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Contents

President's Message

Robert K. Klepac
Dissemination, Dissemination, Dissemination—Redux • *25*

Research Forum

William J. Warzak, Margaret T. Floress, Michael Kellen, Jennifer S. Kazmerski, and Stephanie Chopko
Trends in Time-Out Research: Are We Focusing Our Efforts Where Our Efforts Are Needed? • *30*

Clinical Forum

Sally E. Riggs, Shannon Wiltsey-Stirman, and Aaron T. Beck
Training Community Mental Health Agencies in Cognitive Therapy for Schizophrenia • *34*

Classified • *39*

At ABCT

Minutes of the Annual Meeting of Members • *39*
Preparing to Submit an Abstract • *44*
Call for Papers: 46th Annual Convention • *45*
Call for Award Nominations • *46*

The Academic Training Committee seeks sample course syllabi for ABCT's website

We welcome materials from courses at all levels (graduate and undergraduate) that incorporate assessment and intervention, psychopathology, and research design. If you are interested in submitting your own syllabi for public posting, please email each file as an attached Word document to jlerner@kean.edu and include "Syllabus submission" in the subject line. Thank you for your contribution to this valuable resource!

President's Message

Dissemination, Dissemination, Dissemination—Redux

Robert K. Klepac, ***University of Texas Health Science Center–San Antonio***

It is impossible to find words that communicate the deep sense of pride, as well as humility, that I am enjoying as the new President of ABCT. Serving in this office is a high point, if not *the* high point, in my 42-year career as a behavioral practitioner, researcher, and teacher. I'll do my best to warrant your trust. Thank you for letting me serve you.

In the October 2010 issue of *the Behavior Therapist*, Frank Andrasik's President's Message carried the subtitle, "Dissemination, Dissemination, Dissemination." In his article he reviewed the ABCT Board's focus on dissemination as a key factor in our planning for the future, and outlined the importance, breadth, and challenges involved in transmitting the work of our members to broader audiences, including other members of our association, students, research and practitioner communities outside of the ABCT membership, legislators, and consumers, among others. He also outlined some of the specific directions that were being considered to further these dissemination goals. Dr. Andrasik's column can be read on the ABCT website (www.abct.org → members only → journals and publications → *the Behavior Therapist* → October 2010). Under immediate Past President Debra Hope, his initiative has been further explicated and expanded. My own career as an educator has led me to emphasize

[continued on p. 27]

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New!

ABCT

Live Learning Center

All those who attended the 45th annual ABCT Convention in Toronto as general registrants can take advantage of a special benefit. We captured 64 different sessions at the convention, recording the speakers and their slides. These synched presentations are available, free, to all who registered for the convention. We know you can't attend everything; you can't even attend everything in your specialty. To help you get the most out of the convention, visit www.abct.org and click on the link "ABCT has captured 64 sessions..." Use the unique number sent to you in a broadcast email.

Those who didn't attend the convention can take advantage of this, too. We make these sessions available with attractive pricing (even more attractive to members) and you can choose to view one, a series, or the entire collection.

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**. 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.

[continued from p. 25]

dissemination in my work with ABCT as well. Because dissemination is such a central concern for the organization and its leadership, I've decided to outline some of the many projects that have been implemented and some of those that are currently under discussion.

Attendee feedback every year suggest that the ABCT convention workshops are among the best available to our professionals. Yet we are troubled by the many published studies indicating that even the best short–duration workshops do a creditable job of increasing what attendees *know*, while having minimal if any impact on what they do in their practice and research. The 2012 convention offerings will therefore include a pilot of a program that will hopefully improve workshop attendees' ability to employ what they learn as they return to their jobs. A select few workshops will offer attendees the option of receiving follow-up consultation by the workshop presenters or colleagues in their clinics and laboratories to discuss attendees' questions, problems, and progress in their efforts to add the assessments and interventions they have learned in their own work. We will be closely assessing the success of this effort in the hopes of polishing and refining such efforts in future years.

Another limitation of workshops and other convention sessions is that they have been available only to convention attendees. In addition, the rich convention program often means that attendance at one session rules out attendance at other sessions of interest offered at the same time. Several efforts have been initiated to expand that availability. For the first time, several of the convention sessions were recorded and the audio from these sessions were coordinated with the slides from the presentation and posted online. This affords conventioneers a second-best opportunity to learn from those sessions they missed. The convention registration fees cover the cost of learning from those online sessions. Sessions have also been made available for a fee to those who have not attended the convention. We are assessing use of this new dissemination effort to see whether it warrants continuation and with what, if any, changes.

In the same column referenced above, Dr. Andrasik (2010) announced a major dissemination effort aimed at improving potential students' ability to discriminate between doctoral programs offering quality training in CBT and those programs that have adopted the words "cognitive" and "behavioral" but not the substance of what we do and what we know. At Dr. Andrasik's urging, the ABCT Board authorized and supported a task force on dissemination that was given the specific charge to develop recommendations for quality training in CBT in programs offering applied psychology doctoral programs. My co-chair, George Ronan, and I recruited 14 professional organizations with histories of involvement in higher education with CBT emphases that agreed to support our inter-organizational task force. It is critical to note that these organizations, including ABCT, agreed to support the effort by nominating and paying expenses of task force members. This support of our effort does not imply any kind of support for the *recommendations* that the result from this effort. Such support for the recommendations may be sought from professional organizations once the document is in final form, but this is a separate issue from supporting its development. When asked to chair this group, I accepted reluctantly. I imagined just how miserable it might be if members from different "schools" of cognitive and behavioral psychology saw this task force as a means of enhancing the image of their own particular approaches rather than developing guidelines that serve the greater psychological and public communities by focusing upon the critical things that unite us and describe the most central features of what we as a group value and emphasize. To my great surprise and edification, not a single instance of "turf-related" disagreement arose as these tasks were pursued. It has been a richly rewarding experience to work with such an intelligent and cooperative group of statespersons. At this writing we are one meeting away from finalizing our report and recommendations. That meeting will have occurred by the time you read these words. I am optimistic that this major effort on the part of ABCT and cooperating associations will go a long way towards disseminating the consensus of psychologists representing the whole spectrum of behavioral and cognitive approaches to students seeking quality CBT training, to doctoral programs who want to assure that they are offering what the field considers to be optimal education, and to organizations involved in credentialing practitioners and accrediting CBT-related programs. Details regarding the task force composition, process, and recommendations will be covered as soon as the task force approves its final report—hopefully in my next column.

It is not wise, if even possible, to think about more effective dissemination of what we know and do without thinking about the use of technologies that have mushroomed in recent years. Our own efforts at dissemination include attention to many aspects of those technologies. One such effort involves the use of "webinars" to help interested professionals in and out of ABCT understand current issues, assessments and treatment strategies. On January 26, ABCT will have offered the first of what we hope will be many such webinars. Dr. Patricia Resick will offer a 90-minute online session on cognitive processing therapy for PTSD, and attendees earned 1 CE credit. Other ongoing media-based dissemination efforts include:

- Modifications and enhancements to the ABCT website, improving its relevance to audiences including members, professionals in general, and the public;
- Adding podcasts to that webpage, featuring prominent CBT practitioners and researchers describing their work;
- Creation of a Facebook page fostering communication among those interested in CBT, and regarding it as a laboratory from which we hope to learn how to best use social media in furthering our organizational goals;
- Collaboration with APA Division 53, the Society of Clinical Child and Adolescent Psychology, linking our web page on empirically supported treatments to theirs, which emphasizes working with children;
- Collaboration with Bonnie Spring of EBBP (Evidence Based Behavioral Practice), an NIH–funded organization dedicated to identifying and disseminating information about EBBPs to professionals, educators, and the public.

This is a representative sampling of ABCT's concrete projects designed to enhance dissemination of CBT thinking, research, and skills to the broad array of audiences we hope to affect. More plans are under consideration, and more will undoubtedly be created as we learn more about how to do the job of dissemination well. We are blessed with a number of members vitally interested in developing these efforts, including a very active Dissemination and Implementation Special Interest Group to help in developing strategies and specific programs in the area. You will hear more about the issues over the

coming year, and we welcome your ideas in this area as well. Feel free to e-mail me at bobappic@aol.com.

Postscript: In my first draft of this column, I began citing individual ABCT members responsible for the successes we are enjoying. It soon became clear that including mention of all those who deserved it would just about double the length of this piece. Before getting involved in ABCT governance, I just enjoyed those things the organization offered, and thought little about who brought them about or how it was done. I encourage you to check out the "governance" list on the ABCT website (click "About ABCT" at the top of the home page; then click "Governance") to see what I've learned is a huge number of smart, motivated, and competent colleagues who make things happen. Offer them your thanks—and check out which of those committees, SIGs, and other governance groups interest you—and hop on board. The pay is lousy, but the rewards are great.

Reference

Andrasik, F. (2010). Another look inside the boardroom: Dissemination, dissemination, dissemination. *the Behavior Therapist, 33*, 125, 127.

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Meet ABCT's *Featured Clinicians* of the Month

Alan Berkowitz
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"There are many absurd moments in therapy and I am not shy about laughing about them with my clients."

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Call *for* Papers President's New Researcher

ABCT's 2011–2012 President, Robert K. Klepac, Ph.D., ABPP, invites submissions for the 34th 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 Robert Klepac, Ph.D., Debra A. Hope, Ph.D., and Stefan Hofmann, Ph.D. (ABCT's President, Immediate Past-President, and President-Elect). **Submissions must be received by Monday, August 6, 2012, 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.

