

# *the* Behavior Therapist

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### President's Message

## Clinical Scientists, Scientist-Practitioners, and ABCT

*Dean McKay, Fordham University*



As a practitioner of CBT, do you identify as a clinical scientist or a scientist-practitioner? If you identify as a clinical scientist, you likely (a) emphasize the scientific value of the existing empirical research in guiding treatment decisions, (b) consider the limits of the applicability of these findings for specific populations, and (c) endeavor to determine new applications of existing principles along with evaluating potentially new and promising avenues for intervention. If you said you were a scientist-practitioner, well, you likely emphasized much of the same things listed for the clinical scientist, since, after all, the Boulder model (Raimy, 1950) emphasizes ongoing scientific evaluation of interventions in the application to unique clinical presentations. Both perspectives hold healthy skepticism about the efficacy of clinical interventions, and appreciate the myriad ways clinicians may be blinded to extraneous causes for symptom improvement that are unrelated to the clinical interventions. In considering how clinicians define themselves, there are of course other nuances that go into the differences in how individuals self-identify along the lines of clinical scientist or scientist-practitioner, but these broad commonalities suggest a good deal of overlap in how, ideally, individuals may view these identifiers.

I highlighted the similarities between the clinical scientist and scientist-practitioner to tease apart a practical reality from a political one. The mission of ABCT emphasizes the sci-

[continued on p. 179]



ence of human behavior and how empirically established methods can be used to enhance health and well-being. Clinical scientists could hardly find fault with this mission. Scientist-practitioners should likewise find this mission satisfactory in how they match their daily practices with the mission of ABCT. There are some scholars who strongly believe, however, that the general approach to training scientist-practitioners is inadequately fulfilled by credentialing bodies. The concerns of these scholars are well taken given the additional practical reality of how challenging it is for clients to identify practitioners qualified in scientifically informed psychological interventions. While ABCT has not taken a position on this political reality, we do recognize the problems clients face when attempting to seek solid empirically based treatment. Accordingly, we remain firmly committed to pursuing a more idealistic goal as expressed in our mission.

It is in this spirit that I would like to inform our members of a recent reaffirmation of our commitment to science through a press release related to legislative efforts by the Psychological Clinical Science Accreditation System (PCSAS). The PCSAS's mission ". . . is to advance public health by using the leverage of accreditation to promote science-centered education and training in clinical psychology." (For the full mission statement, visit: <http://www.pcsas.org/missionfunction.php>). To continue advancing its goals, PCSAS has been working to establish legislation across the United States to allow graduates of any doctoral training program solely accredited by PCSAS to be license eligible.<sup>1</sup> Legislation allowing graduates of solely PCSAS-accredited programs license eligibility has been signed into law in Delaware (on July 28, 2014) and Illinois (on August 1, 2014). On July 7, 2014, ABCT issued the following statement of support in a press release<sup>2</sup> approved by the Board of Directors:

As part of its mission, the Association for Behavioral and Cognitive Therapies (ABCT) emphasizes science in clinical practice, including education and training in scientifically informed psychological assessment and treatment techniques. We therefore support any state or province that would grant license-

eligibility to graduates of programs that are accredited by the Psychological Clinical Science Accreditation System (PCSAS), a non-profit organization in recognition that the PCSAS also promotes science-centered education and training, regardless of whether or not the program is also accredited by another body. Moreover, ABCT recognizes that scientific training occurs in other mental health disciplines, and supports scientifically informed practice in all relevant disciplines.

The move to support the PCSAS credentialing body is entirely consistent with the mission of ABCT. Members will recall recently voting to approve the revised mission statement of ABCT, which now reads as follows:

The ABCT is a multidisciplinary organization committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention and treatment of human problems through behavioral, cognitive, and other evidence-based principles.

As part of our mission, ABCT seeks to educate the public regarding the kind of treatments that are based in science, and also seeks to encourage consumers to understand the credentials of providers who are most likely to implement these approaches. Therefore, our statement of support for PCSAS is not exclusionary. The mission of ABCT emphasizes the multidisciplinary features of the organization, and therefore we strongly encourage all mental health training credentialing bodies to emphasize the scientific foundations of practice.

The pursuit of a scientific approach to clinical training is something we can readily view as a critical imperative for the future of mental health care. Consumer confidence is already comparably low for psychological interventions in light of the growing hegemony of medical-based interventions (as discussed in a prior column this year; McKay, 2014). It therefore behooves us to ensure that our interventions, as well as the education offered to clients, is firmly grounded in science as a means to promote engagement in treatments that are more likely to produce beneficial outcomes. Failure to do so will serve only to continue to erode consumer confidence and drive

clients to dubious approaches where nonscientifically informed practitioners may offer questionable, but persuasive, justifications for interventions that lack scientific support or are outright indefensible due to low efficacy. In light of these points, please join ABCT in supporting science in practice in the fullest sense possible, not only at the grass-roots and direct service level but also at the organizational and training level. This includes not only support for the efforts of PCSAS in promoting science-based education in doctoral training, but if you are part of any training program for mental health practitioners that you lend your voice to support science in the delivery of treatment. Only by doing so can we elevate the level of care afforded our clients, improve public mental health, and foster further advances in the science of psychotherapeutic practice.

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. . .

Thanks to Brett Deacon and Jonathan Abramowitz for helpful comments on an earlier draft of this column.

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<sup>1</sup>Note that at the time of this writing (August 1, 2014), there are no programs solely accredited by PCSAS. Instead, doctoral training programs accredited by PCSAS are generally also accredited by the American Psychological Association or Canadian Psychological Association.

<sup>2</sup>The Board of Directors of ABCT approved the statement on May 12, 2014.



## An Historical Perspective on the Impact of Case Formulation

Ira Daniel Turkat, Sarasota, FL

When I introduced the term *case formulation* into the behavioral literature (Bruch & Bond, 1998, p. 3; Johnstone & Dallos, 2006, p. 8; Johnstone & Dallos, 2013, p. 10), the goal was to move the field away from a focus on treatment techniques to developing behavioral conceptualizations of psychopathology (Meyer & Turkat, 1979; Turkat, 1982, 1985; Turkat & Meyer, 1982) as the foundation for intervention innovation, and subsequent scientific investigation. As part of that effort, a definition for a case formulation was provided with specific criteria as to what precisely constituted a case formulation and, therefore, what did not. This appeared essential to me at that time in our discipline's history because, despite concerted effort, I was unable to locate even one definition of what specifically was meant by claiming one had a clinical conceptualization or formulation of a particular case. Back in those days, behavior therapists were a clear minority and the diagnostic manual of American psychiatry, DSM-II (American Psychiatric Association, 1968)—a psychoanalytic-influenced document of unacceptable reliability and validity (Langenbucher & Nathan, 2006)—made us cringe.

Fast forwarding, we find the term “case formulation” has evolved. Today, it represents a core skill required of every clinical psychologist belonging to the 50,000 member British Psychological Society (2011).

Likewise, the latest edition of American psychiatry's diagnostic manual states: “The primary purpose of DSM-5 is to assist trained clinicians in the diagnosis of their patients' mental disorders as part of a case formulation . . .” (American Psychiatric Association, 2013, p. 19). Regardless of where one stands on issues relating to psychiatric diagnosis (e.g., Meyer & Turkat, 1979; Turkat & Maisto, 1983), it is fair to say that decades following its introduction, the term “case formulation” has come a long way.

The British Psychological Society's (2011) issuance of best standard practice guidelines exclusively for case formulation is the first of its kind. Therein, the history of case formulation is summarized and four “influential clinicians” (p. 4) were identified who helped to create the field: Hans Eysenck, Victor Meyer, Monte Shapiro, and me. As the only living member of that group,<sup>1</sup> I would like to offer some ideas I hope will positively impact the future of case formulation and, in turn, help the recipients of our efforts in the mental health professions at large.

### Early Innovations

There is no doubt that the road from clinical hypothesis creation to evidence-based treatment has been a successful journey, exemplified superbly by some of

behavior therapy's early pioneers, such as British psychologist Victor Meyer and South African psychiatrist Joseph Wolpe.

Today, response prevention for compulsive motor rituals is a well-established evidence-based treatment (Simpson, Maher, Page, Gibbons, & Foa, 2010). In the 1950s, this disturbing and often incapacitating clinical abnormality was consensually viewed as untreatable. Creatively applying learning principles in the psychiatric setting at that time (e.g., Meyer, 1957; 1966), Vic developed response prevention from his clinical observations and reasoning about such cases in relation to the animal literature on ritualistic behavior (cf. Abramowitz, Taylor, & McKay, 2012). From there, Vic hypothesized that preventing the performance of such rituals in clinical patients when exposed to the eliciting stimuli would force a reduction in their frequency and then demonstrated it successfully with compulsive hand-washing cases (Meyer, 1966). The rest is history (Foa, 1996). Without Vic's formulation-based treatment innovation, thousands of patients who suffered from debilitating compulsive motor rituals might still be unable to function. Detailed accounts of and references to his clinical ingenuity are available in Bruch (1998; 2014; Bruch & Bond, 1998; Bruch & Prioglio, 2006), the authoritative expert on Vic Meyer's approach and contributions to the field.

Likewise, the development of the first scientifically documented behavioral treatment of phobic conditions—systematic desensitization—traces its historic roots to Joseph Wolpe's conceptualization and demonstration of the genesis of anxiety as a function of conditioning by inducing and eliminating experimental neurosis in cats (Wolpe, 1952). Impressed negatively with the treatments of his day (i.e., psychoanalysis and medication therapy), Wolpe successfully adapted his conditioning conceptualization of anxiety to modify the suffering of “war neurosis” among some of South Africa's World War II soldiers (Wolpe, 1958). His creative desensitization method was revolutionary (Rachman, 2000) and with his quantification of impressive patient improvement, facilitated the rapid growth of empirical approaches to treatment of behavioral problems. Many across the globe view Joe Wolpe as the father of behavior therapy (e.g., DiTomasso, Golden & Morris, 2010; Grawe, 2000;<sup>2</sup> Kaushik, 1988;<sup>3</sup> Prochaska & Norcross, 2013; Stein, 2012), but I suspect he would nominate the Russian physiologist Ivan Pavlov (see Wolpe & Plaud, 1997).<sup>4</sup> Ultimately, Joe was

<sup>1</sup> For readers less familiar with these individuals, a few brief facts might prove beneficial. Hans Eysenck devoted his career to developing clinical psychology in the UK as a science and at the time of his death in 1997, was one of the three most cited intellectuals in history—the others being Sigmund Freud and Karl Marx, according to Social Science Citation Index data (Jensen, 1997 p. 543). In the 1950s, M.B. Shapiro pioneered clinical training in the UK, where he developed and taught his innovative application of the experimental method to the problems of the individual case (cf. Turkat & Maisto, 1985), and was the most impactful British psychologist in developing the integration of science and clinical practice (see D. Shapiro, 2002). Vic Meyer is widely known for his pioneering efforts to creatively apply learning principles to complex cases viewed traditionally as treatment resistant, resulting in a highly individualized, formulation-based approach that broadened behavior therapy beyond the more prevalent technique orientation existing at that time (see Bruch & Bond, 1998; Bruch, 2014).

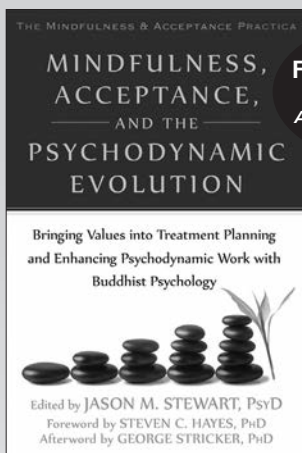
<sup>2</sup> I thank psychiatrist Irmgard Oberhammer of Austria for providing this reference.

<sup>3</sup> I thank Professor Sandhya Kaushik of India for recently confirming her 1988 opinion stands today.

<sup>4</sup> Designation as the “father” of behavior therapy is ultimately subjective and a thorough analysis of the topic is beyond the scope of the present article.

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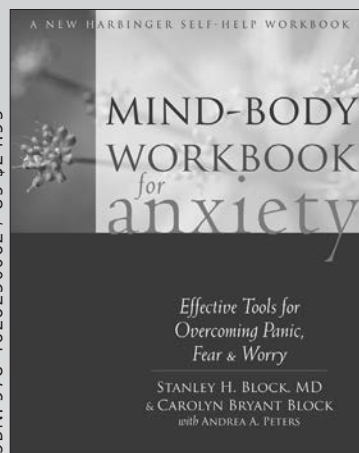
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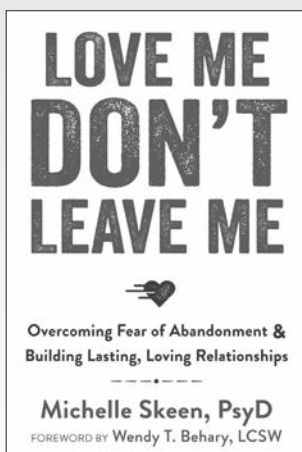


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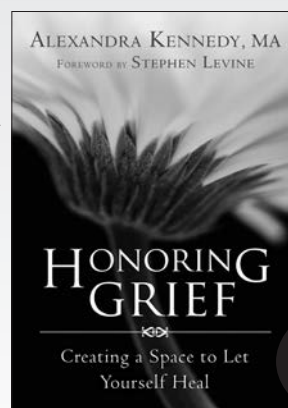


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known best for his innovative treatment method, although his writings on behavior analysis (Wolpe, 1973, 1976, 1977, 1982) were highly instructive and he insisted on first developing a proper case formulation prior to clinical intervention (Wolpe & Turkat, 1985).

From our joint efforts I can assure the reader that Vic Meyer (Meyer & Turkat, 1979; Turkat & Meyer, 1982) and Joe Wolpe (Wolpe & Turkat, 1985) would have advocated against using their (now scientifically supported) intervention procedures with every case of motor rituals and phobias, respectively. Rather, each emphasized the importance of first developing a proper case formulation from which treatment would be devised specific to the clinical indicants of that formulation. For both of these pioneers, the unique aspects of the individual case required an idiographically designed treatment which may or may not require devising novel intervention. In their day, they did not have the luxury of evidence-based treatments; they created them.

Following introduction of the initial definition for the term “case formulation,” interest in the behavioral community accelerated (see Sturmey, 2008), including its utilization in cognitive therapy (Persons, 1989) with continual elaboration (see Persons, 2012; Persons & Davidson, 2010; Persons & Tompkins, 2007), and the term became fashionable more broadly with all kinds of permutations appearing, such as psychodynamic case formulation (Perry, Cooper, & Michels, 1987), psychiatric case formulation (Sperry, Gudeman, Blackwell & Faulkner (1992), psychoanalytic case formulation (McWilliams, 1999), multimodal case formulation (Gardner, 2003), biopsychosocial case formulation (Ingham, Clarke & James, 2008), and psychotherapeutic case formulation (Berthoud, Kramer, de Roten, Despland, & Caspar, 2013)—to name a few.

Putting aside all the spin on the term and the consequent mishmash, the mere fact that specific guidelines on case formulation have been developed as a requirement for practice in the United Kingdom is a landmark event and praiseworthy. Given the range of theoretical diversity among clinical psychologists, I did not imagine this would have been an easy task and a reading of the guidelines on case formulation pro-

vides a sense of the underlying struggles. Nonetheless, a fine effort was made and I am confident that with each successive revision we shall see continual improvement.

