

the Behavior Therapist

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President's Message

Not Your Usual Strategic Planning

*Debra A. Hope, University of Nebraska,
Lincoln*



As an academic, a call for “strategic planning” elicits a big yawn from me. Too often the outcome is a beautifully crafted document that grew out of many hours of discussion . . . that ends up in an administrator’s file drawer. Only occasionally have the promised new resources been forthcoming to achieve the lofty goals set forth in the plan. I consider myself fortunate to be in a terrific Department of Psychology with great leadership that protects us from the more onerous aspects of this process. To our own surprise, my colleagues and I have, upon occasion, used the planning process to make some small positive internal reallocations that have been useful. Mostly though, “strategic planning” makes me roll my eyes and conclude that something I would rather be doing is not going to get done right away.

Fortunately, ABCT has a very different tradition of strategic planning. Once every 3 years, the elected Board members, coordinators, central office staff, and invited consultants come together for a 3-day retreat to build a strategic plan for the next 3 years. I was on the Board and participated in the last retreat in Philadelphia in 2007. I found our discussions to be productive, stimulating, and inspiring. In Philadelphia we came together as a team to bring our collective vision to identify where ABCT should go over the next 3 to 4 years. Since then, I have seen your leadership refer to the strategic plan over and over again as we set annual priorities and make decisions.

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Published by the Association for
Behavioral and Cognitive Therapies
305 Seventh Avenue - 16th Floor
New York, NY 10001-6008
(212) 647-1890/Fax: (212) 647-1865
www.abct.org

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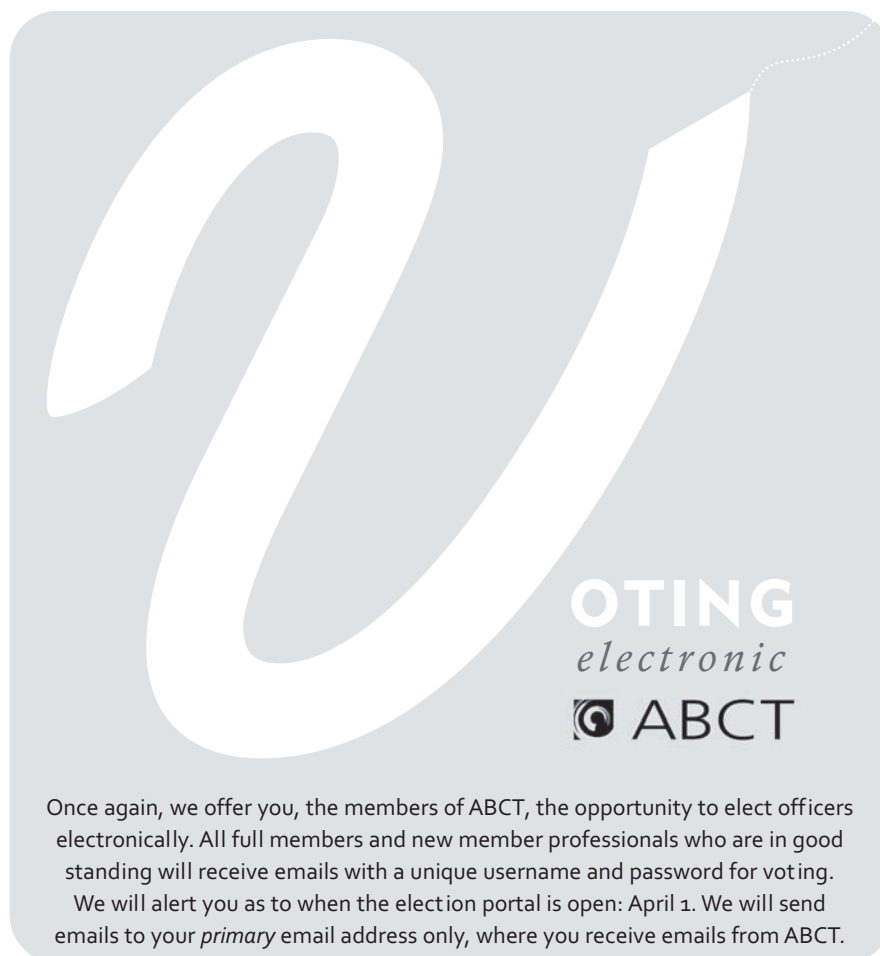
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Subscription information: *the Behavior Therapist* is
published in 8 issues per year. It is provided free to
ABCT members. Nonmember subscriptions are
available at \$40.00 per year (+\$32.00 airmail
postage outside North America).

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The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.

- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.

- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.

- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a **Copyright Transfer Form** (a form is printed on p. 35 of the February 2011 issue of *tBT*, or download a form from our website): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor at gunthert@american.edu. Please include the phrase *tBT submission* and the author's last name (e.g., *tBT Submission - Smith et al.*) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

[continued from p. 37]

We use the plan to keep us focused and moving in one direction, rather than changing our priorities with each new presidency. Not only do we get more done, the strategic plan helps us be fiscally responsible as we follow through on initial investments of time and resources.

There were several concrete outcomes of the 2007 retreat. One outcome was our redesigned website, including the many new and improved resources for members and the public. We made a commitment in Philadelphia to ask committees to focus on providing content for the web and they have responded again and again with terrific material. We carefully considered, and ultimately decided not to pursue, getting into the business of credentialing behavior therapists as a way to promote CBT to third-party payers and the public. That discussion has evolved into our current focus on dissemination, a topic at the next retreat. We decided to collaborate with Boston University and Boston University School of Social Work to sponsor the successful 2010 World Congress of Behavioral and Cognitive Therapies. Another focus of the last retreat involved initiatives to provide more services to members and grow our membership. Although less apparent to the average member, since Philadelphia we have fully implemented our policies and procedures manual. The manual has proven to be a good resource that members of governance and staff turn to often and, more importantly, update as needed. The policies and procedures help keep the Board focused on policy rather than micromanaging small decisions best left to our committees and staff.

This May, the Board and staff will come together in the Washington, DC, area to develop the strategic plan for the next 3 years. (We waited 4 years between retreats this time so our hosting of the World Congress and the retreat would not fall in the same year.) The Board is already discussing the retreat agenda. The major topics on the agenda this year include:

- Growing the next generation of leadership in ABCT;
- Preparing for the future of technology (web, social media, etc.);
- Identifying the next step in dissemination of CBT.

Leadership

Future success for our association will rely on the next generation of leaders. As we

approach the celebration of our 50th anniversary, we need to attend to who will lead our committees and run for Board positions in the coming years. We are more complex than we were even 10 years ago and we want to insure that we have a new generation that feels committed to ABCT and has the skills to lead in the decades ahead. We will consider what skills our future leaders need. We also plan to discuss whether there are communication strategies or structural changes that will facilitate growing leaders up through the levels of governance. Under the leadership of Ray DiGiuseppe, our Committee on Leadership and Elections has begun to explore these issues. At the retreat, we will set some goals and consider where it falls in our priorities to guide decisions regarding time and financial resource allocations.

Technology

The rapid pace of technological change offers ABCT challenges and opportunities, but we must make prudent decisions. At the retreat we plan to discuss where technology and social media may be going so that we can actively participate rather than play catch-up. We have entered this arena already with our improved website, free online journal access for members, and Facebook presence. However, we want to be prepared to meet the expectations of our members for services that could be available in the coming years. Also, some technologies offer opportunities to meet our goals for dissemination, leadership development, an enhanced convention experience, and providing a professional home for our members. Technology does not come cheap and we need to consider both the equipment/services costs as well as supporting sufficient staff time and expertise for these coming changes. I hope that we will leave the retreat with a clear plan of where we are going with new media and where we should make strategic investments.

Dissemination

Under Frank Andrasik's leadership, the Board embarked on a serious discussion of dissemination of CBT. Certainly this has been on the ABCT agenda for many years. As an association and as individual members, we have made great strides in giving away CBT. However, in the past year the Board has honed in on some specific actions to strengthen our leadership role in *advance(ing) behavior therapy* as we called ourselves to do for so many years. We currently are working on a project on training cur-

riculum that you will hear more about in a future issue of *the Behavior Therapist*. At the retreat, we will consider a second concurrent dissemination action plan. Discussions to date have yielded some potential directions for us, including improving dissemination to practicing mental health providers. Our workshops at the annual convention are very popular but there is growing awareness that such workshops have little impact on practice. One direction might be to develop mechanisms for follow-up training or supervision. Another possibility might be to use online resources or videoconferencing to make our training more broadly available, again perhaps with subsequent supervision. We have also discussed taking a different path first, focusing on increasing public awareness of CBT and/or promoting CBT with third-party payers and policymakers. Here I am reflecting a few nuggets from the Board's conversations. At the retreat we intend to open up the discussion and brainstorm the next step in dissemination.

