

# *the* Behavior Therapist

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### *President's Message*

## America Is Hurting and We Can Help: Seven Points to Consider

*Stefan G. Hofmann, Boston University*



America is hurting. The unemployment rate is still high, wages are low, and the housing market that pulled the economy into a deep recession is still not where it should be. To make things worse, the burden of the economic crisis is carried by the middle class and the most vulnerable groups. The poor are getting poorer; the rich are getting richer; and the middle class is eroding. Since 1980, around 5% of the annual national income shifted from the middle class to the nation's richest people. Recent reports show that Americans making \$1 million or more annually has grown 18% since 2009, while the number of jobs fell by half a million. Today, 1 out of 6 Americans lives in poverty, as defined by an income of less than \$22,000 for a family of 4. Not surprisingly, the economy and job security have become the primary concerns for the majority of Americans, far ahead of education, health care, the war on terror, and other big issues.

Many Americans feel a great deal of anger against corporate greed, as well as the political and social systems that have been supporting or tolerating it. As a result, many have begun to openly express their feelings of anger and frustration; some even support extreme political views that might promise a way out of the situation.

Economic hardships can have a profound impact on mental health. Clinicians, researchers,

[continued on p. 3]

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## INSTRUCTIONS for AUTHORS

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

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.

- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.

- Feature articles and brief articles should be accompanied by a 75- to 100- word abstract.

- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a **Copyright Transfer Form** (a form is printed on p. 35 of the February 2011 issue of *tBT*, or download a form from our website): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor at [gunthert@american.edu](mailto:gunthert@american.edu). Please include the phrase *tBT submission* and the author's last name (e.g., *tBT Submission - Smith et al.*) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

and teachers are certainly affected by such economic problems. However, compared to other professions, our jobs are relatively safe. In fact, some of us might even benefit from the current situation because more people are requiring professional help due to their ongoing unemployment stress, at least in the beginning of a recession and in the short term. Similarly, in this economic climate, universities are seeing more people pursuing additional college degrees in order to improve their academic credentials or as an alternative to being unemployed.

As therapists, we should consider the possibility that a client's depression, anxiety, marital conflicts, sexual disorders, substance use problem, and so on, are linked to the current economic situation. Unemployment stress is not always obvious; poverty can be associated with a great deal of guilt and shame and many people are not willing to easily share this with others, including his or her therapist. Even spouses and close friends can be left in the dark for some time before the unavoidable hardship of unemployment hits. For many people, financial failure is a sign of personal failure. After all, the American Dream is built on the idea that "making it" means accumulating wealth, power, and prestige against all odds. Losing a job and being unemployed might, therefore, be interpreted as "not making it," not living the dream, and being a failure. Thus, it is important to consider the economic context and personal financial situation of our clients and to ask direct questions about it, rather than expect clients to volunteer this information.

The self-help bookshelves are filled with literature that promises to reveal the secrets of becoming the next Steve Jobs or Bill Gates. Countless "unemployment survival guides" are advertised on websites of popular online booksellers. I don't want to bore the reader of my column with a review of these pop-psychology books. Instead, I would like to share some of my own thoughts about how to handle the issues of unemployment in clinical practice. This is not to say that I am an expert on this topic. I am not. I am sure many of our readers know much more about the subject than I do. One of ABCT's past presidents, Robert Leahy, is currently writing a book on the psychological stress of unemployment, and I am sure the interested reader will find a lot of helpful information in his upcoming volume. In this column, I would like to share a few of my own thoughts about how to deal with unemployment stress in clinical practice.

First of all, the guilt and shame associated with unemployment, poverty, or financial hardship may or may not be associated with depression, substance use problems, sexual dysfunction, marital conflicts, sleep disorders, anxiety disorders, and the like. Discussing employment issues with a mental health professional does not mean that it is, in fact, associated with a mental health problem. Clearly, some people are better able to cope with unemployment stress than others. However, when unemployment becomes chronic, it will almost certainly have an impact on one's psychological health. In order to understand the client's worldview, the therapist needs to know the economic situation of his or her client. In order to gain good insight into the financial situation of a client, the therapist needs to gather concrete and reliable information about the client's situation. Just as it is uncomfortable to talk about sexual practices, it is considered taboo to discuss income and living expense. But without this information, the therapist can easily miss important information.

Second, acknowledging and discussing financial problems can be enormously helpful to clients and can be very useful when assigning a diagnosis and designing a treatment plan. Instead of receiving the diagnosis of depression, the client might meet criteria for adjustment disorder or even receive a V code. My experience is that simply encouraging clients to share their feelings about their financial hardship can be remarkably beneficial, even if these problems have nothing or little to do with the presenting problem.

Third, although being unemployed is an undesirable situation, it is not a catastrophe, and it is usually a time-limited problem as long as the client is persistent and open to a wide variety of alternative career options. Unemployment does not have to be a life-altering event. It is caused by an economic downturn that is cyclical. In the majority of cases it is not caused by one's personal failures. Cognitive and behavioral strategies can facilitate the shift in the client's perspective to view unemployment as a temporary problem that is caused by external factors rather than a long-term and life-altering catastrophic event caused by personal incompetence. In this case, internalizing the problem tends to be maladaptive, and externalizing tends to be adaptive.

Fourth, it is often helpful to explore creative ways to solve a client's current economic problems by "making lemonade out of lemons." Again, skillfully applied cognitive and behavioral strategies can work

wonders. Younger clients might consider going back to school to become more competitive in their respective field. Or perhaps they might choose a different, more suitable, career. Similarly, middle-aged clients might want to reevaluate their job and consider pursuing a new career altogether, especially if the old job was not satisfying. If the client was considering leaving his/her job, the economic downturn might provide an opportunity to pursue the long-held "dream job." Unfortunately, the choices become much more limited for older clients. Early retirement might be an option. If all fails, the client may just have to settle, at least temporarily, for a job that is below his or her abilities or perhaps combine early retirement with a part-time job. Sometimes, any job can be better than no job.

Fifth, once the client is able to normalize, decatastrophize, and depersonalize a stressful but solvable situation, the therapist will need to help the client to develop and implement specific strategies to solve his unemployment problem head-on. Avoiding the problem makes things much worse. My recommendation is to be as concrete and hands-on as possible. Brainstorming sessions can be helpful. Specific homework assignments can help clients implement these strategies between sessions. Because a job search can be a highly frustrating experience, it is important to encourage perseverance and creativity while developing structure, regimens, and routines.

Sixth, social support and compassion by others are essential. Clients need to be encouraged to share their plans, attempts, and failures with close friends and family members. The stress of unemployment should not rest on only one person's shoulders. Many people are affected by the loss of one person's job. Sharing one's plans and actions relieves the stress that other affected people experience, especially family members and friends.

Finally, I would encourage us, the therapists, to routinely do *pro bono* work with clients who hurt the most financially. We are all in this together. It would be nice if some of the bankers, brokers, and mortgage companies that got us into this mess also showed some compassion for our fellow Americans. But I doubt that this will happen in our lifetime.

...

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## Antidepressant Controversy: A Cause for Concern and an Opportunity for Progress

Nicholas R. Forand, *The Ohio State University Wexner Medical Center and University of Pennsylvania*

Robert J. DeRubeis, *University of Pennsylvania*

Concerns involving antidepressants have recently caught the attention of the popular media. Several reports have focused on findings from recent meta-analyses that question the efficacy of medications compared to placebo in mild to moderate depression (Fournier et al., 2010; Kahn, Leventhal, Khan, & Brown, 2002; Kirsch et al., 2008). These studies have been the subject of numerous newspaper articles (e.g., Mukherjee, 2012; Rubin, 2010), as well as in a recent *60 Minutes* piece featuring Irving Kirsch (Bonin, 2012). They were also among the topics discussed on a CBS News *Sunday Morning* piece that featured, among others, the second author (Weisfogel, 2012). Some reports have focused on accusations of misconduct leveled at drug companies, who have been accused of misleading and fraudulent presentation of data on the efficacy and safety of antidepressants (e.g., Staton & Palmer, 2012; Turner, 2008; Wadman, 2011). These include allegations of cover-ups involving potentially serious negative effects, such as increased suicide risk in adolescents (Jureidini, McHenry, & Mansfield, 2008). More recently, Robert Whitaker's well-sourced book *Anatomy of an Epidemic* proposed that widespread use of psychotropic medications has contributed, through iatrogenic effects, to the dramatic increase in rates of chronic mental health problems and related increases in rates of disability (Whitaker, 2011).

These criticisms have not gone unanswered. Over the past 5 years, several scientific papers have challenged findings indicating that antidepressant efficacy is limited in mild to moderate depression. Some of these papers have included sophisticated methods in attempts to identify the presence of subgroups with good drug responses (Gueorguieva, Mallinckrodt, & Krystal, 2011; Thase et al., 2011). Others have focused on the claimed inadequacies of typical outcome measures in detecting improvement in mild depression (Helmreich

et al., 2012; Isaacsson & Adler, 2012), while still others have presented reanalyses of data sets to address the moderating effect of severity (Gibbons, Hur, Brown, Davis, & Mann, 2012).

Concerned parties have also taken to the media to caution the public about findings that might imply that antidepressants have been overused. A series of editorials in the *New York Times*, by individuals including *Listening to Prozac* author Peter Kramer (2011), journalist Judith Warner (2010), and Cornell psychiatrist Richard Friedman (2010), have challenged the findings of Fournier et al. (2010), Whitaker, and others. In addition, the American Psychiatric Association (APA) took the unusual step of registering an official response to the *60 Minutes* piece. Their press release stated that antidepressants are safe and effective and deemed the aired segment to be "irresponsible and dangerous" (APA, 2012). Each of these accounts, and the ensuing rebuttals, has contributed to a rising tide of confusion and concern about the most common treatment for depression.

Our conversations with mental health professionals have revealed a range of opinions on these issues. Some have expressed concern about treatments that they consider an integral part of client care, whereas others have stated that these reports only confirm what they suspected all along. Still others reject outright the basis of the controversy, believing it to be the work of typical antipsychiatry forces. Whatever our attitudes, however, as mental health researchers and providers we are in the midst of a change in how the public views antidepressant and other psychotropic medications. It is our obligation to understand and, if possible, clarify these issues.

The first step, as always, is to turn to the data. With respect to acute treatment of depression with medications, the evidence is relatively clear. Randomized comparisons to placebo demonstrate that antidepressants are efficacious over short-term treatment.