### Definition of Case Formulation

To the best of my knowledge, the first definition of a case formulation with requisite criteria was provided in 1979 as an explanatory hypothesis that:

(1) relates all of the patient's complaints to one another, (2) explains why the individual developed these difficulties, and (3) provides predictions regarding the patient's behavior given any stimulus conditions. (Meyer & Turkat, 1979, p. 261)

Numerous illustrations of the use of this definition were provided back then along with instruction on how to meet the criteria in clinical practice (see Meyer & Turkat, 1979; Turkat, 1982, 1985, 1986, 1987, 1990; Turkat & Carlson, 1984; Turkat & Levin, 1984; Turkat & Maisto, 1985; Turkat & Meyer, 1982; Wolpe & Turkat, 1985). At the time we introduced this definition, we hoped it would stimulate a new direction in the field. It did. Just a few years following our original definition and subsequent elaborations, I was invited to present our approach to American psychiatry, and in 1986 our definition appeared in the *American Psychiatric Association Annual Review*:

The behavioral formulation is defined as an hypothesis that: 1) specifies the mechanism responsible for all of the symptoms presented by the patient; 2) details the etiology of these problems; and 3) provides predictions of the patient's behavior in future situations. (Leibowitz, Stone & Turkat, 1986, p. 358)<sup>5</sup>

Decades later, one can find a variety of behavioral approaches to case formulation today, and for recommended comparative reviews the reader is referred to Sturmey (2008, 2009). Likewise, other theoretical orientations (e.g., psychodynamic, systemic) have come to offer positions on case formulation as well and an examination of common and contrasting features can be found in thoughtful analyses by Corrie and Lane (2010), Johnstone and Dallos (2006, 2013) and Sturmey (2009).

Now that the term “case formulation” has grown to be commonplace in the mental health literature with its adoption and adaption by diverse schools of thought, it should come as no surprise that there is no universally accepted definition for it (British Psychological Society, 2011). Likewise, the American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) emphasized the importance of case formulation but was silent on its definition. Thus, a significant void remains. What one calls a “case formulation” others do not. This is most unfortunate because without agreement on definition, it perpetuates a sea of conceptual mud. Science cannot advance well without consensually approved operational definitions. And ultimately, the best definition of what constitutes a case formulation is an empirical question.

So what definition of case formulation should we use as a starting point? I would certainly welcome a comprehensive and clearly conclusive body of scientific literature supporting a superior definition than the original one Vic and I provided decades ago that remains commonly used today in various parts of the world (e.g., Antick & Rosqvist, 2002; AuBuchon, 2014; Australian Centre for Posttraumatic Mental Health, 2012; Bruch, 2014; Malatesta, 2010), not to mention others' adaption, evolution, or reformulation of it (see Corrie & Lane, 2010; Lane & Corrie, 2006; Persons, 1989). Unfortunately, that sorely needed body of scientific facts does not exist (cf. Hart, Sturmey, Logan, & McMurran, 2011; Sturmey & McMurran, 2011). So, in the absence of clear scientific data to determine how best to define a case formulation, it leaves us in the unsettled state of competing arguments and advocacy. It is one thing to provide a definition when one did not exist (i.e., Meyer & Turkat, 1979), but quite another to have a scientific consensus for a definition derived from a highly developed, incontrovertible body of research. Science should ultimately dictate the best definition of case formulation for researchers and clinicians to use, not the appeal of any one particular advocate.

From the very beginning, our definition of case formulation aimed to place requirements on the clinician to put one's thinking on the line in a clear and comprehensive way, with potential benefits not just for the client in the room but for the field at large. In other words, we strived to not only provide a definition where one did not exist but to raise the bar. As noted above, we defined case formulation as having specific compo-

<sup>5</sup> As noted in this section of the *Annual Review*, coverage responsibility was assigned as follows: Leibowitz (psychopharmacology), Stone (psychoanalytic psychotherapy), and Turkat (behavior therapy). I provided this definition. Leibowitz and Stone are prominent academic psychiatrists; I did not know them prior to the invitation.



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nents, and failure to meet each component meant one did not have a case formulation. To illustrate this point, the reader may find the case of a “dependent personality” (Turkat & Carlson, 1984)<sup>6</sup> instructive. In that case, initially we were unable to meet our definition for a case formulation and thus our failure was discussed with the patient. This led to symptomatic treatment. It failed. During the course of symptomatic treatment, interactions with the patient led to discovery of clinical information that enabled us to meet the definition of a case formulation. We then went about testing its validity. After documenting objectively successful predictions of the patient’s behavior, we devised a treatment specific to the case formulation that proved efficacious and maintained at follow-up.

Since decades later we do not have a consensual operational definition for case formulation, nor is the science even close to generating the necessary data supporting one, we find ourselves in a dilemma. If we do not agree a priori on what is and isn’t a case formulation for all to use, we remain at risk to find ourselves in a cloud of conceptual clutter. I will propose a potential solution to this dilemma, a little later in this article.

### Psychiatric Diagnosis and DSM-5

Scientists need reliable and valid ways to classify and communicate about the phenomena they study or their field cannot advance optimally (Adams, 1981). Psychiatric diagnosis is a classification system. Whether it is a good classification system or not is beyond the scope of the present manuscript. However imperfect the DSM-5 may be, psychiatric diagnosis aims to provide shorthand descriptions of certain behaviors that tend to group together across individuals that may be exhibited by the person under study. Hence, diagnosis is primarily descriptive.

Case formulation, on the other hand, provides *an explanatory theory with predictive power specific to the behavior of the individual case*. Two individuals with the same diagnosis may have very different case formulations (cf. Leibowitz et al., 1986; Meyer & Turkat, 1979; Turkat & Maisto, 1985; Turkat & Meyer, 1982) and consequently, different treatment. Diagnosis and case formulation complement each other but their purposes are not the same (Turkat & Maisto, 1983)—a point now recognized by

many in psychiatry (Winters, Hanson, & Stoyanova, 2007). Further, some psychiatrists admit that psychiatric diagnoses “. . . do not help us predict which patients are suitable for which therapy” (Sim, Gwee, & Bateman, 2005, p. 289). A good case formulation does.

The most widely used system for classification in the mental health professions today is the DSM-5 provided by the American Psychiatric Association (2013). In light of the importance of classification to science and the widespread acceptance of DSM-5, I support the use of psychiatric diagnosis in appropriate circumstances, mindful of its limitations and potential negative impact (see British Psychological Society, 2011; Frances, 2012; Zeev, Young, & Corrigan, 2010). However, when it comes to case formulation, there is a significant problem with DSM-5. More specifically, as noted above, the current version of the classification system defines psychiatric diagnosis as a component of a case formulation (American Psychiatric Association, 2013, p. 19). It is here where we have a clear and fundamental difference with DSM-5: A case formulation does *not* include psychiatric diagnosis as a part of it. It never has.

Definitionally, developing a case formulation does not preclude or require simultaneous classification via psychiatric diagnosis, but the former does not include the latter. Whether one chooses to utilize the classification system provided in DSM-5 is an independent decision when formulating a case, based on a number of factors the evaluator faces (e.g., client best interest, insurance requirement, research design, etc.). The way DSM-5 uses the term “case formulation” muddies the water. Related terms, such as “diagnostic formulation” (Kuruvilla & Kuruvilla, 2010), however well-intended, perpetuate the confusion (Turkat & Maisto, 1983).

Let us take it upon ourselves to educate our less knowledgeable colleagues and students on the differences between case formulation and psychiatric diagnosis.

### Case Formulation and Clinical Duty to the Field

The first and primary duty of the clinician is to the well-being of the person one is charged with helping. This involves utilizing established scientific findings to guide intervention wherever indicated based on an accurate case formulation. However,

proper application of evidence-based treatments to problems well understood in the scientific literature does not make one’s clinical activity “scientific.” Rather, such application should be considered standard practice today. But when necessary scientific information is unavailable, *the clinician bears a secondary duty* to the field at large. There are several ways to fulfill this responsibility beyond routinely providing the highest level of practical and ethical service delivery. Each has to do with contributing to the scholarly literature.

In that regard, in cases where there is inadequate scientific information, not only is it the duty of the clinician to attempt to conceptualize and hopefully come to ameliorate the presenting difficulties, one should utilize the opportunity when merited to pass worthy information on to those with proper investigative resources and thereby, potentially expedite the growth of scientific knowledge (Turkat, 1988, 1990). More specifically, clinicians can and should contribute useful information about: (a) the mechanisms of poorly understood problems; (b) the etiology of such difficulties; and (c) the creation of new assessment and treatment methods.

Wherever appropriate and reasonably possible, the clinician applies the experimental method to test the validity of one’s thinking (Carey, Flasher, Maisto & Turkat, 1984; Meyer & Turkat, 1979; Turkat, 1984; Meyer & Turkat, 1979; Turkat, 1990; Turkat & Maisto, 1985; Turkat, Maisto, Burish, & Rock, 1988; Turkat & Meyer, 1982) in addition to evaluating treatment efficacy (Barlow, Nock & Hersen, 2008; Kazdin, 2011). Of course, there are plenty of obstacles to consider, especially in regard to the former.

First, compared to the laboratory, there is usually a larger set of uncontrolled variables involved with limited resources to implement control or well-structured study. Second, there are institutional considerations such as insurance restrictions, managed care limitations, mandatory facility protocols, time constraints, and other potential problems (e.g., legal liability) when introducing novel procedures. I think back on a case of formulation-based treatment of an incapacitated and hospitalized vomit phobic (see Turkat & Meyer, 1982) in which we flooded the patient in vivo over 2 days (i.e., numerous individuals actually vomiting on the patient or within her reach); it is hard to imagine such novelty readily receiving institutional approvals today.

Let me now turn to the importance of clinicians reporting information pertaining to the etiology of poorly understood disor-

<sup>6</sup> At the time this case was seen, DSM-III (1980) was the authoritative nomenclature in American psychiatry.



ders. As I have stated elsewhere, “The ultimate goal in the field of mental disorders is to prevent psychopathology from occurring at all” (Turkat, 1988, p.196) and “. . . the clinician can play a useful role in this endeavor” (Turkat, 1988, p.185). Clearly, preventing behavioral problems from developing in the first place has far greater appeal than not doing so and then providing amelioration. Practitioners are the “first responders” and, as such, clinical study of etiological factors may provide important clues for the prevention of particular behavior problems (Turkat, 1986). The recently published American Psychological Association (2014) guidelines on prevention underscore this point.

#### Aligning Scientists and Clinicians on Case Formulation

Finally, I wish to address those researchers with a specific interest in case formulation, and for those scientists who don't have such an interest—I hope you acquire it.

Since we don't have a consensus on an operational definition for case formulation, we need to change this state of affairs. There

are two obvious routes. The first is to wait for our science to generate a solution organically. Unfortunately, over three decades have passed since introducing the initial definition of case formulation requiring specific criteria to be met, and we are still waiting.

The second route is to attempt to speed things up by bringing together leading scientists and clinicians on case formulation to work on providing a consensual statement on an operational definition for it. The aim should be to:

1. Provide no less than one consensually derived operational definition of a case formulation that will meet clinical and research standards;
2. Restrict the number of such definitions to the fewest needed to reach consensus, the ideal number being one;
3. Label the consensually derived operational definition(s) of a case formulation in a distinctive way to facilitate professional communication and signify collective expert endorsement;
4. Promote the use of the consensually derived operational definition(s) of a case formulation actively to all clinicians and

researchers for immediate application; and

5. Evaluate the case formulation operational definition(s) periodically following appropriate intervals of accumulated scientific and clinical findings with an eye toward improvement.

At this time in our discipline's history, I support the second route.

When the American Psychological Association and British Psychological Society addressed case formulation in recent years, their pronouncements were reflective of large memberships holding a wide range of theoretical views that naturally inhibits specificity in some areas in order to bridge significant differences. In contrast, the readership of *the Behavior Therapist* is far more homogeneous and less constrained by the size of the pool of professionals needing to come together. As such, developing a consensual operational definition for case formulation would appear more likely to emerge from this group, if it accepts the challenge to do so. A step back in history may help put the present proposal in perspective.



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As stated on the website of the Association for Behavioral and Cognitive Therapies in regard to its development:

The organization was originally founded in 1966 under the name Association for Advancement of Behavioral Therapies . . . by 10 behaviorists who were dissatisfied with the prevailing Freudian/psychoanalytic model (founding members: John Paul Brady, Joseph Cautela, Edward Dengrove, Cyril Franks, Martin Gittelman, Leonard Krasner, Arnold Lazarus, Andrew Salter, Dorothy Susskind, and Joseph Wolpe).

No doubt, these individuals helped to forever change the mental health professions by taking that step forward. Today, using the same commitment to the same principles, once more we have the opportunity to sharply advance the field by developing an operational definition of case formulation acceptable consensually to clinicians and researchers alike. In 1966, *resistance to a behavioral approach could not ultimately overcome the wealth of forthcoming scientific data* resulting in today's evidence-based treatments. The historical lesson is clear. Right now, the time is ripe, the need is strong, and the potential benefits run deep, if we take the lead once more.

Let us dedicate ourselves today to facilitating a more rapid growth of scientific and clinical knowledge of case formulation along the lines recommended herein and unleash the great potential for its impact. Worry not about the early imperfections that may emerge, for in time—science will remedy them.

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## Clinical Forum

# A Preliminary Investigation of the Effects of Aerobic Exercise on Childhood Tourette's Syndrome and OCD

Loren Packer-Hopke and Robert W. Motta, *Hofstra University*

In the April 2014 issue of *the Behavior Therapist*, ABCT president Dean McKay decried the medicalization of mental illness. One such "illness" that is most frequently treated medically is Tourette's Syndrome (TS). TS is often comorbid with OCD and drug therapies are the most frequently used forms of treatment (Piacentini & Chang, 2001). Given the significant role played by anxiety in TS and the utility of exercise in reducing anxiety, the purpose of this study was to explore the effects of aerobic exercise on children and adolescents with comorbid TS, obsessive-compulsive disorder (OCD), and anxiety.

## TS

TS is characterized by the presence of both motor and vocal tics (Leckman, Bloch, Scahill, & King, 2006). The onset of TS is

before age 18, although most cases present early in life, within the first 7 years. TS is often comorbid with other disorders, most frequently OCD and attention-deficit/hyperactivity disorder (ADHD). The prevalence of individuals with comorbid TS and OCD is high; some researchers have found that the prevalence of this comorbidity is between 40% and 60% (Chang, McCracken, & Piacentini, 2007; Kadesjo & Gillberg, 2000).

## CBT Intervention

The most common forms of behavioral therapy used in treating TS include self-monitoring, habit reversal training (HRT), and CBT (Woods, Conelea, & Himle, 2010). HRT includes awareness training, relaxation, and the regular practice of socially acceptable, competing responses to the tics (Azrin, Nunn, & Frantz, 1980;

Azrin & Peterson, 1988). Similarly, the CBT procedures of exposure and response prevention are behavioral interventions often used in treating OCD.

