

# *the* Behavior Therapist

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### *President's Message*

## Three of My Favorite ABCT Priorities

Stefan G. Hofmann, *Boston University*



It has been a busy time here at ABCT. I would like to take this opportunity to share with our members three of my favorite priorities that have been discussed during our last Board meeting and that we are currently working on. If you have any objections or thoughts, now would be a good time to send me an email at [shofmann@bu.edu](mailto:shofmann@bu.edu).

### Dissemination

We want to continue our dissemination efforts. We decided to use a number of strategies to accomplish this. First, as many of you know, we initiated a Task Force on Dissemination to oversee and encourage our efforts to disseminate our final Task Force Report on Cognitive Behavioral Psychology Doctoral Education. Special thanks to Bob Klepac and George Ronan for starting the ball rolling on this. Second, what better way to disseminate CBT than through our Annual Convention! Therefore, in 2012 we began a new Workshop-Plus consultation program that allows for a more in-depth training experience. Essentially, some sessions offer participants additional consultations via telephone or Skype to discuss the practical implementation of the therapeutic strategies that were discussed during the ABCT sessions. So far we tried this with two Workshops, two Master Clinician Seminars, and one Institute. Depending on the feedback you give us, we will further develop this model. Third, we will continue and further expand our webinars throughout the year. So far, they have been a huge success. Fourth, we have

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**April is election month!** Remember to cast your electronic vote.  
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If you did not receive voting materials, please contact us: [lyarde@abct.org](mailto:lyarde@abct.org)

## 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.

begun to evaluate ways to improve dissemination to other professional groups who use CBT, including, but not limited to, psychiatrists, social workers, mental health counselors, and nurses.

#### Membership Growth

Our organization is very healthy. Financially, we are on very firm ground and our membership number is stable. However, we could—and should—do a lot better at growing our membership and improving our membership retention. CBT has become the dominant orientation in mental health care delivery across the globe and in the U.S. Virtually every evidence-based practitioner is a self-identified CBT therapist. However, our membership has not seen the rise in members one would expect given these changes in health care delivery. In essence: We need to grow our membership to reflect the general trend in health care delivery! There is no single method to do this. Among other things, we need to actively recruit potential members from a variety of professional groups. You can help us with this. In fact, our members are our most valuable resource. So please encourage your colleagues and students to join. We would also like to further develop local communities to attract new members. Finally, we are considering instituting a “Fellow” status to reward and retain our members. More about this at a later point.

#### Visibility

Related to the membership issue is our more general goal to enhance the visibility of ABCT and CBT in general. Again, we heavily rely on you, the members, to spread the word through the media and other means. CBT really does work and investing in the research and practice of our ABCT community pays off enormously! We need to advocate for ourselves and especially to funding agencies, such as the NIH, insurance companies, and policymakers. They need to know that we are here, what we have been doing, what we are planning on doing, and what we could do if we only had more support and resources. The health care delivery system is undergoing some unprecedented changes (and improvements) in the U.S. We need to be a critical part of this.

...

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## What All Treatment Providers Should Know About Sleep Hygiene Recommendations

Taryn G. Moss, Angela M. Lachowski, and Colleen E. Carney,  
*Ryerson University*

Sleep disorder researchers and practitioners are generally concerned with the behavioral practices that interfere with sleep and contribute to the development of chronic insomnia. Sleep hygiene, a practice comprised of behaviors that are believed to support better quantity and quality of sleep, are typically included as part of cognitive-behavioral therapy for insomnia (CBT-I; King, Dudley, Melvin, Pallant, & Morawetz, 2001; Stepanski & Wyatt, 2003). The original list of sleep hygiene recommendations was developed by Hauri (1977) and included general guidelines concerning health practices (e.g., diet, exercise, substance use) and environmental factors (e.g., light, noise, temperature) that may support or hinder sleep (Morin et al., 2006). Since the initial conception of sleep hygiene, sleep specialists have failed to arrive at a consensus regarding the exact recommendations for good sleep hygiene (Stepanski & Wyatt). Although some of the recommendations of sleep hygiene were derived from empirical studies, others were merely a result of clinical observations of poor sleepers (Stepanski & Wyatt). Currently, empirically supported treatments have become the standard of care; thus, this paper will review the evidence for sleep hygiene and will assess health-care provider knowledge about the current state of the evidence in support of sleep hygiene.

Sleep hygiene assumes that sleep difficulties relate to a violation of particular sleep rules (Stepanski & Wyatt, 2003). As such, several researchers have examined the sleep hygiene practices of good sleepers compared to those with insomnia. Lacks and Rotert (1986) found that while both groups had a comparable understanding of sleep hygiene recommendations, the insomnia group was more likely to violate these rules. In contrast, Harvey (2000) failed to find any significant differences in sleep hygiene practices between good and poor sleepers. Interestingly, one study found that patients with insomnia engaged in better sleep hygiene practices when compared to good sleepers (Cheek, Shaver, & Lentz,

2004). Most recently, an internet-based study demonstrated that people generally exhibit good daily sleep hygiene practices across the board, regardless of sleeper status (Gellis & Lichstein, 2009), although certain sleep hygiene factors, such as failing to keep a sufficiently quiet and comfortable sleep environment, were observed to be more prominent in poor sleepers. In sum, the literature is mixed as to whether sleep hygiene behaviors play a prominent role in sleep difficulties (Cheek et al., 2004; Gellis & Lichstein; Harvey; Lacks & Rotert; Stepanski & Wyatt).

A paucity of studies have examined the efficacy of sleep hygiene recommendations as the sole treatment for insomnia (Chesson et al., 1999; Engle-Friedman, Bootzin, Hazlewood, & Tsao, 1992; Friedman et al., 2000; Guilleminault et al., 1995; Hauri, 1993; Schocket, Bertelson, & Lacks, 1988). Although one study found that sleep hygiene could decrease wakefulness after sleep onset, those in the sleep hygiene group were more likely to complain of poor sleep compared to subjects in the other treatment groups (Chesson et al.; Engle-Friedman et al., 1992; Friedman et al.; Guilleminault et al.; Hauri; Schocket et al., 1988). Few studies found sleep hygiene to have modest treatment effects and there is mixed support for patient satisfaction; however, the Standards of Practice Committee of the American Academy of Sleep Medicine have determined that there is insufficient evidence to recommend sleep hygiene as a monotherapy (Chesson et al.). More recently, a paper reviewing the clinical guidelines for the management of chronic insomnia also cautioned against using sleep hygiene as a monotherapy (Schutte-Rodin, Broch, Buysse, Dorsey, & Sateia, 2008).

The committee has recognized several other treatments as effective, including stimulus control therapy, relaxation training, sleep restriction, multicomponent therapy (without cognitive therapy), biofeedback, paradoxical intention, and CBT-I (Chesson et al., 1999; Morin et al., 2006). Although there is a preference to combine

multiple interventions (i.e., CBT-I; Morin et al.; Morin, 2010), the treatments listed above are all well-established monotherapies and sleep hygiene does not appear on this list. It should be noted that in order to be considered a well-established treatment, these treatments must have demonstrated efficacy in a minimum of two good group design studies, conducted by different investigators, or have a large series of single-case design studies demonstrating its efficacy.

Common sleep hygiene recommendations include eliminating or reducing caffeine and/or alcohol consumption. The caffeine recommendation is based on the evidence that it can delay sleep onset and increase wakefulness while reducing slow-wave sleep, thus reducing total sleep time, sleep efficiency, and subjective sleep quality (Hindmarch et al., 2000; Landolt, Dijk, Gaus, & Borbely, 1995; Landolt, Werth, Borbely, & Dijk, 1995; Paterson, Wilson, Nutt, Hutson, & Ivarsson, 2009). Moreover, caffeine also has implications for sleep intensity, as it has been shown to decrease slow-wave activity and increase spindle frequency, the converse of which occurs in recovery sleep (Landolt, Dijk, et al., 1995; Landolt et al., 2004; Landolt, Werth, et al., 1995). However, the actual specific recommendations surrounding the quantity of caffeine intake and proximity to bedtime ingestion of caffeine are vague. While some advise patients to limit their use of caffeinated beverages to no more than three cups of coffee per day and to avoid consumption in the late afternoon or evening hours (Schutte-Rodin et al., 2008), others suggest eliminating coffee altogether (Hauri, 1992). The American Sleep Association recommends that caffeine consumption is acceptable, but cautions that it should not be ingested after noon (American Sleep Association, 1997). Thus, this recommendation remains nonspecific and confusing.

Despite alcohol's sedative effect that can decrease sleep-onset latency (MacLean & Cairns, 1982; Rundell, Lester, Griffiths, & Williams, 1972; Williams, MacLean, & Cairns, 1983), alcohol is an ineffective sleep aid and, in large quantities, it has the ability to worsen sleep quality (Vitiello, 1997). This deleterious effect is presumably from a net sympathetic arousal state that occurs after the blood alcohol level declines during sleep. Awakenings from intense dream activity with sweating and headaches are commonly reported as a result of the sympathetic arousal (Zarcone, 2000). Alcohol's impact on sleep varies and is influenced by



