the Behavior Therapist

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Clinical Forum

There's an App for That: Information Technology Applications for Cognitive Behavioral Practitioners

Adrian Aguilera, *University of
California, Berkeley*

Frederick Muench, *Mobile Health
Interventions* and *Columbia
University College of Physicians
and Surgeons*

Harnessing Power of Technology

the Behavior Therapist has been at the forefront of publishing articles about opportunities to enhance CBT with technology either as therapeutic adjuncts or stand-alone interventions (e.g., Boschen, 2009a; Boschen, 2009b; Hawkins, 1989; Russo, 1984; Smith, Bobicz, & Richard, 2003; Smith, Rothbaum, & Hodges, 1999). Compared to other orientations, CBT practitioners have a long tradition of integrating technology into practice using innovations. However, this enthusiasm has not necessarily translated into CBT therapists actually using the thousands of available Web-based and mobile applications as adjuncts to care. While our patients are using these applications to do everything from tracking their mood to therapeutic breathing, how many therapists are using these applications as treatment adjuncts with their clients? In this article, we present some useful Web-based and mobile applications that can be used as treatment adjuncts for a range of disor-

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ders. We aim to highlight the need for a paradigm shift if trained mental health practitioners want to stay competitive with the range of other individuals offering mental health and behavioral health care who are embracing these new technologies as a crucial component of their services (e.g., life coaches). As technology increasingly pervades the health-care world, we should strive to ensure that principles of scientific inquiry are applied to balance out the priority of profits in the private sector. Including the experience and knowledge of researchers and practitioners during the development and iterations of applications can be particularly beneficial for vulnerable populations with mental health disorders.

More than ever there has been a call to develop innovative ways of improving the quality and reach of psychotherapies using innovative tools such as mobile phones and smartphones in particular (Boschen, 2009a; Kazdin & Blase, 2011). The use of wireless information technology in health applications is experiencing a tremendous boom, in large part as a result of ballooning health care costs and the limitations of one-on-one therapy to meet the mental health needs of the population. In particular, mobile phone applications for health have grown very rapidly and provide opportunities to expand current care beyond the clinic. While there is a large discrepancy in home Internet access between high- and low-income households and ethnicities, this is not the case with mobile phone use: in fact, more Americans own a mobile phone than a computer (Pew, 2010). Smartphones are powerful devices in small mobile packages that are versatile and becoming more prevalent, with over a 50% market share and rapid yearly growth. Their processing power combined with wireless connectivity allows for streamlined data collection, transmission, and analysis.

While many developers are designing applications specifically for end users, many of these can be used by therapists as adjuncts to enhance care. This is especially important because individuals typically do not use apps often after downloading them. Among all application sales for iPhone and Android systems, only 38% are opened more than once after a month—and that drops to 4% after a year (Flurry Analytics & Estimates, 2011). It is our assumption that these numbers are even lower for mental health applications as compared to popular apps such as Angry Birds. This limited adoption by the end user highlights the need for collaborative techniques to enhance and maintain usage in vivo to improve therapy outcomes.

Evidence in Mobile Mental Health

There is growing evidence that consumers of mental health services and information are interested in gaining access to information via mobile phones. For example, in an Australian sample, 76% of people were interested in using mobile phones for mental health monitoring and self-management. Importantly, people with mental health symptoms were more interested in using such services, suggesting that there is indeed an untapped market of consumers of mental health information that could benefit from psychological interventions outside of the traditional tools of psychotherapy practice (Proudfoot et al., 2010). In another study, 98% of low-income, mostly unemployed clients in outpatient substance abuse treatment were interested in using interactive text messaging to help them maintain sobriety (Muench & Weiss, 2011). Reviews have highlighted that mobile interventions are well accepted by end users and are welcome additions to physical and mental health treatments (Aguilera & Muñoz, 2011; Cole-Lewis & Kershaw, 2010; Heron & Smyth, 2010). These interventions have the benefit of ongoing contact and assessment beyond the traditional therapeutic environment.

The research base for mobile technology applications is growing but is still limited in terms of specific applications that can be applied on a broad scale. Studies using mobile phone–based text messaging have the most research basis using CBT techniques, but even those are limited beyond feasibility studies. Evidence-based smartphone applications using behavioral and cognitive methods tend to be in development stages. These include a DBT app for borderline personality disorder (Rizvi, Dimeff, Skutch, Carroll, & Linehan, 2011), a mobile therapy application using CBT techniques (Morris et al., 2010), and an Internet and mobile intervention for depression using context sensing to identify emotional states and intervene appropriately (Burns et al., 2011). Although these applications require a broader evidence base before they are ready for implementation, they foretell future applications for moving psychotherapy beyond the one-on-one encounter.