## Psychological Effects of Aerobic Exercise

Aerobic exercise has been used as an adjunct to therapy, or even a replacement for therapy, for a number of different disorders or ailments including, but not limited to, the following: OCD, chronic fatigue, post-traumatic stress disorder (PTSD), depression, anxiety, low self-esteem, and poor quality of life (Abrantes et al., 2009; Broman-Fulks & Storey, 2008; Brown et al., 2007; Gordon, Knapman, & Lubitz, 2010; Lancer, Motta, & Lancer, 2007; Motta, McWilliams, Schwartz, & Cavera, 2012; Newman & Motta, 2007; Smits et al., 2008). In one study exploring the effects of aerobic exercise on childhood PTSD, anxiety, and depression, participants were required to exercise 3 times a week for 20 minutes each workout, lasting a total of 8 weeks (Newman & Motta, 2007). The results indicated that this type of exercise regimen led to significant reductions in PTSD, anxiety, and depression, with lasting effects measured at 3-month follow-up.

Similarly, studies on the effect of aerobic exercise on OCD symptoms have shown that 12 weeks of moderate-intensity exercise 3 to 4 times per week can reduce OCD symptoms drastically, to the point that

symptoms (as measured by the Yale-Brown Obsessive Compulsive Scale [Y-BOCS]) were in the moderate range at the beginning of treatment and in the mild range by the end of treatment, as well as at 3- and 6-week follow-ups (Brown et al., 2007). Furthermore, another study has found that just 6 weeks of exercising 3 times a week was enough to reduce symptoms of OCD from a moderate level to a mild level (as measured by the Y-BOCS), and depression from a mild level to a minimal level as measured by the Beck's Depression Inventory—Second Edition (BDI-II; Lancer et al., 2007). One study has even documented the significant effects of aerobic exercise on anxiety symptoms in as little as 2 weeks (Broman-Fulks & Storey, 2008).

### Rationale

To date, there is a paucity of research examining the effect of aerobic exercise with TS. Considering that a person's tics and OCD symptoms can be exacerbated by anxiety and that aerobic exercise has been shown to reduce anxiety, it is possible that aerobic activity would result in reductions in both TS and OCD symptoms. Thus, it was expected that participants would experience a reduction in symptoms of TS and OCD, as well as anxiety, and would experience an increase in quality of life, during the intervention phase, as well as at the one-month follow-up interview.

### Method

#### Participants

Participants ( $n = 5$ ) were all male and between the ages of 9 and 13. Participants were recruited from a psychiatrist who works exclusively with children and adolescents with TS and OCD, support group meetings from the Long Island chapter of the Tourette Syndrome Association (TSA), and from an Internet advertisement on a reputable TS website. In order to participate in this study, all participants had to have received a formal diagnosis of both TS and OCD from either a medical professional or from a mental health professional such as a psychologist. Of the five participants, four were on medication to treat their tics during the time of the study and were stable on these medications for at least 3 months prior to beginning the study. None of the participants were currently in any form of psychotherapy and/or behavior therapy.

### Measures

**Tics.** In order to assess participants' tics and symptoms of TS, the Yale Global Tic Severity Scale (YGTSS; Leckman et al., 1989) and Tourette's Disorder Scale-Parent Rated (TODS-PR; Shytle et al., 2003) were administered, as well as a behavioral observation of tic frequency in a 5-minute period. Both the YGTSS and TODS-PR demonstrate excellent psychometric properties (Storch, Murphy, Goodman, & Roberti, 2005).

**Behavioral Measure.** A 5-minute observation was used to measure the frequency of tics. Please see below for a more detailed description of the behavioral measure.

**OCD.** The Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS; Scahill et al., 1997) is an adapted version of the Yale-Brown Obsessive-Compulsive Scale and is designed specifically for children and demonstrates excellent psychometric properties.

**Anxiety.** The Beck Youth Inventories—Second Edition (Anxiety Inventory; BAI-Y; Beck, Beck, Jolly, & Steer, 2005) is a 100-item rating scale designed to measure depression, anxiety, anger, disruptive behavior, and self-concept in children and adolescents ages 7 to 18. The BAI-Y demonstrates excellent psychometric prop-

erties across all five inventories and across different age groups.

Due to the geographic location of a majority of the participants, in-person interviews were not possible. Therefore, all interviews and exercise sessions were conducted with the use of Skype for all participants, regardless of location. This was necessary to allow the researcher and research assistants to physically see and speak with participants and their families.

During the baseline phase, participants and their parent(s) were interviewed by the first author and completed the YGTSS, CY-BOCS, TODS-PR, and BAI-Y. Three participants who were randomly assigned to a 2-week baseline completed the interview twice, and participants in the 4-week baseline completed the interview three times. Varied baselines were used in order to deal with the normal waxing and waning of tics. In order to provide a behavioral measure, participants were observed during each scale administration (starting at the beginning of the baseline and ending with the follow-up visit) in order to measure how frequently the participant was ticcing in a 5-minute period. The most prominent tic for each child was focused on in particular, such as a head jerk or a grunting sound, and was measured consistently throughout the study by the main author. In total, each in-

Table 1

#### Paired Comparisons for All Scales Measuring Symptoms of Tourette's Syndrome

Measure	Baseline Mean (SD)	Intervention Mean (SD)	Change in Mean Scores	Effect Size
YGTSS				
P1	40.33 (5.77)	17.30 (5.50)	-57%	-4.03
P2	47.00 (1.41)	18.30 (3.78)	-61%	-20.35
P3	55.60 (2.51)	23.60 (2.51)	-57%	-12.74
P4	62.00 (16.97)	49.00 (8.18)	-21%	-0.76
P5	60.50 (12.02)	41.00 (5.00)	-32%	-1.62
TODS-PR				
P1	64.60 (19.39)	39.30 (7.57)	-39%	-1.39
P2	84.00 (11.31)	61.30 (29.30)	-27%	-2.41
P3	113.00 (12.76)	102.30 (6.50)	-9%	-0.83
P4	82.50 (3.53)	61.30 (9.71)	-26%	-6.00
P5	62.00 (4.24)	42.60 (5.13)	-31%	-4.57
Tic Frequency in 5-Minute Period				
P1	5.33 (1.52)	3.00 (1.73)	-44%	-1.53
P2	7.00 (2.82)	0.66 (1.15)	-91%	-2.24
P3	5.00 (1.73)	2.33 (0.57)	-53%	-1.54
P4	22.50 (0.70)	15.33 (6.65)	-32%	-10.24
P5	5.00 (2.82)	2.66 (2.08)	-47%	-0.82

Note. Yale-Global Tic Severity Scale, YGTSS; Scores between 10-30 are mild, 30-50 moderate, 50-80 severe, and >80 is extremely severe. Tourette's Disorder Scale-Parent Rated, TODS-PR: There are no cut-off scores for this scale. P1-P5 represents Participants 1-5, respectively.

Table 2

*Paired Comparisons for Children's Yale-Brown Obsessive-Compulsive Disorder Scale*

Measure	Baseline Mean (SD)	Intervention Mean (SD)	Change in Mean Scores	Effect Size
CY-BOCS				
P1	16.60 (4.16)	7.00 (4.00)	-58%	-2.31
P2	11.50 (3.53)	7.30 (3.21)	-37%	-1.19
P3	19.30 (4.04)	14.60 (2.08)	-24%	-1.16
P4	16.00 (2.82)	7.30 (3.78)	-54%	-3.08
P5	17.00***	10.60 (4.93)	-38%	***

\*\*\* Standard deviations and effect size could not be calculated due to a lack of variance in baseline scores.

Note. Children's Yale-Brown Obsessive-Compulsive Scale, CY-BOCS; Scores between 0-7 are subclinical, 8-15 mild, 16-23 moderate, 24-31 severe, and 32-40 extreme. P1-P5 represents Participants 1-5, respectively.

Table 3

*Paired Comparisons for Beck's Youth Inventories-Second Edition (Anxiety Inventory)*

Measure	Baseline Mean (SD)	Intervention Mean (SD)	Change in Mean Scores	Effect Size
BAI-Y				
P1	48.33 (1.52)	34.66 (0.57)	-28%	-8.99
P2	52.00 (7.07)	44.66 (0.57)	-14%	-1.03
P3	41.00 (4.00)	38.00 (1.00)	-7%	-.75
P4	39.00 (2.82)	35.33 (0.57)	-9%	-1.30
P5	38.50 (2.12)	34.66 (0.57)	-10%	-1.81

Note. Beck Youth Inventories- Second Edition (Anxiety Inventory), BAI-Y; Scores <55 are considered average, 55-59 mildly elevated, 60-69 moderately elevated, and 70+ is extremely elevated. P1-P5 represents Participants 1-5, respectively.

terview session took approximately 30 to 45 minutes, with extra time allotted for the first interview to conduct a detailed history.

After the baseline phase, research assistants Skyped with the participants two times a week for 6 weeks in order to ensure participants were engaging in the aerobic exercise. During these sessions, participants followed along to a 30-minute aerobic exercise DVD including videos on kickboxing, dance aerobics, or a Billy Blanks DVD. The research assistants were responsible for measuring the participants' heart rate twice during the aerobic exercise sessions using a heart rate monitor ring (LifeSpan Fitness Heart Rate Monitor Ring), at both 10 and 20 minutes into the exercise session. This was to ensure that participants were achieving 60% to 80% of their predicted maximum heart rate, as dictated by the American College of Sports and Medicine requirements for moderate-intensity aerobic exercise (ACSM, 1992). In order to measure heart rate, the participants each wore the heart rate monitor ring and would provide the research assistant with the reading on the ring when the research assistant instructed them to do so. To ensure accurate reporting, the parents of the participants

would verify the reading on the heart rate monitor, and neither the participants nor family members were aware of what range the heart rate needed to be in. During the intervention phase, participants were reassessed by the first author with the YGTSS, TODS-PR, CY-BOCS, BAI-Y, at 2 weeks, 4 weeks, and 6 weeks after the start of treatment. Tic frequency was also observed during these interviews.

Once the intervention phase was complete, participants were asked to not engage in any additional exercise than what they would normally participate in for 4 weeks, at which point a follow-up scale was administered to determine if there were any persisting effects of the aerobic exercise treatment.

### Results

In the interest of space, results are presented in tabular form rather than text. Effect size was assessed using Busk and Serlin's (1992) method, also known as " $d_1$ " (Beeson & Robey, 2006). Follow-up scores are not reported in the tables as there was only one follow-up time point; thus, a mean could not be calculated. Follow-up results will be explored in the discussion section.

Furthermore, baseline mean and intervention mean refer to all time points and scale administrations during the particular phase. For example, intervention mean refers to the mean of 2 weeks, 4 weeks, and 6 weeks into the intervention phase.

### Discussion and Conclusion

Despite a considerable amount of research exploring the effects of aerobic exercise on OCD and other types of disorders (e.g., Abrantes et al., 2009; Broman-Fulks & Storey, 2008; Brown et al., 2007; Gordon et al., 2010; Lancer et al., 2007; Newman & Motta, 2007; Smits et al., 2008), little is known about the effects for individuals with comorbid TS and OCD. Considering that OCD is an anxiety disorder, and that tics can be exacerbated by anxiety, it is possible that a reduction in symptoms of anxiety could result in a concurrent reduction in symptoms of TS as well as those of OCD. This study sought to explore the effects of aerobic exercise on childhood symptoms of TS, OCD, and anxiety. The results offer support for the value of exercise in reducing TS, OCD, and anxiety. A 6-week treatment of two brief exercise sessions per week of moderate-intensity aerobic exercise yielded large reductions in symptoms of TS and OCD, and moderate to large reductions in symptoms of anxiety.

While all participants reported a decrease in symptoms during the intervention phase, long-term effects of exercise on symptoms were inconclusive. Contrary to previous findings (Abrantes et al., 2009; Broman-Fulks & Storey, 2008; Brown et al., 2007; Lancer et al., 2007; Newman & Motta, 2007; Smits et al., 2008), follow-up varied across participants, with some experiencing a return in symptoms to baseline levels. Similarly, participants' symptoms on follow-up, as measured by certain scales, remained stable with intervention scores, while other scales measuring similar symptoms increased. For example, all participants' scores on the Yale Global Tic Severity Scale at follow-up were lower than their average baseline scores, yet, parental ratings on the Tourette's Disorder Scale-Parent Rated measure for two of the participants returned to baseline level. Similarly, observed tic frequency returned to the baseline level for three of the five participants, one of whom had a medication change prior to follow-up, ultimately making his follow-up scores non-interpretable.



## *Anecdotal Evidence*

Anecdotal evidence suggests that both the participants and their parents found the exercise treatment a suitable means to decrease symptoms of TS and OCD. Because each participant differs from the other, it is important to examine progress independently: Each child made large strides as their symptoms decreased. It must be noted that names have been changed to protect the participants' confidentiality.

*Mike.* Mike's mother reported that Mike's tics decreased in frequency and intensity to the point that she was not even noticing Mike ticcing on a daily basis during the intervention phase. Mike reported during the intervention phase that he was no longer worried when his parents left the house, similar to his mother's reports that Mike stopped checking in with his parents as frequently. On the BAI-Y, Mike (during the baseline phase) frequently endorsed items of feeling nervous, worrying about the future, thinking about scary things, physical sensations associated with anxiety, and problems with sleeping. However, during the intervention phase, Mike only endorsed items pertaining to general worry and worrying that he might get bad grades. Lastly, Mike stated that he enjoyed learning the different kickboxing techniques, and that he would frequently practice these techniques with his father.

*John.* John and his mother reported that John's motor and vocal tics decreased to only one tic in each category at the third intervention time point, and that both tics were no longer interfering with his self-esteem or school functioning. John's mother also reported that she was pleased with the reduction of John's compulsive checking in, and that she was able to go on a date with her husband for the first time in years without John calling to find out when they would be coming home. John was even asleep by the time his parents came home, and he reported that although he felt the urge to check in, it was not as strong as it had been in the past. Moreover he was able to ignore it without becoming anxious. John stated that he was proud of this accomplishment.

*Chris.* Parent reports and Chris's observations of his own tics indicate that out of the three intervention assessments, motor tics were no longer present during the first and second interviews. Chris did have one motor tic on the third assessment of the intervention phase, however, his parents re-

ported that it was minimal and that it was only present every few days, as opposed to daily during the baseline phase. Additionally, parental observations indicated that the frequency and intensity of Chris's vocal tics decreased from the baseline phase. Chris's mother stated that she wants Chris to continue exercising on a regular basis; she also planned to look into different types of sports and aerobic activities he might like to engage in.

*Alex.* Of the five participants, Alex displayed the most intense and frequently occurring tics, both motor and vocal, continuously throughout the study. He was the only participant who engaged in self-injurious tics, albeit not to a dangerous level (i.e., hitting his face lightly with the palm of his hand). After the first 2 weeks of exercising, this self-injurious tic was no longer present. Furthermore, Alex's repetitive foot stomping was nearly extinct and decreased a significant amount in intensity. Alex's mother reported that Alex was no longer asking family members, peers, and school personnel to engage in his rituals, and that his ability to take care of his personal hygiene had greatly improved.

*Kevin.* Parent report indicates that, after the exercise treatment was implemented, Kevin's tics, both motor and vocal, decreased significantly in the number of tics present, frequency, and intensity. Similarly, Kevin's coprolalia became less frequent and was no longer interfering with his school functioning. Lastly, his father reported that Kevin's compulsive hand washing became so minimal that it was no longer present on a daily basis.