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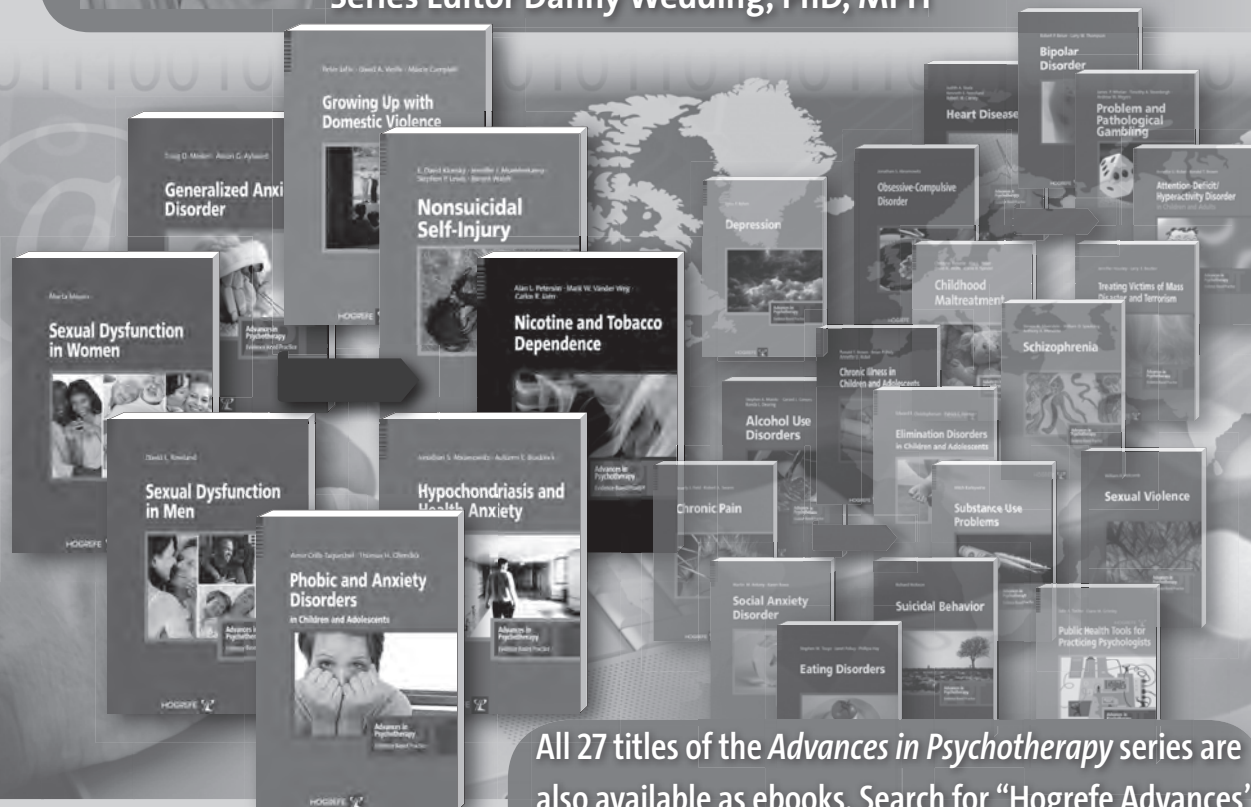
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the total body water percentage, contents of the gastrointestinal tract, quantity and speed consumed, proximity to bedtime, and the blood alcohol concentration (Roehrs & Roth, 2001; Vitiello). Thus, while there is empirical support for the adverse effect of alcohol on sleep, it is still unclear as to specific recommendations (e.g., abstinence versus limited quantities) and in what proximity to bedtime.

Other sleep hygiene rules involve recommendations specific to the sleep environment. While asleep, the body can respond to environmental stimuli; however, the noise sensitivity in each individual can vary depending on the noise type, intensity, frequency, spectrum, interval, signification, and the disparity between the background noise level and the maximum amplitude of the stimulus. Also, other variables, such as age, sex, and personality characteristics, can affect how disturbing the level of noise is to a particular individual. Intermittent noises with a peak noise level of 45 decibel (dBA) and higher can increase sleep onset latency (Muzet, 2007). The World Health Organization specifies 30 dBA as an upper limit for continuous background noise in

the bedroom, and cautions against noises exceeding 45 dBA (e.g., a conversation; World Health Organization, 2009). Thus, a quiet room appears beneficial in order to ensure uninterrupted sleep, but the specific dBA level that is disruptive is variable and differs among individuals.

Temperature also has the ability to influence both sleep structure and body temperature regulation (Haskell, Palca, Walker, Berger, & Heller, 1981; Kumar, Mallick, & Kumar, 2009; Muzet, Libert, & Candas, 1984; Teramoto et al., 1998). Even small variations of ambient temperature within thermoneutral zones (environment that keeps body temperature at an optimum point) can influence modifications of sleep structure (Kumar et al., 2009; Muzet et al., 1984). Several studies suggest that sleeping at temperatures above or below thermoneutrality leads to decreased REM and decreased Stages 3 and 4 sleep (Buguet, Roussel, Watson, & Radomski, 1979; Schmidt-Kessen & Kendel, 1973). Conversely, Henane and colleagues (1977) exposed participants to temperatures up to 39.5°C (103°F) and did not observe changes in sleep patterns. Generally, people prefer to sleep in a room around 19°C (66°F) and, as that temperature increases, it becomes more uncomfortable (Candas, Libert, Vogt, Ehrhart, & Muzet, 1979). The amount and duration of periods of nocturnal awakenings increases if the environmental temperature is extremely low or high (Karacan, Thornby, Anch, Williams, & Perkins, 1978; Muzet et al.). The specific optimal ambient temperature for sleep varies between people and can be affected by clothing and bedding; thus, it would be difficult for medical professionals to make a specific recommendation about the ideal room temperature.

The final environmental recommendation includes sleeping in a dark room to decrease sensory input and stimulate the production of melatonin, a hormone involved in preparing the body for sleep and in the regulation of the circadian cycle (Ferguson, Rajaratnam, & Dawson, 2010; Hardeland, 2009). Melatonin has been linked to improved sleep quality and decreased sleep onset latency in both good sleepers and those with sleep disorders (Stibich, 2008). Moreover, darkness appears to promote relaxation, which has been linked to better sleep. However, a gap in the literature exists that specifically examines this relationship.

Exercise has also been implicated as an effective intervention for prevention or reduction of sleep problems (Brand et al.,

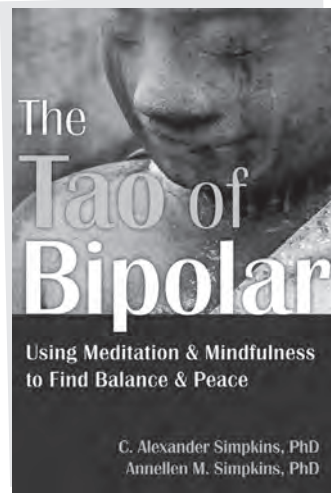
2010; Driver & Taylor, 2000; Hauri, 1993). However, the actual specifications of this recommendation remain unclear. Physical activity leads to physiological changes favorable to homeostatic sleep regulation; that is, physical activity may attenuate the build-up of sleep drive (Driver & Taylor, 2000). Meta-analyses (Kubitz, Landers, Petruzzello, & Han, 1996; Youngstedt, O'Connor, & Dishman, 1997) suggest that exercise increases total sleep time and delays REM latency compared to control conditions; however, these effects are modest. Within the exercise literature, factors such as exercise intensity, type, and timing in relation to sleep are important variables to consider. Whereas exercise does not consistently yield large sleep benefits, the literature does support the notion that exercise is beneficial for sleep under certain conditions. Further investigation into the specifics of type, intensity, duration, and time of the day of exercise is necessary to provide uniformity and empirical rationale for these recommendations.

Finally, another component of good sleep hygiene is the recommendation to eat a snack high in the amino acid tryptophan (TRP; e.g., milk, turkey, peanuts, cheese, yogurt) to help facilitate sleep (Cline, 2009; Southwell, Evans, & Hunt, 1972). However, sleep researchers have been vague regarding which snacks are considered "light." Findings from a self-report study suggest that consuming a warm drink or snack at bedtime is the most effective sleep intervention, as rated by 20% of the participants (Lareau, Benson, Watcharotone, & Manguba, 2008). The literature suggests that hunger can disrupt sleep (Crisp & Stonehill, 1973; Hauri, 1977; Jacobs & McGinty, 1971). Nightly administered TRP has been linked to an increase in the release of melatonin (Richardson, 2005), and even low doses (i.e., 1 gram) can significantly decrease sleep onset latency and increase self-report ratings of sleepiness in insomnia sufferers (Brown, Horrom, & Wagman, 1979; Hartmann, Cravens, & List, 1974; Hartmann & Spinweber, 1979; Spinweber, 1986). While there is empirical support that Stage 4 sleep (deep sleep) increases following TRP administration (Hartmann & Spinweber), other studies have failed to find an effect of TRP on sleep modulation (Brown et al., 1979; Spinweber). Beneficial effects of TRP in good sleepers have also been noted, as they report increased sleepiness and decreased sleep onset latency (Silber & Schmitt, 2010). Thus, while administration of TRP has been shown to promote sleep (Brown et

**Table 1. Demographic Variables**

Variable	Proportion %
<i>Sex</i>	
Female	63
<i>Ethnicity</i>	
Aboriginal	1.0
Caucasian	66.3
South Asian	6.7
East/Southeast Asian	15.4
African	1.0
Caribbean	1.9
West Asian/ Middle Eastern	1.9
Latin/Central/ South American	1.0
Other	4.8
<i>Profession</i>	
Nurse/Nurse Practitioner	9.6
Social Worker	2.9
General Practitioner	52.9
Psychiatrist	7.7
Psychologist	17.3
Other	9.6
<i>Practice in</i>	
North America	89.3
Europe	5.8
Other	4.9

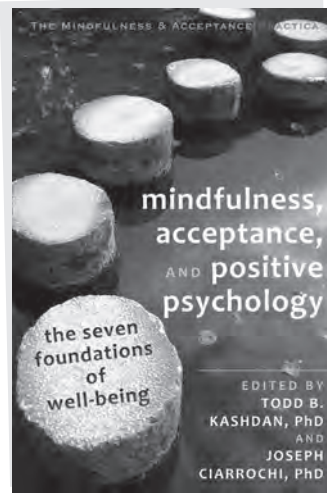
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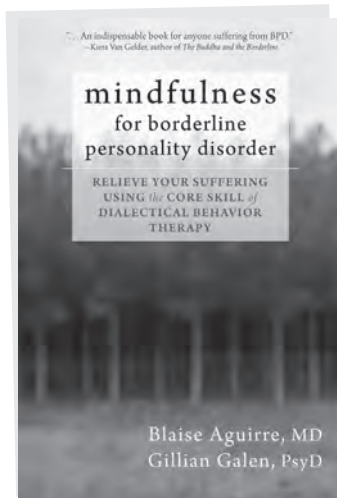


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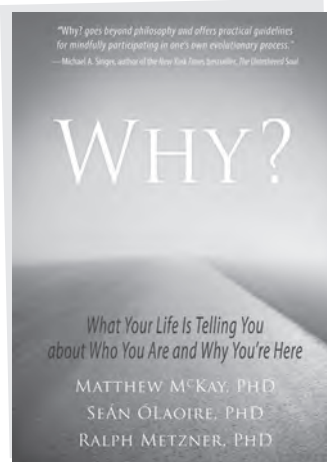
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al.; Hartmann et al., 1974; Hartmann & Spinweber; Minet-Ringuet, Le Ruyet, Tome, & Even, 2004; Silber & Schmitt; Spinweber), there is a gap in the literature examining dietary sources containing this amino acid and the specific association with sleep. No investigations controlling the type or quantity of food, or the time consumed in relation to bedtime, have been employed to date.

