

# *the* Behavior Therapist

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### *Past President's Message*

## Sleep: The New Frontier for ABCT

Frank Andrasik, *University of Memphis*



In keeping with the themes of my ABCT presidency (2009–2010), the need to unify diverse disciplines and the need to disseminate evidence-based therapies, I am writing one last message to share some information that bears on both of these topics. While ABCT has a long-standing interest in insomnia, including a SIG devoted to this topic, dissemination and implementation of cognitive behavioral therapy for insomnia (CBT-I) have not been a major focus for our society. In the past year this has begun to change. The combined efforts of the Insomnia SIG and a “reach out” from the Society of Behavioral Sleep Medicine (SBSM) led to an unprecedented number of presentations at ABCT’s 2010 Annual Convention. While in San Francisco, I also had the opportunity to meet with the then-SBSM President (Michael Perlis, University of Pennsylvania Health System) and President Elect (Christina Smith McCrae, University of Florida) about topics of mutual concern. One issue in particular stood out: there is a critical need for CBT therapists to learn and provide CBT-I. Their best-guess estimate is that between 3,500 and 7,500 such individuals are needed across a wide venue of practice settings, from sleep disorder centers to large primary-care health care systems to private practice. As a result of our talks, I asked them to help me prepare this message for *tBT*.

The central question for my SBSM colleagues was how do we align the major imperatives of their new society with those of ABCT (i.e., unify our diverse disciplines and go about the business of dissemination).

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## INSTRUCTIONS for AUTHORS

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

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a **Copyright Transfer Form** (a form is printed on p. 35 of the February 2011 issue of *tBT*, or download a form from our website): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor at [gunthert@american.edu](mailto: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. 77]

Over the course of our discussion, it became obvious that the therapists within ABCT represent an ideal cohort for dissemination, as our membership has the requisite background training (Ph.D. and Psy.D. studies in clinical psychology and cognitive and behavior theory and practice) and experience (extant expertise with other forms of CBT). The remaining, and somewhat daunting, questions are as follows: How do we get the word out regarding this significant practice opportunity for CBT therapists? How do interested therapists obtain the desired specialized training? How do the newly trained therapists integrate the new skill set into their practices?

### *How Do We Get the Word Out Regarding This Unmet Need That Represents a Significant Practice Opportunity for CBT Therapists?*

Obviously this article represents a first step. I hope that ABCT will continue to consider offering CBT-I related training programs at our conference. Mechanisms already exist at ABCT for announcing training programs that occur outside of ABCT via the SBSM and other nonprofit institutional offerings. These combined efforts will help to make sure that our constituency is aware of available training.

### *How Do Interested Therapists Obtain Training?*

For those who are already licensed and are in practice, the ideal pathway is to complete a series of continuing educational opportunities, including conference workshops (like those offered at ABCT); dedicated multi-day seminars (like the BSM course offered by the SBSM and the CBT-I Seminar offered through the University of Pennsylvania); peer supervision (available via therapists that are credentialed in Behavioral Sleep Medicine); practica experiences (via mini-fellowship or full fellowship opportunities); and self-study (via existing published treatment manuals [e.g., Edinger & Carney, 2008; Morin & Espie, 2003; Perlis, Jungquist, Smith, & Posner, 2008] and principles and practice texts [e.g., Sateia & Buysse, 2010]). Completion of such a regimen not only will insure that the practitioner is ready to offer the evidence-based form of CBT-I, it will also serve as meeting some or all the eligibility criteria for certification, should the individual be interested in obtaining specialty certification.

### *How Do the Newly Trained Therapists Integrate the New Skill Set Into Their Practices?*

Marketing one's practice is, without a doubt, an art form. This said, there are many ways to advertise one's new skill set, including arranging for a collaborative relationship with one's local sleep disorders cen-

ters, HMOs, and getting listed in relevant provider directories.

In closing, there is a need, there is a way to meet the need, and our members can play an important role in this regard. I hope that many of you will see, as I do, a common thread here and view this as a call to arms to help disseminate and implement CBT-I in such a way that it becomes universally available in the near future.

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 ABCT | Please join us in congratulating ...



**Mark Terjesen** was selected by the administration of St. John's University to receive the Outstanding Faculty Achievement Award to be presented at the 2011 Year End Convocation on May 24. Dr. Terjesen has made a significant contribution to the department as a mentor for PSI CHI, organizing colloquia, chairing numerous dissertations, and in many other ways.



**Lily McNair** was named the next Provost and Vice President for Academic Affairs at Wagner College in New York City. Currently at Spelman College in Atlanta, she will begin her new responsibilities on July 1. Wagner College President Richard Guarasci stated, "Her superb leadership will continue Wagner's strong focus on student learning, civic engagement and global education."

## Demystifying the Postdoctoral Experience: A Guide for Applicants

Nicholas R. Forand, *University of Pennsylvania*

Allison J. Applebaum, *Memorial Sloan-Kettering Cancer Center*

Applying for internship is a structured, organized process, with many resources available for applicants. In contrast, applying for a postdoctoral position is chaotic. Individual training goals, sites, applications, and responsibilities are heterogeneous and applicants are generally offered little formal guidance. As we navigated the process a year ago, we encountered many unexpected challenges, and often wished for better resources and advice. These experiences inspired us to write this article. Below, we draw on the knowledge of those familiar with the process, along with professional resources, to provide a detailed look into the process of obtaining a postdoctoral position. We hope the results will give future applicants a guide for navigating the rocky postdoctoral landscape.

A postdoc is a temporary position in which an individual with a doctoral degree obtains mentored training intended to enhance professional skills. It is often an ideal way to obtain the experience necessary to achieve one's career goals, and it has become a popular route for recently graduated psychologists. Despite the attractiveness or even necessity of obtaining one of these training opportunities, the dizzying array of postdoctoral positions and lack of a centralized listing and application process can leave one at a loss. Added to this are the constantly shifting features of the postdoctoral landscape. For example, over the past decade, the American Psychological Association (APA) has begun accrediting postdoctoral programs in general clinical and specialty clinical areas (e.g., child psychology, health psychology, etc.). As of

December 2010 there were a total of 59 accredited programs, with more expected to receive accreditation in 2011. The APA requires postdoctoral programs to meet a strict set of quality and training requirements (available on APA's website).<sup>1</sup> Thus, an applicant seeking high-quality training is advised to look into APA accredited programs. However, by no means must one obtain an APA-accredited position to have an excellent training experience. Currently, the relatively small number of these programs means that applicants must view APA accreditation as another variable added to an already complex model.

Another example of this complexity is the recent push for a uniform notification date (UND), spearheaded by Dr. Russell Lemle of the San Francisco VA. Dr. Lemle found that many postdoctoral applicants felt forced to take expiring offers from their lower-choice programs because they had not yet heard from their preferred choices. Since 2004, he has been coordinating an effort among postdoctoral sites to offer a UND, intended to help applicants make more informed choices. Currently, over 100 sites have agreed to notify their postdoctoral applicants on the same day (in 2011 it was March 9). The UND is another admirable effort to organize the postdoctoral system; however, as Dr. Lemle noted in his Association of Psychology Postdoctoral and Internship Centers (APPIC) e-newsletter article (Lemle, 2008), nonparticipating programs can outcompete UND programs by extending offers before the uniform date. Other programs have been reluctant to join the UND because they are wary of losing their top applicants to programs that ex-

tend offers early. Thus, although a UND will benefit applicants if universally adopted, the current system forces applicants to contend with both participating and nonparticipating programs. Because both APA accreditation and the UND are works in progress, clinical applicants are confronted with an only partially organized system.

These are just two of the issues postdoctoral applicants encounter. This piece offers information and guidance for each step of the postdoctoral process. Our focus is on general research and clinical positions, broadly defined. Specific specialties, such as clinical neuropsychology, have their own standards for postdoctoral training, but this is out of the scope of the current article. To acquire information from a range of sources, we conducted an informal survey. We asked colleagues if they were interested in sharing their experiences, and we posted similar requests for feedback on several professional and scholarly listservs. When individuals responded, we sent them a series of informal questions. For current or former postdocs, these questions asked about their experiences searching for and obtaining postdoctoral positions. For postdoc mentors, we asked about the details of the positions they offer and what they look for in postdoctoral candidates. Over 60 individuals shared their experiences with us, representing a wide range of specialties and career paths. Their responses form the backbone of this piece.

An excellent companion to this piece is Seime and Zeiss (2005), in the April 2005 issue of *the Behavior Therapist*. These authors summarized the presentations from ABCT's (then AABT's) postdoctoral panel from the 2004 convention. We expand on their advice by offering a greater range of perspectives on the postdoctoral process, and organizing them into a "how-to" style guide. Prospective applicants are encouraged to read both pieces.