As noted in recent reviews on mobile interventions (e.g., Riley et al., 2011), the technology is advancing so quickly that research cannot keep up with development. Although there is a limited evidence base

for specific mobile mental health applications, there are basic tools that take aspects of efficacious interventions and repackage them into mobile formats. It is with these tools that therapists can generalize the therapy setting to an individual's everyday environment. In essence, mobile tools should not be considered as anything more than an improvement to ideal therapeutic intervention. From self-monitoring to reminders at specific days and times to increasing salience of the therapeutic environment, a host of existing basic tools can be put into practice by psychotherapists.

We will highlight some examples of tools available that may help cognitive and behavioral psychotherapists impart skill learning and motivation. We are not endorsing any specific applications in this article, and if we do mention a specific application it is to make a point about a feature that can probably be found in many other applications. Also, all applications we mention by name are free (or close to it) to the end user. Moreover, because of the sheer number of applications available, we highly recommend doing your own search for ones that meet your specific needs. For example, a recent review of iPhone applications for intervening with alcohol use found over 150 apps available as of February 2011 (Cohn, Hunter-Reel, Hagman, & Mitchell, 2011). However, there are a number of websites that have aggregated mental health and/or self-tracking applications (e.g., "Happtique" or the "Quantified Self") and most applications can be found using keyword searchers in the application stores. Most important, this article is designed to make the possible uses of these tools more salient to therapists. Simply searching your app store using keywords such as *depression screening* or *sleep tracking* will reveal numerous applications from which to begin.

Self-Monitoring

Perhaps the most useful applications for cognitive-behavioral therapists are self-monitoring applications. The rapid rise of these applications has been termed the "quantified self" movement. In this section we will focus exclusively on self-monitoring via homework or self-report. There are specific applications in which individuals can track everything from food intake to sleep to mood to alcohol use. The problem with these tracking applications is they are typically user initiated, which makes their actual implementation limited without support from a therapist. There are numerous studies highlighting that self-monitoring accounts for a significant portion of the

variance in behavior change outcomes (e.g., Mischie et al., 2009). These outcomes can be enhanced when a therapist is holding the patient accountable. Unlike paper-and-pencil monitoring tools that are often completed retrospectively, individuals can track their thoughts and behaviors in real time. Results are typically displayed graphically, reducing the time for the therapist to review outcomes, and graphical representations can be summed over time. This can be especially powerful to show patients progress when change is smaller than expected but still significant compared to baseline. Self-monitoring tools are perhaps the greatest asset to the cognitive-behavioral therapist because they are simple tools to enhance what we are already doing in our practices. A wonderful reference source for these tools is the quantified-self website (http://quantifiedself.com/guide), which is designed to promote self-monitoring using self-report and automated tracking tools.

Two examples of applications that are available for mood monitoring via mobile phone are Mood 247 (www.mood247.com) and the T2 Mood Tracker. Mood247 utilizes text messaging to collect data and uploads mood data to a website. The data can be shared with a health-care provider or therapist by the patient providing a code that allows one to view mood ratings over time. In addition to mood ratings, individuals can append notes related to the mood rating, potentially adding information about thoughts, behaviors, settings, and emotions that could then be further discussed in a therapy session. The T2 Mood Tracker is a smartphone application developed by the National Center for Telehealth and Technology that allows for individuals to track their mood and emotional states. There are numerous other applications for self-reported monitoring via apps and text messages that practitioners can access (e.g., "Mood Panda"). These are relatively simple technologies that can be added to existing care, and are often more reliable than other means, such as paper and pencil. For example, when patients do not track their mood throughout the week, therapists often ask patients to recall their mood over the past week, but these data are typically inaccurate as demonstrated by numerous ecological momentary assessment studies (Shiffman, Stone, & Hufford, 2008).

Information and Screening

Aside from self-monitoring, simple information applications that patients can download to learn more about their disorder are widely available. Psychoeducation

can now take place on the mobile phone while a client is in the waiting room. Typically these apps have been bundled with screening and brief feedback programs, which probably represent the largest share of the mobile mental health market. For example, a range of substance abuse applications offer validated substance abuse assessments with brief feedback that can help clients obtain objective third-party information on their disorder (Cohn et al., 2011). This can help alleviate resistance or strains to therapeutic alliance with clients who may be resistant to feedback from the therapist. Moreover, as many mental health clinicians are aware, there are numerous diagnostic reference applications specifically for use by the clinician alone, from diagnostic assistance to medication interactions.

Guided Interventions

There are also numerous applications that attempt to provide overlapping services as therapists, and specifically highlight CBT theory, such as iCBT, ICouchCBT, eCBT, CBT Referee. While we do not endorse any of these programs, CBT practitioners should be aware they exist and assess their potential (or lack of potential) to enhance care. Some applications have been developed in clinical settings and take principles of CBT and transfer them to a mobile device very specifically. The VA, in particular, has embraced the use of technology and has developed applications based on evidence-based practices designed for veterans but available to all. One such application is the PTSD Coach, available on iPhone and Android platforms. The application targets the management of PTSD with four modules: education, self-assessment, symptom management, and social support. The application is targeted towards vets but can likely be used by others dealing with PTSD. While these applications have not been directly tested either, they were developed based on empirically supported interventions and principles, providing some foundation for their use in clinical practice.