Anecdotal evidence suggests that sleep hygiene appears to be the most commonly recommended treatment among care providers for patients with insomnia, despite the questionable efficacy. Given the mixed evidence for efficacy among the sleep-specific sleep hygiene recommendations, the main objective of this study was to gain an understanding of the frequency with which sleep hygiene is being recommended by health care providers as a stand-alone insomnia treatment. It was hypothesized that sleep hygiene remains to be the most commonly prescribed insomnia treatment by medical professionals.

## Method

### Participants

Participants ( $N = 106$ ) were self-identified health practitioners (e.g., physician, social worker, psychologist, nurse, psychiatrist) ranging in age from 23 to 72 ( $M = 39$ ,  $SD = 11.6$ ). See Table 1 for additional demographic information. Ryerson University's Research Ethics Board approved this study for use in a human population.

### Measures

The Insomnia Treatment Practices Questionnaire is an online survey designed for use in this study. This questionnaire was brief ( $< 10$  minutes to complete) and inquired about demographic information and

insomnia treatment. For example, *Which insomnia treatments do you provide? Of the following treatments, which are effective treatments on their own?* Each question allowed for multiple responses, including the following: sleep hygiene, pharmacotherapy, stimulus control, sleep restriction, paradoxical intention, cognitive therapy, relaxation therapy, biofeedback, hypnosis, mindfulness, self-help book, sleep referral, none, and other. In an effort to understand what participants consider to be sleep hygiene recommendations, and given that stimulus control is often erroneously confused with sleep hygiene, another example of a question included in the survey is as follows: *Which of the following recommendations are included in your version of sleep hygiene?* Respondents could select multiple responses from the following sleep hygiene and stimulus control recommendations: limit caffeine, limit alcohol, exercise, sleep environment, bedtime snack, get out of bed when unable to sleep, reserve the bed only for sleep and sexual activity, avoid worrying in bed, avoid daytime napping.

### Procedure

A link to the online survey was distributed electronically through professional groups such as LinkedIn (e.g., Canadian Psychological Association, Medical Doctor Network, Psychiatrists) and via email to medical clinic staff participation. Interested participants who clicked on the link were taken to an online consent form and those who provided consent were able to complete the survey. After the survey was completed, participants were debriefed and provided with information on empirically based insomnia treatments (e.g., CBT-I). No compensation was provided.

## Results

Data from the online insomnia treatment practices survey revealed that the three most commonly used sleep treatments include sleep hygiene (88%), pharmacotherapy (63%), and relaxation therapy (44%; see Figure 1 for additional information). Moreover, the majority of medical professionals believe sleep hygiene (80%) and pharmacotherapy (72%) were efficacious monotherapies (see Figure 2 for additional information). The most commonly prescribed sleep hygiene recommendations were as follows: limit caffeine consumption (98%); ensure the sleep environment is quiet, dark, and cool (90%); exercise (89%); limit alcohol consumption (88%); and consume a light bedtime snack (16%). Survey respondents tend to erroneously consider stimulus control recommendations to be part of the sleep hygiene recommendations. The most common stimulus control recommendations were as follows: restricting the bed only for sleep and sexual activity (87%), avoiding daytime naps (82%), getting out of bed when unable to sleep (67%), and avoid worrying in bed (59%).

## Discussion

The results of the online survey suggest that a large majority of medical professionals appear to be misinformed regarding the efficacy of sleep hygiene as a stand-alone treatment. Although the majority of those surveyed endorsed sleep hygiene as an effective monotherapy, only one-third selected stimulus control and sleep restriction to be effective monotherapies, when, in fact, they are efficacious treatments on their own (Morin, Culbert, & Schwartz, 1994). Also, medical practitioners appear to be misinformed as to what constitutes sleep hygiene recommendations, as stimulus control

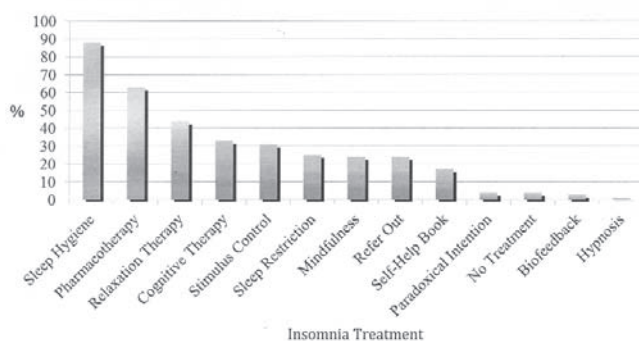


Fig. 1. Percentage of medical professionals who currently recommend the listed insomnia treatments

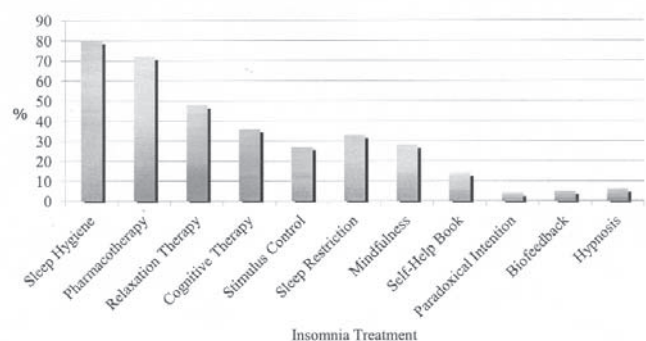


Fig. 2. Percentage of medical professionals who currently perceive the listed insomnia treatments as an efficacious monotherapy



guidelines were commonly endorsed as sleep hygiene recommendations. The implications of this confusion may actually be beneficial, as using sleep hygiene in combination with an efficacious treatment is superior to using it alone. However, the efficacy of using only part of the stimulus control package is unknown, though it appears to be common practice.

Aside from the limited evidence to support the use of sleep hygiene among individuals with insomnia, the specific recommendations within sleep hygiene are vague and not always empirically based. For example, limiting caffeine consumption was the most common sleep hygiene recommendation; however, the actual specific recommendations surrounding the quantity of caffeine intake and the proximity to bedtime ingestion of caffeine are vague. Similarly, the majority of medical professionals make suggestions to their patients that are specific to the sleep environment, exercise, and alcohol consumption, despite the evidence being nonspecific and confusing.

The fact that sleep hygiene is disproportionately advocated among treatment providers as an effective monotherapy for treatment of insomnia is troublesome given

the lack of empirical evidence for its effectiveness as a monotherapy. This finding is inconsistent with the practice parameters for insomnia outlined by leading experts in the field (Chesson et al., 1999). These empirically supported parameters do not include sleep hygiene as a monotherapy; that is, it is not recommended except as part of another effective treatment such as CBT (Morin et al., 2006). Although sleep hygiene recommendations may have an empirical basis for promotion or prevention of sleep problems, further research is required to indicate that any of the recommendations actually lead to improvement of sleep. Further, current sleep hygiene recommendations are vague or inconsistent, leaving important guidelines for sufficient quantities, types, and timing of the particular recommendations unspecified. Stepanski and Wyatt (2003) reviewed the sleep hygiene literature and concluded that the sleep hygiene recommendations are out of proportion to the available data demonstrating the efficacy of this approach. With the current state of the literature, it is important to disseminate to the public and to non-sleep health practitioners that sleep hygiene is not an acceptable stand-alone treatment. It is important to emphasize that it is unlikely

that insomnia will remit by merely following these rules, as they should be combined with an effective treatment such as CBT-I.

CBT-I is an alternative to sleep hygiene; however, the widespread use of CBT-I is limited by the number of specialty-trained clinicians and by the length of the treatment (i.e., four to eight sessions). Fortunately, alternative brief evidence-based treatments for insomnia exist and have been empirically evaluated to be efficacious. Recently, Buysse and colleagues (2011) developed a Brief Behavioral Treatment for Insomnia (BBTI) that can be effectively delivered by health professionals in one 45- to 60-minute intervention session and a 30-minute follow-up session 2 weeks later, in addition to a 20-minute telephone call after Weeks 1 and 3. BBTI yields clinically and statistically significant improvements in sleep outcomes at 4 weeks compared to the control treatment, and these gains were maintained at 6-month follow-up (Buysse et al., 2011). Similarly, Edinger and Sampson (2003) developed an Abbreviated Cognitive Behavioural Therapy (ACBT) for primary care patients, which involved two 25-minute meetings and take-home materials. Compared to the control sleep hygiene condition, ACBT pro-



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duced significant improvements in majority of study outcomes, including clinically significant improvements at study endpoint. Therefore, with the use of these newer therapies for insomnia that are empirically superior to sleep hygiene, clinician availability and time required to conduct the original CBT-I need not be a barrier to treatment. With this information regarding the fallacy of the effectiveness of sleep hygiene, and armed with data about newer efficacious insomnia therapies, health care providers will be able to provide the most current and accurate treatments for their patients with chronic insomnia.

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## in-press article

### Mapping Mindfulness Facets Onto Dimensions of Anxiety and Depression

"Describing, or labeling internal experiences with words, may be associated with lower anxious arousal because the ability to describe reflects decreased experiential avoidance of distressing physiological experiences. In order to describe physiological sensations, one must be capable of tolerating the distress associated with the direct experience of those sensations."

Desrosiers, Klemanski,  
& Nolen-Hoeksema  
*Behavior Therapy*, in press  
doi: 10.1016/j.beth.2013.02.001

## archive

"I am advocating a return to excitement, because psychology deals not with the brain but with the heart."

Salter, A., 1949  
*Conditioned Reflex Therapy*



## ACT vs. ERP for OCD: Is It War or Marriage?

Jonathan Grayson, *Anxiety & OCD Treatment Center of Philadelphia*

As CBT enters its latest and greatest new wave, I shudder—not because I am anti ACT (Acceptance and Commitment Therapy), but because of the tendency of so many to simultaneously embrace a new technology and discard all they know. I'm still having a hard time with those who labeled themselves cognitive-behavioral therapists, but whose knowledge base is almost purely cognitive therapy with little understanding of behavioral principles. And equally disturbing was their tendency to apply a technology developed for depression to anxiety disorders with little modification. In principle, we all agree that for whomever we are treating, for whatever problem we are treating, the techniques must be adapted to the individual. The alternative is a manualized treatment suited for research or a general guide, but ultimately not a model for treatment in the real world.