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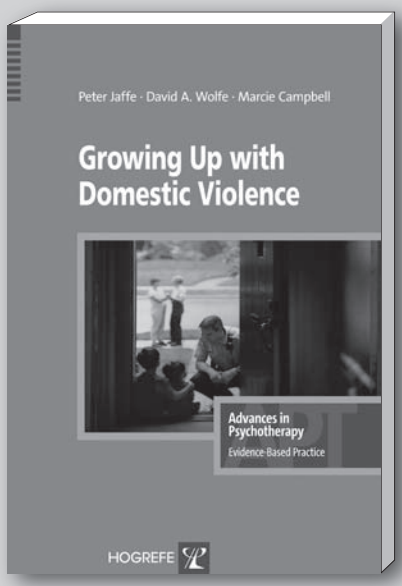

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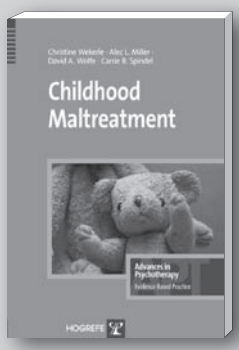

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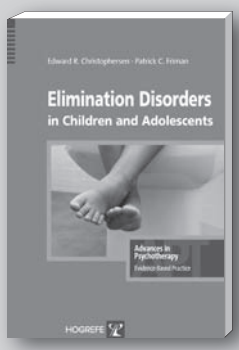

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Trends in Time-Out Research: Are We Focusing Our Efforts Where Our Efforts Are Needed?

William J. Warzak, Margaret T. Floress, Michael Kellen, Jennifer S. Kazmerski, and Stephanie Chopko, *Munroe-Meyer Institute* and *University of Nebraska Medical Center*

Many parents in the United States discipline their children using spanks or other forms of corporal punishment (e.g., Gershoff, 2008; Regalado, Sareen, Inkelas, Wissow, & Halfon, 2004; Socolar, Savage, & Evans, 2007; Straus & Stewart, 1999). Indeed, estimates of parental use of corporal punishment as a disciplinary technique in America range as high as 94% (Murray, Straus, & Stewart, 1999). In contrast to these findings, 30 countries have banned corporal punishment of children, and 28 states and the District of Columbia have banned corporal punishment in schools (Global Initiative to End All Corporal Punishment of Children, 2010). Clearly, many American parents discipline in a way that has become internationally unacceptable and contrary to best practices.

Given widespread international efforts to eliminate corporal punishment with children, the use of time-out (TO) strategies as a behavior management tool are commonly recommended by children's advocacy groups and child-care experts. TO is a procedure used to discipline children for misbehavior by removing access to reinforcing stimuli, events, or conditions for a brief period of time. Generally speaking, a child is told to serve TO and is directed to a TO location (e.g., chair, step, floor). The child remains in TO for a period of time and is then released. The duration of TO is usually specified in minutes, with additional contingencies, such as a period of quiet time often required prior to release (Brantner & Doherty, 1983; Roberts, 1982a; Roberts, 1984; Roberts & Powers, 1990). TO procedures have been well specified and the effectiveness of TO is thoroughly supported by the literature (e.g., Brantner & Doherty; Shriver & Allen, 2008). TO also is advocated by children's advocacy groups, such as the American Academy of Pediatrics (1998), as an acceptable disciplinary strategy and an alternative to spanking.

TO has been widely disseminated through popular media, including books, magazine articles, and instructional videos. Several manualized approaches to parent training have included TO and have contributed to the dissemination of this procedure (e.g., Barkley, 1997; McMahon & Forehand, 2003; McNeil & Hembree-Kigin, 2010; Webster-Stratton, & Reid, 2003). Yet, many parents have difficulty implementing TO (Allen & Warzak, 2000), perhaps because some children learn to be resistant and avoid TO while obtaining parental attention through disruptive behavior (e.g., tantrums, aggression) or escape (Roberts, 1982b). For parents who do not understand the function of these behaviors, implementing TO may become so burdensome and unpleasant that they stop using the procedure. Further impeding the use of TO, some daycare facilities, preschools, and schools prohibit its use, perhaps because of practical procedural obstacles such as peer reinforcement of target behaviors (Turner & Watson, 1999). Other providers discourage TO in the belief that it is deleterious to the emotional development of children (Gartrel, 2001, 2002; Readick & Chapman, 2001).

In an effort to investigate these divergent views and reviews of TO, we have reviewed the TO literature since Brantner and Doherty (1983) to analyze the trends in published TO research. We analyzed 26 years of published abstracts to investigate trends in TO research and the extent to which researchers have addressed parental and staff concerns that impede effective implementation of this evidence-based procedure.

Method

Abstract Selection

A comprehensive search of the PsycINFO, PubMed, and Web of Science databases was conducted to identify abstracts containing the terms *time-out*, *timeout*, or *TO* in the title or abstract. Abstracts published in peer-reviewed journals from 1984 to 2009 were included, regardless of methodology. Exclusionary criteria included studies conducted with lab animals, studies in a language other than English, dissertation abstracts, and self-imposed TO (e.g., removing oneself from a situation as an anger control procedure). Also excluded were the many parent training books that appear in the popular press as well as professional texts (e.g., McMahon & Forehand, 2003; McNeil & Eyberg, 2010) and treatment packages (Webster-Stratton & Reid, 2003) that include TO but are not representative of individual empirical studies. A total of 193 abstracts met criteria for review with 110 articles found in PsycINFO and 83 articles found in PubMed. No relevant abstracts were identified through a Web of Science search over and above those listed above.

Abstract Categories

A preliminary review of 40 abstracts published prior to 1984 suggested that the primary emphasis of TO research could be broken down into five initial categories: application (of TO to new problems or populations), compare (TO with another response reduction procedure), compliance (with TO by the child), procedure (involving parametric evaluation of TO duration, release contingencies, etc.), and miscellaneous. Miscellaneous abstracts were subsequently subdivided into four additional categories: review (of the literature on TO), teaching (TO to parents or staff), treatment acceptability (of TO by parents or staff), and utilization review (of TO use in a given facility or clinic).

Category Definitions

Application. Use of TO to reduce the frequency of target behaviors such as noncompliance, disruptive or aggressive behavior, undesirable mealtime behaviors, etc.

Compare. Direct comparisons of TO, as a specific intervention, compared to another response reduction procedure such as spanks, distraction/redirection techniques, overcorrection procedures, etc.

Compliance. Any procedure designed to increase compliance with TO (e.g., put backs, spanks, restraint).

Procedure. The effect of the various components of TO (e.g., duration of TO, release criteria), or the effectiveness of novel TO procedures (e.g., TO ribbon; Foxx & Shapiro, 1978) on response reduction.

Review. Standard literature reviews about the perceived effectiveness of TO, the uses of TO, the history of TO, etc.

Teaching. Different ways of teaching parents or staff to effectively use TO. This may include an analysis of modeling, written instruction, DVD, etc.

Treatment acceptability. Surveys assessing the acceptance by parents and staff of TO as a response reduction procedure or the willingness of parents or staff to implement TO.

Utilization review. Trends in staff implementation of TO including qualitative interviews with facility staff, or reviews to determine how often parents/teachers implement TO.

Other. Abstracts that mention TO but where TO is not discussed in any detail, including abstracts that discuss several different response reduction procedures and list TO as one of those procedures without specific descriptive or methodological detail.

Review Process

Reviewer training. Ten TO abstracts published prior to 1984 were selected from the source literature for training purposes. These were read and discussed by judges and initial definitions of categories were developed. That is, the focus of each of the abstracts (e.g., application of TO, compliance with TO, procedural analysis of TO) was determined in roundtable discussion. Category definitions were then operationally refined to improve agreement. Subsequently, 30 TO abstracts published prior to 1984, in groups of 10, were independently reviewed by each member of the two rater teams, assigned a category, and agreement obtained. Raters were either doctoral candidates completing their clinical internship or practicing psychologists. Subsequent to reading the first group of 10 abstracts, category definitions were refined to improve agreement. The second group of 10 abstracts was processed similarly. Training concluded when 90% agreement was obtained on ratings of the third group of abstracts. None of these training abstracts were included in the final analysis as they were all published prior to 1984.

Rating. Each abstract was coded independently by one of two, two-rater teams, and placed into one of nine categories. Abstracts were consecutively numbered with even numbered abstracts coded by one pair of raters and odd numbered abstracts coded by the other. If both raters in a team did not agree on the category, the abstract was reviewed and categorized independently by the second team. If three of the four raters agreed on a category, the abstract was assigned to that category; otherwise, a discussion among raters took place until consensus was reached and a category coded.

Interrater reliability. Each abstract was coded independently by at least two raters. Of the 193 post-1984 abstracts coded, independent agreement between the first two raters occurred 148 times (76.7%). The remaining 45 abstracts were then coded by a second pair of raters, yielding agreement of three of four raters of 22 additional abstracts (11.8%). The remaining 23 abstracts were discussed by all four raters until consensus was obtained (12.4%). Kappa was evaluated for each team of raters. A

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kappa value of .69 was obtained with a range .52 to .85, indicating substantial agreement across raters (Landis & Koch, 1977).