As noted above, other intervention apps have been developed for borderline personality disorder (Rizvi et al., 2011), depression using context sensing to identify emotional states and intervene appropriately (Burns et al., 2011), and substance abuse using GPS to trigger reminders when someone may be entering an area previously associated with substance use (Gustafson et al., 2011). Aside from these applications, practitioners should be aware of the numerous applications that target specific components of

Danny Wedding, Mary Ann Boyd, & Ryan M. Niemiec

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Yvonne Hall, MD, in the *Bulletin of the Menninger Clinic*

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CBT and may complement practice—for example, programs that target gratitude, meditation, guided relaxation, therapeutic breathing, and increasing positive emotion. However, like all self-guided change programs, the question becomes, *How many times will a person use an application without therapist support?*

Accessing the Capabilities Built Into the Smartphone

Aside from utilizing mobile phones, other capabilities of the phone can be used today. The multiple features of smartphones make them therapeutic gold. For example, individuals can record their feelings in vivo using the simple audio recordings or videos of themselves for later review with the therapist. These features can be especially useful for child, family, and couples therapists who need to capture real-world situations, which are rarely replicated in the therapeutic environment. Clients can place their phone on the dinner table and send the recording to their therapist to review. Additionally, with new voice recognition built into newer phones, therapists can sit with a client's mobile phone and verbally cue reminders through the week until the next session and remind them of the next appointment. The camera is already being used by numerous health/eating applications (e.g., an individual takes photos of their meals, which in turn is evaluated by a third party). A therapist can ask clients to take pictures of stressful environments or other stimuli that are relevant to treatment goals. These built-in features can also be used to enhance efficacy through feed-forward audio and video modeling; for example, a person records him- or herself successfully completing a task to be replayed later—or therapists can model appropriate behaviors for clients that can offer extra support in difficult situations through video playback.

Text Messaging

Text messaging is perhaps the most widely available mobile tool. Available on nearly all phones, text messaging can be utilized by clinicians and their entire patient population. There is more research on text messaging than any other mobile format, with appointment adherence and smoking cessation showing the most promising results. Text messages can make change goals more salient in one's natural environment. Rather than relying on the client to proactively open an application, the messages push therapeutic content. This reduces the likelihood that clients will be able to ignore change goals in the face of unhealthy environment triggers. There are several simple free messaging services in which clinicians can send one time or repeated reminders to a patient at a specific day and time. There are also more interactive text messaging systems that can be utilized in conjunction with therapeutic goals. For example, the federal government has released "smokefreetxt," a free SMS (short message service) program for individuals attempting to quit smoking. Additionally, SMS can be used to trigger mobile web applications and cloud-based audio and video files when our clients need extra support. Most phones also have MMS (multimedia message service) capability, where pictures of a loved one or a visual goal can be sent to patients at specific times. Not only do these applications help patients make goals more salient or track progress, but they can be used as simple appointment and homework reminders.

Passive Sensing

The most rapidly growing area of mobile health that is being embraced by the general public and that can have tremendous utility to clinicians is ambulatory personal physiological, activity, and location sensing tools (Intille, 2007), which will build on some of the examples presented earlier. Many promising applications are those that passively monitor a range of stimuli, from activity level to heart rate or galvanic skin response, using external sensors. The most basic level of mobile sensing utilizes technologies built into modern smartphones such as accelerometers, gyroscopes, and GPS. A popular application of these technologies is the detection of movement and location. It may soon be common practice for therapists to monitor the activity level of patients through smartphone accelerometers and GPS. With available applications today you can monitor the activity level of depressed patients and see whether they expanded their behavioral repertoires by engaging in new pleasant activities through GPS and even mapping. Sleep disturbances associated with a range of diagnoses can be monitored with a range of apps that track and graph sleep (e.g., sleeptracker). These applications can be combined with self-monitoring to help understand the daily correlates of poor sleep.

As shown, the clear benefit of mobile phones is the ability to capture objective data; nowhere is this more pronounced than with psychophysiological assessment. While biomonitoring typically requires additional hardware, which includes a sensor, we can now review periods when our clients were most aroused or hypervigilant with objective data and help them prepare for these situations when clear patterns are taking place. These apps will increasingly include intervention components such as notifications when an individual is aroused (e.g., through galvanic skin response, heart rate variability, etc.) to engage in stress-management techniques or, as noted earlier, alerts based on GPS or geographic information to avoid high-risk situations as is currently being implemented through the CHESS system (University of Wisconsin; Gustafson et al., 2010).

