

the Behavior Therapist

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Changing of the Guard

Drew Anderson, *SUNY-Albany*

This issue marks Kate Gunthert's first issue as editor of *the Behavior Therapist*, and as the now former editor, I wish her all the best. Kate is the perfect person for the job, and I know we will see great things from *tBT* in the future.

As Kate takes over, I'd like to thank many of those who helped my job as editor these past 3 years. David Teisler, Director of Communications, and Stephanie Schwartz, Managing Editor, provided invaluable advice and help during my editorship. The journal simply wouldn't get produced without their hard work, and they have my profound gratitude. Executive Director M. J. Eimer was also an amazing resource, and our many phone meetings helped me immensely in coming up with new ideas for *tBT*.

Of course, my deepest thanks go to the members of the editorial board. Time and time again they went far beyond the call of duty, soliciting manuscripts, helping with last-minute editorial decisions, and generally making things run smoothly. I will always be in their debt.

I would also like to thank my editorial assistant, Melissa Them. As a former student turned colleague, Melissa was the person responsible for keeping track of all the various manuscripts and their stages in the editorial process (and for keeping track of me and my almost mythically poor organizational abilities). She has apparently not suffered enough, as she has agreed to stay on as editorial assistant for Kate, where I am sure she will help make the transition to a new editor as seamless as possible.

Finally, I would like to express my gratitude to you, the members of ABCT. My editorship was a wonderful experience, and I hope that each of you has gleaned some value from the journal these past 3 years. It has been a pleasure serving you, and I thank all of you for your submissions, comments, and support. ■

A Creative Approach to Teaching Anxiety Management Skills in Children

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Childhood anxiety disorders are common (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003), and not only persist over time (Keller et al., 1992), but also can lead to significant functional impairment and other related issues if not identified and treated (Safford, Kendall, Flannery-Schroeder, Webb, & Sommer, 2005). Extensive evidence supports the efficacy of cognitive behavioral therapy (CBT) for children with anxiety disorders (e.g., Hirschfeld-Becker et al., 2008; Kendall, 1994; Kendall et al., 1997), and treatment gains are maintained over long-term follow-up of up to 7 years (Kendall, Safford, Flannery-Schroeder, & Webb, 2004). Several specific cognitive behavioral treatment protocols have been developed and empirically evaluated, including, for example, the Coping Cat (Kendall, 1994), *Modular Cognitive-Behavioral Therapy for Childhood Anxiety Disorders* (Chorpita, 2007), and *Being Brave: A Program for Coping With Anxiety for Young Children and Their Parents* (Hirschfeld-Becker et al., 2008). Cognitive behavioral protocols, such as Kendall's Coping Cat, have been tested in children between the ages of 7 to 14 and are approximately 12 to 16 sessions in duration. Several separate parent sessions are included, and parents are briefly updated each session. Hirschfeld-Becker and colleagues' modification of the Coping Cat was developed for younger children, ages 4 to 7; this protocol includes up to 20 sessions, and the first 6 sessions are exclusively parent-focused.

Researchers and clinicians alike emphasize the need for dissemination of CBT, with the former advocating that clinicians implement empirically supported treatment protocols and the latter expressing a need to modify those same protocols to make them feasible in "the real world." Obstacles that can interfere with the viability of empirically supported treatment protocols in clinical settings can include the number of sessions required as well as the need to ad-

dress co-occurring challenges. Furthermore, opponents of CBT often cite this treatment approach as being too manualized and inflexible. While we wholeheartedly support the use of empirically supported treatments, we find that a "flexibility within fidelity" approach (Kendall, Gosch, Furr, & Sood, 2008) is crucial. Below, we present what we hope will (a) provide a useful and relevant framework for implementing cognitive behavioral techniques with children with anxiety symptoms and (b) serve as a model for blending evidence-based principles with clinician creativity to meet client needs.

While varying to some degree in terms of session length, frequency, and content, all CBT protocols for anxiety in children include a combination of the following core therapeutic techniques: deep breathing, progressive muscle relaxation, guided visual imagery, problem-solving skills, cognitive restructuring, positive self-statements, and graded exposure to anxiety-provoking stimuli and situations. Another important component of CBT for anxiety disorders is between-session practice of skills learned during therapy sessions, typically assigned as homework. We find the available CBT protocols to be quite useful; however, in our clinical practice, we find several shortcomings with the existent protocols, possibly because of how these manuals are developed and empirically tested. To demonstrate significant and meaningful results, researchers must maintain rigorous standards that may not always mimic the typical conditions in which the average clinician works. First, children who participate in the randomized controlled trials must meet criteria for one or more anxiety disorders, and the anxiety disorder(s) must be the primary presenting problem. In clinical practice, we often see children with subclinical anxiety symptoms, or anxiety symptoms that are secondary to behavioral or other primary concerns. For these children, we find that 12 to 16 sessions of CBT focused on anxiety

often is unnecessary, or not clinically indicated. It is possible that when anxiety is less entrenched (e.g., as is often the case in younger children), fewer sessions may be needed to promote mastery and effective implementation of CBT skills. Additionally, in our experience, children who live in less chaotic environments and have higher functioning parents may require fewer sessions if parents are able to follow through consistently with cognitive behavioral strategies. Thus, we have adapted cognitive behavioral techniques from empirically supported manuals into a briefer framework for treatment, which we hope to be more accessible and useful to children and families. Rather than following a prescribed set of steps or sessions to target anxiety symptoms, we aim to present children and families with a framework for making adaptive anxiety management a way of life.

