

the Behavior Therapist

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President's Message

Dissemination Begins at Home

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



How does an undergrad find doctoral programs that offer solid education in cognitive and behavior therapy (CBT)? Search the web, right? Try it. I did recently, and was guided to some very professional-looking websites that pointed potential students to purportedly quality schools offering CBT training. Many I'd never heard of, and some I know too well from my review of a book on diploma mills.

In the last issue of *the Behavior Therapist* I mentioned a number of dissemination programs from ABCT. Today I will describe in a bit more detail one of those initiatives—one that may help with the kind of problem described above.

A little over a year ago, I accepted then-president Frank Andrasik's invitation to serve as Chair of what was to become the Inter-Organizational Task Force on Cognitive and Behavioral Psychology Doctoral Education (a.k.a. "TF" or "Task Force"). Our charge was to develop a document that articulated optimal doctoral education in CBT.

The first, most arduous, and probably most important step in our work was to assemble a group of Task Force members. We contacted professional organizations that had clearly established histories of involvement in CBT doctoral education. These groups collectively represented the full spectrum of approaches within CBT. We asked each organization to nominate one of its members who could speak

[continued on p. 51]

attention

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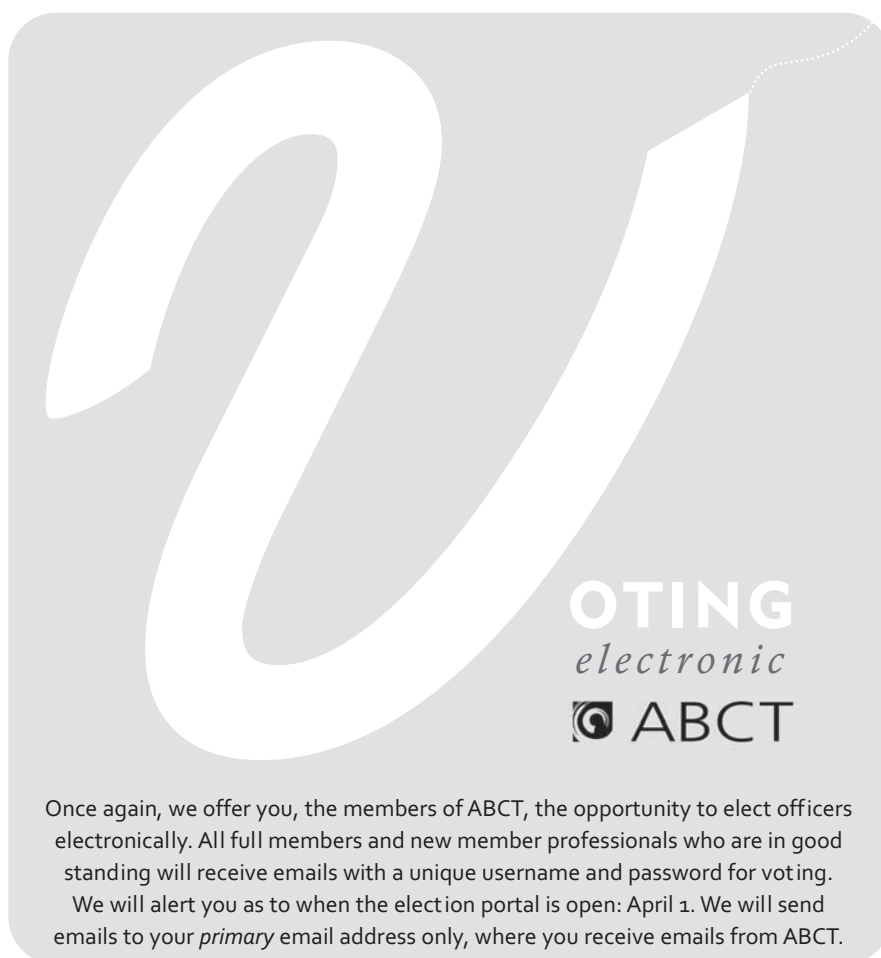
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Once again, we offer you, the members of ABCT, the opportunity to elect officers electronically. All full members and new member professionals who are in good standing will receive emails with a unique username and password for voting. We will alert you as to when the election portal is open: April 1. We will send emails to your *primary* email address only, where you receive emails from ABCT.

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.

for their group, but who also had a broad understanding of CBT and its variants, and who was able to work well with people representing approaches different from her/his own. We also asked that this person have a solid understanding of critical issues and practical challenges in doctoral education. The participating organizations listed in Table 1 supported our effort in creating recommendations for doctoral CBT training—not the recommendations themselves, which were yet to be written.

As we prepared for the first Task Force meeting, I began to wonder why in the world I had accepted Frank's invitation. I doubted aloud whether the task could even be accomplished. True, all of the organizations from which our members were drawn shared many critical views, such as dedication to empirical foundations for their work and scientific evaluation of their concepts and therapy outcomes. They also, however, differed in their emphases, ranging from behavior analytic approaches to those that focused strongly on cognitive factors, and many variants in between. I lost sleep imagining a series of meetings in which each and every proposal led to lengthy, heated arguments about each word in every sentence across all paragraphs.