### Why Get a Postdoc?

Our first question for current and former postdocs asked why they pursued a postdoctoral position. Perhaps the most common response, across both research and clinically oriented postdocs, was to acquire supervised hours and experience for licensure.<sup>2</sup> Other responses affirmed that individuals seek postdocs to develop their skills or improve their credentials. Research-oriented postdocs generally wanted to add publications to their CV or gain expertise in grant writing, whereas clinical postdocs sought specialized training or experience

<sup>1</sup>APA accreditation should not be confused with membership in the APPIC listing service. APPIC has been listing postdoctoral programs since 1991, and has its own set of standards for membership. These are available on the APPIC website (see e-Resource Appendix).

<sup>2</sup>Most states require postdoctoral supervised hours, but some do not (e.g., Alabama, Washington). We recommend familiarizing yourself with the requirements of your state before starting your postdoc search. See the Association for State and Provincial Licensing Boards website for state-by-state licensure requirements.

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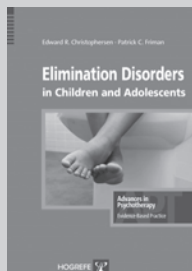
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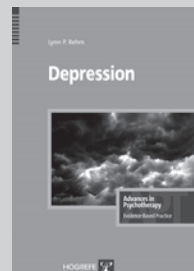
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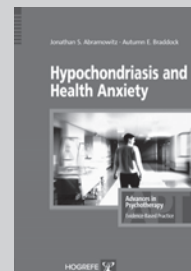
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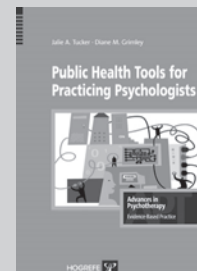
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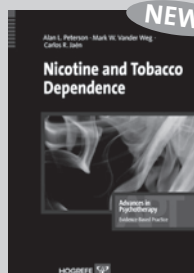
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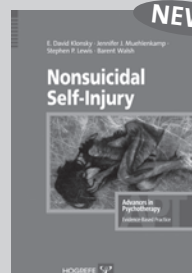
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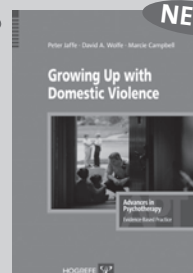
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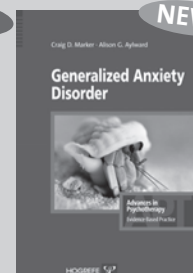
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with certain populations. Others were less sure of their plans, and wanted a postdoc to help sort out career options. One respondent, a university faculty member and accomplished researcher, said that she was unsure what kind of career she wanted, and thought that a postdoc would help her decide. Her experiences as a postdoc confirmed that an academic career was the right fit.

### Types of Postdoctoral Positions

#### *Clinical Postdocs*

The APA Committee on Accreditation sorts clinical postdocs into two major categories: traditional programs in clinical psychology, which include clinical, counseling, and school psychology, and specialty practice programs, which include cognitive, clinical child, clinical health, clinical neuropsychology, family, forensic, and rehabilitation psychology. Most clinical postdocs are offered periodically at sites similar to those that offer internships (e.g., state and private hospitals, clinics, VAs, etc.). There are exceptions, however. One postdoc reported that he provides clinical services for a university faculty member's R01 grant. Thus, he has a "clinical" position funded entirely by a research grant. Thus, individuals searching for clinical postdocs might benefit from attending to advertisements from traditionally research-oriented sites.

Some of the clinical postdocs obtained by respondents offered a substantial amount of research experience, whereas other positions offered little to none. Expectations of clinical mentors were similarly varied. Most clinical mentors said they would support research if a postdoc was interested, but they also suggested that the time available for research was dependent on the time allotted to clinical responsibilities.

#### *Research Postdocs*

Research postdocs are likely to be found in academic hospitals, universities, or VA medical centers. All of the research-oriented respondents had positions supported by grants or other federal monies. The majority had T32 National Research Service Award (NSRA) institutional training grants. These National Institutes of Health (NIH) grants are awarded to institutions to develop mentored research training programs, and their postdoctoral positions are typically 2 years in duration. VA research positions were through the Advanced Fellowship Program for Mental Health Research and Treatment, which offers 2-

year positions that are 75% research and 25% clinical. Others drew support from faculty NIH R-series grants.

Prospective postdocs might also consider NIH's F32 NSRA training fellowships. F32s are 2- to 3-year fellowships that provide support for individuals wishing to obtain mentored training in a specific research area. Applicants select an institution and faculty mentor, and submit an NIH grant application. Similar funding opportunities are available from other federal and private sources. Obtaining independent funding has some major advantages: it demonstrates your ability to attract outside funding early in your career, and you are able to tailor your experience exactly to your training goals. As one respondent noted, the F32 allows you to "write your own ideal job description." Prospective applicants should see Seime and Zeiss (2005) and the NIH website. Of note: according to the NIH, only 28% of F32 applications were funded in 2010, so it is a good idea to have a backup plan.

Perhaps surprisingly, over half of our research-oriented postdocs indicated that their position included supervised clinical hours. Indeed, respondents highlighted clinical experience as a major factor in selecting these postdocs. Again, mentors varied in their support of clinical work. Some said they explicitly include supervised hours in their positions, whereas others support clinical work only insofar as it does not interfere with research activities.

### Where to Find Advice

In an unstructured process, finding good sources of advice is crucial. Respondents obtained advice from their graduate advisors, internship faculty, and current and former postdocs. Other sources included the APPIC postdoc listserv and the ABCT postdoctoral panel. One respondent cited *The Compleat Academic: A Career Guide* (Darley et al., 2003) as a useful resource for those interested in academic careers. To this list we would add Novotney (2010), and the discussion forums at forums.studentdoctor.net. Of course, the idiosyncratic nature of the postdoctoral process can limit the usefulness of any advice. Debra Burock, Ph.D., a licensed psychologist in Lafayette Hill, PA, sums this up nicely:

"I sought out books, articles, and my current and past supervisors for advice; however, I found that each person's experience in securing a postdoc was incredibly unique. There didn't seem to be a standardized process and

mostly appeared to be luck of the draw and persistence in locating a placement that was best suited to the individual's needs and preferences. There was little published information on the process so most was word of mouth from those practicing professionally."

With this in mind, we encourage prospective postdocs to cast a wide net when looking for advice.

### Searching for Postdoctoral Positions

The process of searching for postdocs is another challenge. The APPIC and APA websites are useful but far from comprehensive. At the time of this article, a search for programs in the New York metro area in the APPIC directory produced only 3 listings, and one of these was in New Haven, CT. To supplement these resources, respondents signed up for listservs and contacted their professional networks.

Using their responses, we compiled the following list of advice for the postdoc search:

1. Start early. Many applications are due between December and March, although other positions come open throughout the year. Most applicants start the process around October, but some started while still in graduate school. A few internship sites offer an option to continue as a postdoc, and even if the site does not guarantee interns postdoctoral positions, experience as an intern can be helpful in securing a postdoc at the same site. Thus, if possible, we recommend considering the potential for a postdoc when applying to and ranking internship sites.

2. Use official resources, such as APPIC, APA, and APPCN (for neuropsychology sites). Even if you don't find something that interests you, the listings can give you a good idea of what types of programs are available.

3. Join listservs such as APPIC, ABCT, SSCPnet, and APA divisional listservs. Also look into joining state and local psychological associations and sign up for their email lists. Postdoctoral positions are often posted to these sources in the fall.

4. Look for position listings in professional publications such as the *APS Observer*, the *APA Monitor*, and the *Behavior Therapist*.

5. Check job sites like psychcareers.org, chronicle.com, jobs.phds.org, and Monster.com.

6. Email everyone you know. You should be in touch with all of your professional contacts to let them know you're in the market for a postdoc. In addition to graduate and

internship faculty, you might also contact research collaborators, peers, and previous and current postdocs.

7. Email everyone you don't know, but might be interested in working with. Several respondents, including both of the authors, found open positions by emailing people whose research interested them. Send a brief email stating your interest and a C.V.

8. Identify common postdoctoral sites in your preferred geographical area (hospitals, clinics, VAs, etc.), and contact their faculty members to see if positions might be available.

9. Look into positions at VA medical centers. According to the VA psychology training website, there are 260 clinical postdoctoral positions available across the country. The VA also offers research opportunities at 23 specialized sites (these go by various abbreviations: MIRECC, NCPTSD, etc.). See the e-Resource Appendix for the relevant VA websites.

10. Look into independent funding opportunities, like F32s and other federal and

private sources such as National Alliance for Research on Schizophrenia and Depression.

11. Get creative. Two respondents checked the NIH RePORT website (see e-Resource Appendix) to see who had recently received funding in the areas they were interested in, then emailed those individuals. This might also be a way for clinical applicants to find projects that need a study therapist or clinical coordinator. Also be on the lookout for opportunities to develop your own postdoctoral position. See Novotney (2010) for some advice.

One additional note about searching: A handful of respondents from rural areas noted that they had difficulty finding clinical positions with supervised hours. Individuals in these areas should be prepared to encounter fewer opportunities, and may need to intensify their search.