In this paper, we describe a creative approach to the application of cognitive behavioral techniques for anxiety disorders in children. We do not present a session-by-session guide, but rather a novel application of CBT for addressing childhood anxiety in a creative and flexible manner, while still adhering to cognitive behavioral strategies that have been empirically supported to treat anxiety in children. We use the analogy of children accessing a remote control (e.g., for a television), to "change the channel" when anxiety occurs. This is presented as a quick, simple tool to facilitate utilization of active coping skills in anxious children. With the remote control approach, children learn at least a subset of the typical cognitive behavioral skills taught in the longer protocols, but in a developmentally sensitive manner that allows for selection of coping skills based on the needs and interests of the particular child. In our experience, similar to the Coping Cat and other general anxiety protocols, this technique works quite well for children with separation, generalized, and social anxiety symptoms ranging in age from very young (3 years) through early adolescence.

We find that most children, even children as young as 3, have had exposure to a remote control and understand how it functions (e.g., that pushing buttons leads to new pictures or a new channel); thus, this analogy is accessible to children and parents. "Change your channel" becomes the common language between therapist and child, and later parent and child, to coach the child to implement a specific coping skill. We introduce the concept of the anxiety remote control by telling children that they have the ability to change scary/worry

thoughts and feelings. We are careful not to promote avoidance of anxiety with either the child or the parent. Rather, this is a primitive introduction to the link between thoughts, feelings, and behaviors, designed to promote a sense of mastery over these domains by equipping children with tangible tools and strategies they can successfully use to target these three areas. Each of the various cognitive behavioral anxiety management skills corresponds to a “channel” on the child’s remote, and the child is encouraged to generate many channels, with the help of the clinician and parent. In the following paragraphs we will review how we typically implement treatment using this framework.

In this application of CBT, we view the parents as coaches who are essential in facilitating change in the child’s response to anxiety, and we view the child as an active copier. As parents must learn to structure their child’s environment in a way that reduces avoidance and promotes active coping with anxiety-provoking situations, we typically start with a session of psychoeducation with parents only. We first educate parents about the tripartite nature of anxiety, the role that avoidance plays in maintaining and exacerbating symptoms, and the importance of learning to manage anxiety symptoms over time. In subsequent sessions, we focus on teaching active coping skills to the child and parent(s). In the first child session, we introduce the concept of the anxiety remote control.

We typically devote one session to teaching children deep breathing and relaxation skills. With younger children, we often use bubble blowing to teach them to take controlled, deep breaths (Stolberg, 2002). Rather than exhaling quickly (“blowing hard”) and generating many small bubbles, which is the tendency of most children, they are encouraged to blow a single large bubble, which promotes breathing out in a slow, controlled manner. Not only is this method of teaching deep breathing quite enjoyable for children and their parents, but it also provides visual feedback that children are mastering the breathing technique (e.g., the bigger the bubble, the deeper, slower, and more controlled the breath). Parents are encouraged to practice this skill at home on a daily basis with their child. We usually recommend that parents provide children with a tangible reward for such practice because motivation for practicing is otherwise minimal because children are not actually anxious at the time that parents ask them to practice their new skill (Ollendick, Hagopian, & Huntzinger, 1991). With

younger children, we often recommend the use of a “picture menu” of four to six activities that the child enjoys, allowing the child to pick their reinforcer after each practice. After the child has learned this skill, parents are encouraged to prompt children to “blow a big bubble” without using actual bubble materials; we often refer to this as blowing “imaginary” or “pretend” bubbles. Children first are encouraged to do so in non-anxiety-provoking situations. There are numerous naturally occurring situations during which these skills can be practiced, such as car rides. Upon mastery of bubble blowing (without bubbles), parents are encouraged to prompt children to “blow bubbles” in anxiety-provoking situations (Christopher-Sen & Mortweet, 2003).

Many strategies for teaching children deep breathing exist. Other variations include the leaky tire technique, in which children are encouraged to take a deep breath and exhale making a continuous “s” sound for as long as possible. The automatic reaction after expelling all air is to take a deep, cleansing breath. Alternate strategies include blowing on a pinwheel to make it spin as long as possible and/or lying down and placing objects on the abdomen and chest, with the goal to get the abdominal object to rise with inhalation. For example, one child liked placing his small dog on his stomach and made a game of making the dog move up and down.

Another potentially helpful skill for children to learn is relaxation. In our experience, children, especially younger children, do not benefit much from progressive muscle relaxation, which requires devoted attention to the task for a prolonged period of time. We find it more useful for children to learn a quick method of tensing and relaxing the body. Several abbreviated exercises exist to teach the difference between tension and relaxation. One common exercise we use is the robot/ragdoll exercise in which children tighten their muscles and move rigidly “like a robot,” then alternately let their muscles go limp and loose “like a ragdoll.” Many variations on these themes exist, and clinicians are encouraged to find one that resonates with the child. The goal is to identify a concept or key word that prompts the child to alternate between muscle tightness and relaxation. Additional examples include raw and cooked spaghetti noodles or tortillas and tall and fall (e.g., stand up tall and straight and tight, with arms extended over head as far as possible versus falling back onto soft surface with loose, limp muscles).

