

the Behavior Therapist

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International Scene

An International Comparison Between Different Theoretical Orientations of Psychotherapy: A Survey of Expert Opinions

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Research in psychotherapy is an international endeavour. There is, however, a paucity of data available as to which forms of psychotherapy are most commonly practiced throughout the world. Most articles on this topic have been published with focus on certain treatments for specific disorders in selected countries or regions. Little is known about a comparison between different therapeutic orientations on an international level.

Several surveys of psychotherapy trends have been conducted in the U.S. In a national survey with 100 American therapists (a response rate of 25%), Wildman and Wildman (1967) found eclectic therapy to be the most common, followed by psychoanalysis and client-centered therapy. The frequent use of eclectic therapy has also been indicated by other surveys (Garfield & Kurtz, 1976, 1977; Norcross, 1986; Smith, 1982). Similarly, Corrigan, Hess, and Garman (1998) found, in a sample of 55 psychologists (again a 25% response rate), that 50% were actually trained under a cognitive behavioral orientation (the majority), but more than 60% practiced according to eclectic models. A study by Stevens and Dinoff (1996), which did not include the eclectic orientation, found in a sample of 69 instructors (a response rate of 47%) that cognitive behavioral therapy was

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among the most common forms of therapy being used (30%), followed by perspectives such as the psychodynamic (28%), interpersonal (15%), humanistic (15%), and behavioral (13%). Similar surveys have been conducted for training institutes (Sayette & Mayne, 1990; Weissman et al., 2006) and in medical settings in the U.S. (Scott, Pollack, Otto, Simon, & Worthington, 1999).

Along with research employing survey methodology to assess which psychotherapeutic orientations are being used, polls have been used to predict which orientations are likely to increase in popularity. A panel of 62 psychotherapy experts (the Delphi poll) with diverse theoretical orientations have predicted CBT, culture-sensitive, cognitive, and eclectic/integrative theories to increase the most in the following years, whereas classical psychoanalysis, solution-focused theories, and transactional analysis has been expected to decline (Norcross, Hedges, & Prochaska, 2002).

While eclectic therapy has been quite dominant in the U.S., there have been similar surveys in Europe and many of them have documented an increased use of the cognitive-behavioral approach (Agathon, 1982 [France]; del Barrio & Carpintero, 2003 [Spain]; Meazzini & Rovetto, 1983 [Italy]; Valderhaug, Gøtestam, & Larsson, 2004 [Norway]). Some research documenting that behavior therapy has taken root in

other countries and regions also exists (Ardila, 1982 [Latin America]; Danquah, 1982 [Ghana]; De Silva & Samarasinghe, 1985 [Sri Lanka]; Dowdall, 1982 [South Africa]; Mikulas, 1983 [Thailand]; Tsoi & Lam, 1991 [Hong Kong]; Yamagami, Okuma, Moringaga, & Nakao, 1982, [Japan]).

Although several studies have looked into the status of certain psychotherapeutic orientations in certain regions of the world, only one large international study has been conducted, which included nearly 5,000 psychotherapists from 285 countries (Orlinsky & Rønnestad, 2005). Analytic-psychodynamic (58%) was the most common orientation, followed by humanistic (31%), cognitive (24%), systemic (21%), and behavioral (14%). However, no comparisons regarding possible trends in different countries or regions were analyzed. It seems intuitively important for researchers, educators, clinical administrators, and political policymakers to be able to assess the current status of different types of therapy for different types of problems.

Surveying expert opinions regarding psychotherapy practice may be a potentially fruitful approach. It could give indications of trends and differences regarding the development of psychotherapy progress in individual countries. The goal of this study was to compare the status of different treatment orientations in different parts of the

world and, more specifically, investigate whether there are variances for certain psychological disorders. In order to achieve this goal, we sampled the opinions of leading researchers/clinicians from boards of influential international therapy organizations. Although this did not result in a representative sample of practicing clinicians (a desirable but highly unrealistic goal), our method provided an important first step toward a worldwide comparison of different theoretical orientations of psychotherapies and it is the first study utilizing a standardized Internet survey format. Recent articles (Sanderson & Bruce, 2007; Stallard, Udwin, Goddard, & Hibbert, 2007) have similarly utilized survey methods to assess expert opinions on particular issues. Furthermore, expert consensus is commonly utilized in developing good practice guidelines.

Method

Participants and Procedure

Possible participants were recruited via e-mail. Following the recommendations by Dillmann (2000), reminder e-mails were sent or personal contact was made after 2 weeks of the initial contact. All participants were recruited based on their affiliation with one of three theoretical orientations of psychotherapy: cognitive behavioral, psychoanalytically oriented, and eclectic/inte-

Table 1. Characteristics of the Participating Experts

	CBT group	Psychoanalysis/ psychodynamic group	Eclectic group
Return rate	35 of 69	7 of 39	24 of 75
Female gender	45.7%	28.6%	12.5%
Average age	47.1 (9.0)	65.0 (9.1)	48.3 (15.7)
Countries represented	16	3	8
Type of work:			
Research and teaching	89%	43%	67%
Adult psychotherapy	43%	71%	63%
Adolescent psychotherapy	14%	0%	17%
Child psychotherapy	11%	0%	4%
Psychotherapy with all age groups	0%	14%	0%
More than five years of training in own orientation	80%	100%	71%
Cognitive behavioural orientation	94%	0%	17%
Psychoanalytical orientation	0%	100%	4%
Eclectic (integrative) orientation	3%	0%	58%
Other orientation	3%	0%	21%

grative psychotherapies. A total of 66 experts participated in the survey, resulting in a return rate of 36.1% (66/183) for the total sample, which is considered a low, but still acceptable, response rate (Babbie, 2004) and comparable to similar studies.

The CBT group was chosen based on their names being listed in the scientific committee and the international scientific advisory committee for the 2007 World Congress of Behavioural and Cognitive Therapies in Barcelona. Out of 69 experts contacted, 35 responded. The return rate was 50.7%, which is considered adequate. Seventy-five integrative therapists were contacted based on the fact that they were listed as authors at the congress for The Society for the Exploration of Psychotherapy Integration in Lisbon 2007. Twenty-four participants from this group (32.0%) responded. Psychoanalytically oriented psychotherapists were chosen based on their names being listed on the board of representatives or the research advisory board for the International Psychoanalytic Association. A total of 39 experts were contacted, and of these, 7 responded, resulting in a return rate of 17.9%, which is considered low.