Results

An analysis of the year-by-year data indicates decreasing TO research over time. This is highlighted by comparing the first half of our analysis, between 1984–1996, with the second half, between 1997–2009. Between 1984–1996, 133 relevant papers were published, whereas between 1997–2009, the second half of the analysis, only 60 articles were published (see Figure 1). Application (28% of all abstracts) and treatment acceptability (19% of all abstracts) of TO were researched at the highest rate across the past 26 years based on frequency of abstracts published per year (see Figure 2). Compliance with TO is the least researched area, with 2% of all abstracts coded within this category. The abstracts fell within categories as follows: application (28%), treatment acceptability (19%), other (13%), teaching (11%), procedure (9%), review (8%), compare (6%), utilization review (4%), compliance (2%).

Discussion

Our review of abstracts from 1984 to 2009 yielded 193 abstracts pertinent to TO. A significant amount of research conducted on TO has involved procedures such as restraint and seclusion. Such procedures are often encumbered by legal, ethical, and administrative concerns that may discourage caregivers from initiating or ultimately abandoning this procedure. Legal and ethical concerns have been raised regarding the use of TO, especially when its use is unsupervised, the duration is excessive, or when the manner in which TO is implemented is considered overly punitive or abusive (Brantner & Doherty, 1983; Wolf, McLaughlin, & Williams, 2006). Nevertheless, Yell (1994), upon evaluation of case law pertaining to TO in the classroom, concluded that TO is legally permissible when properly implemented. More recent literature has continued to expand applications of TO, particularly to children in outpatient settings. Treatment acceptability also has been frequently investigated. Much of this latter literature supports the general acceptability of TO, suggesting that difficulty of implementation, and not treatment acceptability, is the typical obstacle to common and effective use of this procedure.

There has been a lack of recent literature evaluating the efficacy of various types of TO, such as *exclusionary* [i.e., the individual is separated from the area of reinforcement without being removed from the room (e.g., facing a wall)], *nonexclusionary* (i.e., the individual may observe a reinforcing activity, but is limited from participating in the activity; Harris, 1985) or TO procedures that avoid restraint and spanks. Recent literature also has not addressed how to best teach children how to comply with TO. In fact, only 2% of abstracts addressed this issue. There also is a dearth of research on how to best teach parents and treatment staff to implement TO effectively and with procedural integrity. The advent of manualized therapies (e.g., Barkley, 1997; McMahon & Forehand, 2003; McNeil & Hembree-Kigin, 2010; Webster-Stratton, & Reid, 2003) may improve upon this because they suggest TO implementation in a standardized way.

Perhaps the decline in TO research in recent years is related to an understanding of many of the basic variables involved in its effective implementation. For example, parametric issues, including the function of longer versus shorter durations of TO and the effects of release contingencies, have been well documented (Brantner & Doherty, 1983; Roberts, 1982a; Roberts, 1984; Roberts & Powers, 1990). Nevertheless, effective procedures to facilitate parental compliance with procedural integrity and child compliance with TO procedures should be areas of continued investigation (Warzak & Floress, 2009). Increased dissemination of TO as an effective and nonviolent disciplinary strategy, as a matter of public health, might also bridge the divide between research and implementation of this procedure. Other variables, such as the optimum age to introduce TO, are individualized and may never be subject to parametric analysis, especially given the large number of children required to conduct an age-by-duration analysis.

We have not delved into the methodological details of treatment outcome studies; rather, we have focused our analysis on broader trends in TO research. With few exceptions (e.g., Warzak & Floress, 2009), there has been limited focus on how best to train children to this procedure and how best to teach parents and treatment staff to implement TO effectively. In fact, there has been a decline in TO research in recent years and a variety of variables, such as cultural, psychosocial, and socioeconomic, that may affect TO implementation have not been considered in the literature. Further research is necessary to increase treatment acceptability, increase child compliance, and

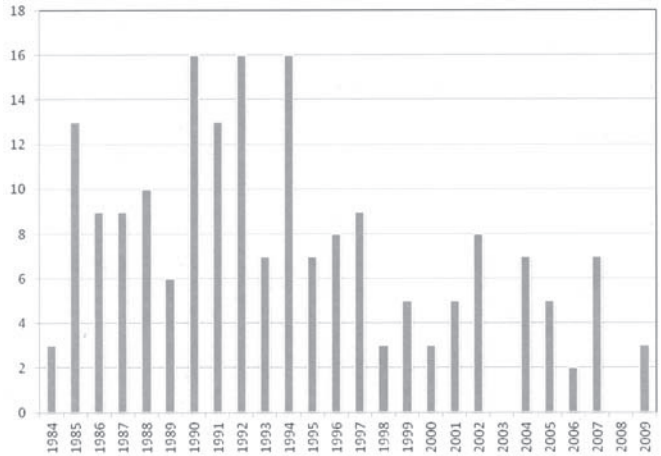

Fig. 1. Frequency of time-out articles by year.

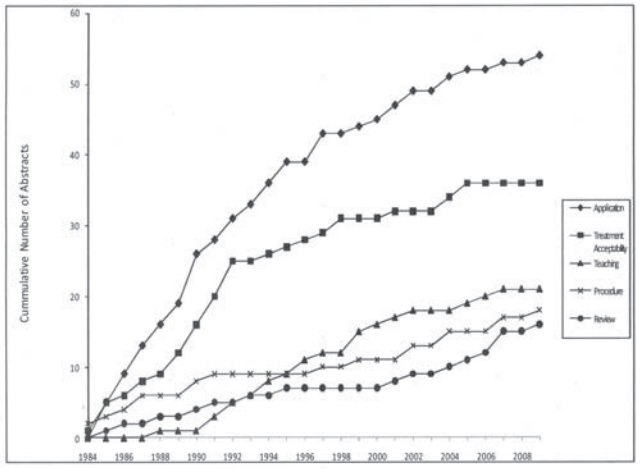

Fig. 2. Cumulative record of annual published abstracts for the five most common categories, excluding "other."

increase implementation of this empirically supported, nonviolent procedure by parents and staff.

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Training Community Mental Health Agencies in Cognitive Therapy for Schizophrenia

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Based on the demonstrated effectiveness of cognitive therapy (CT) with patients with schizophrenia (Pilling, et al., 2002), CT has been included in good practice guidelines for the treatment of schizophrenia in both the U.K. and the U.S. (American Psychiatric Association, 2004; NICE, 2002). Despite these guidelines, and in the face of growing evidence of effectiveness (Gaudiano, 2005; Grant, Huh, Perivoliotis, Stolar, & Beck, 2011), Rollinson et al. (2007) described a "scarcity of trained professionals able to deliver CT for psychosis" (p. 1297). In addition, Mueser and Noordsy (2005) presented a "call to action" for clinical psychologists in the U.S. to design training programs in CT for mental health professionals working with schizophrenia and other severe mental illness.

The dissemination of evidence-based psychosocial treatments (EBTs), the theme of the 2011 ABCT conference, has gained much ground in the last 10 years, albeit haphazardly (McHugh & Barlow, 2010). Dissemination research shows us that workshops and one-time trainings do not provide sustained change in clinician practice to the suggested degree of competence and fidelity (Miller, Yahne, Moyers, Pirritano, & Martinez, 2004; Sholomskas et al., 2005). It has also provided us with models for training community-based clinicians that include strategies to facilitate implementation (Kauth et al., 2010; Stirman et al., 2010). Although CT for schizophrenia may be different from CT for other types of disorders in some respects (Nelson, 2005), it is important that we refrain from reinventing the wheel in our training efforts as we push forward with this very necessary work.

However, in our dissemination efforts, it is also vital to consider what is different in CT for schizophrenia, and one of the primary differences is how and by whom services are delivered. People with schizophrenia often receive therapeutic intervention in inpatient, partial hospital, or community-based therapeutic settings, and this intervention is rarely limited to one-to-one therapy. Master's-level therapists may be available, but interventions are also provided by bachelor's-level or peer support workers. Of paramount relevance here is the therapeutic milieu and considering how CT for schizophrenia can be utilized at this level. Furthermore, direct therapeutic interventions may only be on a group basis. How to train clinicians to deliver CT for schizophrenia in a group format is also crucial.

Empathy has been highlighted repeatedly to be of central importance to therapeutic engagement (Reynolds, Scott, & Jessiman, 1999) and is routinely cited to be crucial in the psychological treatment of schizophrenia (Kingdon & Turkington, 1994; Nelson, 2005). However, another key difference in CT for schizophrenia is that empathy may not be profuse. McLeod, Deane, and Hogbin (2002) suggest that attitudinal factors (such as beliefs that schizophrenia cannot be successfully treated or that working with people with schizophrenia will impede career prospects and job satisfaction) could inhibit empathy. This research also highlights the potential for a lack of empathy due to clinicians' lack of personal experience of psychotic symptoms.

A second fundamental skill for working with schizophrenia from a cognitive behavioral perspective is that of "suspending disbelief" or "working within the patient's belief system" (Nelson, 2005). Again, this is subtly different from standard CT, and clinicians who have some previous knowledge of CT often misunderstand the cognitive aspect of intervention in relation to schizophrenia, thinking that the primary objective is to change or challenge the person's delusional beliefs. Others who have been trained that one must not collude with delusions to avoid strengthening them often extrapolate that one cannot talk about delusions at all. Helping clinicians to understand the concept of *working within a delusional belief system*, as a middle ground between these two alternatives, is vital.