Depending on time constraints and how quickly the aforementioned relaxation techniques are covered, we typically teach visual imagery, often in an additional session. Even very young children (as young as 3) are able to engage in a brief version of visual imagery, though younger children will need more prompting and help from parents. We instruct children to select a memory of a favorite place or experience (e.g., a favorite vacation or a special time with a parent), or an imaginary relaxing/calming place. Children close their eyes and imagine the scene, while clinicians initially, parents subsequently, ask questions about the sensory experiences in that scene (e.g., visual, auditory, gustatory, olfactory, and tactile) to help the child fully engage in the exercise. Use of a color photograph can help make the exercise more concrete and aid in practice efforts, as well. Younger children often choose to imagine a favorite cartoon show, and they are more likely to choose a nonrelaxing image compared to those typically chosen by adults. As long as children are able to redirect from their anxiety and worry, the particular type of image is insignificant. It is not unusual for children to use the visual image practiced during a session several times at home with his/her parents, but then switch to a different visual image and then not use the image that was practiced in session. The image that children use is not important; rather, it is teaching children that they have the ability to change their channels, to change what they are thinking, that is important. Children often choose to have several channels on their remote controls with different visual imagery scenes. For example, a 4-year-old with separation anxiety was taught visual imagery in one session and practiced several different images outside the session on a daily basis with her mother. When the child mastered the skill, her mother prompted her to change the channel with planned brief separations. Caution is warranted, however, that children do not change the channel in an attempt to avoid exposure exercises, given that avoidance defeats the purpose of exposures.

If clinically indicated, cognitive techniques can be incorporated into the remote control. Children can learn to use both positive self-statements and some cognitive restructuring, though these skills must be individually tailored to the developmental level of the particular child. Younger children may be able to benefit from using cheerleading statements such as, “I can do this,” and “This will be hard, but I’ve done it before” prior to confronting anxiety-pro-

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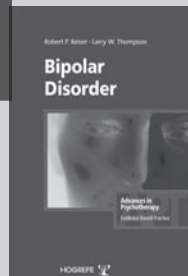
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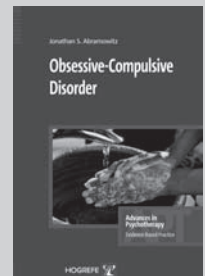
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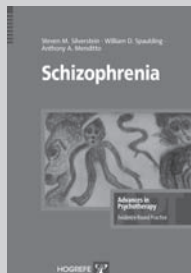
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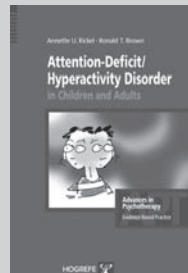
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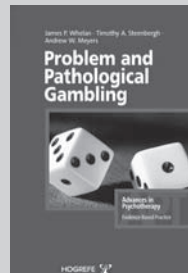
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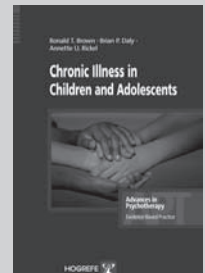
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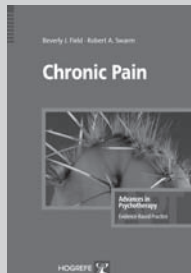
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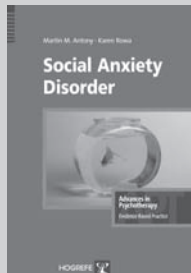
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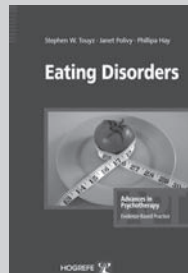
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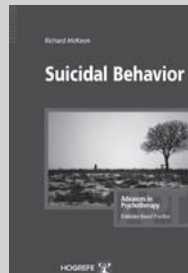
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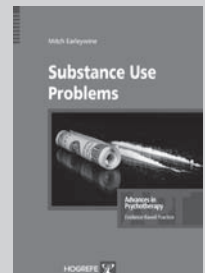
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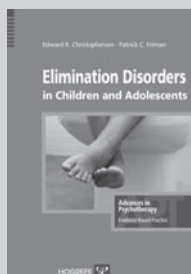
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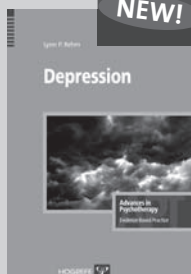
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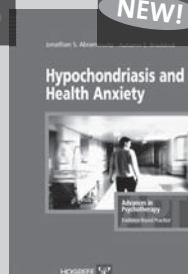
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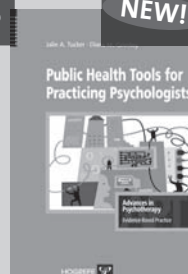
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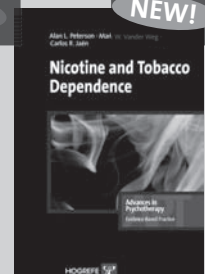
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voking situations/stimuli (and a prompting name can be given to that channel, such as the “cheerleading” or “coaching” channel). Older children can learn cognitive restructuring and often find it helpful to include a channel on their remote for “changing my thinking.” For example, a 9-year-old boy had a concern that his teacher was upset with him and learned to change his channel in school to reinterpret her behavior and think to himself, “She’s not acting any differently with me than she is with my classmates,” which reduced his anxiety.

