals with mental health needs recently supports the assertions I have offered here (Lebowitz, 2014). Lebowitz highlights the need for additional research given the limited experimental research on the topic. However, his review likewise points to the increased pessimism toward treatment when biological explanations are given for mental illness, even if the biological explanation does not interfere with the pursuit of therapy. In short, it appears that medicalization of mental illness can have a range of unintended negative consequences, including extensive adverse outcomes for the conduct of CBT.

### A Role for CBT in Alleviating Stigma

So now that I have may have depressed you (nonbiologically, mind you), please indulge me as I end on a more positive note. While it appears from the research that biological explanations of mental disorders have a net teratogenic effect, there are some glimmers of hope so long as there is a willingness to consider the complex array of factors influencing the development and maintenance of stigma. First, it appears that education about the extent of treatment efficacy for any condition alleviates stigma. For example, Sugihara and Takei (2013) found that a public education program regarding the symptoms of schizophrenia and its associated features significantly reduced stigma in Japan. Corrigan et al. (2012) found, in a meta-analysis, significant positive effect sizes for education programs providing proper education about the symptoms of mental illness, and that contact with individuals with the disorder also had significant positive effect sizes in reducing stigma.

The extant research also suggests that CBT is associated with lowering stigma. As our approach to therapy emphasizes environmental causes and consequences of behavior, as well as focuses upon personal agency in producing behavioral and emotional change, this runs counter to the prevailing assumptions embraced by individuals who struggle with symptoms and who simultaneously espouse a biological basis for their condition. The investigation by Lam et al. (2004) noted earlier highlights the reduction of stigma when psychological explanations are provided. Further, in the aforementioned study by Yanos et al. (2010), individuals in the study who received CBT had lower self-directed stigma and better treatment outcome.

We can safely embrace the view that CBT reduces stigma given that (a) most protocols emphasize education about symptoms, and (b) the approach inherently defines the symptoms as within the scope of self-regulation through specific procedures and exercises. What if our protocols began to include components aimed at self-directed stigma? This would greatly enhance outcome, and possibly also improve treatment retention. If we consider areas of research that are warranted, one question worth pursuing is the degree that stigma, and in particular stigma arising from ascribing a medical cause to mental illness, results in dropout from therapy.We might also aim to quantify the efficacy of CBT in directly reducing self-directed stigma.

We do face an added hurdle in the case of clients espousing stigma-induced pessimism, and so we therefore face a conundrum: Do we hold onto the biological explanations, which in turn have led to greater public support for mental health programs, but on the other hand have had the adverse effects on stigma? This may not be a sound long-term strategy given the reduced enthusiasm for psychosocial interventions when strictly biological explanations are espoused (i.e., Pescodolido et al., 2010). Do we develop "genetic essentialism" (Dar-Nimrod & Heine, 2011), with its attendant determinism and associated bias of ascribing strong genetic cause when weak associations are more often common? Also not necessarily a desirable route to take given that even the biological based aspects of some conditions have been found to be changeable (Lebowitz et al., 2013). These are emerging and active areas for consideration. As policymakers continue to emphasize biological explanations, we may come to appreciate the data showing that, at the very least, combined perspectives integrating psychosocial and biological models better serve our clients. Clearly it is important for clinicians to be aware of the biomedical explanations for mental illness, but it is also essential to be cognizant of how many of these explanations are in direct contraindi-

cation to our models of intervention, and that by deriving more integrative models that address stigma, there should be a corresponding increase in treatment efficacy.

### References


Avery, J., Dixon, L., Adler, D., Oslin, D., Hackman, A., First, M., . . . Siris, S. (2013). Psychiatrists' attitudes toward individuals with substance use disorders and serious mental illness. *Dual Diagnosis, 9*, 322-326.

Barel, S.C., Karki, D.K., & Newell, J.N. (2007). Causes of stigma and discrimination associated with tuberculosis in Nepal: A qualitative study. *BMC Public Health, 7*, 211.

Bruce, B.K., & Stevens, V.M. (1992). AIDS-related obsessive-compulsive disorder: A treatment dilemma. *Journal of Anxiety Disorders, 6*, 79-88.

Corrigan, P.W., Morris, S.B., Michaels, P.J., Rafacz, J.D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta analysis. *Psychiatric Services, 63*, 963-973.

Corrigan, P.W., & Watson, A.C. (2004). Stop the stigma: Call mental illness a brain disease. *Schizophrenia Bulletin, 30*, 477-479.

Dar-Nimrod, I., & Heine, S.J. (2011). Genetic essentialism: On the deceptive determinism of DNA. *Psychological Bulletin, 137,* 800-818.

Deacon, B.J., & Baird, G.L. (2009). The chemical imbalance explanation of depression: Reducing blame at what cost? *Journal of Social and Clinical Psychology, 28*, 415-435.

Douglas, M. (1966). *Purity and danger*. London: Routledge.

Haslam, N. (2011). Genetic essentialism, neuroessentialism, and stigma: Commentary on Dar-Nimrod and Heime (2011). *Psychological Bulletin, 137*, 819-824.

Herek, G.M. (1999). AIDS and stigma. *American Behavioral Scientist, 42*, 1106-1116.

Hsiung, P.C., Pan, A.W., Liu, S.K., Chen, S.C., Peng, S.Y., & Chung, L. (2010). Mastery and stigma in predicting the subjective quality of life of patients with schizophrenia in Taiwan. *Journal of Nervous and Mental Disease, 198*, 494-500.

Kemp, J.J., Lickel, J.J., & Deacon, B.J. (2014). Effects of a chemical imbalance causal explanation on individuals' perception of their depressive symptoms. *Behaviour Research and Therapy, 56,* 47-52.

Kvaale, E. P., Gottdiener, W. H., & Haslam, N. (2013). Biogenetic explanations and stigma: A meta-analytic review of associations among laypeople. *Social Science & Medicine, 96*, 95e103

Lam, D.C.K., Salkovskis, P.M., & Warwick, H.M.C. (2005). An experimental investigation of the impact of biological versus psychological explanations of the cause of "mental illness." *Journal of Mental Health, 14*, 453-464.

Lebowitz, M.S. (2014). Biological conceptualizations of mental disorders among affected individuals: A review of correlates and consequences. *Clinical Psychology: Science & Practice, 21*, 67-83.

Lebowitz, M. S., Ahn, W. K., & Nolen-Hoeksema, S. (2013). Fixable or fate? Perceptions of the biology of depression. *Journal of Consulting and Clinical Psychology, 81*, 518-527.

Luka, E.E. (2010). Understanding the stigma of leprosy. *South Sudan Medical Journal*. Retrieved from www.southernsudanmedicaljournal.com.

McMenamin, D. (2011). *Leprosy and stigma in the South Pacific: A region-by-region history with first person accounts*. Jefferson, NC: McFarland.

Miller, W.I. (1997). *The anatomy of disgust*. Cambridge, MA: Harvard University Press.

Pescosolido, B.A., Martin, J.K., Long, J.S., Medina, T.R., Phelan, J.C., & Link, B.G. (2010). "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry, 167*, 1321-1330.

Rozin, P., & Fallon, A.E. (1987). A perspective on disgust. *Psychological Review, 94*, 23-41.

Sugihara, G., & Takei, N. (2013). Renaming schizophrenia coupled with proper public education is an optimal way to overcome stigma. *Psychological Medicine, 43*, 1557-1558.

Yanos, P.T., Lysaker, P.H., & Roe, D. (2010). Internalized stigma as a barrier to improvement in vocational functioning among people with schizophrenia-spectrum disorders. *Psychiatry Research, 178*, 211-213.


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## *in-press*

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Bryan et al.
*Cognitive and Behavioral Practice*
doi: 10.1016/j.cbpra.2014.04.006

## *archive*

"The things which have to be equal in the case of the law of exercise are the force of satisfyingness; that is, the action of the law of effect, and again the readiness of the response to be connected with the situation."

E. L. Thorndike
"Provisional Laws of Acquired Behavior or Learning"
In Birney & Teevan (Eds.) (1961)
*Reinforcement*

*Clinical Training Update*

# The Mississippi Center for Contextual Psychology *Lab Manifesto*

**Kelly G. Wilson,** ***University of Mississippi***

***Our Lab Motto*:**

"World domination through peace,
love, and understanding."
(And dangerously strong coffee)

### About the Manifesto

This statement is an evolving document aimed at members, and potential members, of my lab. In some ways it is a natural extension of my own training experience. When I came to Ole Miss, I realized that I had been sitting at my mentor, Steve Hayes', right hand for 11 years at the University of Nevada. I knew a lot about running a vertical lab group. The time came for me to have my first lab meeting and I realized that I knew nothing at all about starting such a group. Steve's lab was up and running when I got there in 1989. I called him a few days before the first meeting in a panic. In his usual steady way he told me to spend a lot of time with the students and that the lab would evolve and grow. I think Steve trusted that my own natural enthusiasm for the work, and for the students, would be infectious. I woke very early on my birthday, September 2000, with the idea that I could invent any lab group I wanted. So, I put pen to paper in an attempt to articulate my ideal lab. Both the lab, and this document, are works in progress. As time goes by, I teach my students and they teach me. Slowly but surely we have built a wonderful little world where we can work together. Most recent additions to the manifesto include some work on the "one life" section. Stay tuned for new developments.

### The Mission

I was trained in Steve Hayes' lab at the University of Nevada, Reno. Being in that lab was one of the most stimulating and densely meaningful experiences of my life. The time I spent there changed me. It connected me to people and to a tradition. I joined a stream of extraordinary depth. We have created a tributary here at Ole Miss. Here is the way we have accomplished this:

#### *Part 1: The Content Mission*

Yes, the lab has a mission: To make theoretical and empirical analyses of the role of basic verbal processes in complex human behavior; to aim these analyses at topics that seem central to a life lived well; and to pursue the applied implications of these analyses in the service of improving lives.

#### *Part 2: The Process Mission*

To create an environment in which behavioral scientists are nurtured. The lab will mindfully pursue the professional development of its members in order to equip them to play important roles in the bettering of the human condition through the development, dissemination, and application of this science. Professional development is understood in our group in the very broadest possible sense. Too often in psychology and other disciplines, professional development has been very narrowly construed (e.g., becoming a competent psychologist). In our lab, we are interested in the development of whole persons. Joining the lab means making a commitment to mutual support—supporting others and allowing yourself to be supported. In lab, we learn to carry and be carried.

### The Method

#### *One Life: Family and Community*

Lab is first and foremost a community. I am deeply distrustful of the modern dichotomization of professional and personal life. These domains have been construed as mutually exclusive categories that require balance. While balancing work and personal life sounds very sensible, I believe that it begins with the assumption of a divided world, and an adversarial relationship between the parts. I do not accept this division. I am one person and I seek one life. The lab is committed to the development of a model of professional development that does not require students to lop off their personal lives until they are trained. We believe that doing so merely trains them to go on to the next place, where they lop off their personal life until they are tenured, promoted, retired, and on. We believe that if we are to have satisfying careers, we need, from the very beginning, to seek an integration of activity that feels whole and vital. There does not appear to be any ready model for what we seek, so we are feeling our way along. Part of the activity of the lab is densely social. We celebrate births, arrivals, and departures. We share our experience as we grow. The lab is built upon the core assumption that there is no joy or sorrow, no burden or blessing, which is not improved by sharing. Once upon a time people nearly always lived in the midst of extended family. Modern life takes many of us far from home. The lab is a sort of extended family. Being in the lab means sharing your joys and sorrows. Rather than let go of the notion of family, we seek to create a community that fulfills some of the functions that family fulfilled.

Over the course of my career, I have heard things that were frightening, painful, and terribly important to hear. Sometimes disciplines need powerful devotion, focus, and concentrated effort to move ahead. But we must be thoughtful about the sacrifices we make. At a workshop in 2005, a friend asked if it were possible to create psychology in a way in which someone's father did not have to be sacrificed in order for great things to emerge. Although I am capable, at times, of great insensitivity, this question penetrated. It launched a host of questions in me. How many husbands, wives, fathers, and mothers have we sacrificed in the creation of empirical clinical psychology? Am I, or perhaps in what ways am I, sacrificing my children's father for the work? In what ways have I supported my own mentors in sacrificing their children's father or mother? Am I teaching my students to sacrifice their husband's wife, their wife's husband, their children's parent? I do not know the answers to these questions, but I feel in my bones that time needs to be spent in the dense ambiguity that surrounds them.