These discussions will happen in the context of reviewing our mission statement and hearing an updated financial report. I am hoping to facilitate a process in which we tap into our creativity with unfettered brainstorming, and then, as the research on problem solving tells us, begin to narrow possibilities and consider practical issues. The retreat will be successful, in my view, if we set some longer-term goals and begin to identify the steps needed to achieve those goals. As you can probably tell, I am not yawning over this one—I am looking forward to our strategic planning retreat.

Your Ideas

Reading this article may have sparked ideas in your own mind about directions in which ABCT should be moving. Your thoughts might be related to one of the topics I mentioned above or to something else entirely. We are still considering several other topics that are less well developed than the three I mentioned at this point. Please e-mail me or any other Board member if you want to contribute ideas to our retreat planning process. We will definitely put all ideas into the mix.

...

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On the Situational Variability of Social Competence and the Stability of Traitlike Conceptions

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Jessica Fales, *University of Maine*

That behavior is situation specific is a hallmark assumption of behavioral assessment. It is in our roots. Though situational specificity is embedded within the philosophical foundations of behavioral assessment, including empiricism, functionalism, and contextualism (Nelson & Hayes, 1986), Mischel (1968) is often credited with the concept (e.g., Eysenck & Martin, 1987; Nelson & Hayes, 1979; Ollendick, Alvarez, & Greene, 2004). Indeed, some have even attributed the decline of personality assessment and the subsequent rise of behavioral assessment to him (Weiner & Greene, 2008; Zuckerman, 1979).

Mischel's 1968 book, *Personality and Assessment*, threatened the core assumption of the traditional personality theory paradigm: that behavior was a function of stable dispositional characteristics and, as a result, should be relatively stable across both time and situation. It was exactly that stability that had made the assessment of personality characteristics so worthwhile. Mischel questioned this assumption and presented a review of the extant empirical evidence in support of instability. One of many studies he cited was an investigation by Dudycha (1936) that found a mean cross-situational correlation coefficient of .19 for thousands of punctuality observations in a sample of college students. Mischel concluded, "The assessor who tries to predict the future without detailed information about the exact environmental conditions influencing the individual's criterion behavior may be more engaged in the process of hoping than of predicting. . . . Predictions should be most accurate when the past situations in which the predictor behavior was sampled are

most similar to the situations at which predictions about future behavior are aimed" (Mischel, p. 140). This conclusion was embraced by the behaviorists, but sternly criticized by others, some of whom offered alternative methodological approaches thought to better address the question of cross-situational consistency and perhaps preserve personality theory in the process (e.g., Bem & Allen, 1974; Epstein, 1979). Regardless of the many strong responses, it was clear that the role of situation in determining behavior could no longer be ignored.

Resilience of Traitlike Conceptions of Social Competence

Almost 15 years after Mischel's (1968) seeming death blow, however, traitlike perspectives continued to influence behavioral assessors. In his seminal analysis of the social skills literature published in *Behavioral Assessment*, McFall (1982) asserted that, despite its many critics, the personality trait model of social skills continued to dominate the field. He suggested that although most behavioral assessors were aware of its serious problems and would probably deny its adoption, most uses of the social skills concept betrayed a traitlike perspective.

In this paper, we revisit McFall's (1982) situation-based critique of traitlike conceptions of social competence.¹ Few constructs match the overarching nature of social competence and its widespread implications for psychological adjustment. Social skills deficits and problematic social relationships contribute to a full range of more normative adjustment difficulties, and clinical disorders. Indeed, almost half of the Axis I clinical

syndromes and nearly all of the Axis II personality disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*, American Psychiatric Association, 2000) have problematic social functioning listed as a possible criterion, and the majority of the remaining disorders have important social ramifications (Campbell, Hansen, & Nangle, 2010; Hansen, Giacoletti, & Nangle, 1995). As such, social interventions are applied broadly and are particularly central in treatments for anger, aggression, social anxiety, autism, and other developmental disabilities, schizophrenia, and substance abuse (Nangle, Hansen, et al., 2010).

In the 30 years since the publication of McFall's (1982) often-cited review, there has been some progress in incorporating the notion of situational variability. Many newer models of social competence focus on situation, though a number of these also integrate person factors that may also exert an influence (e.g., Felner, Lease, & Phillips, 1990; Rose-Krasnor, 1997; see Nangle, Grover, Holleb, Cassano, & Fales, 2010, for a review). Studies by Dodge and colleagues have also convincingly demonstrated the importance of situation in assessing children's social performance (e.g., Dodge, Laird, Lochman, & Zelli, 2002; Dodge, McClaskey, & Feldman, 1985; Dodge, Pettit, McClaskey, & Brown, 1986). Interestingly, these studies have shown that the social deficits of rejected children are most evident in a relatively restricted, rather than a broad, range of social situations. In keeping with an idiographic perspective, the rejected children also evidenced increased "within-child" variability across the assessed situations compared to their nonrejected classmates (Dodge et al., 1985).

Despite these signs of progress, however, we argue that McFall's contention that behavioral assessors continue, though perhaps unwittingly, to embrace a traitlike perspective in their use of the construct still holds today. As in the original review, many of our examples are psychometric in nature. Importantly, in the spirit of others suggesting rapprochement in the long-running battle between traditional and behavioral assessment (Barrios & Hartmann, 1986; Foster & Cone, 1995), we simply call for a closer match between the assessor's conceptual basis and the manner in which an assessment is implemented, interpreted, and evaluated, and offer some suggestions for doing so. We conclude with a discussion of some arguments for, and the challenges fac-

¹ We fully acknowledge the difference and overlap between the terms "social competence" and "social skills" (see Nangle et al., 2010, for a review). Social skills are the molecular responses necessary for socially competent responding in a given situation. Given the limited scope of the current review and the fact that the identification of social skills hinges on an agreed determination of competence, we have chosen to limit our analysis to social competence.

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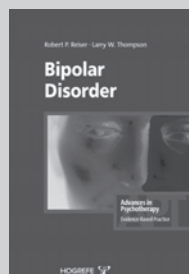
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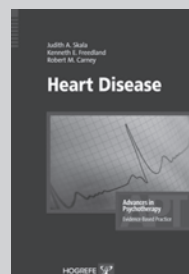
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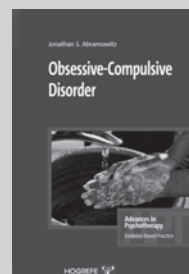
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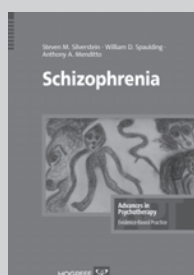
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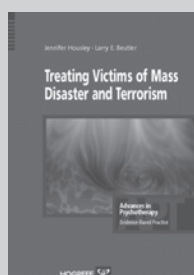
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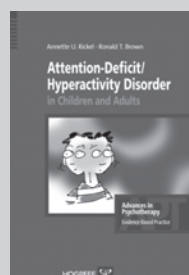
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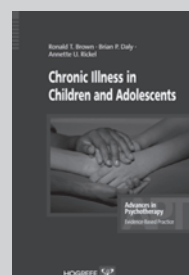
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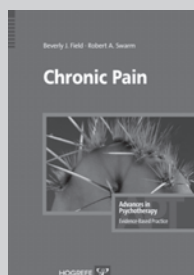
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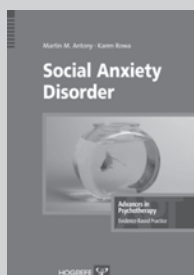
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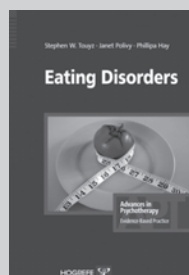
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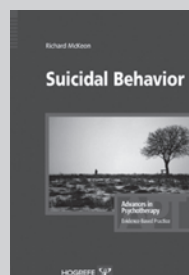
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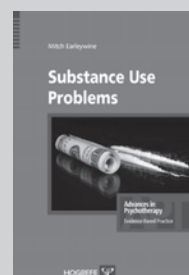
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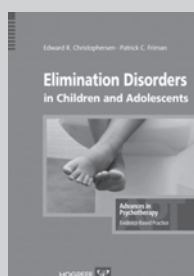
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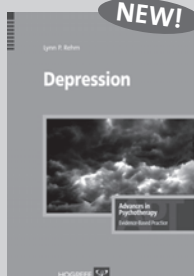
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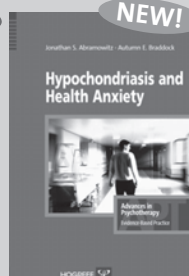
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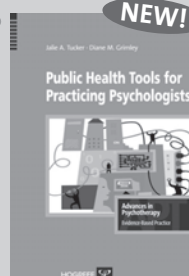
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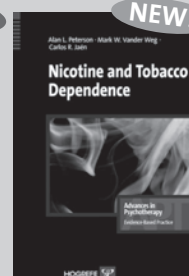
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ISBN: 978-0-88937-325-9



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ing, the continued growth of situation-based assessment.