Table 1 shows the demographic characteristics of the participants. Besides the differences in response rates among the theoretical orientations surveyed, the CBT respondents were more likely to be of female gender and the psychodynamic re-

spondents were somewhat older than the respondents from the other orientations. Furthermore, the CBT group represented 16 countries (10 from UK, 4 from Australia, 4 from the USA, 3 from the Netherlands, 3 from Canada, and 1 each from New Zealand, Turkey, Slovenia, Poland, Serbia, Germany, Belgium, Austria, Estonia, Iceland, and Japan). Even though they were recruited for the CBT group, 2 of the participants listed other orientations as their own (eclectic and empirical validation). The eclectic/integrative group represented 8 countries (3 from U.K., 3 from Canada, 4 from U.S., 3 from Switzerland, 7 from Portugal, 2 from Italy, 2 from Germany, and 2 from Japan). The eclectic/integrative group consisted of several different specific theoretical orientations, including experiential/emotion-focused therapy, humanistic/interpersonal/object relational, clinical biopsychology, and systemic. The psychoanalysts were from the U.S. ($n = 4$), Canada ($n = 2$), and Brazil ($n = 1$).

The participants were then grouped into different clusters depending on their geographical belonging. A total of 7 regions were identified: North America, United Kingdom, Northern Europe (including Central Europe), Southern Europe, Eastern Europe, Oceania (Australia/New Zealand), and Japan. The experts from Turkey and Serbia were clustered as belonging to Eastern Europe.

Measures

A questionnaire was designed specifically for the present study in order to describe the experts' perception of the status of different orientations for their country. A total of 23 items were included. The first items asked for name, gender, age, and country, followed by items asking for main area of work and theoretical orientation. The participants could choose from four possible orientations: (a) CBT, (b) psychoanalysis/psychodynamic, (c) eclectic, and (d) other treatments. The final items asked for the most common treatments for patients with depression, anxiety disorders, and personality disorders. The last item was open-ended, asking for general comments regarding the status of their orientation in their country. The survey was posted on our university's website and took 10 to 15 minutes to complete.

Results

Results were analyzed for the three questions regarding what therapy is delivered in the participants' country for (a) anxiety disorders, (b) depression, and (c) personality disorders. Participants responded in percentages (i.e., What percentage of people with anxiety disorders receive CBT in the U.K.?). Participants with percentages totalling more or less than 5% off the total 100% were accepted. Nine participants had to be excluded because they reported percentages that did not meet this criterion. Only one participant from South America responded to the survey and was therefore left out of the following analyses. This left a total of 56 participants for the following analyses.

Figure 1 shows error bars with means and 95% confidence intervals for treatment of anxiety disorders, depression, and personality disorders across all countries. CBT was described as the most frequently used therapy for anxiety disorders and depression, but in treatment of personality disorders it was a different pattern with psychoanalysis/psychodynamic therapy and eclectic therapies being just as common.

Comparison Between Regions

Regions with more than one participant were analyzed to examine specific regional effects for the three different disorder groups. Table 2 shows the pattern for the treatment of anxiety, Table 3 shows the pattern for the treatment of depression, and Table 4 shows the pattern for the treatment of personality disorders.

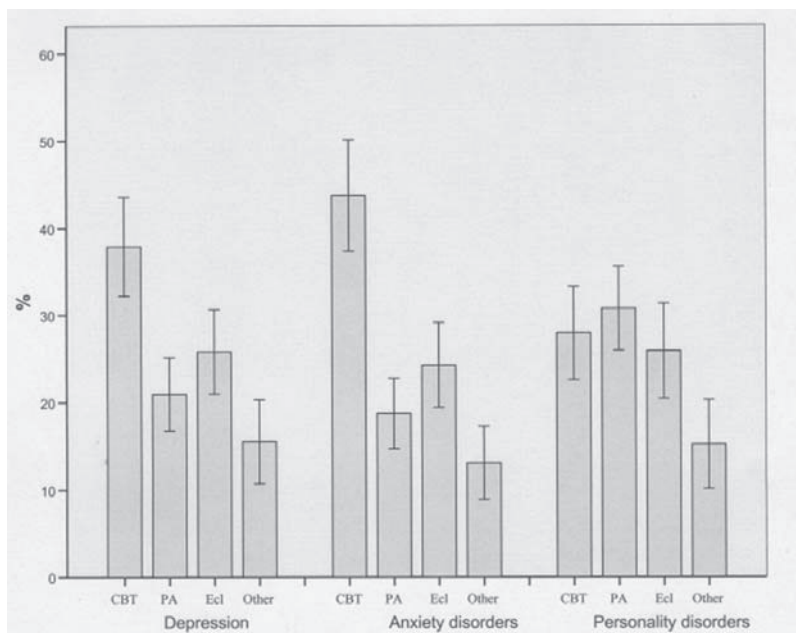


Figure 1. Comparison between cognitive behavior therapy (CBT), psychoanalytic/psychodynamic approaches (PA/PD) and eclectic/integrative orientations (ECL) and other approaches (Other) for the treatment of depression, anxiety disorders, and personality disorders across all countries. The Figure shows means and 95% confidence intervals.

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Anxiety disorders. For treating anxiety disorders, CBT seemed to be the most common therapy for most regions. Two exceptions were Japan, where psychoanalysis seemed more common, and Eastern Europe, where eclectic therapies were at least as common for treating anxiety disorders as CBT. In Southern Europe psychoanalytic treatment was also seen as just as common as CBT. However, the significance of these differences is in doubt given the large standard deviations and small samples from each country, so these findings should be considered suggestive of trends.

Depression. Similar to the results for anxiety, the results from Northern Europe, the U.K., and Oceania indicated that CBT was the most common treatment for depression. Southern Europe and Japan both provided more psychoanalytical treatment for depression. In Eastern Europe an eclectic approach was more common. Finally, in North America there appeared to be a disagreement as to whether it is CBT or eclectic therapy that was the most common treatment for depression.

Personality disorders. For treating personality disorders the results indicate that there was no clear treatment trend. In general, CBT was more commonly administered in

Oceania; psychodynamic treatment was somewhat more prevalent in Southern Europe and Japan; and eclectic therapy seemed more common in Eastern Europe.

Discussion

There is, to a certain extent, general agreement among the experts from several countries and differing theoretical orientations about the status of psychotherapy practice throughout the world. A CBT orientation is prevalent in many countries for the treatment of anxiety and depression as predicted by previous research (Norcross, Hedges, & Prochaska, 2002). The three major treatment orientations focused on in this survey seem to be employed equally, often in the treatment of personality disorders. Some regional variations in this pattern occur, but only in a few regions. Southern Europe and Japan had more psychoanalytical treatment both for depression and for anxiety disorders, while eclectic therapy is frequently used in North America and in Eastern Europe.

Although there is mounting evidence supporting the effectiveness of CBT (e.g., Hofmann & Smits, 2008), the regional differences apparently uncovered by this sur-

vey suggest obstacles regarding the dissemination of CBT. How to overcome these obstacles is uncertain due to the lack of research conducted in this area, but a recent paper addressed some critical issues (Shafran et al., in press). Patients are not receiving evidence-based and well-delivered CBT in routine clinical care. Some of the obstacles to this dissemination could involve the structure of the health service delivery, financial barriers, and knowledge and beliefs among practitioners.