Is there another way? Honestly, I do not know. However, I commit to the members of my lab, and in honor of the sacrifices that have been made, to stay awake, to be teachable, and to stretch towards a way of working that fosters whole lives. When I look within myself and examine how much of what I have done that is truly meaningful, and how much was devoted to getting a pat on the head, some meager, transient sense

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of approval, I am saddened. I find that I have devoted a tremendous amount of effort to looking good and being right. I am done using the lab and my life for this paltry end, and commit to rooting it out and letting it go whenever I see it. If you join me, I commit to support you in doing the same. To join the lab means to join me in this commitment.

What this means at a practical level is that seeing a baby sitting on my lap during a lecture or rolling around on the floor during lab will be common and welcome. Men and women who have children will be invited to bring them to these activities. We have a lab tradition of babies in lab. As long as I am in charge, they will continue to be welcome. We are not working on a factory floor. Babies will not likely be crushed between a couple big ideas. If we do not have enough room in our lives for the occasional whimpering, there is something wrong with our lives, not with the babies and their parents. Also, if whimpering excluded people from lab, I and all of the grad students would have to leave too. Babies in lab are a reminder of why we do our work.

### *Diversity*

Diversity is a core lab value. It is not diversity per se that is important, though. It is the fruits of diversity that we pursue. Diversity as a lab value is born out in my own experience coming up against limitations imposed by my idiosyncratic history. Too many times, when I thought something was indubitable, I have had my perception dramatically altered with the assistance of someone with a different history and a different view. There are important differences inherent in the experiences of individuals who find themselves in a majority or a minority group. Differences are scary and we often run from them. It is our aim to explore, celebrate, and exploit the new things that can come from an open dialogue. We are persistently curious about the effects of bringing diverse perspectives to bear on our work. Just as in a biological system, diversity in a population is survival insurance for a changing environment. Behavioral health care is a changing environment. We want to prepare ourselves to participate fully in its evolution.

### *Discourse and Intellectual Generosity*

The lab is a place for free and open discourse on any and all topics relevant to the lab mission. No appeal to authority holds sway. Ideas rise or fall on their merits. We share our ideas freely. My good friend (and one of my mentors) Pat Friman told me once: "If you only have one good idea—guard it with your life." My experience tells me that the world of ideas is not a zero-sum game. When you give away ideas you do not end up with fewer ideas. You end up with more—more ideas, more colleagues, more integrity, more fun, more.

We will never shy away from talking about ideas prior to their publication. Sometimes this means that we will get scooped. Someone else will publish our ideas before we do. Good! If the ideas are good, we want them to be out there as soon as possible. The more people are speaking about them, the better.

### *Densely Vertical Structure*

All lab members are expected to mentor. You have a responsibility to other members of this lab. Part of the process mission of the lab is not only to provide mentoring, but also to teach mentoring. Mentoring has been terribly important to me and this lab will both offer mentoring at all levels and will expect mentoring at all levels. We will do this by explicitly building mentoring into the culture of the lab. Students often come to the lab well-equipped to carry others. The grads are generally serious overachievers. These are the students who were involved in class group projects and did 90% of the work in the group. It is hard to get into a Ph.D. program in clinical psychology. These students have distinguished themselves by their strength. Lab calls them to do a harder thing. They need to learn to carry others, but they also need to learn to allow others to carry them. We all need carrying at times. Having spent a decade and a half running this lab, I can say with confidence that I have said "I don't understand" more times during lab presentations than anyone in lab. When I do not understand, I do not sit there, nod, and try to look like someone who understands. Instead, I say, "Say that again a different way until I understand it." When you do not understand, when you need help, it is your job to seek it and to seek it openly. I understand that it is scary to show any weakness, but few things will impede growth more than an unwillingness to show that you need help. Everyone learns to play out of their strength. Most learn to conceal their weakness. What this means is that you get to play on your strong days. And, on your weak days, you must either stay home or lie. If you can learn to play out of both your strength and your weakness, you get to play every single day of your life. Life is far too short and sweet and good to squander on hiding.

### *Don't Do Stupid Research*

There are already enough people working on that stuff. They don't need any help. The late Gordon Paul gave some advice once that I took very seriously—choose your research topics carefully. He admonished the audience to do work that was personally meaningful. Eventually, no matter what you choose, it will be a pain in the ass. You will encounter a dark night of the soul. Make sure that when that night comes, you will be working on something that makes carrying that weight worth it. Research and training in research is hard work—make your work count. In this lab, I want you to do something that you can care about.

### *Make Research Count Double*

When we are doing basic research, we will think about the implications of that research for the clinic. When we do applied research, we will ask ourselves how that research could answer a question about basic behavioral processes underlying clinical change. We will fall short, but this will be our intention. Another way to make your work count double is to create a coherent body of work. If you have to write a paper for a class, or take a comp, look for ways it can further your development in an area you care about. For example, in the 1996 experiential avoidance paper in the *Journal of Clinical and Consulting Psychology*, there are keystrokes and references from the first paper I wrote in graduate school in 1989. The paper was a research proposal to empirically analyze the effects of Gestalt exercises. Feel for a direction that is meaningful to you. Anything you do in that direction is more likely to become part of a stream of emerging expertise.

### *Make Stuff Happen*

We will be busy. People should be active in the lab. This means that two things should be true at all times: (1) you should be running or planning some empirical project, and (2) you should be writing or at least actively planning some manuscript with the end goal of publication. Great research projects that never get run can't make a difference. Great ideas that do not get published and disseminated can't make a difference. They are a disservice to you and to your fellows. If you already have some good ideas on paper, come to me and we will see where they might publish. If you

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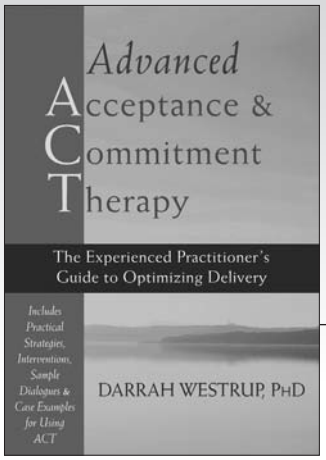


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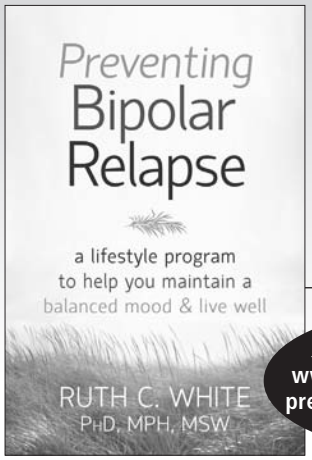


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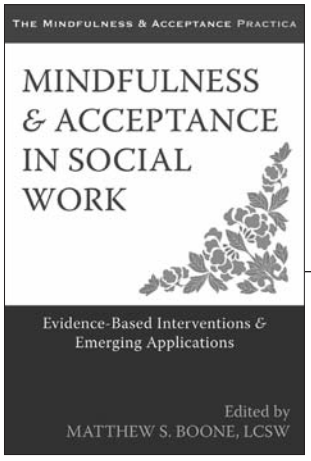


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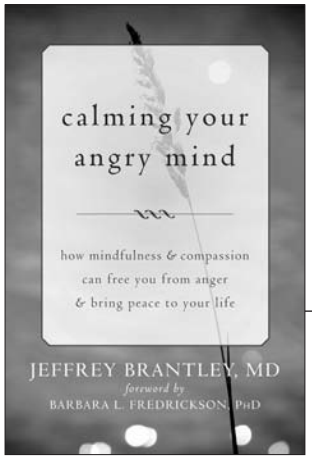


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don't we should set a meeting to talk about what we can start writing. If this seems too big, we can start with something very small. There are a lot of places to publish and levels at which to publish. Consider newsletters for professional organizations. You will get a few soft publications and you will get networked with other professionals. Come and talk to me about how this can fit with your professional development. There may be a way to generate a short, but sensible, publication on the way to a master's or dissertation project or out of a class paper. You will be thinking and working hard. Let's have that hard work benefit others.

### *Take Responsibility*

This is an issue at two levels. First, we are the beneficiaries of a lot of people's hard work. Most of the population of the planet would happily live what we would consider the most meager grad student existence. The resources that make this possible come from somewhere. Here in Mississippi, and elsewhere, people get up every morning and hammer nails, pour concrete, plant, harvest, check groceries, and on—we have a debt to them. Therefore, we take responsibility by doing work that can at least potentially make a difference for our fellows who do not live such privileged lives.

Second, we have a responsibility to the lab as a member of the lab-as-community. This means that we support our fellow labbies in the pursuit of both parts of the lab mission. In order to do this we have to be in lab. This means that lab meetings are not optional. They are not attended when convenient, or when we need some help from the lab. This means speaking up in lab and helping in the development of ideas, projects, and analyses. This means helping labbies in running projects, collecting data, writing, photocopying, recruiting subjects, running to the library, making coffee, whatever gets the work done. If the lab's work is to move ahead, it has to be each person's responsibility to help make it so.

One aspect of this is presenting your ideas, projects, intellectual, and professional development struggles to the lab so that we can work on them as a community. We can help you and you will be helping us in doing this. We will ask members of the lab to present to the lab on a regular basis. If there is a week that is not filled, it is your job to request the time for an impromptu discussion of some idea in psychology that you have been thinking about. Ideas do not need to be fully formed to speak about them. Use the lab as a place to work ideas out in community.

### *Attend to Relationships*

Science occurs in a social context. The lab is our most local social context—our community. I want people to leave the lab knowing how to build a vertical workgroup. We will be mindful of the culture of the lab. We can create a culture in which people are free to speak and explore. Help to raise people up and to pull them in. This does not mean rescuing people from their feelings. Sometimes when a colleague is floundering, bringing it up can be painful. It is painful to have your work criticized. The only way to avoid criticism, however, is to keep anyone from seeing your work. This violates the mission of the lab. I won't support it.

Sometimes people hesitate to offer correction because they are afraid they will say it wrong. The only way to learn to say it right is to say it wrong and to be corrected. Give yourself permission to say it wrong. Give others permission to say it wrong. Together, we can learn to say it right.

Seek criticism. Seek correction. Use the lab as a place where you seek out the criticism of your fellows. It is seductive to avoid criticism and seek out the comments of people who will give uncritical praise. By seeking criticism, our work improves and becomes less susceptible to criticism. It is better to have work criticized in lab than in print, at a conference, or in a dissertation defense. If you see a fly in the ointment, someone else will too. It is better to have the lab as a resource for cleaning up any errors in thinking before they are broadly disseminated. As members of the lab we have a responsibility to help improve one another's ideas and critical thinking skills. Solid criticism is a gift—give freely. Give freely of support, resources, and time. Be critical, but be kind. Criticism is much easier to hear when it is crystal clear that the critic cares about you and is standing for you. Stand for your fellows in the lab. Such effort will come back to you—sometimes from very unexpected sources. It is surprising how often we can get what we need by helping those around us get what they need.

### *If There Are Problems, Come to Me*

I am a heck of a problem solver. (I've had so many of my own to practice on.) Do not allow a sense of weakness dictate your growth. I have made a career from the two things I have in abundance: problems and heart. I have made those things very publicly available and have survived and thrived doing so. Let me do my job. If you are having problems, come and talk to me. Don't let problems fester.

## Career Goals

I am open to a wide variety of career goals that are consistent with the lab mission. This includes academic, research, and service delivery roles. Be prepared for me to push on you to make as large a contribution as you are capable of (and which is consistent with your values). Sometimes people pick goals for very negative reasons: "I'm afraid." I won't support that. I promise to relentlessly point toward your values and ask you if you can be afraid, and step up to what is in front of you.