Traitlike Conceptions and Situation-Based Alternatives

We offer three major examples of the continued use of traitlike conceptions in the assessment of social competence. More specifically, we discuss the continued reliance on single score indexes, linear scaling, and traditional psychometrics (see Nangle, Hansen, et al., 2010, for a complete review of social competence measures). We acknowledge that the present review is neither as deep nor as broad as it could be, but ask the reader to bear in mind that we have limited space. A reading or rereading of the McFall review, as well as papers by Foster and Cone (1995) and Barrios and Hartmann (1986), is suggested for a fuller understanding of the issues.

Single Score Indexes

Most competence measures rely on either single score indexes or limited numbers of summary scores. For example, the frequently used Rathus Assertiveness Schedule (RAS; Rathus, 1973) is a 30-item self-report measure that yields one total score. The often-cited Elementary School version of the Social Skills Rating System for Teachers (SSRS-T; Gresham & Elliott, 1990) has 57 items from which a total social skills score, as well as three subscale scores reflecting cooperation, assertion, and self-control, result. To be sure, such summary scores can be both meaningful and useful. RAS scores have been found to relate to the impressions of others, depressed mood, and are sensitive to assertiveness intervention (cf. Nangle, Hansen, et al., 2010). SSRS-T scores have been found to discriminate between students with social deficits and those with appropriate social skills (cf. Nangle, Hansen, et al.). Such scores, however, also tend to ignore situation and this has important conceptual and applied implications for behavioral assessors.

Coming from a traitlike perspective, reliance on a total score is appropriate since competence is presumed to be attributable to a single underlying factor. Put nicely by McFall, “a person’s observable behavior is [viewed as] only a reflection of that individual’s underlying degree or amount of social skillfulness” (1982, p. 2). Like the underlying trait they tap into, total scores should thus be stable across situation and time and individual items should correlate highly with one another and with total scores. For the behavioral assessor, however, reliance on

a single score index clearly runs counter to the assumption of situational variability.

A more suitable alternative would be to attend to situations and base scores on them. This sounds simple enough, but it is not because of what Kazdin (1979) referred to as the “two-edged sword” of behavioral assessment. That is, if behavior is indeed completely tied to situation, we would theoretically need to assess behavior in an infinite number of situations and prediction would be impossible. McFall (1982) noted sarcastically that predictions based on the notion routinely attributed to Mischel (1968) that “the best predictor of future behavior is past behavior in similar situations” are akin to a meteorologist needing to look out of the window to forecast the weather in the next 5 minutes.

Practically speaking, of course, we would need to decide when it is appropriate to generalize across different situations. The question is at *what* point would we feel comfortable treating two different situations alike (McFall, 1982). A number of methods for clustering or developing situation-based taxonomies have been proposed (Dodge & Murphy, 1984; Goldfried & D’Zurilla, 1969; McFall). Central to these approaches is that the sampled situations be particularly meaningful (e.g., relevant, critical, problematic) to the targeted individual or group. For example, Dodge and colleagues used the Goldfried and D’Zurilla approach to identify critical social situations for elementary school children (Dodge et al., 1985). In the initial step, 50 teachers and six child clinical psychologists were asked to come up with situations observed to be particularly problematic. The 64 resulting situations were then grouped into eight categories based on a literature review and further response inspection. In a third step, a clinical child psychologist and 50 undergraduate students were asked to independently classify the original 64 situations into the eight categories. Situations that could not be classified reliably were dropped to further pare the list down to 44 situations. The resulting measure was then completed by the teachers of students who were previously classified as “socially rejected” or “socially adaptive” using sociometric interview scores. A factor analysis yielded six factors that were very similar to the original eight (peer group entry, response to peer provocations, response to failure, response to success, social expectations, and teacher expectations) and factor scores were able to significantly predict children’s social status.

In his reformulation, McFall (1982) suggests that the “task” unit be used in delimit-

ing situations for further study. A task is defined as an “organizing and directing force on behavior,” can be summarized using “doing” statements, and has distinct beginning and ending points (p. 14). Examples offered include “having a conversation” and “developing an intimate relationship” (pp.14–15). Note that this approach does not necessarily solve the problem. Tasks have many levels and can be hierarchically organized. For this reason, McFall emphasizes that task identification and structural organization must proceed empirically using the scientific method to determine what works best for describing, predicting, and explaining behavior.

Before moving on, we should note that McFall (1982) did acknowledge that there was “one limited way” for a behavioral assessor to interpret a total score in a manner consistent with a situational approach (p. 21). That is, a total score could be interpreted probabilistically. The item pool could be seen as a sample of the full range of situations and higher scoring individuals could thus be judged more likely to exhibit a competent response in any given situation. Of course, however, the confidence one would have in that judgment would increase based on the degree of overlap between that situation and those sampled in the measure. In addition to the already stated concern that sampled situations be particularly meaningful to the targeted individual, the behavioral assessor would also want to ensure that they be suitably broad and representative.

Linear Scaling

From a traitlike perspective, a score on a measure is interpreted as an indirect reflection of the underlying “true” amount of a given trait “possessed” by an individual. Those with higher scores are thought to have “more” of the underlying trait or construct. An individual who performs well in a social situation is said to “have” social competence or be “high” in social skills (McFall, 1982, p. 2). Implied in this approach is that social competence exists on a linear continuum. The majority of existing measures rely on such linear scaling. Response choices are most often ranked in order of competence, difficulty, or likelihood.

McFall (1982) argued that judgments of social competence in real life are actually more categorical (e.g., okay, not okay) than linear and added that the threshold for such determinations is likely to vary by task and other contextual factors.

In a classic paper, Bem and Allen (1974) offered a situation-based critique that also questioned the scalability of traitlike conceptions of behavior. In a poignant illustrative example, they described an attempt to compare two professors on their levels of "friendliness." The first is very friendly with students she meets in her office, moderately outgoing in seminars, but somewhat reserved in large classes. In contrast, the second is rather formal when meeting students in his office, moderately outgoing in seminars, but very friendly and open in large classes. The first professor manages to pass the "easy" item, but fails the "most difficult" item, whereas the second professor fails the easy item and passes the most difficult item (p. 509). Nonetheless, both would be characterized as being moderately friendly, belying the fact that they show very little cross-situational consistency.

To address such linear scaling concerns, McFall (1982) recommended that social competence measures be criterion-referenced and rely on categorical competence judgments. This would not involve comparing performance across individuals, but rather a determination of whether or not a respondent could competently perform a

given social task. Key for our purposes, he emphasized the importance of basing the competency criteria in situation- or task-specific terms. He also suggested that the criteria be as explicit as possible, allow for variations in other contextual factors, and have an empirical basis. Regarding other contextual factors, performance standards may vary by age, gender, ethnicity, or importance of the task to the individual (e.g., tied to a job). Returning to the Bem and Allen example, rather than a scaling issue per se, the problem lies in the generality of the assessed dimension. The addition of situational parameters provides important information about the relative "friendliness" of the two professors in question.

Traditional Psychometrics

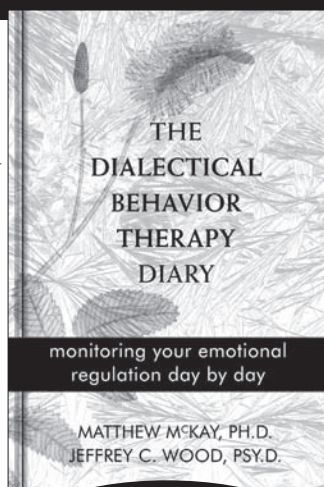
Almost reflexively, developers of new measures (as well as editors and reviewers) invoke traditional psychometric analyses in the demonstration of measure quality. This makes perfect sense when coming from a traitlike perspective. Since behavior is presumed to be a reflection of an underlying factor that is stable and enduring, a valid measure of it should exhibit consistency

across time and situation (Barrios & Hartman, 1986). Likewise, to the extent that the underlying factor is thought to be unidimensional, there should be consistency in responses across test items. These are the conceptual bases for test-retest reliability and internal consistency. In a traditional assessment framework, validity hinges on such properties because what is assessed is not observable. True score variance, or the amount of latent trait a person actually "has," is not attainable. The assessor must instead rely on "signs" or indirect indicators of the underlying trait or construct. In a sense, evidence of the very existence of a trait or other hypothetical construct is limited to demonstrations that scores on a measure(s) "behave" in concordance with the underlying theory (i.e., construct validity; Foster & Cone, 1995).