With new voice capture and analysis technologies becoming more commonplace (entering the app market soon), therapists will be able to assess the emotional tone of speech or use text recognition software to assess depressive or other symptomology (De Giacomo, L'Abate, Pennebaker, & Rumbaugh, 2010; Rude, Gortner, & Pennebaker, 2004). Newer technologies also include facial scans to determine emotion from subtle facial cues. This information could be reflected back to the individual to prompt a mood promoting action or to make them more aware of their patterns. Additionally, these data could be sent to a database and/or a provider to track the occurrence of mood state over time.

Social Support

Finally, there are a number of social networking applications to help connect individuals with similar problems or disorders and provide peer social support. These applications are typically available both through websites as well as through mobile applications. For example, SupportBuddy is an app that lets users create social support networks for specific problems, which will alert individuals in your network when one indicates he or she is not doing well. This is a perfect example of connecting individuals in a therapy group to support each other outside the clinic, which could potentially enhance cohesion and independence or simply could be used by therapists as a means to be alerted when a patient indicates they are having problems. This type of application may or may not be advised, depending on rules that therapy groups have regarding contact outside of therapy. However, support applications could potentially be used after time-limited therapy groups have concluded or with substance abuse support groups. With the rise of broadband speeds mimicking wi-fi, the quality of mobile applications and Web-based mobile content will improve, using user-friendly interactive programming, which may make the nu-

merous Web-based support groups available to individuals 24/7.

Considerations for Practice

The range of features available via mobile devices appears to be a natural extension of the spirit of CBT and can help clinicians do their jobs more effectively and efficiently. Possibly the most important realization attained in writing this article is that the overwhelming majority of these applications are not new or novel in terms of mechanisms of change but rather they are now available for use because technology has caught up with what we know helps facilitate change. These technologies can be used with the broadest range of clientele. For example, studies have already demonstrated feasibility and acceptability utilizing SMS as a monitoring adjunct to CBT in a low-income, ethnically diverse population (Aguilera & Muñoz, 2011). These patients expressed being more aware of their mood states as well as feeling a sense of support and feeling cared for by their therapist. Rather than reducing therapeutic alliance, mobile interventions can extend the reach of therapy beyond the walls of the clinic when clients need the most support. Depp and colleagues (2010) have shown initial success using mobile self-management and between-session therapist contact with patients with severe mental illness. If mobile technology is helpful in interventions for these populations that often lack resources, it is likely that it can be disseminated in other settings. Individuals without transportation or those who live in rural settings may have access to interventions that otherwise might not be available to them.

Challenges and Limitations

Although there is interest in mobile technology information and interventions, barriers still exist. For example, some patients/clients simply may not like using mobile phones. Others may find mobile technology intrusive or cite privacy concerns (Proudfoot et al., 2010). While these barriers may reduce adoption, understanding them should also be used as an important part of maximizing adoption as well. For example, Muench and Weiss (2011) found that 40% of individuals interested in using text messaging for addiction continuing care preferred *not* receiving texts that reference drug use in the messages. These findings require us to conduct research on how to individualize applications for our clients to suit their preferences and needs. By no means are mobile applications a panacea, but they are a potentially powerful tool to increase the impact of interventions that we know work when applied properly.

In addition to challenges from patients and clients, therapists are sometimes reluctant to implement the technology. One concern that therapists often have is added ethical responsibilities and HIPAA concerns. These are valid concerns but they should not be barriers to innovation. Security steps, such as limiting the transfer of sensitive information, using code words, ensuring the information is secure on a single phone, using passwords, and deleting messages, can be implemented. Protocols that are in place to address crises should remain in place and do not need to be supplanted by the use of technology. It is important to inform patients about how to use technology and that the use of mobile technology does not necessarily mean that a therapist will be available or monitoring messages at all times. Other safety measures could include integrating safety protocols such as texting the word "HELP" to receive information about a suicide hotline and instructions on going to the emergency room (Aguilera & Munoz, 2010). There is also the concern of increased therapist time commitment if one is constantly connected to clients via technology. However, boundaries can be set up similar to boundaries used in DBT regarding phone contact.

Finally, when we inform therapists and mental health professionals about utilizing technology, oftentimes there is concern that the technology will simply duplicate their efforts and will result in reduced treatment seeking by potential clients. We assert that such thinking does not recognize that technological applications are meant to be used to enhance care, that personal contact and real-time intervention and feedback will still be required to treat most individuals seeking in-person services. Stepped-care models using these technologies as first-line treatments are already happening and there are simply not enough individual therapists to address the unmet need for mental health problems in the U.S. and globally. Furthermore, the application of technology is improved when combined with a live, trained support (Mohr, Cuijpers, & Lehman, 2011). As Kazdin and Blase (2011) have stated, we do indeed need a paradigm shift and technology will be at the center of the shift.