However, several studies suggest that much of this superiority is derived from the treatment of severely depressed individuals (Fournier et al., 2010; Kahn et al., 2002; Kirsch et al., 2008). In less severe individuals, medications and placebo tend to do equally well, although drugs might be effective for mild to moderate depression with certain features such as a chronic course (Keller et al., 2000).<sup>1</sup> Second, continued medications after acute response are associated with a reduced rate of relapse in comparison to discontinued medications (Geddes et al., 2003). Long-term studies suggest that protection against relapse and recurrence lasts at least 6 months (Reimherr et al., 1998), but that maintenance treatment is less effective for those with chronic or recurrent depression (Kaymaz et al., 2008; McGrath, 2006). Risk of relapse after discontinuation is mitigated somewhat by the gradual tapering of medication, especially in those with recurrent depression (Baldessarini, Tondo, Ghiani, & Lepri, 2010). However, there is no clear empirical guidance at this time as to the optimal length of medication maintenance (Kaymaz et al.). Side effects are common (Anderson et al., 2012), and upon discontinuation many individuals experience a "discontinuation syndrome" marked by uncomfortable and distressing physical symptoms (Howland, 2010), making it difficult for some to stop taking their medication. Evidence regarding iatrogenic effects of long-term medication use is circumstantial but suggestive (Fava & Offidani, 2011). Perhaps the best established finding is that increased exposure to antidepressant medications predicts resistance to their effects in subsequent treatment trials (Amsterdam et al., 2009; Leykin et al., 2007).

Strategies that will optimize antidepressant efficacy would appear to be relatively straightforward, considering these findings. Antidepressants are appropriate treatments for moderate to severe depression. If acute remission is achieved, medication should be tapered and discontinued for most individuals after a symptomatically stable period. Maintenance treatment might be considered for those at heightened risk for recurrence (e.g., those with recurrent illness).

<sup>1</sup>Importantly, most reports suggest that evidence-based psychotherapies are as effective as medications in this severe population (with some exceptions, e.g., Elkin et al., 1989). Furthermore, psychotherapy also derives most of its benefit over placebo in severely depressed individuals (Driessen et al., 2010).

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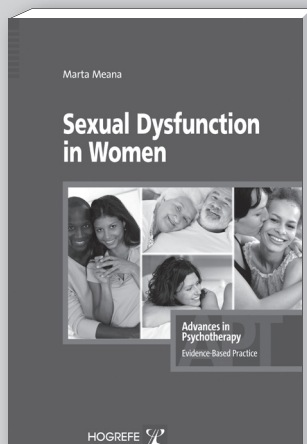
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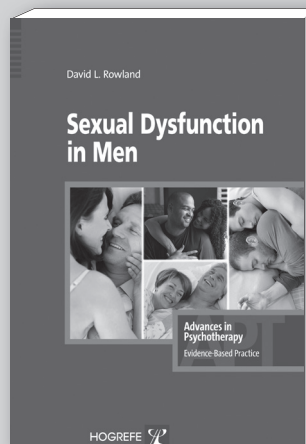
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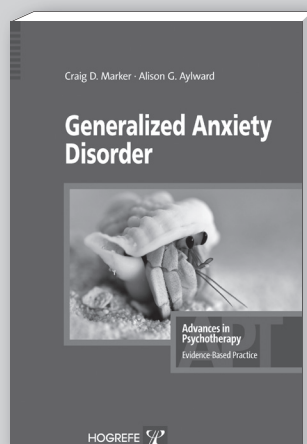
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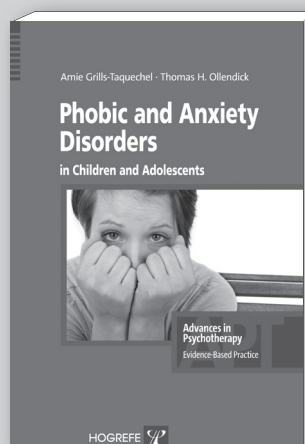
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This strategy offers the best balance of the benefits, risks, and costs of these medications and is, with some minor differences, the strategy for antidepressant monotherapy recommended by major treatment guidelines (APA, 2010; National Institute for Health and Clinical Excellence [NICE], 2009).

However, findings from a recent survey suggest that the actual usage of antidepressants far exceeds the limits recommended by treatment guidelines. A recent report by the National Center for Health Statistics (NCHS) found that 11% of Americans 12 and older are currently taking antidepressants, and that 48% of these individuals take more than one (Pratt, Brody, & Gu, 2011). Only about half of these individuals regularly see a psychiatrist, leaving the bulk of prescriptions to be managed by primary care physicians. Duration of treatment is frequently greater than 2 years (60%), with nearly 14% of individuals having taken an antidepressant for 10 years or more. Given that the 12-month prevalence of a major depressive episode of all levels of severity is only 6.6% (Kessler et al., 2003), these rates appear to indicate usage beyond what the data support.

Despite evidence of overuse, some medication advocates claim that the risks of antidepressant treatment are rare and largely overshadowed by the risks associated with untreated depressive episodes. The usage data suggest otherwise. In the approximately 33 million Americans who currently take an antidepressant, an adverse reaction that occurs in only 0.01% of the population affects more than 33,000 individuals. Other cost/benefit arguments are also upended. Thase et al. (2011) estimated that 20% of individuals taking antidepressants receive benefits that they would not have received had they been given placebo. However, even if all 33 million Americans taking antidepressants meet criteria for a major depressive episode of sufficient severity to warrant medication treatment, 26 million of these individuals are taking an active medication from which they likely receive no benefit over the effect of placebo. Thus, current trends in antidepressant usage suggest that we are in the midst of a potentially serious public health dilemma. Although these medications are effective and safe if used properly, the majority of individuals taking them do not meet the criteria outlined above, and are thus exposed to additional risk, perhaps without compensating benefits. Given these sobering numbers, there is ample reason for the mental health community to be concerned.<sup>2</sup>

Serious problems such as these demand serious action. And given the current skepticism regarding the dominant treatment paradigm, psychologists, in collaboration with willing peers from medicine and psychiatry, have a remarkable opportunity to reshape how medications and other interventions are used in the treatment of depression. The task we face is to determine how medications best fit into a system of care that includes the full range of effective treatments. The primary questions are these: For whom and under what conditions are medications most effective? How might medications be combined, sequentially or simultaneously, with other treatments to improve acute outcomes? Finally, how do medication strategies fit into relapse prevention and long-term care? In the remainder of this article, we briefly present a research agenda for addressing these questions.

The first priority will be familiar to anyone who has read the mental health treatment literature over the past 50 years: efforts are needed to understand which treatments are effective for which individuals. Progress in the development of valid and clinically useful methods of selecting treatments will increase pressure to move away from the current one-size-fits-all treatment paradigm. Two methods for selecting acute treatments show the greatest promise: (a) using research on moderators of outcome to inform treatment selection, and (b) adjusting treatment strategies based on continuous monitoring of response. Both of these have been attempted within the antidepressant medication (ADM) literature (see pharmacogenetics research, treatment algorithms, and “measurement based care”) thus far with equivocal success (e.g., Gvozdic, Brandl, Taylor, & Muller, 2012). However, most of these efforts have focused on selecting or sequencing different pharmacological agents. Larger treatment effects become more likely as the differences in mechanism of action between treatments increase. The most promising treatments for inclusion in this type of research are empirically supported psychotherapies for depression, which include cognitive therapy (CT; Beck, Rush, Shaw, & Emery, 1979), behavioral activation (BA; Martell, Addis, & Jacobson, 2001), and interpersonal therapy (IPT; Klerman, Weissman, Rounsaville, & Chevron, E.S., 1984), each of which is

equally efficacious to medication in the acute treatment of depression.

Regarding moderators of treatment response, several groups have identified variables that predicted better response, within their samples, to medication versus psychotherapies such as CT or IPT (e.g., Fournier et al., 2008; Fournier et al., 2009; Frank et al., 2011; Leykin et al., 2007). However, these variables are rarely used to select treatments in practice. One problem is the infrequency with which these findings are replicated. Another barrier appears to be the difficulty in integrating multiple moderators of response. For example, if an individual has both a personality disorder, which predicts better acute response to medications (Fournier et al., 2008), and is unemployed, which predicts better response to cognitive therapy (Fournier et al., 2009), there is no currently available method for choosing between the treatment recommendations indicated by these two variables. A clinically useful treatment selection procedure would implement a means of combining multiple predictors and produce estimates of the expected benefits from each of the treatments under consideration. If such a method can be developed and proven valid for predicting response, individuals can be directed toward specific treatments with more confidence regarding the expected outcome. Such a method for determining the expected benefit for cognitive therapy versus medications on the basis of patient characteristics has been developed by our lab and is currently under review (DeRubeis et al., 2012). One advantage of this approach over recent attempts to identify whether there are (latent) subgroups of responders (e.g., Gueorguieva et al., 2011; Thase et al., 2011) is that our prediction approach identifies specific individuals who are expected to benefit from specific treatments, on the basis of information obtained prior to the initiation of treatment.

Given the difficulty of moderator research, which is best conducted in the context of a randomized trial, a second and possibly more feasible effort involves the development of methods to select or adjust treatment strategies based on ongoing monitoring of treatment response. Strategies using this logic are variously known as sequenced treatments, stepped care, or clinical staging. These approaches

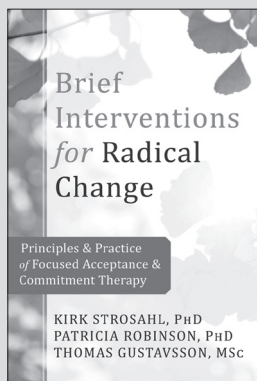
<sup>2</sup> Importantly, placebo responders in antidepressant medication trials do receive treatment, including psychoeducation, instillation of hope, contact with a care provider, etc. Thus, medication treatment is not equivalent to no treatment at all in lower severity depression.