## Tradition

Being a member of this lab means joining an intellectual tradition—a stream of scientific inquiry that has made a difference. I am not being in any way comprehensive; however, consider a few pieces of the intellectual line. My principle mentors were Steve and Linda Hayes and Bill and Victoria Follette. Steve's mentors included Hayne Reese, John Cone, Charlie Catania, and Dave Barlow. He also had colleagues who mentored him early in his career, like Aaron Brownstein and Rose Nelson. Among their mentors were Fred Keller, B. F. Skinner, Stewart Agras, Hal Leitenberg, Allen Edwards, Nat Schoenfeld, Joe Wolpe, and Joe Cautella, to name a few. Linda was trained at Western Michigan under Jack Michael and Dick Mallott. Linda was also arguably Jacob Kantor's last student. Bill Follette was Allen Edward's last student. Victoria Follette was a student of the late Neil Jacobson. Bill and Vic were both influenced by Bob Kohlenberg. The late Willard Day had a tremendous influence on me, along with his student (and my undergrad mentor) Sam Leigland. Last, I could not leave out Lois Parker, at the University of Nevada Counseling Center, whose patience and persistent support over the years shaped my training philosophy in very important ways. There is a bit of all of these people in me. All either directly or indirectly contributed to who and what I am. I would dearly love to pass those contributions on.

## Taking Credit, Getting Credit, Giving Credit

People are usually most concerned with getting credit. They are afraid that it might not be given freely. Sometimes people take

credit for things that aren't their doing. Sometimes they "get away with it"—but over the long haul, I doubt it. We each have to live in our own skin and some skins are more comfortable than others. The best way to get credit is to give it and give it freely. Always remember to acknowledge your sources—whether in speaking or in print. As an example, take a look at the overlap between this manifesto and my mentor's advice on success to grad students in his 1998 ABCT President's Message—"13 Rules for Success: A Message for Students" (Hayes, 1998). I did not write the manifesto from this paper; but, the paper represents the intellectual environment that nurtured me.

*Authorship*

We will write a lot. There is not a great deal about the APA that I like, but I think they have it right on the issue of authorship. Authorship is earned. This does not always mean the raw number of keystrokes. Intellectual contribution is the central consideration. Work hard. Earn lead authorship. If you are not ready, crew hard on writing projects. Learn the craft. Always, always, always be generous in giving authorship. If there is any reasonable argument that someone should be an author on a paper, give authorship. If you make an error, let it be on the side of generosity.

**Graduating and the B.J. Degree**

As a holder of the Behavioralis Junkus Degree, I will exercise my right to award the much coveted B.J. degree to students who complete their Ph.D. under my direction; to initiate the holder with the swearing of the science pledge; to teach the secret behavioral handshake; and to bestow all of the other rights and privileges that attend this highest of high honors (including the right to award the B.J. degree).

**The Life Lived Well Is the Thing**

We don't live forever, at least not this life. What lasts is our contribution. This means our intellectual contribution, but it means, every bit as much, the love we contribute. We are not aware of any good models of scientifically oriented groups with this mission. There is no one who can tell us how to do it. I have been told that this is not possible. I refuse to accept that answer. If you are moved to do so, please join us in the effort to create a work space that holds its humanity close as it performs its work.

(v. 4-27-14)

http://kellygwilson.com/Manifesto.html

**Reference**

Hayes, S. C. (1998). 13 rules for success: A message for students. *the Behavior Therapist, 21*, 47-48, 55.

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Kelly G. Wilson's Lab Manifesto can be found at http://kellygwilson.com/Manifesto.html

***Correspondence to*** Kelly G. Wilson, Ph.D., B.J., University of Mississippi, Department of Psychology, 311C Peabody Bldg., University, MS 38677; kwilson@olemiss.edu

*Research Practice Links*

# Cognitive Behavioral Therapies in Southern California

**Lynn McFarr, Lily A. Brown, Rhea Holler, Lauren Jackson, Wendy Morgan, and Ulises Ramirez,** ***Harbor-UCLA Medical Center*** **and** ***University of California, Los Angeles***

From the ivory towers of the University of California, Los Angeles (UCLA) to the mean streets of South Central LA, cognitive behavioral therapy (CBT) is practiced to varying degrees of fidelity and flexibility in the Southland. The wide range of its inquiry, implementation, and adoption is remarkable. Rather than attempting a comprehensive summary of all of the CBT activities in the Southland, we will focus on the prominence of CBT from UCLA's main campus to the limited training opportunities at master's programs and professional schools. Then we will discuss the large-scale rollout of CBT for the Los Angeles County Department of Mental Health, with special consideration to the practice of CBT with Latinos and welfare-to-work recipients.

## Research in Southern California

Southern California is a hub of research activity on CBT. UCLA, the RAND Corporation, University of Southern California, and other universities have active research programs examining outcomes, mediators, and processes in CBT, Dialectical Behavior Therapy (DBT; Linehan, 1993), Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), and the Cognitive Behavioral Analysis System of Psychotherapy (CBASP; McCollough, 2000). For instance, researchers at UCLA work on the dimensional nature of anxiety and depression, alterations in treatment based on dimensional research, and obstacles to dissemination of evidence-based treatments. UCLA uses multimethod designs, including psychophysiology, self-report, behavioral, and neural data to enhance the retention of learning in exposure therapy. One recent study found that for patients with spider phobia, engaging in affect labeling during exposure significantly reduced physiological arousal and increased behavioral approach toward spiders at follow-up compared to exposure with cognitive reappraisal, exposure with distraction, or exposure alone (Kircanski, Lieberman, & Craske, 2012). Affect labeling is also being applied to an imaginal exposure-based intervention for trauma exposure to determine whether outcomes are enhanced (Brown et al., 2014). Dour and Craske (2014) are attempting to enhance the positive valence of feared stimuli.

Southern California also hosts multi-institution collaboration aimed at evaluating threat and reward sensitivity. One of these studies involves collaboration between UCLA and UC San Diego and focuses on identifying dimensional variables of positive (i.e., reward sensitivity) and negative (i.e., threat detection) valence that coincide with the National Institute of Mental Health (NIMH) Research Domain

Criteria (RDoC) initiative (Principal Investigators at UCLA: Susan Bookheimer and Michelle Craske; Principal Investigator at UCSD: Martin Paulus). The goals of this study are to use dimensions to predict treatment outcome, to determine whether interventions aimed at changing these variables are successful, and to gather neural data about the expression of these dimensions to inform our understanding of them. Another collaboration, between UCLA and Northwestern University, will follow participants over 3 years to discern threat and reward neural circuitry and their behavioral, physiological, and self-report correlates (Principal Investigators at UCLA: Susan Bookheimer and Michelle Craske; Principal Investigators at Northwestern: Robin Nusslock and Richard Zinbarg). Collectively, these studies will provide insights into the expression of anxiety and depression and will help inform methods of enhancing CBT.

Other teams in Southern California are investigating adolescent DBT (Berk et al., 2014) and processes in adult DBT, CBT, and ACT. For instance, investigators are assessing daily or weekly changes in patients who are in DBT as well as how therapists change in response to training in this therapy. Specifically, preliminary analyses suggest a quadratric relationship between the occurrence of therapy-interfering behaviors (i.e., missing a session, not using phone coaching) and time in DBT (Dexter et al., 2013). Daily diary card ratings are also being collected to examine the trajectory of suicidality, self-harm, and emotion changes in DBT, and preliminary analyses similarly show a quadratic relationship between treatment duration and urges to engage in self-harm, and an overall decrease in self-harm throughout treatment (Brown et al., 2013). Therapists who complete a 2-day training in DBT also experience a significant increase in their ability to think dialectically, which may allow them to teach this skill to their patients (Gaona et al., 2013). These studies are anticipated to provide further support for DBT, as well as to inform methods for enhancing its effectiveness for treatment.

Researchers and developers in the area are also assessing other areas of interest in CBT, including examining the effectiveness of CBT with minority populations (Huey & Polo, 2008), matching evidence-based practices with patient problems (Chorpita et al., 2013), and even developing CBT smartphone apps (Erhardt & Dorian, 2010). Likewise, there are multiple CBT authors, trainers, and delivery organizations in the area. Orange County is home to the authors of *Mind Over Mood* (Greenberger & Padesky, 1995), while both Los Angeles and Orange County host both large and small private practice groups and training centers focused on the delivery of CBTs. All of the above rests on the assumption that practitioners in LA are proficient in the delivery of CBT, but, unfortunately, there are barriers to the widespread training and adoption of CBT in the Los Angeles area.

### Training the Novice Therapist in Southern California

While UCLA and other local university-based doctoral programs favor a CBT orientation, professional schools at both the doctoral and master's level do not. In stark contrast to the mandated CBT training for psychiatry residents (albeit without agreed-upon standards for measuring competency), most master's-level programs in Southern California do not offer a solid foundation in CBT. While there are exceptions and some programs (notably Pepperdine University and UCLA's social work program) do promote CBT, the licensing requirements of the state make learning CBT difficult. For instance, the requirements for the Marriage and Family Therapy (MFT) license are set by the California Board of Behavioral Sciences (BBS) rather than the Board of Psychology. Educational requirements for these programs have recently been updated by the BBS. Applicants for licensure who entered these programs after August 1, 2012, are now required to complete additional units of study in order to remain familiar with the latest and most modern approaches to mental health care. It should be noted that an increased exposure to CBT training is not yet part of this requirement.

The great majority of MFT programs in Southern California do not offer courses specific to cognitive therapies. Regulations for teaching the recovery model, which is consistent with CBT, are in place; however, given that the recovery model is a set of principles rather than an empirically supported psychotherapy, programs are given a lot of latitude about how to apply these principles. Exposure to CBT as a package tends to be limited to brief overviews, usually covered in either theory or process courses. Additionally, while some colleges and universities may list specific CBT course availability in their catalogs, some courses rarely find a place in the actual quarterly/semester schedule. Graduate students in MFT programs wishing to practice cognitive therapies when licensed have also described a culture of academic resistance directed against evidence-based practices such as CBT, despite an increased demand for therapists specializing in CBT-based work. In addition, the limited availability of appropriate clinical practicum sites where a student might experience quality CBT training must also be considered. While it may be safe to assume that California will eventually include CBT competency in its licensing requirements, in the meantime a person wishing to acquire CBT training will need to be extremely careful in the selection of a training program in order to ensure a CBT-friendly curriculum and environment.

### Disseminating CBT Throughout Los Angeles

Although it is possible to work with established clinicians to adopt an alternative theoretical orientation, it can be an uphill battle. Furthermore, if CBT is not valued in the workplace, it may be hard to maintain fidelity. The largest employer in the Los Angeles area of master's-level clinicians is the Los Angeles Department of Mental Health (LADMH). LADMH employs clinicians either in directly operated clinics or through contracts with independently operated clinics that are legal entities of LADMH. Fortunately, LADMH has committed to training the entire clinical workforce in CBT as part of the Affordable Care Act and the Mental Health Services Act.

The Mental Health Services Act has placed emphasis on early identification and treatment for persons affected by a wide range of Axis I and Axis II diagnoses through a program called Prevention and Early Intervention (PEI). PEI in LADMH has made it possible to disseminate various gold-standard treatments that aim to mitigate the long-term consequences of untreated mental health disorders. Among these gold-standard treatments are Parent Child Interaction Training (Bell & Eyberg, 2002), Trauma Focused CBT (TF-CBT; Cohen, Deblinger, Mannarino, & Steer, 2004), Seeking Safety (Najavits, 2002), Prolonged Exposure for PTSD (Foa & Rothbaum, 1998), as well as Group CBT for Depression (Muñoz & Miranda, 1996).

In addition to the manualized treatments noted above, LADMH has elected to roll out CBT to the entire clinical workforce (up to 4,000 clinicians). Currently in its pilot phase, this rollout has paired CBT trainers from Harbor-UCLA Medical Center with LADMH social workers, marital and family therapists, and psychologists.

Trainers involved in the CBT rollout are LADMH-employed psychologists and social workers, all of whom have had extensive experience in both providing and teaching CBT within the LADMH system.

The model for dissemination has relied on both didactic training as well as ongoing consultation. All clinicians began this training by attending a 3-day intensive workshop that emphasized the theoretical underpinnings of the CBT model, traditional Beckian CBT session structure, as well as classic CBT interventional strategies. After completing the training, all clinicians were assigned to weekly consultation calls and asked to demonstrate basic CBT competency. Trainers assess for clinician competency by rating case conceptualizations using the Case Review Rating Scale (CRRS) as well as coding session audio tapes using the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980).