Increasing the availability of training in CBT, which has been identified as a priority in NIMH's strategic plans (Insel, 2009), and including therapists/students in clinical research could be an important first step in socializing clinicians to the value of CBT approaches. Another important first step would be making treatment manuals from RCTs easily available, and in languages other than English. The data from our study showed poorest CBT dissemination and response rates to our English survey from non-English-speaking countries. Treatment manuals based on effectiveness studies are also needed to address clinician concerns about patient complexity and comorbidity. A therapeutic culture that encourages regular evaluation of treatment

Table 2. Treatment of Anxiety Disorders

Region	N	CBT	Psychoanalysis/ Psychodynamic	Eclectic	Other
North America	16	44 (18)	18 (11)	31 (19)	7 (9)
UK	12	50 (24)	11 (8)	24 (15)	15 (13)
Northern Europe	10	43 (26)	21 (17)	14 (7)	23(24)
Southern Europe	6	39 (14)	36 (10)	13 (4)	13 (6)
Eastern Europe	5	31 (26)	23 (21)	39 (31)	7 (6)
Oceania	5	61 (33)	5 (5)	19 (13)	15 (21)
Japan	2	20 (0)	40 (14)	30 (14)	10 (0)

Note. Figures represent mean percentage and standard deviation. *N* = number of responding experts from the selected country.

Table 3. Treatment of Depression

Region	N	CBT	Psychoanalysis/ Psychodynamic	Eclectic	Other
North America	16	37 (15)	20 (11)	34 (20)	9 (12)
UK	12	45 (22)	11 (6)	26 (14)	17 (14)
Northern Europe	10	37 (26)	22 (16)	15 (8)	26 (22)
Southern Europe	6	28 (9)	41 (11)	18 (6)	13 (8)
Eastern Europe	5	29 (27)	13 (10)	47 (33)	11 (7)
Oceania	5	51 (28)	8 (8)	17 (11)	24 (38)
Japan	2	20 (0)	40 (14)	25 (7)	15 (7)

Note. Figures represent mean percentage and standard deviation. *N* = number of responding experts from the selected country.

Table 4. Treatment of Personality Disorders

Region	N	CBT	Psychoanalysis/ Psychodynamic	Eclectic	Other
North America	16	23 (10)	28 (11)	35 (21)	15 (15)
UK	12	31 (20)	34 (15)	23 (12)	11 (14)
Northern Europe	10	29 (19)	31 (18)	14 (7)	25 (24)
Southern Europe	6	28 (11)	44 (10)	19 (9)	9 (7)
Eastern Europe	5	18 (20)	26 (23)	45 (33)	13 (12)
Oceania	5	48 (38)	13 (9)	19 (19)	19 (38)
Japan	2	10 (0)	50 (28)	30 (28)	10 (0)

Note. Figures represent mean percentage and standard deviation. *N* = number of responding experts from the selected country.

outcomes needs to be developed and competency requirements for therapist training in CBT are also needed. The role of government incentives and the support of consumer groups may be essential in this part of the process.

A relatively new development that could aid dissemination of CBT involves more use of modern technology in both treatment and supervision. Electronic communication systems like videoconferencing and the Internet can make access to expert supervision and, in some cases, expert treatment available in rural settings and around the world (Himle et al., 2006). This could be essential to avoiding theoretical “drift.” Administration of poor-quality CBT could yield poorer outcomes, which would be devastating to the dissemination of CBT. Similar questions could arise when discussing minimal treatment dose and therapist background/training required.

It seems quite clear that there are obvious gaps in our current knowledge about training, measuring competence, how treatment works, especially with more complex cases, and the minimum dose required for treatment. All these issues may limit the adoption of CBT protocols to clinical settings around the world.

An important limitation of this survey is the small number of experts sampled with few or no respondents from several countries. The Internet-based survey operating with a strict time limit can have produced a lower response rate. The sample size obviously limits the interpretability of the results obtained. The low overall rate of response, except from CBT-oriented experts, may have biased the results in favor of suggesting more CBT prevalence than is warranted. However, the responses from non-CBT-oriented respondents were not significantly in disagreement from the CBT-oriented respondents on most issues. The number of respondents and the response rate was also within the range reported in most previous studies. The study by Orlinsky and Rønnestad (2005) have a much larger sample, but cognitive behavioral therapists are not as well represented in that study, they did not assess the therapists’ perception of the most commonly used methods in their country, and no regional comparisons were made. The problem of possible arbitrariness of the labels employed for the three theoretical orientations is an additional limitation, and reducing practiced orientations to only four theoretical frameworks may be insufficient to describe in detail the practice throughout different countries and regions. The low

number of non-CBT expert respondents remains an important limitation and the results cannot be said to be representative of the opinions of psychodynamic or eclectic expert opinions. A future study should try to obtain more equal representation from different theoretical perspectives on therapy.

The responses to this survey should be considered a "snapshot" of the current opinions of many respected experts from around the world. Hopefully, the results presented here will stimulate discussions within national and international organizations about these questions. Other forms of surveys that increase the representativeness and sample size to these and other questions would be useful for further study.