With this concern paramount in my mind, my goal for our inaugural meeting was simply to seek agreement within our newly formed group on our mission, the general nature of the product we would produce, and the procedures we would follow in evolving that product. If we could get that far in our 2-day meeting, I felt, we had a chance of actually making progress on this challenging task. We met in Las Vegas in March 2010. Were we able to agree on those structural and procedural ground rules in just 2 days? The group not only agreed on the mission, the general nature of what we should produce, and the general nature of the process we would follow—they also developed a rough draft of the entire document in that first meeting. We left Las Vegas with a plan of action, a draft of our recommendations for CBT education in doctoral psychology programs, and work groups formed to further develop and polish each of the document's sections. Each member proved adept at both strongly articulating her/his own positions, while also maintaining a keen sensitivity to views of others who see the world a bit differently. The incredible collegiality, intelligence, and collaboration that characterized this first

meeting were amazing, and set the tone for the entire project.

Our inaugural meeting was followed by monthly teleconferences in which work groups presented revisions of sections of the initial crude draft that they had revised, and led a discussion with the entire Task Force to further polish that section. When each section had been dealt with, the Task Force looked at the document as a whole and continued the work of being sure we were saying what we meant, and meaning what we said—and in some semblance of clear English. In October 2010, the document was in good enough shape to send to the leadership of each of the participating organizations, who were invited to make suggestions for improvement before the document was put into final form. On February 27 and 28, a few days before I sat down to write this article, the Task Force met in New Orleans for its second and final face-to-face meeting. We reviewed the suggestions we had received from our organizations, and where warranted, revised the document yet again.

The document assumes that CBT training will rest upon and be integrated within an accredited doctoral program in an ap-

plied area of psychology, such as clinical, counseling, or school. The recommendations do not take the form of lists of course titles that should be included in a doctoral curriculum. Rather, the focus is on competencies that should be nurtured in such programs. Clinical and research competencies are described, along with the basic knowledge and skills upon which those competencies must be based. Attention is paid to clinical and research skills needed by a CBT-trained psychologist, and the resources and methods important in honing those skills. In addition, the critical importance of understanding the evolving nature of philosophies and methods of science is strongly emphasized. Ethics is treated not as a list of "don'ts" that must be followed to avoid lawsuits or formal complaints, but as a system of values that pervade the psychologist's research and practice and guide the making of decisions sensitive to their impact on all involved parties.

The full report is now waiting its turn for final editing, a task that George Ronan and I will undertake. While the participating organizations have supported the process we are concluding, none of them (including ABCT) has yet endorsed the document it-

Table 1. Task Force Members and Organizations

| Member | Participating Organizations |
|---|---|
| Frank Andrasik, Ph.D. Kevin Arnold, Ph.D., ABPP Cynthia Belar, Ph.D., ABPP | Association for Behavioral and Cognitive Therapies Behavioral and Cognitive Psychology Specialty Council American Psychological Association, Education Directorate |
| Sharon Berry, Ph.D. | Association of Psychology Postdoctoral and Internship Centers |
| Karen Christoff, Ph.D. | Association for Behavioral and Cognitive Therapies, Academic Training Committee |
| Linda W. Craighead, Ph.D. Michael J. Dougher, Ph.D. Thomas Dowd, Ph.D., ABPP James Herbert, Ph.D. Robert K. Klepac, Ph.D., ABPP | Council of University Directors of Clinical Psychology Association for Behavior Analysis International American Board of Cognitive and Behavioral Psychology Association for Contextual Behavioral Science Association for Behavioral and Cognitive Therapies |
| Lynn McFarr, Ph.D. Shireen Rizvi, Ph.D. | Academy for Cognitive Therapy International Society for the Improvement and Teaching of Dialectical Behavior Therapy |
| George F. Ronan, Ph.D., ABPP | American Board of Professional Psychology & Association for Behavioral and Cognitive Therapies, Committee on Affiliations and Specializations |
| Eric M. Sauer, Ph.D. Timothy J. Strauman, Ph.D. | Association of Psychology Training Clinics Academy of Psychological Clinical Science |

Note. Chair: Robert K. Klepac, Ph.D., ABPP; Co-Chair: George F. Ronan, Ph.D., ABPP

self. We expect to send a request for such endorsement within a week, after which we will submit it for publication and make it generally available once publication arrangements are made. We are also hatching plans for wide distribution of the recommendations through e-mail to a wide array of professional associations, presentations at conventions and organizational meetings, distribution to doctoral and undergraduate programs and their students, and many other avenues.

This document is in essence a strong recommendation from a panel of 15 leaders, chosen from 10 organizations representing the breadth of expertise in cognitive and behavioral psychology regarding what optimal doctoral training should include. It is not prescriptive. Its adoption is binding on no one. The future of these recommendations will lie in the hands of our professional public—but following are some of the functions that the document may serve. Whether these effects or others will be realized remains to be seen. Discussions will continue within ABCT, among Task Force members, and in participating organizations regarding how to foster the visibility and acceptance of the recommendations that the Task Force worked so hard to develop.