### *Applications and Interviews*

*Applications.* In addition to the standard cover letter, C.V., and three letters of recommendation, many sites have additional application requirements. Some are minor, such as standardized application forms and

transcripts. Other common requirements are statements of career goals or research interests and work samples, such as case reports or publications.

Some sites, however, required our respondents to put an extensive amount of work into their applications. One postdoc reported that two sites asked her to answer four 500-word essay questions. Research-oriented positions, such as T32s, often asked applicants to submit a research plan or to propose a project. Some programs also asked applicants to propose how they will accomplish their training goals at the site. One former postdoc, who developed her own postdoctoral position, had to describe her desired responsibilities and training requirements, propose a salary, and provide productivity estimates. Given the time needed to complete some of these requirements, we advise that postdocs start their applications early and budget their time accordingly.

In the interest of helping aspiring postdocs fine-tune their applications, we asked postdoc mentors what they looked for in a good applicant. All mentors said they re-



## **NeuroDevelopmental Science Center PEDIATRIC PSYCHOLOGIST**

The NeuroDevelopmental Science Center is seeking a full-time clinical child/pediatric psychologist specializing in behavioral intervention strategies. The NeuroDevelopmental Science Center combines the disciplines of Psychology, Neuropsychology, Psychiatry, Neurology, Neurosurgery, and Developmental-Behavioral Pediatrics to form the only facility of its kind in the State of Ohio. The Center's vision is to provide exceptional care and value that enriches the quality of life for young people and families affected by neurological and developmental disorders.

The primary responsibility of this position will be to deliver inpatient and outpatient diagnostic and treatment services to the children and families served by the NeuroDevelopmental Center. This position affords a unique opportunity to develop psychological and behavioral services in our growing spasticity and epilepsy programs, as well as other service needs for children and families dealing with developmental disabilities.

There are excellent opportunities for collaboration with physicians, nurses and other health care professionals as members of the multidisciplinary team. Supervision, teaching, and training are available of graduate students and postdoctoral fellows in psychology, pediatric residents, and child psychiatry fellows. Research opportunities, depending on the applicant's area(s) of interest, are available.

Akron Children's Hospital is a full-service pediatric medical center for children from birth through young adulthood, serving a pop-

ulation of 2.5 million in northeastern Ohio ([www.akronchildrens.org](http://www.akronchildrens.org)). It is the 9th largest freestanding pediatric hospital in the country and the largest pediatric care provider in Northeast Ohio, serving a population base of 2.5 million in over 25 counties. Every year, Children's Hospital cares for about 400,000 patients and performs more pediatric surgeries than any other hospital in Northeast Ohio. Children's is a teaching and research hospital affiliated with the Northeast Ohio Medical University (NEOUCOM). It also offers more than 100 advocacy, education, outreach and research programs.

Please refer to our website ([www.akronchildrens.org](http://www.akronchildrens.org)) and click NewsRoom, About Akron Children's, for detailed information about Akron Children's programs and initiatives in Northeast Ohio.

**Requirements:** Ph.D. or Psy.D. in child clinical psychology/pediatric psychology including completion of an internship in an APA-accredited child psychology/pediatric psychology program. Applicants who have completed a post-doctoral fellowship in pediatric psychology and with hospital-based work experience preferred. Experience in evaluation and treatment of the specialized populations treated by the Center strongly preferred, with special emphasis on behavioral assessment and intervention strategies. Must be license-eligible in the State of Ohio. Candidates from minority and diverse cultural backgrounds are encouraged to apply. Akron Children's is an affirmative action and equal opportunity employer. Competitive stipend and benefits package are provided.

Interested candidates should send a letter of interest, a curriculum vitae, and the names and contact information of three professional references to: Akron Children's Hospital, One Perkins Square, Akron, Ohio 44308-1062, Attn: Georgette Constantinou, Ph.D., Division of Pediatric Psychiatry and Psychology.

quire a certain degree of experience (e.g., training, hours, relevant experience) or professional accomplishment (e.g., publications, grant applications). Many also want applicants with clear career goals, and a plan for how they will use their postdoctoral experiences to achieve them. Along the same lines, mentors looked at work samples for quality and clarity of thought. Interestingly, mentors were somewhat skeptical of letters of recommendation. Letters with specific examples from the recommender's experience with the applicant were valued, whereas letters with lists of positive adjectives were not. Whenever possible, applicants should make sure their recommenders are producing letters of high quality that include specific examples. This is also advice to keep in mind if you are asked to write your own letter on behalf of the recommender.

*Interviews.* Interviews ranged from an informal chat to multi-day affairs including one or more job talks. Indeed, a handful of respondents reported that sites required them to complete both a multi-day interview and a job talk, in addition to providing extensive application materials. Group interviews and panel interviews were also common. Sites that were outside applicants' geographical areas sometimes offered interviews via phone or Skype video chat, but if an in-person interview was required, most sites did not pay for travel expenses.

Questions for clinical postdocs appeared similar to those asked on internship interviews. Applicants were asked to describe their theoretical orientation, clinical experience, and preferred style of supervision. They were also sometimes asked to present a case, or conduct a role-play. One respondent said that a site asked him to write a testing report on the spot. Questions for research postdocs included fit with the site and/or mentor, prior experience with grant writing and securing funding, and discussions of research interests and career goals.

Mentors appeared to weight the interview heavily in the selection process. Many stated that a combination of personality and fit is more important than an applicant's achievements. Mentors look for candidates who are personable, dependable, confident, and capable of excelling within the demands of the position (e.g., self-motivated, able to work with a team, etc.). Clinical mentors valued strong interpersonal skills, whereas research mentors valued intellectual curiosity and potential for independent research.

These responses suggest that credentials will get you through the door, but that the

interview is the key for securing an offer. Applicants will likely need to dust off the skills learned for internship interviews. Be prepared to "sell" yourself during the interview, both in terms of your accomplishments and fit for the position.

### *Offers and Acceptances*

*Offers.* The responses of postdocs regarding the process of receiving and accepting positions paint a stressful picture. There was little uniformity regarding how soon offers were given. Some offers were given on the spot, while other individuals had to wait weeks—and in one case 3 months—before an official offer was made. Of those who applied to programs in the UND, several described problematic situations resulting from conflicting notification dates between participating and nonparticipating programs (and for one respondent, from conflicting notification times on the same day between UND programs in different time zones). There was also variability in the amount of time applicants were given to accept or reject offers. Times ranged from a month or more to a few hours after receiving the offer. These pressured situations created problems for applicants, some of whom rejected early offers because they were waiting to hear from more preferred sites. This decision resulted in one respondent receiving no other offers.

Applicants should be aware of these complexities, and prepare accordingly. Except in some cases (e.g., the UND), there are no rules and few protections. This makes the process more "interpersonal and political" than the internship process, in the words of one current postdoc. Although these features can make the process stressful, they also suggest there is more opportunity for applicants to influence sites. For example, some sites will ask if their program is your top choice (there are no rules against this). If it is, saying so might improve your chances of getting an offer. One postdoc was able to obtain an offer from a site by calling a contact there and reiterating his strong interest. Initially (according to the contact), the site was not going to extend an offer because of a perceived lack of fit, but did eventually extend one as a result of the phone call.

Because there are no standardized interview dates, receiving an offer from one site before even interviewing at another is common. In these instances, time frames for accepting offers might be negotiable. Sites also want to secure their top candidates, so an applicant with an offer from a less pre-

ferred choice might be in a position to negotiate with a preferred choice, provided the interest is mutual. One postdoc stated that he obtained an early offer from one site by informing them about a deadline on another less-preferred offer.

Negotiating can be difficult, but basic assertiveness skills can help. When negotiating a deadline extension, state your interest in the position, describe your problem (e.g., I have another interview), and politely but assertively ask for your desired outcome (e.g., Will you extend your deadline?). Certainly there will be variability with respect to outcome; some sites will act in good faith and allow applicants to weigh their options, and others will force applicants to accept or reject on their terms. Negotiating strategies might also have a higher probability of success with informal postdocs, but this is not always the case.

*Acceptances.* Respondents reported a number of concerns when it came to accepting offers, reflecting both their training goals and their personal priorities. The most common reasons for accepting an offer were the availability of supervised hours and the geographical location of the position. Other reasons included the salary, the "fit" between applicants and the site or to-be mentors' personal style, and the possibility of being hired at the site after the postdoc. As expected, nearly all applicants highlighted the importance of specific training or research opportunities.

We also advise applicants to keep their post-postdoc plans in mind when considering offers. For individuals who want to improve their research vitas, 1-year postdocs are not ideal because they provide very little time to publish before the job search starts again. For clinically oriented individuals, it is important to know the licensing requirements for the preferred state of residence, and whether you can meet them. Also, it is important to pay attention to the experiences of current or former postdocs at the site. These individuals have first-hand experience, and can help you determine whether your training needs can be effectively met if you take the offer.