References

- Agathon, M. (1982). Behavior therapy in France 1976-1981. *Journal of Behavior Therapy and Experimental Psychiatry*, 13, 271-277.
- Ardila, R. (1982). International developments in behaviour therapy in Latin America. *Journal of Behavior Therapy and Experimental Psychiatry*, 13, 15-20.
- Babbie, E. (2004). *The practice of social research*. Belmont, CA: Wadsworth.
- Corrigan, Hess, & Garman (1998). Results of a job analysis of psychologists working in state hospitals. *Journal of Clinical Psychology*, 54, 11-18
- Danquah, S. A. (1982). The practice of behaviour therapy in West Africa: The case of Ghana. *Journal of Behavior Therapy and Experimental Psychiatry*, 13, 5-13.
- del Barrio, V., & Carpintero, H. (2003). Clinical psychology in Spain. *Journal of Clinical Psychology*, 59, 687-699.
- De Silva, P., & Samarasinghe, D. (1985). Behavior therapy in Sri Lanka. *Journal of Behavior Therapy and Experimental Psychiatry*, 16, 95-100.
- Dillman, D. A. (2000). *Mail and internet surveys: The tailored design method*. New York: John Wiley & Sons.
- Dowdall, T. (1982). Behavior therapy in South Africa: a review. *Journal of Behavior Therapy and Experimental Psychiatry*, 13, 279-286.
- Garfield, S. L., & Kurtz, R. M. (1976). Clinical psychologists in the 1970's. *American Psychologist*, 31, 1-9.
- Garfield, S.L. & Kurtz, R. (1977). A study of eclectic views. *Journal of Consulting and Clinical Psychology*, 45, 78-83.
- Himle, J. A., Fischer, D. J., Muroff, J. R., van Etten, M. L., Lokers, L. M., Abelson, J. L., et al. (2006). Videoconferencing-based cognitive-behavioral therapy for obsessive-compulsive disorder. *Behaviour Research and Therapy*, 44, 1821-1829.
- Hofmann, S. G., & Smits, J. A. J. (2008). Cognitive-behavioral therapy for adult anxiety disorders: A meta-analysis of randomized placebo-controlled trials. *Journal of Clinical Psychiatry*, 69, 621-632.
- Insel, T. R. (2009). Translating scientific opportunity into public health impact: a strategic plan for research on mental illness. *Archives of General Psychiatry*, 66, 128-133.
- Meazzini, P., & Rovetto, F. (1983). Behaviour therapy: The Italian way. *Journal of Behavior Therapy and Experimental Psychiatry*, 14, 5-9.
- Mikulas, W. L. (1983). Thailand and behaviour modification. *Journal of Behavior Therapy and Experimental Psychiatry*, 14, 93-97.
- Norcross, J. C. (1986). *Handbook of eclectic psychotherapy*. New York: Brunner/Mazel.
- Norcross, J. C., Hedges, M., & Prochaska, J. O. (2002). The face of 2010: A Delphi Poll on the future of psychotherapy. *Professional Psychology: Research and Practice*, 33, 316-322
- Norcross, J. C., Karpiak, C. P., & Lister, K. M. (2005). What's an integrationist? A study of self-identified integrative and (occasionally) eclectic psychologists. *Journal of Clinical Psychology*, 61, 1587-1594.
- Orlinsky, D. E., & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, DC: American Psychological Association.
- Pachana, N. A., O'Donovan, A., & Helmes, E. (2006). Australian clinical psychology training program directors survey. *Australian Psychologist*, 41, 168-178.
- Sanderson, W. C., & Bruce, T. J. (2007). Causes and management of treatment-resistant panic disorder and agoraphobia: A survey of expert therapists. *Cognitive and Behavioral Practice*, 14, 26-35.
- Sayette, M. A., & Mayne, T. J. (1990). Survey of current clinical and research trends in clinical psychology. *American Psychologist*, 45, 1263-1266.
- Scott, E. L., Pollack, M. H., Otto, M. W., Simon, N. M., & Worthington, J. J. (1999). Clinician response to treatment refractory panic disorder: A survey of psychiatrists. *The Journal of Nervous and Mental Disease*, 187, 755-757.
- Shafran, R., Clark, D. M., Fairburn, C. G., Arntz, A., Barlow, D. H., Ehlers, A., et al. (in press). Mind the gap: Improving the dissemination of CBT. *Behaviour Research and Therapy*.
- Smith, D. (1982). Trends in counseling and psychotherapy. *American Psychologist*, 37, 802-809.
- Stallard, P., Udwin, O., Goddard, M., & Hibbert, S. (2007). The availability of cognitive behaviour therapy within specialist child and adolescent mental health services (CAMHS): A national survey. *Behavioural and Cognitive Psychotherapy*, 35, 501-505.
- Stevens, H.B., & Dinoff, B.L. (1996). Orientations and characteristics of psychotherapy instructors in clinical psychology programs: A national survey. *The Clinical Psychologist*, 49, 11-15.
- Tsoi, M. M. & Lam, D. J. (1991). The practice of behavior therapy among clinical psychologists in Hong Kong. *Journal of Behavior Therapy and Experimental Psychiatry*, 22, 75-82.
- Valderhaug, R., Götestam, K. G., & Larsson, B. (2004). Clinicians' views on management of obsessive-compulsive disorders in children and adolescents. *Nordic Journal of Psychiatry*, 58, 125-132.
- Weissman, M. M., Verdelli, H., Gameraff, M.J., Bledsoe, S. E., Betts, K., Mufson, L., Fitterling, H., & Wickramaratne, P. (2006). National Survey of Psychotherapy Training in Psychiatry, Psychology, and Social Work. *Archives of General Psychiatry*, 63, 925-934
- Wildman, R. W., & Wildman II, R. W. (1967). The practice of clinical psychology in the United States. *Journal of Clinical Psychology*, 23, 291 - 295.
- Yamagami, T., Okuma, H., Morinaga, Y. and Nakao, H. (1982). The practice of behaviour therapy in Japan. *Journal of Behavior Therapy and Experimental Psychiatry*, 13, 21-26.

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Substance Abuse Research at Harvard Medical School

Two junior faculty to serve as project directors for two 5-year NIH-funded Harvard Medical School randomized trials in Boston area and Worcester. Studies compare behavioral couples therapy (BCT) vs. individual treatment for substance abuse patients. One project studies BCT with female drug patients; the other examines group BCT with alcoholic patients.

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Professional Identity Based on Learning

Warren W. Tryon, *Fordham University*

Open-minded professional identity can be a good thing. It can give definition and direction to research and clinical work leading to consistent methods with clear theoretical bases. Such clarity is preferable to a vague eclectic identity. A clear professional identity can also help locate professionals with similar and/or compatible research and/or clinical interests. However, Leahy's (2009) "Confessions of a Cognitive Therapist" indicates that we unfortunately have a degree of closed-minded professional identity with us today and apparently have had so for a long time. Leahy confessed that in addition to being a cognitive therapist, he also uses behavioral and existential methods, depending upon the presenting clinical situation. Leahy specifically raised the issue of professional identity when he wrote, "Many people who don't really know me will easily identify me as a 'cognitive therapist' . . ." (p. 1). The word "confession" implies wrong-doing that was hidden but is now revealed. Wrong-doing is typically hidden in order to avoid punishment, which, in his case, might involve public criticism, possible problems publishing future articles, and maybe greater difficulty getting grants.

At least the following five features of professional identity characterize both open- and closed-minded professional identity to varying degrees: (a) psychologists are classified by their theoretical orientation by themselves and by other people; (b) psychologists derive their professional identity from this classification; (c) this identification influences the professional organizations they join, the journals they read, the manuscripts and grants they review, the meetings they attend, and what they teach through workshops and/or classes; (d) allegiance to the in-group, defined by similarly classified individuals, is expected; and (e) defense of the in-group is valued and merits/motivates opposition to alternative approaches. The resulting dominance competitions can obscure our focus on patient care and need to move our field forward.