It is important to note that my “accusation” is not directed at ACT's theory, but toward those who misuse it. In this article, I'm going to focus on the use of these techniques with regard to OCD. The complexity of OCD and its sufferers provides an ideal model for understanding the limitations of forcing a model upon a client population with little regard for those complexities. Before turning to ACT and the current treatment of choice for OCD, exposure and response prevention (ERP), allow me to briefly review the early (and among many practitioners, ongoing) issues with cognitive therapy, ERP and OCD. I think this is important to review, because ABCT members like to believe that our treatments are based on empirical evidence, but we still have not fully recovered from uncritically embracing and incorporating cognitive techniques into our treatments. Just to be clear, the problem is not using cognitive techniques, but using them wrongly. I believe examining the mistakes of our past will lay the groundwork for seeing how these same mistakes are being repeated by some ACT practitioners.

At this point in time almost all CBT professionals believe that intolerance of uncertainty is the core cognitive distortion of OCD, and that ERP is the first-line treatment. The implication of accepting intolerance of uncertainty as OCD's core distortion is that the client needs help tolerating a variety of potential outcomes that he/she has been desperately trying to avoid. Allow me to clarify this point with two non-OCD problems. Imagine a client with social anxiety who is concerned about being disliked by guests at a party; no one is going to suggest this possibility is unlikely. The client needs to learn to live in a world in which there are people who don't like them. Now imagine a client with a fear of flying: The therapist will need to establish the basis of the fear—Is it the possibility that a plane may crash (intolerance of uncertainty) or a lack of knowledge about flying safety (overestimation of threat based on a lack of education)? If it is the latter, the focus does not need to be on the possibility of the plane crashing, but upon education and the actual odds. Treatment should be based on the client's cognitive distortions, not how the therapist feels about the likelihood of the client's fears.

Now consider a client whom I was seeing a number of years ago, who worried that her thoughts might harm or kill another. She became concerned about this possibility after reading an article claiming that people who were prayed for in hospitals did better than those who were not. Overlooking the research flaws in the study, she reasonably assumed that if thoughts could help people, then why couldn't they hurt people? Previous therapy attempts to convince her that this couldn't happen had failed. Although she worked and functioned, she spent countless hours trying to make sure she wasn't hurting anyone in her thoughts and desperately trying to undo possible harm thoughts she may have had. In our first session, I agreed that she may be able to kill people with her thoughts, but noted that if her hit rate was low, it would be impossible for us to determine whether or not she actually had this power. I went on to

suggest that we would work on killing people with her thoughts in treatment.

This was not done as a behavioral experiment. In a behavioral experiment, the individual engages in a behavior and uses the data to modify his/her beliefs about the environment; i.e., if the client tried to kill me with her thoughts and I didn't die, it proves her thoughts can't kill. A behavioral experiment is not the proper treatment for intolerance of uncertainty, since it implies treatment will provide indisputable proof. Instead, the goal was to help her to learn to tolerate these thoughts, because she spent all of her time trying to prevent herself from thinking about hurting another or trying to undo thoughts of what she might have done. In undertaking this treatment, I told her that during treatment someone might die and that if this happened, I would urge her to continue treatment, since a single death might be a coincidence. I did agree that if she could kill three or four people in quick succession on separate occasions (a busload of people would still be one), treatment would be altered and we would contact the CIA, since they might have a special use for her. However, if this criterion wasn't reached and only one or two people died, treatment would continue and she would never know whether or not she was responsible for the death/s. If this were a behavioral experiment, no one dying would be taken as proof she didn't have to worry about her power. In the first week the focus of treatment was the client's father. He died at the end of the week! He had been sick, but he hadn't been on the verge of death.

If we had been conducting a behavioral experiment and the goal of treatment had been to prove that her thoughts were harmless, what could I have said? How could I prove coincidence? The client stayed in treatment and recovered; she was willing to learn to cope with never knowing the potential power of her thoughts. Unlikely events can happen and OCD sufferers understand this better than most. The second wave, cognitive therapy, added much to our arsenal of therapy techniques, but to properly use it with any client population, we need to understand that population.

This brings us to ACT, the proclaimed third wave; does it add anything to treatment for OCD? Although the behavioral core of ERP remains unchanged, our understanding of how to implement it has. As currently practiced, ERP is an acceptance-based treatment (Hannan & Tolin, 2005). At my center, my colleagues and I go a step further; we say exposure is acceptance. Many of the techniques and concepts that

comprise our treatment are consistent with ACT. But this is not a declaration of, *We already do this, so ACT is superfluous*. The work done by Hayes and his colleagues provide new insights and modifications that inform our work with OCD. On the other hand, there are those ACT therapists who fail to view ACT as a part of the CBT framework, and make the mistake of applying ACT principles to the treatment of OCD without understanding the intricacies of OCD. History is repeating itself.

In reconciling ACT and ERP for OCD, the core issue is simply this: Is ERP a method to be used within an ACT framework; or does CBT for OCD involve ERP, ACT, and a broader knowledge of cognitive behavioral theory and principles? ACT involves helping individuals change their entire relationship to their thoughts and the world by targeting six psychological processes: acceptance, defusion, values, committed action, self as context, and contact with the present moment (Hayes, 2005). ACT is a top-down approach. ACT practitioners would assert that if ACT is the primary mode of treatment, the power of meaning and thought will have been defused, experiencing anxiety will be accepted, and an individual will decide to undertake exposures as part of committed action to living a values-driven life. Directed hierarchical exposures will rarely be necessary.

My current belief is that this is an attempt to adapt the client to the technique. In the treatment of OCD, we ultimately include the goals of ACT, but believe a bottom-up approach is necessary. First and foremost, for most sufferers of OCD, desperate attempts to obtain certainty are so overwhelming that the macro-changes proposed by ACT will be lost in the sufferer's current relational frame. It is akin to working on an alcoholic's life problems while the client is drunk. Instead, we propose targeting the same processes as ACT, but the starting point will be the sufferer's presenting problem: OCD. Although the overall form of our treatment appears to follow the traditional ERP approach to OCD, let's examine it through the lens of the six processes targeted by ACT.

### Acceptance

We believe that exposure is acceptance; however, ACT practitioners would correctly point out that in our usage, acceptance is narrowly targeting the feared consequences of the obsession and the resulting anxiety—that the broader implications and finer

points of ACT are not fully realized. This is exactly what we mean by a bottom-up approach. The language of ACT does not target the sufferer's current relational frame, which is hyper-focused on avoiding uncertainty. However, our focus on OCD's core distortion is comforting to sufferers; we are speaking their language. In other words, working within their relational frame increases our influence because they feel understood.

Some ACT proponents, in a manner similar to the cognitive therapists who preceded them, suggest that techniques like ACT may be more acceptable to the high proportion of sufferers who refuse ERP and, if so, this justifies its use as treatment. I find this confusing. We don't offer a cancer patient a less effective chemotherapy because it has fewer side effects. The key issues of compliance and accepting the goals of treatment depend upon the therapist's understanding of the disorder, the treatment, and, most critically, how to present this information to the client. Lower refusal rates result from the sufferer understanding the nature of the problem and believing that the therapist also understands.

Initially, clients are overwhelmed by their OCD, having thoughts that seem crazy, engaging in rituals that seem pointless. We tell our clients that the goal of treatment in OCD is learning to live with uncertainty, or alternatively, to learn to accept the impossibility of ever obtaining absolute certainty. Presumably everyone would agree that the first step of change is getting the client to agree to treatment. ERP is a very challenging treatment and for a sufferer to be fully on board, it is important that the client gains an understanding of OCD and believes that the therapist understands the problem. Helping an OCD sufferer to make sense of what is happening to them is the first step toward acceptance. In order to lead them to acceptance, we often go through the following dialogue:

**THERAPIST:** You know that suffering from OCD is very painful and that it has many manifestations, but what do you think ties them together, what do you think is the core of OCD?

*[Typically, client will respond with "fear" or "compulsions" or "anxiety," or some combination of these.]*

After explaining why each of the above isn't the core of OCD:

**THERAPIST:** In whatever the sufferer's area of concern, the anxiety and rituals are driven by the attempt to be 100% certain. One hundred percent certain that you are clean, that the lights are off, that you aren't gay, that you won't molest your children, etc.

Most sufferers report feeling relieved at this point. This simple concept of being driven to be 100% certain suddenly explains what has been going on with them. What we are saying is consistent with their current relational frame as opposed to trying to change their worldview. Our dialogue guiding them toward acceptance continues:

**THERAPIST:** Do you know why you can't be 100% certain?

*[Clients either acknowledge that it is impossible or ask why.]*

**THERAPIST:** Is your spouse [mother, father, sister, etc.] alive?

**CLIENT:** Yes.

**THERAPIST:** How do you know?

**CLIENT:** I talked to them 10 minutes ago.

**THERAPIST:** And it isn't possible that they died in the last 5 minutes? You've responded to this question in the normal way. You feel like they are alive and you then decide to pretend this is true and to not worry about it, unless you get a horrible phone call. With your OCD issues, you change the rules. You have to know right now and it has to be 100%. Unfortunately, certainty is not a fact, it's a feeling. You believe your loved one is alive, but you don't actually know. Most of the time the things you feel certain about turn out to be true. Your car isn't stolen, your house hasn't burnt down, and your spouse is alive. However, certainty isn't a truth, it is a feeling that often correlates with reality, but as you know and fear, there are surprises.

It is impossible to be 100% certain of anything. Research has shown us that the only people who are 100% certain are stupid. We don't know how to make you stupid. The goal of treatment in overcoming OCD is learning to live with uncertainty and we know that you can do this. Let me make a guess about you. I believe that you don't want to be maimed, paralyzed and disfigured; am I right?

**CLIENT:** Yes.

**THERAPIST:** Did you get here by car?

**CLIENT:** Yes.

**THERAPIST:** So you risked some idiot ramming your car and leaving you in a state you are sure you don't want to be in. For some sufferers, the odds of this are actually greater than their OCD fears. And your brilliant plan for coping? Wait until you are crushed under the metal. You even risk death just to see a movie – that's crazy. And the goal of treatment is to help your OCD fears to be experienced like the car crash, possible, but you will wait until it happens.

Accepting uncertainty means accepting the possibility of life disasters taking place and deciding that, should they occur, the sufferer will hope to cope with the disaster as opposed to giving up in the face of it. This is very important, because it is the decision to live with potential disaster rather than running from it that makes accepting uncertainty possible. We are providing reasons to give up on experiential avoidance with regard to their feared consequences. Accepting uncertainty sets the stage for defusion—again just with regard to OCD.