The future of health information technology will be best served by allowing for multiple ways of accessing data and information. Access and individual preference will determine what best suits each person. Just as it is important to stay on top of latest developments of new evidence-based practices, we propose that therapists should seek to improve their current practice and contribute to the evidence base of technology and mental health. These technologies will soon be able to provide intelligent interventions based on real-time data capture, helping us understand and intervene with our clients on an exponentially different level. Our enthusiasm does not support using untested applications or abandoning the empirical process; rather, we urge practitioners and researchers to use the technology—report your experiences so that trained mental health professionals can be a crucial part of the development process to improve the application of these technologies in an evidence-based manner.

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CBT Training at the Beck Institute for Cognitive Behavior Therapy

Judith S. Beck, *Beck Institute for Cognitive Behavior Therapy*

The Beck Institute, a nonprofit organization in suburban Philadelphia, has had an interesting evolution. Established in 1994 by Aaron T. Beck, M.D., and me, it was primarily a clinical site at first. But from the beginning, we had a vision of transforming the Institute into a national and international training center. This vision was gradually realized, greatly aided by the explosion of research that demonstrated the efficacy of CBT for a wide range of psychiatric disorders, psychological problems, and medical conditions with psychological components, and by the Internet, which allowed literally millions of professionals, students, researchers, educators, and consumers to discover and learn about evidence-based treatment. (Our websites alone now get over 100,000 visitors per year.)

As of 2011, we have trained approximately 3,000 health and mental health professionals at our Institute through our workshop and supervision programs. Our trainees, who have ranged from novice therapists to experts in CBT, have been from all 50 states and 75 countries. They come from many mental health and related fields. We have trained many thousands more via off-site (customized) workshops, conferences, and webinars and will soon be offering online training programs.

Historical and Ongoing Collaborations With University of Pennsylvania

Our involvement in training began in the 1970s, when Dr. Aaron Beck taught psychiatric residents at the University of Pennsylvania to use cognitive therapy, which he was continuing to develop and refine. In 1974, he established the Center for Cognitive Therapy at Penn (a previous incarnation had been the Mood Clinic) and began to train postdocs as well, which he continues (at the age of 90, through his iPhone, iPad, and Skype) even to this day. In 1980, to offer supervision to a wider range of mental health professionals, he inaugurated a distance learning program. Mental health professionals traveled to Penn for workshops and received weekly phone supervision from master supervisors based on tape reviews of their therapy sessions.

Establishing the Beck Institute for Cognitive Behavior Therapy

For a variety of practical reasons, we opened our own autonomous institute in 1994 while still maintaining a close connection with Penn. Dr. Beck continued his research with his team at Penn, but we moved our clinical and educational operations to our current site. Several Penn faculty members still supervise in what is now called our supervision program and teach both at our on- and off-site workshops. Dr. Beck occasionally teaches residents and medical students, and I regularly teach two courses to second- and third-year psychiatric residents.

On-Site and Off-Site Training Opportunities and Scholarships

We offer both on-site and off-site opportunities for students and professionals from other institutions to learn more about CBT. For many years, we have invited students and faculty from all the mental health disciplines to attend case conferences, in which Dr. Beck interviews a patient live, via close-circuit television. Following the interview, I conduct a review of the therapy session and moderate questions and answers with Dr. Beck. Participants have driven from as far as 4 or 5 hours away to be able to take part in these conferences. In 2009 we began a new initiative, Soldier Suicide Prevention, at Beck Institute, in which we offer partial scholarships to health and mental health professionals working with active duty and veteran military service members and their families. And in 2010 we established a student scholarship competition. Last year, we received almost 800 entries from students, describing their exposure to CBT and plans to use CBT in the future. We awarded 10 full scholarships to our special 3-day student and faculty workshop, and we plan to continue the competition each year.

In addition to training individuals, we work with hospitals, health systems, community mental health centers, and other organizations whose aim is to establish or improve the delivery of CBT by their staffs. Training is individualized and often involves a hybrid of workshops, supervision, and supervision on supervision.

Current Research Activities

Current research activities at our Institute are also related to training. We are conducting a pilot study on the efficacy of a CBT program for weight loss and maintenance. A third generation in the Beck family, Deborah Beck Busis, LSW, is currently working on a therapist manual for weight loss and maintenance in anticipation of developing a training program for health and mental health professionals to test the program more widely. Other research activities related to training at Beck Institute include consultation with researchers to set up robust CBT programs and to train, monitor, supervise, and/or assess the competence and fidelity of research therapists. At Penn, Dr. Beck and colleagues continue researching suicidality (categorizing and measuring suicidality and developing, evaluating, and disseminating cognitive therapy interventions for suicidal patients) and schizophrenia (focusing on improving the global functioning and quality of life of patients with chronic schizophrenia). They have published two ground-breaking studies that demonstrate the efficacy of cognitive therapy for both these populations.