The importance of Leahy's "confession" is augmented by a recent special issue of *the Behavior Therapist* (Moran, 2008) that car-

ried a section discussing the fact that behavior therapists are at another theoretical crossroad. This could set the occasion for further turf wars that require public personas that may contrast with private professional practices. Staats (1983) long ago documented the corrosive effects that professional motives to be new and different can have. Perhaps it is time to focus on what we share in common rather than what makes us different. Tryon (2000) reminded us that "All successful psychotherapy, and especially behavior therapy, entails some degree of new learning. Our theoretical differences concerning what is learned and how it is learned neither negate nor diminish the central relevance of learning per se to psychology and behavior therapy" (p. 131). Carlson (2010) wrote, "Learning refers to the process by which experiences change our nervous system and hence our behavior. We refer to these changes as *memories*" (italics in the original) (p. 440). The main point here is that had Leahy's professional identity been about learning rather than a specific mode of intervention he would not have had to hide a portion of his professional practice. The various clinical practices noted by Leahy (2009) can be considered methods for identifying what needs to be learned and how it should best be taught to specific clients. On the other hand, one might observe that the history of psychology contains multiple theories of learning (e.g., Bower & Hilgard, 1997) and that fierce rivalries once existed among various schools and camps based on strong professional identification with particular theories of learning. How is the recommended refocusing on learning to avoid a return to such conflicting schools and camps? The answer is that modern neuroscience has replaced theories of learning with empirically supported mechanisms of learning and memory formation (cf. Tryon, 2010). These developments provide us with a unified empirically supported understanding of learning and memory upon which we can build our field (e.g., Tryon, 2005; Tryon & McKay, 2009; Tryon & Misurell, 2008). Given our present position at yet another theoretical crossroad, I recommend that our way forward is to emphasize our common interest in learning and its therapeutic ap-

plications. Such a move would bring us back to the vision that the founding fathers had for our organization (cf. Tryon, 2010).

References

- Bower, G. H., & Hilgard, E. R. (1997). *Theories of learning*. New York: Prentice Hall.
- Carlson, N. R. (2010). *Physiology of behavior* (10th ed.). Boston: Pearson.
- Leahy, R. L. (2009). The confessions of a cognitive therapist. *the Behavior Therapist*, 32, 1, 3.
- Moran, D. J. (Ed.). (2008). The three waves of behavior therapy: Course corrections or navigation errors? [Special issue]. *the Behavior Therapist*, 31(8). Retrieved December 8, 2009, from <http://www.abct.org/docs/PastIssue/31n8.pdf>
- Staats, A. W. (1983). *Psychology's crisis of disunity: Philosophy and method for the revolution to a unified science*. New York: Praeger.
- Tryon, W. W. (2000). Behavior therapy as applied learning theory. *the Behavior Therapist*, 23, 131-134.
- Tryon, W. W. (2005). Possible mechanisms for why desensitization and exposure therapy work. *Clinical Psychology Review*, 25, 67-95.
- Tryon, W. W., & McKay, D. (2009). Memory modification as an outcome variable in anxiety disorder treatment. *Journal of Anxiety Disorders*, 23, 546-556.
- Tryon, W. W., & Misurell, J. R. (2008). Dissonance induction and reduction: A possible principle and connectionist mechanism for why therapies are effective. *Clinical Psychology Review*, 28, 1297-1309.
- Tryon, W. W. (2010). Learning as core of psychological science and clinical practice. *the Behavior Therapist*, 33, 10-12.

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Learning as Core of Psychological Science and Clinical Practice

Warren W. Tryon, *Fordham University*

A recent special issue of *the Behavior Therapist* (Moran, 2008) revealed that behavior therapists seem to be at another theoretical crossroad. As one of those ABCT members "... with ages that start with 6 or more ..." (Hayes, 2008, p. 150) who began their formal study of psychology as an undergraduate in 1962, I write with a personal historical perspective on these transitions. I was a psychology major in college when Eysenck (1964) wrote, "Behaviour therapy may be defined as the attempt to alter human behaviour and emotion in a beneficial manner according to the laws of modern learning theory" (p. 1), when Wolpe and Lazarus (1966) wrote that behavior therapy entailed "... the application of experimentally established principles of learning" (p. 1). I was a graduate student when Wolpe (1969) defined behavior therapy as "...the use of experimentally established principles of learning for the purpose of changing unadaptive behavior" (p. vii). It turned out that these definitions of behavior therapy were mainly aspirational because learning theory was in disarray at the time and only partially able to support clinical practice (cf. Tryon, 2000, 2002). The cognitive revolution that swept psychology in general, and behavior therapy in particular, during the 1970s ushered in the second wave of behavior therapies, and now a third wave seems under way. In the recent *tBT* discussion of these issues cited above, DiGiuseppe (2008) suggested "... that we explore what unites behavior therapy" (p. 155).

I proposed that our interest in learning and memory provides us with a solid and useful professional identity (Tryon, 2010; this issue). Carlson (2010) wrote, "*Learning* refers to the process by which experiences change our nervous system and hence our behavior. We refer to these changes as *memories*" (italics in the original; p. 440). Learning requires memory and memories are learned. Learning and memory are two facets of one major developmental mechanism. If infants were unable to learn and/or form memories, they would never develop into the children, adolescents, and adults that we are familiar with. In short, learning

and memory mechanisms enable virtually all psychological development and interventions. We can therefore confidently conclude that all clinically effective empirically supported psychological interventions entail learning. A corollary point is that all evidence of altered cognition, affect, and behavior is also evidence that learning has occurred. *Therapists, and the therapeutic approaches that currently divide us, differ only with regard to what is to be learned and how it is to be acquired.* It is therefore ironic that neglect of learning by both psychological science and clinical practitioners has jointly exacerbated the science-practice gap. Psychologists once studied learning but the cognitive revolution abandoned such inquiry and focused intellectual and financial resources on how people process information. Learning was assumed rather than investigated. This shift away from learning aggravated the science-practice gap because it neglected to study the most basic process upon which therapists depend: how to get people to learn to change the way they think, feel, and act. Clinicians also contributed to the science-practice gap by moving away from learning principles and theory. For example, Hayes (2008) noted that "Some previously foundational ideas (e.g., behavior therapists needed extensive training in the psychology of learning) began heading toward extinction" (p. 150). With regard to specific therapies, Hayes noted that "...the underlying principles became looser and less linked to behavioral science, resulting in theories that were harder to disprove. The original goal of empirically validated procedures was retained, but the original vision of a translational applied science linked to well-established basic principles weakened" (p. 151). These trends continue unabated today.

During the several decades in which most psychologists neglected the study of learning, neuroscience replaced our theories of learning (e.g., Bower & Hilgard, 1997) with detailed mechanism information regarding how *experience-dependent plasticity* (EDP) enables learning to occur and memories to form through the modification of synaptic architecture and function. Tryon

(in press) and Tryon and McKay (2009) provided an overview of some of this mechanism information. Squire et al. (2008), Bear, Connors, and Paradiso (2007), and Carlson (2010) provided many more details. The *Journal of the American Academy of Child & Adolescent Psychiatry* has recently informed child psychiatrists about the clinical implications of biological learning mechanisms (cf. Lombroso & Ogren, 2008, 2009). Operant and respondent conditioning may have been the first two controlled methods that were used to systematically study the functional relationships between experience and behavior but people learn in other ways as well (e.g., observational learning). Psychologists deferred to psychiatrists regarding diagnosis, who then developed the *DSM* series that now dominates psychological research and clinical practice. Will psychologists now also defer to psychiatrists regarding learning and lose a second opportunity to lead our field?