Similar to deadlines, other aspects of offers can be negotiated. Start dates are often changed to accommodate internship end dates (these conflicts can also preclude some sites from giving offers, so make sites aware of your internship end date early). Applicants might also discuss increased compensation or benefits, including cost of living supplements. Clarification and negotiation of responsibilities is also important. In theory, the flexibility of postdocs allows



individuals to shape the training experience to fit their needs. However, unclear standards or an inadequate initial agreement can result in a poor training experience. We know of several instances in which postdocs took positions that advertised a certain set of responsibilities, only to find the time or opportunity for a desired feature of the position limited. For example, several respondents found themselves in research positions where clinical involvement was discouraged, despite the promise of supervised hours in the program description. Applicants are advised to clarify the time and scheduling for each of their responsibilities before accepting offers.

Whenever possible, applicants should obtain an offer letter or other written agreement describing the details of the position. The letter should include, at least, the title of the position, the dates of appointment (including the end date and possibility and terms of renewal, if applicable), the salary or stipend, and some description of your anticipated role and responsibilities. Letters might also include the source of funding, benefit information, and other policies to which you must agree. The letter and all

supporting information should be read carefully. If you have questions, or see anything that is discrepant from what you and your prospective mentor had agreed, do not sign it until the issue is resolved to your satisfaction. A detailed initial agreement can help sort out responsibilities, and also offer protection against other problems that can occur once the postdoc starts.

#### Some Concluding Thoughts

As our own experiences and those of the respondents demonstrate, obtaining a postdoctoral position can be time-consuming and stressful. The large number of emails we received in response to our listserv postings suggested others also recognized a lack of guidance, and were eager to help fill the void. We hope that we have provided a resource that will be useful to future applicants.

Overall, a few points stand out. A general impression we formed while reading the responses is that there is no one way to get a postdoc; each applicant's experience is unique. Some succeeded by starting the process while still in graduate school. For one of the authors, this meant creating a 3-

year plan, thinking about the ideal geographical location and work setting, and then tailoring the internship application process and even rotations while on internship to this plan. Others worked tirelessly on internship, exploring multiple possibilities until they found the right fit, whereas a fortunate few found ideal positions with little effort. Because the process is so unpredictable, we urge you to be persistent, creative, and proactive at all stages. You never know what opportunity will bear fruit.

Another consistent message was to network, network, network! Whether that means contacting individuals you exchanged business cards with or "cold calling" (or more likely, emailing) individuals with whom you share a particular interest, the point is to let anyone and everyone know that you're on the lookout for a postdoc. It can also be helpful to find a trusted mentor or friend to help guide and support you through this process. Recent applicants or peers are particularly suited to provide information as well as a supportive shoulder. In fact, the co-authors of this article found themselves doing just that while each

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of us was going through the process! Despite the trouble, though, many of the past postdoc respondents said the process itself was a period of growth for them, in which they were able to meet a major challenge head-on with limited support.

Finally, for all, a postdoc is a stepping stone to a more secure position; it is a period of transition, of becoming a professional in the field. Whether that means securing a license and going on to a clinical practice, or writing one's first grant and demonstrating one's ability as an independent researcher, the postdoctoral years represent a transitional state. And like all periods of transition, it can be challenging. However, once the transition is complete, the rewards are often worth the struggle.

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We would like to thank all those who shared their experiences regarding the postdoctoral process. Without your contributions, this article would not have been possible.

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### Appendix: e-Resources

#### • Sites That List Postdoctoral Positions

**Association of Postdoctoral and Psychology Internship Centers (APPIC):**

<http://www.appic.org/postdocs/index.html>

**Association of Postdoctoral Programs in Clinical Neuropsychology (APPCN):**

<http://www.natmatch.com/appcnmat/>

**APA accredited programs:**

<http://www.apa.org/ed/accreditation/programs/index.aspx>

**Veterans Affairs Mental Illness, Research, Education and Clinical Centers:**

<http://www.mirecc.va.gov/mirecc-fellowship.asp>

#### • Sites That Provide Useful Information

**APPIC Membership:**

[http://www.appic.org/about/2\\_3\\_2\\_about\\_policies\\_and\\_procedures\\_postdoc.html](http://www.appic.org/about/2_3_2_about_policies_and_procedures_postdoc.html)

**APA Accreditation:**

<http://www.apa.org/ed/accreditation/programs/accred-postdoc.aspx>

**VA Psychology Training:**

<http://www.psychologytraining.va.gov/>

**NIMH Research Training:**

<http://www.nimh.nih.gov/research-funding/training/index.shtml>

**NIH NSRA F32:**

<http://grants1.nih.gov/grants/guide/pa-files/PA-11-113.html>

**NIH RePORT website:**

[http://report.nih.gov/investigators\\_and\\_trainees/index.aspx](http://report.nih.gov/investigators_and_trainees/index.aspx)

#### • Forums and Organizations

<http://forums.studentdoctor.net/>

<http://www.nationalpostdoc.org/home>

<http://www.phds.org/postdoc/>

### Classifieds

**UNIVERSITY AT BUFFALO, THE STATE UNIVERSITY OF NEW YORK.** The State University of New York at Buffalo's Department of Psychiatry currently has a fulltime position for a child and adolescent psychiatrist to work in Adolescent Inpatient Psychiatry. Candidate will need expertise in community psychiatry to work on a number of projects in the division of community psychiatry. Rank dependent upon qualifications. Competitive salary and attractive benefits package available to qualified candidates. *The University at Buffalo is an Affirmative Action/Equal Opportunity Employer. Applicants must apply online at: [www.ubjobs.buffalo.edu](http://www.ubjobs.buffalo.edu)*

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**POSTDOCTORAL FELLOWSHIP IN CHILDHOOD ANXIETY AND SLEEP DISORDERS.** The Dept of Psychology at the University of Houston invites applications for a postdoctoral fellowship beginning in Aug/Sept 2011. Responsibilities include coordinating an NIH funded study examining sleep in anxious children, manuscript preparation, mentoring students, and grant writing. Mentorship in the childhood anxiety and sleep disorders will be provided. Applicants must have a Ph.D. from an APA-accredited clinical psychology program and training in behavioral and child interventions. Send letter of interests, CV, and 3 letters of reference to Candice Alfano, Ph.D., at: [drcandicealfano@gmail.com](mailto:drcandicealfano@gmail.com).

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## Wrestling With the Beaver: Embracing Absurd Exposure in the Treatment of Social Anxiety Disorder

Ashleigh Golden, *Pacific Graduate School of Psychology—Stanford Psy.D. Consortium*

The words “social” and “anxiety” both fluttered about in the nebula of my 16-year-old vocabulary, but somehow never managed to flap in unison. The indomitable words could not be tamed into orderly diagnosis by the pocket-sized version of the *DSM-IV*, a resource that was not part of the required curriculum in Grade Eleven.

All that I had was a seemingly amorphous collection of experiences whose commonality I failed to recognize. During conversations at parties, I leaned against walls or any other available surfaces, desperately attempting to appear stable while sweat snaked through the spirals of my corkscrew bangs. My hammering heartbeat seemed to pulverize my ability to think. Walking from my house to the post office, I wiggled my fingers in peculiar patterns, unsure how to maintain them in a steady swinging motion. (This, of course, only drew more attention to me, thus exacerbating my efforts to devise a seemingly normal stride.) At restaurants with friends, I was convinced that I had a piece of food lodged between my two front teeth; I compensated by downing glasses of water both to distract myself from my own discomfort and my friends from the putative dental detainee. I thought that I was being watched, not by a group of government spies or a band of extraterrestrials, but by the far more terrifying prospect of a scrutinizing jury assigned to judge my every social interaction.

In college, I paid a visit to the counseling center for an unrelated matter. The therapist took a psychosocial history, examined my current thoughts and emotions, and revealed to me that I met criteria for social anxiety disorder. I was thrilled to have a label for my endless series of insufferable interpersonal experiences and bizarre compensatory behaviors. “I have social anxiety disorder!” I euphorically informed my roommate after my first session. “That’s fantastic?” she replied.

The next week, I began a course of what the therapist deemed cognitive-behavioral group therapy (CBGT) for social anxiety disorder (SAD). Cognitive-behavioral therapy (CBT) is based on the premise that changes in dysfunctional cognitive schemas (i.e., cognitive restructuring) and maladaptive patterns of behavior will reduce distress and improve psychological functioning (Barlow, 2002). In Heimberg’s CBGT for social phobia (Heimberg & Becker, 2002), cognitive restructuring involves identifying automatic thoughts and cognitive errors, disputing automatic thoughts, and generating rational (adaptive) responses. Numerous studies conducted to date have demonstrated the efficacy of CBGT for SAD (Heimberg, Becker, Goldfinger, & Vermilyea, 1985; Heimberg, Dodge, Hope, Kennedy, & Zollo, 1990; Heimberg et al., 1998; Heimberg, Salzman, Holt, & Blendell, 1993; Liebowitz et al., 1999). Many researchers concur that effective treatment of social phobia necessitates changing dysfunctional thoughts and beliefs regarding social situations (Beidel, Turner, & Dancu, 1985; Butler, 1989; Heimberg et al., 1990), especially excessive fear of negative evaluation. Butler asserts that since thoughts are critical to the condition of social phobia, there is a *prima facie* reason to believe that cognitive methods should play a role in its treatment.