Another channel that can be included on the remote control is a “facing my fears” channel, which essentially represents exposure exercises. This particular channel may be less important for younger children because parents primarily are responsible for setting up times for their children to practice changing their channels to manage anxiety. We anticipate that opportunities for both formal and naturalistic exposures will occur naturally in many cases, however, given that the emphasis in the remote control framework is education of the parents with regard to changing the environment in a way that reduces avoidance, while simultaneously encouraging children to change the channel to manage their anxiety (e.g., actively confront). Older children or those who are more symptomatic, however, may need formal exposures, and thus this channel may be useful for them.

The children with whom we have worked have devised other creative channels to include on the remote control. For example, some children choose to engage in a variety of activities in order to distract attention from anxiety and worry. These activities have included singing a song, reading a book, watching a television show, playing a game, or doing something active. Caution is necessary, however, so that children are not distracting themselves in order to avoid anxiety, which would defeat the purpose of using coping skills for anxiety. The idea is for the child to be able to move past nonproductive worry and rumination and to do something else, but not to avoid or escape from an anxiety-provoking situation.

The remote control can either be metaphorical or physical. Many children can utilize the change-the-channel strategy without using a physical remote control. Other children, however, prefer to create a replica of a remote control or to draw a picture of a remote control that is portable and can be kept with them throughout the day. Alternately, it can prove useful to create separate remotes for home and school, in

order to facilitate accessibility. For example, some children choose to create a physical replication of a remote control that resembles a television remote containing numbered channels as well as up and down buttons. The numbers can contain either verbal descriptions of the channels (e.g., “bubbles” or “coaching”) or pictures of the strategies (e.g., a beach for visual imagery) the child has available with which to manage his/her anxiety. While having a number of anxiety management skills at their disposal can be beneficial, we caution against children having too many channels, which can be overwhelming and can impede selection of an appropriate channel.

Similar to the empirically supported treatment manuals for anxiety, we believe that homework assignments are extremely important in order for children to change the channel most effectively. We typically teach one or two new skills per session, with homework assignments for daily practice in non-anxiety-provoking situations until skills are mastered. We encourage parents of young children to practice with the child for approximately 3 to 5 minutes per day. Older children may monitor their own practice time, but are still encouraged to practice for several minutes daily. Children then practice implementing skills in anxiety-provoking situations. It is extremely important that parents learn and practice these skills as well, in order to promote generalization outside of therapy. Furthermore, parents may need to prompt children to change the channel, particularly when this technique is first being implemented.

We believe that there are a number of advantages to the remote control analogy. First, it provides a comprehensive framework for managing anxiety with a common language that children and parents can use to prompt the implementation of specific coping skills. It also promotes the idea that thoughts, feelings, and behaviors can be changed, just like the picture on a television screen. Another advantage of this framework is the flexibility it affords clinicians. Our strategy does not require any specific training, beyond training in cognitive-behavioral therapy, for clinicians. The remote control is not based on a manual; rather, it is based on general cognitive behavioral strategies—thus, there are no requirements for number of sessions or certain techniques that children must learn. Instead, clinicians, children, and families focus on particular coping skills that are most helpful rather than being bound by a set treatment protocol. Additionally, learning to use the remote control is not time intensive. A major ad-

vantage is that the idea of (as well as physical representation of) the remote control is portable. A child can access the remote control in any situation, and under any circumstances. Finally, this approach may be particularly useful for children who present with anxiety and other issues because additional coping skills that may be helpful for comorbid symptoms could be incorporated into the same framework (e.g., a “pleasant events” channel for depression, “time-out” channel for excessive anger, a “social problem-solving” channel, etc.).

A note of caution is necessary when using the remote control framework for anxiety management. It is very important that children are not encouraged to change the channel in an attempt to avoid exposure exercises, which would undermine the purpose of exposures, as well as interfere with active engagement in these exercises. If parents understand the premise of exposure and the role that avoidance plays in maintaining anxiety and are confident that their children possess skills to manage anxiety (e.g., can successfully change their channels to implement adaptive coping skills), they seem to be more willing to seek out or construct exposure opportunities for their children. We think of changing the channel as helping children cope with anticipatory worry and rumination, or with coping after the event, or exposure exercise. Also, clinical experience has taught us that children can misuse the remote at times. For example, one 9-year-old boy attempted to mute his teacher in class! When he was informed that using the mute button was not appropriate, he attempted to fast forward the class to recess.

Case Example

A 9-year-old boy with generalized anxiety was treated with CBT using the remote control framework. He struggled with social and academic worries and had a number of somatic complaints, which led to him asking to go to the nurse’s office and missing a significant amount of class time. The severity of anxiety symptoms increased dramatically on the drive to school in the mornings. He selected a number of different coping skills for his channels, including taking deep breaths, positive self-statements, changing his thinking, visual imagery and singing songs from his favorite movie (*High School Musical*). When he became anxious on the drive to school in the mornings, he often changed his channel to sing *High School Musical* songs, which would improve his mood and made his transition

to school easier. This strategy prevented him from ruminating on the way to school, and also prevented him from seeking reassurance from his mother as well as expressing somatic complaints. He also frequently selected the positive coping thoughts channel, which cued him to think to himself, "I can get through this" and "I've done this before and it was fine." He changed his channel numerous times in class when he worried about upsetting his teacher and found the changing his thinking channel to be helpful in this setting.