### Defusion

Defusion is the process of detaching our thoughts from the meanings and importance we give to them. Successful defusion does not mean that the thoughts go away or that the positive or negative emotions associated with thoughts are absent. However, how the person relates to thoughts changes. Rather than experiencing the thoughts/feelings as truths, they are seen as hypotheses that can be rejected. Part of this process is learning to think without judgment and to see thoughts just as thoughts. It is here that many ACT therapists run into trouble with OCD and accidentally violate their own rules. For an OCD sufferer, the statement that a thought is just a thought is a judgment. Because if this is true, then they don't have to worry about any potential consequences. Although this is not the meaning the ACT therapist is trying to convey, there is the promise that perceiving a thought as just a thought will take power away from it. In the mind of the sufferer this is translated to the idea that there is no reality basis to the thought, so they don't have to worry. The ACT therapist is falling into the same trap as earlier cognitive therapists who used behavioral experiments and wanted to argue about the probability of an event happening. The sufferer will obsess about whether the current thought is really just a thought or a real concern. Again, when intolerance of uncertainty is the cognitive dis-

tortion, then living with potential consequences, regardless of the probability, is the goal.

Some might argue that concern over a possible future event that might not happen doesn't make sense, but the reality is that it might happen. Remember the client who worried about the possibility of killing people with her thoughts. Did she kill her father? If you answered no, how do you know? What if this was the one time in which she "had the power"? We believe that thinking about coping with a potential negative consequence rather than obsessing about one makes sense. Everyone would agree that if you have just lost a loved one, mourning that loss and working on adjusting to a new life is necessary. Equally important would be thinking about mourning the coming loss of a loved one, who is terminally ill with only 6 months to live. Attempting to not think about the impending loss would only serve to make those thoughts more present and would make enjoying those last few months impossible. We would also argue that thinking about the potential loss of a loved one who isn't sick or dying is adaptive. After all, isn't that one of the reasons there are so many medical series on TV, that we all wonder about the loss of ourselves and loved ones? Coping with potential consequences is a creative and adaptive process that is very different than ritualizing. Obsessing and ritualizing are generally attempts to deny possible realities that upset the sufferer. Fostering this type of acceptance uses the language of the sufferer (i.e., the importance of learning to live and cope with uncertainty) and that old cognitive therapy standard, Socratic reasoning, sets the stage for defusion.

Socratic reasoning can be used in a few ways. First, it can demonstrate all of the ways in which the sufferer's rules for ritualizing are not sufficient. Just as they can always find holes in their rituals, it is the therapist's job to do so. For example, it may be true that handwashers who simply remove their shoes when entering the house and then wash their hands do not worry about what the rest of their family has done. For us this is critical, because it means that exposure is taking place, but they are pretending that it isn't. Second, sufferers and nonsufferers often seem to believe in "civilized" germs. In this belief system, whatever germs their hands have come into contact with, have agreed to do no harm to the sufferer before they go home; however, once home, the truce is terminated and the germs will attack if handwashing doesn't quickly take place. Finally, there are always

ways in which rituals can be refined and improved, and this puts the sufferer in the position of either giving up on certainty and doing ERP or further trying to perfect their rituals and becoming more severely anxious and disabled. Or as we put it: "The saddest thing is that for all of your pain and agony, you don't even get the prize. You are not living your life and the disasters you fear may still occur."

In some cases, we can use Socratic reasoning to make ritualizing as dangerous as exposure with regard to feared consequences. Recently, I was working with a client with fears of "hit and run"; that is, how could they be sure they hadn't accidentally hit someone while driving without being aware of it. I noted that the time spent looking in the rearview mirror potentially increased the odds of failing to see someone crossing the street. In addition, the extra time driving around the block looking for bodies increased the opportunities to hit someone.

Sufferers with primary mental obsessions, such as, "How do I know that I won't slice and dice my wife tonight?" are constantly trying to figure out the meaning of their thoughts. They may want to know if this means they will engage in the act or perhaps having the thought makes them evil. On the one hand, we will normalize such thoughts by pointing out their universality:

1. Everyone wants to understand the nature of evil in others and themselves—it's a part of our creative drive.

2. Images from popular culture, such as the sexually explicit scenes in the HBO series *True Blood*, in which sex between the good vampire and heroine involves him biting her neck and showing the blood pouring from his lips and down her neck—and this is a good thing in this show. Are the sufferer's thoughts really stranger?

Although we are normalizing the communal aspect of such thoughts, we continue to note that there is always a possibility that they may be the person who acts on them or has some evil in them.

In addition, we note the obvious—that ritualizing ultimately leads to more anxiety and ritualizing. This is a fact clients recognize but often ignore in moments of panic. All of these coalesce to change the meaning of ritualizing from a means to try to establish certainty to a pain that will never eliminate uncertainty. As Hayes points out, there are many paths to defusion. When there is



no certainty to a thought or its absolute meaning, defusion is taking place.

By using language that is consistent with the sufferer's relational frame (i.e., the impossibility of definitely avoiding disaster or of ever being sure), the sufferer's view of their own thoughts changes. Their obsessions become hypotheses that are impossible to test—that is, defusion has taken place. As noted earlier, this is still just with regard to their OCD, not to their conception of all of their thinking; however, the seeds for such changes are being planted.

### Values

The sufferer is almost ready to take on treatment: learning to live with uncertainty and hoping to be able to cope with whatever life throws at them now seems to be the only choice. But ERP is a difficult treatment; we tell sufferers that both treatment and ritualizing are very painful and that the only difference is that the first leads to an end of rituals and the latter to endless rituals. Exposure will often be painful, no matter how much defusion and acceptance has taken place, the sufferer has conditioned emotional responses and conditioned thoughts to obsessive stimuli, as well as emotions to those conditioned responses. Under such conditions, they may forget to practice what we have been trying to teach them. We have developed two simple value-based forms to address this problem: one focusing on all they have lost to OCD and the other focusing on all the suffering they have inflicted on their loved ones. We ask them to fill these out in grueling detail, describing situations that may even bring tears to their eyes, rather than simply noting that they have lost time or missed important events. This may seem painful and cruel, until we explain that when they are in the midst of their OCD urges and about to give in, we want them to remember these events to motivate them.

We focus on their values, their hopes, and what kind of person they want to be in the service of fostering exposure. One of our most used dialogues focuses upon parenting:

**THERAPIST:** Do you love your children?

*[The client, of course, responds with a "yes."]*

**THERAPIST:** And you would do almost anything for them?

*[And again they will respond in the affirmative.]*

**THERAPIST** *[in a very empathetic voice]:* I'm sorry, but you are lying. I believe that you

would like to be that way, but right now, you put your OCD fears in front of your child's welfare. How often have you made your child late because you were ritualizing? Or forced them to ritualize? Or yelled at them because they weren't making rituals easier for you? I believe you love your children and that you have a lot to offer, but at this moment, you are risking having a 13-year-old who tells his/her friends what a crazy joke you are. Or worse, your child has a one-in-four chance of having OCD; do you want them to be able to cope with it or to handle it the way you do?

*[Predictably, the parent doesn't want the child to be like them.]*

**THERAPIST:** Your child will learn by what you do, not what you say. If you continue to handle your OCD this way, you will teach them that they will be helpless in the face of OCD. I know that you feel like you are trying to protect your child, but as we have discussed, your efforts to prevent your child from contamination are doomed if you plan to allow your child to go to school and have friends. And if you were to actually deprive them of friends, then what are you allowing your OCD to do to their future? The reality is that your child will be exposed to all of the horrors you fear and, like all parents, all you have in the end is luck. Most of the time the worst disasters don't happen.

The only time you ever have your children is when you are with them. At this moment with me, they are memories of good times past and a hope they will be there when you get home. Except, you don't even get to have the present, because rather than being with them, you are in OCD-Land.

I know what I'm saying is scary, but what I'm suggesting is that you make your earlier statement true, that your children come first and you will make your love for them greater than your OCD fears.

By using their values, exposure to a contaminant now becomes an act of love over fear. The values we are identifying will be both life values and, more narrowly, what valued parts of their life have been lost to OCD.

### Committed Action

Committed action is simply living your values. Like so many ideas and techniques,

simple is not the same as easy. ACT urges us to stop delaying our lives and work toward being the person we choose to be. For many diagnoses, the most reasonable place to start is with the core problems that make committed living, let alone living, almost impossible. Time-consuming rituals and a mind consumed by trying to avoid uncertainty leave the sufferer little time to devote to their broader goals. Both ACT and ERP suggest sitting with anxiety, but to do so outside the context of confronting uncertainty and deciding how to cope with potential disaster is not unlike telling the sufferer, "Don't worry," or "It's just your OCD," as if this is an idea that hasn't occurred to them. The committed action necessary to overcome OCD is exposure to their fears and coping with the possibility of having to live with feared consequences becoming a reality. In the treatment of OCD, ACT, without ERP as the primary tool, is helping the cancer patient to eat healthily, while ignoring chemotherapy. In our bottom-up approach, values are used to motivate and transform the meaning of ERP.

### Self as Context

ACT discusses three aspects of self:

1. The Conceptualized Self: the verbal categorizations and evaluations we use to define ourselves. From any theoretical view, this is the overarching belief system that shapes our perceptions and interpretations of how we see the world and what it may mean about ourselves. Seeing the flaws in our own system is a difficult task; whether the flaws are described on the macro-level of cognitively fused thoughts or on the level of examining the particular cognitive distortions and schemas we rely upon.

2. Self as a Process of Ongoing Self-Awareness: the fluid awareness of what we are experiencing in the present moment. On the one hand, this is critical for negotiating our way in the world, but our constant categorizing and judging what is happening can get in the way of living.

3. The Observing Self or Self as Context: living, experiencing and observing the present without fusing our thoughts; this is the goal we strive for. I can and will feel disappointment and pain; but these will not define me, and by not judging my experience, I am more likely to experience a reality not as altered by my biases. For example, anxiety in response to a social situation may become an uncomfortable feeling, but not a sign of failure or inadequacy or a signal that I must escape the situation.