In 2007, the Beck Initiative, a partnership between the University of Pennsylvania and the city of Philadelphia's Department of Behavioral Health and Mental Retardation (Stirman, Buchhofer, McLaulin, Evans, & Beck, 2009), was formed to provide training in CT to providers in the Philadelphia community mental health system. As part of this initiative, a specific training in CT for schizophrenia was designed for staff in a recovery-oriented, partial hospital program. Staff at all levels of the organization (peer support, bachelor's, master's) were involved in training, which focused on group-based interventions and the general therapeutic milieu, with a particular emphasis on improving empathy and working within a patient's belief system.

This paper presents details of the development of the training, according to the ACCESS model: assess and adapt, convey basics, consult, evaluate work samples, study outcomes, sustain (Stirman et al., 2010). It will highlight elements of this model that are particularly relevant to CT for schizophrenia and provide details of specific components of the didactic and consultation elements, to provide ideas and guidance for future dissemination of CT for schizophrenia.

Assess and Adapt

Agency-Level Assessment and Adaptation

Stirman et al. (2010) highlight that gaining agency input prior to the preparation of any training, and adapting plans accordingly, is crucial to success. These considerations are equally relevant to training in CT for schizophrenia. As part of the Beck Initiative (Stirman et al., 2009) training had originally been provided in 2008 to master's-level clinicians in the agency, focusing on the basic CT model as it applied to depression, anxiety, and suicide. Shortly thereafter, feedback and needs assessment within the Department of Behavioral Health network facilitated an expansion of the Initiative to include training in CT for specific populations. The Wellness Alliance, Horizon House, Inc., requested additional specialist training in CT for schizophrenia.

An initial meeting with the medical director determined which of their programs would be most suited and secured the commitment and enthusiasm of agency leadership. To engage the clinical staff and gain

their perspectives, we then met with the program manager and her team leaders. A draft proposal was presented as a starting point for discussion and adaptation. In this meeting, and in subsequent discussions with clinical staff members, the instructor took the role of "ambassador" for CT for schizophrenia, and discussed not only the efficacy of the treatment and its relevance to the agency, but also her experience in working in public and community health.

In addition to factors such as readiness for change, staff turnover, agency climate and culture as factors that affect the uptake of training initiatives, agency productivity requirements and other competing demands were assessed (Stirman et al., 2010). This program had been the recipient of numerous recent innovative trainings and initiatives, and it became important to consider the relevance of "training fatigue" and "innovation burnout" in preparation. It was critical that staff and leadership perceived that this training initiative "added value" to the agency, and the timing had to be considered carefully. Several meetings were necessary to discuss reimbursement for staff time and administrative issues such as scheduling conflicts, space availability, and time management.

Clinician-Level Assessment and Engagement

Success in any training initiative is often conditional upon staff buy-in, which can be optimized by concentrating on training applications for staff (Knowles, 1980), addressing staff concerns, and assessing how receptive to training staff may be (Stirman et al., 2010). In particular, open communication and emphasizing shared aims and areas of similarity can facilitate engagement. Such effort is particularly relevant to the field of schizophrenia. Many mental health workers in this difficult field may have been working for years with minimal clinical supervision or effective therapeutic interventions. Cynicism and burnout are high, and engagement, just as with consumers, can be difficult to come by (Mueser & Noordsy, 2005).

In continued meetings with the program manager and senior program staff, the instructor again played the role of ambassador. Instructors heard about the agency program, its structure, its strengths and weaknesses, and how CT might best be used and targeted. The instructor also attended the program at several different points throughout the week, joining groups, community meeting, and "drop-in" sessions to assess the current therapeutic milieu, as well as the content and structure of the program. The program had recently been transformed into the recovery-oriented approach (SAMHSA, 2006), with consumer support and intervention largely delivered by weekly scheduled groups facilitated by master's-level and peer-support staff. Individual treatment plans used Wellness Recovery Action Planning (Copeland, 1997) provided by bachelor's-level "recovery coaches," who were also available to the consumer for problem-solving type case management work. Thus, it was important to determine how CT training could be integrated with the recovery approach (Bellack, 2006).

Of particular relevance was the role of the different staff members, especially that of the peer support staff, now common in agencies serving people with severe mental illness. Instructors needed to develop an understanding of their role within the program, to assess current staff knowledge and understanding of schizophrenia, and to facilitate their engagement with the training. These aims were achieved by an initial meeting with peer support staff only, followed by an additional pretraining workshop. This workshop took a two-way educational format. The instructor learned about peer support certification in the city of Philadelphia, assessed for previous experience and understanding of CT, and provided a brief framework for the future didactics. She also fostered an open floor on personal experiences of psychosis that peers might want to share, and allowed consideration of how best to incorporate these into the training.

As a result, key objectives for the training were as follows:

- To train all staff within the program to use elements of CT for schizophrenia; namely empathy, rapport building and working within a strongly held belief system, to enhance the therapeutic milieu, and support individual and group CT work;
- To train all staff in basic strategies for coping with voices, delusions, thought disorder, and negative symptoms and how to implement these with consumers;
- To train all staff in the use of coping cards, activity scheduling, problem solving, and other CT strategies for recovery and rehabilitation;
- To give bachelor's and peer support staff an understanding in the basic concepts of CT: thoughts, feelings and behaviors; and how these might relate to psychopathology; as well as reinforcement of homework and coping strategies, and

Table 1. **Content of the Workshops**

Workshop	Topic
1	Basic introduction to the theory of CT
	Practical details on how to support consumers who might be receiving individual CT (thought records, coping cards, activity monitoring and scheduling, graded task assignment)
2	Information about schizophrenia and exercises designed to improve empathy (see Boxes 1, 2, and 3)
3	Information and exercises designed to improve consumer engagement and to help staff understand how and why to avoid challenging consumer's delusional beliefs (see Boxes 1 and 3)
	Practice in specific tools to achieve this such as summaries and guided discovery
4	Information on particular coping strategies relevant to hallucinations and delusions, and exercises to help enhance these
	A discussion of the key components of the recovery approach and CT, and how these mesh

***Box 1*. Empathy for Delusions Exercise**

The trainees are split into two groups, with one taken out of the room by the instructor. The instructor tells this group that they are ''patients'' in an in-patient psychiatric unit due to concerns that people are poisoning their food, and that the group in the original room are "staff" in the hospital. He then tells them the instructor is actually a terrorist who has planted a bomb somewhere in the building (they are shown "the bomb"; i.e., a newspaper or something similar that the instructor puts on the floor). Finally, they are told that when they return to the room they should explain to the ''staff '' that unless the ''terrorist'' is given a large sum of money the bomb will detonate in 30 minutes.

The instructor then meets with the original group of "staff," telling them that they work in an inpatient psychiatric setting, and that those who left the room will play the role of a patient with ''chronic paranoid schizophrenia.'' He tells the "staff" to do whatever they need to keep the "patient" calm and distract them from any delusional talk.

Finally the "patients" return to the room and pair up with a member of "staff." The instructor then subtly leaves the room and removes the "bomb." The exercise is allowed to run for 10 minutes, at which point feedback is taken from both "staff" and "patients" on the experience.

Key points to highlight in discussion:

- "Patients" are not easily distracted from their concerns
- Disbelief or dismissal causes frustration, anger, and sense of being devalued or ignored
- "Patients" who found the "bomb" missing don't think they were mistaken about seeing it planted (i.e., the evidence does not persuade them out of their belief)
- It's easy to assume it was a delusion because this was a "patient"

Note. Adapted from "Changing Staff Attitudes and Empathy for Working With People With Psychoses," by McLeod et al., 2002, *Behavioural and Cognitive Psychotherapy, 30*, p. 463.

***Box 2*. Empathy for Hallucinations Exercise**

In groups of 3 (or 4)

- Two people have conversation about weekend plans/last weekend, etc.
- Other(s) are each person's "voice"
- Whisper into their ear personal comments continuously for 2 minutes
- Rotate roles until each has had a turn of experiencing the voice

Key discussion questions:

- What was it like to hear the voice?
  Distracting? Confusing? Exhausting? Comforting?
- What was it like to be the voice?
  What kinds of things did you find yourself saying?

Key points to highlight:

- It is difficult for a person to pay attention to both the conversant and the "voice" at the same time, or to decide who to listen to
- With preexisting attention and concentration difficulties (common symptoms of schizophrenia), this must be even more difficult
- It is hard to ignore the "voice," even if the person wants to do so

the use of behavioral experiments used in individual weekly therapy;

- To train master's-level therapists to run a CT group for voices and paranoia.

Convey the Basics

Although intensive workshops in treatment model basics can be important in getting staff up to speed quickly, Stirman et al. (2010) also highlight that it can be difficult for agencies to dedicate time for their whole team to attend such didactics, and that staff may become overwhelmed if too much information is delivered too quickly. Keeping this in mind, the instructor delivered four 3-hour workshops to all staff at the peer support and bachelor's-level staff over a 1-month period. Master's-level clinicians, who had received the Beck Initiative's general training, elected to rotate through the workshops while still covering the agency. Table 1 contains a list of topics covered and Boxes 1, 2, and 3 show key exercises utilized to enhance empathy and understanding of how to work with delusions. We attempted to sustain a balance between didactic material, group discussion, and experiential exercises.