The dissemination of CBT in LADMH is complicated by the fact that the consumers of mental health services, like many individuals seeking services at the community level, present with very complex diagnostic pictures and psychosocial histories. In addition to often being diagnosed with multiple Axis I and Axis II disorders, these individuals are often impoverished and frequently struggle with chronic physical problems, legal problems, and lack of social support or access to other resources. Due to the complexity that these consumers present, it has long been speculated that the use of CBT would be an ineffective means of creating lasting change in mental health outcomes among this population. Clinicians within the LADMH system historically pointed to issues of homelessness, literacy, or diagnostic complications—stating that CBT is too structured of a model to be used with the county population. In order to account for the complexity of these consumers, the LADMH rollout of CBT has emphasized a case conceptualization approach to therapy. Given that the complexity of these consumers' lives oftentimes results in thoughts and behaviors that derail therapy (e.g., homework noncompliance, difficulty adhering to session structure, hesitation to develop a close working relationship with a therapist), clinicians are learning how to conceptualize these in-session behaviors as being a microcosm of larger issues that these clients face.

## CBT and Cultural Competence in Southern California

Given the diverse landscape of cultures in Los Angeles, the implementation of CBT in this rollout (and for CBT in general) must include an emphasis on cultural competence. By far, the largest minority population in Southern California is Latinos. California's population is approximately 38 million: 38% Latino and 27% being foreign born (U.S. Census Bureau, 2012). Additionally, the U.S. Census Bureau (2012) indicated that Southern California has an estimated 24 million residents, with approximately 3.6 million people in LA County whose primary language is Spanish (County of Los Angeles Department of Mental Health, 2008). The rates for psychiatric disorders among U.S.-born Latinos is similar to other U.S. citizens; however, immigrants from Mexico show lower rates (Vega et al., 1998). Providing an evidence-based approach such as CBT in a culturally competent manner to these individuals is essential. Treating monolingual Spanish-speaking clients could be conceptualized as a three-prong approach in which the clinician provides adherent CBT interventions, provides culturally sensitive treatment, and effectively adapts the CBT model to this specific population.

The Latino population has traditionally been underserved and underutilizes mental health services. Therefore, it is important for clinicians to be aware of effective Latino values that could enhance the retention rate and effectiveness of treatment. Latino cultural values that can enhance the therapeutic relationship and effectiveness of *formalismo* (formality), *personalismo* (personalism), *amabilidad* (amability), and *respeto* (respect). Formality suggests the importance of communicating respect and courtesy through the use of Spanish words such as the formal *usted* (you) in place of the familiar *tu* (you). The use of principles of *formalismo* is particularly important when a relationship has not yet been established between the therapist and the patient. *Personalismo* refers to the value of treating people with respect and dignity, and often includes therapeutically appropriate self-disclosure about hobbies, number of children, or other aspects of the therapist's life that have particular cultural meaning. *Amabilidad* refers to the values of amiability, gentility, and civility in the Spanish language (Falicov, 1998).

Organista and Muñoz (1996) suggested these values could be incorporated to adapt the CBT model to treat monolingual Spanish-speaking clients. They describe this as "culturally responsive applications of CBT." For example, *personalismo* could be applied to engage the client through the use of appropriate self-disclosure and *respeto* by formally addressing the client as Mr./Mrs. and the surname. Organista and Muñoz described streamlining cognitive restructuring by teaching clients the difference between helpful versus unhelpful thoughts and using the "yes, but" technique. Other adaptive CBT interventions could be the use of *dichos* (proverbs) as a way to address behavioral activation in depressed clients. For example, the clinician can use the proverb *Poco a poco se anda lejos* (little by little, you go far) as a successive approximation CBT intervention.

Treating monolingual Spanish-speaking clients through a CBT approach has progressed; however, even in a region rich with bilingual clinicians, there are still a limited number of Spanish-speaking CBT practitioners and a limited amount of CBT resources in Spanish. The LADMH dissemination project will help with increasing qualified CBT clinicians. However, in order to become competent CBT therapists treating monolingual Spanish-speaking clients, it is recommended that bilingual clinicians become more effective at delivering culturally competent treatment. Southern California is fortunate to have the annual Latino Behavioral Health Institute (LBHI) conference, where clinicians can increase their levels of cultural competency and the ability to network with other bilingual clinicians through the Cognitive Behavioral Therapy Society of Southern California (CBTSSC).

## CBT and Unemployment in Southern California

CBT is also being adopted in Southern California to enhance employment for individuals with mental health concerns. The California Work Opportunity and Responsibility to Kids (CalWORKS) program began in California in 1997 as a unique, time-limited welfare-to-work program. It was designed to help parents in poverty access education, housing, employment, and career opportunities while receiving medical and financial support from Los Angeles County Department of Public Social Services (LA DPSS). The program also provides services to reduce barriers to employment, including depression, anxiety disorders, anger problems, substance abuse, parenting issues, and family/intimate partner violence (DeLapp, 2001). The CalWORKS

consumers who access mental health services through this partnership are typically ethnically diverse, clinically complex, and presenting to treatment with several psychosocial stressors. These stressors include transportation issues, inconsistent social support and/or child care, limited access to education, and few job opportunities flexible enough to accommodate these various needs. There is also often a need for trauma-focused treatments that address compound traumas in childhood and/or the impact of high exposure to community violence.

The CalWORKS program is unique in that it provides CBT to a diverse population of low-income parents who originally sought financial support and help to return to work, but then were redirected into mental health services after expressing distress in some way (often through a simple face valid clinical checklist). While most therapeutic relationships begin by clarifying the goal of treatment, the overarching goal of the CalWORKS program is very clearly to return participants to school or living-wage employment full-time and off public assistance. The CBT clinician working with CalWORKS participants is faced with several unique variables that require flexibility and understanding beyond the traditional approaches often described in CBT texts and manuals. Clients referred by LA DPSS have unique considerations around confidentiality and privacy, with the ultimate fear being loss of custody of their children if they disclose the nature of their problems to a therapist. This fear can impact the collaborative, transparent quality of an effective therapeutic relationship for the CBT therapist. When the parent referred from a DPSS office is the first person in his or her family to ever receive mental health services, there is significant stigma attached to seeking treatment. The reasons for this may include generations of denial ("There is no problem in our family"), expectations of family privacy ("We don't air our dirty laundry"), or misunderstanding the debilitating nature of mental health problems such as bereavement, anxiety, or depression ("You're just not looking hard enough for a job, you're lazy" or "You must be crazy if you're going there"). There is also the complicating issue of fear of loss of benefits. Often therapy participants perceive engagement in mental health services as a means to an end (e.g., "I have to attend groups and individual therapy to keep my benefits"). This may have the "court-ordered" effect on the therapeutic relationship, resulting in good patient attendance but poor engagement, confusing or vague goals, and eventually, poor clinical outcomes. These considerations can make enrollment and participation in individual therapy and group CBT a challenge, as this process includes socialization to sharing their feelings, mental health symptoms, substance abuse problems, family conflict, and other vulnerable struggles in ways that may not always be encouraged in their home culture or community. Given this complicated clinical picture, the CBT treatment providers for the CalWORKS participants in Los Angeles have to maintain a flexible person-centered approach that maintains the integrity of the CBT frame while taking into consideration these factors.

### Networking in Southern California

As in many major metropolitan areas, CBT in Southern California includes an expansive network of professional contributors. These include researchers, trainers, clinicians, and students from a vast network of hospitals, universities, private practices, and professional programs. The way the entire CBT community in LA and Orange Counties can connect is through the Cognitive Behavioral Therapy Society of Southern California (CBTSSC; www.cbtssc.wordpress.com). Like many of the local CBT organizations, CBTSSC offers an opportunity for local CBT clinicians and researchers to network, exchange information, and socialize. All of the myriad ways that CBT is implemented are represented at our functions. Meetings have resulted in grants, papers, jobs, and even a marriage! This organization allows multi-institution collaboration, and is instrumental in propelling the status of CBT forward in Southern California.

### References


Bell, S. K., & Eyberg. S. M. (2002). Parent-child interaction therapy. In L. VandeCreek, S. Knapp, & T. L. Jackson (Eds.), *Innovations in clinical practice: A source book* (Vol. 20, pp. 57–74). Sarasota, FL: Professional Resource Press.

Berk, M., Adrian, M., McCauley, E., Asarnow, J., Avina, C., & Linehan, M. (2014). Conducting research on adolescent suicide attempters: Dilemmas and decisions. *the Behavior Therapist, 37*, 65-69.

Brown, L. A., Davies, C. D., Lieberman, M., Stevens, S., Cooper, R., & Craske, M. G. (2014). *Affect labeling during script-driven imagery following trauma exposure*. Manuscript in preparation.

Brown, L. A., Forsyth, J., Dour, H. J., Dexter, M., Nehme, J. R., Naman, K., Wickremasinghe, N., & McFarr, L. (2013, November). *Reduced self-harm and negative affect in dialectical behavior therapy: Preliminary analysis of daily diary cards in a community mental health setting*. Poster presented at the meeting of the Association for Behavioral and Cognitive Therapies, Nashville, TN.

Chorpita, B. F., Weisz, J. R., Daleiden, E. L., Schoenwald, S. K., Palinkas, L. A., Miranda, J., . . . Research Network on Youth Mental Health. (2013, August 26). Long-term outcomes for the Child STEPs randomized effectiveness trial: A comparison of modular and standard treatment designs with usual care. *Journal of Consulting and Clinical Psychology*. Advance online publication. doi: 10.1037/a0034200

County of Los Angeles Department of Mental Health. (2008). V*ulnerable communities in Los Angeles County: Key indicators of mental health.* Retrieved from http://file.lacounty.gov/dmh/cms1_159048.pdf

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multi-site, randomized controlled trial for sexually abused children with PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 393-402.

DeLapp, L. (2001). *Connecting different worlds: Mental health, alcohol and drug, and family services in CalWORKS*. California Research Bureau, California State Library.

Dexter, M., Gaona, L., Brown, L. A., Forsyth, J., McFarr, L., Henriquez, S., & Farias, A. (2013, January). *Frequency of therapy interfering behaviors of client population at Harbor-UCLA Medical Center.* Poster presented at the Harbor-UCLA Scientific Sessions in Mental Health, Torrance, CA.

Dour, H. J., & Craske, M. G. (2014). *Positive training for spider fear*. Manuscript in preparation.

Erhardt, D., & Dorian, E. (2010). Going mobile: A case vignette illustrating the integration of mobile technology in psychotherapy. *Bulletin of Psychologists in Independent Practice, A Division of the American Psychological Association, 33*, 15-21. Retrieved from http://www.thriveport.com/resources/downloads/GoingMobileErhardt&Dorian.pdf

Falicov, C. J. (1998). *Latino families in therapy: A guide to multicultural practice*. New York: Guilford Press.

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive behavioral therapy for PTSD*. New York: Guilford Press.

Gaona, L., Jackson, L., Fried, R., Graling, K. B., Dour, H., Brown, L. A., . . . McFarr, L. (2013, November). *Clinicians' self-perception of dialectical thinking: Pre and post DBT training at Harbor UCLA Medical Center.* Poster presented at the meeting of the Association for Behavioral and Cognitive Therapies, Nashville, TN.

Greenberger, D., & Padesky, C. (1995). *Mind over mood: Change how you feel by changing the way you think*. New York: Guilford Press.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change*. New York: Guilford Press.

Kircanski, K., Lieberman, M. D., & Craske, M. G. (2012). Feelings into words: Contributions of language to exposure therapy. *Psychological Science, 23*, 1086-1091.

Huey, S., & Polo, A. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child and Adolescent Psychology, 37*, 262–301.

Linehan, M. M. (1993). *Cognitive behavioral therapy of borderline personality disorder*. New York: Guilford Press.

McCollough, J. P. (2000). *Treatment for chronic depression: Cognitive Behavioral Analysis System of Psychotherapy.* New York: Guilford Press.

Muñoz, R. F., & Miranda, J. (1996). *Group therapy manual for cognitive-behavioral therapy of major depression*. Santa Monica, CA: RAND Corporation.

Najavits, L. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford Press.

Organista, K. C., & Muñoz, R. F. (1996). Cognitive-behavioral therapy with Latinos. *Cognitive and Behavioral Practice, 3*, 255-270.

U.S. Census Bureau. (2012). *State & County Quickfacts: California*. Retrieved February 21, 2014, from http://quickfacts.census.gov

Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., & Caraveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry, 55*, 771-778.