Therapeutically, these are the work of life that we hope we can teach to all of our clients, and although we may present these concepts to a client early in therapy, it is to provide a map that they can decide to use or not. At each step in therapy, choosing a goal is not achieving a goal, it is mapping a path to follow for a journey. The goal of deciding to live with uncertainty sets the groundwork for the individual to continue down this path after his/her OCD is under control. Living with uncertainty is the beginning of not accepting thoughts and feelings as truths. Because OCD can be such a severely disabling disorder, overcoming it is a life-changing experience. "Crazy thinking" suddenly makes sense, "irresistible urges" are found to be resistible. Fused language is constantly challenged. "Can't" becomes "I choose not to" and successful therapy means that just because I'm afraid to choose, doesn't mean that I have to let fear make my choices. Overcoming OCD provides fertile ground for ACT. Living with uncertainty has taught the sufferer that the only thing they have is the moment and running from potential fears is impossible. They are ripe and ready to learn the principles of ACT.

### Mindfulness

In the public's eye, mindfulness is an oft-misunderstood concept, confused with the idea of being in a relaxed Zen-like state, in which bliss replaces all problems and negative feelings. Perhaps this may be possible for the 90-year-old Zen master who has meditated for a lifetime. In a sense, mindfulness is being in the state of the observing self. Life with all of its diversity is a part of our experience. Mindfulness exercises can be very useful in learning to sit with negative feelings, because cognitive defusion from our feelings allows us to experience them, to feel the pain, but to not increase the suffering with judgments of "I can't take this for another second," or "why am I so sick and weak."

For many OCD clients, working on exposure to the feared consequences of their OCD makes the teaching of mindfulness superfluous in the short run. There is a subgroup of clients whose anxiety is intense and a part of their feared consequence network. A modified version of mindfulness can help them learn to sit with anxiety feelings. Our first task is convincing them that there is a cognitive component to their anxiety:

**THERAPIST:** I'm curious. If in the middle of your worst anxiety, for some reason, I could assure you that it would be over,

forever, in ten minutes, would that change anything? Would you be able to put up with it?

*[Generally clients respond yes, that knowing it will end would make this okay.]*

**THERAPIST:** That's interesting. That means that something is different about your thinking, because for the first ten minutes the pain of the anxiety is exactly the same, whether it is going to be over or continue forever. We know it's not the sensations of anxiety, because if I subject you to the worst physical torture imaginable, ten minutes may be better than ten hours, but it isn't tolerable. I know you are saying that the fact that it will be over is the reason, but cognitively, there is something different you are doing as a result of this reason. Do you have any idea what it is?

*[Usually sufferers cannot identify what would be different.]*

**THERAPIST:** Let me describe a different situation. Imagine that your spouse died three weeks ago and now you are back to work. Thoughts of your spouse would pop into your mind and would probably interfere with what you are doing. Are these obsessions? And if you say no, the answer is not because mourning is normal. The difference in both situations is that you decide to allow the thoughts or feelings to be there rather than trying to stop them. Our goal is to help you get into, what we might call, "the ten-minute frame of mind."

Mindfulness training to cope with the sensations of anxiety would follow its normal course, with the caveat that during this practice, uncertainty and its feared consequences wouldn't be addressed. When not engaging in this targeted practice, ERP will be practiced as normal, while simultaneously using what was learned during mindfulness training for anxiety. Note, in so doing, we are also defusing experiencing anxiety sensations from the other feared consequences of OCD.

### Summary

Too much of our field is ideologically driven as opposed to being an empirical exchange of ideas. There are two core points this article is trying to make. The first is, let's not throw out the baby with the bath water. The ideas of ACT in some form or other have been in use by CBT therapists for some time. The directed effort of Hayes and his colleagues has been vital in expanding

our understanding of mindfulness and ways of helping clients free themselves from their maladaptive schemas and mind-sets. But ACT is not a replacement for learning behavioral and cognitive principles. Those ACT therapists who are comfortable narrowing their training and therapy do a disservice to the field.

The second is that treatment needs to be tailored to the client. Every client and presenting problem has its own special language or relational frame that a good therapist needs to be conversant in and, often, there are solidly researched techniques that are important to use. The suggestions I have made for incorporating ACT into OCD treatment are not new or even original to my Treatment Center. Hopefully my suggestions reflect the role ACT can play within our CBT framework as opposed to an uncritical acceptance of ACT as a replacement for much of what we know.

Ultimately, the ideas presented here are research hypotheses. If one is going to incorporate ACT into treatment for OCD, is there a reason to use language focusing on the intolerance of uncertainty, which may be more consistent with the sufferer's relational frame? Which approach works best with OCD: a bottom-up approach in which the initial focus of treatment is primarily on OCD-related issues using ERP supplemented by ACT principles; or a top-down approach in which sufferers are taught the concepts of ACT and in which exposures may "naturally" occur as a part of the sufferer's committed living of their values?

The importance of seeing ACT as a part of our CBT universe should result in research focused on real questions, such as the ones suggested above, instead of creating an industry of GIGO (Garbage In–Garbage Out) studies. I don't believe that head-to-head comparisons of ACT to a "pure" ERP protocol (i.e., the way ERP was practiced in the early 1980s) are ultimately useful in improving our treatments. Similarly, does anyone really think that the concepts of ACT add nothing to our treatment protocols? Obviously, there is a need for basic research, but I long for researchers to turn their attention to what is the best way to tailor what we know to the client.

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### Obituary

## In Memoriam: Susan Nolen-Hoeksema, Ph.D.

Amelia Aldao, *The Ohio State University*

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Blair Wisco, *National Center for PTSD, VA Boston Healthcare System, Boston University School of Medicine*

Susan Nolen-Hoeksema unexpectedly passed away on January 2, 2013, at the age of 53 at Yale–New Haven Hospital following complications from heart surgery. She is survived by her husband, Richard; her son, Michael; her father, John; and her brothers, Jeff and Steve. Susan was the chair of the Psychology Department at Yale University, where she had been a professor since 2004. Prior to that, she had been on the faculty at the University of Michigan and Stanford University. Susan received her Ph.D. from the University of Pennsylvania and her B.A. from Yale University. She was originally from Stonington, Illinois.

Susan was a world-renowned scholar who was best known for her work on gender, depression, and bereavement. Susan began her career by conducting pioneering research on gender differences in the cognitive processes that characterize depression. Through this work, Susan identified and operationalized the construct of rumination, which she defined as thinking repetitively and passively about the possible causes and consequences of one's distress without moving into active problem-solving.

Susan devoted over two decades of research to elucidating the role of rumination in the development, maintenance, and treatment of mental disorders. Most recently, she conceptualized rumination as a transdiagnostic factor involved in the etiology of numerous forms of psychopathology. Susan was a remarkable scholar. As an investigator, she was innovative and thoughtful, and as a writer, she had a knack for parsimony and elegance. Susan's work was recognized by a number of awards during her lifetime, including an early career award from APA Division 12, a National Institute of Mental Health Research Career Award, and the APA Committee on Women in Psychology Leadership Award.

But most important, Susan was an exceptionally generous mentor and colleague who supported the career development of innumerable psychologists. She was available to anyone—student, faculty, or staff—in need of guidance or mentorship. Her lab meetings were open to anyone who was interested and, consequently, were attended by students from all areas of psychology. Susan was a model for balance, excelling at mentoring, scholarship, teaching, and ad-

ministrative work, while also being a devoted mother, wife, and friend to many.

Some of our fondest memories of Susan involve stimulating conversations around her table while feasting on her culinary creations, celebratory toasts after passing an academic hurdle, and heart-to-heart conversations about both professional and personal life. We could always count on her to promptly give us the answer we were looking for. On more than one occasion, we have called her for a few, quick words of wisdom. She always picked up.

The following are memories of Susan provided by colleagues and students whose lives she touched.

*"Susan has been a committed mentor at every stage of my career. She has provided me with invaluable guidance, advice, and opportunities both personally and professionally. I remain eternally grateful to Susan for this support and know that my career would not have been possible without her dedicated, compassionate, and astute mentorship."*

...

*"Susan was an amazing mentor. I knew that I could go to her for advice at any time, and I always trusted that she had my best interests in mind. She was incredibly generous and made me feel as if my professional development was her top priority. I feel so sad that I won't be able to share the rest of my career with her, but I am incredibly lucky for her guidance until now."*

...



*"Susan embodied the dream of the perfect graduate mentor. She was generous with her resources and time, thoughtful and timely with her feedback, and so supportive in helping me reach my goals. When I wanted to spend time teaching, she fully supported that, and when I wanted to learn neuroscience methods, she helped make it happen. Her support made me feel like I could achieve anything I wanted to."*

...

*"Susan was a breath of fresh air in the Stanford Psychology Department from the day she arrived—full of wisdom beyond her age, talent blended with modesty, always accessible to students and colleagues. She lectured regularly in my large introductory psychology course with poise and precision. She was a much-adored young faculty member to whom many students flocked. I think her major contribution was becoming an ideal role model for many young female graduate students in personality, cognitive and developmental areas."*

...

*"She was always a quick study, extraordinarily focused, and very practical in the way she did science, cutting to the chase, so to speak, and leaving the side questions for another day. Equally present was her willingness to help students and junior colleagues, and here again, she always had practical yet essential advice about issues they needed to deal with in moving their career forward. Overarching all this was an abiding interest in understanding both the broad structure as well as the details of psychological science. There was a considerable sense of loss in Ann Arbor when Susan decided to move on to New Haven, but she helped us with that by remaining connected, sustaining collaborations, and by her visits back. At the same time, we all felt the hole she left could not be filled. Her death is an ever so much stronger blow. She is vividly remembered by those who had the privilege of knowing her."*

...

*"I recall several times approaching Susan with a new set of ideas that were not yet well-formed and coherent. Susan was*

*quickly able to organize, filter, and refine these ideas, easily recognizing what is important and what is not. Talking to Susan about ideas always led to greater clarity in my thinking. More important, she invited me into her thinking process, allowing me to learn just how she is able to reach that clarity. She had an uncanny ability to give direction and freedom at the same time."*

...

*"A story that clearly illustrates Susan's commitment to every aspect of graduate education comes from a Visiting Day at Yale. Applicants who had been admitted to the graduate program were invited to spend time in New Haven getting to know the university and the city. They were instructed to arrive in New Haven on a Sunday afternoon so that their student hosts could take them to a dinner with other students in the program before the visit officially started. One of the admitted students encountered travel delays and, as a result, she ended up taking a flight that was to land in Hartford, an hour north of New Haven, at the same time dinner was starting. Most of the students at the dinner were hosting admitted students and driving people around New Haven, so none of them was free to drive to the airport and bring the student to New Haven in time for dinner. As soon as Susan found out about our predicament, she got in her SUV, drove to Hartford, picked up the admitted student, and dropped her off in time for dessert. We were utterly surprised and grateful for her generosity. As we got to know Susan better, we quickly learned that this type of behavior was the norm. She was always there to help out, no matter how big or small, personal or academic, our predicaments might have been."*

Susan was truly one of a kind. She will be dearly missed by all whose lives she touched. She leaves a tremendous legacy with many articles and books for both academic and popular audiences and with all the research programs she helped inspire.