In conclusion, we have described a flexible, creative approach to the application of cognitive behavioral techniques for anxiety disorders in children. We presented the analogy of using a remote control to "change the channel" when anxiety occurs, which serves as a model for blending evidence-based principles with clinician creativity to meet client needs. We view parents as crucial in this framework, such that they serve as coaches who facilitate change in the child's response to anxiety. Child engagement is extremely important and we encourage clinicians to be as creative as possible in order to facilitate their involvement. We identified a number of advantages and disadvantages to this

approach, but we believe that the benefits outweigh any pitfalls of this framework.

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The 2010 NIMH Professional Coalition for Research Progress Report

Brook A. Marcks, *Ohio University, ABCT Research Facilitation Committee Member*

The sixth annual Professional Coalition for Research Progress meeting for the National Institute of Mental Health (NIMH) was held on April 23, 2010, in Washington, DC. The goals of the meeting were to: (a) discuss current and future priorities for the NIMH; (b) hear about recent mental health research advances; (c) allow representatives from professional organizations to share views and opinions with the NIMH Director, Dr. Thomas Insel, and other senior NIMH staff; and (d) network with colleagues from other organizations. Representatives from 25 to 30 professional organizations with an interest in NIMH research along with NIMH staff attended the meeting. Below is a summary of the topics discussed by the invited speakers and Coalition members:

The State of the NIMH

Dr. Insel provided an update on the state of the NIMH as well as an overview of budgetary and other issues facing the NIMH. In the past year, the National Institute of Health (NIH) has come under the directorship of Francis Collins, M.D., Ph.D. Under this new leadership, the following major opportunities for NIH research have been set forth:

1. Applying high throughput technologies to understand fundamental biology, and to uncover the causes of specific diseases;
2. Translating basic science discoveries into new and better treatments;
3. Putting science to work for the benefit of health care reform;
4. Encouraging a greater focus on global health; and
5. Reinvigorating and empowering the biomedical research community.

Dr. Insel briefly discussed the NIMH incentives, including genomics of mental disorders; new drug development; mental health economics; research on disparities and global mental health; and Bio-

behavioral Research Awards for Innovative New Scientists (BRAINS) and Exceptional, Unconventional Research Enabling Knowledge Acceleration (EUREKA) awards along with new and early state investigator policies. The following major objectives of the NIMH's strategic plan were reviewed: (a) promote discovery in brain and behavioral sciences to fuel research on the causes of mental disorders; (b) chart mental illness trajectories to determine when, where, and how to intervene; (c) develop new and better interventions that incorporate the diverse needs and circumstances of people with mental illnesses; and (d) strengthen the public health impact of NIMH-supported research.

The American Recovery and Reinvestment Act (ARRA) and budgetary issues were discussed. Dr. Insel reported that NIMH received \$366 million from ARRA, much of which went to new investigators and first-time institutions. This money was used to expand the payline; fund supplements, challenge grants, grand opportunities grants, and grants submitted in response to the autism request for application; fund faculty recruitment initiative; and supplement contracts and support the NIMH Division of Intramural Research Programs (to see grants funded by ARRA: <http://report.nih.gov/recovery/arragrants.cfm>). Dr. Insel discussed potential aftereffects of ARRA, including a lower success rate, many unsuccessful applications being re-submitted in 2010, and both unsuccessful and successful applications being submitted in 2011. The presidential budget for FY2010 included a 2.7% increase for the NIMH, with total funding of \$1.489 billion. Dr. Insel indicated that this budget should allow funding of 15% to 20% of new and competing applications. The FY2011 budget request for the NIMH has been submitted to Congress; it includes a 3.4% increase above FY2010 level to \$1.540 billion. Dr. Insel discussed 2010 priorities, including funding for the BRAINS program, which targets innovative and groundbreaking research from early-stage investigators to explore complex mecha-

nisms underlying mental disorders or novel treatments and prevention strategies; research on sensitive periods in neurodevelopment; state policy laboratories; and the Human Connectome project.

Dr. Insel reviewed issues currently facing the NIMH. A major issue is whether the NIMH should be more involved in drug development, given that the pharmaceutical industry is not heavily investing in (or developing) new psychiatric medications. Dr. Insel discussed the pros (e.g., public health need, scientific opportunity, congressional mandate) and cons (e.g., high costs, strong likelihood of failure) of this, with him noting that the current plan is to identify areas where the NIMH can catalyze drug discovery and development. Another issue facing the NIMH is charges of financial conflict of interest (COI) against researchers and the resulting loss of public trust. Dr. Insel indicated that NIMH is taking this issue very seriously and has responded by increasing scrutiny of grants and researchers funded by the NIMH, as well as setting new regulations and COI training requirements. Issues related to the Patient Protection and Affordable Care Act (HR 3590) were also discussed, including the Cures Acceleration Network, which is a new network dedicated to advancing science from the laboratory into practice; comparative effectiveness research and the development of the Patient-Centered Outcomes Research Institute (PCORI); the Melanie Blocker-Stokes Postpartum Depression Act; and development of Centers of Excellence for Depression.