I was at the time what I might now call a “highly motivated” client. I listed aloud my automatic thoughts with the glowing pride of a mother who has laid eyes on the fuchsia face of her newborn for the first time. “Everyone is watching me!” “I’m behaving abnormally!” “I am stupid!” I chanted like a zealous devotee of the Automatic Thoughts Cult. Every week, I dutifully completed my thought records until I could recite the column headings like a blessing and fill in the columns like they were simple requests for my basic biographical information. My roommate looked on in well-meaning horror as I plastered my side of the room with

helpful disputing questions and expatiated about the varieties of cognitive distortions.

It did not work. I became my own expert; I became my own therapist. I endured social situations, yet my anxiety did not diminish. My room became a shrine to a promising idol that had neglected one of its most ardent disciples. I later learned that most individuals do continue to show some residual symptoms and impairment post-CBGT, and approximately 25% of individuals are considered nonresponders to treatment (Eng, Coles, Heimberg, & Safren, 2001).

Granted, my group therapy had concentrated only on cognitive strategies; it did not include a formal behavioral exposure component, which is a core feature of authentic CBGT. Interestingly, however, whether cognitive therapy is used alone or in conjunction with an exposure component does not seem to matter. The evidence from studies comparing the effects of exposure alone to cognitive therapy alone indicate that significant differences do not exist between the two modalities (Emmelkamp, Mersch, Vissia, & van der Helm, 1985; Scholing & Emmelkamp, 1993), suggesting that cognitive therapy and exposure therapy are equally powerful treatments.

Studies exploring the benefits of adding cognitive therapy (such as cognitive restructuring) to an exposure condition show that cognitive therapy does not bestow added value upon exposure alone (Feske & Chambless, 1995; Taylor, 1996). As summarized by Feske and Chambless (p. 713), “Current interventions directly focused on cognitive modification do not result in greater improvement [than exposure alone] on cognitive variables or on measures of social phobia.” In a study comparing *in vivo* exposure alone (EXP) to a combined treatment integrating exposure and cognitive restructuring (COMB), Mattick and Peters (1988) found that the combined treatment produced greater effects on actual behavior and self-rated avoidance of the target feared situation than the EXP condition. The COMB condition also showed better end-state functioning and improvement. Mattick and Peters concluded that the greater effects of the addition of cognitive restructuring argued for an advantage of a treatment integrating cognitive techniques with exposure. However, in a follow-up study comparing *in vivo* exposure, cognitive restructuring without exposure (CR-Alone), and COMB, Mattick, Peters, and Clarke (1989) found that there were no significant between-group differences in end-state functioning and improvement.

Mattick et al. concluded that "Exposure-alone . . . had substantial effects on measures of the phobia in the long-term . . . It is apparent that the effects of adding cognitive restructuring to exposure were not substantial" (p. 21). Hope, Heimberg, and Bruch (1995) compared CBGT to an exposure-based treatment (exposure without formal cognitive restructuring) and a wait-list control. Although participants in the CBGT condition showed more improvement than participants in the exposure alone condition at posttreatment (measured by SUDS during a behavioral test), this difference vanished at 6-month follow-up. Hope et al. asserted that the findings of the study support the in vivo exposure component of CBGT, noting that over half of the participants in the exposure-alone condition, who did not experience cognitive restructuring, displayed clinically significant cognitive changes. Hope et al. concluded, "For many social phobics, the experiential learning that accompanies exposure may provide ample evidence to counter dysfunctional beliefs without direct intervention" (p. 648). Hofmann (2004) randomized 90 individuals to an exposure group therapy without explicit cognitive interventions condition (EGT), a CBGT condition involving both exposure and cognitive restructuring, and a wait-list control condition. The EGT and CBGT conditions were not found to be significantly different from one another at posttreatment.

These findings indicate that a cognitive therapy component is likely unnecessary, as exposure alone may be sufficient to treat social anxiety effectively. Further, there is evidence that behavioral treatments (i.e., exposure alone) adequately affect cognitive factors implicated in social anxiety, as even a pure form of exposure is likely to include implicit cognitive elements (Newman, Hofmann, Trabert, Roth, & Taylor, 1994). For example, repeated exposure to feared social situations without the occurrence of negative consequences may compel individuals to reconsider the validity of their dysfunctional cognitions (Hofmann, 2004). It may be that clients being treated with exposure alone are engaging in a form of self-administered cognitive restructuring (Rodebaugh, Holaway, & Heimberg, 2004). Because exposure may intrinsically comprise an instrument for cognitive change, cognitions in SAD may be altered without the use of specifically cognitive methods (Heimberg & Ritter, 2008).

At age 19, I was a nonresponder to cognitive therapy, but not a defeated one. I retained a blithe sense of optimism, coupled

with the recent acquisition of the idea of the *reductio ad absurdum* (I had recently declared my major in Latin and Greek Language and Literatures, perhaps anticipating that I would ultimately thrive in my practice treating an ancient-Greek-speaking population). So I decided that I would push my social anxiety to its absurd extremes.

Over the summer, I forced my resistant but vaguely amused friends to dress up in our old Grade Eight school uniforms, holding hands and gallivanting around our hometown of Vancouver, B.C. We went on a "field trip," taking the bus downtown while singing our high school hymn. It is highly likely that we appeared to onlookers as deranged, overgrown trick-or-treaters. It was thrillingly fun. Inspired by the movie *Elf* (in which Buddy the Elf travels from the North Pole to New York City to search for his human father), I bribed my friend to wander around the city with me, locating businesses that labeled themselves as "the world's best \_\_\_\_ [coffee, etc.]" and offering exuberant congratulations to the employees. Returning to college in the U.S. the next fall, I held the esteemed title of Head of the Classics Club. I commanded my reluctant legion to participate in such activities as Toga Bowling, during which I wore a SpongeBob Squarepants toga (crafted by cutting a hole in a sheet for my head) to the bowling alley while the Senior Citizens Bowling Club stared in shock as my soldiers and I competed for the prize for "Most Hideous Bowling Technique." Accompanied by a mortified friend, I entered a designer handbag shop and asked the retail assistant where I could find the "legbags." Bewildered, she summoned her colleagues and asked me to elaborate. I explained that in my homeland of Canada, it was trendy to carry one's injured leg in a bag with extra-long straps. I recounted how I had recently broken my leg while wrestling a beaver, Canada's national animal, and thus required a legbag. I stifled a smile while the retail assistants glanced at each other and my contrite American friend retreated slowly out of the store.

I did not engage in any explicit mental or written cognitive restructuring before or after my absurd, self-designed exposure activities. However, each time I seemed to emerge with a similar coping statement: "If I can pretend to be an obsequious elf, bowl while prouetting in children's bedding, etc., then I can handle engaging in an everyday conversation."

While narrowing down my dissertation topic, which would inevitably focus on SAD, I recalled David Burns' shame-at-

tacking exercises from a course the previous year. Precursors to the concept of shame-attacking exercises were present in Kelly's (1955) Construct Theory, and its derivative, Fixed Role Therapy (FRT). Essential to the therapy was the tenet of *constructive alternativism*, the assumption that all of our current interpretations of the universe are subject to revision and replacement (Kelly, 1955). Karst and Trexler (1970), comparing FRT to Albert Ellis' Rational Emotive Therapy (RET; 1958) in the treatment of public speaking anxiety, designed an FRT condition in which (a) participants observed another individual's responses to public-speaking situations, (b) inferred the role that the individual was adopting (including underlying thoughts and feelings), (c) compared the role to their own typical thoughts and feelings, and (d) discussed how the alternative role might serve to decrease anxiety. The participants ultimately enacted the alternative role in front of the group (Karst & Trexler). The FRT treatment group improved more than the RET group on all self-report measures (Karst & Trexler). I can recall that during my high school years, before engaging in the nausea-producing task of delivering a speech before my English class, I premeditatively took on the role of my best friend Tamryn, who always seemed unnaturally composed when under fire. When I took on the role of her psychological replica (Kelly's notion of enactment), I felt my anxiety gradually subside.

Shame-attacking exercises, like the deliberate enactment of an alternative role in FRT, are those in which an individual intentionally does something in public so that he/she can overcome the fear of negative evaluation and appearing foolish (Burns & Burns, 2004). Acknowledging shame-attacking exercises as an interpersonal exposure technique, Burns observes that socially anxious individuals expect that they will be judged negatively by others (2006): When they have an experience that disproves these negative expectations, their anxiety decreases. Burns asserts that, "You'll usually discover that the world doesn't come to an end after all. This can be a liberating discovery" (Burns & Burns, p. 652). This description certainly fit with my own experience; after my self-administered shame-attacking exercises, I drew my own cognitive conclusions. Not only this, but my experience also matched Burns' prediction that "You'll usually discover that most people don't look down on you . . . In fact, most of the time, everyone ends up having a lot of fun" (2006, p. 203).