Psychologists require more than biological mechanisms upon which to base their explanations and interventions. Brains consist of neural networks. Formal connectionist network models that extend informal psychological network models (e.g., Chemtob, Roitblat, Hamada, Carlson, & Twenty-man, 1988; Creamer, Burgess, & Pattison, 1992; Foa, & Kozak, 1986; Lang, 1977; 1985; 1994) have been developed and are capable of simulating a broad range of psychological and behavioral phenomena (e.g., Arbib, 2002; Bechtel & Abrahamsen, 2002; McLeod, Plunkett, & Rolls, 1998; O'Reilly, & Munakata, 2000; Rumelhart & McClelland, 1986a, 1986b). These network models are generalizations of the classic S-O-R cognitive-behavioral model (Tryon, in press). Siegle (2001) discussed the relevance of connectionist models of psychopathology and Siegle (1991) used connectionist models to explore attention biases in depression. Tryon (1999) applied the part-whole pattern completion connectionist principle and property of the Bidirectional Associative Memory model to explain posttraumatic stress disorder according to criteria specified by Jones and Barlow (1990) and Brewin, Dalgleish, and Joseph (1996). Tryon (2005) reviewed existing explanations of why systematic desensitization and exposure therapy work, found them all to be flawed, and proposed an alternative connectionist network model containing a specific change mechanism. Tryon and Misurell (2008) extended this connectionist model/change mechanism to depression and formulated a *dissonance induction/reduction* (DIR) principle that ex-

plains why empirically supported treatments for anxiety and depression work. Tryon (in press) described how network models form cognitions, explained how placebos, nocebos, and psychoactive medications work, and extended network learning principles to the cognitive specificity hypothesis. Renewed interest in the mechanisms by which empirically supported treatments work (e.g., Kazdin, 2007, 2008; Tryon, 2009b) has set the occasion to reconsider how we learn. The 12 network learning principles identified by Tryon (2009a) constitute a phylogenetically general modern learning theory based on empirically supported principles (cf. Rosen & Davison, 2003) that might provide a unified way forward. Recognition of the key role played by learning and memory and recent advances in neuroscience regarding the experience-dependent plasticity mechanisms that enable learning to occur and memories to form enables our field to return to the theoretical basis that Wolpe and Eysenck envisioned for it.

The learning perspective I recommend informs and supports clinical practice but space limitations require me to be brief. First, a focus on learning as our common science base enables us to focus on what needs to be learned and how best to teach it. These themes should provide common ground for both clinicians and researchers and may suggest a way for investigators to repackage their findings so that they appear more relevant and useful to practicing clinicians. Second, the empirically supported DIR principle can be used to optimize interventions by finding ways to induce and sustain specific forms of dissonance and control its reduction. Motivational interviewing already explicitly uses dissonance induction and its controlled reduction as a planned intervention (Tashiro & Mortesen, 2006). Although derived from clinical experience rather than connectionist network learning theory, the unified protocol described by Allen, McHugh, and Barlow (2008) prepares clients for and then explicitly implements the DIR principle. Creative clinical variations prompted by client characteristics and other constraints designed to maximize DIR illustrates the application of empirically supported principles that Rosen and Davison (2003) recommended. Third, recognition of the neuroscience mechanisms that enable learning and memory by modifying synapses and neurotransmitters places learning-based therapists on the same page as pharmacologists who also seek to alter synapses and neurotransmitters. This synergy may explain why combined treatments

are often more effective than either behavior therapy or pharmacotherapy. Fourth, connectionist models of experience-dependent plasticity inform us regarding the course of clinical change. They predict that cognition, affect, and behavior change *simultaneously*, in parallel, not *sequentially* (Tryon, 2005). Connectionist models predict that cognition does not change before affect and/or behavior, that affect does not change before cognition and/or behavior, and that behavior does not change before cognition and/or affect. Cognition, affect, and behavior change simultaneously and incrementally on every processing cycle. Research generally confirms this result. Fifth, a focus on learning and memory expands our perspective on what constitutes a good outcome. Tryon and McKay (2009) discussed how learning therapies necessarily modify memory and suggested that such memory modifications may be used to assess outcome.

In conclusion, the modern learning theory provided by neuroscience and connectionist models enables us to confidently follow DiGiuseppe's (2008) recommendation "... that we explore what unites behavior therapy" (p. 155)—our conviction that learning and memory are fundamental to psychological development and change. Perhaps this reorientation will begin to close the science-practice gap and thereby advance our field.

References

- Allen, L. B., McHugh, R. K., & Barlow, D. H. (2008). Emotional disorders: A unified protocol. In D. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed., pp 216-249). New York: Guilford.
- Arbib, M. A. (Ed) (2002). *The handbook of brain theory and neural networks* (2nd ed.). Cambridge, MA: The MIT Press.
- Bear, M. F., Connors, B. W., & Paradiso, M. A. (2007). *Neuroscience: Exploring the brain* (3rd ed.). Baltimore: Lippincott, Williams & Wilkins.
- Bechtel, W., & Abrahamsen, A. (2002). *Connectionism and the mind: An introduction to parallel processing in networks* (2nd ed). Cambridge: Blackwell.
- Bower, G. H., & Hilgard, E. R. (1997). *Theories of learning*. New York: Prentice Hall.
- Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of posttraumatic stress disorder. *Psychological Review*, 103, 670-686.
- Carlson, N. R. (2010). *Physiology of behavior* (10th ed.). Boston: Pearson.
- Chemtob, C., Roitblat, H. L., Hamada, R. S., Carlson, J. G., & Twentyman, C. T. (1988). A cognitive action theory of post-traumatic stress disorder. *Journal of Anxiety Disorders*, 2, 253-275.
- Cremer, M., Burgess, P., & Pattison, P. (1992). Reaction to trauma: A cognitive processing model. *Journal of Abnormal Psychology*, 101, 452-459.
- DiGiuseppe, R. (2008). Surfing the waves of behavior therapy. *the Behavior Therapist*, 31, 154-155.
- Eysenck, H. J. (1964). *Experiments in behaviour therapy: Readings in modern methods of treatment of mental disorders derived from learning theory*. New York: Macmillan.
- Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, 99, 20-35.
- Hayes, S. C. (2008). Avoiding the mistakes of the past. *the Behavior Therapist*, 31, 150-153.
- Jones, J. C., & Barlow, D. H. (1990). The etiology of post-traumatic stress disorder. *Clinical Psychology Review*, 10, 299-328.
- Kazdin, A. E. (2007). Mediators and mechanism of change in psychotherapy research. *Annual Review of Clinical Psychology*, 3, 1-27.
- Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist*, 63, 146-159.
- Lang, P. J. (1977). Imagery in therapy: An information processing analysis of fear. *Behavior Therapy*, 8, 862-886.
- Lang, P. J. (1985). The cognitive psychophysiology of emotion: Fear and anxiety. In A. H. Turner & J. Maser (Eds.), *Anxiety and the anxiety disorders* (pp. 131-170). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Lang, P. J. (1994). The motivational organization of emotions. In S. van Goozen, N. E., van de Poll, & J. A. Sergeant (Eds.), *Emotions: Essays on emotion theory*. Hillsdale, NJ: Lawrence Erlbaum.
- Lombroso, P., & Ogren, M. (2008). Learning and memory, Part I: Brain regions involved in two types of learning and memory. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47, 1219-1223.
- Lombroso, P., & Ogren, M. (2009). Learning and memory, Part II: Molecular mechanisms of synaptic plasticity. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48, 5-9.
- McLeod, P., Plunkett, K., & Rolls, E. T. (1998). *Introduction to connectionist modelling of cognitive processes*. Oxford: Oxford University Press.
- Moran, D. J. (Ed.). (2008). The three waves of behavior therapy: Course corrections or navigation errors? [Special issue]. *the Behavior Therapist*, 31(8). Retrieved December 8, 2009, from <http://www.abct.org/docs/PastIssue/31n8.pdf>
- O'Reilly, R. C., & Munakata, Y. (2000). *Computational explorations in cognitive neuro-*