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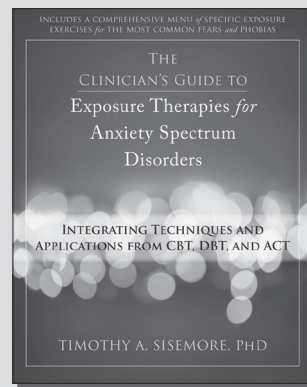
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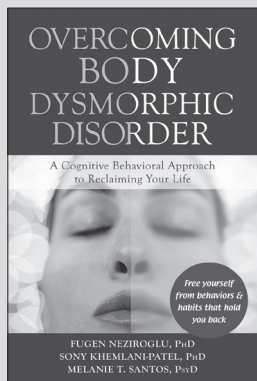
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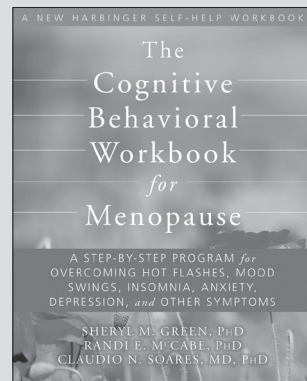
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have several features to recommend them. First, in stepped care approaches, patients are given a low-risk, low-cost intervention as a first step (e.g., psychoeducation, monitoring, diet and exercise, or computerized CBT). Riskier and more intensive treatments (i.e., medication, structured psychotherapy, or any combination of these) are reserved for individuals who do not respond to the initial treatment. An additional advantage of sequencing approaches is that the relative strengths of treatments can be maximized based on the needs of the patient. A specific treatment model known as the “sequential approach” involves the use of medications for acute treatment and a planned switch to CBT to treat residual symptoms as well as to provide protection against relapse (Fava & Tomba, 2010). Some evidence suggests that medication-CBT sequential treatments outperform medication treatment alone in producing acute and sustained response, and reduce costs at the same time (Bockting et al., 2009; Fava & Tomba; Frank et al., 2000; Scott, Palmer, Paykel, Teasdale, & Hayhurst, 2003). Further research is needed to refine these approaches; specifically, to determine for which individuals stepped treatment (versus continued monotherapy) is indicated, the optimal sequencing and timing of the steps, as well as the duration of continuation or maintenance treatment.

Stepped approaches also offer a more rational method for implementing treatment combinations, such as medications combined with therapy or combinations of medications (Forand, DeRubeis, & Amsterdam, in press). Although these treatments are, on average, superior to monotherapies in the short run, they are riskier and costlier, and the evidence for improvements in sustained response relative to cognitive therapy alone is limited (Cuijpers, Dekker, Hollon, & Andersson, 2009; Cuijpers, van Straten, Warmerdam, & Andersson, 2009; Vittengl, Clark, Dunn, & Jarrett, 2007). Thus, they should be reserved for cases in which a full course of monotherapy or a sequence of lower risk therapies has proven ineffective.

Improving response to acute treatment is imperative, but it is not enough. The high rate of recurrence after successful acute treatment with medications (40% to 85%; Hughes & Cohen, 2009) suggests that increased effort is needed to understand and prevent the return of symptoms. Thus, our second priority is the prevention of relapse and recurrence. Research findings indicate that prolonged medication continuation

(the so-called “insulin for diabetes” approach) is inadequate due both to its cost and inefficacy (Bockting et al., 2008; Vos, Corry, Haby, Carter, & Andrews, 2005). It might also expose individuals to additional risk. For example, it has been suggested that long-term medication usage can contribute to iatrogenic processes such as tachyphalaxis (the loss of clinical effect during continuation or maintenance ADM treatment) and progressive resistance to future trials of medications (Amsterdam et al., 2009; Leykin et al., 2007). As noted above, several cognitive-behavioral approaches designed for preventing relapse have been tested as add-on or sequential treatments after acute medication treatment (Fava & Tomba, 2010). Evidence suggests that this strategy is superior to medication maintenance alone, whether the continuation of medications accompanies CBT or not (Guidi, Fava, Fava, & Papakostas, 2011). In such cases, the prophylactic effects of CBT might preclude the need for prolonged medication maintenance. Furthermore, efforts at identifying risk for relapse have uncovered important predictors, including the number of previous episodes and the presence of residual symptoms following the termination of a successful treatment (Ma & Teasdale, 2004; Vittengl, Clark, & Jarrett, 2010). However, as with prediction of acute response, these efforts are useful only insofar as they can be applied to improve clinical outcomes. Thus far, there have been few (if any) systematic efforts to identify and integrate predictors of relapse to assist in the selection of appropriate relapse prevention strategies. Efforts are needed to integrate such findings in order to determine the need for relapse prevention as well as the most appropriate choice of treatment.

This is clearly an ambitious agenda involving multiple possible avenues for the advancement of depression treatment. These efforts are consistent with a number of sociocultural and economic influences, including the NIMH’s push for the development of personalized medicine, and continued pressure from managed care organizations to increase cost-effectiveness of care. Pharmaceutical companies have also begun to direct internal funding away from neuroscience research (Abbott, 2011), which will likely create a vacuum in clinical research related to depression. The waning influence of pharmaceutical companies in the field would create both a need for redoubled research efforts and a remarkable opportunity to reshape care. The barriers to such efforts are familiar: with an increased

role for empirically supported psychotherapy come problems related to training, treatment fidelity, and dissemination. Some countries, such as the U.K., have had success in integrating low intensity and psychotherapeutic services into their national health care system. Their efforts can serve as a model for such approaches in the U.S. (Clark, 2011). Furthermore, once systems of care are developed, they must be implemented in such a way that they reach the greatest number of individuals. Programs such as Collaborative Care, a systematized approach to depression treatment that has proven effective in primary care, might be a useful model for the rollout of other empirically supported approaches into these settings (Unützer & Park, 2012). Finally, a skeptical public as well as the medical/psychiatric treatment community must be convinced, with evidence, that empirically supported methods of depression treatment other than or in addition to medications are feasible and effective. With the current renewed public interest in depression treatment, it is time for the research community to step up and deliver these advancements.

Despite a stance that some would term controversial, we have no interest in starting or continuing a turf war between psychology and psychiatry. An objective look at the evidence leads to the following conclusions: (a) our treatments, including both psychotherapy and medications, are currently inadequate, and (b) there is little reason to be optimistic that any novel treatment will substantially improve care in the near or intermediate term. Given these conditions, the next logical step is to improve the deployment of current treatments to maximize their efficacy. This involves an honest appraisal of the strengths and weaknesses of each treatment, and continued research to identify which treatment works best for specific individuals and specific phases of illness. Research of this type, and the subsequent dissemination of such systems into practice, requires the close collaboration between mental health researchers and practitioners of all disciplines. We truly hope for an open and fruitful collaboration between psychiatry and psychology in the development and refinement of our treatments.

## References

- Abbot, A. (2011). Novartis to shut down brain research facility. *Nature News*. Retrieved from <http://www.nature.com/news/novartis-to-shut-brain-research-facility-1.9547>



- American Psychiatric Association. (2010). *Practice guidelines for the treatment of patients with Major depressive disorder* (3rd ed.). Washington, DC: Author. Available at <http://psychiatryonline.org/guidelines.aspx>.
- American Psychological Association. (2012). "60 Minutes" Segment on Antidepressants "Irresponsible and Dangerous" [Press release]. Retrieved from <http://www.psych.org/File%20Library/Advocacy%20and%20New%20room/Press%20Releases/2012%20Releases/12-07--60-Minutes-on-Depression--Irresponsible.pdf>
- Amsterdam, J. D., Williams, D., Michelson, D., Adler, L. A., Dunner, D. L., Nierenberg, A. A., & Schatzberg, A.F. (2009). Tachyphylaxis after repeated antidepressant drug exposure in patients with recurrent major depressive disorder. *Neuropsychobiology*, 59(4), 227–233. doi:10.1159/000226611
- Anderson, H. D., Pace, W. D., Libby, A. M., West, D. R., & Valuck, R. J. (2012). Rates of 5 common antidepressant side effects among new adult and adolescent cases of depression: A retrospective US claims study. *Clinical Therapeutics*, 34(1), 113–123. doi:10.1016/j.clinthera.2011.11.024
- Baldessarini, R. J., Tondo, L., Ghiani, C., & Lepri, B. (2010). Illness risk following rapid versus gradual discontinuation of antidepressants. *The American Journal of Psychiatry*, 167(8), 934–941. doi:10.1176/appi.ajp.2010.09060880
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford Press.
- Bockting, C. L. H., ten Doesschate, M. C., Spijker, J., Spinhoven, P., Koeter, M. W. J., & Schene, A. H. (2008). Continuation and maintenance use of antidepressants in recurrent depression. *Psychotherapy and Psychosomatics*, 77(1), 17–26. doi:10.1159/000110056
- Bockting, C. L. H., Spinhoven, P., Wouters, L. F., Koeter, M. W. J., & Schene, A. H. (2009). Long-term effects of preventive cognitive therapy in recurrent depression: A 5.5-year follow-up study. *The Journal of Clinical Psychiatry*, 70(12), 1621–1628. doi:10.4088/JCP.08m04784blu
- Bonin, R. (producer) & Stahl, L. (correspondent). (2012, February 19). Treating Depression: Is there a placebo effect? In Fager, J. (Executive Producer), *60 Minutes*. New York, NY: CBS News.
- Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International Review of Psychiatry*, 23(4), 318–327. doi:10.3109/09540261.2011.606803
- Cuijpers, P., Dekker, J., Hollon, S. D., & Andersson, G. (2009). Adding psychotherapy to pharmacotherapy in the treatment of depressive disorders in adults: A meta-analysis. *The Journal of Clinical Psychiatry*, 70(9), 1219–1229. doi:10.4088/JCP.09r05021
- Cuijpers, P., van Straten, A., Warmerdam, L., & Andersson, G. (2009). Psychotherapy versus the combination of psychotherapy and pharmacotherapy in the treatment of depression: A meta-analysis. *Depression and Anxiety*, 26(3), 279–288. doi:10.1002/da.20519
- DeRubeis, R.J., Cohen, Z., Forand, N.R., Fournier, J.C., Gelfand, L.A., & Luaces, L.L. (2012). *A method for constructing treatment selection algorithms using multiple predictors: An example from the treatment of depression*. Manuscript submitted for publication.
- Diessen, E., Cuijpers, P., Hollon, S. D., & Dekker, J. J. M. (2010). Does pretreatment severity moderate the efficacy of psychological treatment of adult outpatient depression? A meta-analysis. *Journal of Consulting and Clinical Psychology*, 78(5), 668–680. doi:10.1037/a0020570
- Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., ... & Docherty, J.P. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program. General