## *Practical Implications*

Based on the above-mentioned results, it is possible that aerobic exercise can be of benefit in treating symptoms of TS, OCD, and anxiety. All participants experienced a reduction in symptoms measured through self-report, parent report, clinician-rated interview, and behavioral observation. Anecdotal evidence also suggests that participants' symptoms that were present for years (such as a certain motor tic or a certain compulsion) dissipated to the point of extinction. These changes in persistent symptoms caused participants to have higher expectations of treatment efficacy, which in turn helped to keep them motivated throughout the study.

There are many barriers to treatment of TS, in particular the high prevalence rate of comorbid disorders such as OCD and

ADHD (Chang et al., 2007; King, Leckman, Scahill, & Cohen, 1999). As discussed previously, many people avoid seeking or obtaining treatment due to cost (Woods et al., 2010). Aerobic exercise is a relatively inexpensive prescription, and all of the participants in this study were able to complete the exercise sessions from the comfort of their own home, simply by watching an exercise DVD. Allowing participants to exercise and participate in interviews from the comfort and privacy of their own home may have contributed to the 0% attrition rate. Furthermore, all participants completed 100% of the exercise sessions, a number that suggests that this approach to exercise may result in higher compliance with treatment. Future research may benefit from adapting this approach. Finally, aside from the effects of aerobic exercise on symptoms of TS, OCD, and anxiety, there are additional benefits of exercise in terms of disease prevention and overall physical health functioning (Lungu, 1991). Similarly, exercise can have positive effects on academic performance (Morrand, 2004). These reasons alone might be causes for practitioners to prescribe a daily exercise regimen for children and adolescents.

Although all participants showed a significant decrease in symptoms of TS, OCD, and anxiety, there are several factors that may limit the generalizability of the results. First is the sample size, as results from small samples are not generalizable. Furthermore, statistical analyses in small-N studies are considered to have less reliability than larger sample size studies, due to the decreased level of power that accompanies small-N designs. Another limitation of this study is that, while all participants experienced a reduction in symptoms, individual patterns of symptoms were not consistent across all five participants. Thus, this study was unable to demonstrate that symptom reduction and level of exercise were linearly related. Another limitation was that all of the participants in the current study were aware that they were receiving treatment, and their reported reduction in symptoms may have been influenced by a placebo effect (Desharnais et al., 1993).

Future research is necessary to address the inherent limitations in the design of the current study, such as the small sample size, the lack of a true control group, and a minimal follow-up phase. Further research using a larger sample size may help to determine if there are long-term effects of aerobic exercise on symptom reduction in children and adolescents with comorbid TS and OCD. Similarly, the use of a larger sample size may

allow for a true control group and between-group comparisons.

In conclusion, an exercise prescription is cost-efficient and may allow families to receive some form of treatment when other forms (such as medicinal or therapeutic) are not a viable option. The ultimate goal of this study was to determine if there are methods other than medical treatments that can be used to treat individuals with comorbid TS, OCD, and anxiety. This goal was achieved and, as a result, families may have gained more knowledge and options regarding the treatment of their children.

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## Spirituality/Religion: Beliefs, Practices, Attitudes, and Training Among ABCT Members

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Philosophically, cognitive behavioral therapy (CBT) is predicated upon the tenets of logical positivism (Dobson & Dozois, 2010; Waltz & Hayes, 2010), which bases all knowledge on observable variables. While this has grounded CBT in empiricism and facilitated its widespread acceptance in the medical arena, positivism is widely construed as incompatible with spirituality/religion (S/R) (Russell, 1959)<sup>1</sup> and CBT may therefore be seen as incongruent with these domains. Indeed, some of the foremost CBT thinkers espoused that religious beliefs and practice constitute irrational and even pathological behavior (e.g., Ellis, 1983). To the empirically minded mental health practitioner, however, it is ironically quite important to attend to S/R issues. Estimates from national studies in the United States suggest that over 73% of the population believes in God with “certainty” (Gallup Poll, 2006); over half view religion as “very important” (top anchor on a 5-point scale; Pew Forum, 2007); and in the least religious states (New Hampshire, Vermont) more than a fifth of residents attend religious services weekly (Pew Forum). While a number of studies have been conducted on attitudes towards S/R and mental health among mental health practitioners in general, we are unaware of any previous research that is specific to CBT practitioners. We therefore conducted a survey study of members of the Association for Behavioral and Cognitive Therapies (ABCT) on this subject matter.

### Methods

We administered a brief (5-minute) online survey to ABCT members between December 2009 and June 2010, assessing for personal spiritual/religious belief and practice; previous training in this area; interest in further training; and attitudes towards the relevance of religion/spirituality to mental health and the practice of psychotherapy. The total sample was comprised of 262 ABCT members (5.4% of ABCT membership), of which 60% were full or new professional members and 40% were student members. Median age was 34 years ( $M = 38$ ,  $SD = 12.65$ ), over half of respondents (60%) ranged in age from 25–40 years, and the majority of participants were male ( $n = 189$ ; 72% of the sample). Please contact the study authors for a list of measures and to see the original manuscript for full sample demographics.

### Results

Just more than two thirds of the sample reported affiliation with a religious group, with Jewish affiliation as the most common response among the affiliated ( $n = 57$ ; 22% of the sample), followed by Protestant ( $n = 46$ , 18% of the sample), and Catholic ( $n = 35$ , 13% of the sample). However, 30% of respondents—the modal response overall—reported no religious affiliation. With regards to belief in God, 46.7% of respondents ( $n = 123$ ) reported no belief in a personal God, though 29% of these individuals ( $n = 36$ ) reported belief in a Higher Power. Only 25.8% of the sample reported “certain” belief in God, and an additional

20.7% reported belief with some level of doubt. Religious practice was endorsed to a lesser extent than affiliation or belief in God in that 64% of the sample reported attending a place of worship “rarely” or “never,” and 57% of the sample reported praying once/month or less. Nevertheless, 19% of respondents endorsed weekly or greater service attendance and 19% reported daily or greater prayer. Roughly half of respondents reported that religion ( $n = 133$ , 51%) has little or no personal importance, but that spirituality ( $n = 139$ , 54%) was important or very important to them (top two anchors on a 5-point rating scale).

Over 71% of the sample reported receiving little to no clinical training in how to assess and address S/R issues in the context of treatment. Perhaps relatedly, 36% of the sample failed to endorse a high degree of comfort (i.e., less than 4 on a 5-point scale of comfort) in discussing S/R issues in treatment, and 19% reported rarely/never inquiring about S/R. However, 51% of respondents reported a high level of interest in clinical training about S/R, and the same number reported they would be highly likely to attend a symposium or workshop on S/R and mental health. We also observed that higher levels of personal S/R involvement significantly predicted more favorable attitudes towards S/R and more comfort in inquiring about this domain in treatment,  $F(1, 225) = 57.77$ ,  $p < .001$ ,  $R^2 = .20$ ,  $B = .25$ ,  $SE = .03$ ,  $\beta = .46$ . However, previous training in S/R issues had a significant effect on attitudes towards S/R and mental health/treatment above and beyond personal S/R involvement. In fact, an interaction was observed such that among those with low levels of training in S/R and mental health ( $-1 SD$ ), respondents with high S/R involvement were more likely to hold positive attitudes towards S/R and mental health/treatment,  $B = .34$ ,  $SE = .04$ ,  $t(223) = 7.97$ ,  $p < .001$ . However, this difference became significantly smaller among respondents with high levels of training in S/R ( $+1 SD$ ;  $B = .14$ ,  $SE = .04$ ,  $t[223] = 3.35$ ,  $p < .001$ ), such that for participants with previous training, attitudes towards S/R and mental health/treatment were relatively favorable irrespective of personal S/R.

### Discussion

In contrast with the negative attitudes towards S/R conveyed by some of the pioneers of CBT, about half of the respondents in this study reported a strong sense of personal spirituality, and approximately one fifth of participants reported high levels of

<sup>1</sup>See Wilber (1999) for a discussion of the merits and shortcomings of the logical positivist position on spirituality/religion (S/R).



**Table 1.**

## Spiritual/Religious Involvement of ABCT Members

Question and Anchors	ABCT Member Responses <i>n</i> / %
<i>Religious affiliation</i>	
Judaism	<i>n</i> = 57 / 22%
Protestant	<i>n</i> = 46 / 18%
Catholic	<i>n</i> = 35 / 13%
Buddhism	<i>n</i> = 21 / 8%
Greek/Eastern Orthodox	<i>n</i> = 4 / 2%
Other	<i>n</i> = 19 / 7%
None	<i>n</i> = 79 / 30%
<i>Which statement best describes your beliefs about God?</i>	
I know that God really exists and I have no doubts about it.	<i>n</i> = 66 / 25%
While I have some doubts, I feel I do believe in God.	<i>n</i> = 53 / 20%
I find myself believing in God some of the time, but not at others.	<i>n</i> = 14 / 5%
I don't believe in a personal God, but I do believe in a Higher Power of some kind.	<i>n</i> = 36 / 14%
I don't know whether there is a God, and I don't believe there is any way to find out.	<i>n</i> = 49 / 19%
I don't believe in God	<i>n</i> = 38 / 14%
<i>During the past year, how often did you participate in religious services at a place of worship?</i>	
Once a Day or More	<i>n</i> = 7 / 3%
Almost Daily	<i>n</i> = 3 / 1%
Twice a Week	<i>n</i> = 7 / 3%
Once a Week	<i>n</i> = 32 / 12%
Twice a Month	<i>n</i> = 27 / 10%
Once a Month	<i>n</i> = 19 / 7%
Rarely	<i>n</i> = 93 / 36%
Never	<i>n</i> = 74 / 28%
<i>During the past year, how often have you prayed?</i>	
Once a Day or More	<i>n</i> = 49 / 19%
Almost Daily	<i>n</i> = 26 / 10%
Twice a Week	<i>n</i> = 10 / 4%
Once a Week	<i>n</i> = 20 / 8%
Twice a Month	<i>n</i> = 8 / 3%
Once a Month	<i>n</i> = 20 / 8%
Rarely	<i>n</i> = 65 / 25%
Never	<i>n</i> = 62 / 24%
<i>How important is religion to you?</i>	
Very Important	<i>n</i> = 45 / 17%
Important	<i>n</i> = 34 / 13%
Moderately Important	<i>n</i> = 48 / 19%
Of Little Importance	<i>n</i> = 62 / 24%
Unimportant	<i>n</i> = 71 / 27%
<i>How important is spirituality to you?</i>	
Very Important	<i>n</i> = 83 / 32%
Important	<i>n</i> = 56 / 22%
Moderately Important	<i>n</i> = 57 / 22%
Of Little Importance	<i>n</i> = 36 / 14%
Unimportant	<i>n</i> = 27 / 10%

Note: percentages are rounded to the nearest whole number.

religious practice including weekly service attendance and daily prayer. While it is possible that these latter figures do not represent the entirety of ABCT membership

and may be somewhat inflated (discussed below), it is also possible that spiritual identity has grown among CBT practitioners over the decades alongside widespread pro-

mulgation of "third wave" approaches, which have clear roots in Buddhist philosophy (Carmody, Reed, Kristeller, & Merriam, 2008). Nevertheless, our findings are consistent with previous research suggesting that mental health professionals are more likely to report a spiritual than religious identity, and less likely than the general population to value and practice religion overall (Zinnbauer et al., 1997).

It is also notable that a sizable number of respondents failed to report comfort in addressing S/R issues with clients and nearly one fifth reported never inquiring about S/R. Behaviorally speaking, these two findings may be related in that avoidance of discussing S/R issues may be negatively reinforced. It is also possible that therapist discomfort in discussing S/R and reluctance to inquire about this domain represents a skill deficit. Indeed, over two thirds of respondents in this study reported little to no clinical training in S/R, which is consistent with the training models of many doctoral programs and predoctoral internships (Vogel et al., 2013). To this end, it should be noted that over the past 4 years, three clinical workshops and one clinical panel on S/R and CBT have been offered at the ABCT annual convention, and in each of the past 5 years 10 to 20 posters reporting empirical findings on S/R and mental health have been presented. Further, the ABCT Spiritual/Religious Issues Special Interest Group—one of the largest such groups within the association, with 192 members<sup>2</sup>—has hosted a well-attended annual meeting at each of the past five conventions, including invited addresses from several prominent CBT figures (see [www.abctspirituality.com](http://www.abctspirituality.com)). While these training programs cannot supplant clinical supervision on actual cases, ABCT is nevertheless on the cutting-edge of this area by offering many opportunities for training in S/R and CBT.

It is not entirely surprising that more personal S/R predicted more favorable attitudes towards S/R and mental health, since practitioners with high S/R may better recognize the clinical relevance of this domain and be more comfortable with the subject matter. Of even greater interest, however, is our finding that previous training on S/R issues was associated with more favorable attitudes towards S/R and mental health. In and of itself, this suggests that formal attention to the role of S/R in clinical settings

<sup>2</sup> As of August 25, 2014.

**Table 2.**

Attitudes Towards and Training in S/R and Mental Health among ABCT Members

Question	Item Anchors & Responses [n (%)]				
	Never	Rarely	Sometimes	Often	Always
<i>How often are S/R issues relevant to mental health?</i>	1 (<1%)	11 (4%)	141 (54%)	98 (38%)	10 (4%)
<i>How often are S/R issues relevant in the treatment you provide?</i>	10 (4%)	57 (22%)	151 (59%)	37 (14%)	2 (1%)
<i>How often do you inquire about or assess your clients' S/R?</i>	10 (4%)	38 (15%)	79 (31%)	78 (31%)	51 (20%)
<i>How often was S/R incorporated into your clinical training?</i>	75 (29%)	108 (42%)	59 (23%)	13 (5%)	2 (<1%)
	Not at all	Slightly	About halfway	Mostly	Very Much
<i>How comfortable are you in addressing S/R issues in treatment?</i>	5 (2%)	28 (11%)	60 (23%)	117 (45%)	48 (19%)
<i>Are you interested in furthering your training in S/R?</i>	16 (6%)	48 (19%)	74 (29%)	62 (24%)	60 (23%)
<i>How likely would you be to attend a workshop or symposium on S/R and mental health?</i>	16 (6%)	35 (14%)	76 (29%)	70 (27%)	62 (24%)

Note: percentages are rounded to the nearest whole number.

has a rightful place in clinical training, as this may help develop clinician competence in addressing client S/R in the context of treatment. More important, our results suggest that with adequate training, clinicians who profess lower levels of S/R can

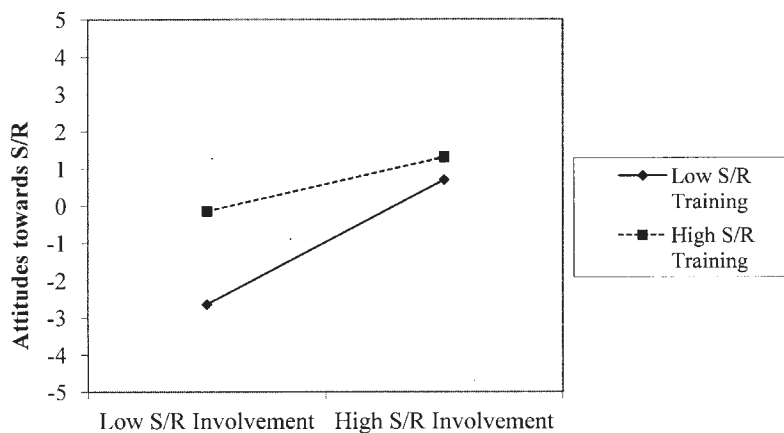
learn to recognize links between S/R and mental health and gain competence in addressing client S/R. These findings are congruent with those of Propst et al. (1992), who found that irreligious therapists providing religious CBT were even more effec-

tive than their nonreligious therapist counterparts.