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Marco-Antonio S. Brown  
Bridget M. Brush  
Nicole Elise Bryan  
Amanda Chue  
Sara Conley  
David Contrada  
Kelly Correa  
Irina Lorian Costinean  
Sarah Dewdney  
Alexandra Dick  
Britta A. Ekdahl  
Elisabeth Ertel  
Molly R Franz  
Emily J. Ginger  
David Andrew Heilman  
Adam C. Jaroszewski  
Jessica Kansky  
Sima Kaplan  
Claire L. Kirk  
Mark Knepley  
Lindsey Knowles  
Lindsay Labrecque  
Mikyung Karen Lee  
Amanda Lefrancois  
Amanda Levinson  
Fiona Lesley Macphee  
Gina M. Mattei  
Suzanne Meller  
Jonah Meyerhoff  
Jennifer Anne Lorraine  
McLellan Morrison  
Melanie Morse  
Kristina Murani

[Welcome, New Members, con't]

Alyssa F. Niman  
 Mary Elizabeth Oglesby  
 Daniel J. Paulus  
 Katherine Pawlicki  
 Andrea Spacone Pratt  
 Danielle M. Purvis  
 Kesley Anne Ramsey  
 Ashley Reynolds  
 Elizabeth Riley  
 Jaci Rolffs  
 Corey Roos  
 Allison K. Ruork  
 Tara J. Ryan  
 Raha Forooz Sabet  
 Roger I. Salas  
 Dawn Schpak  
 Rachael Sharon Seeman  
 Joshua Semiatin  
 Nicole Ama Short  
 Amanda Simmons  
 Brooke Lyn Slawinski  
 Jessica Lee Sousa  
 Nora J. Sporn  
 Abigail Margaret Stark  
 Robyn Starr  
 Meredith Story  
 Allison Mary Stuppy  
 Katherine Sonja Toder  
 Amanda Unruh  
 Christine Hannah Wang  
 Patrick Brendan Wester  
 Danielle Nicole Whitworth  
 Sara Wigderson  
 Mr. Gregory Williams  
 Johannes Mosquera Wilson  
 Alicia Wiprovnick  
 Robyn Wright  
 Christina Lynn Yang  
 Jacqueline Young

***Student***

Maryam Abdullah  
 Amitai Abramovitch  
 Zachary W. Adams  
 Olutoba Adewusi  
 Nicholas William Affrunti  
 Kelly Allred  
 Kristina Skye Anderson  
 Margaret Teresa Anton  
 Kelly Appino

Matthew Cody Arias  
 Jessica Arizaga  
 Jessica Lee Armstrong  
 Prerna Arora  
 Tara M. Augenstein  
 David James Austern  
 Andrea Avila  
 Nicholas Brian Bach  
 Stephanie Bachtelle  
 Jaye A. Bahre  
 Kyoung Deok Baik  
 Brittany A. Bailey  
 Corina D. Baldwin  
 Noelle Balliett  
 Wendy Bamatter  
 Gabrielle Banks  
 Kelly Nicole Banneyer  
 Althea Bardin  
 Laura Barnard  
 Alexandra L. Barnett  
 Mr. Tristan Barsky  
 Ashley Bartner  
 Sarah Bauman  
 Katherine Bedard  
 Jennifer M. Belus  
 Brittani Berbette  
 Staci Alana Berkowitz  
 Erica L. Birkley  
 Shannon Michelle Blakey  
 Claire Blevins  
 Hannah T. Boettcher  
 Jaclyn Bogner  
 Saray Bonete  
 Taylor Bos  
 Michelle L. Bourgeois  
 Theresa Boyd  
 Patrick Dennis Boyle  
 Frances Mary Bozsik  
 Rosanna Patrice Breaux  
 Lauren Breithaupt  
 Meagan Jacquelyn Brem  
 Lauren Jaye Brickman  
 Davis Brigman  
 Cole Brodsky  
 Jessica Brodsky  
 Bonnie Jean Brown  
 Clare Brown  
 Kate Brungardt  
 Michael Brus  
 Jennifer Marie Buchman  
 Pamela Buck  
 Kelly E. Buckholdt

Magdalena Buczek  
 Marc Budgazad  
 Matteo Bugatti  
 Nora Bunford  
 Brianna M. Byllesby  
 Kenneth Richard Cabell  
 Rachel Camhi  
 Nicole Campbell  
 Shushan Campbell  
 Scott Patrick Campion  
 Mallorie Carroll  
 Alvina Cawston  
 Brad Joseph Chapin  
 Tina Chen  
 Soumia Cheref  
 Jessica Chiu  
 Su Cho  
 Jenny Chong  
 Carol Chu  
 Deborah Chu  
 Caroline Gray Clark  
 Joshua Clark  
 Stephanie Clarkson  
 Ross David Connolly, B.A.  
 Samantha L. Connolly  
 Natalie M. Cook  
 John Bernard Correa  
 Lauren Correll  
 Ashleigh Coser  
 Christina Lynn Costello  
 Lauren E. Cox  
 Sarah Crawley  
 Spencer J. Cruz-Katz  
 Jocelyn Curchack-Lichtin  
 Melissa Cyperski  
 Kimberly N. Dalve  
 Lynndal Daniels  
 Martale Jerrell Davis  
 Ryan C. T. DeLapp  
 Hilary L. DeShong  
 Kara Devers  
 Deborah L. DeVincent  
 Michelle Dexter  
 Gregory Digiacomo  
 James DiLoreto  
 Kristy DiSabatino  
 Gabrielle Maria D'Lima  
 Alexa Donnelly  
 Claire Dowdle  
 Ryan Draper  
 Julissa A. Duenas  
 Ellen Shaina Dulaney

Gerardo Duque  
 Margaret Durham  
 Sunny Dutra  
 Courtney E. Dutton  
 Cassandra Lynn Ebert  
 Steven Edwards  
 Dorianne Brooke Egan-Wright  
 Natasha Emmerson  
 Stephanie M. Ernestus  
 Jennifer Espinoza  
 Joshua M. Eudowe  
 Laura Ariel Faith  
 Antonina Farmer  
 Aliza Feldman  
 Geraldine Fernandez  
 Lindsay Fero  
 Lauren Flegle  
 Jessica Flores  
 Autumn Rae H. Florimbio  
 Carmelita Sharonique Foster  
 Stephanie A. Fox  
 Emily Foxen-Craft  
 Melville Malone Francis  
 Niela Fuchs  
 Lauren Michelle Fussner  
 Emily Caitlin Gagen  
 Tara Colleen Galaugher  
 Neville Galloway-Williams  
 Jadig Garcia  
 Laura Marcela Garcia  
 Bryan Terence Gastelle  
 Susanna Gehring Reimer  
 Nicole German  
 Pasha Gill  
 Christopher J. Gioia  
 Neha Godiwala  
 Jacquelyn Gola  
 Jennifer Amanda Gola  
 Amanda Golden  
 Alex Edgar Gonzales Harsha  
 David Andres Gonzalez  
 James Kenneth Goodlad, III  
 Nada Goodrum  
 Dessaray Monique Gorbett  
 Avi Jonah Gordon  
 Whitney L. Gore  
 Anjali Gowda  
 Kelly Graling  
 Stephanie Grayson  
 Emily Jaffess Green  
 Preston A. Greene  
 Brenna Greenfield



[New Student Members, con't]

Anne Greenwalt  
Garrett Colin Groves  
Roberto Guerra  
Cristina Gutman  
Caroline Haimm  
Danielle Halachoff  
Lacey Hall  
Amanda Elizabeth Halliburton  
Jami Halpern  
Rebecca Hamblin  
Benjamin Hamburger  
Jessica Hamilton  
Eric James Harmes  
Shannon Harper  
Taylor Harris  
Aubrey Harrison  
Kristin Michelle Healey  
Kate Helbig  
Leigh Hellinghausen  
Jordan Leigh-Marie  
Hemingway  
Justin Joel Hempfling  
Peggy A. Henninger  
Joanna Herres  
Tracy Herring  
Kylee J. Heston  
Anita Sarah Hibbert  
Karen Hill  
Peter Hitchcock  
Sheau-Yan Ho  
Ariana Hoet  
Elana Hoffman  
Jasara Hogan  
Tara Caitlin Holaday  
Lindsay E. Holly  
Caroline Holman  
Kasaan Elyse Holmes  
Jacob B. Holzman  
Natalie Hong  
Yue Hong  
Tiffany A. Hopkins  
Kean J. Hsu  
Mary Huang  
Christopher D. Hughes  
Jessica Hughes  
Alexandra Carlyle Hummel  
Lisa Hunsperger  
Arlisa Hurd  
Ruxandra Isacescu  
Margot Iverson  
Olga Jablonka

Amber Marie Jarnecke  
Sara Rose Jarosiewicz  
Joanna Jaworowski  
Alexander A. Jendrusina  
Hyejin Maria Jin  
Jonathan Jore  
Elizabeth Kaiser  
Yuliya Kaplinska  
Thomas Kasper  
Andrea Ellen Kass  
Albert Scott Keenan  
Nicole Keir  
Jessica Leigh Kelliher  
Natalie Kelso  
Matthew Stephen Kendra  
Rachel Kentor  
Laura Khan  
Lauren Khazem  
Jennifer Khoury  
Hannah R. King  
Megan Kirkpatrick  
Benjamin Arthur Kite  
Tracey Kniffin  
Kevin Michael Knight  
Lindsey Knott  
Samantha E. Kobylnik  
Kristen Kochanski  
Sarah Catherine Krill  
Emily Brenny Kroska  
Lauren Krumholz  
Laura Kurzius  
Amanda M. Kutz  
Jake Lackow  
Monica Lackups  
Patrick LaCount  
Michael Lafasakis  
Ross Michael Lafleur  
Jessica Erin Lajos  
Dorian A. Lamis  
David Michael Lawrence  
Eleanor Ladd Leavens  
William V. Lechner  
Chi-Chun Lee  
JooHyun Lee  
Brian Thomas Leitzke  
Bert Lenaert  
Rene Lento  
Francesca Lewis-Hatheway  
Adrienne Lidgard  
Amanda Miguella Limon  
Christina Lipinski  
Melanie Lipton