In addition, two master's-level therapists were identified to be trained to run a CT group for voices and paranoia, designed to fit the program's group schedule: a 1-hour, 14-session closed group of 4 to 10 consumers. Group material was presented through PowerPoint slides and discussion facilitated by two therapists. Trainees attended a 1-hour didactic to orient them to the group model and content, and then completed three semester-long phases of training and consultation: first, they observed Beck Initiative instructors facilitateing the group; next, they co-facilitated with one of the instructors; finally, staff facilitated with instructor observation. Each phase included 30 minutes of feedback directly following the group.

Consult

The consultation phase was likely the most important part of the training program. As mentioned above, it is now recognized that trainees receiving didactics alone do not characteristically reach competence in their new skill, in contrast to those who also gain consultation as part of their training (Miller et al., 2004; Sholomskas et al., 2005). In addition, this phase is of particular relevance to transforming a program's therapeutic milieu, with staff bringing weekly examples to be evaluated and addressed in real time, and live demonstration from the

instructor. At this point, buy-in and engagement reached an optimum level, and change began. Qualitative feedback from staff (Riggs et al., 2010) suggests this was due to staff observing firsthand the efficacy of interventions and the experience of the instructor with the consumer group in question.

Twenty-two weekly consultation sessions were provided over a 6-month period. Consultation took place for 1 hour once a week, with all staff mandated to attend. Staff presented case examples for feedback and troubleshooting. The instructor then presented a review topic with an experiential exercise, followed by new intervention setting and summary. Topics initially flowed from didactic workshops, but quickly became based on requests from staff for troubleshooting and additional information. Initially a role-play between pairs of staff members was always included. However, because staff had been disengaging during the role-play, this was revised to watching the instructor role-play with a member of staff, and team-by-team case presentation with whole group discussion.

In addition, the instructor attended each team's meeting on a three weekly rotation, at which staff presented a particular participant with whom they were struggling. A CT-based formulation was constructed, and interventions were suggested. Finally, the instructor was also on site informally 1 hour a week, interacting with consumers, modeling good practice interventions, and able to answer additional staff questions.

For the CT for Voices and Paranoia group, the later phases of training/consultation were also found to be enormously valuable, with the greatest amount of learning taking place when trainees were co-facilitating. For future trainings in this group format, it was subsequently decided to accelerate the co-facilitating process and have therapists rotate in with an instructor after about a month of observation.

Evaluate Work Samples

When disseminating any evidence-based practice, it is of course crucial to determine that clinicians are showing fidelity to the intervention modality being taught. In CT training the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980) is commonly used, and research demonstrates that in-depth casework review can provide greater increase in skills maintained over a longer period of time (Miller et al., 2004; Sholomskas et al., 2005). Unfortunately, when training staff in therapeutic milieu enhancement, interactions are not directly amenable to taping or formal rating. Therefore, work samples were evaluated indirectly during team meeting and weekly consultation discussion and through direct observation by the trainer of role-plays, the CT group, and during her informal attendance throughout the program. Feedback was then provided immediately and in situ.

Study the Outcomes

The ACCESS model highlights the importance of studying outcomes in collaboration with the agency but that it may be difficult to do this in a formal or controlled fashion (Seiber, 2008). When working with a community team or partial hospital program, outcomes can be difficult to define, especially when particular program participants have not been identified for intervention. However, it is hoped that all attendees at the program will benefit from this enhancement. It is possible to administer pre-, post-, and follow-up questionnaires to staff and program attendees, but for data to be meaningful instructors need to be aware that this will take some considerable time and effort. Ideally, questionnaires would be administered to respondents in small groups with a trainer or research assistant available to answer any questions and ensure completion, and then anonymously tagged for data comparison. However, in a community agency setting, such time is rarely available. Questionnaires to consider include the following: The Staff Attitudes Survey (McLeod et al., 2002), The Community Oriented Programs Environment Scales (COPES; Moos, 1972), The Community Assessment of Psychic Experiences scale (CAPE; Stefanis et al., 2002), and the Competency Assessment Inventory (CAI; Chinman et al., 2003).

With regard to the CT for Voices and Paranoia group, for which individual consumers were identified for inclusion, pre and post measures were routinely administered (Beliefs About Voices Questionnaire–Revised [Chadwick, Lees, & Birchwood, 2000]; Beck Depression Inventory II [Beck, Steer, & Brown, 1996]; Beck Anxiety Inventory [Beck & Steer, 1990]; Psychotic Symptom Rating Scale [Haddock, McCarron, Tarrier, & Faragher, 1999]). However, time constraints may prevent ongoing assessment when instructors are no longer involved in data collection.

Box 3. **How to Work With Delusions Exercise: "What Happens When We Challenge?"**

Exercise in pairs—10 minutes

- One person describes something they know to be true about themselves (job/family/birthplace, etc.—keep away from religion/politics)
- Other person responds, "No, I don't think that's true," and cites evidence to contradict the person's initial assertion (fabricated, of course)
- Then swap (5 minutes each)

Key questions to ask in discussion:

- How was it being challenged? Thoughts/feelings?
- How was it being the challenger?

Key points to highlight:

- "Challenging," even with evidence, does not serve to change the person's mind, it just makes them look for more evidence of their own and hold their belief more strongly
- It can make the person being challenged very irritable
- It can very seriously damage the relationship with the "challenger" and paint them in a less intelligent/believable light
- It is not courteous—in everyday social interactions we think it impolite to question a person's beliefs, so why should we do it with patients?

Note. Based on the principles of Nelson (2005)

Sustain

This is the most difficult component of any dissemination project, particularly when instructors are not permanent staff members at the agency. The ACCESS model recommends regular ongoing internal consultation sessions to be facilitated by internal clinicians identified by instructors as skilled among their peers, with access to instructors for additional support as needed. In other Beck Initiative training programs, internal consultation is initially audiotaped to allow instructors to provide support and feedback. It was suggested that the same process occur here, with the monthly team meeting as a possible vehicle. Unfortunately, this was not realized due to time pressures during this meeting. However, a year after the ending of the original consultation, the agency requested that didactics be provided to new staff members. This proved valuable in both helping orient new staff and inciting fresh enthusiasm in the whole team. Requests by the staff for access to ongoing written materials and information, and the availability of instructors for consultation on a case-by-case basis, have been evidence of ongoing engagement and efforts to receive support.

Conclusion

Although CT for schizophrenia dissemination might be a relatively new and challenging endeavor in the United States, it has been possible to apply a model of training in evidence-based treatments to the staff in a community health agency, who are now using CT to enhance program milieu and have a positive effect on consumers. We hope that this demonstration of the implementation of CT within a program for schizophrenia provides insights regarding opportunities to increase consumer access to cognitive and behavioral therapies. It would also be wonderful if this positive collaboration between dissemination research and CT for schizophrenia continued, with the ABCT and particularly its annual conference as an excellent vehicle for facilitation.

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. . .

We would like to thank all the staff, clinicians, participants, and leadership at Horizon House, Wellness Alliance in Philadelphia, who participated in this training program for their time, feedback, and participation.

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Classified

THE UNIVERSITY OF CENTRAL FLORIDA ANXIETY DISORDERS CLINIC has THREE opportunities for Postdoctoral Fellowships:

Two Post-doctoral Fellows needed to participate in a Department of Defense funded research program to treat veterans of the Iraq and Afghanistan conflicts who are suffering from post-traumatic stress disorder (PTSD). One Post-doctoral Fellow needed to participate in a National Institute of Mental Health funded clinical research program to develop and assess the feasibility, acceptability and efficacy of virtual environments as a treatment for childhood social phobia.

All post-doctoral fellows will be responsible for the assessment and treatment of study populations, including implementing individual treatment using virtual-reality exposure therapy and conducting group treatment sessions using social skills training and behavioral therapies. Additionally, the fellow may participate in data analysis and manuscript preparation, and provide supervision of graduate and undergraduate research assistants.

Applicants should have a Ph.D. in clinical psychology and completed a pre-doctoral clinical psychology internship, both from programs accredited by the American Psychological Association. Experience providing exposure therapy and other behavioral treatments to individuals with anxiety disorders is required. Application deadline for both is 3/1/12; positions begin 7/1/2012.

Interested applicants may contact Deborah C. Beidel, Ph.D., ABPP at dbeidel@mail.ucf.edu or apply online at www.jobswithucf.com/applicants/Central?quickFind=75748. The University of Central Florida is an equal opportunity, equal access, and affirmative action employer.

At ABCT

Minutes of the Annual Meeting of Members

Saturday, November 12, 2011 | Toronto Sheraton Hotel, Toronto, Canada

Call to Order

President Hope welcomed members to the 45th Annual Meeting of Members and called the meeting to order at 12:35 P.M. Notice of the meeting had been sent to all members in September.

Minutes

Secretary-Treasurer Davis asked for any comments or corrections on the minutes from last year's meeting. M/S/U: The November 20, 2010, minutes were unanimously accepted as distributed.