Current and Future Directions

We also seek to educate others in a variety of different ways. We interact with professionals and consumers and keep them up to date on cutting-edge research and practice through a variety of social media platforms, including Facebook, You-Tube, Twitter, LinkedIn, and our blogs.

What does the future bring? We continuously update our basic (depression and anxiety) and advanced (personality disorders and challenging problems) workshops and expand our specialty workshop offerings (current plans include workshops for the military, children and adolescents, schizophrenia, substance abuse, and group treatment, as well as a workshop in Spanish) and we will broaden our range in the future. While we have a large faculty of supervisors from North America, we also have a few supervisors to whom trainees send therapy tapes in their native languages (chiefly Spanish, Chinese, and Thai), though many of our international trainees currently find English-speaking clients or submit translated transcripts of their sessions. So another

goal is to develop a larger group of international supervisees. We will also expand our supervision-on-supervision program, in which therapists first reach significant proficiency in delivering CBT to clients and then learn how to supervise other therapists. And we are eager to reach many more students and mental health professionals with our forthcoming online training programs.

Now that CBT is becoming (more of) a household name, and especially as social service and governmental agencies recognize the importance of evidence-based treatment, we foresee an ever-expanding role for training in the field. The mission of our nonprofit Institute is to encourage the growth and dissemination of CBT throughout the world through leadership in the field and the provision of professional training, outpatient clinical services, and research. We welcome ideas and collaboration of ABCT members in fulfilling this mission.

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Debunk, Debunk, Debunk: Some Evidence for Why Dissemination Is Only Half the Battle

Stephen D. A. Hupp, Amanda K. Stary, Katie N. Bradshaw, and Sarah A. Owens, *Southern Illinois University Edwardsville*

While widespread dissemination of evidence-based treatments (EBTs) continues to be a challenge, ABCT has been a leader in dissemination advances (Becker, Nakamura, Young, & Chorpita, 2009). In two recent presidential columns in *the Behavior Therapist*, ABCT Past-President Frank Andrasik and President Robert Klepac each emphasized the central importance of dissemination, and they each punctuated their message by including the phrase "Dissemination, Dissemination, Dissemination" in the titles of their articles. In one article, Andrasik (2010) discussed the importance of training with students. As the next generation of professionals, doctoral students are especially critical to effective dissemination of EBTs. Similarly, Klepac (2012) highlighted several other evolving dissemination efforts coordinated by ABCT, such as additions to the ABCT website, podcasts, and the development of a Facebook page.

However, with just a few notable exceptions (e.g., Miller & McLean, 2007; McLean et al., 2007), ABCT has focused considerably less attention on debunking pseudoscientific and additional treatments that may be harmful, ineffective, misapplied, or underresearched. The term "dissemination" itself typically implies providing information and training about what works; however, another type of dissemination (i.e., "debunkation") involves debunking what does not work. While disseminating information about EBTs is critically important, dissemination may happen more effectively if it is enhanced by simultaneously debunking pseudoscientific treatments. It seems, however, that we spend less effort in actively debunking treatments. Perhaps when we teach students about methods that have been supported through rigorous scientific efforts, we assume that they learn to bring more skepticism to the table when considering other treatments.

This article will use data collected from students in an undergraduate child psychology course to indicate why debunking is an important type of disseminating.

Undergraduate psychology courses are an excellent setting for studying dissemination for several reasons. First, undergraduate psychology courses are often filled with hundreds of students, thus a large number of potential consumers receive the information. Second, many psychology courses (e.g., Introduction to Psychology, Child Psychology) include students from a wide variety of majors. Thus, it is valuable to disseminate EBTs to the large number of the future medical professionals, lawyers, school teachers, and many other professionals whose work will intersect with psychology. Finally, an undergraduate course offers convenience and time-efficiency in terms of measuring the results of dissemination efforts.

The original purpose of the present study was to examine initial beliefs about EBTs and additional treatments at the beginning and end of an undergraduate course in child psychology .

Method

The participants included 17 (out of a possible 24) undergraduate students who consented to being in the study. The students were enrolled in a summer section of a child psychology course at a midsized university in the Midwest. Participants consisted of 13 females and 4 males with a mean age of 24.53 (SD = 7.35). One participant was African American, 1 participant was Asian, and the rest of the participants were Caucasian. One participant was a freshman, 10 participants were juniors, and 6 participants were seniors. Finally, 5 of the participants had at least one child.

The measure used for this study was the Specific Therapeutic Approaches Rating Scale–Child Form (STARS-CF), which was developed by the first author to measure students', therapists', and parents' beliefs regarding EBTs and additional treatments for children. The STARS-CF has 40 items in which participants rate their beliefs regarding the effectiveness of treatments for four common childhood disorders (i.e., autism, ODD, ADHD, and depression). Each item uses a 5-point Likert scale (0 = *NOT effective*, 1 = *probably NOT effective*, 2 = *unsure*, 3 = *probably effective*, 4 = *effective*). The two primary subscales are the Evidence-Based Psychosocial Treatments (EBPT) subscale, which includes treatments that have been identified as evidence-based for children (e.g., cognitive-behavioral therapy for depression, applied behavior analysis for autism, etc.), and the Additional Treatments (AT) subscale, which includes treatments that have NOT been identified as evidence-based for children with the indicated diagnosis (e.g., psychodynamic psychotherapy for depression, dolphin-assisted therapy for autism). There are also four items about medication that are not included in either subscale but can be used for additional qualitative information.