The present study is limited by an informal recruitment process that may have resulted in self-selection of ABCT members who professed a personal interest in the subject matter. Further, we observed some overrepresentation of members from the Spiritual/Religious Issues SIG within the sample relative to ABCT membership as a whole, though SIG membership did not predict attitudes towards treatment above personal S/R or previous training. As well, our brief survey did not assess for personal mindfulness practice, preference for utilizing "third wave" CBT methods with clients, or personal definitions of spirituality (e.g., whether these include mindfulness), and further research should address these questions directly. Despite these limitations, the following is clear: Given the sheer prevalence of S/R within the general population, there is a pressing need for more research on S/R issues within the context of CBT and a corresponding need to advance core clinical competencies in this area.

**Figure 1.**

Interaction Between Personal S/R and Training on Attitudes towards S/R &amp; Mental Health



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## Clinical Training Update

# The Clinical Psychology Training Program at the University of Nebraska–Lincoln

David J. Hansen, Timothy D. Nelson, David DiLillo, and Debra A. Hope,  
*University of Nebraska–Lincoln*

The Clinical Psychology Training Program (CPTP) at the University of Nebraska–Lincoln (UNL) has been continuously accredited by the American Psychological Association (APA) since 1948, the first year any programs were accredited. The CPTP's history and approach to training through the years have been described in numerous articles (DiLillo & McChargue, 2007; Hargrove, 1991; Hargrove & Howe, 1981; Hargrove & Spaulding, 1988; Hope, Hansen, & Cole, 1994; Howe, 1974; Howe & Neimeyer, 1979; Jones & Levine, 1963; Rivers & Cole, 1976). Our program was historically described as a "Community-Clinical" psychology training program, and this focus on understanding and enhancing well-being at the individual, family, and community levels continues to be valued in our program

today across a variety of clinical and research activities.

## The Program

### Training Model

The CPTP has followed the scientist-practitioner, Boulder-model of clinical training since its inception. Our Director of Clinical Training in 1949, Marshall Jones, was a participant in the Boulder Conference on Graduate Education in Clinical Psychology. Both clinical and research training are continuous, integrated processes in the CPTP, continuously supervised and monitored by the clinical faculty.

The CPTP subscribes to the APA evidence-based practice model (APA, 2006) across all of our clinical training. Integration of EBP into our scientist-practitioner curriculum was highlighted in a spe-

cial issue of *Journal of Clinical Psychology* that focused on EBP training (DiLillo & McChargue, 2007). Students in the CPTP are trained to be both consumers and producers of research, applying best research evidence in clinical practice and generating new knowledge to improve treatment. Within this EBP framework our emphasis is on behavioral and cognitive behavioral therapies. The department made an active decision, beginning in 1990, to hire scientist-practitioner faculty members with a behavioral or cognitive-behavioral orientation. The core clinical faculty provide clinical and research training in behavioral and cognitive-behavioral therapies, third-generation cognitive-behavioral approaches (e.g., mindfulness and acceptance-based), motivational enhancement approaches, and, to a lesser degree, family systems. The CPTP was honored to receive the 2013 ABCT Outstanding Training Program Award. The award is given for "significant contribution to training behavior therapists and/or promoting behavior therapy."

The CPTP follows a "junior colleague" approach to training, which promotes professionalism and collegiality among faculty and students. Students participate in the ongoing development of the program and are viewed as colleagues in a common endeavor with the faculty. Students elect peers to serve as voting members in department



and clinical faculty meetings, a student serves as Assistant Director of our training clinic, and we have a number of subcommittees that involve students (e.g., Interview/Recruitment Weekend). Our junior colleague approach is also evident in the successful collaborations between faculty and students in coauthoring publications and presentations, submitting grants, and engaging in professional development opportunities.

### *Clinical Faculty and Students*

The CPTP currently has seven tenured/tenure track clinical faculty members plus a half-time director of our in-house clinic for training, research, and service, the Psychological Consultation Center (PCC). The clinical faculty members and their primary research interests are as follows: David DiLillo (interpersonal violence victimization and perpetration); Mary Fran Flood (early childhood, child maltreatment); David Hansen (child maltreatment, social skills); Debra Hope (anxiety, gender, and sexual orientation); Dennis McChargue (comorbid addiction and mental illness, brief motivational enhancement treatments); Timothy Nelson (pediatric health); Mario Scalora (targeted violence, threat assessment); and Will Spaulding (schizophrenia spectrum disorders: psychopathology, treatment, and social policy). All clinical faculty are committed to providing training on the integration of science and practice. For example, all are licensed psychologists, provide clinical supervision, and oversee service delivery efforts that provide training opportunities for students and generate data for research programs. The faculty also model and involve students in service contributions to the profession, including ABCT.

The CPTP recruits outstanding doctoral students from all over the country and abroad. Our program admits and graduates an average of approximately 8 to 9 students per year. Among current students, 63.8% are women, 14.9% identify themselves as ethnic minority students, and 6.4% are international students. All clinical students receive assistantships with full tuition waivers, which aids in recruiting top students and helping them progress in a timely manner. The average time to graduation is approximately 5.5 years, with 90% of students finishing within 6 years.

Our alumni go on to successful careers as licensed psychologists, with varied professional contributions across research, clinical practice, supervision, teaching, and admin-

istration. Alumni work in academic departments of psychology and psychiatry, hospitals, mental health agencies, forensic settings, public sector facilities, research institutes, and private practice settings.

### *Training Experiences*

As described in DiLillo and McChargue (2007), training in EBP is integrated throughout the program in a number of ways, including: (a) EBP-related core coursework, including Proseminar in Clinical Psychology, Evidence-based Clinical Interviewing, Psychotherapy, and Fundamentals of Behavior Therapy; (b) child clinical courses with EBP emphasis, including Child Therapy and Child Psychopathology and Assessment; (c) EBP in practicum training, including two Clinical Intervention courses in our clinic, specialty clinics for training and research, and offsite practica; and (d) a Clinical Comprehensive Exam that includes an oral exam and the student preparing a document describing EBP for a specific case and presenting video segments from therapy sessions for that case.

An important part of the CPTP is our in-house clinic, the Psychological Consultation Center (PCC; <http://psychology.unl.edu/pcc/>). The PCC is open year round and functions as a community-based clinic, providing a broad range of clients and presenting problems. Students have many opportunities to develop skills in evidence-based practice, including assessment, therapy, consultation, supervision, and clinical research. The PCC is staffed by a faculty director, an advanced graduate student who serves as assistant director, and a full-time administrative assistant. Supervision is primarily provided by core clinical faculty, with adjunct faculty periodically contributing. Practicum training begins in the second year with a full-year Clinical Intervention course in which students receive intensive faculty and peer supervision via live observation and immediate feedback on their performance. In addition to general clinical services, the PCC includes specialty clinics led by faculty that provide students with clinical training and research opportunities. Specialty services include the Anxiety Disorders Clinic, Family Interaction Skills Clinic (with services in Head Start settings and a Child Advocacy Center), Substance Abuse Clinic, Rainbow Clinic (for LGBT community), and the Telehealth Clinic.

Training in multicultural competency is integrated across the curriculum and training settings. All students complete at least

one required course on cultural diversity. Clinical courses highlight consideration of cultural issues throughout coverage of topics at hand, avoiding reliance on compartmentalized class periods for addressing multiculturalism. Clinical practicum sites provide opportunities to serve individuals from a variety of backgrounds. Faculty and students frequently collaborate on research and clinical papers that have a multicultural focus.

Clinical practica in community agencies are also an essential component of our scientist-practitioner training. Annually we have "Educational Partnership Contracts" with 13 to 15 community agencies that fund 22 to 24 graduate assistantships. Recognizing the importance of these partnerships, the university provides full tuition waivers for each agency-funded assistantship. The agencies and opportunities are diverse, including Head Start, Houses of Hope (substance abuse treatment facility), Nebraska State Penitentiary, Lincoln Regional Center (state psychiatric facility), Madonna Rehabilitation Hospital, OMNI Behavioral Health, People's Health Center, State of Nebraska Office of Probation, and others. These assistantships provide real-world experience and many opportunities for integrating science and practice, often with collaboration between faculty and clinical staff at the agencies.

All students complete a master's equivalency research project and dissertation (a formal thesis is not required for our M.A.). Although students identify one faculty member as a primary research mentor, many students participate in more than one research team and have multiple research projects going at any given point in time. All students present research at professional conferences and approximately 90% of students coauthor published research. Many students are successful in receiving external awards and fellowships that facilitate their training and research, including NIH NRSA fellowships, DHHS Head Start Graduate Student Research Grants, and Doris Duke Fellowships.

Our students compete successfully for outstanding internships and postdoctoral positions. Recently, students completed predoctoral internships at the Boston Consortium in Clinical Psychology, Medical University of South Carolina/Charleston Internship Consortium, Nebraska Internship Consortium, UCLA/Semel Institute for Neuroscience & Human Behavior, University of Mississippi Medical Center/VA Jackson, and the University of Oklahoma Health Sciences Center. We have a 98.8%

match rate over the past 10 years, with 80 of 81 students matching with an APA accredited internship.

### *The Department and University*

The CPTP exists within the Department of Psychology and the College of Arts and Sciences at UNL. UNL is the flagship of the state university system, with approximately 25,000 undergraduate and graduate students. UNL joined the Big Ten Conference and its academic counterpart, the Committee on Institutional Cooperation, in 2011.

The department has a 125-year history of leadership and innovation in the teaching of psychology. It was one of the earliest providing formal teaching of psychology west of the Mississippi, with one of the earliest psychological laboratories in the U.S. (6th and 8th by different accounts) and the first devoted to training undergraduates. Six presidents of the APA have been undergraduate alumni of the University of Nebraska, more than any other institution. The Nebraska Symposium on Motivation began in 1953 and is the longest running symposium in psychology in the world, with a tremendous national and international reputation. The Law-Psychology program, established in the 1974, was the first dual-degree (J.D.-Ph.D.) program of its kind and continues to be a premier program.

The department has 26 tenured/tenure-track faculty members and a number of active adjunct faculty. The graduate program includes approximately 100 graduate students across five programs: Clinical, Developmental, Neuroscience and Behavior, Social and Cognitive, and Law-Psychology. Clinical students may also be a part of the Law-Psychology program and pursue a J.D. or M.L.S. (Master's in Legal Studies) while earning their Ph.D. Our faculty are key players in a variety of interdisciplinary centers and initiatives that provide

valuable training and research opportunities for our students, including the Center for Brain, Biology and Behavior; Center on Children, Families and the Law; Nebraska Center for Research on Children, Youth, Families and Schools, Public Policy Center; Substance Abuse and Violence Initiative; and the Minority Health Disparities Initiative.

### *The Community*

Lincoln, the state capitol of Nebraska, is a city of approximately 265,000 people. Students find Lincoln to be a welcoming city with an affordable cost of living and an excellent variety of recreation and leisure activities. There are many restaurants, coffee houses, museums, theaters, and music venues within walking distance of campus. The Lied Center for Performing Arts and the Pinnacle Bank Arena regularly host a variety of theatrical and musical events featuring national and international artists. Lincoln has many beautiful city parks and nearby state parks with a variety of recreational activities, including golf, fishing, hiking, and horseback riding. There are over 130 miles of bike trails in the Lincoln area, as well as trails reaching out to nearby communities. And of course, there are many opportunities to enjoy sporting events, including premier college athletics.

Omaha, home to the University of Nebraska Medical Center, is about an hour away. With a population of approximately 885,000, the greater Omaha metropolitan area provides many venues for shopping and entertainment, as well as additional air travel options. Kansas City is a 3-hour drive and a popular destination for amusement parks, museums, professional sports, and cultural events. Denver and Rocky Mountain parks and ski slopes are within an 8-hour drive. Nestled in the heartland of the United States, travel is equally convenient to both coasts.

### *For More Information*

To learn more about our department and program, please consult our web page at <http://psychology.unl.edu/>. Questions may be addressed to David Hansen, Director of Clinical Training ([dhansen1@unl.edu](mailto:dhansen1@unl.edu)), or Jamie Longwell, Graduate Admissions Secretary ([jlongwell1@unl.edu](mailto:jlongwell1@unl.edu)).

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## CBT-I in the News

Cassidy A. Gutner and Jennifer Gamarra, *Boston University School of Medicine*

Cognitive behavioral therapy for insomnia (CBT-I), or sleep disturbance, has recently made headlines in the popular media. The coverage of CBT-I has appeared on many peoples' news feeds, and has ranged from articles on what not to say to someone with insomnia to popular press coverage of recent advances in insomnia research. In September 2013, the *Wall Street Journal* published an article entitled, "Are Insomnia's Effects on the Brain as Bad as They Feel?" (Reddy, (2013). This article features work by Dr. Sean Drummond and colleagues (2013), which examined the neural correlates of working memory performance in primary insomnia compared to people with good sleep. Cerebral activation was measured with functional magnetic resonance imaging during cognitive performance tasks and results demonstrated a unique profile related to abnormal neural functioning in primary insomnia. Individuals with insomnia had reduced engagement of task-related brain regions and difficulty modulating task irrelevant brain regions during working memory. Despite a subjective report of cognitive difficulties in individuals with primary insomnia, there were no differences in cognitive functioning between the two groups. This study provided evidence that individuals with insomnia have difficulty controlling the regions of the brain that control the mind from wandering during goal-directed behaviors, which is not a pattern seen in good sleepers.

Increased attention has also been paid to how the treatment of insomnia affects comorbid mental health disorders. In two *New York Times* articles, "Sleep Therapy Seen as an Aid for Depression" (Carey, 2013) and "Curing Insomnia to Treat Depression" (2013), recent findings from related NIMH-funded pilot studies at Ryerson, Stanford, Duke, and University of Pittsburgh were highlighted to demonstrate how successful psychotherapy for insomnia improves symptoms of depression and increases the recovery rates of stand-alone treatments for depression. Dr. Rachel Manber, who presented on insomnia at ABCT in a 2011 Master Clinician Seminar, reported that poor sleep and depression are

interconnected in a bidirectional relationship, where poor sleep is a common symptom of depression, or poor sleep increases an individual's risk of becoming depressed. The first pilot study, led by ABCT member Dr. Colleen Carney and colleagues (2013) found that brief CBT-I significantly improves both insomnia and symptoms of depression. In her research, depressed patients were taking either antidepressants or placebo pills, and 87% saw their insomnia disappear after only four biweekly sessions of CBT-I. Furthermore, there were dramatic improvements in depression after 8 weeks. In Manber et al.'s (2008) pilot study at Stanford University, 60% of patients who received seven sessions of CBT-I in addition to antidepressants recovered from depression, whereas recovery was only demonstrated in 33% of those who received only sleep hygiene sessions, one component of CBT-I, and antidepressants.