- The full recommendations might guide the creation of new doctoral programs with heavy CBT components, and guide the evaluation and evolution of such programs already in existence.

- Programs that want to include some CBT, while not offering it as a major area of study, might use portions of the recommendations to inform decisions about their program design and content.
- Undergraduate students seeking solid training in CBT in a doctoral program might use the recommendations as a template against which to evaluate programs to which they might apply.
- Other organizations, such as the Cognitive and Behavioral Specialty Council, the Council of Specialties in Professional Psychology, etc., might choose to adopt the recommendations as definitions of CBT training appropriate to their functions.
- While this document assumes and rests upon general doctoral education in applied psychology, portions of the document may serve as aids to other professions, such as social work, psychiatry, and nursing, that are interested in developing or enhancing CBT training integrated into their own graduate programs.
- In a similar vein, an interdisciplinary task force might use portions of these recommendations to develop guidelines for background and in-service education for master's-level practitioners, who are increasingly important as front-line providers of service nationwide.

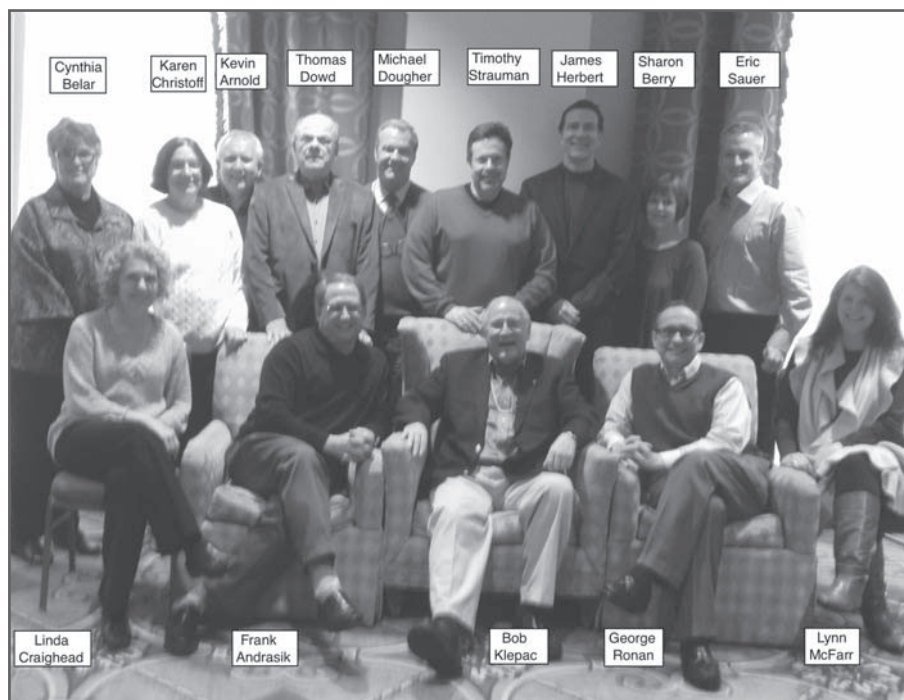
I must emphasize that the effort described here is but one effort at dissemination of cognitive and behavioral findings and

methods. I fully expect to see much more from ABCT, and hopefully from other like-minded associations. ABCT's discussions of dissemination have included audiences well beyond graduate students in the helping professions. Dissemination efforts need to include a wide range of other audiences, including high school teachers and their students, the consumers of our services, legislative and funding bodies, and the general public, to name a few. Such dissemination efforts are clearly overdue, and it is organizations like ours that are best equipped and most highly motivated to pursue those tasks.

Finally, I offer my hearty thanks to Frank Andrasik for initiating this effort, to all of the members of the Task Force and their sponsoring organizations, and to the ABCT Board of Directors and central office staff for their ongoing support. Special thanks are due to George Ronan, who worked tirelessly and effectively as the best co-chair for which one could hope, and to Mary Jane Eimer and Mary Ellen Brown, who took excellent care of logistics, allowing the rest of us to focus on the heart of our task.

...

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Call for Papers

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.

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Disseminating Empirically Supported Principles to Populations With Addictive Behavior: A Challenge

Hank Robb, *Private Practice, Lake Oswego, OR*

I am writing while on an airplane returning from the 2011 ABCT Annual Convention. The theme of the conference was the dissemination of empirically supported treatments. My experience at the conference inspires me to come out of the closet, so to speak, with the hope that my report on a 10-year experience will help that dissemination effort.

About 20 years ago, an organization now known as SMART Recovery (Self-Management and Recovery Training) was brought into existence. Its founders were mainly health-care professionals hoping to establish self-help/mutual-support groups for addictive behavior based on scientific, rather than spiritual, principles. SMART Recovery (SMART) emerged because of those all-too-often-heard complaints by individuals suffering with addictive behavior that they were not interested in declaring themselves powerless over their problems, turning their lives over to a "Higher Power," or getting a sponsor. Like cancer patients, they wanted to someday "recover" rather than remain "in recovery," attending meetings for the rest of their lives. In short, they were looking for mutual support that was something other than a "spiritual fellowship." SMART was, and is, a response. A response based on empirically supported principles (www.SMARTRecovery.org).