Jody Ann Long  
Tracy Loppatto  
Hannah G. Lund  
Hila Lutz  
Megan MacDougall  
Joseph M. Magness  
Catherine Majestic  
Leon Jacob Mandler  
Laura Maphis  
Toni Marie Maraldo  
Lavinia L. Marchis  
Katherine Marczyk  
Ryan J. Marek  
Mazinella Angelova Marinova  
David Daniel Maron  
Daniel J. Martinez-Torres  
Holly Mathews  
Lauren Marie Matthews  
Conner McClure  
Katherine McCoy  
Ashley McDonald  
Lauren B. McSweeney  
Meredith McWilliams  
Julie Meade  
Gustavo Ramos Medrano  
Jessica Michelle Meers  
Katie M. Meidlinger  
Alexander James Melkonian  
Franklin Mesa  
Bitia Mesri  
Erin Marie Miga  
Michelle Jean Miller  
Eleni Miltiadou  
Frances Mitchell  
Jonathan Clovis Mitchell  
Maureen Monahan  
Elaina Montague  
Justin Anthony Moore  
Lindsay Moran  
Emily Morgan  
Jessica R. Morgan  
Wendy Marie Morgan  
John Moring  
Sacha Nicole Morris  
Reeva Morton  
Alicia Murray  
Gabriela Alejandra Nagy  
Emily Necrason  
Casey Nelson  
Rachel Nelson  
Scott Andrew Niewinski  
Emily O'Bryan

Erin Elizabeth O'Connor  
Katherine B. Oddi  
Jessica Oddo  
Lauren O'Donnell  
Alexander Pasqual Ojeda  
Maeve O'Leary-Barrett  
Antonia P. O'Planick  
Adriana Osegueda  
Amy Otto  
Floencia Pahl  
Mina Park  
Rebecca Parmiter  
Aleja Parsons  
Courtney Peasant  
Jessica Peatee  
Stephanie Pennings  
Catalina Perez  
Eunice Joy Perez  
Lori Ann Maria Perretta  
Elan Samuel Perry  
Amy Perschbacher  
Rachel A. Pess  
Jessica Peterson  
Marilyn Piccirillo  
Jane R. Piesman  
Rana Pishva  
Zachary Cole Pittman  
Mitchell Glenn Plemmons  
Garrett Pollert  
Ashleigh Pona  
Byron J. Powell  
Julie Elizabeth Premo  
Blair Olivia Prescott  
Rachel Anne Proujansky  
Dana Maurice Pugh  
Stephen James Puliafico  
Meghan Quinn  
Rae Rabideau  
Liya M. Rakhkovskaya  
Timothy Ralston  
Hannah Frea Rapport  
Erin M. Reese  
Deborah Reichman  
Erin Elizabeth Reilly  
Alana Resmini  
Jacqueline C. Reyner  
Katharine Reynolds  
Joan Patrica Rhule  
Heather N. Richard  
Lauren Richards  
Dipali V. Rinker  
Fiona Catherine Ritchey

[New Student Members, con't]

Marianne Rizk  
 Lauren Rodriguez  
 Vivian M. Rodriguez  
 Mary Grace Rosekrans  
 Deborah A. Rosenberg  
 Andrea Catherine Roth  
 Sara Roth  
 Haley Jill Rottenberg  
 Marissa Rudolph  
 Ericka L. Rutledge  
 Lauren A. Rutter  
 Bethany Sabourin  
 Samiram Saghafi  
 Katie Lee Salis  
 Amanda Sanchez  
 Wesley Sanders  
 Raelle Saulson  
 Danielle Sauro  
 Valerie Kathleen Scheller  
 Megan Ryan Schmidt  
 Michelle Schoenleber  
 James Ayan Scholl  
 Elizabeth Ashley Schultz  
 Leah Schumacher  
 Amihai Y. Schwab  
 Kelli Scott  
 Laura Ana Scudellari  
 Paige L. Seegan  
 Andrea Segal  
 Batsheva Serota  
 Georgia Leigh Shaheen  
 Sarah Shankman  
 Lauren Ashley Shapiro

Heather Ashley Shaw  
 Brynn E. Sheehan  
 Amanda Sherman  
 Jennifer Shindman  
 Kendahl Shortway  
 William H. Shunkamolah  
 Stephanie Sienkiewicz  
 Erica Silberstein  
 Samantha Michelle Silverberg  
 Alaina Tate Silverman  
 Rajinder Jitkaur Singh  
 Joseph Charles Slimowicz  
 Jacquelyn Norry Smith  
 Marissa Smith  
 Molly F. Smith  
 Rachel Marie Smith  
 Victoria Smith  
 Rebecca Ann Smith-Casey  
 Anastasia J. Sokol  
 Shannon Michelle Sorenson  
 Fatima Hanif Sozzer  
 Ashley H. Spada  
 Brandi R. Spaulding  
 Mackenzie Spellman  
 Corey M. Spickler  
 Carolyn Spiro  
 Sylvia Maria Spyрка  
 Akanksha Srivastav  
 Kimberley Stanton  
 Laura Stayton  
 Ellen H. Steele  
 Emily Claire Stefano  
 Erin Stevens  
 Jeremy W. Stout

Jamie Sturm  
 Christina Lynne Sullivan  
 Michael Sun  
 Tonya Swartzendruber  
 Kristin Szuhany  
 Alayna Pauline Tackett  
 Caitlyn Tarsia  
 Erin K. Taylor  
 Missy L. Teatero  
 Jessica Technow  
 Olivia Teer  
 Marget Thomas  
 Caitlin C. Thompson  
 Sierra Thompson  
 Edda Bjork Thordardottir  
 Christine Tirabassi  
 Marissa Tolep  
 Alexis Touros  
 Kim Tran  
 Ria Travers  
 Aaron Tropper  
 Ana F. Trueba  
 John Trujillo  
 Megan Elissa Tudor  
 Kristen Marie Uhl  
 Anna Urbaniak  
 Philip Joseph Uy  
 Lisa M. Valentine  
 Sarah E. Valentine  
 Rachel Ann Vaughn  
 Renata Vaysman  
 Ailee Marie Velazquez  
 Pedro Vieira Oliveira  
 Amanda Marie Vincent

Fawad H. Viqar  
 Lauren Page Wadsworth  
 Nancy Marie Wallace  
 Jessica Wallerstein  
 Lucia Marie Walsh  
 Jessica M. Walther  
 Anne Ward  
 Ciara Warren  
 Cynthia Weinstein Coyle  
 Stephanie Wemm  
 Shavonne Westerfield  
 Thomas William Westerling  
 Heather Whipple  
 Lisette Blumenthal Wilcox  
 Alexander Williams  
 Coleen R. Williams  
 DeAnna Lisette Williams  
 Lindsay Dawn Wilson-Barlow  
 Corrine Winters  
 Diane Marie Word  
 Qi J. Wu  
 Sara V. Wyman  
 Christopher Wyszynski  
 Yishan Xu  
 Wern How Yam  
 Yan Yang  
 Vivian M Yeh  
 Sarah Elizabeth Yurinch  
 Kerry Zelazny  
 Linda Chen Zhang  
 Mimi Zhao  
 Sigal Zilcha-Mano  
 Jaclyn Zocca  
 Ashley Zultanky

## Gift Membership!

Many of you will be hooding your students this spring, a truly significant moment. Are you searching for the perfect gift to honor this achievement? ABCT membership makes a meaningful gift for recent graduates, with benefits that can be enjoyed throughout the membership year, including registration for the 47th Annual Convention in Nashville.

It's easy to give with our online form. Go to [www.abct.org](http://www.abct.org) and click on GIFT OF MEMBERSHIP (below the gift box on our home page). We'll take care of the rest of the details, including obtaining membership information from your gift recipient.



## CBT Medical Educator Directory

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

### Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.
2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.
3. Training should take place or be affiliated with an academic training facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

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

### How to Submit Your Name

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

Descriptions of training programs, teaching outlines and/or syllabi, and other supplemental teaching materials for courses specific to medical training that can be shared with others (i.e., through posting on ABCT's website or via the listserv) are also welcome. Please submit syllabi and teaching materials

Syllabi for traditional CBT graduate and postgraduate courses outside the medical community may be sent to Kristi Salters-Pedneault at [saltersk@easternct.edu](mailto:saltersk@easternct.edu).

 <http://www.abct.org>

[Professionals, Educators, & Students](#) ↗

[CBT Medical Educator Directory](#) ↗

## ABCT, Launching — in Spring —

We're pleased to announce the development of a new database, designed with a fresh new look and optimized navigation to give you easy access to your ABCT information and allow us to serve you better. A newly designed e-commerce site will enable you to find what you need quickly. In the coming weeks, expect to receive updated log-in and password information. Nothing else will have changed.

Please take a few minutes during this transition to review your current information, make any necessary corrections, and ensure that we have accurate data in the new database. Do we have the right affiliations for you? Are your primary address, telephone, and email correct? What about any alternate contact information? Is your demographic data, such as gender and ethnicity, included in your listing? Do we have your nickname for convention badges? By providing us with the most current information, you can make sure that *the Behavior Therapist*, any print journal subscriptions, and additional mailings reach you at the right address. The correct email address guarantees that you never miss important notifications, including membership renewal and convention registration, or submission deadlines.

We remain focused on the growing needs of our membership, including the ability to access robust technology in a user-friendly application. We hope you'll appreciate the improvements we have made.

## ABCT's 47th Annual Convention

Nov. 21–24  
NASHVILLE

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



***the Behavior Therapist***  
**Association for Behavioral  
and Cognitive Therapies**  
**305 Seventh Avenue, 16th floor**  
**New York, NY 10001-6008**  
**212-647-1890 | [www.abct.org](http://www.abct.org)**

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## ABCT's New Facebook Page

ABCT relaunched its new Facebook page in March.

If you have not yet transitioned to our new page, here's how to do it:

1. Sign into Facebook using your normal account.
2. Go to: <https://www.facebook.com/AssociationForBehavioralAndCognitiveTherapies>
3. Click the "Like" button to the right of the "Association for Behavioral and Cognitive Therapies" title (directly under the page's picture).

Please stay connected to us via Facebook!

- For real-time interaction with colleagues and friends
- For participation in the professional community of ABCT
- For inspiration, refreshment, advice
- For allowing us to communicate quickly and efficiently with you