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- effectiveness of treatments. *Archives of General Psychiatry*, 46(11), 971–982.
- Fava, G. A., & Offidani, E. (2011). The mechanisms of tolerance in antidepressant action. *Progress in Neuro-Psychopharmacology & Biological Psychiatry*, 35(7), 1593–1602. doi:10.1016/j.pnpbp.2010.07.026
- Fava, G. A., & Tomba, E. (2010). New modalities of assessment and treatment planning in depression: The sequential approach. *CNS Drugs*, 24(6), 453–465. doi:10.2165/11531580-000000000-00000
- Fournier, J. C., DeRubeis, R. J., Hollon, S. D., Dimidjian, S., Amsterdam, J. D., Shelton, R. C., & Fawcett, J. (2010). Antidepressant drug effects and depression severity: A patient-level meta-analysis. *Journal of the American Medical Association*, 303(1), 47–53. doi:10.1001/jama.2009.1943
- Fournier, J. C., DeRubeis, R. J., Shelton, R. C., Gallop, R., Amsterdam, J. D., & Hollon, S. D. (2008). Antidepressant medications v. cognitive therapy in people with depression with or without personality disorder. *The British Journal of Psychiatry: The Journal of Mental Science*, 192(2), 124–129. doi:10.1192/bjp.bp.107.037234
- Fournier, J. C., DeRubeis, R. J., Shelton, R. C., Hollon, S. D., Amsterdam, J. D., & Gallop, R. (2009). Prediction of response to medication and cognitive therapy in the treatment of moderate to severe depression. *Journal of Consulting and Clinical Psychology*, 77(4), 775–787. doi:10.1037/a0015401
- Frank, E., Grochocinski, V. J., Spanier, C. A., Buysse, D. J., Cherry, C. R., Houck, P. R., ... & Forgiione, R. M. (2000). Interpersonal psychotherapy and antidepressant medication: Evaluation of a sequential treatment strategy in women with recurrent major depression. *The Journal of Clinical Psychiatry*, 61(1), 51–57.
- Frank, E., Cassano, G. B., Rucci, P., Thompson, W. K., Kraemer, H. C., Fagioli, A., Maggi, L., et al. (2011). Predictors and moderators of time to remission of major depression with interpersonal psychotherapy and SSRI pharmacotherapy. *Psychological Medicine*, 41(1), 151–162. doi:10.1017/S0033291710000553
- Forand, N. R., DeRubeis, R. J., & Amsterdam, J. D. (in press). The combination of psychotherapy and medication in the treatment of major mental disorders. In A. Bergin & S. Garfield, *Handbook of psychotherapy and behavior change* (6th ed.). New York, NY: Wiley.
- Friedman, R. A. (2010, January 11). Before you quit antidepressants. *The New York Times*. Retrieved from: <http://www.nytimes.com/2010/01/12/health/12mind.html?r=1&ref=antidepressants>
- Geddes, J. R., Carney, S. M., Davies, C., Furukawa, T. A., Kupfer, D. J., Frank, E., & Goodwin, G. M. (2003). Relapse prevention with antidepressant drug treatment in depressive disorders: A systematic review. *Lancet*, 361(9358), 653–661. doi:10.1016/S0140-6736(03)12599-8
- Gibbons, R. D., Hur, K., Brown, C. H., Davis, J. M., & Mann, J. J. (2012). Benefits from antidepressants: Synthesis of 6-week patient-level outcomes from double-blind placebo-controlled randomized trials of fluoxetine and venlafaxine. *Archives of General Psychiatry*. doi:10.1001/archgenpsychiatry.2011.2044
- Gueorguieva, R., Mallinckrodt, C., & Krystal, J. H. (2011). Trajectories of depression severity in clinical trials of duloxetine: Insights into antidepressant and placebo responses. *Archives of General Psychiatry*, 68(12), 1227–1237. doi:10.1001/archgenpsychiatry.2011.132
- Guidi, J., Fava, G. A., Fava, M., & Papakostas, G. I. (2011). Efficacy of the sequential integration of psychotherapy and pharmacotherapy in major depressive disorder: A preliminary meta-analysis. *Psychological Medicine*, 41(2), 321–331. doi:10.1017/S0033291710000826
- Gvozdic, K., Brandl, E. J., Taylor, D. L., & Müller, D. J. (2012). Genetics and personalized medicine in antidepressant treatment. *Current Pharmaceutical Design*. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/22681166>
- Helmreich, I., Wagner, S., Mergl, R., Allgaier, A.-K., Hautzinger, M., Henkel, V., ... & Tadic, A. (2012). Sensitivity to changes during antidepressant treatment: A comparison of unidimensional subscales of the Inventory of Depressive Symptomatology (IDS-C) and the Hamilton Depression Rating Scale (HAMD) in patients with mild major, minor or subsyndromal depression. *European Archives of Psychiatry and Clinical Neuroscience*, 262(4), 291–304. doi:10.1007/s00406-011-0263-x
- Howland, R. H. (2010). Potential adverse effects of discontinuing psychotropic drugs, part 2: Antidepressant drugs. *Journal of Psychosocial Nursing and Mental Health Services*, 48(7), 9–12. doi:10.3928/02793695-20100527-98
- Hughes, S., & Cohen, D. (2009). A systematic review of long-term studies of drug treated and non-drug treated depression. *Journal of Affective Disorders*, 118, 9–18. doi:10.1016/j.jad.2009.01.027
- Isacsson, G., & Adler, M. (2012). Randomized clinical trials underestimate the efficacy of antidepressants in less severe depression. *Acta Psychiatrica Scandinavica*, 125(6), 453–459. doi:10.1111/j.1600-0447.2011.01815.x
- Jureidini, J. N., McHenry, L. B., & Mansfield, P. R. (2008). Clinical trials and drug promotion: Selective reporting of study 329. *International Journal of Risk & Safety in Medicine*, 20(1/2), 73–81. doi:10.3233/JRS-2008-0426
- Khan, A., Leventhal, R. M., Khan, S. R., & Brown, W. A. (2002). Severity of depression and response to antidepressants and placebo: An analysis of the Food and Drug Administration database. *Journal of Clinical Psychopharmacology*, 22(1), 40–45.
- Kaymaz, N., van Os, J., Loonen, A. J. M., & Nolen, W. A. (2008). Evidence that patients with single versus recurrent depressive episodes are differentially sensitive to treatment discontinuation: a meta-analysis of placebo-controlled randomized trials. *The Journal of Clinical Psychiatry*, 69(9), 1423–1436.
- Keller, M. B., McCullough, J. P., Klein, D. N., Arnow, B., Dunner, D. L., Gelenberg, A. J., ... & Zajecka, J. (2000). A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. *The New England Journal of Medicine*, 342(20), 1462–1470. doi:10.1056/NEJM200005183422001
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., Rush, A. J., ... & Wang, P. S. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R). *Journal of the American Medical Association*, 289(23), 3095–3105. doi:10.1001/jama.289.23.3095
- Kirsch, I., Deacon, B. J., Huedo-Medina, T. B., Scoboria, A., Moore, T. J., & Johnson, B. T. (2008). Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. *PLoS Medicine*, 5(2), e45. doi:10.1371/journal.pmed.0050045
- Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. S. (1984). *Interpersonal psychotherapy of depression*. New York, NY: Basic Books.
- Kramer, P. D. (2011, July 9). In defense of antidepressants. *The New York Times*. Retrieved from <http://www.nytimes.com/2011/07/10/opinion/sunday/10antidepressants.html?ref=antidepressants>
- Leykin, Y., Amsterdam, J. D., DeRubeis, R. J., Gallop, R., Shelton, R. C., & Hollon, S. D. (2007). Progressive resistance to a selective serotonin reuptake inhibitor but not to cognitive therapy in the treatment of major depression. *Journal of Consulting and Clinical Psychology*, 75(2), 267–276. doi:10.1037/0022-006X.75.2.267
- Ma, S. H., & Teasdale, J. D. (2004). Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. *Journal of Consulting and Clinical Psychology*, 72(1), 31–40. doi:10.1037/0022-006X.72.1.31
- Martell, C. R., Addis, M. E., & Jacobson, N. S. (2001). *Depression in context: Strategies for guided action*. New York: Norton.