In brief, SMART is an abstinence-oriented mutual support group that addresses four basic points: (a) enhancing and maintaining motivation, (b) coping with urges, (c) managing thoughts, feelings, and behavior, and (d) living a balanced life. Participant manuals and other items are available for sale and the organization is additionally funded by pass-the-hat donations collected by facilitators as well as the generosity of benefactors.

What is important for consideration here is SMART does not subscribe to the notion that a person has to have had a problem with addictive behavior in order to facilitate a meeting. In fact, professionals without a history of addictive behavior who

helped found the organization facilitated many of the earliest meetings and some still continue to do so.

For the past 10 years, I have supervised or consulted with clinical psychology students facilitating SMART meetings. This began because practicum students I was supervising knew of my interest in SMART and asked about opportunities to become involved.

Over the years we evolved the following model. Students download and read the free SMART facilitator's manual. Examine the manual yourself and you will find a cornucopia of empirically supported practices: conducting a cost-benefit analysis when addressing point one, urge surfing when addressing point two, detecting and disputing unhelpful beliefs when addressing point three, and setting goals that are specific, measurable, achievable, realistic, and timed when addressing point four. Students observe two SMART meetings and co-facilitate two additional meetings. They also receive approximately 3 hours of training from me in a group format. Without further training, they begin facilitating meetings on their own while also attending a 1-hour-per-week supervision/consultation meeting with me. Because of the chaos that surrounds facilitators "stepping out" and "stepping in," I have asked students to commit to a year as a facilitator. It hasn't always worked out that way, but that is the general expectation. Facilitators also have access to a basic SMART meeting model on DVD and, recently, SMART has begun an online training program for facilitators, though it has not been a requirement for the students with whom I work. Historically, students have worked in pairs facilitating meetings. On occasion, they have facilitated meetings on their own, as is typically the case with those who once had difficulty with their own addictive behavior, became abstinent, and now facilitate SMART meetings.

The advantages for students are many. They learn how to facilitate groups. These are much needed skills if empirically sup-

ported treatments are to be more widely delivered. Though the format is largely psychoeducational, they encounter some of the most painful of human experience and have direct opportunity to make a difference in the lives of others by using the very empirically supported principles they will be applying in other treatment contexts. Addictive behavior constitutes the largest group of psychological problems and facilitating SMART meetings can be a significant opportunity to learn skills relevant to its treatment, and often, their only opportunity. Because of donations and the sale of participant manuals, they learn to deal with the "issue" of money—not an insignificant skill for psychological service providers who do not work as employees for organizations and, perhaps, even for those who do. For those who choose to stay for a second or even third year, as some students have done, they learn how to help new facilitators acquire and develop their own facilitation skills in a collaborative manner.

Do these facilitators flounder, feel awkward, and behave ineptly, especially in the beginning? Yes, they do. That's how it is when you start anything. Even after a year, are they always as seamless and sophisticated in their delivery of empirically supported methods as fully trained practitioners might be? No, but they are much improved. They have gained a great deal.

However, the big payoff is for meeting participants. A large number of individuals suffer with addictive behavior. Approximately 30% of those with diagnosable psychological disorders will also have a co-occurring substance use disorder. The numbers grow when addictive behavior problems like gambling are added to the addictive behavior mix. Participating in the mutual support activities provided at SMART meetings can stop the spiral that can lead to outpatient and inpatient treatment, serve as co-occurring support to such treatment, and be part of an aftercare program. However, many suffering individuals cannot access either outpatient or inpatient treatment. Self-help or mutual support groups may be all they have if they are not interested in becoming members of a spiritual fellowship where a prayer is recited at the end of practically every meeting. However much they may want to participate in a spiritual fellowship, they also want something else when it comes to addressing their addictive behavior.

Over the last 10 years we have had as many as 10 student-facilitated groups operating at the same time. Literally hundreds, and perhaps thousands of individuals have

Olle Jane Z. Sahler, John E. Carr (Editors)

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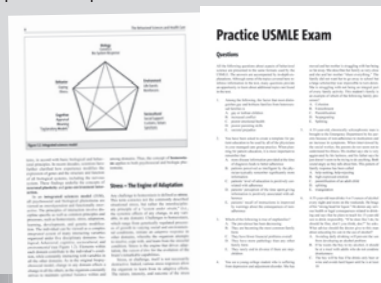
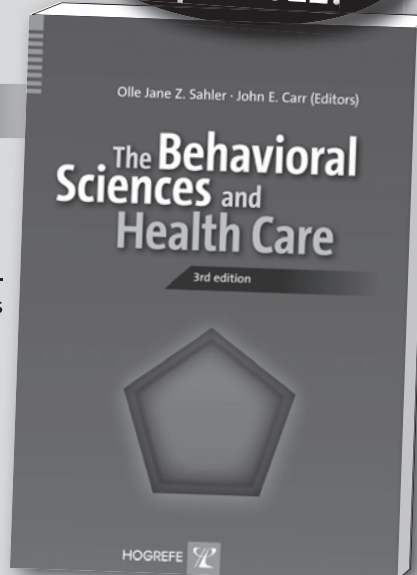
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come into contact with empirically supported methods to address addictive behavior through these groups and many of them have ended, or significantly reduced, that behavior. Participants don't have to be "patients." They don't have to come in to a "clinic" and fill out paperwork. They don't have to establish a "therapeutic contract" with their "therapist." It is stigmatizing enough to step up to the problem of addictive behavior on one's own or be mandated to participate by the courts. Through SMART, empirically supported methods meet these individuals where they are without requiring that they first step through a clinic or hospital door. And, they teach their friends! When you learn you don't have to be controlled by your thoughts, feelings, urges, or the behavior of others, and you can learn to choose your actions, you want to show others how it's done!