More recently, NPR highlighted the benefits of CBT over medication in the treatment of insomnia. The article, "Working With a Therapist Can Help When Sleeping Pills Don't" (Shute, 2014), features work led by Manber. The article discusses the benefit of CBT-I over medication and highlights a recent article published in *Behaviour Research and Therapy* on the effectiveness of CBT-I in veterans with insomnia (Trockel, Karlin, Taylor, & Manber, 2014). This research highlights the effectiveness and feasibility of training in, and implementation of, CBT-I in large health care systems. It also suggests that both CBT-I therapists and training programs should place greater emphasis on increasing patient adherence to achieve the greatest symptom reduction. Also of note, this NPR article highlights the launch of the CBT-I coach app that was released by the VA, and is available to the public to use in combination with CBT-I. The CBT-I coach provides a digital treatment aide that provides everything from sleep diaries to reminders about completing daily diaries and adjusting sleep schedules.

The media coverage of insomnia is noteworthy for several reasons. First, it highlights advances in research that combine

bench and clinical science to further target the neural mechanisms involved in the sleep-wake cycle. Second, it highlights the possibility of a shift in the public perception away from viewing medication as a front-line treatment for insomnia and other mental health disorders and informs the public about the effectiveness of cognitive behavioral therapies for insomnia. Third, it demonstrates the importance of studying sleep in relation to mental health, given the bidirectional nature of sleep and other mental health disorders such as depression. Finally, it highlights the need to more broadly implement CBT-I and incorporate technology as an effective treatment aide.

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### There's Something About Intern Tasha

Jonathan Hoffman, *Neurobehavioral Institute*

Dean McKay, *Fordham University*

O' Dear Readers of CBT/AT comunicados prior, allay ye any and all apprehensions regarding our future past! Our acumen in deciphering the nuances of psychological interventions for superheroes is increasing geometrically, at a rate comparable only to the deluge of new case referrals of this cohort, or at the very least to our incredibly dated references. By word of mouth, starship, telepathy, and of course, the ubiquitous circulation of *the Behavior Therapist*, news of our mounting expertise in this subspecialty is sweeping through the observable universe and osmosing into various parallel and bizarro ones as well. Our waiting room is starting to look like the Mos Easley Cantina.<sup>2</sup> Boy, are we swamped!

Here's the current skinny: As you no doubt recall, our former intern's utter lack of professionalism resulted in our paradigm-shattering therapeutic group mixing superheroes and powertypicals going all pear-shaped. But was your preternaturally skilled CBT/AT daunted? Don't be preposterous! Even as we transmit this widely anticipated update, our jam-packed caseload of legendary personages is happily reaping the benefits of our theoretical prescience and overflowing toolbox of clinical stratagems. We have even initiated a new clinical track for supervillains whose nonsensical, self-sabotaging plots to take over various worlds turn out to be more reflective of poor self-image or problems in executive functioning than primary malevolence. As part of this modality, they are afforded the op-

portunity to meet with the superbeings that defeated them and make amends. In fact, we just witnessed a contrite and teary supervillain sharing how never feeling accepted during grade school was the "real reason" he felt compelled to try putting all other sentient life forms under his thumb (well, not actually a thumb in this particular instance, more like a spiked pincer, but you get the idea). Talk about a heart-tugging scene! Just shows that whether you can bend steel with your bare hands, pulverize asteroids into sand, or control magnetic fields at will, deep down you can still be a softie that just needs some tender understanding.

So, the inverse u-shaped curve so classic of readiness-for-change challenged patients exemplified by genus superhereous is now in full effect, so kindly box score any little bumps in the road that we experienced in the past in the section labeled "transitory artifacts of truncated range of observations." Simply put, with all due scientific detachment, your humble and loveable CBT/AT is declaring total victory in this new specialty area.<sup>3</sup> In your face, naysayers and cynical purveyors of plausible rival hypotheses!!!

Interesting correlation side note—these most excellent developments occurred almost immediately after hiring our new intern, Natasha (although she prefers the less formal Tasha), who handily passed the CBT/AT's notoriously rigorous vetting process, which wasn't, we can assure you, influenced in the slightest by her being the sole applicant. Her letters of recommenda-

<sup>1</sup> Once again, it is our duty to advise the uninitiated that undertaking reading what follows is best left to those who have the prerequisite experience, i.e., lonely days and nights spent in a fantasy world of comics, manga, gaming, playing Trivial Pursuits, memorizing obscure facts to impress his or her imaginary "friends," and the like. Just having some fun, we know very well that all ABCT members were always totally popular in High School.

<sup>2</sup> The Mos Easley Cantina is aka The Chalmun's Cantina; in case you don't know, now you know.

<sup>3</sup> At our customarily barely marginal levels of statistical significance, and damn the power analysis!

tion were sterling. Among her endorsers, the Hawkeye Foundation's Chair Emeritus, none other than Clint Barton himself! The fact that this prestigious doctoral program for archers re-specializing in Clinical Psychology was so enthusiastically in her corner increased Intern Tasha's probability of acceptance into our program to just over 100 per cent (Alright, we never said advanced stats were the CBT/ATs strong suit).

After the group therapy debacle chronicled previously, we, of course, meaning our acolyte Intern Tasha, embarked upon creating and implementing a series of evidence-based treatment plans. These interventions were soundly grounded in the available refereed literature and tailored to the unique personal and situational profiles of each superhero. Following the case relevant psychoeducational modules, each participant was assigned a series of individualized therapeutic exercises designed to increase discomfort tolerance, restructure overvalued beliefs, and modify behaviors toward value-based interpersonal adjustments. Intern Tasha further specified dependent variables to be dynamically assessed with reliable and valid outcome measures. Ah, the ingeniousness of Newbies lacking real-life experiences!

Not surprisingly, the superheroes were not keen on this intervention model, volubly favoring instead modalities that would confirm their existing belief systems and provide reinforcement of their already highly preferred behaviors, regardless of their rationality or adaptive value to self or others. Consequently, in accord with our highly responsive "patient-centered" philosophy, we instructed Intern Tasha to rapidly change gears toward interventions high in "patient acceptability." Intern Tasha's revised *modus operandi*, under our Odin's eye-like supervision, of course, was modified to concentrate upon matching interventions and reinforcement schedules with superhero's "likes" and extant cognitive schemas, as opposed to such subjective and discomforting matters like their actual psychological "needs." Further, in accordance with studies generously underwritten by the behavioral health-care industry, Intern Tasha was encouraged to rely upon a patient satisfaction measure as her singular metric for assessing efficacy of clinical outcomes. This not only upholds our characteristically impeccable levels of research integrity, but also as a lucky coincidence, increases the likelihood of the CBT/AT's ongoing access to future streams of "Benjamins," scientifically essential grants, that is.

We are thrilled to report that in terms of these aforementioned, all-important patient satisfaction ratings, our intervention programs conducted by Intern Tasha are presently succeeding even beyond the CBT/AT's radical optimism, as detailed just below. (By the way, you can proudly show the flag by displaying items, from hoodies to coffee mugs, emblazoned with one of the CBT/ATs inspiring mottos, e.g., "An empty glass is full of emptiness." These sure-to-be-treasured collectibles are now available for purchase on our website: [www.America'sClinicians.com](http://www.America'sClinicians.com), soon to be amended to [www.TheMultiverse'sClinicians.com](http://www.TheMultiverse'sClinicians.com) in response to our ever-widening sphere of influence. We are pleased to announce that Bitcoins are now accepted as payment for our swag throughout the multiverse, with the one exception being Planet Earth.)

Harken:

- A gentleman-scientist with fantastic stretching abilities, a colleague of the rock-studded orange gigantor our loyal aficionados will no doubt recall from the last episode, underwent sessions utilizing kundalini yoga for stress management. He is learning asanas at an amazing clip. Patient satisfaction on Likert scale ranging from a low of 1 to 10 = 10!
- Similarly, to address posttraumatic effects of being "accidentally" shot by an old, albeit magnetically polarized friend, a clairvoyant docent at a school for the "gifted," i.e., fledgling superpowered mutants, underwent extensive treatment consisting of moving his eyes in synchrony to the metronomic "Human Beat Box," a phenomenological experience he described as "thoroughly enjoyable." Another 10 score, high five!
- An adamantium clawed carcajou-like mutant received assertiveness training, as well as a mani-pedi he insisted on being administered by his primary physician, Dr. Jean Grey, another superpowered patient. Wanna guess his patient satisfaction score? If you guessed 10, your perspicacity is showing.
- As a final exemplar among the multitude of possibilities, the good doctor Grey, a tightly wound telepath obsessing whether or not to accept a medical post in Phoenix, received a course of mindfulness training. Her indubitably credible rating, 8 . . . Just having some more fun, of course it was a perfect 10!

"No way," might say the skeptics; to which the ever-loving CBT/AT counters with a hearty, "WAY!!!" In point of fact, to time current, each and every superhero in our program continues to respond, mutatis mutandis, mustering perfect 10s on our definitive measure. In other words, we have now achieved the holy grail of outcome psychometrics—total patient satisfaction. That's going to look real good on our C.V.s, wouldn't you agree?

These unprecedented findings emboldened us to agree to let Intern Tasha, attired as usual in one of her charming skintight black "power suits," always displaying her Psi Chi pin on the collar, to take her motley collection of superheroes on an outing to practice their nascent social and self-regulatory skills in public settings. While applauding her initiative and desire to promote cross-situational generalization, in light of the obvious risk-management concerns, the leadership of the CBT/AT of course took the necessary steps to distance us from her actions and create the "plausible deniability shield" demanded by our always bustling legal team and insurance carriers. At this point Intern Tasha is like a family member but, after all, we can always get another intern, but like the Maltese Falcon (or in this case the Millennium Falcon), there is only one CBT/AT!

And now, a complete non sequitur, as is our prerogative, if not our sacred duty. Allow us to illustrate our supervision style with our star, the inimitable Intern Tasha. Now, Tasha has excellent clinical intervention skill, whose "hands-on" style belies her being in the early career category. Following her second group session, we had the following exchange:

SUPERVISOR: So Tasha, how did Ben G. do in group today?

TASHA: Well, he is still self-conscious of his orange hue and rock-covered epidermis and insists in speaking in an unnaturally "street" Brooklyn accent although he was raised on an estate in Greenwich, Connecticut. For example, when I asked him if he could "let go" of his anger at more classically handsome superheroes, he was dismissive, saying, "listen missy, I gots bizness to deal with, and can't be bothered with whether someone's a good guy or not. So how about lightin' my see-gar before you hustle your way out?" He's kinda a poser.

S: He has been struggling with his anger ever since he arrived here.

T: Yes, but then I urged him to consider alternatives to his outbursts with his colleagues, like saying, “you’re not my cuppa tea.” He then blurted out that it was “clobberin’ time!”

S: Tasha, you know we value the safety of our interns. If ever you feel in danger, you need to seek safety.

T: *<glared at supervisor for an uncomfortably long time>*. Uh, yeah, okay. Look, Ben will not be a problem in the future.

S: What does that mean?

T: Let’s just say I stopped him by “tapping” one of his “meridian” points.

S: You know that the CBT/AT does not support energy therapies or meridian tapping.

T: Well, this was more like “sapping energy” therapy.

We chose not to pursue this line of inquiry with Tasha any further, although we did observe more of her innovative interventions through our one-way observation room mirror. She was conducting another group session. When one of the participants—our adamantium clawed hero, in fact—was get-

ting riled up, Tasha suddenly did a back flip and swiftly thrust her high heel into his chest, putting him to sleep temporarily. She bounced back quickly and, without missing a beat, calmly turned to query Dr. Banner if he was still practicing mindfulness exercises to control his own anger. He replied non-verbally by simply maintaining pranayama as he smiled beatifically at the metallically clawed muscle man lying unconscious on the floor.

Adroitly returning from this aside and resuming our tale, we are just tickled to report that Intern Tasha’s naturalistic therapeutic experience with her gaggle of superheroes was a smashing success, so we instantaneously reversed our risk-management position to take full credit for this innovative enterprise, as well deserved given our standing on the ultimate rung in the CBT/AT’s authority hierarchy.

So, there you have it. The expansion of CBT to the hitherto underserved population of superheroes is well under way and in the best of all possible hands. And now, with someone as talented as Tasha on our team, we are embarking on mentoring dissertations with our unique sample. Tasha’s topic on metacognition and social decision-

making among superbeings is sure to be path breaking and we expect we’ll be able to expand our services to tackle even more refractory supervillain cases. Thank you, CBT/AT. Yeah, we said it. Saves you some time.

#### Episode Last <sup>4</sup>

Finally, the curtain is pulled back, all is revealed. We learn the astonishing secret reasons for the strange goings-on regarding the avalanche of superhero referrals to the CBT/AT. A small hint: foul play is afoot, a sitting ABCT President is in jeopardy. In fact, it turns out that there IS something about Intern Tasha, far more than we intimated here. Be patient, Dear Readers!

...

*Correspondence to* Jonathan Hoffman, Ph.D., Neurobiological Institute, 2233 North Commerce Pkwy, Ste #3, Weston, FL 33326; drhoffman@nbiweston.com

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<sup>4</sup> Or, perhaps, NOT!



*Acknowledge  
the accomplishments  
of your colleagues  
or graduating  
students.*

**Give the Gift of ABCT Membership today.**

For more information, visit [www.abct.org](http://www.abct.org), or contact Lisa Yarde at [lyarde@abct.org](mailto:lyarde@abct.org)



## Nominations for ABCT Officers: Everyone's Opportunity

Christopher Martell, *Chair, Leadership and Elections Committee*

In the history of ABCT, an average of 37.7% of members have cast votes in leadership elections. Well below half of our members make decisions that effect the entire membership. Even fewer members participate in the nominations process. We are, once again, approaching the nominations period and it is the chance for all of us to improve on our numbers and have more participation in this process than ever before. We all can contribute to ABCT as our professional home, and help in guiding the future of ABCT by participating in the election of the association's leadership. Also, please consider running for office! Self-nominations are accepted. If you don't wish to hold an office, nominate someone you know who would be willing and capable of holding an office. We honor our colleagues by nominating them.

This coming year we need nominations for three elected positions: President-Elect, Representative-at-Large, and Secretary-Treasurer. Those members who receive the most nominations for the slates available

will go forward to appear on the ballot. In April, members in good standing vote for the candidates of their choice to serve for 3 years. The President-Elect serves in that function from 2015-2016, then as President from 2016-2017, and then as Past President from 2017-2018.

Each of the Representatives serves as a liaison to one of the branches of the association. The representative position up for 2015 election will serve as the liaison to the Convention and Education Issues. Their term of office will be from November 2015 to November 2018.

The Secretary-Treasurer serves as the Finance Committee Chair and the Chair of Development in addition to oversight of the minutes from the Board of Directors meetings and the Annual Meeting of Members. The Secretary-Treasurer is responsible for reviewing the annual income and expense, reviewing the forecast budgets, and making recommendations for our investment policies to insure a good cash flow and solid fiscal foundation. The term of office is from

November 2016 to November 2019. We elect this position early so the candidate has a full year of training prior to taking office.

All full members in good standing are eligible to be nominated, and there is no limit to the number of members you can nominate for any of the positions. Electioneering starts at the Annual Convention. So, if you have a candidate in mind, start the campaign now with the nominations and go to the Annual Convention and start making your case to the electorate.

### *How to Nominate: Three Ways*

- ➔ Mail the form to the ABCT office (address below)
- ➔ Fill out the nomination form by hand and fax it to the office at 212-647-1865
- ➔ Fill out the nomination form by hand and then scan the form as a PDF file and email the PDF as an attachment to our committee: [membership@abct.org](mailto:membership@abct.org).