Young, J., & Beck, A. T. (1980). *Cognitive Therapy Scale rating manual*. Beck Institute for Cognitive Behavior Therapy. Retrieved from http://www.beckinstitute.org/cognitive-therapy-rating-scale.

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*Technology Update*

# A Primer on Internet Interventions for Child Anxiety

**Muniya S. Khanna,** ***The Children's and Adult Center for OCD & Anxiety***

Tremendous progress has been made over the past few decades in the identification and treatment of mental health disorders. Cognitive behavioral therapy (CBT) has been identified as effective for a range of conditions for both adults and youth (Hollon & Beck, 2013). Despite the advances in treatment, there remains a high rate of unmet need (U.S. Department of Health and Human Services, 2012). With over 57 million Americans per year in need of services, face-to-face individual psychotherapy as the dominant model of treatment delivery is not likely to be able to meet this need, and supply of practitioners adequately trained in empirically supported treatments is unlikely to ever catch up. New modalities and levels of care must be considered in order to meet this need, including the utilization of technology (see Kazdin & Blase, 2011).

We are amidst a growing interest, at the global level, in the development of mental health practice supported by technology and electronic communication (see Myers & Turvey, 2013). Efficiency, accessibility, affordability, and a high standard of consistency are among the potential advantages of computer-based approaches (Marks, Cavanagh, Gega, 2007; Myers & Turvey; Ritterband et al., 2006). The Internet and cloud-based services are reducing disparities in access to information both nationally and internationally and it has the potential to do so with evidence-based treatments.

Currently, there are three dominant types of technologies being used for delivery of mental health services: (a) computer or Internet delivery, (b) videoteleconferencing (VTC), and (c) mobile app delivery. Telehealth, e-health, mhealth, or telemental health are umbrella terms used to describe delivery of health or mental-health-related services via any telecommunications and/or computer technology including phone, smartphone (e.g., alerts, monitoring tools), and internet. Computer-based treatment or Internet-based treatment typically refers to standalone treatments that are distributed and completed online or on the computer via DVD or downloadable content. These are akin to self-help programs, where the patient interacts with (or reads from) the program with no support, or minimal support from a professional. Telemental health, E-therapy, or teletherapy typically refers to treatment being provided directly in real-time by a mental health professional through an online VTC platform such as Skype, Webex, or GoToMeeting. There are also several computer-assisted or Internet-assisted treatments that are programs designed to buttress face-to-face treatment with computer-presented interactive content. Mobile health or mhealth apps are health management software applications designed to run on smartphones, tablets, and other mobile devices. Mental health mobile apps typically serve to provide a platform for real-time symptom assessment/monitoring, psychoeducation, strategy reminders and alerts, and tracking of progress.

## Computer-Based Cognitive Behavioral Therapy (cCBT) for Adult Anxiety

Evidence supports the use of computer-based cognitive-behavioral treatments (cCBTs) in the treatment of a wide range of psychiatric conditions in adults (see Andersson, 2010; Griffiths & Christensen, 2007, for review). In addition to demonstrating symptom reduction, preliminary findings (e.g., Proudfoot, 2004) suggest that cCBT programs are acceptable, with patient satisfaction with the computer-based treatment significantly higher than with treatment as usual.

cCBTs for anxiety disorders in adults are among the most well-studied and empirically supported computer-based interventions. In 2011, the UK National Institute for Clinical Effectiveness (NICE) deemed cCBT, specifically the FearFighter (ST Solutions Ltd.; Marks et al., 2004; McCrone et al., 2004) program, safe and acceptable therapeutic option as part of stepped care for the management of panic disorder, with or without agoraphobia, and GAD in adults in primary, secondary, and community care (NICE, 2011). Computer-based approaches may be particularly beneficial for the treatment of anxiety because they can present both still and video images of feared stimuli in hierarchies, and offer a medium by which exposure to feared situations can occur in a controlled manner (Lack & Storch, 2008).

## cCBT for Child Anxiety

There have been several exciting advances in cCBT for youth anxiety over the last 10 years (Cunningham et al., 2009; Khanna & Kendall, 2010; March, Spence, & Donovan, 2009; Spence et al., 2011; for review see Donovan & March, in press). Spence and colleagues (2006) reported the feasibility of CBT delivered partially via the Internet (a group format for youth ages 7 to 14). They also reported that the Internet-assisted program (8 of 16 sessions delivered via the Internet) and a traditional group CBT both resulted in significantly greater reductions in anxiety symptoms compared to a waitlist (WL). The Internet-assisted treatment was acceptable to families, with minimal dropout and a high level of compliance.

March et al. (2009) evaluated BRAVE, an Internet-based treatment (minimal therapist contact via phone/email) in anxious children (aged 7 to 13). Children receiving BRAVE, compared to WL, showed small posttreatment reductions in anxiety and increases in functioning. A third study involved the development of the BRAVE-ONLINE Internet intervention for adolescents (ages 12 to 17 years). In this study, Spence and colleagues (2011) found that adolescents receiving BRAVE-ONLINE demonstrated similar improvements in anxiety symptoms and loss of diagnosis compared to adolescents receiving individual, face-to-face therapy, with almost 80% being free of their primary anxiety disorder diagnosis 12 months following the completion of the program.

Camp Cope-A-Lot (CCAL; Kendall & Khanna, 2008; Khanna & Kendall, 2010) is a computer-assisted intervention for anxious children ages 7 to 13. CCAL combines evidence-based CBT with state-of-the-art interactive computer technology. The program is based on the Coping Cat program (Kendall & Hedtke, 2006), a CBT that has been found to be effective for the treatment of anxiety in youth (e.g., Kendall et al., 2008; Walkup et al., 2008; see also review in Hollon & Beck, 2013). CCAL uses computer flash animation, audio, 2D animations, photographs, videos, schematics, a built-in reward system, self-check system,

written text and a fun cartoon character, "Charlie," to guide the user through the program. Youth complete one 30- to 40-minute level each week for 12 weeks.

In one research evaluation, Khanna and Kendall (2010) compared CCAL to CBT and to a computer-assisted education/support/attention condition (CESA). Participants were 49 children (33 males; ages 7 to 12) who met criteria for an anxiety disorder. Therapists ($N=16$) were volunteers from school districts and Ph.D. and Psy.D. training programs with no previous training or experience in CBT for child anxiety. Findings indicated that CCAL was acceptable to children and to parents, feasible for implementation by treatment providers with no specialty CBT training, and efficacious for anxiety symptom reduction. It is worth noting that the degree of improvement produced by CCAL was consistent with the amount of improvement reported in previous studies of face-to-face (not computer-assisted) delivery that employed trained CBT therapists supervised by CBT experts. Also important, and in contrast to concerns voiced about computer-based interventions, the therapeutic alliance did not suffer: there were no significant differences in the child-therapist alliance between the conditions with a fully face-to-face therapist and the computer-assisted program with a coach.

Currently, there are several funded and ongoing investigations examining CCAL and its feasibility and effectiveness in community settings. For example, an effectiveness trial being conducted by Storch and colleagues is evaluating the CCAL in community mental health centers in the state of Florida. Thus far, the open trial phase has been completed with promising results (Crawford et al., 2013) and the randomized control trial has begun. In the pilot study, 17 youth, ages 7 to 13 years, diagnosed with a primary anxiety disorder, were enrolled at three community mental health centers across Florida. All children received cCBT as delivered by therapists with limited CBT experience. Significant reductions in anxiety severity and impairment were demonstrated at the posttreatment assessment. High levels of family satisfaction were reported. Additionally, children, parents, therapists, and administrators found the program to be an acceptable form of treatment (Salloum, Crawford, Lewin, & Storch, 2013). These results provide preliminary support for the effectiveness of a computer-assisted treatment in community mental health centers, and replication in a controlled setting is currently under way.

CCAL has also been used and found to provide benefit in other samples struggling with anxiety. For example, a recent study by Blocher and colleagues (2013) found that CCAL significantly reduced symptoms of anxiety and depression in youth with epilepsy and anxiety disorders following the intervention and at 3-month follow-up.

### VTC for Child Anxiety

VTC methods help overcome geographical obstacles to care and extend the availability of expert services (see Flaum, 2013; Kazdin & Blase, 2011). Families in rural or other underserved regions can participate in real-time treatment conducted by experts, regardless of their geographic proximity to an expert facility. Moreover, delivering the interventions directly to families in their natural settings may extend the ecological validity of treatments, as services can be delivered in the very context in which the symptoms may likely occur.

Evidence is accumulating on the effectiveness of VTC for childhood anxiety and related disorders. Himle and colleagues (2010) evaluated VTC-delivered Habit Reversal Training (HRT) for 3 children with Tourette's syndrome using a multiple-baseline across participants design. Similar to results from randomized controlled trials studying face-to-face delivered HRT, VTC-delivered HRT was effective for reducing tics. All three children demonstrated significant tic reduction following videoconference HRT delivery. All participants and their families rated the delivery modality as acceptable and the therapeutic relationship as strong.

Storch and colleagues (2011) conducted a WL controlled randomized trial of family-based VTC-delivered CBT with exposure and response prevention (EX/RP) for children and adolescents with OCD. Thirty-one youth with OCD (7 to 16 years) were randomly assigned to VTC or a WL. When controlling for baseline group differences, VTC was superior to the WL on all primary outcome measures and gains were generally maintained in a naturalistic 3-month follow-up for those randomized to VTC.

Comer and colleagues (2014) evaluated VTC-delivered family-based EX/RP treatment for OCD in very young children (4 to 8 years) directly to families in their homes. Participants in the preliminary case series included 5 children who all showed OCD symptom improvements and global severity improvements from pre- to posttreatment, showed at least partial diagnostic response, and 60% no longer met diagnostic criteria for OCD at posttreatment. No participants got worse, and all mothers characterized the quality of services received as "excellent."

### Internet-Based Parent-Training for Child Anxiety

Previous trials have found video-based self-help parent-training programs to be effective (e.g., Parent Effectiveness Training, see Cedar & Levant, 1990; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). Computer-based programs offer an alternate, equally accessible, equally private and convenient, and engaging resource for parents who would like to learn more about their child's difficulties and help their child better manage anxiety (Spence et al., 2006). Giving concerned parents access to web-based information may promote attention to and initiation of empirically supported treatments for youth who are in need (Kenardy, McCafferty, & Rosa, 2003). An online format transportable to work and home settings has 24-hour access and anonymity and thus may facilitate parent involvement (Bogels & Phares, 2008).

There are several Internet-based resources emerging for parents of anxious youth. The Anxiety Disorders Association of British Columbia has developed a free online resource for parents and teens at www.anxietybc.com. Another project is under way from the developers of the BRAVE programs evaluating a parent-only Internet-based CBT intervention for preschool anxiety (Donovan & March, in preparation).

A NIMH-funded project is also under way to develop and evaluate the Child Anxiety Tales program (Kendall & Khanna, 2014), an evidence-based online parent-training program to offer parents an accessible, affordable, confidential, convenient, and reliable resource from which to learn about anxiety and the empirically supported strategies to help their child develop coping skills. Child Anxiety Tales, available from www.copingcatparents.com, is a 10-module web-based program that illustrates the principles of CBT for anxiety management and guides parents to encourage approach while providing step-by-step instructions on planning opportunities for in vivo exposure or real-world practice. Preliminary findings are promising (Carper,

Khanna, & Kendall, 2013; Khanna et al., in preparation) and indicate that the web-based parent training modality is acceptable and feasible. Like other computer programs for mental health, web-based programs for parents may ease access to care (New Freedom Commission on Mental Health, 2003).

### Mobile Apps for Child Anxiety

Smartphone applications (apps) for mental health function in a variety of ways, including symptom assessment, psychoeducation, and tracking of treatment progress. The mobile platform has potential to improve CBT efficacy by allowing "ecological momentary assessments" (EMAs) or "ecological momentary intervention" (EMI) to patients to support learning and practicing CBT skills in real time. At present, the majority of available mental health apps are designed for adults. For example, PTSD-Coach (U.S. Department of Veterans Affairs, 2011) is an app developed by the VA's National Center for PTSD and the Department of Defense's National Center for Telehealth and Technology that provides users with information about PTSD, tools for tracking symptoms, and skills to manage PTSD symptoms (Kuehn, 2011).