For years I have tried to cajole my professional colleagues into providing some of their time to facilitate SMART meetings. They haven't been interested. However, students are very interested. They are looking for an opportunity to "make a difference" from the moment they walk through their program's door. We are looking for opportunities to disseminate empirically supported

treatments and methods. Since SMART is friendly to research, there may be many opportunities for that as well.

So here's my question to the training members of ABCT: How about taking the opportunity to do what you can with what you've got? Will you help establish and support student-facilitated SMART Recovery meetings in your area? Accept this challenge and students can develop important skills while literally tens of thousands of individuals struggling with addictive behavior can get more exposure to empirically supported practices to address this behavior. Getting empirically supported principles and procedures to those who could greatly benefit from them is a challenge. Facilitating SMART meetings is one way you and your students, and even your interns and post-doc's, can meet that challenge.

Will there be problems? You bet! "The rules," and there are lots of rules, may have to be reconsidered or widened. In my own situation, and at the suggestion of a university attorney, students have been forbidden to hold meetings on university, or university controlled, property lest their enrollment in a university program while facilitating a meeting on university property be construed as grounds for a suit should "some-

thing go wrong," even though a protocol for handling threats of suicide during meetings has been established. Thoughtful concerns will have to be addressed, and anonymous members of organizations who believe their way is the only way, no matter what their organizations maintain, may make it difficult to determine exactly what agendas are at work. I encourage those who accept this challenge not to be surprised when "rules as roadblocks" appear. While I cannot even begin to forecast the specific roadblocks that will be raised for specific individuals in specific situations, those wishing to push dissemination of empirically supported principles and procedures through this avenue will either effectively address these roadblocks or give up. That is the choice.

I close by thanking the members and staff of ABCT for choosing this convention theme, providing a conference filled with efforts to speak to it, and providing me the push to make this appeal. I know it can work because it already has.

...

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Cognitive-Behavioral Therapy for Adjustment Disorder: A Preliminary Study

Colin van der Heiden and Kim Melchior, *Outpatient Treatment Centre PsyQ, Rotterdam*

Adjustment disorders (ADs) are described as maladaptive reactions to identifiable psychosocial stressors or changes in life circumstances (*DSM-IV-TR*; American Psychiatric Association, 2000). ADs are common, particularly in primary care and general medical settings (Casey, 2001). According to the *DSM-IV-TR*, AD is the principal diagnosis in 5% to 20% of patients in outpatient treatment. Despite this rather high incidence, the diagnostic category has received little attention in the research literature, as a result of which little is written to guide clinicians about the treatment of ADs (van der Klink & van Dijk, 2003). Although high-level evidence for any type of intervention for ADs is lacking, it has been argued that therapy should (a)

enable reduction of the stressor(s), (b) enhance coping with the stressor(s) that cannot be reduced or removed, and (c) establish support systems that can assist in enhancing adaptation and coping (Carlson, 1996; Strain & Diefenbacher, 2008). As such, treatment goals should include a return to baseline functioning and the establishment of adaptive coping skills. Coping is defined as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141). Coping strategies are commonly divided into emotion-focused and problem-focused coping. Emotion-focused coping strategies are aimed at reducing negative emotional

impact of stressful situations, for example, by seeking emotional support, behavioral and cognitive avoidance (such as substance abuse), or expression of emotions. Such strategies are used when people think they can do little to change the stressful situation. Problem-focused coping, which are attempts to deal with stressful situations, such as direct action, palliative reaction, seeking social support, or developing reassuring thoughts, are used when people believe they are able to tackle the stressful condition (Lazarus, 1999; Lazarus & Folkman, 1984). Both types of coping include adaptive strategies to handle stressful situations, including active coping, suppression of competing activities, positive reinforcement, seeking social support, and positive reappraisal. Strategies that have been suggested to be nonadaptive include denial, behavioral disengagement, focus on emotions, and alcoholism (Carver, Scheier, & Weintraub, 1989).