New Opportunities for Behavioral and Social Science Research at NIH

Dr. Richard Hodes, Director of the National Institute on Aging, shared information on the Basic Behavioral and Social Science Opportunity Network (OppNet), which is a trans-NIH initiative launched by Dr. Francis Collins in November 2009. The purpose of OppNet is to expand funding of basic behavioral and social science research (b-BSSR). The b-BSSR field examines mechanisms and processes that influence behavior at the individual, group, community, and population level. This research can lead to novel approaches for reducing risky behaviors and improving healthy practices. Given that all NIH Institutes and Centers (ICs) share the b-BSSR mission, 24 ICs and five programs within the Office of the Director will integrate existing NIH efforts, target research challenges that may be better met collectively, and collaborate on new ini-

tiatives in complementary areas. OppNet will develop a plan for multi-year programs across ICs to advance high priority topics within b-BSSR. The first year of OppNet activities has been funded with \$10 million from the ARRA, and starting in FY2011, OppNet will be supported by NIH's pool of common funds. Coalition members indicated that they were pleased with the increased emphasis on social science and behavior change research within the NIH. The importance of dissemination of the findings to the field was also discussed.

NIH Human Connectome Project

Dr. Mike Huerta, Program Lead for the NIH Human Connectome Project, provided an overview of the project. The Human Connectome Project (HCP) is a large-scale, transformative initiative that is part of the NIH Blueprint for Neuroscience Research. The purpose of the HCP is to systematically and comprehensively collect, characterize, and share data about the structural and functional connectivity of the human brain. Dr. Huerta indicated that the project will utilize state-of-the-art brain imaging tools and techniques (e.g., resting state fMRI, high angular resolution diffusion imaging with magnetic resonance, electrophysiology and magnetoencephalography combined with fMRI) to examine the connectivity of the healthy adult human brain. In addition to collecting brain imaging data from hundreds of subjects, the HCP will collect DNA samples, demographic information, and behavioral data. There will be a focus on rapid, user-friendly dissemination of HCP data, models, and tools to the research community. Dr. Huerta reported that the implementation of the HCP will cost \$36 million over a 5-year period. The project will open up new lines of inquiry for human neuroscience. Furthermore, it will provide insight on how brain connectivity is influenced by genetics and the environment, and in turn how individual differences in connectivity relate to differences in behavior.

Economic Perspectives on Mental Health Research

Dr. Michael Schoenbaum, Senior Advisor in the Division of Services and Intervention Research at the NIMH, presented an economic perspective to conducting mental health research. His research focuses on the costs and benefits of interventions to improve health, evaluated from the perspectives of patients, providers, payers, and society. The key margins for im-

proving mental health care are to: (a) increase efficacy of treatment; and (b) enhance treatment fidelity, including targeting effectiveness, coverage and access issues, treatment adherence, and personalization of treatment. He discussed the use of effectiveness trials, training grants, policy evaluations, and dissemination research. Dr. Schoenbaum demonstrated how data on mental health burden, service use and costs, and intervention opportunities could be used in Institute decision-making. The goal of such work is to maximize the public health impact of NIMH-supported research.

Novel Therapeutics and Biomarkers of Response for Mood Disorders

Dr. Carlos Zarate, Chief of Experimental Therapeutics, Mood, and Anxiety Disorders Program, Division of Intramural Research Programs at the NIMH, presented research on novel therapeutics for treatment-resistant mood disorders. He discussed the importance of identifying pharmacological agents with more rapid antidepressant effects. Dr. Zarate shared results from a randomized trial of an N-methyl-D-aspartic acid (NMDA) antagonist, ketamine, for treatment resistant depression. The study found rapid and robust antidepressant effects from a single intravenous dose of ketamine, with 71% meeting response and 29% remission criteria the day following the infusion. These results are promising, given that the sample was treatment-resistant and that traditional antidepressants typically take several weeks to achieve such response rates. Ketamine has also been tested in bipolar disorder, with similar findings. Dr. Zarate indicated that this research is being used to identify biomarkers of treatment response. He briefly discussed studies implicating the anterior cingulate cortex (ACC) in the pathophysiology of depression and that activity in the ACC could be used to identify subgroups of individuals who will experience a rapid antidepressant response to ketamine. Dr. Zarate indicated that additional work is underway to develop ketamine-like compounds with fewer side effects and to determine if other compounds could be used to maintain the antidepressant effects after an initial dosage of ketamine.

The Climate for Research Support

Mr. John Porter, Chair of Research!America and former member of the U.S. Congress, discussed the current climate for research support. He shared his

past experience serving on the Appropriations Committee and provided insight on the appropriation process. Given the current economic time, there are competing priorities within our nation, which make increasing funding for biomedical research challenging. Despite this, he reported that the FY2011 budget request submitted to Congress included a 3.4% increase above the FY2010 level of funding for the NIMH. Although this increase sounds promising, Mr. Porter stated that given inflation, the requested budget is about comparable to the current level of funding. Mr. Porter encouraged coalition members and the public in general to advocate for making research a higher national priority. He provided examples of ways to do this, including being cognizant of where political candidates and elected officials stand on health care issues and research, volunteering to serve on political candidates' scientific advisory committees, and encouraging researchers and scientists to run for office. Additional suggestions for advocacy and action can be found on the Research!America website (<http://www.researchamerica.org/>).