Apps for childhood anxiety, relaxation, mood monitoring, pain management, and other uses have also been developed. For example, Mayo Clinic Anxiety Coach (Mayo Clinic, 2012) is a self-help iPhone app for adults and children designed to encourage engagement in exposure tasks, provide support during exposure tasks, provide information about anxiety, assess symptoms in real time, and provide easily accessible communication with therapists. These functions are ultimately aimed at improving outcomes through support outside of session. A smartphone app has been developed for the Coping Cat program called Smart-CAT (Pramana et al., 2014). The app cues youth to use CBT skills taught in sessions and has an online portal that allows therapists to monitor skill use, to send cues and treatment-related materials, to engage youth in real time via secure messages, and to manage rewards, with real-time bidirectional exchange. A pilot study found the program to be feasible and acceptable by both therapists and youth patients. The Anxiety Disorders Association of British Columbia, in collaboration with the British Columbia Mental Health & Addiction Services, has also developed a free mobile app called Mindshift (http://www.anxietybc.com/mobile-app). Designed for teens and young adults, this app provides tools to support coping with anxiety, including relaxation and cognitive restructuring tools.

The growing number of studies evaluating the feasibility and efficacy of computerized treatments for child anxiety support the promise of these treatments and underscore their place in the diverse milieu of mental health care offerings. The rapid, dramatic technological advances of the past decade will likely be matched, if not surpassed, in the decades ahead. Regardless of how we might feel about Internet-based interventions for mental health, telemental health and Internet interventions are here, and they are here to stay. From a public health perspective, there is substantial potential in interventions utilizing technology to improve the mental health of children and families who suffer from mental disorders and related emotional problems but who are unable to access services (Scogin, 2003).

However, several questions remain on when, where, and for whom the use of these technologies are indicated or counterindicated for the diverse range of youth and providers they are designed to assist. Computerized treatments merit large-scale, well-controlled trials with active control groups such as treatment as usual in community settings. Such work will be critical to determining whether or not there is empirical support for these treatments and therein to establishing their efficacy and effectiveness. Further, though a dialogue about how to secure confidentiality and privacy through encryption techniques has begun, a consensus has yet to be reached regarding how computerized interventions can be best integrated and supported in the current mental health care system (Kramer et al., 2013; Schwartz & Lonborg, 2011; Yuen et al., 2012). The continued development of regulatory, ethical, financial, and legal standards pertinent to the delivery of technologically enhanced psychological treatments will be critical for the widespread adoption of these treatments (Comer et al., 2014).

### References


Andersson, G. (2010). The promise and pitfalls of the internet for cognitive behavioral therapy. *BMC Medicine, 8*, 82.

Blocher, J.B., Fujikawa, M., Sung, C., Jackson, D.C., & Jones, J.E. (2013). Computer-assisted cognitive behavioral therapy for children with epilepsy and anxiety: A pilot study. *Epilepsy & Behavior, 27*, 70-76.

Bogels, S., & Phares V. (2008). Fathers' role in the etiology, prevention, and treatment of child anxiety: A review and new model. *Clinical Psychology Review, 28*, 539-558.

Carper, M.M., Khanna, M.S., & Kendall, P.C. (2013). *Efficacy of a web-based parent training program for parents concerned about their child's anxiety: Child Anxiety Tales*. Symposium conducted at the 47th annual convention for the Association for Behavioral and Cognitive Therapies, Nashville, TN.

Cedar, B., & Levant, R.F. (1990). A meta-analysis of the effects of parent effectiveness training. *The American Journal of Family Therapy, 18*(4), 373.

Comer, J.S., Furr, J.M., Cooper-Vince, C.E., Kerns, C.E., Chan, P.T., Edson, A.L., . . . Freeman, J.B. (2014). Internet-delivered, family-based treatment for early-onset OCD: A preliminary case series. *Journal of Consulting & Clinical Psychology, 43*(1), 74-87.

Crawford, E.A., Salloum, A., Lewin, A.B., Andel, R., Murphy, T.K., & Storch, E.A. (2013). A pilot study of computer-assisted cognitive-behavioral therapy for childhood anxiety in community mental health centers. *Journal of Cognitive Psychotherapy, 27*(3), 221-234.

Cunningham, M., Wuthrich, V., Rapee, R., Lyneham, H.L., Schniering, C.A., & Hudson, J.L. (2009). The Cool Teens CD-ROM for anxiety disorders in adolescents. *European Child and Adolescent Psychiatry, 18*(2), 125-129.

Donovan, C.L., & March, S. (in press). Computer-based treatment programs for youth anxiety: A systematic review. *Psychopathology Review.*

Donovan, C. L., & March, S. (in preparation). *A randomized controlled trial of a parent-only, internet-based CBT intervention for preschool anxiety*. Manuscript in preparation.

Flaum, M. (2013). Telemental health as a solution to the widening gap between supply and demand for mental health services. In K. Myers & C.L. Turvey (Eds.), *Telemental health: Clinical, technical, and administrative foundations for evidence-based practice* (pp. 11-25). New York: Elsevier.

Griffiths, K. M., & Christensen, H. (2007). Internet-based mental health programs: A powerful tool in the rural medical kit. *Australian Journal of Rural Health, 15*, 81-87.

Himle, M.B., Olufs, E., Himle, J.A., Tucker, B.T.P., & Woods, D.W. (2010). Behavior therapy for tics via videoconference delivery: An initial pilot test in children. *Cognitive and Behavioral Practice, 17*, 329-337.

Hollon, S. D., & Beck, A. T. (2013). Cognitive and cognitive-behavioral therapies. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (6th ed., pp. 393–442). Hoboken, NJ: John Wiley & Sons.

Kazdin, A.E., & Blase, S.L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science, 6*, 21-37.

Kenardy, J., McCafferty, K., & Rosa, V. (2003). Internet-delivered indicated prevention for anxiety disorders: A randomized controlled trial. *Behavioural and Cognitive Psychotherapy, 31*, 279−289.

Kendall, P.C., & Hedtke, K. (2006). *Cognitive-behavioral therapy for anxious children: Therapist manual* (3rd ed.). Ardmore, PA: Workbook Publishing. www.WorkbookPublishing.com.

Kendall, P. C., Hudson, J., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disordered youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology, 76,* 282-297.

Kendall, P.C., & Khanna, M.S. (2014). *Child Anxiety Tales*©. Workbook Publishing. Retrieved: http://www.copingcatparents.com/Child_Anxiety_Tales

Kendall, P.C. & Khanna, M.S. (2008). *Camp Cope-A-Lot: The Coping Cat DVD* [DVD] Ardmore, PA: Workbook Publishing.

Khanna, M., Carper, M.M., Harris, M.S. & Kendall, P.C. (in prep). *Web-based parent-training for parents of youth with impairment from anxiety.*

Khanna, M., & Kendall, P.C. (2010). Computer-assisted cognitive behavioral therapy for child anxiety: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 78*, 737–745.

Kramer, G. M., Mishkind, M. C., Luxton, D. D., & Shore, J. H. (2013). Managing risk and protecting privacy in telemental health: An overview of legal, regulatory, and risk-management issues. In K. Myers & C.L. Turvey (Eds.), *Telemental health: Clinical, technical, and administrative foundations for evidence-based practice*. New York: Elsevier.

Kuehn, B. M. (2011). Health agencies update. *Journal of the American Medical Association, 306*, 815.

Lack, C.W., & Storch, E.A. (2008).The use of computers in the assessment and treatment of obsessive-compulsive disorder. *Computers & Human Behavior, 24*, 917–29.

March, S., Spence. S.H., Donovan, C.L. (2009). The efficacy of an internet-based cognitive-behavioral therapy intervention for child anxiety disorders. *Journal of Pediatric Psychology, 34*, 474-487.

Marks, I.M., Cavanagh, K., & Gega, L. (2007). *Hands-on help: Computer-aided psychotherapy* (Vol. 49). New York: Psychology Press.

Marks, I. M., Kenwright, M., McDonough, M., Whittaker, M., & Mataix Cols, D. (2004). Saving clinicians' time by delegating routine aspects of therapy to a computer: A randomized controlled trial in phobia/panic disorder. *Psychological Medicine, 34*, 9−17.

Mayo Clinic. (2012). *Anxiety Coach*. Retrieved from https://itunes.apple.com/us/app/anxietycoach/id565943257?mt=8

McCrone, P., Knapp, M., Proudfoot, J., Ryden, C., Cavanagh, K., Shapiro, D.A., . . . Tylee, A. (2004). Cost-effectiveness of computerized cognitive-behavioral therapy for anxiety and depression in primary care: Randomized controlled trial. *British Journal of Psychiatry, 185*, 55-62

Myers, K., & Turvey, C.L. (Eds.). (2013). *Telemental health: Clinical, technical, and administrative foundations for evidence-based practice*. Waltham, MA: Elsevier.

National Institute for Clinical Excellence. (2011). *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care*. Retrieved from http://www.nice.org.uk/nicemedia/live/13314/52599/52599.pdf.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health in America, Final Report* [DHHS Publication SMA-03-3832]. Retrieved from http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf

Pramana, G., Bambang-Parmanto, M., Kendall, P. C., & Silk, J. (2014). The SmartCAT: An mHealth platform for Ecological Momentary Intervention (EMI) in child anxiety treatment. *Telemedicine and E-Health, 20*(5). doi:10.1089/tmj.2013.0214.

Proudfoot, J. G. (2004). Computer-based treatment for anxiety and depression: Is it feasible? Is it effective? *Neuroscience and Biobehavioral Reviews, 28,* 353−363.

Ritterband, L.M., Cox, D.J., Gordon, T.L., Borowitz, S.M., Kovatchev, B.P., Walker, L.S., & Sutphen, J.L. (2006). Examining the added value of audio, graphics, and interactivity in an Internet intervention for pediatric encopresis. *Children's Health Care, 35*, 47-59.

Salloum, A., Crawford, E.A., Lewin, A.B., & Storch, E.A. (2013). Consumers and providers perceptions of utilizing a computerized cognitive behavioral therapy for childhood anxiety. *Behavioral and Cognitive Psychotherapy*, 1-11. doi: http://dx.doi.org/10.1017/S1352465813000647

Schwartz, T. J., & Lonborg, S. D. (2011). Security management and telepsychology. *Professional Psychology: Research and Practice, 42*, 419–425.

Scogin, F.R. (2003). Introduction: The status of self-administered treatments. *Journal of Clinical Psychology, 59*(3), 247-249.

Spence, S.H., Holmes, J.M., March, S., & Lipp, O.V. (2006). The feasibility and outcome of clinic plus internet delivery of cognitive-behavior therapy for childhood anxiety. *Journal of Consulting and Clinical Psychology, 74*, 614-621.

Spence, S. H., Donovan, C. L., March, S., Gamble, A., Anderson, R. E., Prosser, S., & Kenardy, J. (2011). A randomized controlled trial of online versus clinic-based CBT for adolescent anxiety. *Journal of Consulting and Clinical Psychology, 79*, 629-642.

Storch, E.A., Caporino, N.E., Morgan, J.R., Lewin, A.B., Rojas, A., Brauer, L., Larson, M.J., & Murphy, T.K. (2011). Preliminary investigation of web-camera delivered cognitive-behavioral therapy for youth with obsessive-compulsive disorder. *Psychiatry Research, 189*, 407-12. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21684018

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2012). *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings* [NSDUH Series H-42, HHS Publication No. (SMA) 11-4667]. Rockville, MD: Substance Abuse and Mental Health Services Administration.

U.S. Department of Veterans Affairs. (2011). *PTSD Coach*. Retrieved from https://itunes.apple.com/us/app/ptsdcoach/id430646302?mt=8

Walkup, J. T., Albano, A. M., Piacentini, J., Birmaher, B., Compton, S. N., Sherrill, J. T., . . . Kendall, P. C. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *New England Journal of Medicine, 359*, 2753–2766.

Webster-Stratton, C., Hollinsworth, T., & Kolpacoff, M. (1989). The long-term effectiveness and clinical significance of three cost-effective training programs for families with conduct-problem children. *Journal of Consulting and Clinical Psychology, 57*(4), 550-553. doi: 10.1037/0022-006X.57.4.550

Yuen, E. K., Goetter, E. M., Herbert, J. D., & Forman, E. M. (2012). Challenges and opportunities in Internet-mediated telemental health. *Professional Psychology: Research and Practice, 43*, 1–8.