Hofmann and Otto (2008) recently developed a CBT manual for the treatment of SAD that incorporates the use of absurd exposures. Although guided discovery, such as disputing questions, is used in the model, the main tool for change is that of graduated exposure. Indeed, Hofmann (2010) considers exposure tasks to be cognitive restructuring, in that the experiences result in a change in the cognitive dimension. By the beginning of the 8th session, participants begin to engage in in-vivo exposure tasks (Hofmann & Otto). Some can be classified as bizarre, ridiculous shame-attacking exercises, involving a component of social mishap/error or challenge that pushes the participants to engage in situations most people would find uncomfortable (Hofmann & Otto). Examples include standing in a subway station and singing "God Bless America" for 30 minutes, asking a female pharmacist for the smallest-size condoms, going to every man sitting at a table in a crowded restaurant and asking, "Are you Carl Smith?", going to a bookstore and asking a clerk where to find books on farting, and walking backward slowly in a crowded street for 3 minutes (Hofmann & Otto). Hofmann and Otto explain that some individuals with SAD believe that social mishaps have disastrous consequences for themselves; thus, the treatment seeks to engender the realization that even if a social encounter objectively does not go well, "it just doesn't matter that much" (p. 177). Hofmann asserts that the experiences are akin to "opening a genie's bottle," as participants eventually begin to feel liberated, develop a sense of humor about the situations, and truly begin to love and enjoy the experiences.

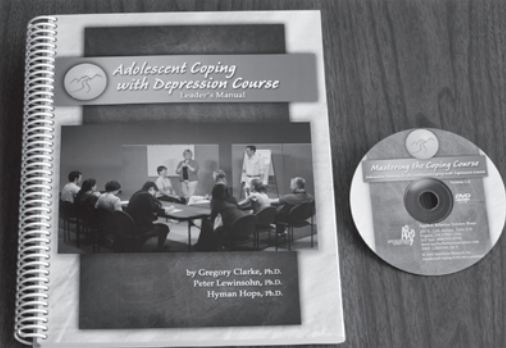
Shame-attacking exercises have an element of comic hyperbole to them, so much so that Burns and Hofmann alike insist that group members may come to enjoy the exercises. Like shame-attacking exposures, acceptance and commitment therapy (ACT) also embraces a sense of the exaggeratedly absurd (i.e., its *cognitive defusion* exercises, such as saying the word "milk" as quickly as possible; Hayes & Smith, 2005). The goal of exposure from an ACT perspective, rather than a focus on extinguishing or reducing negative thoughts and feelings as in CBT exposures, is to engender *experiential acceptance*; that is, a willingness to experience uncomfortable thoughts and feelings (Eifert & Forsyth, 2005). According to ACT, anxiety disorders are believed to develop and persist through *experiential avoidance*, such that anxiety results from an unwillingness to experience anxious thoughts, feelings, and

# Mastering the Coping Course

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bodily sensations (Orsillo, Roemer, Lerner, & Tull, 2004). A core theme of ACT is the paradox that when one struggles to control undesirable private events, the effect can be counterproductive, possibly resulting in increased distress (Abramowitz, Tolin, & Street, 2001; Forman, Herbert, Moitra, Yeomans, & Geller, 2007; Orsillo et al.; Wegner, 1994; Wegner & Smart, 1997; Wenzlaff & Wegner, 2000). If a socially anxious individual can integrate the idea of experiential acceptance from ACT with the ludicrous shame-attacking exercises recommended by Burns and others, welcoming rather than fighting the flood of negative emotions and thoughts during such zany experiences, he/she may ultimately generate autonomous realizations without formal cognitive restructuring.

Employing exposures to work through a patient's fear and avoidance hierarchy is typically considered central to CBT for social anxiety, and this usually entails beginning with exposures that elicit SUDS ratings in the mild to moderate range and systematically progressing to the highest rated items. Creative CBT providers may already incorporate absurd exposure interventions into their treatment of socially anxious patients as they ascend the hierar-

chies of feared and avoided situations. The practice of shame-attacking, however, suggests a direct ascension to the highest-rated items without first successfully conquering those situations that fall in the mild and moderate ranges. I am drawn to the idea of making available another option for individuals who are nonresponders to CBT or an alternative treatment path for SAD altogether, devising a treatment protocol that takes an evidence-based yet playful approach to treating social anxiety. The idea is to enable socially anxious individuals to see that by repeatedly acting in extreme, outlandish ways, mundane social interactions do not appear to be so bad.

Now, during social encounters, my perspiration no longer accumulates torrentially into invisible buckets. Now, not afraid that I appear anxious and my fingers awkward, I no longer transform them into miniature contortionists. I no longer worry that I appear idiotic, because I have already appeared as idiotic as possible, and embarrassment did not asphyxiate me. Now, I simply think to myself, "Ashleigh, if you can tolerate convincing a luxury goods store that you require a legbag due to an injury sustained in a wrestling match with a beaver—and even have fun doing so—

then you can handle the thoughts and feelings that arise for you during this humdrum interaction.”

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## Obituary

# G. Alan Marlatt, Ph.D.

Linda Sobell and Mark Sobell, *Nova Southeastern University*

When G. Alan Marlatt died unexpectedly in March at the age of 69, the fields of clinical psychology, cognitive-behavioral therapy, and addictions lost a giant. “Giant” is a term that can easily be misused, but when talking about Alan it is an understatement. Alan was a role model for all of the things to which clinical scientists aspire. Over his career he demonstrated classic applications of moving science from bench to bedside and conducting innovative basic research that had strong clinical implications. His work on relapse prevention produced a model that has strengthened over the past few decades and that had a revolutionary effect on the addictions field, including making it respectable for people to discuss the possibility of relapse with clients. His advocacy of harm reduction not only made him a leader in that important area of policy, but also was reflected in his work on reducing college students’ drinking, a program of research established long before that area became a national priority. His recent research on mindfulness also has led rather than followed a major addition to cognitive-behavioral therapies. He mentored an enormous number of students and was the mainstay for the Addictive Behavior Research Center at the University of Washington, a center that he founded and led for many years. Finally, he also set an example for being a person of integrity and principle. How many others could lay claim to even a small part of such a legacy? That is why “giant” is truly warranted.

Canadian by birth, Alan was born in Vancouver and did his undergraduate work at the University of British Columbia. He undertook his postgraduate training in the United States at Indiana University in Bloomington, and was awarded a Ph.D. in clinical psychology in 1968. After serving on the faculties of the University of British Columbia (1968-1969) and the University of Wisconsin (1969-1972), in 1972 Alan took a position with the University of Washington where he was a landmark and beacon for nearly four decades, attracting

high-caliber students and postdoctoral fellows. In 1981 he founded the Addictive Behavior Research Center, including its famous BARLAB, as part of the Department of Psychology. Alan’s research prominence is a result of his making quantum leaps into new and uncharted areas of research that led the way for others. For example, in the early 1970s, a particularly clever approach involved his pairing of two innovations, the balanced placebo design and the taste test. The balanced placebo design was a perfect tool for exploring common ideas about the effects of alcohol, namely whether effects were mainly a pharmacological by-product or influenced by drinkers’ beliefs. Under the guise that they were participating in a taste test comparing different versions of tonic water or vodka and tonic drinks made with different tonic waters, participants sampled the beverages and filled out a rating form, but the real measure of interest was how much beverage was consumed. In the balanced placebo design participants were assigned to receive either real vodka and tonic or only tonic, but some were told that they were consuming vodka and some were told they were tasting tonic. Using participants who had alcohol problems and who had not stopped drinking, it was found that the main determinant of consumption was the belief that alcohol was being consumed. This powerful research design was used by Alan, his students, and colleagues to explore a variety of determinants of drinking (e.g., social modeling, aggression, social anxiety).

We feel that Alan’s most significant research legacy was his model of relapse prevention that has been extended well beyond the addictions field into several other areas of health and mental health. Alan told us that his decision to study the process of relapse began with research on aversive conditioning treatment while he was an intern at Napa State Hospital in California. He said he was intrigued by the fact that the vast majority of participants returned to drinking soon after leaving the hospital, suggesting that further studies of aversive

conditioning would be unlikely to bear fruit. Good science involves matching the research strategy to the research question, and because little, if anything, was known about the relapse process, Alan’s initial research strategy was at the observational level, namely interviewing persons who had relapsed and asking them to describe events they felt had precipitated the relapse. These categories of situational factors, later referred to as high-risk situations, turned out not only to be highly stable but also to be associated with relapse to other drug use and smoking. With that as a starting point, Alan developed his well-known cognitive-behavioral model of the relapse process that has served as the basis for relapse prevention treatment. Although Alan’s relapse model led to the development of several treatment strategies (e.g., considering slips as unfortunate learning experiences; interrupting the slip or lapse early; developing strategies to avoid a similar lapse in the future), perhaps the most important impact of the relapse prevention model on the addiction field has been that it legitimized speaking with clients about the possibility that relapses might occur. Young readers of this obituary may find it hard to believe, but at the time that Alan introduced his relapse prevention model the prevailing clinical wisdom was not to speak of the possibility of relapse to clients, despite knowing that relapse was likely to occur.