**The nomination form with your original signature is required**, regardless of how you get it to us.

ABCT needs our participation to insure good governance to continue to thrive as one of the world's leading associations representing behavioral and cognitive therapies. Let's improve our numbers and make this an exemplary year for numbers of nominations and ultimately for percentage of members casting votes! ■

## NOMINATE the Next Candidates for ABCT Office

*I nominate* the following individuals:

PRESIDENT-ELECT (2015-2016)

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REPRESENTATIVE-AT-LARGE (2015-2018)

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SECRETARY-TREASURER (2016-2019)

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NAME (printed) \_\_\_\_\_

SIGNATURE (required) \_\_\_\_\_

## *2015 Call for Nominations*

**Every nomination counts!** Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2015, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions.

**Please complete, sign, and send this nomination form to Christopher Martell, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.**

# Call

## for Award Nominations

**The ABCT Awards and Recognition Committee, chaired by Katherine Baucom, Ph.D., University of Utah, is pleased to announce the 2015 awards program, to be presented at the 49th Annual Convention in Chicago. Nominations are requested in all categories listed below. Please see the specific nomination instructions in each category. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.**

### Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Recent past recipients of this award include Antonette M. Zeiss, Alan E. Kazdin, Thomas H. Ollendick, Lauren B. Alloy, and Lyn Abramson. Please complete the nomination form found online at [www.abct.org](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include "Career/Lifetime Achievement" in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

### Outstanding Contribution by an Individual for Clinical Activities

Awarded to members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Past recipients of this award include Marsha Linehan, Marvin Goldfried, Jacqueline Persons, and Judith Beck. Please complete the on-line nomination form at [www.abct.org](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include "Outstanding Clinical Activities" in your subject heading. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

### Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Past recipients of this award include the Doctoral Program in Clinical Psychology at SUNY Albany, Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology, and Clinical Psychology Training Program at the University of Nebraska-Lincoln. Please complete the on-line nomination form at [www.abct.org](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include "Outstanding Training Program" in your subject heading. Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

### Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include The Honorable Erik K. Shinseki, Michael Gelder, Mark S. Bauer, and Vikram Patel. Please complete the nomination form found online at [www.abct.org](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include "Distinguished Friend to

BT” in the subject line. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

## Student Dissertation Awards

- *Virginia A. Roswell Student Dissertation Award* (\$1,000)
- *Leonard Krasner Student Dissertation Award* (\$1,000)
- *John R. Z. Abela Student Dissertation Award* (\$500)

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT; 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined; 3) The dissertation must have been successfully proposed; and 4) The dissertation must not have been defended prior to November 2014. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents. Self-nominations are accepted or a student's dissertation mentor may complete the nomination. Nominations must be accompanied by a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at [www.abct.org](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include candidate's last name and "Student Dissertation Award" in the subject line. Also, mail a hard copy of your submission to ABCT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

## Student Travel Award

This award is designed to recognize excellence among our student presenters and to aid in allaying some of the significant travel costs associated with presenting at the convention. Accompanying this honor will be a monetary award (\$500) to be used to facilitate travel to the ABCT convention. Eligibility requirements for this award specify that nominees must be 1) speaking at the 2015 convention as a symposium presenter (i.e., first author on a symposium talk), panel participant, or moderator; 2) student members of ABCT in good standing; 3) enrolled as a student at the time of the convention, including individuals on predoctoral internships in the 2015–2016 year but excluding postbaccalaureates. Information about the nomination form and application will be available following announcement of conference acceptances.

■ **Nomination deadline: August 3, 2015**

. . .

*Nominations for the following award are solicited from members of the ABCT governance.*

## Outstanding Service to ABCT

Please complete the nomination form found online at [www.abct.org](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include "Outstanding Service" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

## President's New Researcher Award

ABCT's 2014–2015 President, Jonathan Abramowitz, Ph.D., invites submissions for the 37th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of \$500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent work published in high-impact journals; and promise of developing theoretical or practical applications that represent clear advances to the field. While nominations consistent with the conference theme are particularly encouraged, submissions will be accepted on any topic relevant to cognitive behavior therapy, including but not limited to topics such as the development and testing of models, innovative practices, technical solutions, novel venues for service delivery, and new applications of well-established psychological principles. Submissions must include the nominee's current curriculum vita and one exemplary paper. Eligible papers must (a) be authored by an individual (an ABCT member) with five years or less posttraining experience (e.g., post-Ph.D. or post-residency); and (b) have been published in the last two years or currently be in press. Submissions will be judged by a review committee consisting of Jonathan D. Abramowitz, Ph.D., Dean McKay, Ph.D., and Michelle G. Craske, Ph.D. (ABCT's President, Immediate Past-President, and President-Elect). Submissions must be received by Monday, August 3, 2015, and must include one hard copy of the submission (mailed to the ABCT central office) and one email copy (to [PNRAward@abct.org](mailto:PNRAward@abct.org)) of both the paper and the author's vita and supporting letters, if the latter are included. Mail the hard/paper copy of your submission to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001. In addition, email your submission to [PNRAward@abct.org](mailto:PNRAward@abct.org).

■ **Submission deadline: August 3, 2015**

NOMINATE ONLINE:  
**[www.abct.org](http://www.abct.org)**



# call

for

## Continuing Education Sessions

*Please send a 250-word abstract and a CV for each presenter.*

*For submission requirements and information on the CE session selection process, please see the Frequently Asked Questions section of the ABCT Convention page at [www.abct.org](http://www.abct.org).*

49th Annual Convention | November 12–15, 2015 | Chicago

### Workshops and Mini Workshops

Workshops cover concerns of the practitioner/educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than FOUR presenters.

Mini Workshops address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention. Please limit to no more than FOUR presenters.

*When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.*

**Barbara Kamholz, Workshop Committee Chair**  
[workshops@abct.org](mailto:workshops@abct.org)

### Institutes

Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday.

Please limit to no more than FOUR presenters.

**Lauren Weinstock, Institute Committee Chair**  
[institutes@abct.org](mailto:institutes@abct.org)

### Master Clinician Seminars

Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday through Sunday.

**Sarah Kertz, Master Clinician Seminar Committee Chair**  
[masterclinicianseminars@abct.org](mailto:masterclinicianseminars@abct.org)

DEADLINE

*for Submission : February 1, 2015*

## ABCT 2014: Welcome Back to Philly

Michael McCloskey, *Local Arrangements Chair*

Deborah Drabick, *Local Arrangements Co-Chair*

Rob Fauber, *Temple University*

Hello and welcome to Philadelphia, the home of cheesesteaks, the Liberty Bell, Rocky Balboa, and the friendliest, most easygoing sports fans on earth (well, that last part may be a bit of a stretch). ABCT and the Local Arrangements Committee are excited that, after a 7-year hiatus, “the City of Brotherly Love” will again host the Annual Convention (November 20–23, 2014). Philadelphia (or “Philly” as it is called by the locals) is a diverse and vibrant city with numerous museums and exhibits, wonderful eateries, and (my students tell me) a great nightlife. For those interested in American history, Philadelphia played a central role in the birth of our country and boasts historical landmarks such as the aforementioned Liberty Bell, Independence Hall (where both the Declaration of Independence and Constitution of the United States were drafted and signed), and Betsy Ross House. For fans of the more macabre, we have the Edgar Allan Poe Historical Site, Eastern State Penitentiary (home to Al Capone), and my personal favorite, the Mütter Museum (a magnificently macabre medical museum whose current exhibits include “Death Under Glass”). Fitness enthusiasts can work out in our many gyms, take a jog along scenic Kelly Drive, or try their luck running up the art museum steps à la Rocky. For those whose sports interests steer more towards the spectator side, the Philadelphia Flyers are playing at home that weekend. Those of you bringing your children will want to visit the Franklin Institute, Philadelphia Zoo, and the Please Touch Museum. In short, no matter your tastes, Philadelphia has something to offer.

### Hotel and Immediate Surroundings

Located in the heart of Center City, Philadelphia Marriott Downtown (corner of 12th and Market Streets; 1201 Market Street, 215-625-2900; [www.marriott.com/hotels/travel/phltdt-philadelphia-marriott-downtown/](http://www.marriott.com/hotels/travel/phltdt-philadelphia-marriott-downtown/)) will be hosting this year’s ABCT convention (just as it did in 2007).

The Marriott Downtown’s hotel restaurant, “13,” serves “American classics with a contemporary twist” ([www.opentable.com/thirteen-philadelphia-marriott/](http://www.opentable.com/thirteen-philadelphia-marriott/)). They also have a bar/lounge, Circ, for drinks, light snacks, and appetizers ([www.yelp.com/biz/circ-at-the-philadelphia-marriott-downtown-philadelphia](http://www.yelp.com/biz/circ-at-the-philadelphia-marriott-downtown-philadelphia)) . . . and, yes, to satisfy your caffeine needs, a Starbucks is also located in the hotel. There is wireless connectivity in public areas, while in-room high-speed Internet access is \$12.95 per day (\$16.95 for “enhanced” high-speed Internet). The Marriott has an on-site laundry, valet dry cleaning, and even an on-site Hertz car rental office in case you want to rent a car to go exploring.

Numerous restaurants are located within walking distance of the convention. The Stephen Starr restaurants El Vez (<http://www.elvezrestaurant.com/>) and Alma de Cuba (<http://www.almade-cubarestaurant.com/>), the upscale Morimoto ([www.morimotorestaurant.com/](http://www.morimotorestaurant.com/)) and Buddakan (<http://www.buddakan.com/>), and family-friendly Maggiano’s (<http://locations.maggianos.com/us/pennsylvania/philadelphia/12th-filbert>) are all less than a mile from the hotel.

Furthermore, just a block east from the Marriott on 12th Street you will find the Reading Terminal Market ([www.readingterminalmarket.org/](http://www.readingterminalmarket.org/)). This famous indoor market is a mecca of fresh, local, and delicious food. Reading Terminal Market offers the sale of fresh meats, seafood, and poultry, handmade confections and baked goods, and is home to a wide variety of restaurants that will satisfy all of your mouth-watering food wants and needs. With a selection ranging from crepes, to hoagies, pasta, Cajun, BBQ, Amish, Middle Eastern, Mediterranean, Greek, Chinese, German, cheesesteaks, salad, and Mexican, you will be sure to leave full and happy. Open from 8 A.M. to 6 P.M. Monday to Saturday and 9 A.M. to 5 P.M. on Sundays, the Reading Terminal Market is a stop you will not regret. The convention is also within a few blocks of an indoor shopping

mall ([www.Galleryatmarketeast.com/](http://www.Galleryatmarketeast.com/)), and within a mile of Independence Hall ([www.nps.gov/inde/index.htm](http://www.nps.gov/inde/index.htm)) and the Liberty Bell ([www.nps.gov/inde/liberty-bell-center.htm](http://www.nps.gov/inde/liberty-bell-center.htm)).

### Getting to Philadelphia and the Marriott Downtown

#### By Plane

Philadelphia International Airport (PHL) is located 7 miles southwest of Center City. PHL is serviced by all the major airlines and is a hub for U.S. Airways, so getting a reasonable flight with minimal layovers should not be a problem. Once at PHL you can either take a taxi or a regional rail (train) to get to the Marriott in Center City. Taxi services can be accessed at Zone 5 (there will be signs in the airport directing you where to go; also see [www.phl.org/](http://www.phl.org/)). The cost of a cab is a flat rate of \$28.50 (plus \$1.00 for each additional passenger). The regional rail is a form of public transit (SEPTA: see below) that will take you from the airport (with stops at Terminals A, B, C/D and E/F) to Center City. During weekdays before 7 P.M., a one-way ticket is \$6.50 in advance or \$8.00 on board the train (cash only). After 7 P.M. or on weekends, the one-way fare costs \$5.00 in advance or \$7.00 on board the train (cash only). You may also purchase round-trip tickets in advance or on the train. From 5 A.M. until just past midnight the train departs 9–13 minutes and 39–43 minutes past the hour and takes approximately 25 minutes to get to Center City ([www.septa.org/schedules/rail/pdf/air.pdf](http://www.septa.org/schedules/rail/pdf/air.pdf)). To get to the Marriott, take the airport train to the Jefferson Station stop, which is located between 10th and 12th streets on Market (about 1 block from the Marriott.)

#### By Train

The Philadelphia Amtrak station is located at 30th Street Station to get to the Marriott. You can either take a taxi located right outside of the 30th Street Station (trip cost about \$8.00 to \$15.00 depending on traffic) or transfer to a SEPTA regional rail (also located in 30th Street Station) and take it two stops to Jefferson Station (about a 5–10 minute trip and a free ride if you have your Amtrak ticket stub).

#### By Bus

For those traveling to the ABCT meeting by Greyhound, Peter Pan, or Chinatown Bus lines, your bus ride ends at 10th

and Filbert. It is only a two-block walk from the bus terminal to the Marriott (you can enter the Marriott through its back entrance on Filbert Street), but there are cabs in front of the bus terminal if you prefer.

### *By Car*

For those of you who plan on driving to the ABCT convention, the main routes that run into the city are I-76 and I-95. Traffic on both of these interstates can be very busy, especially during rush hour. Parking in the hotel is expensive (valet in-out privileges \$48.00 per day). However, if you are just driving in for the day there are less expensive options in the area (e.g., around \$10-\$25 for 8 hours if you get in before 9 a.m.; see <http://www.philapark.org/locator/> or <http://www.parkwhiz.com/philadelphia-marriott-downtown-parking/>).

### **Things to Do in Philadelphia**

Below we try to provide a feel for the city, especially the Center City area where the convention is located. However, there are simply too many things to see and do in Philadelphia to include in a brief article. So for more information on planning activities while you are here in Philadelphia, please contact the Local Arrangements Committee (mikemccloskey@temple.edu) and/or check out some of these sites:

<http://www.visitphilly.com/>

<http://philadelphia.about.com/>

<http://www.phillymag.com/best-of-philly/>

### *Center City, Philadelphia*

Just a few blocks from the Marriott at 10th and Arch Street you will find the Friendship Arch in the heart of Chinatown. You can visit some of the most historical and important buildings to the Chinese community, look at brilliant and breathtaking art and sculptures created by Chinese artisans, or stroll through the streets window shopping. Of course, food is one of the highlights of Philadelphia's Chinatown. Come feast on a variety of Asian cuisines, including Dim Sum, Chinese, Vietnamese, Malaysian, and Burmese food. Want a recommendation? Ting Wong, located on 138 N. 10th Street, was voted 2014 best Chinese restaurant in Philadelphia! Also, for an inexpensive and delicious treat, try the Shanghai soup dumplings (#1 on the menu) at nearby Dim Sum Garden at 1020 Race Street.

If shopping is what you seek, you can head to Walnut Street between 13th and

18th, just a few blocks South West from the hotel. Walnut Street is home to a variety of stores, such as Michael Kors, Armani Exchange, Tiffany & Co., Barneys New York, Ralph Lauren, Juicy Couture, Club Monaco, Guess?, Williams Sonoma, Brooks Brothers, Cole Haan, Ann Taylor, Kenneth Cole, Coach, Talbots, Banana Republic, Anthropologie, and Apple. After a day of shopping, you can head one street over to Chestnut Street to enjoy cuisine and drinks at your choice of eclectic restaurants and bars that line this street.