Summary and Closing Remarks

Dr. Insel briefly summarized the topics discussed at the annual meeting and provided closing remarks. Coalition members had the opportunity to ask Dr. Insel any remaining questions. Dr. Insel thanked the invited speakers and coalition members for participating in the meeting and providing useful feedback. Additional information regarding the meeting can be found on the following NIMH website: www.nimh.nih.gov/outreach/coalition/coalition-meeting-april-23-2010/professional-coalition-for-research-progress-meeting-summary.shtml

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Dr. William Spaulding Awarded the Mike S. Neale Award From the American Psychological Association's Division of Psychologists in Public Service and the Schizophrenia SIG's Trailblazer Award at ABCT's 2010 Convention

Felice Reddy and Nicholas R. Forand, *University of Pennsylvania*

William D. Spaulding, Ph.D., professor of psychology at the University of Nebraska–Lincoln and ABCT member, was awarded the first ever Mike S. Neale Award from the American Psychological Association's Division of Psychologists in Public Service at the APA Convention in San Diego in August. The Mike S. Neale Award honors those who have shown commitment to serving individuals with severe and persistent mental illness, and to service, advocacy and mentorship. Dr. Spaulding was recognized for his “outstanding career serving individuals with severe and persistent mental illnesses.” He was also awarded the ABCT Schizophrenia Special Interest Group's Trailblazer Award for his innovations in service for people with serious mental illness (SMI) at ABCT's 2010 Convention; this award recognizes pioneers in the areas of treatment and rehabilitation. The two awards are in recognition of Dr. Spaulding's contributions to the dissemination and implementation of effective treatments for persons with SMI.

Dr. Spaulding's efforts in treatment outcome research, program and service-system development, and public advocacy have helped change the ways people conceptualize and treat these most severe and debilitating psychiatric disorders. In 1982, Dr. Spaulding and colleagues founded the Community Transition Program (CTP), a state-of-the-art psychiatric rehabilitation program housed within an otherwise unreformed state psychiatric institution. The empirical evidence quickly accumulated to attest to the program's effectiveness and similarly modeled programs were soon opened around the country (Sullivan,

Richardson, & Spaulding, 1991). The CTP served as a springboard for much of Dr. Spaulding's innovations and activism.

The treatment program at the CTP was a forerunner of the change that would take place in the greater research community: that contrary to conventional beliefs, persons with schizophrenia can be effectively treated with cognitive and behavioral interventions, and that these interventions lead to measureable functional change. These innovative treatments were part of the CTP's standard rehabilitation model many years before they became recognized as an evidence-based practice (Lehman et al., 2004). In the 1990s, Dr. Spaulding's lab conducted the first large-scale NIMH-funded clinical trial of a manual-based neuropsychologically oriented cognitive therapy for schizophrenia (Spaulding, Reed, Sullivan, Richardson, & Weiler, 1999). The trial showed that, when added to comprehensive psychiatric rehabilitation, cognitive therapy produced better outcomes in interpersonal problem-solving skills and attentional processing than supportive group therapy. This finding demonstrated that targeting cognitive impairments in persons with schizophrenia spectrum disorders can enhance patients' response to standard psychiatric rehabilitation. Dr. Spaulding's research has evolved to highlight the implications of cognitive treatment for the social competence impairments of schizophrenia and the relationship between socio- and neurocognitive functioning (Spaulding & Poland, 2001).

Dr. Spaulding was a member of the American Psychological Association's Committee for the Advancement of Professional Practice Task Force on Serious

Mental Illness and Serious Emotional Disturbance from 2000 to 2007, and served as the chair for the final 2 years. His contributions include work on the first proposal for an SMI proficiency designation and serving as the primary author of APA's official policy on outpatient commitment. In 2002, he received the APA's Karl F. Heiser Award for Advocacy for challenging the institutional psychiatry establishment in Nebraska state hospitals, and successfully getting Medical Staff membership for psychologists. Dr. Spaulding supplements these efforts with activism on the state level. He served on a state-level task force charged with developing service-related policy for people with SMI in Nebraska, he was the primary author of Nebraska's Best Practices for SMI document, and he is currently the President-Elect of the Nebraska Psychological Association. Dr. Spaulding is also a member of a World Health Organization work group advocating for a more functionally oriented, recovery-inspired and systems-friendly diagnostic system for psychotic disorders, in the context of the anticipated update of the International Classification of Disease (ICD). This work is an opportunity to foster global appreciation of the contribution of psychologists to research, treatment development, clinical practice and administration leadership in areas relevant to SMI.

Most recently, Dr. Spaulding initiated an innovative project that integrates the state-of-the-science in psychiatric rehabilitation and advanced informatics; he is in the process of developing an empirically based technological tool to help facilitate clinical decision making. In 2007 he was awarded a NIMH research infrastructure grant to create a clinical informatics system that will provide information and recommendations to human decision makers, bringing advanced analytical techniques to clinical rehabilitation data. This project is a new and creative way that Dr. Spaulding is working to bring together experts from a variety of fields to improve clinical treatment within psychiatric rehabilitation.

Dr. Spaulding's work has demonstrated that comprehensive cognitive and behavioral treatments for people with SMI are feasible and effective, and that their widespread implementation can be achieved through political and social activism. That this comprehensive approach to care is embodied in one individual is impressive and exceptional in the field of clinical psychology. Dr. Spaulding's integrative approach to the treatment of SMI continues to be a model and inspiration for his students, col-

leagues, and all those involved in the care of this challenging population.