The next area where Alan again was a pioneer is harm reduction, an approach to alcohol and drug problems that emphasizes reducing the risks and harmful consequences associated with substance use rather than a singular focus on abstinence. The harm reduction approach, seen by much of the rest of the world as practical, realistic, and likely to reduce harm to problematic alcohol and other substance users and society at large, still encounters stiff opposition from traditional substance abuse counselors in the U.S. where abstinence approaches strongly prevail. In this regard, Alan’s support of a harm reduction approach to the treatment of substance abuse strengthened his international prominence in the addictions field, and his international impact was further enhanced during terms as a visiting professor in South America, Europe, Australia, and New Zealand.

Harm reduction is also the area where Alan’s integrity and principles are best exemplified. In 1982, we were accused of scientific fraud regarding a study we conducted in the early 1970s that involved a moderation rather than abstinence goal for some participants. The attack was

steeped in national and international publicity. Serendipitously, before the attack was made public Alan visited the Addiction Research Foundation in Toronto where we were employed. Although he did not tell us that he had heard about the forthcoming attack while he was a visiting scholar in London, when we apprised him of the attack he asked if he could examine our records for the study. A few weeks after that visit, Alan wrote a letter to his colleagues in the U.K. stating his opinion that the attack was groundless. Eventually several hundred copies of that letter were distributed worldwide, sounding a loud note of caution that was later reinforced by vindications in multiple investigations. By making his views known and allowing them to be widely distributed before any investigations had been conducted, Alan took an enormous chance. In explaining his actions several years later, Alan stated that he viewed the attack as an attack on addictions research, and that he was simply defending science. That view exemplifies the quiet humility that Alan exuded, and it speaks to his character that he was willing to jeopardize his career to do what he felt was right. This is another important way in which Alan was a giant.

An excellent example of how Alan applied the harm reduction approach in the U.S. involved developing interventions to reduce the drinking behavior of college students. His research in this area predated an emphasis on this high-risk population by the National Institute on Alcohol Abuse and Alcoholism. Further, the Brief Alcohol

Screening and Intervention for College Students (BASICS) approach that Alan and his colleagues developed at the University of Washington is now in widespread use throughout the U.S.

Alan's most recent research contributions involved the application of mindfulness approaches to treatment. Long a Buddhist, this line of research was a natural extension of meditation techniques, designed to help people cope with triggers for use such as perceived cravings.

In addition to his pioneering lines of research, Alan contributed to his profession in many other ways, including being President of the Association for Advancement of Behavior Therapy (now ABCT) in 1991-1992, serving on more than 24 editorial boards and many scientific advisory boards. He also found time to publish 23 books and more than 300 journal articles and book chapters. For his research advances Alan received numerous prestigious awards, including the Jellinek Memorial Award, the Distinguished Scientific Contributions Award from the Society for Clinical Psychology (Division 12) of the American Psychological Association, the Robert Wood Johnson Foundation Innovators in Combating Substance Abuse Award, and the 2010 Lifetime Achievement Award from the Association for Behavioral and Cognitive Therapies.

Alan's legacy also encompasses all the students and postdoctoral fellows he mentored. Those who worked with him and those who had the privilege to know him

well found him to be a gentle and humble leader who did not seek the spotlight and for whom self-aggrandizement was unknown. As a mentor he inspired and fostered mentee's individual development, as demonstrated by the large number of former trainees who have gone on to establish their own highly successful careers. Despite being extremely busy, Alan was always kind, open, gracious, and welcoming to everyone.

Alan is survived by his wife, Kathryn (Kitty) Moore-Marlatt; his son, Christopher Alan (Kit) Marlatt, and daughter-in-law Ashley Rachel Marlatt; his half-brother, Robert Whitehead; his step-daughters Melanie and Charlotte Miller and Iara Coltrim; his step-son, Colin Maclay; his step-granddaughters Amanda and Seraphina White and Hazel Maclay; and his grandson, Aidan-Jack Marlatt. He will be sorely missed by them and by a host of colleagues and former student whose lives he affected.

When the field first learned of Alan's illnesses and then his passing, the outpouring over social networks was amazing and continuous, reflecting not only his contributions to the field, but also how large a part he had played in so many lives. An important part of Alan's legacy is that his work has helped and will continue to help hundreds of thousands of individuals with alcohol and drug problems who want alternatives to traditional services. ■

## Call for PAPERS

### President's New Researcher

**Submission  
Deadline:**

**August 8, 2011**

ABCT's 2010-2011 President, Debra A. Hope, Ph.D., invites submissions for the 33rd Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of \$500. Submissions will be accepted on any topic relevant to behavior therapy, but submissions consistent with the conference theme emphasizing dissemination are particularly encouraged. Within the dissemination theme, papers could describe and test models or innovative practices including technological solutions and novel venues for service delivery. Examination of dissemination outcome would also be of interest.

Eligible papers must (a) be authored by an individual with five years or less post-training experience (e.g., post-Ph.D. or postresidency); and (b) have been published in the last two years or currently be in press. Submissions can consist of one's own or any eligible candidate's paper. Papers will be judged by a review committee consisting of Debra A. Hope, Ph.D., Frank Andrasik, Ph.D., and Robert Klepac, Ph.D. (ABCT's President, Immediate Past-President, and President-Elect). Submissions must be received by Monday, August 8, 2011, and must include four copies of both the paper and the author's vita.

**Send submissions to:** ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.



## Member Update on 2011 NIMH Research Priorities and Advances

Jason Luoma, *Portland Psychotherapy Clinic, Research, and Training Center*

The National Institute of Mental Health (NIMH) Professional Coalition for Research Progress is an annual 1-day meeting between NIMH staff and relevant mental health-related associations such as professional organizations, researcher organizations, and health insurance companies. The meeting provides an update on recent work by NIMH and describes current research priorities. NIMH also facilitates discussion and feedback from attendees. Each year, ABCT is invited and sends a representative. This article reports on the seventh annual meeting that met on April 13, 2011.

### Overview of Activities by NIMH

Dr. Thomas Insel, Director of NIMH, led off the meeting with an overview of recent NIH and NIMH activities, showcasing larger initiatives. Two large changes at NIH involve the creation of or consolidation of institutes. The first involves the creation of a new institute, named the National Center for Advancing Translational Science (NCATS), which will begin operating in October 2011. According to Dr. Insel, NCATS will focus on bridging basic and applied research in the development of new medications. While NCATS will be a primary home for developing methods to accelerate translational research, each institute will continue to fund a portfolio of translational research focused on their specific interests. The second major change is the merger of the National Institute on Drug Abuse (NIDA) and the National Institute for Alcohol Abuse and Alcoholism (NIAAA) into a single institute, yet to be named. This new institute is expected to begin functioning in October 2012.

As much of the purpose of the meeting was to let stakeholders know what NIMH is involved in, Dr. Insel provided a brief overview of NIMH involvement with several current or recently finished projects, some of which are described below. First he reviewed two recent NIMH efforts to assist the U.S. Army in reducing suicide rates through research and prevention interventions. Second, he outlined a large study, Recovery After an

Initial Schizophrenia Episode (RAISE), that involves 34 sites testing the dissemination of evidence-based interventions for first-episode schizophrenia. Other projects reviewed included EMBARC, which assesses biomarkers in the treatment of depression, and a large study called "Transcriptional Analysis of Human Brain Development." He also highlighted NIMH funding for the Human Connectome Project, which attempts to map all the major circuits in the brain. Another recent development is the "Moonshot for the Mind," a private initiative by retired senator Patrick Kennedy. NIMH is playing an advisory role in this initiative intended to promote private and government funding for neuroscience research. The initiative is intended to be modeled on John F. Kennedy's challenge that galvanized U.S. efforts to land a man on the moon. Finally, Dr. Insel reviewed data from a NIMH-funded study, The National Comorbidity Study, Adolescent Supplement, that has shown that only 36% of diagnosable adolescents receive any treatment. He used this as evidence that adolescents are an underserved population in the U.S.

### Continued Funding Cuts

Dr. Insel regretfully reported on substantial budget cuts that will result in large cuts to new, competing, and continuing grants. At the time of the meeting, NIMH was expecting a .9% budget reduction for 2011. The number of funded new and competing grants has been fairly stable since 2008, when 581 new and competing projects were funded. However, in 2011, only 423 new and competing awards are expected, representing a 27% drop compared to 2008 levels. Success rates are also expected to decrease. The overall success rate in 2008 was 21%, while the expected success rate for 2011 is 15% to 16%. In 2008, the payline was the 18th percentile while 2011 sees an expected payline of the 13th to 15th percentile. Dr. Insel reported that the future is even more bleak with even larger cuts to new and competing grant funding expected in 2012.