- science: Understanding the mind by simulating the brain.* Cambridge, MA: The MIT Press.
- Rosen, G. M., & Davison, G. C. (2003). Psychology should list empirically supported principles of change (ESP's) and not credential trademarked therapies or other treatment packages. *Behavior Modification, 27*, 300–312.
- Rumelhart, D. E., & McClelland, J. L. (1986a). *Parallel distributed processing: Explorations in the microstructure of cognition, Vol. 1: Foundations.* Cambridge: MIT Press.
- Rumelhart, D. E., & McClelland, J. L. (1986b). *Parallel distributed processing: Explorations in the microstructure of cognition psychological and biological models, Vol. 2.* Cambridge: MIT Press.
- Siegle, G. J. (2001). Connectionist models of psychopathology: Crossroads of the cognitive and affective neuroscience of disorder. *Cognitive Processing, 2*, 455-486.
- Siegle, G. J. (1999). A neural network model of attention biases in depression. In J. A. Reggia, E. Ruppini, & D. L. Glanzman (Eds.), *Disorders of brain behavior and cognition: The neurocomputational perspective* (pp. 415-441). New York: Elsevier.
- Squire, L. R., Berg, D., Bloom, F. E., du Lac, S., Ghosh, A., & Spitzer, N. C. (2008). *Fundamental neuroscience* (3rd ed.). New York: Elsevier.
- Tashiro, T., & Mortensen, L. (2006). Translational research: How social psychology can improve psychotherapy. *American Psychologist, 61*, 959-966.
- Tryon, W. W. (1999). A bidirectional associative memory explanation of posttraumatic stress disorder. *Clinical Psychology Review, 19*, 789-818.
- Tryon, W. W. (2000). Behavior therapy as applied learning theory. *the Behavior Therapist, 23*, 131-134.
- Tryon, W. W. (2002). Neural network learning theory: Unifying radical behaviorism and cognitive neuroscience. *the Behavior Therapist, 25*, 53-57.
- Tryon, W. W. (2005). Possible mechanisms for why desensitization and exposure therapy work. *Clinical Psychology Review, 25*, 67-95.
- Tryon, W. W. (2009a). *A modern learning theory.* Manuscript submitted for publication.
- Tryon, W. W. (2009b). Missing mechanisms information. *American Psychologist, 64*, 273-274.
- Tryon, W. W. (in press). Cognitive processes in cognitive and pharmacological therapies. *Cognitive Therapy & Research.*
- Tryon, W. W. (2010). Professional identity based on learning. *the Behavior Therapist, 33*, 9.
- Tryon, W. W., & McKay, D. (2009). Memory modification as outcome variable in anxiety disorder treatment. *Journal of Anxiety Disorders, 23*, 546-556.
- Tryon, W. W., & Misurell, J. R. (2008). Dissonance induction and reduction: A possible principle and connectionist mechanism for why therapies are effective. *Clinical Psychology Review, 28*, 1297-1309.
- Wolpe, J. (1969). *The practice of behavior therapy.* Elmsford, NY: Pergamon Press.
- Wolpe, J., & Lazarus, A. A. (1966). *Behavior therapy techniques: A guide to the treatment of neuroses.* New York: Pergamon.

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Letter to the Editor

Treatment Specificity for Panic Disorder: A Reply to Wampold, Imel, and Miller (2009)

Jedidiah Siev, *Massachusetts General Hospital/Harvard Medical School*, Jonathan D. Huppert, *The Hebrew University of Jerusalem*, and Dianne L. Chambless, *University of Pennsylvania*

Wampold, Imel, and Miller (2009) raise a number of interesting points, and overall, we are pleased that they agree that techniques are important. We are in agreement, as well, that more fine-grained analyses are necessary to better identify and determine the active ingredients. We will leave it to other venues to address in more detail Wampold et al.'s critiques regarding the specificity of treatment effects (e.g., in PTSD), the circularity or consistency of the term "bona fide treatments," and the "clear" evidence of the predictive power of the alliance within CBT, as well as other points raised. We wish to reply herein to two specific issues regarding the Siev and Chambless (2007) meta-analysis and the importance of specific effects on specific

outcome measures. Wampold et al. discount the differences between CBT and relaxation for panic disorder with two assertions: (a) those differences were driven by a single, flawed study (viz., Clark et al., 1994), and (b) the fact that CBT outperformed relaxation on panic-related, but not secondary, measures implies "removing symptoms but not benefitting patients" (p. 148).

Between Groups Differences Are Driven by a Single Study

Wampold et al. (2009) state that, "The advantage to CBT in the Siev and Chambless (2007) meta-analysis was entirely accounted for by the one study that found a large effect for CBT" (p. 147). This claim is unfounded.

First, five effect sizes were calculated for primary panic-related domains: percent panic-free, clinically significant change, panic symptom measures, fear of anxiety, and panic-related cognitions. Wampold et al. (2009) refer only to the one effect size (panic symptom measures) for which the Clark et al. (2009) study appeared to have the largest effect, and ignore all four other indicators. They do not articulate a rationale for doing so, and none is easily inferred. Indeed, Öst and Westling (1995) found effects in favor of CBT similar to or larger than the weighted means on at least three of those effect sizes (larger even than did Clark et al. on one), and Öst developed applied relaxation, to which one might imagine he has an allegiance. By Wampold et al.'s own logic, Öst's allegiance should have minimized the between groups differences. In any case, on what basis do Wampold et al. select the single effect size out of five most influenced by Clark et al. and assert that "evidence for specificity rests solely on this one study" (p. 147)? If we were seeking treatment for panic disorder, we would care deeply about the probability of being rid of disabling panic attacks following treatment (i.e., percent panic free), a domain in which CBT unambiguously outperforms relaxation (even with the largest difference in Clark et al.'s study and the smallest found

by Öst and Westling), but a domain ignored by Wampold et al.