In contrast, behavioral assessors are most interested in the responses (i.e., behaviors) themselves. The focus is on what a person "does" rather than "has" and the interpretation of measures requires less inference (Barrios & Hartman, 1986). At least theoretically, the assessed dimension can be "completely operationalized" by the measure assessing it (Foster & Cone, 1995, p.

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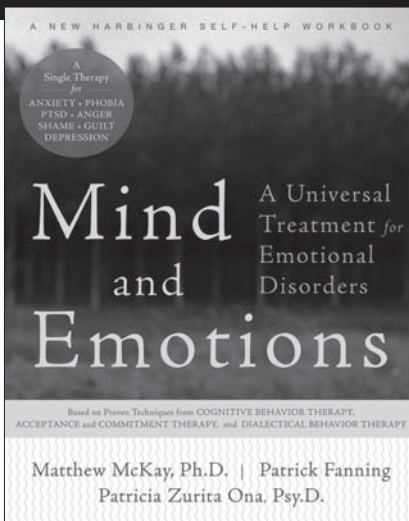
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248). This has important implications for the interpretation of measures. Presuming that one has an accurate measure of behavior (see Foster & Cone for a thorough discussion of accuracy and how it differs from reliability), for instance, the failure to demonstrate test-retest reliability or internal consistency would not be an indictment of measure quality, but rather a reflection of the true properties of the assessed behavior.

In practice, however, most behavioral assessors actually function in the gray area between traditional and behavioral assessment. There is a lack of established accurate measures for most behaviors of interest and accuracy information may not even be attainable in some instances (Foster & Cone, 1995). As such, traditional psychometric considerations continue to play an important role, but with a different theoretical twist (Barrios & Hartman, 1986; Foster & Cone). Consider temporal stability. It is important to both traditional and behavioral assessors, though for very different reasons. For the behavioral assessor, a lack of stability would not lead to a questioning of measure quality; it may reflect actual instability in the behavior of interest. From a utility perspective, however, the lack of stability would bar the measure's use as a dependent

variable for intervention purposes. Also consider internal consistency. For the traditional assessor, it is critical because all item responses are thought to be driven by a common underlying factor. For the behavioral assessor, it may also be critical because we most often assess response classes rather than molecular behaviors (e.g., "aggression" as indicative of hitting, swearing, name-calling, and property destruction; Foster & Cone, p. 253). Thus, a determination of whether each of the molecular responses actually fit into the superordinate response class would be of interest. Foster and Cone also give an example of when internal consistency may not be important to the behavioral assessor. In developing a self-report inventory of social skills, Inderbitzen and Foster (1992) asked adolescents how different behaviors described in a series of hypothetical vignettes would impact their liking of a teen displaying them. Socially skilled responses were defined as those that increased liking, whereas unskilled responses were defined as those that decreased liking. Although the resulting scales evidenced internal consistency, such consistency would not be required because the grouping of responses was based solely

on their consequences or how they impacted liking.

A lack of consistency across situations in a measure would not be inherently problematic from a behavioral standpoint; indeed, as discussed, a certain degree of situational variability is to be expected (Barrios & Hartman). But Barrios and Hartman (1986) point out that working with situationally inconsistent behaviors may eventually prove too "burdensome" for behavioral assessors (p. 89) and that such behaviors lack utility. In the spirit of the earlier alluded to rapprochement, they suggest that we will need to identify behaviors with some degree of situational generalizability. This will require the use of more traditional psychometrics. For example, ensuring that sampled situations are broad and representative is a question of content validity. Testing to see if situations cluster in meaningful ways can be accomplished through internal consistency and factorial validity analyses. Determining whether performance in the assessed situations predicts some "real-world" criterion is a matter of criterion-related validity.

Conclusions and Future Directions

Arguments for stepping up progress in the development of situation-based measures and the refinement of conceptual frameworks can be made on both theoretical and practical grounds. First, situation-based approaches are more congruent with behavioral theory. Behavioral theory is contextual (Nelson & Hayes, 1986). With regard to the social competence construct, McFall (1982) aptly noted, "no particular behavior can be considered intrinsically skillful, independent of its context" (p. 7). Second, prevailing models of social competence, behavioral and not so behavioral, have increasingly incorporated the notion of interplay between person and situation factors (see Nangle, Grover, et al., 2010, for a review). Third, empirical evidence in support of situational variability in social competence continues to mount (e.g., Dodge et al., 1985; Dodge et al., 1986; Wright, Zakriski, & Drinkwater, 1999).

Perhaps the most convincing argument from a behavioral standpoint is the one based on treatment utility. A defining feature of behavioral assessment is that it "serves" treatment. Rather than description or diagnosis, the major goals of behavioral assessment are the identification of target behaviors, selection of a treatment strategy, and monitoring of treatment effectiveness (Nelson & Hayes, 1979, 1986). A target

Table 1. An Incomplete List of Social Tasks

Entering a Group	Helping
Responding to Ambiguous Provocation	Asking for Help
Managing Conflict	Responding to Cheating/Unfairness
Coping with False Accusations	Resisting Distraction by Others
Listening	Persuading
Negotiating Rules	Achieving Equity/Fairness
Retrieving Belonging	Complimenting
Generating "Fun" Ideas	Coping with Frustrating Situations
Sharing Resources/Belongings	Getting Picked for Teams/Activities
Maintaining Interaction	Expressing Affection
Making Requests	Coping with Teasing
Eliciting Disclosure	Avoiding Dangerous Peer Contexts
Self-Disclosure	Comforting
Responding to Requests	Defending Self
Expressing Appreciation	Communicating Contingently
Coping with Public Failure	Sticking Up for a Friend
Coping with Rejection	Refusing a Dare
Dealing with Losing	Responding to Winning/Success
Apologizing	Keeping Secrets
Forgiving	Terminating Interaction

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behavior cannot be understood outside of its context and behavior change results from the identification and manipulation of this context or the "situational controlling variables" (Nelson & Hayes, 1986, p. 15). Situational variability (and consistency) provides information critical to the identification of these controlling stimuli and hence to subsequent intervention. Measures that ignore situations remove social behaviors from their context and this critical information is lost in the process. Though such measures may have some limited utility in screening those in need of intervention, they have almost no utility in the identification of target behaviors and subsequent treatment planning.

Dodge and Murphy (1984) proposed a social competence assessment approach that better comports with behavior theory and attends to situation. The initial step involves client identification, which can involve a referral by a parent or teacher or some other source. Worth noting, the referral by a "real-world" source appears to supercede the need for a global social competence screening measure at this step. In the second step, a survey of relevant,

problematic tasks for the client is conducted. Previously referenced situational taxonomies can be used as a starting point in this process. Next, the situational sources of incompetence are determined by asking the client and/or significant others to identify particularly problematic situations. Another suggested strategy is to ask the client how he or she typically responds in the previously identified situations. These responses can then be judged by another for competence. The fourth step is to determine why the client responds incompetently in particular situations. A task analysis is used to identify component skill deficiencies (i.e., decoding, decision, and enactment). The fifth step involves the construction of a profile of specific skill deficits. Also described by McFall (1982), a profile approach allows for each individual to display "a scatter of situation specific social strengths and weaknesses" (Dodge & Murphy, p. 83). The remaining two steps entail the design of an individualized intervention tailored to the derived profile and outcome evaluation.

The challenges posed by attending to situation in the assessment of social compe-

tence are quite significant, but so is the potential payoff. Avoiding a major obstacle cited by virtually all behavioral assessors is one of the more prominent challenges. Unlike those calling for a purely molecular model of social competence, we must not fall prey to the forces of reductionism (Kazdin, 1979; McFall, 1982; Nelson & Hayes, 1986). Rather, we will have to find ways to sift through the limitless number of different social situations and identify those with particular meaning and some degree of functional similarity.

To illustrate the difficulty involved, we borrow from the analysis of Asher and McDonald (2009). These authors generated a list, which they readily acknowledged as being incomplete, of everyday social tasks faced by children, adolescents, and adults (see Table 1). After noting the sheer number and variety of listed tasks, consider that the situations on the list were already culled using the same type of social tasks approach described by McFall (1982). They estimate that fewer than 10 of these tasks have received significant research attention to date.

In highlighting the promise of this approach, however, these authors point to the



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considerable knowledge gained in studies with children focusing on particular social tasks, such as peer group entry, help seeking, and conflicts of interest. Nowhere is the promise more evident than in the landmark research on response to provocation situations conducted by Dodge and his colleagues (e.g., Crick & Dodge, 1994, 1996; Dodge, 1980; Dodge & Frame, 1982). Aggressive children tend to exhibit particular deficits when faced with ambiguous peer provocations (e.g., another child bumps into his/her lunch tray in the school cafeteria causing a glass of milk to spill). In such situations, aggressive children tend to attribute hostile intentions to the provocateur and hence are more likely to respond with aggression. This work helped to establish the basis for the social information processing model, stimulated hundreds of studies by other investigators, and the related publications have been cited thousands of times. Hopefully, some more of the social tasks listed on Table 1 will bear such fruit.

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What Are the Active Therapist Ingredients in Successful Client Treatment?

Edward H. Tiller, *Williamsburg Centre for Therapy*

Cognitive behavior therapists and relationship therapists disagree over the necessary components of desired psychotherapeutic change. Cognitive behavior therapists state that beneficial change occurs because the therapist employs specific therapeutic ingredients (e.g., cognitive restructuring, exposure to traumatic memories, stress inoculation training), whereas relationship therapists note that positive outcomes result from the skillfulness of the therapist and the quality of the therapist–client relationship.

This conflict, as expressed within *the Behavior Therapist*, is between Wampold (e.g., Wampold, Imel, & Miller, 2009) and several cognitive behavior therapists (e.g., Siev, Huppert, & Chambless, 2009, 2010). Wampold is an advocate of the common factors position, a type of relationship therapy (RT). He sees beneficial client change as the result of a common core of healing experiences (including the therapist–client relationship).

DiGiuseppe (2007) stated in *the Behavior Therapist* that the use of empirically supported treatments has been limited by the perception “that all psychotherapies are equally effective (the Dodo Bird verdict), and . . . that common factors, therapist and relationship variables account for the majority of variance in outcome studies” (p. 118). This was in response to Wampold’s (2001) conclusion that, based on extensive research data, “the evidence is clear that the type of treatment is irrelevant and adherence to protocol is misguided, but yet the therapist, within each of the treatments, makes a tremendous difference” (p. 202).

In response to the DiGiuseppe’s article, Siev et al., in the April 2009 issue of *the Behavior Therapist*, challenged the perception that cognitive behavior therapy (CBT) interventions are relatively ineffective in

achieving desired treatment outcomes. They stated, “putative common factors, such as therapist skill, the therapeutic alliance and treatment expectancy are likely influenced by technique” (Siev et al., p. 75). They differentiated the effects of therapist–client relationship factors from the “variance accounted for by active ingredients (e.g., technique)” (Siev et al., p. 69). Similarly, for Perplechikova, Treat, and Kazdin (2007), CBT techniques are used to develop (active) client skills, whereas RT interventions (e.g., psychodynamic, nondirective, and common factors therapies) are viewed as minimally effecting (passive) desired behavior change.

The treatment distinctions these authors make are based on perceiving differences in what client behaviors are targeted for change, what therapist behaviors are seen as necessary to bring about these changes, and the psychological mechanisms by which the desired changes are believed to occur.

The purpose of this article is to discuss some of the contentions that cognitive behavior therapists and relationship therapists make about the necessary components of effective psychotherapeutic change, outline some perceived similarities and differences,

question some beliefs and practices, and finally, express one view of a more effective treatment model.

Techniques vs. Beliefs

Psychological therapies use techniques or treatments designed to produce changes in client behavior, hopefully not only in session, but afterwards, as clients live everyday life. Therapists may use other techniques to help clients maintain these new behaviors and use them across different settings. The use of technique or treatment is common to all therapeutic interventions, including psychodynamic, nondirective, and cognitive-behavioral. Therapist treatments consist of an acknowledged set of verbal and behavioral interactions with clients. This instructed practice follows defined sequences, is modified contingent upon client responses, and is directed towards obtaining desired changes in client behavior (e.g., acquisition of coping skills, reduction of expressed distress, etc.).

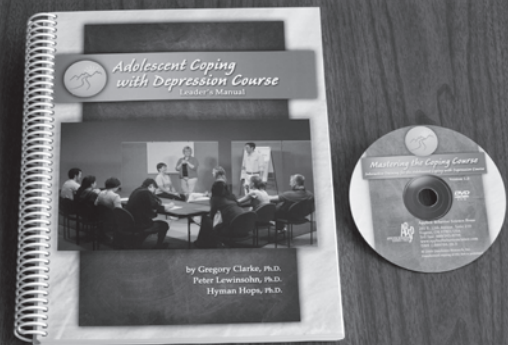
Before describing the similarities and differences between the practice of CBT and RT, it is necessary to look at some of the theoretical assumptions of Wampold’s form of RT. These assumptions are not part of

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most other RTs. Since he is the principal critic of CBT within *the Behavior Therapist*, it may be useful to see how these assumptions influence his perception of how psychotherapy works and how they may guide the focus of his treatment effectiveness research.

Wampold's (2001) *The Great Psychotherapy Debate* describes his contextual model (CM) of psychotherapy. Therapeutic change is seen from an RT perspective. He refers to Frank and Frank (1991) as providing the working model he adopted for his CM of psychotherapy. Wampold espouses a common factors position, (i.e., all psychotherapeutic treatments obtain almost equal, or insignificantly different, results due to a common core of healing processes). He rejects both CBT and many RTs (such as client-centered therapy), seeing them as reflective of the medical model because "the specific therapeutic ingredients are remedial for the disorder, problem or complaint" (2001, p. 14). Wampold makes a radical distinction between CBT treatments and treatments in his CM, because the particular components of a treatment are unimportant within the CM, whereas they are crucial to CBT. Within the CM, so long as the therapist and client believe that a treatment will effectively change client behavior, the client will benefit from the treatment.

The client's belief in the explanation for their disorder and its treatment is paramount to the treatment benefitting the client. The active ingredient is the client's belief in the effectiveness of treatment, not the actual therapist treatment behaviors (techniques). The therapist enhances client belief through the quality of the therapist-client relationship and through therapist allegiance to the therapy—"the greater the allegiance to the therapy, the better the outcome" (Wampold, 2001, p. 41). As described by Frank and Frank (1991), therapist allegiance to or belief in the effectiveness of the therapy is developed by having a "rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and provides a ritual or procedure for resolving them" (Wampold, p. 25). This rationale has to be both sensible and understandable to the therapist.

Wampold further adds, "... the basis of the therapy need not be scientifically proven" (2001, p. 250). Within the CM, for believing followers, "Interventions administered by clergy, indigenous healers, occult practitioners, motivational speakers or other non-traditional healers may be effective or as effective as psychological treatments" (2001, p. 223). If the active

treatment ingredients within the CM are therapist and client belief in the effectiveness of the therapy, how do therapists gain this belief if empirical support isn't necessary? This is perplexing! Wampold notes that these other "practitioners" are very effective at installing beliefs. Why then are psychologists (and other mental health practitioners) the providers of psychotherapy? Is psychology's scientist-practitioner training model the most relevant for changing client beliefs? Wampold doesn't seem to share these concerns, but comments that, "Psychologists should only find treatments that are well-grounded in psychological principles to be congenial and convincing" (2001, p. 223). Nevertheless, the CM assumes that beneficial client behavior change results solely from a change in client beliefs, not from any specific therapist actions based on psychological principles (e.g., reinforcement and punishment).

Within the CM, clients seeking therapy are seen as demoralized and typically suffering from "inner" anxiety and depression. Frank and Frank (1991) state that "psychotherapy achieves its effects largely by directly treating demoralization and only indirectly treating overt symptoms of covert psychopathology" (Parloff, 1986, p. 522). This understanding of treatment reflects a mind/body dichotomy. Cognitions, imagery, affect, sensations, behavior, etc., aren't seen as essential, interdependent, interactive functions of a whole person. Instead, disordered inner thoughts, beliefs, and attitudes are at the core of the psychopathology. If these are changed, the assumption is that behaviors and physiological activity will also change, as they are symptoms of "underlying" psychopathology. Isn't this consistent with the medical model? Wampold was critical of CBT and some RTs for this type of association.