### Transforming Practice in Research

The second speaker was Dr. Greg Simon, an investigator at the Group Health Research Institute and research professor at the University of Washington, who presented on "Transforming Practice Into Research." His talk aligned with clinical and research traditions represented in ABCT when he stated that "transforming research into practice is an outdated activity" because it presumes that research is a separate activity from practice. Instead, he said we need to work to better integrate research and practice in a seamless manner.

Dr. Simon compared improvements over the last 25 years in the treatment of depression versus the treatment of cancer. While twice as many people receive some treatment for depression today, he reviewed data showing there has been little improvement in depression treatment outcomes over the last 25 years. In contrast, there have been huge improvements in cancer care, particularly childhood cancer. He stated that much of the improvement in cancer care has come not from new biological agents, but continuing improvement in care, based on continuous improvement in practice. He believes that the integration of research and practice can result in similar improvements in treatment of common psychological problems such as major depression.

Dr. Simon lamented the slow pace of mental health research and suggested that integrating research and practice could be one answer. For example, he stated that it typically takes 6+ years from conception of ideas to dissemination of results, that studies are very expensive due to poor research infrastructure, that there are often a limited range of comparison conditions, and there is a lack of consistent study designs and measurement that results in problems aggregating results across studies. To address these barriers, he has worked with collaborators to create the Mental Health Research Network, a consortium of 11 public domain research centers affiliated with not-for-profit integrated health systems. Core efforts of this network include creating (a) a common electronic medical records system, (b) a shared infrastructure for assessment, (c) a "virtual warehouse" for historical data, and (d) procedures for protecting members' rights and privacy and engagement with providers and system leaders.

The Mental Health Research Network (MRN) is focused on creating a "learning mental health care system." Dr. Simon provided guidelines on what this kind of a care system would look like for patients,

providers, and system administrators. He also reviewed barriers to implementing this kind of system with a particular focus on barriers to protecting the privacy of patients from technical, cultural, and legal standpoints.

Dr. Simon discussed a perceived conflict between evidence-based medicine and personalized medicine. His resolution of this problem is that larger studies are needed to be able to look at interaction effects that will allow matching or adaptation of treatments to patients. MRN will provide the infrastructure such that these larger studies can be run more efficiently.

Finally, Dr. Simon reported on some early results emerging from the MRN. Research typically shows that approximately 30% of patients who attend psychotherapy for depression do not return for a second visit. He showed how the MRN data can help identify where the rates of dropout are highest. For example, in their sample, return after an initial session was lowest in people of color and the elderly. Contrary to expectations, they also found that therapists who reported higher rates of CBT use had higher rates of dropout after the first session. However, other data showed that therapists with highest rates of dropout also had the highest satisfaction rates. He felt that these results could indicate that CBT therapists are (a) more likely to have higher treatment dropout or (b) that they get quicker results, resulting in higher satisfaction. He hypothesized that a learning mental health care system that actually follows up on the outcome of dropouts could disentangle these sorts of explanations and thus guide future implementation efforts.

### Global Mental Health

Next up was Dr. Pamela Collins, Director of the Office of Rural Mental Health and the Office for Research on Disparities and Global Mental Health at NIMH. She spoke on the topic of mental health equity at a global level and the increasing focus on this topic at NIMH (including new funding mechanisms). She began by discussing how resources for mental health are scarce and inequitably distributed both between and within countries. She reported data on the continued increase in diversity in the U.S. For example, Asian and Hispanic populations represent the fastest growing racial/ethnic groups in the U.S. over the last 10 years, with a 43% increase. She also reviewed data showing that racial/ethnic disparities in access to and quality of health care continue to persist in the U.S.

Dr. Collins then focused specifically on the global mental health. Mental disorders rank highly in the contribution to the global burden of disease, with major depression alone ranking third in its contribution to the burden of disease at the global level. Mental health treatment systems compared to “physical health” treatment systems receive much lower levels of funding compared to their relative impact on quality of life. Further evidence of inequity can be seen in that approximately 90% of the world’s investment in health research addresses conditions that only affect 10% of the world’s population (typically those conditions prevalent in higher-income countries). Many low- and middle-income countries have only begun to include mental health as a focus of their national health care programs in the last couple of decades. Overall, she reported an increasing recognition of the importance of mental health in low- and middle-income countries. As an example of research addressing these disparities, she described studies on “task shifting,” in which less specialized providers are trained in evidence-based interventions such as CBT. Most of these studies have examined treatments for depression, showing that nonspecialists can implement effective treatments for depression in low-income countries.

She then described recent initiatives of her office. They created a funding mechanism (the U19) that was released in September 2010, called “Collaborative Hubs for Global Mental Health.” Resulting meetings have focused on developing strategies and targets for research in global mental health. She also outlined a number of funding mechanisms available for researchers who are interested in global mental health and described how her office is working to improve the funding mechanisms for students and early career professionals in this area. Finally, she described the World Health Organization Mental Health Gap Action Plan that focuses on how to implement evidence-based interventions in low- and middle-income countries. Finally, she reported the availability of a newsletter, called *Global Tracks*, that outlines training opportunities in global mental health.

### “Big Science” in Mental Illness: Neurodevelopmental Genomics

The last speaker was Dr. Raquel Gur, a professor of psychiatry at the University of Pennsylvania, and an experienced schizophrenia researcher. She spoke on the topic of neurodevelopmental genomics and the general lack of neuroscience data on development. A recent study funded by stimulus

monies will address this gap. This study assesses a sample of 10,000 children (~7,000 currently completed) on a broad battery of genetic, psychological/behavioral, neurocognitive, and neuroimaging measures. Data from this study will be published publicly on the Internet and all participants provided consent to be followed up for later longitudinal study. Behavioral measures focused on assessments of *DSM-IV*-based disorders, including prodromal psychotic symptoms. Neurocognitive measures included measures of basic memory and executive functioning and also recognition of facial expressions. MRIs looked at structural changes in the brain as well as measures of white matter in the brain. Functional imaging looked at the fractal N-back task assessing short-term memory and emotion identification tasks, all of which are tasks on which people with schizophrenia tend to perform poorly. She reviewed baseline data suggesting that their sample is representative of the larger population of children in the U.S. She believes that this study represents the start of “big science” in the field of mental illness. This study provides opportunities for studying developmental trajectories, integration of behavior and genomics, identification of vulnerable populations, and the development of early interventions. They expect that a number of training awards, supplemental awards, and career awards will stem from this data set.

In addition to the four speakers, each presentation included a brief discussion period. During these periods, Dr. Bruce Cuthbert stated that while late-life depression and dementia were not being reported on at this meeting, NIMH continues to fund studies in this area and that this is an important and active area of research for NIMH. He also discussed the Research Domain Criteria Project (RDoC; <http://www.nimh.nih.gov/research-funding/rdoc.shtml>), a series of NIMH-funded meetings focused on developing a new nosology of psychopathology based on neuroscience. The initial review focuses on five domains: negative affect, positive affect, cognition, social processes, arousal/regulatory systems. This nosology will then be used to guide research priorities at NIMH. A final piece of news was the appointment of Dr. Robert Kaplan as director of the Office of Behavioral and Social Science Research.

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# TORONTO

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## Pre-Convention Institutes

*Thursday, 8:30 a.m. – 5:00 p.m.*

- **The Inclined Heart: A Mindfulness and Values Focused Workshop** | *Kelly G. Wilson & Emily K. Sandoz*
- **Introduction to Motivational Interviewing** | *Daniel W. McNeil*

*Thursday, 1:00 p.m. – 6:00 p.m.*

- **OCD Treatment Compliance/Resistance Issues Exposure & Response Prevention** | *Jonathan Grayson*
- **Pushing Past Perfectionism: Using Cognitive-Behavioral Strategies to Treat Perfectionism Across the Anxiety Disorders in Children and Adolescents** | *Deborah Ledley & Lynne Siqueland*
- **Behavioral Activation for Treating Depression: Putting Guided Action into Action**  
*Christopher Martell & David Pantalone*
- **Dialectical Behavior Therapy for Emotion Dysregulation and Non-Suicidal Self-Injury in Adolescents**  
*Lorie Ritschel & W. Edward Craighead*
- **Mindfulness- and Acceptance-Based Behavioral Therapies in the Treatment of Anxiety and Related Disorders** *Susan Orsillo & Lizabeth Roemer*
- **Concurrent Treatment for Alcohol Dependence and PTSD** | *David Yusko & Edna Foa*

## Advanced Methodology and Statistics Seminars

*Thursday, 8:30 a.m. – 5:00 p.m.*

- **Developing Dynamic, Sequential Interventions that Optimize Mental Health Outcomes: Novel Clinical Trial Design and Data Analysis Strategies** | *Susan Murphy & Daniel Almirall*

*Thursday, 2:00 p.m. – 6:00 p.m.*

- **Item Response Theory: Fundamentals and Application of Modern Psychometric Analysis**  
*James Henson & Abby Braitman*

*Sunday, 8:00 a.m. – 12:00 p.m.*

- **An Introduction to Modern Missing Data Handling Techniques** | *Craig Enders*

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