Because there was not a control group, the study used a pretest-posttest quasi-experimental design. The participants completed the STARS-CF on the first day of class and the last day of class. They were informed that the purpose of the STARS-CF was to assess their opinion and that they would not receive a grade based on their responses. All of the students in the course received a small amount of extra credit for completing the rating scale whether they consented to being in the study or not. The course content focused primarily on typical child development, and it also covered each of the four disorders that are included in the STARS-CF (approximately 75 minutes per disorder). The concept of evidence-based treatments was discussed in the course as were each of the 13 evidence-based psychosocial treatments represented on the STARS-CF. The 23 "additional treatments" were not discussed in the course. Also, the potential benefits and limitations of medication were discussed for only two of the disorders (ADHD and depression).

The first hypothesis was that students would rate evidence-based psychosocial treatments as higher in effectiveness at the end of the course than they did at the beginning. The second hypothesis was that students would rate the additional treatments as lower in effectiveness at the end of the course than the beginning. This second hypothesis was made based on the assumption that as students learned about EBTs, they would find additional treatments to be less

effective even though they were not specifically addressed in the course. No hypotheses were made regarding beliefs about medication.

Results and Discussion

Two paired samples t-tests were conducted to test the hypotheses. The Bonferroni correction was used to adjust for using two t-tests (i.e., p was set at .025). The results indicated that only one of the two hypotheses was supported. Specifically, scores on the EBPT subscale significantly increased from pretest ($M = 2.58$, $SD = .44$) to posttest ($M = 3.21$, $SD = .33$), $t(16) = 6.137$, $p < .001$. On the other hand, scores on the AT subscale did not decrease from pretest ($M = 2.28$, $SD = .45$) to posttest ($M = 2.36$, $SD = .49$), $t(16) = .704$, $p = .491$.

Table 1 includes means of each of the treatments for the pretest and posttest and also provides some other qualitative information. Students appeared to begin the course with a decent idea of which treatments were evidence-based as represented on the pretest for ODD, ADHD, and depression (but not autism). On the posttest, their ratings for each of the evidence-based psychosocial treatments increased. At the beginning of the course students gave low ratings to some of the additional treatments, but they also rated some of the additional treatments rather high. For example, play therapy and facilitated communication for autism were rated higher than applied behavior analysis (ABA). At the posttest, their ratings for over half of the additional treatments actually increased. For example, facilitated communication for autism increased from pretest ($M = 2.82$) to posttest ($M = 3.12$). In retrospect, the increase in ratings about facilitated communication makes sense because the class discussion on ABA largely centered on increasing communication; thus, "facilitated communication" may have sounded as if it would be an effective intervention. Therefore, a limitation to the study could be the rating scale's exclusive focus on the labels of treatments rather than a more detailed description of the treatment components.

Taken together, these results suggest that the course was effective at strengthening students' beliefs about the effectiveness of evidence-based psychosocial treatments; however, this did not have the intended side effect of simultaneously weakening their beliefs about additional treatments that are not evidence based. In fact, the course may have accidentally strengthened student beliefs in some of the additional treatments.

Clinical Psychologist

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Miller and McLean (2007) argue that in addition to teaching about EBTs, it is valuable to teach students about pseudoscientific treatments, and the present study provides some evidence for why this may be the case. Some universities have psychology courses that specifically address science and pseudoscience (McLean et al., 2007); however, these specialized courses reach a relatively small number of students. Thus, in addition to offering specialized courses, a broader range of students can be reached by incorporating learning activities dedicated to improving critical thinking and debunking pseudoscience into several other psychology courses as well. In turn, this may increase awareness of both treatments that are effective as well as those that are harmful, ineffective, misapplied, or underresearched.