The present study reports an initial evaluation of a cognitive-behavioral treatment for AD that has been developed to meet these goals (Van der Heiden & Verbraak, 2010). The aims of this study were to inves-



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Table 1. Means, Standard Deviations, and *t* Statistics at Pretreatment (Pre), Posttreatment (Post), and Follow-Up (F.u.) Assessments

| Measure | Pre | | Post | | F.u. | | Pre/Post | | Pre/f.u. | |
|---------|----------|-----------|----------|-----------|----------|-----------|----------|-------------|----------|-------------|
| | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>t</i> | <i>p</i> | <i>t</i> | <i>p</i> |
| SCL-90 | 181.50 | 62.24 | 121.50 | 27.06 | 117.50 | 22.53 | 2.82 | 0.03 | 3.13 | 0.02 |
| UCLact | 15.25 | 4.03 | 16.00 | 2.39 | 16.63 | 2.33 | 0.55 | 0.60 | 0.88 | 0.41 |
| UCLpal | 18.88 | 3.60 | 18.25 | 3.24 | 17.75 | 4.03 | 0.48 | 0.65 | 0.77 | 0.47 |
| UCLavo | 13.63 | 2.26 | 14.25 | 3.06 | 14.50 | 3.34 | 0.86 | 0.42 | 1.18 | 0.28 |
| UCLsoc | 12.75 | 2.19 | 13.75 | 2.71 | 13.88 | 2.53 | 1.25 | 0.25 | 1.52 | 0.17 |
| UCLpas | 14.75 | 1.91 | 10.63 | 2.45 | 11.13 | 3.04 | 4.61 | 0.00 | 3.34 | 0.01 |
| UCLexp | 6.38 | 2.62 | 5.75 | 1.28 | 5.75 | .89 | 0.76 | 0.47 | 0.68 | 0.52 |
| UCLcom | 11.25 | 2.19 | 14.75 | 11.61 | 15.38 | 11.34 | 0.85 | 0.43 | 1.02 | 0.34 |

Note. Figures in bold indicate a significant result; UCLact = active coping; UCLpal = palliative reaction pattern; UCLsoc = seeking social support; UCLcom = having comforting thoughts; UCLavo = avoiding or awaiting the problem; UCLpas = passive coping; UCLexp = expression of emotions.

tigate the effectiveness of the treatment and to explore changes in coping styles.

Method

Participants and Design

Patients were drawn from consecutive referrals made by general practitioners to an outpatient treatment center. Inclusion criteria were (a) a primary diagnosis of adjustment disorder, and (b) age 18 to 65. Diagnosis was established using the Dutch version of the Structured Clinical Interview for DSM-IV Axis I (SCID-I; Van Groenesteijn et al., 1999), which was administered by a trained psychologist. At the end of the clinical screening patients received extensive information about the design and procedures of the study. Following informed consent, 10 patients were included in the study. Subtypes of AD that best characterized the predominant symptoms were “with depressed mood” ($n = 5$), “with anxiety” ($n = 3$), “with mixed anxiety and depressed mood” ($n = 1$), and “with disturbance of conduct” ($n = 1$). In six cases the duration of symptoms was specified as “chronic,” indicating that symptoms persisted for more than 6 months in response to a chronic stressor. In the remaining four cases symptoms persisted less than 6 months (specified as “acute”). Half of the patients were male. The mean age of the participants was 43.6 years (range 20 – 62 years). None of them were currently taking psychotropic medication. One patient was a student and 9 were professional workers.

Patients received individual weekly 45-minute sessions of CBT. Treatment followed a manual consisting of the various cognitive-behavioral techniques (van der Heiden & Verbraak, 2010). After providing information on adjustment disorders and stress reactions, treatment proceeds with self-monitoring of symptoms of stress: Using daily diaries, patients record hourly both their level of stress on a scale from 0 (*no symptoms of stress*) to 10 (*very high symptoms of stress*) and the events that triggered increasing levels of stress. As such, patients learn to recognize how cues and symptoms of stress interact early in the sequence, as a result of which they will later be able to apply new, more adaptive coping strategies as soon as symptoms of stress emerge. Another goal in this first treatment phase is improving lifestyle, by adopting a more healthy lifestyle (e.g., eating more fruit and vegetables, adopting a regular day-night rhythm), and engaging in so-called RES-activities (relaxing, exercising, and socializing). For the latter purpose, patients first list, and then practice, relaxing activities (e.g., reading a book), physical exercises (e.g., running), and social contacts (e.g., calling a friend). In the next phase, patients learn to apply the RES-activities once they notice triggers and/or symptoms of stress, anxiety, or a negative mood. In the final phase, negative thoughts about stressful events and stress symptoms are modified by cognitive therapeutic interventions, such as questioning the evidence supporting dysfunctional thoughts and behavioral experiments.

The therapist team consisted of three staff psychologists of the participating mental health care centre. All of them were familiar with the provision of cognitive-behavioral treatment manuals. Supervision was provided by the first author, an experienced clinical psychologist and one of the developers of the treatment manual.

Measures

The Dutch version of the Symptom Checklist (SCL-90; Arrindell & Ettema, 2003) was used as an outcome measure to assess general psychopathology. This 90-item self-report measure has been shown to possess good psychometric qualities (Arrindell & Ettema, 2003). Respondents are asked to indicate the extent to which they suffered from various physical and psychological complaints during the last week. All items are scored on a 5-point Likert-scale ranging from 1 (*not at all*) to 5 (*very much*), so total scores range from 90 to 450.