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Web Corner

Getting By With a Little Help From Our Friends

Kristina Coop Gordon, *University of Tennessee*

Over the course of the last several years, ABCT has been making a concerted effort to upgrade our website into the premiere website for anyone interested in the cognitive and behavioral therapies. In addition, these upgrades are designed to make the site more user-friendly and directly applicable to science, teaching, and practice. To that end, the editorial staff of the website and other associated ABCT members have been collecting and posting relevant articles and links that can help ABCT members' professional lives run more smoothly. By sharing our resources, information, and what we've learned from our experiences, collectively we can make our lives a little easier.

Along these lines, I want to draw your attention to the section for ABCT members. This section of the website is replete with a number of useful gems. For example, you can watch a podcast in which Lata McGinn, Michelle Newman, Diane Chambless, Edna Foa, Robin Jarrett, Marsha Linehan, Barbara McCrady, Susan


Mineka, and Rosemary Nelson-Gray, discuss their adventures in overcoming the glass ceiling. Other podcasts allow you to hear ABCT leaders explain ways that you can become more involved in ABCT. One link explicitly provides a list of the best professional advice ABCT members have ever received, which was compiled from a recent popular listserv discussion. These are but a few of the offerings available on this section of the website. I haven't even mentioned all the useful convention links, membership forms, and other helpful resources. Check it out and benefit from the collective wisdom of your fellow members. www.abct.org

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Call

for Award Nominations

The ABCT Awards and Recognition Committee, chaired by Shelley Robbins of Holy Family University, is pleased to announce the 2011 awards program. Nominations are requested in all categories listed below. Please see the specific nomination instructions in each category.

Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Outstanding Contribution by an Individual for Clinical Activities

Awarded to members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Past recipients of this award include Albert Ellis, Marsha Linehan, Marvin Goldfried, Frank Datillio, and Jacqueline Persons. Complete the on-line nomination form at www.abct.org. Then e-mail the completed form to srobbins@holysfamily.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Clinician, 305 Seventh Ave., New York, NY 10001.

Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Past recipients of this award include the Clinical Psychology Program at SUNY Binghamton, The May Institute, the Program in Combined Clinical and School Psychology at Hofstra University, and the Doctoral Program in Clinical Psychology at SUNY Albany. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to srobbins@holysfamily.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Ave., New York, NY 10001.

Student Dissertation Awards:

- Virginia A. Roswell Student Dissertation Award (\$1,000)
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- John R. Z. Abela Student Dissertation Award (\$500)

Each award will be given to one student based on his/her doctoral dissertation proposal. The research should be relevant to behavior therapy. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligible candidates for this award should be student members who have already had their dissertation proposal approved and are investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor may complete the nomination. Self-nominations are also accepted. Nominations must be accompanied by a letter of recommendation from the dissertation advisor. Please complete the on-line nomination form at www.abct.org. Then e-

mail the completed form to srobbins@holysfamily.edu. Please include an e-mail address for both the student and the dissertation advisor. Also, mail a hard copy of your submission to ABCT, Student Dissertation Awards, 305 Seventh Ave., NY, NY 10001.

Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include Jon Kabat-Zinn, Nora Volkow, John Allen, Anne Fletcher, Jack Gorman, Art Dykstra, Michael Davis, and Paul Ekman. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to srobbins@holysfamily.edu. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001.

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Questions? Contact: Shelley Robbins, Ph.D., Chair, ABCT Awards & Recognition Committee; e-mail: srobbins@holysfamily.edu

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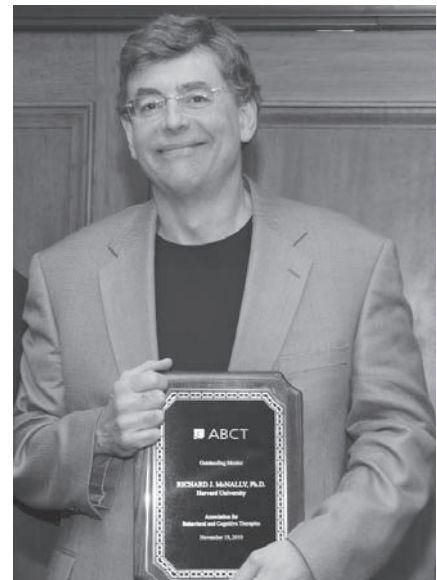
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Top left: President Frank Andrasik congratulating **Outstanding Researcher** Steven D. Hollon; *top right:* Richard McNally, **Outstanding Mentor**; *bottom left:* G. Alan Marlatt, **Lifetime Achievement**; *bottom right:* Lee Ward Henderson (center), receiving the **Distinguished Friend to Behavior Therapy Award** on behalf of Paul Ekman (pictured with Frank Andrasik, President, and Shelly Robbins, Awards & Recognition Chair)

Elsie Ramos Poster Award Winners

Brooke Marie Huibregtse, Abby Jenkins, and David Hillel Rosmarin



Margaret Sibley, Virginia Roswell Dissertation; Shari Steinman, Leonard Krasner Student Dissertation; Matthew T. Tull, President's New Researcher



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

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

Information for submitting abstracts will be on ABCT's web site, www.abct.org, beginning in mid-January. The on-line submission portal will open in early February and the deadline for submission is March 2, 2011.

The deadline for submission is March 2, 2011

Additional information can be found after January 1 at www.abct.org

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Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions.

Please complete, sign, and send this nomination form to Raymond DiGiuseppe, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001. Signed forms can be also be send via fax: 212-647-1865 or via email to membership@abct.org (PDF attachment).