Second, there was scant evidence of heterogeneity of effect sizes, even using a conservative alpha of .10. Wampold et al. (2009) correctly note that homogeneity tests are underpowered in such a small sample; however, there was only mild to moderate heterogeneity as evidenced by the I^2 index (Higgins & Thompson, 2002; Huedo-Medina, Sanchez-Meca, Marin-Martinez, & Botella, 2006; in which a finding of 50 would be interpreted as moderate heterogeneity). Hence, the claim that Clark et al. represents an outlier is empirically unfounded.

Essentially Wampold et al. (2009) would like to remove or discount the difference in efficacy between CBT and relaxation for panic disorder on the basis of a large effect size in the Clark et al. (2009) study on one of five primary outcome measures without evidence of heterogeneity. This is tantamount to saying that if we remove all evidence to the contrary without empirical justification, the data are consistent with a different conclusion.

Furthermore, Wampold et al. (2009) identify two ways in which Clark et al. (1994) “severely, if not fatally, modified” their relaxation treatment, namely by altering the treatment rationale and “more consequential[ly]” by introducing exposure too early, such that “it is quite possible that Clark et al. may have actually conditioned panic symptoms . . . whereas Öst’s protocol correctly desensitized the patients” (p. 148). It seems that this suggestion is essentially that Clark et al. modified the active ingredients necessary for maximal improvement. If nonspecific factors account entirely for therapeutic change, of what consequence is the particular timing of exposure? Similarly, benefits would not depend on the mechanism of conditioning. Therefore, paradoxically, this very critique of Clark et al.’s study apparently relies on the premise that specific techniques are responsible for improvements via specific mechanisms of change.

Symptom Reduction on Primary Measures Does Not Demonstrate Patient Benefit

Wampold et al. (2009) argue that “the issue of primary and secondary variables attenuates the importance of psychological functioning of patients” and that the analysis by Siev, Huppert, and Chambless (2009) is “disappointing” because it demonstrates “relative advantage on targeted symptom measures but . . . little impact on important

measures of the quality of patients’ lives” (p. 148). They also state, “removing symptoms but not benefitting patients generally is not a desirable outcome to many—most importantly to patients” (p. 148).

There are two responses to this contention, one clinical and one statistical. Clinically, it is not plausible that a patient suffering from primary panic disorder derives as much benefit from reductions on symptoms of depression as from improvements in panic-related measures. A patient with a primary diagnosis of panic disorder is by definition suffering the most distress from panic attacks and their sequelae (and not primarily from depression, for example). Furthermore, in considering whether CBT outperforms relaxation in treating panic disorder, there is no tradeoff between benefit in panic-related symptoms and improvement in depression. That is, relaxation does not outperform CBT on secondary measures. Rather, the choice is between treatments that are differentially effective for the specific presenting complaint, and similarly effective in other areas. At the very least, a clinician who offers relaxation instead of CBT to a patient seeking treatment for panic should inform the patient that relaxation may not be as successful as CBT in treating the panic attacks and panic disorder for which the patient has sought treatment, but the degree of change in symptoms of depression and generalized anxiety may be similar.

We agree, however, that reductions in panic-related symptoms do not necessarily imply maximal improvements in quality of life (e.g., Rapaport, Pollack, Wolkow, Mardekian, & Clary, 2000), although it may depend on which symptoms (e.g., Telch, Schmidt, Jaimez, Jacquin, & Harrington, 1995). It is therefore important to assess improvements in quality of life directly (i.e., not relying only on primary or secondary symptom measures). For a review of issues and challenges in assessing quality of life and the relationship to symptom improvement, see Gladis, Gosch, Dishuk, and Crits-Christoph (1999). Incidentally, these measures are routinely included in funded clinical trials today but were not at the time the studies in our meta-analysis were conducted.

Statistically, participants in a study of panic disorder are selected because they meet criteria for panic disorder. Some will have comorbid depression but many will not. For example, in Arntz and van den Hout (1996; one of the studies included in the meta-analysis), only 6/36 participants received a secondary diagnosis of a mood

disorder. The fact that CBT does not outperform relaxation on measures of depression in a study of individuals with panic disorder may imply mostly that people do not get differentially better on symptoms of disorders that they do not have (even if they experience subclinical elevations on them). One might speculate about a possible floor effect or the possibility that common factors are indeed sufficient for this secondary outcome.

Summary

In summary, Wampold et al. (2009) discount meta-analytic data demonstrating that CBT outperformed relaxation on primary measures of panic-related symptoms on the grounds that the findings were driven entirely by a single study, and that differential treatment response on primary but not secondary outcomes does not indicate patient benefit. Regarding the former assertion, there is a consistent pattern of differential improvement in favor of CBT on measures in five panic-related domains, four of which Wampold et al. ignore. Furthermore, there is no statistical justification to remove that single study. Regarding the latter assertion, an individual with primary panic disorder is by definition suffering most from panic-related symptoms, and we find it unconvincing that greater improvement on those symptoms does not indicate greater benefit. Ethical considerations require that a clinician offering relaxation inform a patient with panic disorder that the patient is less likely to achieve improvements in panic-related domains than if the patient were to engage in CBT. Nevertheless, we agree with Wampold et al. more broadly that specific mechanisms of psychotherapeutic gain, whether treatment techniques or therapist effects, require elucidation and that doing so has potential to improve patient outcomes.

References

- Arntz, A., & van den Hout, M. (1996). Psychological treatments of panic disorder without agoraphobia: Cognitive therapy versus applied relaxation. *Behaviour Research and Therapy*, 34, 113-121.
- Clark, D.M., Salkovskis, P.M., Hackmann, A., Middleton, H., Anastasiades, P., & Gelder, M. (1994). A comparison of cognitive therapy, applied relaxation, and imipramine in the treatment of panic disorder. *British Journal of Psychiatry*, 164, 759-769.
- Gladis, M. M., Gosch, E. A., Dishuk, N. M., & Crits-Christoph, P. (1999). Quality of life: Expanding the scope of clinical significance.

Journal of Consulting and Clinical Psychology, 67, 320-331.

- Higgins, J. P. T., & Thompson, S. G. (2002). Quantifying heterogeneity in a meta-analysis. *Statistics in Medicine*, 21, 1539-1558.
- Huedo-Medina, T. B., Sanchez-Meca, J., Marin-Martinez, F., & Botella, J. (2006). Assessing heterogeneity in meta-analysis: Q statistic or I^2 index? *Psychological Methods*, 11, 193-206.
- Öst, L.-G., & Westling, B. E. (1995). Applied relaxation vs cognitive behavior therapy in the treatment of panic disorder. *Behaviour Research and Therapy*, 33, 145-158.
- