

the Behavior Therapist

Contents

Research Forum

Marvin R. Goldfried

Generating Research Questions From Clinical Experience: Therapists' Experiences in Using CBT for Panic Disorder • 57

Clinical Forum

*Julie A. Schumacher, Michael B. Madson,
and Grayson S. Norquist*

Using Telehealth Technology to Enhance Motivational Interviewing Training for Rural Substance Abuse Treatment Providers: A Services Improvement Project • 64

Professional Development

Mitch Prinstein

Why Volunteer for Psychology Association Governance Groups and Committees? • 71

At ABCT

Kristene A. Doyle and Kamila White

A Closer Look at the Benefits of ABCT Membership • 72

Welcome, New Members! • 73

Call for Web Editor • 75

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leaders
of our field
(see p. 70)

Research Forum

Generating Research Questions From Clinical Experience: Therapists' Experiences in Using CBT for Panic Disorder

Marvin R. Goldfried, Stony Brook University

The overall goal of this new initiative by the Society of Clinical Psychology is to provide a mechanism whereby practicing therapists could participate in the research process. Much has been said about the dissemination of research findings to the practicing clinician, and it is now important to provide practicing therapists with a way of disseminating their clinical experiences in using empirically supported treatments (ESTs) to the research community—as well as to other practitioners. This mechanism has been in place for practicing physicians, who have the opportunity to give the U.S. Food and Drug Administration (FDA) feedback on the problems encountered in using research-based, empirically supported medications in clinical practice. In developing this initiative for ESTs, the Society provides a two-way bridge between research and practice, not only to ensure a firm clinical basis for our research efforts, but also to hopefully encourage practitioners to use research findings in guiding their clinical work. Although there is certainly a long history of a gap between research and practice, there now exists growing pressure for accountability by governmental agencies and insurance companies, which I would maintain needs to be informed by both research findings and clinical practice.

[continued on p. 59]

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- 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.

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[continued from p. 57]

The first of what will be several surveys of practicing clinicians on the use of ESTs has focused on the treatment of panic disorder, a clinical problem one is likely to encounter in clinical practice, and one for which there exists a fair amount of research evidence. At present, the only EST for panic consists of CBT. The goal of the clinical survey was not only to determine the extent to which CBT works in actual clinical practice, but also to uncover those mediators and moderators that may create obstacles for effective clinical intervention. Indeed, the question of how to further improve our intervention for panic disorder has been something raised by others (e.g., McGabe & Antony, 2005; Otto & Gould, 1996; Sanderson & Bruce, 2007). Moreover, the identification of variables that interfere with clinical effectiveness have long been thought of as potential research questions, derived from clinical practice, and in need of further investigation (Foa & Emmelkamp, 1983).

The items included in this survey involved treatment, therapist, patient, and contextual variables, which were generated by a group of clinicians who were experienced in using CBT clinically. The following therapists graciously participated in extensive open-ended interviews that were used to develop the questionnaire items: Dianne Chambless, Steven Fishman, Joann Galst, Alan Goldstein, Steven Gordon, Steven Holland, Philip Levendusky, Barry Lubetkin, Charles Mansuto, Cory Newman, Bethany Teachman, Dina Vivian, and Barry Wolfe. In addition, a special committee within the Society of Clinical Psychology was formed to develop the survey, and consisted of individuals having a long-standing commitment to closing the gap between research and practice: Louis Castonguay, Marvin Goldfried, Jeffrey Magnavita, Michelle Newman, Linda Sobell, and Abraham Wolf.

The survey itself, which took approximately 10 minutes to complete, was advertised internationally to practicing clinicians experienced in using CBT for panic. The following categories were included in the survey, where clinicians responded to a number of variables in each category that they found to limit the successful use of CBT in reducing symptoms of panic:

- patient's symptoms related to panic
- other patient problems or characteristics
- patient expectations
- patient beliefs about panic

- patient motivation
- social system (home, work, other)
- problems/limitations associated with the CBT intervention method
- therapy relationship issues

Overview of Panic Survey Findings

A total of 326 therapists responded to the questionnaire, most of whom had their degrees in clinical psychology. The median age was 45 years, with a range of 25 to 81 years of age. Consistent with this broad age range, a little more than one third had 20 or more years of clinical experience, and a comparable amount less than 10 years. Close to half of the respondents indicated that the duration of therapy with panic patients typically lasted between 3 and 6 months, although there was a substantial number that saw patients 6 months to a year. Interestingly enough, practicing therapists indicated that their success rate in using CBT to reduce panic symptoms was approximately 80%, which is consistent with the findings from randomized clinical trials.

When asked about those patient symptoms related to panic that undermined effectiveness, 62% indicated that chronicity played a major role. Other symptom characteristics that make symptom reduction less possible included the presence of post-traumatic stress disorder (PTSD), the tendency to dissociate, functional impairment, and severity. With regard to other patient characteristics that created difficulties, the two most typical patient problems consisted of their inability to work between sessions and their unwillingness to give up safety behaviors. Several of the other patient problems that made symptom reduction more difficult were reflective of the complexity of the case—an observation made by Chambless and Goldstein several years ago (Chambless & Goldstein, 1982).

With regard to patient expectations that limited clinical effectiveness, the most typical reported were patient expectations that they would be free of all anxiety, that the therapist would do all the work and make things better, and that medication was needed to reduce panic. One of the most problematic beliefs about panic, reported to limit the clinical effectiveness of CBT, was the thought that their fears were realistic (e.g., they would have a heart attack, they would faint). Interestingly enough, relatively few therapists reported clinical limitations resulting from patients' belief that symptom reduction would have a negative impact on their relationships. Not surpris-

ingly, the role of patient motivation was highlighted, with approximately 67% of therapists noting that not only was this a problem at the outset of therapy, but also that it contributed to premature termination.

A large percentage of therapists pointed to the patient's social system as an important factor that could potentially undermine clinical effectiveness, such as the environment at home and at work. This underscores the importance of research that is needed to assess and modify relevant environmental antecedents and consequences of panic, and the role of significant others in their support or sabotage of the therapy.

When asked about the problems and limitations associated with the CBT intervention itself, close to 61% indicated that it did not provide sufficient guidelines for dealing with patients' reluctance to eliminate safety behaviors. Interesting enough, however, more experienced therapists did not find this as much of a problem as did therapists who were less experienced. Other limitations of the treatment protocol involved the logistical problems associated with in vivo exposure, its inability to deal with comorbid problems, and the difficulty in simulating panic symptoms in the session.

Therapy relationship issues were highlighted as contributing to clinical difficulties. No less than 61% of the respondents indicated that the therapy alliance was not strong enough to bring about change, and another 60% noted that patients did not feel that their distress was sufficiently understood or validated by the therapist. Of particular significance was that close to one third of the therapists admitted that their frustration with progress and their negative feelings for the patient created difficulties.

There was another interesting finding regarding experience level, which raises the question about the extent to which therapists adhered to the CBT protocol. Experienced clinicians are more likely to make use of breathing retraining, to work on resolution of stressful conflicts that may lead to panic (e.g., relationship issues), and to help the patient understand the developmental roots of panic. In addition, they more often use assertiveness and communication training. The issue here is why more experienced therapists go beyond the CBT protocol: Because of their greater clinical experience? Because they may have learned to use CBT later in their career? Because younger therapists may have learned to conduct CBT from manuals? With regard to experience level, it might be noted that,

in a controlled clinical trial, it was found that more experienced CBT therapists treating panic patients were more likely to be clinically effective than less experienced clinicians, even though both were rated as being comparably effective in implementing the protocol (Huppert et al., 2001). Regardless of experience level, however, 73% of the therapists in our survey indicated that more than symptom reduction was needed in working with panic disorder patients.

As noted above, the detailed findings of the survey appear in *The Clinical Psychologist*, the newsletter of the Society of Clinical Psychology (American Psychological Association [APA] Division 12 Committee on Building a Two-Way Bridge Between Research and Practice, 2010).

The survey findings are intriguing and, in many ways, raise as many questions as they answer. However, this is precisely the purpose of the survey—to provide the researcher with clinically derived directions for future research. It is also a step in the direction of closing the gap between research and practice. The objective is to give clinicians a voice in the research agenda; hopefully make them more willing to reap the benefits of research findings; and point to research questions that come from clinical experience.

Closing the Clinical-Research Gap

An important step in closing the gap between research and practice involves the question of how to best disseminate research findings to the practicing clinician. One recent finding that addresses this question revealed that practicing therapists are more likely to be interested in ESTs when the dissemination of information includes case illustrations (Stewart & Chambless, 2010). In considering other ways for researchers to more effectively get their message across, it is important to appreciate the various issues that might prevent practicing therapists from making use of research findings—such as the difficulty in fully comprehending the methodological and statistical complexity of the research literature, having the available time to learn new interventions, and needing to learn a new theoretical approach. However, I suspect there is more to it than that.

My concern is that in our eagerness to disseminate research findings, we as therapy researchers may have inadvertently alienated our clinical colleagues. I know this to be the case with two CBT colleagues who, as practicing clinicians, could not be faulted

for failing to make use of research findings; they were avid readers of the research literature (Fensterheim & Raw, 1996). Despite their commitment to using empirically supported interventions, they confessed that they felt betrayed by researchers who recommended interventions without consulting their clinical colleagues. In their comments about the pressure they felt to conduct therapy only in ways that were proposed by research findings, Fensterheim and Raw confessed that they were concerned about

who should make the decision about how much flexibility is allowable, of how large should be the Procrustean bed. We doubt that it will be the practicing therapist who does so. So, once again, the standards and methods of clinical therapy will be set by those who do the least amount of clinical practice. (pp. 169-170)

In their review of therapy research findings and the impact that a list of ESTs might have for clinical practice in the United Kingdom, Roth and Fonagy (1996) pointed to some of its unintended adverse consequences—especially as it pertains to the third party certification of which therapies are approved:

Where payers yield to this temptation in the design of managed care programs and directives regarding first-line treatments, the reaction of many clinicians is to become suspicious of moves toward (or demands for) evidence-based practice. This adversarial process threatens to set those paying for care against those providing it, and indeed, providers against researchers. In this context, there are clear perils along the path of applying research findings to clinical practice. On the one side, the risk that practitioners reject psychotherapy research out of hand; on the other, the possibility that purchasers embrace it uncritically, leading to a cookbook approach to planning. (p. 40)

One of the goals of closing the gap between research and practice is to prevent this from happening.

Using their newfound clinical appreciation for the need to establish a collaborative relationship with their patients, two graduate students—the future of clinical psychology—have argued that the question is not how researchers can disseminate information about data-based interventions to practitioners. Instead, they pose the question in a more collaborative way:

“How do researchers and clinicians work together to develop efficacious treatments?” . . . we the researchers should not be disseminating onto the clinicians but rather engaging in dialogues with the professional community as we create new interventions. We believe that if we continue to frame this issue as an “us” versus “them” predicament, we will perpetually be stuck where we are, and, even worse, may continue to grow further polarized rather than closer together. (Hershenberg & Malik, 2008, pp. 3-4)

The idea of having clinical researchers and practicing therapists work together in developing clinically meaningful and empirically sound interventions is not new. It is a theme that runs through Chambless and Goldstein's (1982) *Agoraphobia: Multiple Perspectives on Theory and Treatment*. It is also inherent in Foa and Emmelkamp's (1983) *Failures in Behavior Therapy*, in which they indicate that “Contact with clients has taught us that clinical practice is not as simple as that portrayed in textbooks. . . . It seems that once a technique was endorsed as effective, it became almost taboo to admit that sometimes the expected positive results were not obtained” (p. 3). The challenges of using ESTs in clinical practice are especially evident in dealing with complex clinical cases, which particularly calls for an “increased dialogue between scientists and practitioners at a field-wide level” (Ruscio & Holohan, 2006, p. 158). Although the two-way bridge initiative described above is one way this can be done, there are numerous other approaches as well (e.g., Barkham, Hardy, & Mellor-Clark, 2010; Castonguay et al., 2010; Eubanks-Carter, Burckell, & Goldfried, 2010; Sobell, 1996).

What's Next?

As noted above, the use of the two-way bridge project was developed by the Society of Clinical Psychology, Division 12 of the APA. The initiative has been expanded so that it is now a collaborative effort of both Division 12 and Division 29—the psychotherapy division. This joint effort reflects the growing awareness on the part of researchers and practitioners that, more than ever before, collaboration is needed.

Also indicated earlier was that the survey on the treatment of panic disorder was the first of a series of surveys to be conducted. The next two involve the use of ESTs—also in these cases, CBT—for the treatment of social anxiety and of generalized anxiety disorder. *I invite the reader to take 10 minutes to complete each of the two*

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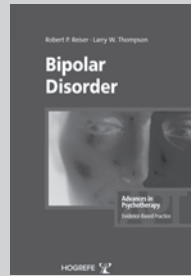
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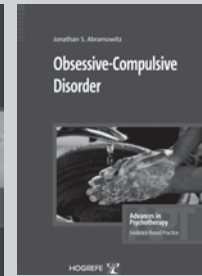
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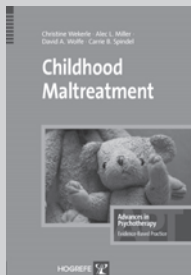
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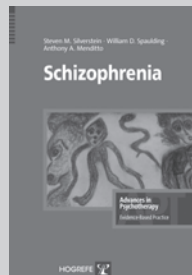
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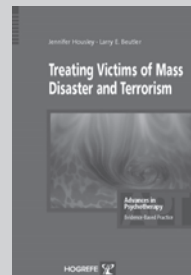
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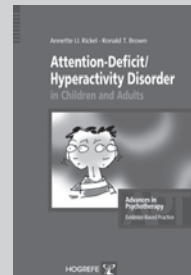
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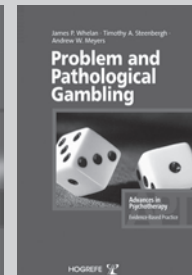
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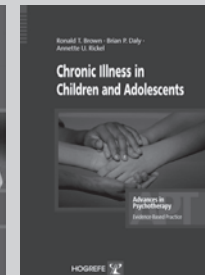
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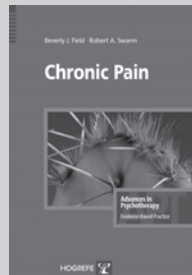
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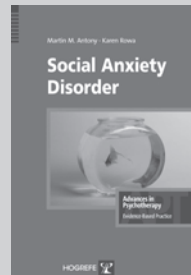
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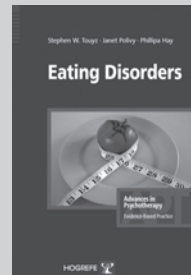
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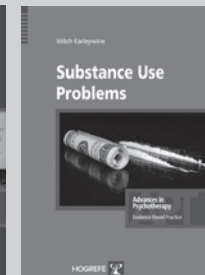
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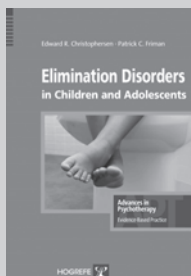
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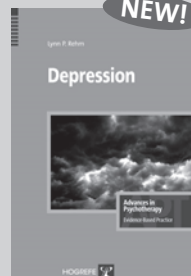
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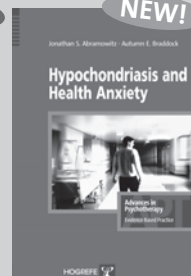
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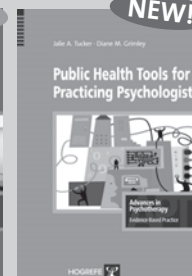
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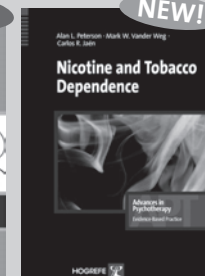
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surveys, the results of which we hope to present at conferences, publish in journals and newsletters, and disseminate on the Internet. Many of the items included in these surveys are the same as those used for the survey on panic, making it possible to obtain information on clinically based issues that may cut across different clinical problems. The survey on social anxiety can be found at <http://www.surveymonkey.com/s/6L9CLHN>, and the survey on generalized anxiety disorder is at: <http://www.surveymonkey.com/s/Z8QPRH7>.

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Wanted!

Clinicians' Feedback on Treating Social Anxiety

www.surveymonkey.com/s/6L9CLHN

Your responses to this brief survey, which will be anonymous, will be tallied with those of other therapists and posted on the Division 12 and 29 websites at a later time. The results of the feedback we receive from clinicians will be provided to researchers, in the hope they can investigate ways of overcoming these obstacles.

As part of an ongoing collaborative initiative to establish a two-way bridge between research and practice, the Society of Clinical Psychology (Division 12 of the American Psychological Association) and Division 29 of the American Psychological Association, have created a mechanism whereby practicing therapists can report on their clinical experiences using empirically supported treatments (ESTs). Much in the way that the Food and Drug Administration provides physicians with a method for giving feedback on their experiences in using empirically supported drugs in clinical practice, we have established a procedure for practicing therapists to disseminate their clinical experiences. This is not only an opportunity for clinicians to share their experiences with other therapists, but also can offer clinically based information that researchers may use to investigate ways of improving treatment.

We started with the treatment of panic disorder, and some of you may have taken that survey, for which we are grateful. The findings of the panic survey appear in APA (2010; see full reference above). You can obtain a copy of this on page 10 of the newsletter by either clicking, using control+click, or copy and pasting the following:

http://www.div12.org/tcp_journals/TCP_Fall2010.pdf#page=10

We would now ask you to complete a very brief survey of your clinical experiences in using an EST—specifically CBT—in treating social anxiety. By identifying the obstacles to successful treatment, we can then take steps to overcome these shortcomings.

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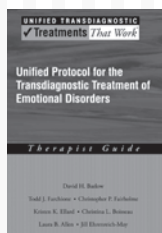
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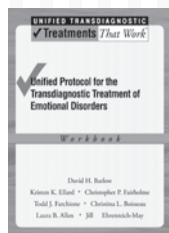
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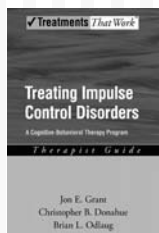
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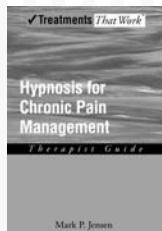
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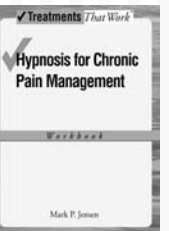
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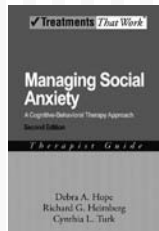
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Using Telehealth Technology to Enhance Motivational Interviewing Training for Rural Substance Abuse Treatment Providers: A Services Improvement Project

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The annual prevalence of alcohol, drug, or combined alcohol-drug use disorders is approximately 9%. However, each year only about 10% of those who meet criteria for a substance use disorder receive treatment of any kind (SAMHSA, 2009). Even when individuals with substance abuse treatment needs access care, those who do so outside the context of research protocols are unlikely to receive evidence-based practices and are at risk for early treatment attrition, because of low motivation, conflicts with treatment staff, and other factors (Ball, Carroll, Canning-Ball, & Rounsaville, 2006; Miller, Sorensen, Selzer, & Brigham, 2006). This information bespeaks an urgent need in the U.S. for successful implementation of evidence-based practices designed to enhance treatment engagement.

Motivational interviewing (MI), a relatively brief and flexible intervention that is designed to enhance patient readiness to change health behaviors, is well-suited to help satisfy that need (Miller & Rollnick, 2002). Although initially developed as an intervention for alcohol use disorders (Miller, 1983), MI has been shown in several controlled trials to produce significant changes in a variety of substance-related health behaviors, including alcohol-related problems, marijuana-related problems, and drug-related problems (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). MI is also uniquely suited to address the problem of nonengagement. Utilizing a combination of relational components, based on traditional client-centered counseling, and technical components, MI helps individuals explore and resolve ambivalence and enhance readiness for behavior change (Miller & Rose, 2009). MI was shown in a large effectiveness trial to increase engagement and retention in substance abuse treatment

(Carroll et al., 2006), which has been associated with better substance abuse treatment outcomes (Stark, 1992).

MI may also be uniquely suited to address substance abuse treatment needs in rural and underserved areas. Roberts, Battaglia, and Epstein (1999) reported that at least 24% of residents of rural areas in the U.S. suffer from substance or mental health disorders. A key problem with access to health care of all types in rural areas of the U.S. is the limited number of providers in these regions. For example, as summarized by McDonald, Harris, and LeMesurier (2005), although approximately 25% of the U.S. population lives in rural areas, only 10% of physicians practice in rural areas. Not surprising, given the overall lack of providers in rural areas, specialty care, including mental health and substance abuse treatment services, may be particularly difficult for rural populations to access. In a survey of rural mental health providers in Idaho, lack of psychiatrists or other appropriately trained mental health staff was the second most cited barrier to adequate mental health care (McDonald et al., 2005). Thus, MI's adaptability to varied treatment sites and provider types is ideal for rural and underserved areas where patients may not have access to substance abuse facilities (e.g., Bernstein et al., 2005; Senft, Polen, Freeborn, & Hollis, 1997).

Promises and Problems in MI Dissemination and Implementation

Given its promise to address important public health issues, including alcohol and other drug use disorders, MI has attracted a large following of clinicians and scientists from various disciplines who share a commitment to research, practice, and dissemination of MI (Adams & Madson, 2006). This dedication was emphasized by the de-

velopment of the Motivational Interviewing Network of Trainers (MINT) in 1995. The main emphasis of this group is not only to prepare individuals to become trainers focused on the dissemination of MI but to advance how others are trained in MI. For instance, members of this community have engaged in designing training activities (Rosengren, 2009), studied the efficacy of MI across diverse behaviors (Lundahl et al., 2010), and developed various measures with utility in training and evaluation of MI skill (for a review see Madson & Campbell, 2006). Beyond these activities the MI community has emphasized the importance of empirically investigating the outcome of MI training approaches.

Several authors have highlighted the importance of documenting training processes and practitioner skill development (Dunn, Deroo, & Rivara, 2001), where clinical outcomes following MI interventions were difficult to interpret due to a lack of information regarding how practitioners were trained in MI (Madson, Campbell, Barrett, Brondino, & Melchert, 2005). Two recent reviews have attempted to outline the empirical evidence relating to MI training with similar findings. Through a systematic review of 27 published MI training outcome studies, Madson, Loignon, and Lane (2009) found generally favorable results in relation to (a) confidence using MI, (b) knowledge, (c) increased skill, (d) interest in learning more about MI, (e) intention to use MI, and (f) integration into practice. These findings were supported by Söderlund, Madson, Rubak, and Nilsen (in press) in their review of MI training with general health-care practitioners. One concern raised by these reviews was the questionable results due to lack of validated outcome measures. The majority of trainings were provided in the format of workshop or classroom trainings and the length of time ranged from 9 to 16 hours. This discovery is somewhat concerning in light of the finding that workshop training may foster improvements in knowledge and intention to use MI but is less likely to generalize better MI practice as initial skill accomplishments fade (Walters, Matson, Baer, & Ziedonis, 2005) and highlighted the need for training evaluation that extended beyond the workshop format.

Few documented efforts have been made to extend the MI training research beyond the traditional workshop format. To date, the most comprehensive attempt to identify the best MI training model was a randomized trial conducted by Miller, Yahne, Moyers, Martinez, and Pirritano (2004), which compared five different training con-

ditions (wait-list, workshop, workshop plus practice feedback, workshop plus individual coaching sessions, and workshop, feedback and coaching) in a group of self-selected, highly skilled clinicians. Although all active training conditions outperformed the wait-list control, only the workshop-plus conditions resulted in enduring training gains. Additional advantage was shown for the workshop plus feedback and coaching condition when client utterances were examined; this condition resulted in significantly more MI-consistent client language during sessions.

Overall, the findings of Miller and colleagues (2004) were very promising and have provided an important springboard for research in MI training. First, Miller and colleagues underscored not only the importance of training that extends beyond an initial workshop, but also the value of feedback and coaching based on objective evaluation/coding of sessions versus clinician self-report. Clinician self-report of MI adherence and skill was not reliably associated with objective measures of adherence and skill in this study. Second, in this study, workshop alone outperformed this condition in a prior study of less highly skilled

clinicians who attended training through their employer (Miller & Mount, 2001), suggesting that baseline skill and trainee motivation are important factors to consider in MI training. Third, the rapid attrition of participants and the reduction in work samples for review across the study period, falling from 76% at 4 months to 45% at 12 months, calls for caution in interpreting these favorable results and highlights the need for methods to improve the submission of work samples. Finally, even in this skilled, motivated group, some clinicians were unable to achieve beginning proficiency in MI, suggesting enhancements or modifications to the training protocol may be warranted.

Since the original project by Miller et al. (2004), there have been attempts to replicate and extend the findings with different populations. Moyers et al. (2007) attempted to replicate and extend these findings in 129 practitioners from 54 Air Force bases. Participants in this study had, on average, less education, fewer years of experience in counseling, less experience with substance abuse clients, and expressed less interest in learning MI at the outset of training than those in the Miller et al. study. All

participants received an MI book and video training series. Participants were randomized to receive workshop only, an enhanced training condition that included workshop training plus personalized feedback based on one interaction with a simulated patient, or a self-directed training condition that included the book, video series, and a delayed workshop. Although initial increases in clinical skills were found after the workshop, they were not as large as those found in the 2004 study by Miller and colleagues. Surprisingly, providers in the group receiving feedback and coaching did not differ in their improvements from other groups. Further, at posttraining a larger percentage of participants in the self-directed group (who received no workshop) met all criteria for MI proficiency.

Low compliance with work-sample provision was also a problem in the Moyers et al. (2007) study. Audible work samples were submitted by 68%, 58%, and 38% of participants at 4, 8, and 12-month follow-up, respectively. Interestingly, participants in the self-directed training group were also most likely to comply with work-sample submission. The authors speculate that this was influenced by the fact that workshop

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training was only available to this group after all work samples had been submitted, and thus these participants may have perceived greater incentives for submitting the samples. In the enhanced condition, in which participants had up to 6 consultation calls available to them, only 20% completed all six calls, and 36% did not complete any of the calls. All participants in this condition received personalized feedback based on an interaction with a simulated patient conducted at workshop completion.

More recently, Walters, Vader, Nguyen, Harris, and Eells (2010) emphasized the necessity of ongoing coaching and feedback as part of successful MI training. In taking their training "out of the lab," Walters and colleagues compared an enhanced MI training program for probation officers with two groups of untrained officers (those who wanted MI training and those who did not want MI training). All participants ($N = 30$) completed work samples at three times during 6 months (baseline, 2 months, and 6 months). Probation officers who received a training package that included a 2-day workshop, a half-day booster session in the first month and one or two coaching sessions monthly during 6 months maintained improvements in MI skills over 6 months. These skill improvements were greater than officers who received no MI training. While this finding replicates previous research, many participants in the enhanced MI training group still did not meet MI beginning proficiency levels. Seven officers total from all three groups (three from the MI training group) did not complete the project; however, only one officer chose to discontinue and all others discontinued because of transfers. Thus, the retention rate was good. Because training was not the sole focus of this project, less information was provided about the specific aspects of the training package such as the nature and focus of coaching or organization support for officer involvement in the program.

Taken together, these results highlight that MI is not easy to train or learn, an assertion emphasized by Miller and Rollnick (2009). Additionally, while the workshop format may continue to be the preferred method for MI training, it appears to be insufficient for helping providers competently integrate MI into their clinical repertoires. Researchers suggest that more comprehensive training models that include feedback and coaching revolving around work samples may be more appropriate to build beginning proficiency. Moreover, there is clear evidence that additional modifications or enhancements to training will be required

to enable most clinicians to achieve expert competence in motivational interviewing. As a final note, the existing literature on MI training reveals that in addition to cost, a major barrier to ongoing feedback and supervision is the provision of work samples; even groups of providers who are "highly motivated" for MI training exhibit limited compliance with this with this aspect of training.

Continuing Education and Telehealth Technology

Barriers to sufficient, efficacious MI training may be compounded in rural and underserved areas, where clinicians have difficulty accessing continuing education opportunities. Fortunately, there is growing evidence that rural health professionals are open to receiving continuing education through telemedicine technologies and perceive such training as beneficial. For example, evaluation of continuing medical education programs in Vermont and upstate New York offered via telemedicine technologies, such as videoconferencing, revealed that 70% of providers who remotely attended these programs would not have attended if it had not been available over telemedicine. Moreover, 73% of those who remotely attended the programs reported that it was as effective as having a presenter in the room (Callas, Ricci, & Caputo, 2000). Participants in a video-conferencing education program for mental health professionals in six rural Canadian communities similarly reported high levels of satisfaction with the training received, particularly the opportunity to interact with other professionals. Participating professionals also reported significant pre-post gains in confidence with interventions and issues on which they had received training (Church et al., 2010). However, as noted previously, despite clinician confidence, it is doubtful that typical continuing education offerings, even when offered in traditional face-to-face contexts, are adequate to help providers achieve proficiency in MI (Walters et al., 2005).

Schafer, Rhode, and Chong (2004) examined the impact of MI workshop training offered via telehealth technology to staff at substance abuse treatment agencies throughout the state of Arizona. Training was delivered as five, 3-hour live video workshops broadcast one per month for 5 months. Findings of the study provide promise for use of telehealth technology to broadly disseminate MI, while at the same time further underscoring the need for en-

hanced training. Although participants were moderately satisfied with all aspects of the training and reported significant increases in self-perceived MI knowledge and skills, objective measures revealed statistically significant, but clinically insignificant improvements in MI knowledge. Additionally, although there was evidence of significant increases in reflective listening on a vignette-based measure, MI proficiency as a result of the workshops was difficult to assess. Only 9 participants (out of 351 who observed at least one workshop) submitted work samples across the study, and these individuals demonstrated minimal, non-significant improvements in MI skill.

The low rate of work sample submission and training completion in the Schafer et al. (2004) study are also important to note. Although the original intent of the trainers was to have 30 participants submit audiotapes of sessions with clients before, immediately after, and 4 months after the five telecasts, only 23 agreed to do so, and only 9 actually submitted all five recordings. Additionally, although 351 providers attended the first workshop broadcast, only 145 attended all 5 telecasts. While generally consistent with prior research about training attrition over time (e.g., Miller et al., 2004), this finding is still somewhat surprising. Broadcasts were made to 19 sites, 13 of which were in rural areas. Thus, for many of the participating providers, training was likely far more convenient than typical continuing education opportunities.

The research on use of telehealth technology to promote dissemination of MI and other evidence-based practices to rural substance abuse and mental health settings suggests that practitioners are open to this method of delivery of continuing education programs. However, the research also suggests that without modifications, such programs will result in dissemination of information, but will not result in true technology transfer. In real-world settings, with real-world practitioners, even intensive MI training programs with significant in-person components have failed to produce the skill acquisition necessary for posttraining implementation of MI by participating practitioners (Moyers et al., 2007; Walters et al., 2010).

In a services improvement project, we implemented a continuing education package adapted from the training protocol described by Miller and colleagues (2004) utilizing a combination of intensive face-to-face training with telehealth technologies as well as the use of telehealth technologies alone to implement an enhanced training

protocol for MI in rural community substance abuse treatment settings. In developing the training protocol, we sought to emulate successes observed and address barriers identified in research on MI training.

Method

Participants

Participants in the services improvement project were 16 providers at two community substance abuse treatment facilities in rural Mississippi. Twelve participants were alcohol and drug counselors and 4 were supervisory staff at these facilities. Six participants reported college or graduate-level training and the mean number of years of experience was 5.7 ($SD = 5.7$).

Measures

Attendance at postworkshop group and individual coaching sessions and compliance with submission of requested work samples served as measures of training engagement. This information was supplemented with qualitative comments from participants about the reasons for nonattendance and noncompliance and trainer observations.

Procedures

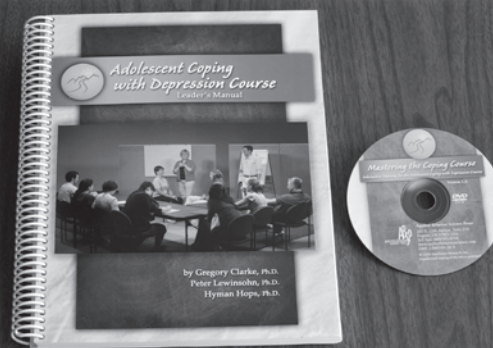
The training was designed to include a 2-day MI introductory workshop followed by 10 weeks of individual and group coaching. Individual coaching involved five 15-minute individual sessions during which adherence and competence feedback was provided based on audiotaped work samples. These sessions also included problem solving, demonstration of skills, and role-play related to how to individualize MI to specific client issues. Because MI is more than what clinicians are already doing (Miller & Rollnick, 2009), individual sessions often focused on the use of questions, reflections, summaries, and affirmations in an MI-consistent way. Group coaching involved five 1-hour sessions during which progress and problems were discussed, skills and concepts were reviewed, and practice exercises were conducted. All coaching sessions were provided in a style consistent with MI with the goal of modeling MI skills (Madson et al., 2008; Martino et al., 2006). For example, coaching sessions included (a) a summary or review of previous sessions, (b) agenda setting, (c) eliciting trainee evaluation of the sample, (d) feedback about the sample, and (e) eliciting trainee response to the feedback. Coaches were mindful to also

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use MI-consistent reflections, questions, affirmations and summaries as well as to ask permission to provide feedback or give information. The individual and group coaching were provided on alternating weeks. Due to delays in the installation of equipment at the first site ($n = 12$), all workshop training and group coaching was provided in person by the first author at this site. At the second training site ($n = 4$), workshop training and group coaching were provided via video-conference by the first author. All individual coaching was provided by telephone by the first and second authors, both of whom are academic, licensed clinical psychologists and members of MINT with 6.5 and 4.5 years of MI training experience, respectively. To supplement this training, each participating facility received two copies of the book *Motivational Interviewing: Preparing People for Change* (2nd ed.) and one copy of an MI DVD training series (Miller et al., 1998; Miller & Rollnick, 2002).

Several modifications were made to the Miller et al. (2004) training protocol. First, all training was offered on-site at community substance abuse treatment facilities. This modification was made primarily to reduce trainees' travel time, thereby increas-

ing the ability of facilities to allow all of their clinical staff to participate in training. The management teams at the facilities expressed a strong desire for the training to result in implementation of MI at the facilities. It was also hoped that this modification would enhance technology transfer by increasing facility-level participation, support, and motivation for the training—allowing providers to share their successes and enthusiasm for the approach and collectively problem solve barriers to implementation. It was hoped that use of group coaching, a second modification made primarily to reduce the amount of trainer time required for coaching provision, would similarly foster technology transfer. A third modification to the Miller et al. protocol was provision of a greater amount of personalized feedback in the weeks immediately following training through individual coaching. Additional and related modifications, intended to increase compliance with this aspect of training were the provision of digital audio-recorders and a secure web-based portal for submission of work samples and a request for work samples to be submitted every 2 weeks following the training, rather than every 4 months.

Results

The modifications to the training protocol appeared successful in the goal of increasing participation. All group coaching sessions at both sites were attended by 75% to 83% of participating clinicians, with 87% of trainees across the two sites attending at least 4 out of 5 coaching sessions. In addition, facility-level support and motivation for the training was evident in the group coaching sessions. At most of these coaching sessions, several minutes at the outset were spent with several clinicians describing their successes in using MI and the positive differences they noticed in client reactions. Modifications to the training protocol were also generally successful in the goal of enhancing compliance with work-sample submission. All trainees across the two facilities completed at least two individual coaching sessions, with 94% completing 3 or more and 50% submitting all requested samples and completing all 5 individual coaching sessions.

Despite the overall high level of engagement with the training, participants expressed several difficulties with providing work samples. Only one trainee provided all samples as scheduled. Thus, the coaching initially scheduled to take place over 10 weeks continued for over 18 weeks at the first facility due to missed and rescheduled sessions. Trainees provided various reasons for missed and rescheduled sessions, such as lack of appropriate cases, client refusal, and competing work demands. Although few trainees openly expressed anxiety about having their performance reviewed, the trainers suspected that evaluation anxiety likely contributed substantially to problems with work sample submission. Additionally, very few of the work samples provided were optimal for MI training purposes. Many were very brief (≤ 15 minutes), with clients who had been in treatment for several weeks, and involved reviewing 12-step homework. At the second site, following initial problems with sample submission (25% of samples submitted), trainees were instructed to audio-record role-plays in lieu of work samples when necessary. Following this modification, we were able to achieve 95% compliance with submission of requested samples. However, trainees continued to experience difficulty finding time to record samples (coaching period extended from 10 weeks to over 30 weeks) and we continued to receive samples that were brief and focused on suboptimal content for MI training.

Discussion

The goal of this services improvement project was to facilitate the dissemination of MI by implementing an evidence-supported training program in rural communities using telehealth technology. Given that previous studies identified trainee attrition and decreasing work sample submissions as major concerns in the training methods outlined by Miller and colleagues (2004), these methods were adapted for this project not only to address the unique needs of trainees in rural areas, but also to target these concerns. Relative to published information about trainee attrition and compliance (e.g., Miller et al., 2004; Moyers et al., 2007), these modifications appeared successful in keeping trainees involved in the training and work sample submission process. In particular, it appears that on-site training and group supervision might have reduced barriers such as travel and increased work absence that can often interfere with intensive training programs. Further, the steps to leverage current technology (use of digital recorders, on-line submission portal) for work sample submissions might have eased the process for trainees in such a way that increased their willingness, from a procedural standpoint, to submit samples. Thus, based on these very preliminary results it appears that attempts to reduce as many barriers to trainees' engagement as possible might improve their involvement and motivation to follow through with training procedures.

Limitations

Although this work provides important insights and ideas for future work in technology transfer, the fact that this was a small services improvement project (with an objective of improving services and client outcomes in real-world settings), rather than a large, rigorously controlled research project (with an objective of contributing to our body of knowledge), limits conclusions that can be drawn. For example, the small sample and nonrandom selection of participating sites limits the generalizability of findings. It may be that the sites that participated in this project are more committed to adoption of evidence-based practices than typical substance abuse treatment facilities. Additionally, although one site received all training via telehealth technology (video-conference and telephone) and one group received all training except individual in-person coaching, the fact that this occurred because of delays in installation of telehealth equipment rather than random as-

signment (as would be the case in a typical research project) precludes us from drawing conclusions about the relative efficacy of these two approaches. This is an important question that must be addressed in future work. It is also difficult to understand exactly how to contextualize the outcomes of our project in the research literature. Given that this project was explicitly identified by our IRB as not meeting the federal definition of "research," the work was subject to HIPAA and other regulations and policies governing standard operating procedures at the sites, but was not subject to research regulations. It is possible that clinicians are more willing to participate fully in training opportunities offered outside a research context (without extensive informed consent documents and assessment batteries) and that this, rather than modifications to the training protocol, is responsible for our relatively high rates of training compliance.

Future Directions

When examining the results of this project with those from Miller et al. (2004) and Moyers et al. (2007), it appears that work sample submissions is a major training barrier. Although our submission rates were good, the length and type of samples made observation and feedback difficult. To correct this problem in the future, projects might include specific guidance about selecting and securing appropriate cases for work samples and suitable length and focus of sessions. Further, if using role-plays or real-plays (i.e., practice MI sessions in which the partner playing the client discusses a behavior change he or she is really considering, such as increasing exercise or reducing television watching), specific guidelines for organizing the client role may help. These instructions might include how to choose a target behavior as the client (i.e., not too personal or too trivial—something you feel two ways about), provide examples of potential behaviors, and any specific guiding rules (e.g., avoid being too resistant or too accommodating). Finally, projects may consider using simulated standardized patients (Lane et al., 2007; McNaughton et al., 2008). Using simulated standardized patients may allow trainers to structure work samples in a fashion that allows for consistency and better evaluation of MI skill.

With regard to the use of distance technologies in training, future work might explore how newer technologies, such as mobile phone applications, might be applied to this task. As clinicians, continuing education providers, and researchers move

forward in this area, it is important to work with information technology experts familiar with HIPPA and other relevant regulations to ensure that communications comply with rigorous ethical and confidentiality standards. In the current project, all participating clinicians obtained written informed consent from clients to records sessions and submit the sessions to the first and second author via a secure web-server verified by the IT department at our academic medical center as HIPPA-compliant.

Overall, these results highlight the potential value in embracing and integrating technological advances in training programs, especially for rural trainees. Therefore, trainers might consider the various modifications in planning trainings. This project also highlighted barriers to technology transfer and opportunities for future investigation.

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April is election month

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Remember to cast your electronic vote. If we do not have your email in our system, then we mailed you a paper ballot. If you did not receive voting materials, please contact us!

Why Volunteer for Psychology Association Governance Groups and Committees?

Mitch Prinstein, *University of North Carolina, Chapel Hill*

It is not easy to maintain a career in clinical psychology these days. Whether employed primarily as a scientist, instructor, or clinician, and no matter what your career stage (i.e., student, early career professional, senior psychologist), one's to-do list is perpetually overflowing.

So, the prospect of volunteer work seems especially infeasible for most.

But volunteering as a member of a committee or running for an elected position within professional societies in psychology may offer more to the field, and for your career, than you may realize. This article offers a brief list of factors that may help you reconsider why volunteering can be worth your valuable time.

1. *The Field Needs You!*

As a discipline, clinical psychology has made enormous strides in a relatively brief period of time. In just over 60 years or so, tremendous advances have been offered in the areas of psychopathology classification and treatment, clinical psychology training, and clinical science. The field truly has transformed within the time of one generation. But there is much work to do be done. Active debates continue in many areas, including many current hot topics, such as evidence-based practice, transportability of efficacious treatments, internship supply/demand, clinical psychology training models, accreditation practices, the DSM, public education, and the globalization of clinical psychology. What most do not realize, however, is that the most impactful decisions regarding these extremely important issues

usually occur within small groups of 10 to 15 clinical psychologists who meet within a governance group or committee. In short, you can be one of these 10 to 15 people! Such committees and governance groups often struggle to find volunteers to fill its vacancies, and often a range of expertise and professional backgrounds are preferred. If you thought that only the most well-known and experienced psychologists have an opportunity to make such an impact, then think again!

2. *Immediate Gratification Is Possible!*

Let's face it. There is little we do as clinical psychologists that helps us to feel immediately efficacious. It can take years to see the fruits of one's research take hold. And even when we do make a difference in the life of a client, we are trained to emphasize their contributions, not our own, in their progress. In short, it's often hard for a clinical psychologist to feel like they have made a quick and lasting professional impact. This is why volunteer work within professional societies can be so gratifying. Here is an opportunity to contribute to a policy, a resource, or a professional opportunity that can change the field in a quick and dramatic way. There is so much to work on within the field, and governance groups most often are comprised of very bright, motivated, and innovative people who are ready to make a difference. This can be an invigorating context in which ideas turn into action and problems find quick solutions. This type of atmosphere can provide the perfect complement to what many clinical psychologists do during their "day job," and can offer

quick and effective respite from the routine of one's full-time responsibilities.

3. *The Dividends of Networking*

Many psychologists and psychology trainees truly want to make a difference in the field and crave the opportunity to feel quickly gratified by their work. But there are only a certain number of hours in the day, and their well-meaning intentions give way to an understandable diffusion of responsibility. If this sounds familiar, then perhaps this last selling point will be useful for you: Volunteer work, and its concomitant opportunities for professional networking, likely will have a direct benefit for your career. Students and early career professionals: Guess who will be sitting across the table from you as you volunteer? . . . The same people who likely will read your applications for internship, write your promotion letters, and offer you jobs. Mid-career and senior psychologists: You already know that your colleagues within a committee will also be your peer reviewers on manuscripts and grants. A context to chat informally with these fellow volunteers can offer enormous opportunities for professional development. A single trip to a governance meeting can give you tremendous insight into factors that will improve your work and your professional trajectory.

Still don't think you have the time to get involved? If you read this blurb, then you must have 5 minutes to spare! Let this be an initial investment into a new aspect of your career that will help you feel empowered, gratified, and perhaps most importantly, will help the field that you have dedicated your professional life to.

ABCT has many opportunities to get involved. Visit www.abct.org/Members for more information (and see below).

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Getting Involved

Ever have aspirations of running for office or getting more involved in ABCT governance? A terrific first step is to become a member of an ABCT committee. For example, if you are a regular user of Facebook, Twitter, or other forms of social media, we could use your help on the Social Networking Media Committee. Like to know what members are thinking or just like to help? We could use more members on the List Serve Committee. This is, after all, a membership organization. So we are always looking for members to serve on the Membership Committee, Student Membership Committee, Ambassador Program, and members in academic settings for our Graduate Mentor Directory. Involvement does take time but not a lot of it. There are email exchanges, teleconferences, and a face-to-face meeting of the committee during the Annual Convention. If you're ready, drop a line to Mary Jane Eimer, Executive Director, mjeimer@abct.org She will be happy to hear your interests and suggest the appropriate committee(s) for your skill sets.

A Closer Look at the Benefits of ABCT Membership

Kristene A. Doyle, *Albert Ellis Institute*

Kamila White, *University of Missouri–Saint Louis*

If someone asked you why you belong to this professional organization as opposed to another, how would you respond? Perhaps your answer would be because of our fantastic annual convention, or maybe it is because ABCT was your first “professional home.” ABCT is an organization where you can build relationships, remain current in scholarly research, network, earn continuing education credits, and grow your leadership skills through many volunteer opportunities within the organization. In addition, it may surprise you that many of the benefits of ABCT are available to you 365 days a year. What are some of these benefits of ABCT membership?

List-Serve

Many members of ABCT work hard every day to help their clients function better in their environment, and the ABCT list-serve is a great resource for recommendations on treatment manuals, assessment challenges, self-help manuals, referrals, and discussions about issues affecting our field. In one recent interesting list-serve thread—“The greatest advice I ever received”—members shared the most influential recommendations they had received during their careers. The effect was that one piece of advice was spread to all of our members who participate on the list-serve, generating more posts with more valuable advice, and so on . . .

Online Access to Scholarly Journals

All members receive free online access to *Behavior Therapy* and *Cognitive and Behavioral Practice*. Both journals help scholars and practitioners stay at the forefront of the field as they relate to clinical problems.

Special Interest Groups (SIGs)

Members can become involved in any of over 40 SIGs within the organization. SIGs serve as a smaller community within the larger ABCT community. SIG membership can be a great opportunity to facilitate collaborations on shared interests and develop

leadership skills through many volunteer opportunities within the organization. In addition, the Association hosts the popular Friday-night SIG expo during our annual convention, where members can meet one another with similar interests as well as interact with many of the influential leaders and past presidents of ABCT .

Mentorship

Another benefit of membership is mentorship. The opportunity to mentor a younger professional or be mentored by a seasoned professional permeates the stages of one’s career development. If you are a student member or a new professional member, there is the opportunity to link with and be guided by one of ABCT’s many experienced members—some of whom have had a seminal impact on the field. Believe it or not, these influential members are approachable and genuinely interested in our younger members’ career development. On the other hand, for our veteran members of ABCT, there is the opportunity to foster the development of our next generation of leaders in the field and in our organization. If you have already done so, you may want to join our Graduate Mentorship Directory if you are in academia or check it out if you are a student.

Website

As a service to its members, the ABCT website (www.abct.org) maintains a large and growing library of videos and podcasts to help demonstrate clinical techniques to illustrate behavioral and cognitive therapies. Members can download free fact sheets of various psychiatric disorders (which are very helpful to clients), and receive sizable discounts on the purchase of Clinical Grand Rounds, Professional Development series, and the Clinical Assessment series. Finally, perhaps the most popular hit on our website is the Find-a-Therapist service. If you have not signed up for this clinical benefit, please be sure to do so. For only \$50 more, we can list your prac-

tice particulars and philosophy. We also highlight a new clinician each month with our “ABCT Clinician of the Month.” The website also includes teaching resources (i.e., CBT course syllabi) and includes regular updates on obtaining your continuing education credits.

The benefits of membership in ABCT are exciting and wide-ranging. Our membership is strong and continues to grow stronger each year. There is a culture of community within ABCT. Our members come back year after year because of the breadth of the offerings in the program, the opportunity to reconnect with old colleagues and graduate school friends, as well as network and develop new professional relationships. There are numerous ways to get involved to contribute to influencing the direction of the field, from joining a SIG, volunteering on a committee, or generating interesting and insightful conversations on the list-serve. At the forefront of its goals, ABCT wants to ensure that members continue to take advantage of the many benefits offered. ABCT wants to continue to be your professional home.

Correspondence to Kristene A. Doyle, Ph.D., Albert Ellis Institute, 45 E. 65th St., New York, NY 10065; krisdoyle@albertellis.org.

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IN-PRESS

“ . . . therapist avoidance and therapist fear are likely critical to most instances of treatment failure in DBT, as well as other treatments.”

—Rizvi, “Treatment Failure in Dialectical Behavior Therapy”
doi:10.1016/j.cbpra.2010.05.003

Cognitive and Behavioral Practice’s landmark special issue on Treatment Failure is now online:
sciencedirect.com/abct

ABCT *Welcome, New Members!*

*The individuals listed below
have recently joined ABCT.*

FULL MEMBERS

Adrian Aguilera
Charlene Bang
Peter Barnes
Bekh Bradley
Debra M. Burnett
Daniel J. Buysse
Erin L. Cassidy-Eagle
Brian Peter Chiko
Larry Cohen
Kellie Condon
Eileen I. Correa
Eugene Joseph D'Angelo
Daniel Scott DeBrule
Jacqueline Dillon DeMarco
Grace Eleanor Dent
Shannon Dorsey
Colleen J. Doyle
Michael E. Dunn
Elizabeth EllisOhr
Emmanuel E. Enekwechi
Pablo Gagliesi
Eda Gorbis
Robert Michael Gresham
Tracy D. Guiou
Susan Haverty
Efren F. Hilera
Kimberly Renee Hill
J. Bruce Hillenberg
Barron Hung
Matthew L. Israel
Peter S. Jensen
Ertugrul Koroglu
Margaret (Peggy) Kriss
Julie Ann London
Jennifer Lynn Martin
Joshua Masse
Georganne M. Neufeld
Noosha Niv
Kevin N. Ochsner
Samantha D. Outcalt
Meghan Carrie Prosser
Margaret Rea
Mary Catharine Rimsans
Prathima Setty
Carla Sharp
K. Bryant Smalley
Michelle Sun Smith
Kevin Douglas Stark
Jill A. Stoddard
Dustin K. Teruya
Chrystal D. Tunstall
Robert Joseph Vanecek
Zachary Warren
Paula Wilbourne
Alison M. Yaeger

NEW PROFESSIONALS

Andrea R. Ashbaugh
Amanda Gale
Clare Smith Gaskins
Chloe Hoang
Amanda LintsMartindale
Emily Malcoun
Debra L. Mishler
Stephen Stuart O'Connor
Sydney Savion
Karen E. Seymour

POSTBACCALAUREATE

Lauren Asarnow
Lauryn Bauerband
Kalpa Bhattacharjee
Jacquelyn Bridgette Blocher
Jennifer Ann Czarlinski
Perry I. Factor
Elizabeth Henry
M. Alexandra Kredlow
Kimberly Ann Martin
Christina Metcalf
Stephanie Nicora
Kathryn Phillips
Amelia McMorris Rowley
Catherine Shaffer
Hannah Weisman

STUDENT

Tara Elizabeth Adams
Molly Adrian
Casey E. Allington
Rachel Dawn Amodio
Lindsay Anderson
Brooke J. Arterberry
Kelsey Elizabeth Banes
Michael John Baniewicz
Leland R. Bardsley
Erik Benau
Dana Elizabeth Bender
Lisa Betthausen
Vickie Bhatia
Sarah Ann Bilsky
Michael James Bordier
Lauren Bradley
Beau Charles Brendley
Lara C. Buckley
Lisa Jane Burklund
Alisa Burpee
Tara M. Calafiore
Barbara Duff Calvert
Robert A. Caponetti
Larisa Cicila
Lauren Coby
Sadie Cole
Gina T. Cortesi

Stuart Patrick Cotter
Sarah Dahl
Alison Darcy
Lily Davis
Rachel Davis
Qianqian Fan
Ben Ben Felleman Felleman
David Fingerhut
Caitlin Lee Fissette
Philip Joseph Fizur
Mara Fleischer
Sarah E. Forsberg
Andrew Frane
Ann Nita Frankel
Zachary D. Friedman
Jessica Lauren Fugitt
Ingrid Galfi
Kerri Marie Garruba
Darya Gaydukevych
Daniel L. Gering
Michael Joseph Gillen
Jenna Lynn Godfrey
Kate Golash
Joshua Caplan Gottlieb
Natasha Gouge
Bethany S Gourley
Jessica Lynn Graber
Laura Frances Graham
Maya Gupta
Kelly Haker
Julie P. Harrison
Alison Hartwig
Ashley Tate Hatton
Avi Helman
Rachel Hibberd
Roger Elliot Hicks
Bridget Mary Hirsch
Katherine Holshausen
Alexandra Melissa-Anne
Inzunza
Nadia Islam
Michelle L Jaques
Tami Rene Jeffcoat
Kathryn Jones
Matthew Ryan Judah
Lauren Kerwin
Katherine R. Keyser
Cara J. Kiff
Michael Brandon Klein
Sam Klugman
Lauren Knickerbocker
Rachel P. Kolko
Amanda Kuryluk
Abigail Lamstein
Brian Eugene Lattner
Robert Daniel Laxson
Daniele V. Levy

Michelle Lupkin
Laurin Jarrold Mack
Mallory Laine Malkin
Megan Mawson
Charles David Maxey
Andrew McAleavey
Wendy Lee McMahon
Peter Carl Meidlinger
Colleen L. Merrifield
Jennifer Maye Milliken
Daisy Minter
Kelly Nicole Moore
Jessica Diana Nasser
Dia Nath
Erica Joy Natwick
Elizabeth Ann Nicola
Kristen Elizabeth Ogilvie
Anthony Oliver
Jennifer Kathleen Olivetti
Daniel R. Pastel
Janice Rose Paton
E. Brodie Pope
Kaitlyn A Powers
Alexander Harrison Queen
Laura Quentin
Greer Raggio
Esty Rajwan
Jesse Renaud
Michael Bruce Roberts
Adrienne Lynn Romer
Elizabeth Love Ross
Mary Gilman Simmering
McDonald
Noelle Bassi Smith
Alexis Smith-Baumann
Carol Swann
Koki Takagaki
Jeannette D. Tappe
Sarah Ann Thomas
Andres G. Viana
Megan Viar-Paxton
Muthumbi wa Kimani
Jolie Weingeroff
Lauren K. White
Gail Williams
Hannah Camille Williamson
Nina S. Wommack
Bethany Wootton
Sanne Nyke Wortel
Victoria Wright
Katelin Janine Wyness
Angelina Yiu
Nicole Zaha
Annie Zhang
Abe Zubarev

ABCTAMBASSADORS

are needed to:

messenger

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

guide

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

signify

Act as the eyes and ears of the association locally

ABCT's Ambassador program is a brand-new initiative promoting leadership, participation, and membership in ABCT.

ABCT Ambassadors are easily recognized at the annual meeting by their special ribbons. They also receive a certificate of recognition and are featured on our website and in tBT.

For more information, contact Lisa Yarde at ABCT's central office (lyarde@abct.org)

CALL *for* WEB EDITOR

ABCT is seeking a Web editor to assist in updating material in, and developing policies for, its Web site. The position is funded with both an honorarium and editorial support. The role principally involves helping to develop content for the Web site and determine the site and navigational structure best suited to our audiences. Technological knowledge is less essential. The following mission statement and strategy statement detail information on the proposed aims, activities, and audiences of this new Web site effort.

Web Page Mission Statement

The Web page serves a central function as the public face of ABCT.

As such, it has core functions linked to the mission and goals of the organization: facilitating the appropriate utilization and growth of CBT as a professional activity and serving as a resource and information source for matters related to CBT.

Informational and resource activities are directed toward three conceptual groups:

- Members—with emphasis on providing an interface for many of the administrative functions of the organization, including conference information, dues, public listing of therapists, etc.
- Nonmember Professionals—to advertise the comparative efficacy, diversity of styles, and methods of cognitive-behavior therapy, with additional information on training opportunities, available syllabi, and new findings in the scientific literature.
- Consumers—to provide information and treatment resources on disorders and their treatment, with emphasis on the style, “feel,” and efficacy of cognitive-behavior therapy, as well as information on additional issues that consumers confront in treatment (e.g., combined treatments, relapse prevention, etc.).

Web Page Strategy Statement

One of the broader changes in the architecture of the Web page is that our content will now come up on searches.

Accordingly, we need to plan content that will bring professionals and consumers to our site.

The Web editor will need to liaise with associate editors, periodical editors, committees, and SIGs for content. Such content includes:

- Diagnosis-specific information pages (e.g., information on depression and its treatment)
- Efficacy information (comparative, combination treatment issues)
- The “feel” of cognitive-behavioral treatment
- CBT, BT, DBT, RET . . . what is in a name?
- Recent research findings
- Position statements—regarding issues in the field (to clarify what our organization stands for)
- Speakers bureau
- Links to publications
- Helping media find the right person to discuss a topic
- CBT curricula
- Featured therapist of the month
- Research funding available
- Learning opportunities

ABCT’s web site is now a mature site, having undergone several structural revisions. Now, we are looking for a member to help us maximize our own web’s outreach potential and grow it while maintaining structural integrity. In addition, candidates can apprentice with our current web master, learning the interface among web editor, web master, and central office.

How to Apply

ABCT members interested in applying for this position should contact David Teisler, Director of Communications, ABCT, at teisler@abct.org. **The deadline for applications is April 15, 2011.**

the Behavior Therapist
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—PATRICK B. McGRATH, PH.D.

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