Expressions of Appreciation

President Hope thanked the Board members for their hard work this year. She especially thanked Frank Andrasik, rotating off as Immediate Past President, and Cheryl Carmin, Representative-at-Large from 2008–2011. President Hope thanked M. Joann Wright, Academic and Professional Issues Coordinator; Rochelle Robbins, 2010–2011 Awards and Recognition Committee Chair; Jonathan Abramowitz, 2009–2010 Self-Help Book Seal of Merit Committee Chair; Hilary Vidair, 2008–2011 Membership Committee Chair; Colleen Carney, 2008–2011 Special Interest Groups Committee Chair; Mitchell Prinstein, 2007–2011 Web Editor; and David DiLillo, our 2011 Program Chair.

President Hope noted that "We all know that to put together a program of this size takes a lot of time and dedication. This year we had 124 members help review program submissions." She said that without their work, there is no program. She thanked Drew Anderson, Peggy Andover, David Atkins, Sonja Batten, J. Gayle Beck, Kathryn Bell, Timothy Brown, Steven Bruce, Will Canu, Cheryl Carmin, Corinne Cather, Anil Chacko, Eunice Chen, Mari Clements, Meredith Coles, Dennis Combs, James Cordova, Lisa Coyne, Rudi De Raedt, Ronda Dearing, Patricia DiBartolo, Ray DiGiuseppe, David DiLillo, Brian Doss, Laura Dreer, Greg Dubord, Jill Ehrenreich-May, Miriam Ehrensaft, Susan Evans, Todd Farchione, Edna Foa, Beverly Fortson, Patti Fritz, Richard Gallagher, Scott Gaynor, Brandon Gibb, Cameron Gordon, Kim Gratz, Amie Grills-Taquechel, Rachel Haine-Schlagel, Tae Hart, Trevor Hart, Kristin Hawley, Flora Hoodin, Curtis Hsia, Jennifer Hudson, Melissa Hunt, Barbara Kamholz, Robert Kern, Muniya Khanna, David Kolko, Sara Landes, Jennifer Langhinrichsen-Rohling, Robert LaRue, Jean-Philippe Laurenceau, Robert Leahy, Penny Leisring, Jennifer Lerner, Gabrielle Liverant, Sarah Markowitz, Lata McGinn, Dean McKay, Carmen McLean, Daniel McNeil, Elizabeth Meadows, Douglas Mennin, Terri Messman-Moore, Alicia Meuret, Catherine Michas, Alec Miller, Todd Moore, Sandra Morissette, James Murphy, Brad Nakamura, Douglas Nangle, Lisa Napolitano, Tara Neavins, Karl Nelson, Timothy Nelson, Jennifer Nelson, Roisin O'Connor, Phyllis Ohr, Bunmi Olatunji, Dan OLeary, Camilo Ortiz, John Pachankis, David Pantalone, Sandra Pimentel, Donna Pincus, Donna Posluszny, Sheila Rauch, Simon Rego, Sarah Reynolds, Galena Rhoades, Lorie Ritschel, Shireen Rizvi, Patricia Robinson, Ronald Rogge, Kelly Rohan, Steven Sayers, Brad Schmidt, Sonja Schoenwald, Tamara Sher, Sandra Sigmon, George Slavich, Jasper Smits, Jennifer Snyder, Susan Sprich, Eric Storch, Gregory Stuart, Mary Sullivan, Dennis Tirch, Kimberli Treadwell, George Tremblay, Matthew Tull, Cynthia Turk, Lisa Uebelacker, Robert Weiss, Adam Weissman, Amy Wenzel, Kamila White, Shannon Wiltsey Stirman, Doug Woods, and Michael Zvolensky.

President Hope also thanked the Local Arrangements Committee for a terrific job and making us all feel very welcome in Toronto. She thanked Cynthia Crawford, 2011 Local Arrangements Committee Chair, and Rixi Abrahamsohn, Martin Antony, Amy Brown-Bowers, Stephanie Cassin, Susan Chudzik, Eilenna Denisoff, Elissa Golden, Joelle LeMoult, Danielle MacDonald, Randi McCabe, Candice Monson, Alex Naber, Karen Rowa, Alex Vasilovsky, Andrea Woznica, and Sandra Yuen.

Appointments

President Hope said she was pleased to report the following appointments: Kamila White will serve as 2011–2014 Academic & Professional Issues Coordinator; Jeffrey Goodie will serve as 2012 Program Committee Chair; Justin Weeks as 2012 Associate Program Chair and 2013 Program Committee Chair; Barbara Kamholz as 2012–2015 Workshop Committee Chair; Kathyrn Roecklein will serve as 2011–2014 Special Interest Groups Committee Chair; and Carmen McLean as 2011-2014 Web Editor.

Finance Report

Secretary-Treasurer Denise Davis reported on the health of the organization and the work of the Finance Committee. She noted the Finance Committee protects the fiscal health of ABCT; tracks income, expenses, and projections; evaluates requests for funding special projects; reviews personnel recommendations; monitors the management of our investment portfolio; ensures the property maintenance of permanent headquarters; and serves as liaison to development activities.

The Finance Committee is comprised of the Secretary-Treasurer, Denise Davis, and two selected members, Mike Petronko and Christopher Mosunic, plus the President-Elect (Bob Klepac in 2011 and Stefan Hofmann in 2012).

She reported that the gross income last year was $1,856,304 against gross expenses of $1,663,193, leaving the organization with a net income of $193,111. She noted that 43% of our revenue comes from the convention; 28% from membership; and 23% from publications; the rest of our income comes from other sources. She noted that in 2012, our projected costs can be seen as follows: gross expenses of $1,778,908 from $310,497 in convention; $282,445 in publications, $27,695 from membership, and all other expenses at $1,158,271.

She projects a modest surplus for 2012–2013, and sees us focusing on strengthening our core financial areas.

For our short-term investments, we have a conservative income strategy with high liquidity and blue-chip fixed income instruments. We also have a Capital Expense Fund, currently at $180,000; and a Special Project Fund, currently at $128,616. For our long-term investments, we have a moderately conservative strategy aimed at preserving capital and generating moderate growth. She noted that returns compare favorably to S&P 500. The Endowment Total is $891,139, with Named Award Funds at $40,907 and Fund the Future at $850,232. In development news, donations are up significantly; we hope to use these funds to strengthen our mission. She noted that an updated policy eternalizes new funds while silent auctions, VIP registration, and donor recognition all serve to reinforce giving to the organization, with more to happen in 2012.

She noted that the organization is fiscally sound; we consistently pass yearly independent audits; we follow generally accepted accounting principles (GAAP); we are compliant with all state and federal regulations; our budget is transparent; and staff time and task allocations are congruent with our stated goals. She said that lots of people have worked hard to get us here—kudos to all!

Coordinator Reports

Academic and Professional Issues

The Coordinator of Academic and Professional Issues reported that her committees are hard at work and showing great results. The Academic and Training Committee is working toward a new resource for the "Teach CBT" section of the ABCT website as well as on short therapy demonstration videos, much like those already in *C&BP*. She noted that the Graduate Mentor Directory has 66 members and is growing. The Coordinator encouraged those who may be interested in serving as a mentor, to please sign up. It is easy to do on our website.

The Committee on Specialization continues to discuss the possibility of a name change to either Committee of Professional Associates or the Committee on Inter-Organizational Collaboration. It plans to add new members. Most exciting, it is reviewing the Report of the Las Vegas Conference of the Inter-Organizational Task Force on Cognitive Behavioral Psychology Doctoral Education. Expect to hear more about this project on in coming issues of *the Behavior Therapist*.

The Professional Issues Committee, in the absence of a targeted task, is being dissolved.

For the Committee on Research Facilitation, Jason Luoma attended the NIMH professional coalition for research progress meeting this past April as a representative of ABCT and reported to ABCT's Board. He also had a review of the meeting published in *the Behavior Therapist*. This committee developed and had approved rules and regulations for the posting of research studies on ABCT's website and Facebook page. They are writing a piece for *tBT* explaining these rules. They will also post the rules on the website, Facebook, and send them to the list-serve.

The Awards and Recognition Committee will be discussing a means of honoring ABCT Past President Alan Marlatt, who had received the 2010 Lifetime/Career Achievement Award. In addition, the Self-Help Book of Seal of Merit Award Committee nominated 56 books for the award, and they were approved by the Board. The list includes the following titles and authors:

Coping With Erectile Dysfunction: How to Regain Confidence and Enjoy Sex by Michael Metz and Barry McCarthy

The Procrastinator's Guide to Getting Things Done by Monica Ramirez-Basco

10-Minute CBT: Integrating Cognitive-Behavioral Strategies in Your Practice by Michael Otto et al.

Overcoming Health Anxiety: Letting Go of Your Fear by K. M. Owens and M. M. Antony

Up and Down the Worry Hill by Aureen Wagner

What to Do When Your Child Has OCD by Aureen Wagner

Worried No More: Help and Hope for Anxious Children by Aureen Wagner

Living With Bipolar Disorder (Guide for Individuals and Families) by Michael Otto et al.

Reclaiming Your Life From a Traumatic Experience (Client Workbook) by Barbara Rothbaum, Edna Foa, and Elizabeth Hembree

Controlling IBS the Drug-Free Way by Jeffrey Lackner

Mind and Emotions: A Universal Treatment for Emotional Disorders by Patrick Fanning et al.