RT and CBT Components

Although Wampold's CM conceptually differs in several important ways from CBT (and many other RTs), there are also many similarities. Frank and Frank (1991) describe common components of psychotherapy and of therapist practice. These include a safe, emotionally charged, confiding relationship with a therapist, plausible explanation for the patient's distress, therapist and client belief in the treatment as a way of helping the client, new learning experiences for the client, and the opportunity to practice new behaviors. What are the typical practice components of CBT and RT?

Let's consider, for example, that a client's presenting problem is significant distress that is triggered by recollections of a traumatic event. Some form of exposure therapy might be appropriate. A cognitive behavior therapist might perceive the primary tasks for successful treatment as (a) gathering information from the client to identify all traumatic stimuli that elicit fear, avoidance, and distress; (b) selecting a type of exposure procedure (e.g., brief, prolonged, in-vivo, imaginal, interoceptive, gradual, intense, etc.) that maximally exposes the client to all of the traumatic stimuli, while utilizing the knowledge and skills of the therapist; (c) obtaining the active cooperation of the client; and finally (d) conducting exposure therapy, and other interventions, until treatment is completed (i.e., traumatic recall no longer occurs in session after exposure to previous trauma-eliciting stimuli, nor between sessions, in the client's everyday life). Information gathering for a cognitive behavior therapist usually means observing and targeting client behaviors immediately preceding and following the client's identified problem behaviors. The cognitive behavior therapist usually isn't interested in knowing about other events in the client's life, the client's developmental history, or the extent and quality of the client's interpersonal relationships. However, both a cognitive behavior therapist and a relationship therapist may focus on the anticipatory anxiety/dread the client may experience at the beginning of the therapeutic process (Heimberg, 2009) and/or with confronting traumatic memories.

Conversely, relationship therapists, who believe that the therapist-client relationship is a primary factor in changing identified client problem behaviors, usually are interested in the client describing many more life events. This includes the client's developmental history, interpersonal relationships, and any factors that impede or enhance the therapeutic relationship (e.g., client's prior experiences, beliefs, expectations, ability to recall past events, ability to identify and communicate feelings, etc.). The skillfulness of the therapist in establishing and maintaining an effective therapeutic relationship is perceived as necessary for bringing about successful treatment outcomes.

The perception of cognitive behavior therapists is that effective treatment requires therapy clients to acquire and demonstrate newly learned skills. Furthermore, CBT research frequently requires therapists to conduct treatment according to written technique instruction (manuals).

Its purpose is to facilitate the correct application of therapist treatment behaviors. The therapist functions as a teacher and the client as a “motivated student.” In the case of dealing with traumatic recall, the client is expected to learn new ways of responding to stress-inducing events so that the newly acquired responses result in a reduction of distress.

In contrast, the RT focus is on skillfully developing a close interpersonal bond with the client. The therapist helps the client to develop the expectation/belief that positive therapeutic outcomes will result from their therapist-client collaboration (therapeutic alliance). The client willingly becomes actively involved in the treatment process. This may allow the client to endure the negative affect, sensations, and cognitions that are elicited by distressing experiences (e.g., traumatic recall), without avoiding or prematurely ending the therapy.

Effective Therapeutic Relationships

Goldfried and Davila (cognitive behavior therapists) have concluded that “the use of exposure in the treatment of . . . PTSD, which involves reexperiencing and tolerating emotions associated with trauma, . . . requires a strong interpersonal bond” (2005, p. 425). Without this bond, and the expectation that their therapist has the skills to successfully treat their disorder, clients may well avoid this stressful experience by not initiating therapy (Heimberg, 2009) or dropping out of therapy before it is completed (Cahill, Foa, Hembree, Marshall, & Nucash, 2006; Cloitre, Koenen, Cohen, & Han, 2002). This is consistent with Wampold’s research. Effective therapy requires a strong alliance between therapist and client.

A strong, interpersonal bond may function for the therapist like a setting or establishing operation function in an operant conditioning experiment (i.e., depriving a rat of water or food prior to putting it in a Skinner box increases the likelihood that it will engage in lever pressing to obtain food or water). A strong bond between therapist and client makes it more likely that the client will remain in therapy until treatment is completed. The client believes the therapist’s treatment efforts will result in a positive outcome for the client, and that exposure to traumatic recall, although unpleasant, can be successfully tolerated in order to obtain a significant reduction in distress.

What behaviors do therapists exhibit in order to create this strong, positive interper-

sonal relationship? Keijsers, Schaap, and Hoogduin (2000) identified two clusters of interpersonal behaviors that were clearly associated with positive therapeutic outcomes: the therapeutic alliance and client-centered therapy variables (e.g., empathy, warmth, positive regard and genuineness). Horvath and Symonds (1991), in a meta-analysis of therapeutic studies, concluded therapeutic alliance had been significantly associated with treatment outcome not only across a number of investigations but also across different types of psychotherapy. Similarly, Krupnick et al. (1996) found a significant relationship between total therapist alliance ratings and treatment outcome for depression across modalities (distinctly different types of psychotherapy and pharmacotherapy), with more of the variance attributed to alliance than to treatment method. A strong alliance has been associated with improved outcome in the treatment of depression (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996), personality disorders (Hellerstein et al., 1998), alcohol dependence (Connors et al., 1997), and cocaine dependence (Carrol, Nich, & Rounsaville, 1997).

There are different kinds of desirable therapist relationship skills (Ackerman & Hilsenroth, 2003) and a level of proficiency that a practitioner demonstrates in each. An example of this can be found in Carkhuff’s (1969) texts on *Helping and Human Relations*. Carkhuff developed a treatment model based on the relationship between therapist and client, conceptually similar to client-centered therapy. He operationally defined effective helping, then developed measures, behavioral rating scales, of the skills constituting effective helping (e.g., empathic understanding, communication of respect, genuineness, self-disclosure, concreteness or specificity of expression, and confrontation). The helpfulness rating a therapist receives is based on several trained raters observing and rating a therapist’s treatment performance. Therapist skillfulness in each area of effective helping is rated, the ratings are summed, and the average is computed. This averaged rating is perceived as indicating the therapist’s level of potential helpfulness to the client. The extent to which these core conditions (i.e., warmth, empathy, respect, etc.) that facilitate communication have been developed in the therapist allows similar development in the client. Higher development of core condition levels in the therapist indicates that higher levels of core conditions can be developed in the client, facilitating self-explo-

ration, self-understanding, and constructive courses of action (Carkhuff).

Experience appears to contribute directly to a therapist’s skillfulness in developing an effective therapeutic relationship (Huppert et al., 2001; Luborsky, McLellen, Woody, & Seligman, 1997). It takes years of repeated practice and learning from trial and error to hone one’s skills. Nevertheless, as with any other set of complex behaviors (e.g., skiing, fishing, writing books, childrearing, teaching, etc.), some people become more effective than others in achieving desirable outcomes. Within any one grouping of therapists (e.g., doctoral-level graduate students), there will be variability in skillfulness, as well as that usually found between different groupings of therapists (e.g., client-centered therapists and behavior therapists).

Experimental Evaluation of Therapist Skillfulness

Many treatment outcome studies use designs that deemphasize the effects that therapist experience and skillfulness can have on client behavior. These variables are not evaluated to see if they have significant differential effects on client treatment outcomes (Rothbaum, Astin, & Marsteller, 2005; Van Minnen & Foa, 2006; Westra, Dozois, & Marcus, 2007). However, a substantial literature exists asserting the importance of therapist skillfulness and therapist-client relationship. This includes, as discussed previously, the therapeutic alliance (e.g., Baldwin, Wampold, & Immel, 2007; Norcross, 2002; Wampold, 2001; Zuroff & Blatt, 2006); allegiance (meaning that the therapist is committed to and believes in the effectiveness of the treatment; Wampold); and facilitative communication skills (Carkhuff, 1969).

Variations in therapist skillfulness may reduce or enhance the effectiveness of treatment technique on client behavior. For example, if there are two or more treatment technique groups, one cannot assume that each contains, on the average, therapists with similar levels of skillfulness (a controlled variable). Groups may contain a majority of highly skilled therapists, minimally skilled therapists, or a mixture of each—producing an average level of therapist skillfulness. This can confound the interpretation of treatment effects (i.e., variation in the dependent variable measure attributable to treatment technique versus that resulting from therapist skillfulness).