Changes in preferred coping strategies were assessed with a multidimensional self-report questionnaire called the Utrecht Coping List (UCL; Schreurs et al., 1993). The scale consists of 47 items, measuring seven styles of coping: direct action, palliative reaction or distraction, seeking social support, having comforting thoughts, avoiding or awaiting the problem, passive or depressive reaction, and expression of emotions. In accordance with the theoretical construct of Lazarus and Folkman (1984) the first four subscales are considered to represent problem-focused coping,

whereas the latter three are considered to be emotion-focused strategies (Van Hooren, Vermeiren, & Bolman, 2008). Patients are asked to indicate how they usually react to problems or unpleasant events. Items are scored on a 4-point Likert scale (1 = *hardly ever or never* to 4 = *very often*). The UCL has been demonstrated to possess sound reliability and validity in both clinical and community samples (Evers, van Vliet-Mulder, & Groot, 2000).

Results

Of the 10 patients initially entering treatment, 8 completed treatment and 2 dropped out, for unknown reasons. Among the 8 completers, the range of treatment sessions was 3 to 11 (mean: 7.1). During treatment or follow-up none of the patients received additional treatment.

In the completers sample, all patients improved during the course of treatment. Table 1 shows mean scores and standard deviations on both measures as obtained during the pretreatment, posttreatment, and follow-up assessments. On the SCL-90, the pretreatment score was indicative of a high level of complaints, whereas both the posttreatment and follow-up scores were indica-

tive of moderate levels of general psychopathology. Paired samples *t*-tests showed significant improvements on this measure from pre- to posttreatment, with improvements remaining significant at follow-up. Significant improvements also occurred from pre- to posttreatment and pretreatment to follow-up on the Passive Coping Subscale of the UCL. No significant improvements were found on the other six subscales of the UCL.

To gain further insight into the statistical significance of the improvements, Cohen's *d* statistic ($M1 - M2 / \text{pooled } SD$; Cohen, 1992) was employed to calculate within-group effect sizes (ES). Large ESs were found for the SCL-90 at posttreatment (1.25) and at follow-up (1.37). The same was true for the Passive Coping Subscale of the UCL (1.88 and 1.43, respectively). The ESs found for the other subscales of the UCL were only small to moderate at both posttreatment (ranging from 0.18 to 0.42) and follow-up (ranging from 0.30 to 0.51).

Discussion

Results of this preliminary study are encouraging, with individual CBT for AD producing significant pre- to posttreatment

decreases on the self-report symptom measure, with a large ES, suggesting that treatment was effective. Effects were maintained at follow-up. Examination of the effects on different coping styles revealed that treatment was only associated with a significant reduction and large ES on the Passive Coping Subscale, indicating that after treatment patients feel more capable of taking action. This finding suggests that the changes in symptoms resulted from modification of this specific coping strategy, although no definitive conclusions can be drawn as no formal mediation analysis has been carried out. Moreover, it could be argued that treatments that have a general impact across coping styles would lead to better results. As the interventions in this study were mainly aimed at managing the maladaptive reaction to the stressor(s) and changing the meaning of the stressful event(s), future studies might benefit from building in coping strategies that are more directly aimed at reducing or changing the stressor itself, such as Problem Solving Training (D'Zurilla & Nezu, 1999). It should be noted though, that a negative consequence of this could be the lengthening of treatment for patients whose prob-

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lems by definition should resolve within 6 months upon removal of the stressor.

Results of this study should be interpreted in the context of a number of limitations. To begin with, results are based on a small number of cases, which limits generalizability. Also, the absence of a no-treatment control group means that it cannot be ruled out that the improvements were not a function of other uncontrolled variables, such as spontaneous fluctuation in symptoms. However, the changes produced on the subscale of passive coping suggest some degree of specificity of this cognitive-behavioral intervention. Furthermore, we relied on single self-report measures that were completed by only one informant (i.e., AD patients) to assess both symptoms and coping styles, whereas a multitrait-multimethod approach would have been preferable (Kotov, Watson, Robles, & Schmidt, 2007). Finally, the 3-month follow-up period in this study is not optimal. In spite of the finding that patients did not seem to relapse at follow-up, it would be of particular interest to examine whether treatment gains are maintained over follow-up intervals that extend 1 year and beyond.

Conclusions

The results of this preliminary study appear encouraging and support the continued evaluation of CBT for ADs. However, future studies should use (a) no-treatment control groups, (b) larger number of patients with AD, (c) more than one measure for each construct, preferably completed by more than one informant, and (d) treatments that include other coping strategies, such as problem-solving training.

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Both authors have no competing interests.

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Applied Psychophysiology in Cognitive-Behavior Therapy: Research Questions and Training Paradigms

John R. Davis, *McMaster University*

Paul Lehrer's (2011) recent letter to the editor commented on ideas that Marvin Goldfried (2011) presented earlier in *the Behavior Therapist* about how clinical experience can generate research questions. Professor Lehrer discussed his experience of using breath training to treat panic disorder, despite such training being somewhat unconventional from the perspective of current cognitive-behavior therapy. He concluded with his opinion that the training of behavior therapists should include applied psychophysiology as a standard part of the curriculum.