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*Past Presidents Series*

# Perspectives From Past Presidents: Resources for Evidence-Based Practice

**Alayna Schreier and David J. Hansen,** ***University of Nebraska–Lincoln***

This brief article is the fourth and final piece in a series that provides recommendations on valuable literature and resources from expert researchers and clinicians: past presidents of the Association for Behavioral and Cognitive Therapies (ABCT). Past presidents were surveyed for their perspective on research articles, theoretical articles, books, websites, and self-help books they would recommend to members of ABCT and readers of *the Behavior Therapist.* The previous articles in this series can be found in the October, January, and February issues of *the Behavior Therapist* (Schreier & Hansen, 2013, 2014a, 2014b). The following suggestions are resources for evidence-based practice, beginning with self-help books and websites and followed by materials that provide information relevant to the field of clinical psychology.

Self-help books based on evidence-based treatments have been developed to provide flexibility in mode of service delivery. Dr. Philip Kendall, president from 1989-1990, recommended *A Guide to Rational Living* (Ellis & Harper, 1975). This book teaches cognitive, emotive, and behavioral skills to change unwanted patterns of thought. Dr. Steven Hollon, president from 1998-1999, recommended *Mind Over Mood* (Greenberger & Padesky, 1995), which teaches cognitive skills to improve mood. This book provides specific worksheets and questionnaires to assess, monitor, and change thoughts and feelings. Similarly, Dr. Rosemery Nelson-Gray identified the self-help book *Thoughts and Feelings* (McKay, Davis, & Fanning, 2011) for use in addressing a multitude of presenting problems. In its fourth edition, this book uses components of CBT and ACT to guide change.

To treat more specific disorders, Dr. Thomas Ollendick, president from 1994-1995, recommended *Coping With Panic* (Clum, 1990), because it is "straightforward yet elegant in its theoretical underpinnings, approach, and clinical utility." Another self-help text, *Feeling Good: The New Mood Therapy* (Burns, 2008), was recommended by three past presidents: Dr. J. Gayle Beck (2004-2005), Dr. Debra Hope (2010-2011), and Dr. Jacqueline Persons (2002-2003). In its fourth edition, this self-help book teaches skills designed to reduce negative emotions and improve self-esteem for individuals seeking treatment for depression. Dr. Anne Marie Albano, ABCT's president from 2007-2008, recommended a treatment for children with challenging behaviors, *Parenting the Strong-Willed Child* (Forehand & Long, 2010). In its third edition, this book describes a 5-week program that teaches parents to use positive reinforcement to manage disruptive behavior, including providing praise and giving effective commands. Each of these self-help texts can each be used independently or in conjunction with a service provider.

The field of psychology has also changed in response to the tremendous opportunities provided by the Internet and web-based resources. Recommendations from past presidents included resources for researchers, therapists, and consumers alike. For both consumers and therapists, Dr. Persons recommended an Australian website for the Centre of Clinical Interventions, which provides free self-help materials (www.cci.health.wa.gov.au/resources/consumers.cfm). Dr. Hollon recommended the website of the Academy of Cognitive Therapy (www.academyofct.org), which features professional development resources and a "Find a Therapist" tool. Dr. Beck recommended a website on research-supported psychological treatments (www.psychologicaltreatments.org) from the Society of Clinical Psychology, Division 12 of the American Psychological Association (APA). Similarly, Dr. Ollendick recommended the website for the Society of Clinical Child and Adolescent Psychology (SCCAP, Division 53) of the APA (www.clinicalchildpsychology.org), because it has "moved the field of evidence-based practice forward." In collaboration with ABCT, SCCAP created an informative website, EffectiveChildTherapy.com, for professionals and parents seeking information about evidence-based treatments for youth. Dr. David Barlow, president from 1978-1979, recommended the website of the Cochrane Collaboration (www.us.cochrane.org), which provides information to help improve health care decisions and lays out the evidence through "their expert reviews on current interventions in our field." Dr. Barlow also recommended the website for the National Institute of Health and Clinical Excellence in the United Kingdom, "the leading and most objective purveyor of clinical practice guidelines in the world" (www.nice.org.uk). Finally, Drs. Hope and Nelson-Gray directed readers to the ABCT website (www.abct.org). The ABCT website provides a variety of valuable resources, including fact sheets and information related to various clinical problems and treatments, links to resources on evidence-based treatments, as well as a growing list of self-help books that have received the ABCT Self-Help Book Recommendation.

As we close the series, there were a few additional recommendations that offer valuable background to the field and connect to the practice of clinical psychology. Routh's (1994) *Clinical Psychology Since 1917: Science, Practice, and Organization* provides a thorough overview of the history of clinical psychology, with a focus on the development of organizations and leaders within the field. Recommended by Dr. Beck, this book describes a detailed chronology of the various divisions, sections, and specialties of clinical psychology within professional organizations. A section on "Issues and Personalities" focuses on research and scholarly activities related to assessment and intervention.

Dr. Hope recommended an article written by Dr. Gerald Davison, president from 1973-1974, which she described as a "wonderful example of how a leading scientist can make an informed statement on an important social issue." Nearly 40 years ago, in an article titled "Homosexuality: The Ethical Challenge," Davison (1976) suggested that the field of behavior therapy was not fully appreciating the ethical and societal implications of clinical practice. He stated, "even if we *could* effect certain {behavior} change, there is still the more important question of whether we *should*" (p.162).

Dr. Ollendick recommended an article by Bandura (1982) that also focused on a broader understanding of psychological practice, through a discussion of the role of psychology in appreciating the importance of chance encounters in daily life. Dr. Ollendick stated that this article had a sig-

nificant impact on him, noting that "much of what unfolds for us is due to chance encounters; however, we remain active agents of change reflecting the underlying principle of 'reciprocal determinism.'"

Finally, Dr. Beck recommended an article providing future direction for the field of clinical psychology. Biglan, Flay, Embry, and Sandler (2012) propose a public health movement that could be used to prevent the development of many mental, emotional, and behavioral disorders. The article identifies nurturing environments as key to fostering healthy development, as these environments minimize exposure to risk factors and opportunities for problems, promote and reinforce prosocial and self-regulatory behavior, and support psychological flexibility (Biglan et al., 2012). The authors propose a paradigm shift away from a focus on individual problems to an emphasis on prevention through continued integration of research and practice.

Throughout this series, ABCT past presidents have provided their expert recommendations on the history and foundation of behavior therapy, best practices for research design and data analysis, and assessment and evidence-based practice for the continued education of professionals, educators, students, and readers of *the Behavior Therapist*. We have been delighted to benefit from the input of these leading researchers and clinicians in our field and express our appreciation for their participation in this series.

### References


Bandura, A. (1982). The psychology of chance encounters and life paths. *American Psychologist, 37*, 747-755.

Biglan, A., Flay, B. R., Embry, D., & Sandler, I. N. (2012). The critical role of nurturing environments for promoting human well-being. *American Psychologist, 67*, 257-271.

Burns, D. D. (2008). *Feeling good: The new mood therapy*. New York, NY: William Morrow and Company.

Clum, G. (1990). *Coping with panic: A drug-free approach to dealing with anxiety attacks*. Pacific Grove, CA: Brooks/Cole.

Davison, G. C. (1976). Homosexuality: The ethical challenge. *Journal of Consulting and Clinical Psychology, 44*, 157-162.

Ellis, A., & Harper, R. A. (1975). *A guide to rational living*. Englewood Cliffs, NJ: Prentice-Hall.

Forehand, R., & Long, N. (2010). *Parenting the strong-willed child* (3rd ed.). New York, NY: McGraw-Hill.

Greenberger, D., & Padesky, C. A. (1995). *Mind over mood*. New York, NY: Guilford Press.

McKay, M., Davis, M., & Fanning, P. (2011). *Thoughts & feelings* (4th ed.). Oakland, CA: New Harbinger.

Routh, D. K. (1994). *Clinical psychology since 1917: Science, practice, and organization*. New York, NY: Plenum Press.

Schreier, A., & Hansen, D. J. (2013). Perspectives from past presidents: Foundations of behaviorism and studying behavior change. *the Behavior Therapist, 36*, 184-185.

Schreier, A., & Hansen, D. J. (2014a). Perspectives from past presidents: Research design and data analysis. *the Behavior Therapist, 37*, 18-19.

Schreier, A., & Hansen, D. J. (2014b). Perspectives from past presidents: Assessment and evidence-based practice. *the Behavior Therapist, 37*, 45-46.


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*The Lighter Side*

# CBTers Assemble! Episode Next: "This Ain't No Disco"[1]


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**Dean McKay,** ***Fordham University***


The realm of clinical interventions with superheroes is ever evolving, like any new subspecialty. Bluntly, however, the learning curve with this population turns out to be even steeper than your uncannily experienced Cognitive Behavioral Therapy/Action Team (CBT/AT) could have prognosticated. But disheartened in the slightest are we? 'Course not! We've endured years of education and training to work in a profession whose entire existence is predicated upon an unremitting supply of overachieving naïfs willing to assiduously toil under the most fiendishly parsimonious intermittent reinforcement schedule ever conceived outside of Las Vegas. Consequently, our drive to expand the purview of CBT regardless of rational contingencies is now virtually invulnerable to extinction. (Also see: cognitive dissonance, identification with the aggressor, and Stockholm syndrome).

But without further ado bringing you up to speed, dear readers, the gist of erudition we've gained the hard way from Episode First (Hoffman & McKay, 2014) up to time present is summarized thusly:

1. Available data suggest that therapeutic groups combining superheroes with typical subjects may work better in theory than in actuality. As you no doubt recall, our team speculated that the group modality would be advantageous in acclimating those of the superhero persuasion to the process therapeutae. Unfortunately, our scrupulously modeled notion that these demographics would synergize toward mutually positive outcomes proved Panglossian to the extreme, as the real-world result more closely resembled unfettered nuclear fis-

[1]Dear reader—as you peruse this article, you may ask yourself, "Where is my beautiful newsletter?" Well, in the words of one of our superhero clients, "There's a party in my mind, and I hope it never stops. There's a party up there all the time, and they'll party until they drop." Okay, I may have given it away that this was from our narcissistic iron-clad scientist, who was a bit of a David Byrne fan. This is the second in our series of "fan-person" inspired portrayals of CBT in the superhero realm. Accordingly, the material presented herein may be somewhat murky for those who have not kept up with the latest offerings from Marvel Studios or other Hollywood renderings of emotional reactions and psychopathology in individuals endowed with superhuman powers. Inquiries may be directed to either author.

sion than kumbaya. In the very first group, C.K., a bespectacled mild-mannered reporter, was encouraged to practice assertive communication in a role-play with the orange-hued ubermesomorph introduced in our prior missive. However, no sooner did he utter his first barely audible "I-statement" than said behemoth rendered him unconscious by poking him in the forehead with one of his ginormous digits. This socially maladaptive response was inadvertently reinforced when the intern facilitating the group shrieked rather unprofessionally and fled the scene. Lacking professional stewardship, the group quickly degenerated into a free-for-all, with the powertypicals, whose numbers included an older new wave musician in an oversized white suit just looking to make some sense of the goings-on, decidedly disadvantaged in the ensuing scrum involving the assortment of gigantors, shape-shifters, and teleports, that we had convened in accordance with our highest aspirational principals regarding inclusivity. Strangely, the one group member who seemed disengaged from the tussle was our latest enrollee, a certain Dr. Banner. . . . More about this to follow.

2. Clinical work with superheroes presents a plethora of risk-management challenges that, in retrospect, we may have underestimated a tad. Chief among our concerns, it must be said, lies in the intern selection process. The vulnerability inherent in neophyte clinicians who are insufficiently indoctrinated into the traditional omerta regarding the essential importance of safeguarding the interests of senior faculty and staff cannot be overstated. Sadly, the aforementioned intern did not adhere to the time-honored principal of "what happens in your training program stays in your training program."[2] Suffice to say the authorities that be were not amused. They actually castigated the leadership of the CBT/AT for "failure to adequately supervise." What audacity! Naturally, we opted not to lower ourselves by contesting this egregious and scurrilous allegation, choosing instead the higher road of consenting to a totally superfluous refresher course in basic supervisory responsibilities. Really, we ask you, dear reader, are we our intern's keeper?