The cognitive behavior therapist’s perception of RT techniques as being passive or

non-skill building results, in part, from how therapist skillfulness has been evaluated in CBT treatment outcome research. Typically, skillfulness is not treated as an independent variable (i.e., when clients are exposed to different levels of therapist skillfulness to determine the resulting therapeutic outcome). However, therapist communication/relationship enhancement skills, therapeutic alliance and treatment alliance would be seen as active ingredients when experimental designs directly measure their effects on client behavior. For example, train a group of raters to evaluate therapist communication enhancement/relationship building skills according to measurable criteria (Carkhuff, 1969). Next, have these raters repeatedly evaluate a group of therapists on their demonstrated skillfulness in working with various clients. Then divide the therapists into two groups, one with high and the other with low ratings of demonstrated skillfulness. The therapists are then assigned new clients and the effect of therapist skillfulness on therapeutic outcome is measured for each group. All therapists use the same technique; therefore, technique becomes a controlled or common factor, while therapist skillfulness becomes the active or skill-building variable.

CBT research frequently uses manualized treatment (i.e., implementing treatment by adhering closely to what is described in a treatment manual) as a way of helping to insure treatment integrity. In their article on treatment integrity in psychotherapy research, Perepletchikova et al. (2007) discuss how the interpretation of treatment effects requires some assurance that treatment was carried out as it was designed. They differentiate between adherence, attempting to exactly replicate what is described in a treatment manual and competence, which they describe as a “qualitative aspect [that requires a high] . . . level of therapist’s skill and judgment. [Competence is] . . . how well prescribed procedures are implemented” (Perepletchikova et al., p. 829). The authors describe the relationship between adherence and competence as not straightforward, and that research examining this relationship produces conflicting results. Because strictly following instructions from a treatment manual does not necessarily achieve treatment integrity, it might be that the treatment manual does not (or cannot) contain a description of all that must be done to obtain desired treatment outcomes. The competent practice of psychotherapy, that may include skillfully selecting and applying specific procedures,

requires therapists to skillfully develop a therapeutic alliance with the clients. Therapists must believe in the therapy’s effectiveness and skillfully communicate this to their clients (e.g., Wampold, 2001). They must work to enhance their therapeutic relationship with their clients and their clients’ communication and relationship-building skills (e.g., Carkhuff, 1969).

Treatment Outcomes

Does therapist skillfulness in establishing a close interpersonal bond with a client ensure a positive treatment outcome? Comparative therapy effectiveness studies typically assess change in depressed or anxious clients, but avoid presenting problems that are too “complicated,” such as multiple diagnoses, clients exhibiting behaviors that are difficult to change (i.e., delusions, hair pulling, cocaine use, compulsions, vivid traumatic recall), or where client behavior change is not adequately measured by solely using self-report inventories (e.g., Beck Depression Inventory). Examples of this include clients hitting others, avoiding driving a vehicle, compulsive hand washing, and the number of hours of sleep per night. Documenting desirable treatment outcomes for these kinds of clients requires direct measurement of client behavior change or its consequences. How many treatment outcome studies assess therapy effectiveness in changing these complicated, difficult-to-change, multidimensional behaviors? The treatment effectiveness, meta-analysis literature reviews conducted by Wampold, and those done by cognitive behavior therapists, do not sufficiently sample this client population. Yet it would be on this population that the addition of specific CBT techniques for changing client behavior would be most effectively demonstrated! The typical subject for treatment effectiveness research (one who is depressed and/or anxious), if provided with a competent relationship therapist, almost always benefits from the helping relationship (as reflected by a significant change in pre-post self-report inventory scores).

Usually clinical researchers select treatment outcomes that are a reduction or elimination of undesirable behaviors (e.g., client-reported distress, compulsions observed in session, patient’s behavior no longer meets *DSM* criteria for a diagnosed disorder, etc.). What happens when unwanted behaviors are decreased (for cognitive behavior therapists, most likely by using extinction or punishment)? This in-

creases the likelihood that alternative or competing behaviors will increase in frequency. The undesirable behaviors have been temporarily suppressed. What is done to increase the likelihood of desirable replacement behaviors? This issue is rarely addressed in most CBT journal articles, especially when the focus is on treatment outcomes in outpatient therapy settings. What happens next can be left up to “chance,” the “survival of the fittest,” or contingent reinforcement can be provided for behaviors incompatible with the undesirable behaviors. Malott, Whaley, and Malott (1993) suggest that therapists need to reinforce “functionally incompatible behaviors . . . that will be of value to the individual and the social system where the individual lives . . . these behaviors should produce built-in, intrinsically reinforcing consequences that are powerful enough to maintain the behavior” (Malott et al., 1993, p. 318).

Shedler (2010) asserted, in a recent *American Psychologist* article on the efficacy of psychodynamic psychotherapy (another type of RT), “Successful treatment should not only relieve symptoms (i.e., get rid of something) but also foster the positive presence of psychological capacities and resources” (p. 100). Siev et al. (2010), strong advocates for the effectiveness of empirically supported treatments, “agree . . . that reductions in panic-related symptoms do not necessarily imply maximal improvement in quality of life . . . it is therefore important to assess improvements in the quality of life directly” (p. 13). Contemporary psychodynamic therapy brings about desired treatment outcomes by using a variety of techniques: help the client to recognize and describe emotions; discuss attempts to avoid distressing thoughts and feelings; describe past childhood experiences; recognize and describe components of past relationships that are being enacted in the therapy relationship; etc. The goal of this in-session work is to bring about healthier client functioning, or as Shedler (2010) describes, “tolerate a wider range of affect, have an active and satisfying love life, maintain a realistically based sense of self-esteem” (pp. 100-101).

After reviewing the psychodynamic therapy research literature, Shedler (2010) concluded, “the reoccurring finding [is] that the benefits of psychodynamic therapy not only endure but increase with time, a finding that has now emerged from at least five independent meta-analysis” (pp. 101-102). He also found that the effect sizes for

psychodynamic therapies were as large as that reported for CBT.

Shedler's (RT) therapeutic approach is in marked contrast to what cognitive behavior therapists do. He is interested in identifying and reinforcing broad, valued, behavioral outcomes. He doesn't describe using specific techniques for reducing/eliminating undesirable behaviors, such as excessive anxiety and worry, traumatic recall, and hitting others. However, CBTs (e.g., Kazdin, 2001; Malott et. al., 1993) have found that in order to facilitate development of desirable behaviors, you first must significantly reduce the frequency of undesirable ones. If you don't, occasions for therapist-delivered social reinforcement of desirable behaviors will not occur; therefore, desired behaviors will not increase. Treatment will fail to reflect enduring positive outcomes.

Conclusion

The most likely strategy for producing enhanced treatment outcomes is to combine the effective elements of RT and CBT interventions. These include initially developing a strong client-therapist alliance, enhancing the therapist's allegiance to the therapy, and engaging the client in the process of self-exploration and self-reflection. These processes result from using techniques central to RT's, whereby the therapist skillfully facilitates communication and enhances the therapist-client relationship. Secondly, it may be necessary to use specific CBT techniques to reduce distressing, intractable problems (e.g., obsessions, skin picking, dissociation, avoiding driving, etc.), or to increase desirable behaviors that the client wants to develop, but is blocked from doing so because of fear, insufficient knowledge, or inadequate skill.

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essment and treatment of veterans with PTSD, implementing individual treatment sessions using virtual-reality exposure therapy and conducting group treatment sessions using social skills training and behavioral therapies. Additionally, the fellow may participate in data analysis and manuscript preparation, and provide supervision of graduate and undergraduate research assistants. The position is available immediately (1/7/2011). Interested applicants may contact Deborah C. Beidel, Ph.D., ABPP at dbeidel@mail.ucf.edu or apply on line at www.jobswithucf.com/applicants/Central?quickFind=75748. The University of Central Florida is an equal opportunity, equal access, and affirmative action employer.

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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.
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Obituary

Lynn P. Rehm, Ph.D., ABPP (1941–2010)

Nadine J. Kaslow, *Emory University School of Medicine*

Lynn P. Rehm, Ph.D., ABPP, board certified in cognitive and behavioral psychology, self-identified as a cognitive behaviorally oriented clinical psychologist, a depression researcher, an educator/mentor, a credentialer, an evidence-based practitioner, and a public servant to the profession. Born in 1941, he died shortly after he was diagnosed with cancer on September 29, 2010. He is survived by his wife (Sue), two daughters (Elizabeth, Sarah), three grandchildren (Jackson, Eleanor, Meredith), his mother (Bernice), and his three siblings (Allan, Len, Donna). He was predeceased by his father, Stanley.

In high school, he was an active tennis player, actor, math whiz, voted “most talented” in his senior yearbook, and class valedictorian. An undergraduate at the University of Southern California, he rowed on the crew team, worked for J.P. Guilford writing social intelligence test items, participated in campus politics, served in the undergraduate Senate, and met Sue. After traveling in Europe on a motorcycle and breaking his collarbone, he returned to the States to sell boys clothing and married Sue, his wife of 46 years.