Reading Professor Lehrer's letter reminded me of my own clinical experience using biofeedback (i.e., applied psychophysiological methods), which leaves me feeling more proficient in the practice of cognitive-behavior therapy.

What I think applied psychophysiology adds to my practice is an understanding of the physical and neural substrates of psychological disorders. In addition to more conventional cognitive, behavioral, and environmental variables that enter into assessment and treatment, the perspective of applied psychophysiology and biofeedback enables a more comprehensive biopsychosocial case formulation, and suggests novel intervention methods, as described in Professor Lehrer's letter.

If psychophysiological methods are relevant for panic, what about other disorders that are treated by cognitive-behavior therapy? A quick search of PsychInfo using terms "psychophysiology" and either "anxiety," "fear," or "depression" produced upwards of 2,000 hits, while "psychophysiology" and either "schizophrenia," "bipolar," or "personality disorder" produced close to 200 hits. Biofeedback has a long history of empirical support in the treatment of health-related problems such as headache, insomnia, epilepsy, and neuromuscular disorders, for example (e.g., Schwartz & Andrasik, 2003). This might suggest that psychophysiological underpinnings of the disorders we treat as cognitive-

behavior therapists are important, and could enhance case conceptualization.

A recent article (Forgeard et al., 2011) emphasizes the idea that psychobiological processes are integral to our understanding and treatment of emotional disorders in the context of research, diagnosis, and treatment of depression. One of the authors (Seligman) concludes by stating that one of the two best candidates for a biologically informed understanding of psychological processes is emotional regulation. If that is true, then a host of methods are currently accessible for directly assessing and treating the psychophysiological markers of emotional regulation. Those methods, which fall under the rubric of applied psychophysiology, are founded in learning theory, and may provide a significant increment in treatment effectiveness in addition to interventions aimed at behavioral, cognitive, and environmental change.

How could training in applied psychophysiology be accomplished? In the Faculty of Health Sciences at McMaster University, medical students do not take any specific anatomy course. Instead, they engage in small group, self-directed, problem-based learning (Zehr, Butler, & Richardson, 1996). When scheduled for a module in respiration, for example, they are presented with a set of clinical cases involving the respiratory system. The students, with guidance from a faculty tutor, recruit an anatomist to discuss dissections, that is, dissected lungs and models. The anatomical knowledge is then integrated with a variety of other perspectives to generate a holistic understanding of the patient, their disease, what to assess, how to treat, and prognosis to anticipate. What if a similar pedagogical method were used in the training of cognitive-behavior therapy? Instead of a course in biofeedback, faculty member with skill in applied psychophysiology would present the anatomy and physiology relevant for anxiety disorders, for example, along with demonstrations of psychophysiological assessment and biofeedback methods, linking biological substrates to the cognitive, be-

havioral, emotional, environmental, and social factors that comprise a biopsychosocial formulation.

I echo Professor Lehrer's call to integrate applied psychophysiology as a standard part of training of behavior therapists. Does adding a psychophysiological component to cognitive-behavior therapy contribute to better case formulation and outcome, as I have seen in my own experience? Does integrating applied psychophysiology in training of behavior therapists enable them to use these empirically supported methods to produce better outcome? Perhaps these clinic-derived questions merit research investigation.

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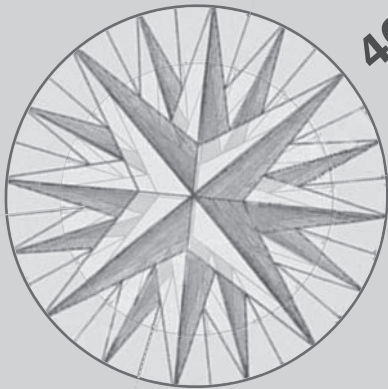
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Barrera et al., *Cognitive and Behavioral Practice*, in press, corrected proof;
<http://dx.doi.org/10.1016/j.cbpra.2011.05.007>


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Hersen & Bellack, 1978, *Behavior Therapy in the Psychiatric Setting*



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**Acceptance and Commitment Therapy:
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James D. Herbert, Ph.D., Drexel University

Over the past decade, Acceptance and Commitment Therapy (ACT) has rapidly grown in popularity. As an applied arm of a field known as contextual behavioral science, ACT is a psychotherapy model that is at once quite familiar to more traditional cognitive behavior therapists in some respects, yet also strikingly different in other ways. A substantial body of research supports the effectiveness of ACT for a wide range of psychological conditions, with a growing literature also supporting its theorized mechanisms of action. This webinar will provide an overview of the ACT model, including its underlying philosophy of science, its theoretical basis, and its technical applications. Typical ACT interventions will be reviewed, including how these can be applied in conjunction with well-established behavioral approaches. Similarities and differences between ACT and more traditional forms of CBT will also be explored.