- McGrath, P. J., Stewart, J. W., Quitkin, F. M., Chen, Y., Alpert, J. E., Nierenberg, A. A., ... & Peykova, E. (2006). Predictors of relapse in a prospective study of fluoxetine treatment of major depression. *The American Journal of Psychiatry*, 163(9), 1542–1548. doi:10.1176/appi.ajp.163.9.1542
- Mojtabai, R., & Olfson, M. (2008). National trends in psychotherapy by office-based psychiatrists. *Archives of General Psychiatry*, 65(8), 962–970. doi:10.1001/arch-psyc.65.8.962
- Mukherjee (2012, April 19). The science and history of treating depression. *The New York Times Magazine*. Retrieved from: <http://www.nytimes.com/2012/04/22/magazine/the-science-and-history-of-treating-depression.html?pagewanted=all>
- National Institute for Health and Clinical Excellence. (2009). *The treatment and management of depression in adults* (update). Clinical Guideline 90. London: Author. Available at [www.nice.org.uk](http://www.nice.org.uk).
- Pratt, L. A., Brody, D. J., & Gu, Q. (2011). Antidepressant use in persons aged 12 and over: United States, 2005–2008. *NCHS data brief* (76), 1–8.
- Reimherr, F. W., Amsterdam, J. D., Quitkin, F. M., Rosenbaum, J. F., Fava, M., Zajecka, J., ... Sundell, K. (1998). Optimal length of continuation therapy in depression: A prospective assessment during long-term fluoxetine treatment. *American Journal of Psychiatry*, 155(9), 1247–1253.
- Rubin, R. (2010, January 5). Study: Antidepressant lift may be all in your head. *USA Today*. Retrieved from: [http://www.usatoday.com/news/health/2010-01-06-antidepressants06\\_ST\\_N.htm](http://www.usatoday.com/news/health/2010-01-06-antidepressants06_ST_N.htm)
- Scott, J., Palmer, S., Paykel, E., Teasdale, J., & Hayhurst, H. (2003). Use of cognitive therapy for relapse prevention in chronic depression: Cost-effectiveness study. *British Journal of Psychiatry*, 182(3), 182, 221–227. doi:10.1192/bjp.182.3.221
- Staton, T., & Palmer, E. (2012). *Pharma's Top 11 Marketing Settlements*. *Firece Pharma*. Retrieved from: <http://www.fiercepharma.com/special-reports/top-10-pharma-settlements/top-10-pharma-settlements>
- Thase, M. E., Larsen, K. G., & Kennedy, S. H. (2011). Assessing the “true” effect of active antidepressant therapy v. placebo in major depressive disorder: Use of a mixture model. *The British Journal of Psychiatry: The Journal of Mental Science*, 199(6), 501–507. doi:10.1192/bjp.bp.111.093336
- Turner, E. H., Matthews, A. M., Linardatos, E., Tell, R. A., & Rosenthal, R. (2008). Selective publication of antidepressant trials and its influence on apparent efficacy. *The New England Journal of Medicine*, 358(3), 252–260. doi:10.1056/NEJMsa065779
- Unützer, J., & Park, M. (2012). Strategies to improve the management of depression in primary care. *Primary Care*, 39(2), 415–431. doi:10.1016/j.pop.2012.03.010
- Vittengl, J. R., Clark, L. A., Dunn, T. W., & Jarrett, R. B. (2007). Reducing relapse and recurrence in unipolar depression: A comparative meta-analysis of cognitive-behavioral therapy's effects. *Journal of Consulting and Clinical Psychology*, 75(3), 475–488. doi:10.1037/0022-006X.75.3.475
- Vittengl, J. R., Clark, L. A., & Jarrett, R. B. (2010). Moderators of continuation phase cognitive therapy's effects on relapse, recurrence, remission, and recovery from depression. *Behaviour Research and Therapy*, 48(6), 449–458. doi:10.1016/j.brat.2010.01.006
- Vos, T., Corry, J., Haby, M. M., Carter, R., & Andrews, G. (2005). Cost-effectiveness of cognitive-behavioural therapy and drug interventions for major depression. *Australian and New Zealand Journal of Psychiatry*, 39, 683–692. doi:10.1111/j.1440-1614.2005.01652.x
- Wadman, M. (2011). Paxil study under fire. *Nature News*, 475(7355), 153–153. doi:10.1038/475153a
- Warner, J. (2010, January 8). The wrong story about depression. *The New York Times*. Retrieved from <http://www.nytimes.com/2010/01/09/opinion/09warner.html?ref=antidepressants>
- Weisfogel, A. (producer) & Spencer, S. (correspondent). (2012, March 18). Examining the broad reach of depression. In Morrison, R. (Executive Producer), *CBS Sunday Morning*. New York, NY: CBS News.
- Whitaker, R. (2011). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness*. New York: Crown Publishing Group.
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## Treating Tourette Syndrome: A Broad Yet Specialized Clinical Expertise

Meir Flancbaum, *Tourette Syndrome Program, Rutgers University, and Behavior Therapy Associates, Somerset, NJ*

Lori Rockmore, *Tourette Syndrome Program, Rutgers University, and Positive Developments, Millburn, NJ*

**T**ourette syndrome (TS) is a neurobehavioral disorder characterized by short, repetitive, stereotypic muscle movements or vocalizations called tics. Competency to treat TS and its associated disorders requires an in-depth knowledge of tics, a proficiency in evidence-based treatments for a variety of disorders, and the ability to prioritize treatment goals with often complex patients. This paper presents an overview of this unique clinical skill set and provides a description of one training program designed to foster these skills in clinical psychology doctoral students.

While medications have traditionally been the first-line intervention for tic disorders, including TS, many individuals discontinue their use due to aversive side effects (Piacentini & Chang, 2001). Fortunately, there has been a resurgence of research supporting a behavior therapy for tics called habit reversal training (HRT), which can be implemented alone or in conjunction with medication management (Cook & Blacher, 2007). HRT (Azrin & Nunn, 1973) is a multicomponent treatment that includes awareness training, self-monitoring, and competing response training. These core components are often augmented by psychoeducation about tics, a function-based assessment and intervention to modify situational triggers that exacerbate tics, relaxation training, and the identification and utilization of social support (Woods et al., 2008). HRT is typically 8 to 10 sessions, with booster sessions conducted as needed; however, the duration of treatment may vary according to patient motivation, ability to successfully implement the HRT procedures, and compliance with between-session tasks. HRT is now considered a "well-established" treatment based on guidelines outlined by the American Psychological Association's Division 12 Task Force on Promotion and

Dissemination of Psychological Procedures (Chambless et al., 1998; Cook & Blacher).

Though working with individuals with TS can be seen as quite narrow, in actuality the opposite is true. The vast majority of youth with TS have co-occurring psychological disorders, most commonly attention-deficit/hyperactivity disorder and obsessive-compulsive disorder, followed by other anxiety disorders and depression (Lombroso & Scahill, 2008; Scahill, Bitskio, Visser, & Blumberg, 2009). Thus, it is typical for individuals with TS to receive treatment for their co-occurring disorders, even when their tics are manageable or well-controlled with medication. In such cases, many families benefit from having a provider who has expertise in tic disorders as well as the co-occurring conditions.

In addition to managing the tics themselves and the frequently co-occurring psychological conditions, treatment of individuals with TS often involves addressing associated psychosocial stressors. For example, individuals may struggle with self-disclosure to peers or experience bullying as a result of their tics. Thus, treatment also entails psychoeducation, acceptance strategies, assertiveness training, and social problem solving. Effectively helping such individuals requires not only a foundation in cognitive-behavioral techniques, but also an understanding and sensitivity to the experience of living with TS.

Given the complexity of individuals with TS, working with this population requires a uniquely broad yet specialized clinical skill set. Data from a recent survey study of mental health practitioners nationally indicates that there are very few therapists with training to treat clients with TS, and particularly to provide HRT (Marcks, Woods, Teng, & Twohig, 2004). This finding is consistent with our experiences treating individuals with tic disorders, with some clients traveling well over an hour for weekly sessions or groups. Furthermore,

many practitioners misunderstand the complex presentations of individuals with TS (Jankovic, 2001).

To address this shortage of practitioners, further training of psychologists in the assessment and treatment of TS is sorely needed. One group, clinical psychology graduate students, is particularly amenable to training: Their accessibility, openness to new clinical experiences, and receptivity to ongoing supervision make them an optimal group to target. Below is a description of the key elements and methods of the TS Program at Rutgers University, a specialized training clinic located in a graduate school.

### Program Overview

The TS Program at Rutgers University, established in 2000, is a specialty clinic developed in collaboration with Rutgers' Graduate School of Applied and Professional Psychology (GSAPP) and the New Jersey Center for Tourette Syndrome & Associated Disorders. The TS Program provides clinical care for children, adults, and families with TS and related disorders, including attention-deficit/hyperactivity, anxiety, and depressive disorders. Clinical services take place at the GSAPP Psychological Clinic, a fee-for-service, sliding-scale training clinic that serves the local community. The TS Program also recently launched a clinical research program.

### Clinical Training

All clinical services are provided by clinical psychology doctoral students who elect to complete an 8- or 16-hour practicum at the TS Program. Practicum participants range from first- to fifth-year students. The practicum consists of didactic training, clinical experience, and supervision. Since September 2011, the experience has also included serving as a therapist for ongoing clinical research projects.

The foundations for clinical work are provided during weekly seminars. Didactics are 90-minute meetings that follow a syllabus with set topics and readings. Through the seminars, students learn the theoretical background and evidence-based clinical techniques for the management of TS and its co-occurring disorders. Thus, students receive training in the implementation of habit reversal training, exposure, exposure and response prevention, behavior activation, and parent management training. Numerous guests with expertise in TS are invited to present at seminars throughout the year. Consistent with a patient-centered

training model, clients with TS present their story and experience with the disorder towards the beginning of the training period. Additionally, medical professionals from the community present on medications for tics and co-occurring conditions, and discuss their role on the treatment team. Another facet of the training includes a discussion with the director of the local TS chapter about current advocacy efforts and resources for clients and their families.

Clinical experiences consist of conducting phone screens, intake assessments, and individual and group therapy. Students rotate returning phone inquiries and conducting phone screens in place of a clinic coordinator position. Cases are assigned to students with the intention of providing them with experience treating tics as well as the range of co-occurring disorders. Students typically conduct intakes themselves and then add the client to their caseload. The typical caseload for a 16-hour practicum student consists of six to eight individual cases, of which one or two may be research subjects, and a group. Students completing an 8-hour practicum will see fewer individual cases. Clients are typically children and adolescents, though adults are also treated. Groups take place during the second semester of the placement and each student co-leads a 10-week group for children with TS, their siblings, or their parents.

All clinical work is closely supervised by a licensed psychologist with expertise in treating TS. Supervision aims to assist practicum students with applying the theory and clinical techniques learned in didactics to actual clients. The primary goal of supervision is to help foster the clinician's competence and independence in treating this population of patients. Individual supervision is provided weekly for a minimum of 1 hour. All treatment sessions are recorded and review of these recordings is done on an as-needed basis.

## Applied Research

Research conducted through the TS Program aims to answer questions pertinent to clinical care. It is our intention for scholarly contributions to bridge the gap between researchers and clinicians through the production of articles applicable to professionals in clinical practice. In the past, students who have completed clinical training at the TS Program and who have developed a particular interest in the population have presented posters at professional conferences and conducted their doctoral dissertations within the program.

The focus of research efforts thus far have included the effectiveness of evidence-based treatments in a community clinic setting, novel applications of established treatments (e.g., massed treatment, use of technology in therapy), and projects to improve the quality of assessment and treatment provided through our clinic. Current projects include a study on the effectiveness of habit reversal for the treatment of tics using an open clinic sample, a survey assessment of social skills needs among youth with TS, and the development of a clinic-wide database to better monitor the outcomes of clinical treatments.

## Future Directions

The TS program will continue to fulfill its mission of training a new wave of clinical psychologists with an expertise in treating children, adults, and families with TS, while at the same time providing a much needed service to the TS community. To date, the TS Program has trained over 20 students—at least 6 of them have gone on to specialize in working with the TS population. While the other students have chosen different areas of clinical specialization, they report having a unique ability to detect tics in individuals and to deliver the appropriate treatments. As we expand our research arm, we hope to continue to provide opportunities for students to pursue independent research

initiatives, as well as to begin to collaborate on projects with other institutions.