Rehm chose to attend the University of Wisconsin for graduate school in clinical psychology based on his desire to learn from Carl Rogers. He was Richard McFall’s first doctoral student. He was a predoctoral intern at the Milwaukee VA. During his time in Wisconsin, his two daughters were born.

After completing his training, Rehm joined the faculty at the University of California Los Angeles Neuropsychiatric Institute. While there, he attended football games, played competitive bridge, and visited his in-laws.

His next job was at the University of Pittsburgh, where he was Director of Clinical Training (DCT) and became involved in the Council of University Directors of Clinical Psychology.

From 1979 through his retirement in 2009, Rehm was on the faculty in the Department of Psychology at the University of Houston. During his tenure

there, he was DCT for many years, developed the Psychology Research and Service Center, and spearheaded efforts to revise the curriculum. He loved teaching at the undergraduate and graduate levels (psychopathology, personality theory, depression, behavior modification), supervising in the Psychology Research and Service Center, running his weekly research team meetings, and advising and mentoring his students.

As a scholar, Rehm had a long-standing interest in the study of depression and its treatment and, as is evidenced by his 2010 book, *Depression* (Rehm, 2010), he was a well-respected leader in the field. Rehm was the creator of the self-control/self-management model of depression, a comprehensive and integrative cognitive-behavioral perspective (Rehm, 1977). The model postulated three processes in a feedback loop that were associated with the development and maintenance of depression: self-monitoring, self-evaluation, and self-reinforcement. He argued that specific deficits at different stages of self-control may be seen as the basis for specific manifestations of depression. These deficits have been found in depressed adults (Roth & Rehm, 1980; Rozensky, Rehm, Pry, & Roth, 1977) and depressed youth and their families (Cole & Rehm, 1986; Kaslow, Rehm, Pollack, & Siegel, 1988; Kaslow, Rehm, & Siegel, 1984). Rehm and his colleagues conducted a series of studies to examine the efficacy of this model, primarily for depressed women (Kornblith, Rehm, O’Hara, & Lamparski, 1983; Rehm, Fuchs, Roth, Kornblith, & Romano, 1979; Rehm, Kaslow, & Rabin, 1987; Rehm et al., 1981). This approach has also been found to be applicable for treating such diverse groups as depressed children (Stark, Reynolds, & Kaslow, 1987), male veterans with comorbid chronic post-traumatic stress disorder and depressive disorder (Dunn et al., 2007), and rural women with depression and physical disabilities (Robinson-Wheelen, Hughes, Taylor, Hall, & Rehm, 2007). Rehm also was interested in applying cognitive-behavioral models

more generally to enhancing our understanding of mood disorders. For example, he and his colleagues examined various behavioral and cognitive-behavioral constructs as predictors of depressive symptoms in women in the postpartum period (O’Hara, Rehm, & Campbell, 1982) and as predictors of treatment process and outcome (Rabin, Kaslow, & Rehm, 1985; Rude & Rehm, 1991). In addition, in recent years he became fascinated by the study of autobiographical and implicit memories in depressed persons (Barry, Naus, & Rehm, 2004, 2006; Yang & Rehm, 1993) and proposed a memory model of emotion (Barry, Naus, & Rehm, 2006).

In addition to his role as an academic, he was very committed to professional service. At the local level, he was the president of both the Houston Psychological Association (HPA) and the Texas Psychological Association (TPA). Among his many awards, he was chosen as the HPA Psychologist of the Year and received from the TPA awards for Outstanding Contribution to Science and their Lifetime Achievement Award. He was honored by these organizations with a proclamation issued by Texas State Representative Coleman.

At the national level, he held multiple roles within the American Psychological Association (APA). For example, he was president and council representative for the Society of Clinical Psychology (Division 12) and a member of the Committee on Structure and Finance of Council, the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology, and the Board of Educational Affairs. From Division 12, he received the Florence Halpern Award for Professional Contributions to Clinical Psychology. Given his interest in licensure and credentialing, he chaired the Association of State and Provincial Psychology Board’s (ASPPB) Examination Committee for 10 years and led the computerization of the Examination for the Professional Practice of Psychology. A fellow of ASPPB, he served on countless editorial boards (e.g., *Assessment*, *Behavior Modification*, *Behavior Therapy*, *Behavioral Assessment*, *Clinical Psychology Review*, *Cognitive Therapy and Research*, *Journal of Abnormal Psychology*, *Journal of Consulting and Clinical Psychology*, *Psicologia Conductual*) and National Institute of Mental Health (NIMH) grant review panels. He was a co-author over the years on a number of articles related to psychology education, training, and credentialing, including licensure (Calhoun, Moras, Pilkonis, & Rehm,

1998; Rehm & DeMers, 2006; Rodolfa et al., 2005). His first national presentations were at the meetings of ABCT (then called AABT), and for that organization he was the Chair of the Student Members Committee, the Convention Volunteers Coordinator, and a member of the Program Committee.

He loved being involved on the international psychology scene as well. Rehm was president of the International Society of Clinical Psychology and the Division of Clinical and Community Psychology of the International Association of Applied Psychology.

The high esteem in which he was held by his students and colleagues was quite evident in March 2009, when former and current students and colleagues held a festschrift in his honor to celebrate his profound influence on their careers and on the specialty of clinical psychology. The festschrift was entitled "The Etiology, Assessment, and Treatment of Depression in Women and Girls" and scholarly papers presented at this event appeared in a special issue of the *Journal of Clinical Psychology* (Kaslow & Pettit, 2009). The presentations at this event focused both on scholarly work that was an outgrowth of Rehm's empirical contributions, as well as panels addressing his role as a mentor and public servant. His approach to advising and mentoring was characterized by an intense search for knowledge, methodological rigor, humility, and a willingness to encourage and support his students' pursuit of their own areas of scholarly inquiry. At the event, he received an APA Presidential Citation.

The University of Houston has established the Lynn P. Rehm Graduate Student Scholarship Fund in his honor: http://www.psychology.uh.edu/GraduatePrograms/Clinical/news/rehm_retires.html

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Obituary

In Memory of Patricia Averill, Ph.D.

Kelly Averill, *University of Texas Health Sciences Center*
J. Gayle Beck, *University of Memphis*

Dr. Patricia Averill passed away on December 20, 2010, bringing to completion a life of service to others. Pat was born in London and moved to the United States in 1979. She graduated from the University of Houston summa cum laude in 1987. She went on to earn a Ph.D. in Clinical Psychology in 1993, also from the University of Houston. At the time of her death, she was Director of Research and Program Evaluation at the Harris County Psychiatric Center in Houston, TX. In addition, she was a full professor in Psychiatry and Behavioral Sciences at University of Texas at Houston Medical Center.

Pat was the recipient of numerous awards, including Outstanding Graduate in the College of Social Sciences (University of Houston), the UT Dean's Teaching Excellence Award (6 times), the UT Award for Mentoring Women, and the Award for Outstanding Service from the Houston Psychological Association. Within ABCT, she served as the Master Clinician Seminar Committee Chair (2006–2009) and provided reviews for both *Behavior Therapy* and *Cognitive and Behavioral Practice*.

Pat was involved in many research projects, sometimes as author and sometimes as Principal Investigator. Her work was funded by NIDA, The Hogg Foundation for Mental Health, the Stanley Foundation, and NIMH. She presented her work at local, national, and international forums. She mentored many young clinicians as they developed their own research projects, encouraging her students to be their best. Her most beloved role was that of an educa-

tor, and she passed her craft down to several succeeding generations of psychologists and psychiatrists. Pat brought a great deal of enthusiasm, optimism, and energy to every project she took on. Pat's quiet presence brought out the best in those who worked with and trained with her. Even during her final illness, Pat continued to work with students and trainees, recognizing the importance of honoring her commitment as an educator.

Outside of her professional life, she was active in her church, St. Mark's Episcopal Church of Houston, and played an integral part in the lives of her two children (Kelly and John) and three grandchildren (Samantha, Jacilyn, and Grant). She enjoyed travel with her partner and husband, Jim, who has been an unofficial member of ABCT.

Pat will be missed deeply by many. To honor her life, donations may be made to St. Mark's Episcopal Church (3816 Bellaire Boulevard, Houston, TX 77025; 713-664-3466; church@stmarks-houston.org) or to the University of Houston, Department of Psychology (Dr. Lolin Wang-Bennett, Director of Development, Department of Psychology, University of Houston; 713-743-8522; Lwang-bennett@uh.edu).

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Special Issue

BEHAVIOR THERAPY

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*“In the absence of clear
and concrete behavioral
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assume that you know
what your patient is
talking about.”*

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