Think Confident, Be Confident: A Four Step Approach to Eliminate Doubt and Achieve Life-Long Self-Esteem by Leslie Sokol and Marci Gittes-Fox

The Dialectical Behavior Therapy Skills Workbook for Bulimia by Ellen Astrachen-Fletcher and Michael Maslar

When Someone You Love Suffers From Posttraumatic Stress by Claudia Zayfert and Jason DeViva

The Mindful Way Through Anxiety by Sue Orsillo and Liz Roemer

Every Parent's Self-Help Workbook (3rd ed.) by Carol Markie-Dadds et al.

The High Conflict Couple by Alan Fruzetti

Getting Past the Affair by Douglas Snyder et al.

The Mindful Way Through Depression by Mark Williams et al.

Staying Sane in the Fast Lane by Anthony Kidman

Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change by Valerie Porr

The Borderline Personality Disorder Survival Guide: Everything You Need to Know About Living With BPD by Alexander Chapman and Kim Gratz

Freedom From Self-Harm: Overcoming Self-Injury With Skills From DBT and Other Treatments by Kim Gratz and Alexander Chapman

Choosing to Live: How to Defeat Suicide Through Cognitive Therapy by Thomas Ellis and Cory Newman

The Mindfulness and Acceptance Workbook for Anxiety: A Guide to Breaking Free From Anxiety, Phobias and Worry Using Acceptance and Commitment Therapy by John Forsyth and Georg Eifert

Feeling Good About the Way You Look: A Program for Overcoming Body Image Problems by Sabine Wilhelm

The Weight Loss Surgery Workbook by Doreen Samelson

Punishment on Trial by Ennio Cipani

The OCD Answer Book by Patrick McGrath

Face Your Fears: A Proven Plan to Beat Anxiety, Panic, Phobias and Obsessions by David Tolin

My Anxious Mind by Katherine Martinez and Michael Tompkins

Sleeping Through the Night: How Infants, Toddlers, and Their Parents Can Get a Good Night's Sleep by Jodi Mindel

A Cognitive-Behavioral Approach to the Beginning of the End of Life by Jason Satterfield

Managing Pain Before It Manages You by Margaret Caudill

Full Catastrophe Living by Jon Kabat-Zinn

Things Might Go Terribly Horribly Wrong by Kelly Wilson

Friends Forever by Fred Frankel

Little Ways To Keep Calm and Carry On by Mark Reinecke

The Dialectical Behavior Therapy Skills Workbook by Matthew McKay et al.

Fighting for Your Marriage by Susan Blumberg et al.

Think Confident, Be Confident for Teens by Marci Fox and Leslie Sokol

The Bipolar Workbook by Monica Ramirez Basco

Panic Attacks Workbook: A Guided Program for Beating the Panic Trick by David Carbonell

Exercise for Mood and Anxiety: Proven Strategies to Overcome Depression and Enhance Well-Being by Michael Otto

The Wellspring Weight Loss Plan by Daniel Kirschenbaum

Reconcilable Differences by Andrew Christensen

The Myth of Self-Esteem by Albert Ellis

The Secret of Overcoming Verbal Abuse by Albert Ellis

A New Guide to Rational Living by Albert Ellis

The Dialectical Behavior Therapy Skills Workbook for Anxiety by Alexander Chapman, Kim Gratz and Matthew Tull

The Anxiety Workbook: The Cognitive-Behavioral Solution by David Clark and Aaron Beck

How Can I Forgive You? By Janis Abrahms Spring

The Mindful Path to Self-Compassion by Christopher Germer and Sharon Salzberg

Getting Your Loved One Sober by Robert Meyers

The Anti-Anxiety Workbook by Martin Antony and Peter Norton

Ending Emotional Eating by Jennie Taitz

Membership Issues

Dr. Wright gave the report for the Coordinator for Membership, who was ill and could not attend the meeting. She noted that the committees under Membership Issues have been quite productive over the last year. Some of the highlights include:

The Membership Committee and the Student Membership Committee continue to address recruitment and retention of members. Both committees are expanding their electronic presence with postings on Facebook, our website, *tBT*, and podcasts. Todd Smitherman and his committee on student membership will be putting together a student calendar. This is the second year for our membership-sponsored panel, "What Professionals Look for When They Hire New Employees." Both committees continue to educate members on the benefits of membership in ABCT. She thanked Hillary Vidair, who is completing her term as Membership Committee Chair, for her tireless work and welcomed aboard Jonathan Grayson as the new Membership Committee Chair.

The Student Membership Committee conducted three surveys examining student member demographics; the annual convention; and benefits of student membership. A very brief synopsis of the results indicates that the majority of the respondents reported being satisfied or extremely satisfied with their ABCT experience and plan on upgrading to Full Professional membership when they complete their degree. Additionally, conference topics with strong interest included publishing in journals, loan repayment options, and what professionals desire in new employees. Finally, the Student Membership Committee will be giving special attention to making our student members aware of all the benefits of membership.

We have almost 40 SIGs! Individual SIGs have received special attention in *tBT* over the last year. The goal is to disseminate information about the SIGs and the specialty content associated with the SIGs as well as increase and retain membership. Colleen Carney is finishing up her term as SIG Committee Chair, and was recognized for all of her outstanding good work. Kathyrn Roecklein was welcomed as the new SIG Committee Chair.

The Committee on Clinical Directory and Referral Issues continues to interview clinicians, drawn from their Referral Service and Clinical Directory expanded listings. These interviews appear on our website under "Information for the Public" as Featured Clinicians. The committee has gathered data on how often the listserve is used to obtain referrals. The committee reminds members to use the clinical directory and the expanded profile for making and giving referrals. Carl Indovina and his List-Serve Committee continue to work to educate members regarding the list-serve rules and guidelines. The list-serve moderator continues to do a great job overseeing the postings. The list-serve continues to grow in usage, and more and more members cite it as an important benefit.

This is the first year that there will be a Leadership Seminar on Sunday, made possible by the Leadership and Elections Committee. The goal of the seminar is to foster future leaders within the organization. In preparation for this year's election, there was an article in the October *tBT* and a Call for Nominations on the back of the program addendum. Members were encouraged to nominate colleagues and themselves in addition to voting online in April.

Social Networking Media Committee designated specific committee members to do Flip camera interviews with members at the convention and post them to Facebook. The committee has been posting mental health- and CBT-related items of interest on FB along with doing a terrific job promoting the Toronto convention.

The Membership Issues Coordinator sent a special thank-you to Deb Hope and the Board of Directors for their support and encouragement throughout the year. She also thanked Cheryl Carmin, Representative-at-Large serving as Liaison to Membership, for her guidance and collaboration. She looks forward to working with our new Representative-at-Large, James Herbert. And finally, where would we be without the phenomenal ABCT Central Office staff? Thank you to all.

Convention and Education Issues

The Convention and Education Issues Coordinator noted that we had 2,853 attendees at this point, and will probably near 3,000 by convention's end. She thanked David DiLillo, Program Chair, for his efforts, and thanked the Institutes Chair, Risa Weisberg; the Workshops Committee Chair, Jillian Shipherd; AMASS Committee Chair, Scott Compton; Master Clinician Seminar Chair, L. Kevin Chapman; and the Local Arrangements Committee Chair, Cynthia Crawford. She noted that we will be taping sessions at this convention and making them available, for free, to all who attended as general registrants. It's a nice benefit to attendees, acknowledging that we can't be everywhere at once. Those who did not attend can also purchase the sessions. Among our efforts to green the meeting, we expanded the number of ticketed sessions that provided handouts online.

Our annual meeting will take place in National Harbor, Maryland, in 2012; Nashville at Opryland in 2013, and back in New York City, for an October meeting, in 2016. We haven't signed contracts yet for 2014 or 2015, but details will be shared as this proceeds.

The Continuing Education Committee has been doing great under Muniya Kahn; they will be presenting ABCT's first ever webinar January 26 with Patti Resick as the speaker. Our thanks, too, to Kelly Koerner, who's provided immense help in putting this together, offering her expertise freely.

Publications

The Publications Coordinator reported several major transitions, with Carmen McLean replacing Mitch Prinstein as Web Editor. Dr. Prinstein made ABCT's website much more accessible and navigable through his reorganization. Editor McLean hopes to make our site more useful for students and increase our hits. While Tom Ollendick has 2 more years at the helm of *Behavior Therapy*, we have selected the next editor, Michelle Newman, whom we enlisted to continue the great work of increasing our impact factor, submissions, and speed of editorial decisions—a tough act. And, for our other journal, *Cognitive and Behavioral Practice*, Maureen Whittal remains the editor for one more year while Steve Safren begins to accept manuscripts as the incoming editor. *Cognitive and Behavioral Practice* has had several years of increased submissions and reduced decision time, the latter down to a couple of weeks.

Kate Gunthert, editor of *tBT*, is acquiring interesting material and reminds us that "you should submit." Susan White heads Public Education and Media Dissemination, where she and her crew are conducting many attendee interviews with the idea of posting them on our website and Facebook.

The Coordinator concluded his report by thanking his committee for the good work they're also doing on fact sheets, our MEDLINE application, and helping with the transition to a new model for the membership year; and thanking staff.

Executive Director's Report

The Executive Director complimented the Board for its dedication to planning, noting that in May they conducted their triannual strategic planning session in which we outline the goals and priorities for the organization. She noted it makes it so much easier to act when we know where we're going. The Board also meets monthly via conference call to ensure we stay on track.