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

PRETEST	POSTTEST
Autism	
3.24 Play therapy	3.37 *Applied Behavior Analysis
3.00 Developmental/Relationship	3.24 Play Therapy
2.82 Facilitated Communication	3.12 Developmental/Relationship
2.50 *Applied Behavior Analysis	3.12 Facilitated Communication
2.33 *Pivotal Response Training	2.75 *Pivotal Response Training
2.24 Medication (such as risperidone)	2.00 Dietary Management
2.13 Dolphin-Assisted Therapy	1.94 Medication (such as risperidone)
1.94 Secretin Hormone Treatment	1.53 Dolphin-Assisted Therapy
1.94 Dietary Management	1.44 Secretin Hormone Treatment
1.75 Vitamin B Treatment	1.24 Vitamin B Treatment
Oppositional Defiant Disorder	
3.10 *Parent-Child Interaction Therapy	3.83 *Parent Management Training
2.94 *Parent Management Training	3.63 *Parent-Child Interaction Therapy
2.82 *Positive Parenting Program	3.59 *Positive Parenting Program
2.56 *Helping the Noncompliant Child	3.25 *Helping the Noncompliant Child
2.50 Medication (such as dextro-amphetamine)	3.19 Reparenting Therapy
2.31 Reparenting Therapy	2.71 Medication (such as dextro-amphetamine)
2.23 Art Therapy	2.56 *Incredible Years
2.13 Holding Therapy	2.53 Art Therapy
1.94 *Incredible Years	2.33 Holding Therapy
1.81 Rebirthing Therapy	1.53 Rebirthing Therapy
Attention-Deficit/Hyperactivity Disorder	
2.94 *Behavioral classroom management	3.82 *Behavioral classroom management
2.94 *Behavioral parent training	3.65 Medication (such as methylphenidate)
2.65 *Behavioral peer interventions	3.56 *Behavioral parent training
2.56 Cognitive Therapy	3.18 Cognitive Therapy
2.44 Medication (such as methylphenidate)	3.13 *Behavioral peer interventions
2.31 Sensory Integration Therapy	3.00 Neurofeedback/Biofeedback
2.31 Neurofeedback/Biofeedback	2.31 Sensory Integration Therapy
2.25 Dietary supplements (such as amino acids)	2.29 Sugar elimination
1.94 Sugar elimination	1.71 Dietary supplements (such as amino acids)
1.81 Feingold diet	1.69 Feingold diet
Depression	
2.81 *Cognitive-Behavioral Therapy	3.56 *Cognitive-Behavioral Therapy
2.71 Medication (such as fluoxetine)	3.18 Medication (such as fluoxetine)
2.71 Animal-Assisted Therapy	3.13 Psychodynamic Psychotherapy
2.65 Recreational Therapy	3.00 Recreational Therapy
2.38 Psychodynamic Psychotherapy	2.81 Animal-Assisted Therapy
2.25 *Self-Control Therapy	2.50 *Penn Prevention Program
2.19 Attachment Therapy	2.13 Attachment Therapy
2.00 Power Therapy	2.12 *Self-Control Therapy
1.88 Herbal Therapy	1.94 Power Therapy
1.81 *Penn Prevention Program	1.81 Herbal Therapy

Note. The evidence-based psychosocial treatments are marked with an asterisk. 0 = *NOT effective*; 1 = *probably NOT effective*; 2 = *unsure*; 3 = *probably effective*; 4 = *effective*.

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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 ("Principles of Behavior Change: The Compass of CBT") 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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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

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ⓖ ABCT

graduate Mentorship

directory

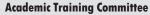*"Every student deserves to be treated as a potential genius."* — Anton Ehrenzweig

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

Want to Get More Involved in ABCT?

ABCT can be seen as an association, a network, a professional home, or an extended family. We are as strong and productive as our members' commitment. For a fuller overview of ABCT activities, take a moment to browse the Association's governance listing: www.abct.org → ABCT Members Only → Governance. These are members who are shaping the Association and the field. If you are looking for a way to become involved in ABCT, below is a list of committees and/or other areas of interest—from publications to training to public education to clinical issues—and the individuals to contact.

Academic Training Committee
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Committee on Research Facilitation
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Behavior Therapy
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Joseph LeDoux
Steven C. Hayes
Kim Mueser
Robert Leahy
Steve Hollon
Lata McGinn
Aaron Beck
Sheila Rauch
Anne Marie Albano

ABCT Podcasts

An array of podcasts and webcasts can be found on our website: www.abct.org

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Self-Help Books of Merit
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Professionals, Educators, Students

Self-Help Books

in-press

Construction and Validation of the South African Version of the Fear Survey Schedule for Children: An Exploratory Factor Analysis

". . . school-related fears are over-shadowed by other, more prominent and dangerous fears, such as HIV and AIDS, wild animals, and being hit by a car or truck. These items represent fears that are stronger than school-related fears, which may reflect the salience of these concerns in South African society . . ."

Burkhardt et al., Behavior Therapy, in press, accepted ms; http://dx.doi.org/10.1016/j.beth.2012.02.001

archive

"Fundamentally, everybody has the same problem and the same cure."

Andrew Salter, 1949, *Conditioned Reflex Therapy*

ABCT WEBINAR

Friday, April 27

11:00 A.M. – 12:30 P.M. Eastern time
Continuing Education Credit available
Members: $30; Nonmembers $45
Details, visit **www.abct.org**

Acceptance and Commitment Therapy: A Radically Different yet Remarkably Familiar Approach to Behavior Change

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.