## References

- Azrin, N. H., & Nunn, R. G. (1973). Habit reversal: A method of eliminating nervous habits and tics. *Behaviour Research and Therapy*, 11, 619-628.
- Chambless, D., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., . . . Woody, S. R. (1998). Update on empirically validated therapies, II. *The Clinical Psychologist*, 51, 3-16.
- Cook, C. R., & Blacher, J. (2007). Evidence-based psychosocial treatments for tic disorders. *Clinical Psychology: Science and Practice*, 14, 252-267.
- Jankovic, J. (2001). Tourette's syndrome. *The New England Journal of Medicine*, 345(16), 1184-1192.
- Marcks, B.A., Woods, D.W., Teng, E.J., & Twohig, M.P. (2004). What do those who know, know? Investigating providers' knowledge about Tourette's syndrome and its treatment. *Cognitive and Behavioral Practice*, 11(3), 298-305.
- Lombroso, P.J., & Scahill, L. (2008). Tourette syndrome and obsessive-compulsive disorder. *Brain Development*, 30(4), 231-237.
- Piacentini, J., & Chang, S. (2001). Behavioral treatments for Tourette syndrome and tic disorders: State of the art. *Advances in Neurology*, 85, 319-331.
- Scahill L., Bitskio R.H., Visser S.N., & Blumberg, S.J.. (2009). Prevalence of diagnosed Tourette syndrome in persons aged 6-17 years. *MMWR Weekly Report*, 58(21), 581-585.
- Woods, D. W., Piacentini, J. C., Chang, S. W., Deckersbach, T., Ginsburg, G. S., Peterson, A. K., . . . Wilhelm, S. (2008). *Managing Tourette syndrome: A behavioral intervention for children and adults*. New York, NY: Oxford University Press.

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## Disseminate, Debunk, Differentiate: Teaching About Evidence-Based Treatments in a Child Psychology Course

Stephen D. A. Hupp, Elizabeth McKenney, Megan Schmitt, Allison McCobin, and Sarah A. Owens, *Southern Illinois University Edwardsville*

Dissemination of evidence-based treatments (EBTs) is a central goal of ABCT, and graduate students have been identified as integral to successful dissemination (Andrasik, 2010). As future professionals, graduate students need to be able to effectively differentiate empirically grounded advances from approaches that have little to no scientific merit. Some leaders within the field have also pointed out that critical thought and its characteristic “open-minded skepticism” are ways of thinking that should be developed and strengthened before graduate training begins (McLean et al., 2007). Critical thinking is interwoven into many undergraduate psychology courses. For example, courses in research methods provide a solid foundation for critically examining research studies, and some universities even offer specific courses that differentiate between science and pseudoscience in psychology (McLean et al.). However, specialized courses in science and pseudoscience only reach a small number of undergraduate students, leaving open a need for an increased emphasis on differentiating science from pseudoscience in other psychology courses.

There are many consumers of psychological information in undergraduate psychology courses, including those who plan to pursue other disciplines (e.g., medicine, education, law), making undergraduate courses an ideal arena in which to study the effectiveness of direct instruction in EBTs and corresponding effects on reactions to unsupported treatments. A recent study measured students’ beliefs about EBTs and unsupported treatments at the beginning and end of an undergraduate child psychology course (Hupp, Stary, Bradshaw, & Owens, 2012). Students received instruction in the course regarding four common childhood disorders (i.e., autism, oppositional-defiant disorder, attention-deficit/hyperactivity disorder, and depression). Direct instruction was provided regarding

the EBTs for each disorder (e.g., applied behavior analysis for autism, cognitive-behavioral therapy for depression), but no direct instruction was provided regarding the unsupported treatments (e.g., dolphin-assisted therapy for autism, recreational therapy for depression). The results of the study revealed that while students rated the EBTs as more effective upon course completion, their ratings of the unsupported treatments were not correspondingly lower at the end of the course. Thus, the study provided “some evidence for why dissemination is only half the battle” (p. 76), suggesting that debunking unsupported treatments is also important.

While the original Hupp et al. (2012) study provided some useful information, the sample size was rather small ( $n = 17$ ), and the results need to be replicated. Furthermore, the present study used the results from Hupp et al. to make adjustments to a larger section of a child psychology course in a later semester and measured the effects of these adjustments.

### Method

The child psychology course in this study had 170 enrolled students, and 144 of these students attended both measurement days and consented to being in the study. The course was taught in the spring semester at a midsized university in the Midwest. The majority of the participants were female (82.2%), and the mean age was 20.93 ( $SD = 3.49$ ). The sample was primarily Caucasian (80.6%), followed by African American (11.1%), Asian (2.1%), Hispanic/Latino (2.1%), and 4.2% of the participants did not classify themselves into any of these categories. Finally, the participants from the course included freshmen (15.8%), sophomores (31.5%), juniors (32.2%), seniors (19.9%), and one graduate student (0.7%).

Students completed the Specific Therapeutic Approaches Rating Scale—Child

Form (STARS-CF; Hupp et al., 2012), which has 40 items, each on a 5-point Likert scale (0 = *NOT effective*, 1 = *probably NOT effective*, 2 = *unsure*, 3 = *probably effective*, 4 = *effective*). The Evidence-Based Psychosocial Treatments (EBPT) subscale includes 13 treatments that have been identified as evidence-based for specific disorders with children (e.g., cognitive-behavioral therapy for depression), and the Additional Treatments (AT) subscale includes 23 other treatments that are not evidence-based treatments for the indicated core symptoms of specific disorders with children. For example, additional treatments include potentially harmful treatments (e.g., rebirthing therapy for oppositional-defiant disorder), pseudoscientific treatments (e.g., facilitated communication for autism), and also treatments that are evidence-based for many problems but that are not currently evidence-based for the indicated problem (e.g., cognitive therapy for the core symptoms of attention-deficit/hyperactivity disorder). There are an additional four items about medication that do not contribute to either of the primary subscales but provide extra qualitative information.

This study used the same pretest-posttest quasi-experimental design used in Hupp et al. (2012), with more specific details presented in the earlier study. The students completed the STARS-CF as a pretest on the first day of class and as a posttest on the last day of class. Evidence-based treatments for children were discussed throughout the course, including all of the treatments covered on the EBPT subscale of the STARS-CF. However, unlike the Hupp et al. (2012) study, 8 of the 23 additional treatments were also discussed in the course.

This study had two primary hypotheses. First, it was predicated that the students would rate evidence-based psychosocial treatments as more effective on the posttest as compared to the pretest, which would be a replication of the finding from Hupp et al. (2012). Second, it was predicted that students would rate the additional unsupported treatments as less effective during the posttest as compared to the pretest. This was also a hypothesis from the Hupp et al. study; however, this hypothesis was not supported in the original study. That is, beliefs about the effectiveness of the additional treatments actually had a slight but insignificant increase from pretest ( $M = 2.28$ ) to posttest ( $M = 2.36$ ). It was suggested that students did not decrease their beliefs about the additional unsupported treatments because they were not directly tar-



geted in the course. Thus, with the new course focus on additional unsupported treatments, it was predicted that student beliefs about the effectiveness of additional treatments would decrease in this revised course.

Because only 8 of the 23 additional treatments were targeted during the course, a few secondary analyses were conducted. Specifically, the Additional Treatments subscale items were further broken down into "Targeted Additional Treatments" and "Untargeted Additional Treatments" to see if increased skepticism would generalize to the additional treatments that were not covered in the course.

## Results and Discussion

The first set of analyses for the two primary hypotheses included two paired samples t-tests with the Bonferroni correction (i.e., the alpha level was set at .025). The first hypothesis was supported and replicated the same finding from Hupp et al. (2012). That is, the EBPT subscale score significantly increased from pretest ( $M = 2.64$ ,  $SD = .40$ ) to posttest ( $M = 2.99$ ,  $SD = .43$ ),  $t(143) = 9.021$ ,  $p < .001$ . Cohen's  $d$  was calculated and indicates that this is a large effect size ( $d = 0.88$ ). Also, unlike the original study, this time the second hypothesis was also supported. That is, the Additional Treatments subscale decreased from pretest ( $M = 2.36$ ,  $SD = .31$ ) to posttest ( $M = 2.10$ ,  $SD = .44$ ),  $t(143) =$

7.326,  $p < .001$ . Cohen's  $d$  for the change in the Additional Treatments subscale score was also a large effect size ( $d = .84$ ).

Another two paired samples t-tests were also conducted to compare changes in beliefs about Targeted Additional Treatments and Untargeted Additional Treatments. Beliefs in the effectiveness of the Targeted Additional Treatments decreased from pretest ( $M = 2.24$ ,  $SD = .39$ ) to posttest ( $M = 1.58$ ,  $SD = .66$ ),  $t(143) = 11.486$ ,  $p < .001$ ; however, this change was not accompanied by a corresponding decrease in ratings of the Untargeted Additional Treatments from pretest ( $M = 2.43$ ,  $SD = .33$ ) to posttest ( $M = 2.38$ ,  $SD = .41$ ),  $t(143) = 1.398$ ,  $p = .164$ . Thus, it appears that skepticism did not generalize to the additional treatments that were not directly covered in the course even though the students demonstrated learning about which treatments were evidence-based.

Table 1 provides mean scores for individual treatments on the STARS-CF for pretest and posttest. Overall, students' beliefs in the effectiveness of 13 out of 13 (100%) evidence-based psychosocial treatments increased from the pretest to posttest. Regarding the additional treatments, mean scores for 7 out of 8 (88%) targeted additional treatments decreased, while mean scores for 8 out of 14 (57%) untargeted additional treatments decreased. Overall, these findings provide additional support that student beliefs about evidence-based psychosocial treatments were strengthened and beliefs about the targeted additional treatments were weakened; however, the course did not appear to encourage skepticism about additional treatments that were not directly covered. For example, at the posttest, the rating for play therapy for autism was around a 3, indicating that students believed that it was "probably effective," and they still rated it higher than pivotal response training, an evidence-based treatment discussed in the class. Similarly, recreational therapy for depression was still rated as higher than self-control therapy.