Looking for a nice park surrounded by upscale restaurants? Walk west past City Hall to Rittenhouse Square (18th and Walnut Streets), one of the five original open-space parks planned by William Penn. Coffee fans can stop by Elixir Coffee or LaColombe before strolling through the park. Rittenhouse Boasts a number of lovely restaurants with terrific food and ambiance, including Le Cheri, Parc, Tinto, Vernick, Barclay Prime, and Pumpkin. After dinner, treat yourself to some delicious gelato at Capogiro. Within a few blocks of Rittenhouse Square is the Mütter Museum of the College of Physicians (<http://muttermuseum.org/>), America's finest museum of medical history, described as a "riveting storehouse for the anatomically strange."

The Art Museum District is a short walk from the Marriott along the Benjamin Franklin Parkway (lined with flags from every country of the world), which runs one mile from City Hall to the Philadelphia Museum of Art. The Art Museum District is a major tourist attraction for the Philadelphia Museum of Art (home to a wealth of impressive holdings in Renaissance, American, Impressionist, and Modern art, including Cezanne's "The Large Bathers"; during the conference, check out visiting exhibitions such as "Paul Strand: Master of Modern Photography" and "Patrick Kelly: Runway of Love") and the famous steps that were once ascended by Rocky Balboa. There are many other excellent museums in the area, including the Academy of Natural Sciences, Franklin Institute, and Rodin Museum. A new addition to the Art Museum area is the Barnes Foundation (<http://www.barnesfoundation.org/>), which contains one of the finest collections of Post-Impressionist and early Modern paintings. But for those of you who just want to run up the Rocky steps, go for it! In fact, we will be doing a fun run on Friday morning from the convention to the top of the Philadelphia Museum of Art steps.

Located on Broad Street, primarily south of City Hall, you'll find another well-visited part of the city, the Avenue of the Arts. The Avenue of the Arts is home to many of Philadelphia's concert halls and theatres, including the Kimmel Center, Merriam Theatre, Wilma Theatre, and Academy of Music. Visit [www.avenueofthearts.org](http://www.avenueofthearts.org) for a calendar of events. There are many high-end restaurants interspersed on this strip, including Capital Grille and Ruth's Chris Steakhouse.

If you walk about three fourths of a mile down Market Street (towards the lower numbered streets) from the convention you will arrive at Old City and Society Hill, Philadelphia's most historic area. At 6th and Market, stop off at the Independence Visitor's Center (<http://www.phlvisitor-center.com/>), where you can get information about historical attractions including the Liberty Bell, Betsy Ross House, and National Constitution Center. Nearby you'll also find Jeweler's Row, the nation's oldest diamond district. Interspersed within the signature redbrick homes of Old City and Society Hill are many shops, galleries, restaurants, and night spots. This area is home to many of the popular Stephen Starr restaurants ([www.starr-restaurant.com/](http://www.starr-restaurant.com/)), including Buddakan (Asian), The Continental (global tapas and martini bar), Jones (American "comfort food"), and Morimoto (contemporary Japanese). If you're looking for more of a pub feel, head to the Independence Beer Garden located at the corner of 6th and Market to enjoy the quaint scenery overlooking the Liberty Bell and Independence National Historic Park. For the beer aficionado, walk a few more blocks down to 2nd and Chestnut Street to Eulogy Belgian Tavern, a former funeral parlor and current home to over 300 international and domestic beers (21 on tap). Last, but certainly not least, if you like ice cream, make sure to stop at the Franklin Fountain on 116 Market Street, a true old-time ice cream parlor with 20-plus flavors of house-churned cream (if you feel up to it, you can tackle the "Mt. Vesuvius" sundae).

### **Other Attractions in Philadelphia Just a Short Subway Stop or Cab Ride Away**

Still within a 15- to 20-minute walk, you will find South Street, with most attractions housed between 8th and Front Streets on South Street ([www.southstreet.com](http://www.southstreet.com)). South Street has a fun, eclectic, and alternative vibe with stores to match. You can get everything from that cool new tattoo, to retro clothes and shoes, to kids' toys, to def-



initely *not* kids' toys. They have it all on South Street. There are also many places for good (but not always healthy) food. If you want a Philadelphia cheesesteak without the walk, visit Jim's Steaks (400 South Street). If you are looking for a great slice of pizza, visit Lorenzo's & Sons (305 S. Street). This pizzeria is open until 4 A.M. and often has a line out the door (but no seats, you eat and stand/walk). If you are looking for music, head on down to the Theater of the Living Arts (<http://venue.tlphilly.com/>) to catch up-and-coming bands. Continue walking east on South Street to Penn's Landing, the waterfront area along the Delaware River (where there are also several excellent restaurants).

Just south of South Street is South Philly, a neighborhood in which many residents have lived for several generations. At the intersection of 9th and Passyunk Avenue, you'll find the famous Geno's Steaks and Pat's King of Steaks, fierce competitors in the cheesesteak business (though there are arguably better cheesesteaks to be had in the city, such as Tony Luke's and John's Roast). Beware of the cultural etiquette that determines what's on your cheesesteak—the "classic" order is "Whiz, wit," denoting "with Cheez Wiz and fried onions." While in South Philly, be sure to visit the Italian Market (9th Street between Fitzwater and Wharton Streets), an area of Philadelphia featuring grocery shops, cafes, restaurants, bakeries, butchers, and cheese shops. The actual market consists of ground floor shops in Philadelphia row homes that line the streets, and they are generally open 9 A.M. to 5 P.M. Some of the city's best Italian restaurants can be found within a few blocks of the market.

At the far end of South Philly is the stadium complex where the four major Philly sports teams play. There is also a large entertainment center right next to the stadiums called Xfiniy Live. This is easily accessed by taking the Broad Street Line from City Hall Station to AT&T Station (about 11 minutes).

### Events in Philadelphia the Weekend of the Convention

If you're a professional football fan, you're in luck—the Eagles have a home game on Sunday, November 23, against the Tennessee Titans. However, be sure you know what you're getting into: Eagles fans take their football very seriously (yes, these are the fans that actually booed Santa Claus). Be sure you purchase your tickets early, as they sell out quickly. For hockey

fans, the Philadelphia Flyers are at home against the Minnesota Wild on Thursday, November 20, and the Columbus Blue Jackets on Saturday, November 22. For the athletically inclined who prefer individual rather than team sports, the Philadelphia Marathon will take place on Sunday, November 23 (<http://www.philadelphia-marathon.com/>). Although you cannot register on race day, registration is extended until November 1, 2014, and there are few restrictions for entering the race (other than the requirement that you must maintain a 16-minute-per-mile pace!).

For those of you who are interested in arts and theater, there are many events taking place in Philly during the convention week/weekend. On Friday, November 21, and Saturday, November 22, the Philadelphia Orchestra, one of the country's finest symphonies, will be playing Brahms and Stravinsky (<https://www.philorch.org/#/>). A variety of shows will be running in Philadelphia during the convention as well. For instance, the Walnut Street Theater (<http://www.walnutstreettheatre.org/>; within walking distance of the Marriott) is hosting *Mary Poppins* during the dates of the convention.

### Getting Around in Philadelphia

You can get virtually anywhere in Philadelphia via our public transportation system, called SEPTA (Southeastern Pennsylvania Transportation Authority). SEPTA consists of buses, subways, trolleys, and trains (called regional rails) that traverse the city and surrounding suburbs. All routes and times can be accessed through [www.septa.org](http://www.septa.org). A trip planner on the main page can help you find the best way to get to and from your destination.

The city is intersected by the subway (also called the Broad Street Line or Orange Line) which travels north-south and the Market-Frankford subway (also known as the Blue Line or simply the "El") which runs east-west. The two lines meet at City Hall in Center City (a few blocks from the conference hotel) where you can transfer from one line to the other for free. The subway and El run every 5 to 15 minutes from about 5 A.M. to midnight. Between midnight and 5 A.M. buses that run along the same routes are used. Speaking of buses, street-level buses can take you pretty much anywhere you need to go in the city that is not directly accessed by the subway, El, or regional rail. The frequency and hours of the buses depend on the specific bus route, but all run from early in the morning until

late in the evening. Finally, the regional rails are the quickest and arguably most comfortable form of public transportation. These trains are designed to transport individuals back and forth from the Center City area to the outskirts of the city and into the suburbs. Unlike the other forms of SEPTA transportation, fares for regional rails are not a single flat rate. They vary by the distance you are going (which SEPTA divides into "zones").

Customers have a variety of fare options to suit their travel needs. Paying the cash fare of \$2.25 (exact fare only, meaning if you only have dollar bills and give them \$3.00, don't expect to get change back) on transit services (excluding regional rails) is the simplest way to ride. However, tickets, tokens, and passes offer additional savings. You can get tokens at most El and subway stops in the Center City area (machines located at El and subway stops dispense tokens). You can also get tokens, passes, and regional rail tickets at the Jefferson Station (about 1 block from the conference hotel). Tokens can be bought in amounts of 2 or more and cost \$1.80 per token (\$3.60 for 2). If you plan on doing a lot of sightseeing via public transportation, you may want to get a one-day convenience pass (valid for eight rides on any bus, trolley, or subway route in one calendar day by one person for \$8.00) or independence pass (unlimited one-day travel on SEPTA services for \$12.00). For more info on SEPTA fare prices/options, go to <http://www.septa.org/sales/index.html>. You can purchase regional rail tickets at the train station, or, if you forget, on the train from the conductor (but it is cash only and there is a surcharge of \$0.75 to \$2.00 for buying your ticket from the train conductor). For more information on the regional rail system go to <http://www.septa.org/service/rail/>.

Taxis are in abundance in Center City and are a convenient way to reach your destination. The Philadelphia Parking Authority currently regulates fare rates, which are an initial flat rate of \$2.70, with a \$0.23 charge for each 1/10 mile or 37.6 seconds of wait time. If you are short of cash, no worries. Taxi cabs in Philadelphia are required to accept credit card payments.

For those of you who prefer to walk, Philadelphia is a very walkable city. Center City is built upon founder William Penn's easy-to-follow grid street design that spans just 25 blocks between two rivers—the Schuylkill and the Delaware. Broad Street is the main north/south street, and Market Street is the main east/west street; they intersect at City Hall. In between, the

## online

### 48th Annual Convention

ABCT's brand-new, interactive, multifaceted **convention app** will be available 2 weeks before the convention. Stay tuned for more information . . .

 <https://www.abct.org/conv14>

## in-press article

### Dialectical Behavior Therapy for School Refusal: Treatment Development and Incorporation of Web-Based Coaching

"... multiple chain analyses . . . revealed that Ricky stayed in school once he was there, but getting out of bed and into the car was most challenging. Graded steps focused on approaching school (e.g., going to school but staying in the counselor's office; going to school for just one class), with many morning routine substeps. . . ."

Chu et al.

*Cognitive and Behavioral Practice*  
doi:10.1016/j.cbpra.2014.08.002

## archive

"A man can not be said to *have* either a type or a trait, but he can be said to *fit* either a type or a trait. At present the fit will be inexact. . . ."

Pratt, 1939

*The Logic of Modern Psychology*  
New York, MacMillan

north/south streets have tree names (e.g., Walnut, Locust, Spruce, Pine). For example, when walking along Market Street, if you notice cross streets with decreasing numbers, you are heading east (toward the historical sites and the Delaware River), and if you notice cross streets with increasing numbers, you are heading west (toward Rittenhouse Square and the Schuylkill River).

## Weather

Late fall tends to be cool in Philadelphia with the average high temperature in November in the mid-50s. In November of 1950 the temperature went up to 84 degrees, but I am not sure we can count on that happening again this year, so bring a jacket and/or coat! Snow is also a possibility, but not a very strong one, as the initial Philly snowfall usually doesn't occur until December. On average it only snows 0.2 days a month in November in Philadelphia.

## Local Arrangements at Your Service

The Local Arrangements Committee is already hard at work to ensure that your stay in Philadelphia is a memorable one. We will have a table located in the registration area from Thursday, November 20, to Saturday, November 22, staffed by Philadelphia ABCT members who can answer your questions. At this table, we will

have materials on local tourist attractions for you to peruse at your convenience. In addition, we will have information on how to get around in Philly.

The Local Arrangements Committee is also planning several organized activities to introduce you to Philadelphia culture. Continuing with the tradition set by the last Philadelphia Local Arrangements Committee, the "Dine with a Philadelphian" program will give you the opportunity to accompany a Philadelphia ABCT member to a local restaurant with fellow convention attendees. We are also organizing a trip to the Wachovia Center to watch the Philadelphia Flyers (a must for aggression and alcohol researchers!). Furthermore, we are planning a Friday-morning "fun run" from the convention hotel to (and up) the "Rocky" steps at the Philadelphia Museum of Art. If you want more information about any of these outings or anything else related to your trip to Philadelphia, please contact the committee's chairperson, Mike McCloskey, at [mikemccloskey@temple.edu](mailto:mikemccloskey@temple.edu). Let us know what we can do to help make your trip more enjoyable. We look forward to seeing you in November!

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Wendy Lauer  
Melissa Miller  
Joshua Rosenthal

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Melissa Barone  
Amit Baumel  
Samantha Beauchman  
Jacinda Cadman  
Celeste Conlon  
Amy Bassell Crowe  
Katherine Kampe  
Dahlsgaard  
Jeffrey L. Dodds  
Cathy Jo Donnell  
Stephanie Dowd  
Sharon Elwell  
Jeff Foote  
Clare Gaskins  
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Goodwin  
Geetha Gopalan  
Peter Harakas  
Dirk Hermans  
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Fedders  
Nicole Kosanke  
Michele Koschin  
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Amanda McGough  
Yeraz Meschian  
Allen R. Miller  
Nira Nafisi  
Carmem Beatriz Neufeld  
Jeffrey R. Nolting  
Aimee Peters  
Alma Lovaton Quagliato  
Elizabeth Keats  
Reynolds  
S. Craig Rooney  
Nancy G. Saenz  
David Byron Sinclair  
Richard Stein

Rebecca Elizabeth  
Stocker  
Rebecca Swan  
Monique Ann  
Thompson  
Bram Vervliet  
Andrew Craig Voluse  
Linda Vono  
Barbra M. Waldfogel  
Kristin M. Weinzierl

## New Professional

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Ariel Campbell  
Christopher Flessner  
John Robert Hawkins  
Philip Held  
Rachel Hutt  
Elizabeth Ann Koenig  
Justin Lavner  
Alicia C. Lesniak  
Mandi Levine  
Mary Lynn McDevitt  
Candice Gail Moore  
Eric Pollak  
Annie Y. Tang

## Postbaccalaureate

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Anakwenze  
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Alyson Baker  
Deepika Bose  
Amanda Bowling  
Allison A. Campbell  
Allison Elise Diamond  
Ariel M. Domlyn  
Miranda Nicole Gerber  
Elizabeth Glaeser  
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Lesley Anne Norris  
Mary Melissa Packer  
Sophie A. Palitz  
Marissa Rachel Schwartz  
Natasha Sidhu  
kathryn Soltis  
Naomi Francine Stahl  
Mark Versella

## Student

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Richa Aggarwal  
Fatimah Samir  
Alghamdi  
Brooke Ammerman  
Cecily Anders  
Molly Elizabeth Arnn  
Danielle Arouty  
Augustus Artschwager  
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Lediya Dumessa  
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Mona Elgohail  
Jordan Ellis  
Kelly Erickson  
Dylan Ermacora  
Hallie Espel  
Marie Faaborg-Andersen  
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Cassie Fichter  
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