She reported that the organization is revamping its website's membership pages to make it easier for people to join, renew, and register for the convention. We also recently expanded our rules for Facebook, including how to handle member surveys. We're hoping to develop mobile apps for next year's convention.

The Executive Director said ABCT enjoyed a fantastically profitable year last year, and the organization is giving back to its members by providing free access to all the sessions taped at this year's convention to anyone who registered for the entire conference. We're also tackling the deficiencies of our existing association management software. She also thanked each of the staff: Damaris Williams, Keith Alger, Lisa Yarde, Tonya Childers, Stephanie Schwartz, Mary Ellen Brown, and David Teisler.

President's Report

President Hope noted that it has been a privilege to serve as President. She echoed the Executive Director in stating that the organization's strategic planning is a great service to ABCT. We work hard and have fun and, hopefully, point the organization in the right direction.

One of the outcomes of the last retreat was a commitment to dissemination, and, particularly, to an outreach effort on behalf of Evidence-Based Behavioral Psychology website. Please take a look and see how prominently ABCT's work is displayed there.

President Hope thanked Frank Andrasik for his 3 years on the Board and Bob Klepac for his first. She noted that the organization is in good hands as Mary Jane Eimer keeps us focused, on task, and on track.

Transition of Officers

Stefan Hofmann becomes President-Elect and James Herbert will serve as Representative-at-Large and liaison to Membership Issues for the next 3 years. While Bob Klepac is not here, it gives me great satisfaction to turn over the gavel to him.

Adjournment

There being no further business, the meeting was adjourned at 12:57 P.M., Eastern Standard Time.

— Respectfully submitted,
Denise D. Davis, Ph.D.
2011–2013 Secretary-Treasurer

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 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.

http://www.abct.org

Professionals, Educators, & Students

CBT Medical Educator Directory

ABCT

graduate Mentorship directory

"Every student deserves to be treated as a potential genius." — Anton Ehrenzweig

ABCT's Mentorship Directory connects exceptional students with the best mentors that psychology has to offer. Promote your lab, and allow your next student to find you by name, interest, location, or program. Signing up is easy and takes just 3 minutes!

Join the ABCT Mentorship Directory

http://www.abct.org/Mentorship

Call for Papers on next page of this issue

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.

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 related to the subject matter.

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 30 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, either 7 or 14 hours, 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.

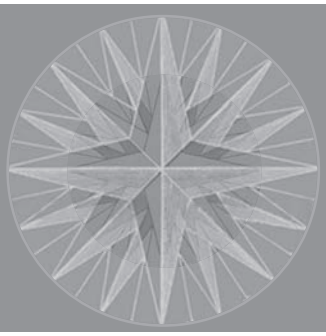
Master Clinician Seminars. The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees.

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.

call for papers

46th Annual Convention

November 15–18, 2012
National Harbor, MD



Principles of Behavior Change: The Compass for CBT

Jeffrey L. Goodie, Ph.D., Program Chair

Over 260 years ago, less than 10 miles down the Potomac River from the National Harbor, George Washington mastered the use of the compass and other surveying instruments. Washington's use of the compass contributed to his adaptability in harsh environments and on the battlefield. When we meet in 2012, it will be 100 years since Watson coined the term "behaviorism." Watson, along with researchers before and after him, established behavior change principles that serve as a scientific foundation and a compass for our current behavioral and cognitive conceptual understandings. Given the contingencies of academic and clinical environments, researchers and clinicians often focus more exclusively on outcomes without explicit consideration of the behavior change principles that guided their efforts. However, just as Washington's use of the compass aided his success, as we adapt cognitive behavioral therapy to environments, such as traditional behavioral health clinics, primary care settings, web-based applications, or even the battlefield, it is important for our success to focus on the principles of behavior change, old and new, that guide our research and practice, wherever it occurs.

The theme for the 46th Annual Convention aims to increase the focus on the behavior change principles that will guide our future assessments, prevention strategies, and interventions. We encourage submissions for research symposia, clinical sessions, and workshops that highlight the search for, explication, and implementation of these basic principles. Special consideration will be afforded to those submissions that contribute to establishing new principles of behavior change or describe how existing principles served as a compass for development of projects and outcomes.

Submissions may take the form of symposia, clinical round tables, panel discussions, and posters:

Symposia: Presentation of data, usually investigating efficacy of treatment protocol or particular research.

Panel Discussions and Clinical Round Tables: Discussion (sometimes debate) by informed individuals on a current important topic.

Poster Sessions: One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees.

SUBMIT! → www.abct.org

Submission deadline:
March 1, 2012

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 2012 awards program. Nominations are requested in all categories listed below. Please visit our website in December for specific submission instructions. 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, and Antonette M. Zeiss. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to 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 Educational/Training Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions toward educating and training behavior therapists. Past recipients of this award include Gerald C. Davison in 1997, Leo Reyna in 2000, Harold Leitenberg in 2003, Marvin R. Goldfried in 2006, and Philip C. Kendall in 2009. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to awards.abct@gmail.com. Include "Outstanding Education/Training" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Education/Training, 305 Seventh Ave., New York, NY 10001.

Outstanding Mentor

This year we are seeking eligible candidates for the Outstanding Mentor award who are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. The first recipient of this award was Richard Heimberg in 2006, followed by G. Terence Wilson in 2008, and Richard J. McNally in 2010. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to awards.abct@gmail.com. Include "Outstanding Mentor" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Mentor, 305 Seventh Ave., New York, NY 10001.

Questions? Contact: Shireen Rizvi, Ph.D., Chair, ABCT Awards & Recognition Committee; e-mail: awards.abct@gmail.com

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. The research should be relevant to behavior therapy. 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. Eligible candidates for this award should be student members who have already had their dissertation proposal approved and are investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor may complete the nomination. Self-nominations are also accepted. Nominations must be accompanied by a letter of recommendation from the dissertation advisor. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to awards.abct@gmail.com. Include "Student Dissertation Award" in the subject line. Please include an e-mail address for both the student and the dissertation advisor. 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, and The Honorable Erik K. Shinseki. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to 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 FOLLOWING AWARD ARE SOLICITED FROM MEMBERS OF THE ABCT GOVERNANCE:

Outstanding Service to ABCT

Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to 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.

Nominate on line: www.abct.org

Deadline for all nominations: March 1, 2012

Find-a-Therapist

Are people finding you?

Help us improve Find-a-Therapist by keeping your listing current and comprehensive!

ABCT's Find-a-Therapist provides a wealth of CBT/EST resources to the public and promotes the practices of our members. We continually work to improve the Find-a-Therapist feature, and we need your help to do so.

To be listed in the Find-a-Therapist directory, or to update your listing, select **ABCT STORE**; then **LOG-IN** (on left side of page); select **MY ABCT INFORMATION** and either join the Find-a-Therapist or choose the option to edit your information and save. Changes will be reflected by the next business day.

glossary of terms

Membership Directory: A directory of all ABCT members, available online to all ABCT members (not available to the public).

Find-a-Therapist Directory: A directory of licensed full and new professional ABCT members who take referrals. This is accessible to the CBT-seeking public from our home page.

Expanded Find-a-Therapist Directory: For an additional $50/year, your practice philosophy, special services, and link to your website will be included in your FAT listing.

now

ABCT

online

visit the ABCT CE Calendar

Educational opportunities abound:

http://www.abct.org

Information for ABCT Members

Continuing Education

in-press

"In some ways the whole point is to try to find the failures, so that further model and technological development can occur. The best way to do that is to push the model as far as it can go and to be prepared to change when deficiencies are contacted. Already, studies show that ACT may not work quite as well for minor problems and less entangled and avoidant clients . . . and instead are leading to model-consistent methods to attempt to overcome this problem by, for example, emphasizing values and compassion more than struggle with personal pain."

Hayes et al., *Behavior Therapy*, in press, corrected proof; "Acceptance and Commitment Therapy and Contextual Behavioral Science: Examining the Progress of a Distinctive Model of Behavioral and Cognitive Therapy" doi:10.1016/j.beth.2009.08.002

archive

"Learned behavior drifts toward instinctive behavior."

Breland & Breland, 1961, *The Misbehavior of Organisms*

the Behavior Therapist
Association for Behavioral and Cognitive Therapies
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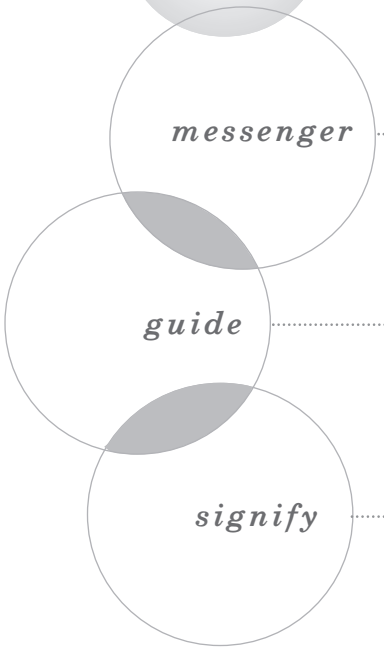
Become an

Ambassador

Promoting leadership, participation, and membership in ABCT. Help us out by becoming an ABCT Ambassador. More information, contact Lisa Yarde: lyarde@abct.org



Articulate ABCT's vision, purpose, and identity to encourage membership

Mentor individuals through the process of presenting at the convention or transitioning into leadership positions

Act as the eyes and ears of the association locally