Together, the present study and the original Hupp et al. (2012) study demonstrate how precourse and postcourse measurement can be used to measure dissemination efforts in a college classroom. They also demonstrate the importance of directly debunking treatments that do not have research support. On the other hand, these studies fall short of demonstrating that skepticism generalized to additional treatments that were not discussed in the classroom. While other college courses have

**Table 1.** Mean Scores of Evidence-Based Psychosocial Treatments, Targeted Additional Treatments, Untargeted Additional Treatments and Medication at Pretest and Posttest

PRETEST	POSTTEST
<b>Autism</b>	
3.02 Play therapy	3.30 *Applied Behavior Analysis
2.75 <i>Facilitated Communication</i>	3.06 Play Therapy
2.72 *Applied Behavior Analysis	2.80 Developmental/Relationship
2.66 Developmental/Relationship	2.43 Medication (such as risperidone)
2.50 Medication (such as risperidone)	2.34 *Pivotal Response Training
2.26 *Pivotal Response Training	2.17 <i>Facilitated Communication</i>
2.08 Dietary Management	1.85 Secretin Hormone Treatment
2.04 <i>Dolphin-Assisted Therapy</i>	1.78 Dietary Management
1.97 Secretin Hormone Treatment	1.56 Vitamin B Treatment
1.97 Vitamin B Treatment	1.06 <i>Dolphin-Assisted Therapy</i>
<b>Oppositional Defiant Disorder</b>	
3.07 *Parent-Child Interaction Therapy	3.30 *Parent-Child Interaction Therapy
2.95 *Positive Parenting Program	3.26 *Parent Management Training
2.92 *Parent Management Training	3.15 *Positive Parenting Program
2.63 Art Therapy	2.86 *Helping the Noncompliant Child
2.51 Medication (such as dextro-amphetamine)	2.74 Art Therapy
2.42 *Helping the Noncompliant Child	2.44 Medication (such as dextro-amphetamine)
2.33 Reparenting Therapy	2.41 *Incredible Years
2.12 <i>Holding Therapy</i>	2.32 Reparenting Therapy
1.97 *Incredible Years	0.95 <i>Holding Therapy</i>
1.86 <i>Rebirthing Therapy</i>	0.65 <i>Rebirthing Therapy</i>
<b>Attention-Deficit/Hyperactivity Disorder</b>	
3.04 *Behavioral classroom management	3.44 *Behavioral classroom management
3.02 Medication (such as methylphenidate)	3.28 *Behavioral parent training
2.79 *Behavioral parent training	3.11 Cognitive Therapy
2.65 *Behavioral peer interventions	3.05 *Behavioral peer interventions
2.65 Cognitive Therapy	2.88 Medication (such as methylphenidate)
2.41 <i>Sugar elimination</i>	2.46 Sensory Integration Therapy
2.39 Neurofeedback/Biofeedback	2.35 Neurofeedback/Biofeedback
2.33 Sensory Integration Therapy	1.79 <i>Sugar elimination</i>
2.17 <i>Diet supplements (such as amino acids)</i>	1.73 <i>Diet supplements (such as amino acids)</i>
1.91 <i>Feingold diet</i>	1.42 <i>Feingold diet</i>
<b>Depression</b>	
2.91 Animal-Assisted Therapy	3.28 *Cognitive-Behavioral Therapy
2.85 Recreational Therapy	3.02 Recreational Therapy
2.83 *Cognitive-Behavioral Therapy	2.89 *Self-Control Therapy
2.83 Medication (such as fluoxetine)	2.88 <i>Psychodynamic Psychotherapy</i>
2.67 *Self-Control Therapy	2.80 Medication (such as fluoxetine)
2.63 <i>Psychodynamic Psychotherapy</i>	2.58 Animal-Assisted Therapy
2.40 Attachment Therapy	2.49 Attachment Therapy
2.22 Power Therapy	2.35 *Penn Prevention Program
2.09 *Penn Prevention Program	2.08 Power Therapy
2.02 Herbal Therapy	1.65 Herbal Therapy

Note. Evidence-based psychosocial treatments are marked with an asterisk; targeted additional treatments are in italics. The Likert scale ranges from 0 (*NOT effective*) to 4 (*effective*).

**Call for**

# Continuing Education Sessions

**47th Annual Convention  
November 21–24, 2013  
NASHVILLE**

## 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.

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.

Risa Weisberg, *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.

L. Kevin Chapman, *Master Clinician Seminar Committee Chair*  
[masterclinicianseminars@abct.org](mailto:masterclinicianseminars@abct.org)

Please send a 250-word abstract and a CV for each presenter. For submission requirements and information on the continuing education session selection process, please see the Frequently Asked Questions section of the ABCT Convention page at [www.abct.org](http://www.abct.org).

**Submission deadline: February 1, 2013**

a built-in emphasis on critical thinking skills (e.g., courses in research methods, courses in skepticism, etc.), this study suggests that a greater emphasis on critical thinking concepts should be incorporated into all psychology courses (or at least the child psychology course that was the focus of this study). Specifically, in addition to disseminating information about existing evidence-based treatments and debunking some unsupported treatments, it is also important to help students be able to differentiate between evidence-based and unsupported treatments, particularly in the absence of direct instruction. Because after the course is over, new effective treatments and pseudoscientific treatments will continue to emerge.

## References

- Andrasik, F. (2010). Another look inside the boardroom: Dissemination, dissemination, dissemination. *the Behavior Therapist*, 33, 125-127.
- Hupp, S. D. A., Stary, A. K., Bradshaw, K. N., & Owens, S. (2012). Debunk, debunk, debunk: Some evidence for why dissemination is only half the battle. *the Behavior Therapist*, 35, 76-78.
- McLean, C. P., Miller, N. A., Lilienfeld, S. O., Lohr, J. M., McNally, R. J., & Stickle, T. R. (2007). Teaching students to think like scientists. *the Behavior Therapist*, 30, 84-87.

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This study was presented as a poster at the 2012 annual meeting of the Association for Behavioral and Cognitive Therapies.

Stephen Hupp uses Twitter to disseminate the science of psychology and debunk pseudoscience (@StephenHupp).

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18th Annual

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# Awards & Recognition Ceremony



TOP ROW, LEFT TO RIGHT: Robert K. Klepac, *ABCT President*; Brian Iacoviello, *ADAA Career Travel Award*; Alan Kazdin, *Career/Lifetime Achievement*; Carl Indovina, *Outstanding Service to ABCT*; Michael Gelder, *Distinguished Friend to Behavior Therapy*; Jonathan Comer, *President's New Researcher*; Mitchell J. Prinstein, *Outstanding Mentor* • BOTTOM ROW, LEFT TO RIGHT: Nicole Caporino, *ADAA Career Travel Award*; Amanda Morrison, *John R. Z. Abela Dissertation*; Shireen Rizvi, *Awards & Recognition Chair*; Lynn McFarr, *Outstanding Service to ABCT*; Caroline Oppenheimer, *Virginia A. Roswell Student Dissertation*; Patricia Resick, *Outstanding Contribution by an Individual for Education/Training Activities*; Johanna Thompson-Hollands, *Leonard Krasner Student Dissertation*; Laura E. Dreer, *Outstanding Service to ABCT*



CLOCKWISE, FROM LEFT: Alan Kazdin receiving the Career/Lifetime Achievement Award; Outstanding Service to ABCT recipients Lynn McFarr, Laura Dreer, and Carl Indovina with President Klepac and Awards Chair Shireen Rizvi; David Barlow and Michael Gelder, Distinguished Friend; Outstanding Education/Training Recipient Patricia Resick





# Preparing to Submit an Abstract

ABCT will once again be using the ScholarOne abstract submission system. The step-by-step instructions are easily accessed from the ABCT home page. As you prepare your submission, please keep in mind:

- **Presentation type:** Please see the two right-hand columns on this page for descriptions of the various presentation types.
- **Number of presenters/papers:** For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The chair may present a paper, but the discussant may not. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.
- **Title:** Be succinct.
- **Authors/Presenters:** Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their ABCT category. Possibilities are **current member**; **lapsed member** or **nonmember**; **postbaccalaureate**; **student member**; **student nonmember**; **new professional**; **emeritus**.
- **Affiliations:** The system requires that you enter affiliations before entering authors. This allows you to enter an affiliation one time for multiple authors. **DO NOT LIST DEPARTMENTS.** In the following step you will be asked to attach affiliations with appropriate authors.
- **Key Words:** Please read carefully through the pull-down menu of already defined keywords and use one of the already existing keywords, if appropriate. For example, the keyword "military" is already on the list and should be used rather than adding the word "Army." Do *not* list *behavior therapy*, *cognitive therapy*, or *cognitive behavior therapy*.
- **Goals:** For Symposia, Panel Discussions, and Clinical Round Tables, write three statements of no more than 125 characters each, describing the goals of the event. Sample statements are: "Described a variety of dissemination strategies pertaining to the treatment of insomnia"; "Presented data on novel direction in the dissemination of mindfulness-based clinical interventions."

**Overall:** Ask a colleague to proof your abstract for inconsistencies or typos.

## Understanding the ABCT Convention

The ABCT Convention is designed for practitioners, students, scholars, and scientists who come from a broad range of disciplines. The central goal is to provide educational experiences related to behavioral and cognitive therapies that meet the needs of attendees across experience levels, interest areas, and behavioral and cognitive theoretical orientations. Some presentations offer the chance to learn what is new and exciting in behavioral and cognitive assessment and treatment. Other presentations address the clinical-scientific issues of how we develop empirical support for our work. The convention also provides opportunities for professional networking. The ABCT Convention consists of General Sessions and Ticketed Events.

### GENERAL SESSIONS

There are between 150 and 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. General session types include:

**Invited Addresses.** Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge on a broad topic of interest.

**Spotlight Research Presentations.** This format provides a forum to debut new findings considered to be groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute question-and-answer period allows for more in-depth presentation than is permitted by symposia or other formats.

**Symposia.** Presentations of data, usually investigating the efficacy or effectiveness of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. A total of 5 or 6 presenters is preferable, and no more than 8 are allowed.

**Panel Discussions and Clinical Round Tables.** Discussions (or debates) by informed individuals on a current important topic. These are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. A total of 5 or 6 presenters is preferable, and no more than 8 are allowed.

**Poster Sessions.** One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,200 and 1,400 posters are presented each year.

**Clinical Grand Rounds.** Clinical experts engage in simulated live demonstrations of

therapy with clients, who are generally portrayed by graduate students studying with the presenter.

**Membership Panel Discussion.** Organized by representatives of the Membership Committees, these events generally emphasize training or career development.