3. Although indisputably well established as an empirically based superhero treatment (EST) for diverse other clinical entities, exposure-based therapy may not be efficacious for many superheroes. In general, they neither habituate nor exhibit any willingness to tolerate internal discomfort or inhibit avoidance strategies, to wit they are ready and able to annihilate anyone or anything that opposes them. Moreover, superheroes appear confoundingly difficult to incentivize, as they tend to have complete on-demand access to the full gamut of reinforcers available in the known universe, or if not, have ready access to an ultrabeing or interdimensional portal that does.[3]

4. When it comes to their value systems, superheroes present as a highly heterogeneous population. While some publicly vaunt sublimating their vast abilities to the admittedly dubious higher purpose of serving mankind, in private it's often a very different story, one of massive entitlement and annoyingly ironic commentary and bad puns. Others in this cohort—like a certain exphysicist transmuted into a blue quantum entity after a bad experience with an Intrinsic Field Subtractor (Moore, 1986-1987)—affect a postmodern insouciance that belies their competing affective and physiological urges, i.e. they simultaneously advocate loving and protecting Earthlings and yet are eminently capable of abandoning them, at least temporarily, to the cruel tutelage of Supervillains.[4] (To gain further knowledge about this subject, the CBT/AT has been conducting a groundbreaking study involving undergraduates rating superhero- and supervillain-relevant clinical narratives, a sure-fire publication if ever there was one.)

But we digress. Enter Dr. Bruce Banner, who arrived in our reception room as prosaically as S. had flamboyantly a week earlier. When retrieved by the unwitting, er, closely overseen, intern who was charged with conducting the initial intake measures, he was seated unassumingly at the far corner of our waiting area leafing through some back issues of *Iron Man Magazine*. Wearing off-the-rack jeans, a mismatched short-sleeved unbuttoned button-down under a corduroy sports jacket capped off by a pair of scuffed Penny Loafers and a notably diffident facial expression, it required enormous suspension of disbelief to remain cognizant that his normcore facade harbored a humongous ire-triggered atavism possessed of both incalculable physical strength and infinitesimal perspicacity. We knew we were in for a wild ride right from the start of the interview. When asked what brought him to the CBT/AT, his first utterance was "I can't seem to face up to the facts. I'm tense and nervous, and I can't relax." He then went on to note, "I found myself living in a shotgun shack, in another part of the world. I blacked out again, only to wake and find myself behind the wheel of a large automobile. Then I ended up here." This put our intrepid intern on high alert, thinking he was about to refer to himself as aggressive, possibly a "psychokiller, qu'est-ce que c'est," maybe even a bilingual gallophile one at that, but he stopped short of such a confession. Upon questioning, Dr. Banner reported "not quite feeling myself lately" and

[2] We lose one intern every 2 years or so due to unexpected outbursts. We have yet to develop an interview method that will screen out those with weak constitutions who might fall prey to these kinds of otherworldly in-session traumas. Interestingly, last we heard the intern who shrieked and bolted in this session now practices primal scream therapy in a posh practice catering to politicians and movie stars.

[3] Behaviorists have studied at least one case of extreme pain desensitization in an individual known to be a superhero, but who lacks actual superpowers (Romita & Lee, 1974). It is not clear, therefore, that the learning histories of our client sample simply have not capacity to experience contingencies as we would expect, or if they simply have extremely atypical learning histories creating contingencies that CBT/AT lacks technology to fully address.

[4] We use the term Supervillain not to be judgmental or demean a group of superpowered beings, but because this group often uses the label as a self-identifier. Indeed, the CBT/AT attempts, however often in vain, to remain objective about the intents and aims of our clientele. For example, we did try to treat one masked and caped superpowered scientist, who had body dysmorphic problems, for his rage reactions directed at four individuals-turned-fantastically endowed. His grievance? That they were responsible for a single minor scar on his face that he felt compelled to disguise with a metallic face plate. Yeah, nobody would notice him in that get-up! Needless to say that when he retreated back to his Latverian lair we knew we had to list him, at least for now, as a treatment failure (Kirby & Lee, 1966).

a vague apprehension that "I might lose control." He said he was referred by a surfer he met "at the beach," but declined to discuss this in more detail. He did not admit to having ever turned into an enormously impulsive insentient green wrecking machine when marginally provoked. When asked if he would be willing to attend a group where he would have the opportunity to express his emotions in a supportive setting amongst an array of powertypical and superpowered peers, he readily agreed. This is how he came to attend the group alluded to above, and you know the rest. Oddly, he has not called to reschedule nor responded to our good-faith attempts to contact him. We wonder if Dr. Banner is truly motivated for treatment. Bye the bye, we have not had any further communication from S. or The Watcher. Yet, we continue to be virtually deluged by superhero referrals. This even ahead of the much-anticipated publication of our sure-to-be-classic textbook *A Comprehensive Guide to Case Conceptualization and Interventions for Superheroes* by a most distinguished purveyor of behavioral health resources, not to mention high-quality mahjong sets. Does writing this book seem a bit presumptuous? Thus far our direct clinical experience with this population has been limited to what we've gleaned from supervising the interns (i.e., the ones who stayed for the whole program) who have actually had to spend time with these vexing personages and generalizing from data from research exclusively mined from college students. (Oh, you perhaps thought that we would deign to squander our valuable time in direct services when we could be off on a junket, uh, we mean to say learned international gathering of scholarly thought leaders? No, instead, we have been interviewed by the usual media Talking Heads). Premature or not, we reckoned it was essential to get the word out so that other CBT practitioners could address the complex problems confronting these superbeings, in the extremely high probability event that the CBT/AT is completely booked. Not only that, by disseminating our methods widely, we can also begin to identify methods for treating the aforementioned "supervillains," a group that so far has proven completely refractory to interventions. Indeed, they are all too accepting of their thought and more than willing to act congruently toward their "best lives," which turn out to be ones dedicated to creating mayhem and extensive corporeal and property damage, especially to innocent bystanders.

### Ongoing Case Formulation

While we await the inevitable return of Dr. Banner—after all, who but the senior members of the CBT/AT have the requisite expertise to help him—our team has tentatively developed some working hypotheses. Examining the observable behaviors, what do we know? For one thing, based upon his response style during the first interview and his transparent exploitation of the earlier described melee as a pretext to flee services from our center of excellence, it's clear that Dr. Banner is experiencing ambivalence about addressing the myriad issues posed by his vacillating ability to effectively contain his jade-tinted demon alter ego. S. expressed heartfelt concern about Dr. Banner's plight, but let's surmise that "superfriend" and conventional connotations of the word "friend" per se might not be equivalent. In fact, contextualized in the superhero zeitgeist, "friend" might actually mean "sucker I wish to set up for a fall," not unlike a gunslinger calling some poor cowpoke "friend" just prior to plugging him in one of the old Western films. Hence, a superfriend in need is an enemy indeed. Follow? Ergo, we must conclude that Dr. Banner was being set up by S. for some reason, and that Dr. Banner only surfaced in our office because he was under some as-of-yet-unknown duress to show up. Game, set, and match, CBT/AT, *n'est ce pas?* Even had we suspected he would flee, our past experience in adapting motivational interviewing to clients such as Dr. Banner has been of limited success. I mean, honestly, how can you build ambivalence in a group that is completely unfamiliar with this phenomenology? So there it is, a solid and overarching clinical picture derived from an objectively mindful functional analysis, all set up on a platter and clear as new crystal for one very lucky intern to capitalize upon in furthering the treatment plan, provided we can reverse the proposed de-credentialing of our training program, of course.

### Episode More

Are you talking heads clamoring for supplementary and once-in-a-lifetime material from the annals of the ever-loving CBT/AT? We are here to provide it! As Ben Grimm complained during one of our group sessions, "If I didn't know better, I'd swear ya wuz bitten by a radioactive thesaurus." So we will write more to educate in the arcane yet totally objective methods of treating superheroes! In our next installment, we will learn whether Dr. Banner is interested in treatment after all, how the group handles his limited engagement, and the secret behind S's interest in contacting the CBT/AT in the first place. And, watch for the surprise new group member! We'll also learn why The Watcher went rogue against his primary directive, which is, after all, to… JUST WATCH! And it's not beyond the realm of possibility that a theoretically unprecedented and incisive explanation of Dr. Banner's overdetermined behavior could be in the offing as well. See ya!

### References


Hoffman, J., & McKay, D. (2014). CBTers ASSEMBLE!! Episode 1: "A Tweet for Help." *the Behavior Therapist, 37*(3), 70-72.

Kirby, J., & Lee, S. (1966). Dr. Doom steals Silver Surfer's powers. *Fantastic Four, 1* (55).

Moore, A. (1986-1987). *The Watchmen*. New York: DC Comics.

Romita, J., & Lee, S. (1974). *The Punisher.* The Amazing Spiderman, 1 (129).


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# CALL *for* WEB EDITOR

*ABCT is seeking a Web editor to assist in updating material in, and developing policies for, its Web site. The position is funded with an honorarium. The role principally involves helping to develop content for the Web site and reviewing the site and navigational structure to ensure it remains best suited to our audiences. Technological knowledge is less essential, and the web editor is not expected to post to the site or otherwise take on the function of a web master. The following mission statement and strategy statement detail information on the proposed aims, activities, and audiences of this new Web site effort.*

## Web Page Mission Statement

The Web page serves a central function as the public face of ABCT.
As such, it has core functions linked to the mission and goals of the organization: facilitating the appropriate utilization and growth of CBT as a professional activity and serving as a resource and information source for matters related to CBT.

Informational and resource activities are directed toward three conceptual groups:

- ***Members***—with emphasis on providing an interface for many of the administrative functions of the organization, including conference information, dues, public listing of therapists, etc.
- ***Nonmember Professionals***—to advertise the comparative efficacy, diversity of styles, and methods of cognitive-behavior therapy, with additional information on training opportunities, available syllabi, and new findings in the scientific literature.
- ***Consumers***—to provide information and treatment resources on disorders and their treatment, with emphasis on the style, "feel," and efficacy of cognitive-behavior therapy, as well as information on additional issues that consumers confront in treatment (e.g., combined treatments, relapse prevention, etc.).

## Web Page Strategy Statement

One of the broader changes in the architecture of the Web page is that our content will now come up on searches.
Accordingly, we need to plan content that will bring professionals and consumers to our site.
The Web editor will need to liaise with associate editors, periodical editors, committees, and SIGs for content.
Such content includes:

- Diagnosis-specific information pages (e.g., information on depression and its treatment)
- Efficacy information (comparative, combination treatment issues)
- The "feel" of cognitive-behavioral treatment
- CBT, BT, DBT, RET . . . what is in a name?
- Recent research findings
- Position statements—regarding issues in the field (to clarify what our organization stands for)
- Speakers bureau
- Links to publications
- Helping media find the right person to discuss a topic
- CBT curricula
- Featured therapist of the month
- Research funding available
- Learning opportunities

ABCT's Web site is now a mature site, having undergone several structural revisions. Now, we are looking for a member to help us maximize our own Web's outreach potential and grow it while maintaining structural integrity. In addition, candidates can apprentice with our current Web master, learning the interface among Web editor, Web master, and central office.

## HOW *to* APPLY

ABCT members interested in applying for this position should contact David Teisler, Director of Communications, ABCT, at teisler@abct.org. The deadline for applications is **August 15, 2014.**

*the Behavior Therapist*
**Association for Behavioral and Cognitive Therapies**
**305 Seventh Avenue, 16th floor**
**New York, NY 10001-6008**
**212-647-1890 | www.abct.org**
ADDRESS SERVICE REQUESTED




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- Statistics seminars: "**Intro to Hierarchical Linear Models for Longitudinal Data**" (Gallop)
  "**Mplus Bootcamp**" (Braitman)

And Institutes covering:

**Radically Open DBT • Adolescent Skills Training • Treating Adult Survivors of Childhood Abuse • Treating Bipolar Disorder in Youth • Parent-Child Interaction Therapy • Neurocognitive and Translational Interventions • Client-Centered Approach to CBT for Insomnia • Compassionate Use of Exposure Strategies in ACT • Motivational Interviewing Skills Building**

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