**Special Sessions.** These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training.

**Special Interest Group (SIG) Meetings.** More than 35 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

### TICKETED EVENTS

Ticketed events offer educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment beyond the general registration fee.

**Clinical Intervention Training.** One- and 2-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction.

**Institutes.** Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday, and are generally limited to 40 attendees.

**Workshops.** Covering concerns of the practitioner/educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees.

**Master Clinician Seminars.** The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees.

**Advanced Methodology and Statistics Seminars.** Designed to enhance researchers' abilities, there is generally one offered on Thursday and one offered on Sunday morning. They are 4 hours long and limited to 40 attendees.

# ABCT's 47th Annual Convention

## CALL *for* PAPERS



PROGRAM CHAIR:  
Justin W. Weeks, Ph.D.

Cognitive and Behavioral Therapies: ***Harnessing Synergy Among  
Multidisciplinary Sciences***

Cognitive and behavioral therapies (CBT) are grounded in empiricism and the scientist-practitioner model. Given its overarching scientific emphasis, it is not surprising that numerous and multifaceted methodologies have proven useful for both measuring and conceptualizing the changes that CBT can yield for patients. However, utilizing diverse methodologies to evaluate CBT-related outcomes represents only one direction of effect. As a scientific discipline, CBT also stands to inform independent disciplines in valuable ways.

Fusion is the process by which two or more objects join together, or “fuse,” to form a single object. Under the proper conditions, the fusion of two objects can result in harnessed energy. Evidence abounds that such conditions are readily achievable when it comes to fusing CBT and related scientific disciplines.

The theme of this year’s conference is “CBT and Harnessing Synergy Among Multidisciplinary Sciences.” The conference will focus on presentations that highlight the integration of a broad range of methodologies, including some disciplines that do not traditionally interface directly with health care. For example, how can we better fuse CBT research with neuroscience; genetics; biology; social sciences; anthropology; linguistics; and other allied disciplines? What more can we learn from these different disciplines and, of equal importance, what can these other disciplines learn from researchers of empirically supported treatments?

We encourage submissions that seek and provide opportunities for an interdisciplinary cross-fostering dialogue, with the goals of fully harnessing knowledge pertaining to CBT and its associated applications and exploring ways in which evidence-based practices can be informed by and, in turn, directly inform related sciences. To this end, submissions focusing on potential synergies between CBT research and the other sciences will receive special consideration. Given the theme focus, representation in disciplines that have been underrepresented in past meetings is welcome.

Submissions may be in the form of Symposia, Clinical Round Tables, Panel Discussions, and Posters.

**Information about the conference and for submitting abstracts will be on ABCT’s website, [www.abct.org](http://www.abct.org), after January 1, 2013. The online submission portal will open in early February.**

**November 21–24, 2013 | Nashville**

DEADLINE FOR SUBMISSION:  
March 1, 2013

# Call

## for Award Nominations

The ABCT Awards and Recognition Committee, chaired by Shireen L. Rizvi, Ph.D., of Rutgers University, is pleased to announce the 2013 awards program. 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. Past recipients of this award include Albert Ellis, Leonard Krasner, Steven C. Hayes, David H. Barlow, G. Alan Marlatt, Antonette M. Zeiss, and Alan E. Kazdin. Please complete the online 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 "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.

### Outstanding Contribution by an Individual for Research Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions to the literature advancing our knowledge of behavior therapy. Past recipients of this award include Alan E. Kazdin in 1998, David H. Barlow in 2001, Terence M. Keane in 2004, Thomas Borkovec in 2007, and Steven D. Hollon in 2010. Please complete the online 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 Research" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Research, 305 Seventh Ave., New York, NY 10001.

### 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 Clinical Psychology Program at SUNY Binghamton, The May Institute, the Program in Combined Clinical and School Psychology at Hofstra University, the Doctoral Program in Clinical Psychology at SUNY Albany, and Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology. Please complete the online 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.

### 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.

[continued on next page]



*{Student Dissertation Awards, continued}*

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 2012. 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 online 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 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.

### **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 Jon Kabat-Zinn, Nora Volkow, John Allen, Anne Fletcher, Jack Gorman, Art Dykstra, Michael Davis, Paul Ekman, The Honorable Erik K. Shinseki, and Michael Gelder. Please complete the online 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 "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.

NOMINATIONS FOR THE OUTSTANDING SERVICE AWARD ARE SOLICITED FROM MEMBERS OF THE ABCT GOVERNANCE:

### **Outstanding Service to ABCT**

Please complete the online 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 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.

### **President's New Researcher Award**

ABCT's 2012–2013 President, Stefan G. Hofmann, Ph.D., invites submissions for the 35th 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 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 Stefan G. Hofmann, Ph.D., Robert Klepac, Ph.D., and Dean McKay, Ph.D. (ABCT's President, Immediate Past-President, and President-Elect). Submissions must be received by Monday, August 5, 2013, and must include four copies of both the paper and the author's vita and supporting letters if the latter are included. Send submissions to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.  
**Submission deadline: August 5, 2013.**

**Nominate online:  
[www.abct.org](http://www.abct.org)**

**Deadline for nominations:  
March 1, 2013**

## online

### Robert Klepac's Presidential Address

Missed it at the convention?  
Lend an ear!

<http://www.abct.org>

## in-press

### Collaborative Empiricism in Cognitive Therapy for Psychosis: A Practice Guide

"Between-session work is not just for clients, of course, and one way to develop the sense of therapist and client being co-investigators is to agree on tasks for the therapist as well. Perhaps the therapist can ask the client to suggest things for him or her to do? An advantage of this is that it makes it more likely the client will persist with his or her plans."

Hutton & Morrison, *Cognitive and Behavioral Practice* (Special Series: Collaborative Empiricism), in press  
doi: 10.1016/j.cbpra.2012.08.003

## archive

"My father, Ogden Richardson Lindsley, taught me to discover. He never directly answered my questions. He always answered by saying, 'How could we find out?'"

Ogden R. Lindsley, "Studies in Behavior Therapy and Behavior Research Laboratory: June 1953-1965." In O'Donohue et al. (2001), *A History of the Behavioral Therapies: Founders' Personal Histories* (Context Press)

## CLINICAL ASSESSMENT SERIES

The ABCT Clinical Assessment Series is designed to simplify the lives of practitioners and researchers alike. These handy, comprehensive guides make assessment more systematic, convenient, and completely up-to-the-minute. Focusing on key clinical areas, they offer organized, readily accessible information on assessment issues as well as the specifics of individual measures, providing reliability and validity evidence and invaluable comparisons of instruments.

### *Practitioner's Guide to Empirically Based Measures of School Behavior* • Edited by Mary Lou Kelley, David Reitman, and George H. Noell

This book provides clinicians and researchers with reviews of a wide range of empirically validated instruments for assessing children's and adolescents' behavior, social, or attentional problems in the school setting. Although the primary focus is school behavior, many of the instruments reviewed are multi-informant and are important tools for evaluating children across settings. A special chapter is included on functional assessment, identifying the function of the behavior with regard to reinforcement contingencies. Also included is a chapter on curriculum-based assessment methods for evaluating academic skill deficits that so often accompany behavior or attentional problems.

### *Practitioner's Guide to Empirically Based Measures of Anxiety*

Edited by Martin M. Antony, Susan M. Orsillo, and Elizabeth Roemer

This remarkable compendium includes reviews of more than 200 instruments for measuring anxiety-related constructs in adults. These measures are summarized in "quick view grids," which clinicians will find invaluable. Seventy-five of the most popular instruments are reprinted, and a glossary of frequently used terms is provided.

### *Practitioner's Guide to Empirically Based Measures of Depression*

Edited by Arthur M. Nezu, George F. Ronan, Elizabeth A. Meadows, and Kelly S. McClure

This volume provides summary tables comparing and contrasting different instruments in terms of their time requirements, suitability, costs, administration, reliability, and validity. These "quick view grids" provide a rapid method of identifying and comparing potentially useful measures.

### *Practitioner's Guide to Empirically Based Measures of Social Skills* • Edited by Douglas W. Nangle, David J. Hansen, Cynthia A. Erdley, and Peter J. Norton

This one-of-a-kind reference approaches social skills from a social learning perspective, combining conceptual background with practical considerations, and organized for easy access to material relevant to assessment of children, adolescents, and adults. Provides in-depth reviews of nearly 100 measures, and full reproduction of more than a dozen measures.

LIST PRICE: \$69.00 per volume

ABCT member discount price: \$54.00

to order:  
[www.abct.org](http://www.abct.org)

## NOMINATE the Next Candidates for ABCT Office

*I nominate* the following individuals:

PRESIDENT-ELECT (2013–2014)

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REPRESENTATIVE-AT-LARGE (2013–2016)

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NAME (printed)

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SIGNATURE (required)

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## 2013 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, 2013, 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 Raymond DiGiuseppe, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.**

*Good governance* requires participation of the membership in the elections. ABCT is a membership organization that runs democratically. We need your participation to continue to thrive as an organization.

**NOTE:** To be nominated for President-Elect of ABCT, it is recommended that a candidate has served on the ABCT Board of Directors in some capacity; served as a coordinator; served as a committee chair or SIG chair; served on the Finance Committee; or have made other significant contributions to the Association as determined by the Leadership and Elections Committee. Candidates for the position of President-Elect shall ensure that during his/her term as President-Elect and President of the ABCT, the officer shall not serve as President of a competing or complementary professional organization during these terms of office; and the candidate can ensure that their work on other professional boards will not interfere with their responsibilities to ABCT during the presidential cycle.

This coming year we need nominations for two elected positions: President-Elect and Representative-at-Large. Each representative serves as a liaison to one of the branches of the association. The representative position up for 2013 election will serve as the liaison to the Academic and Professional Issues Coordinator.

A thorough description of each position can be found in ABCT's bylaws: [www.abct.org/docs/Home/byLaws.pdf](http://www.abct.org/docs/Home/byLaws.pdf).

### Three Ways to Nominate

- Mail the form to the ABCT office (address above)
- 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.





***the Behavior Therapist***

Association for Behavioral  
and Cognitive Therapies

305 Seventh Avenue, 16th floor

New York, NY 10001-6008

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2ND ANNUAL MEETING

**Baltimore**

Hilton Baltimore • June 1-2, 2013

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- BSM & Affordable Care Act
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- Becoming A BSM Provider
- Future Directions for BSM
- Case-based workshops

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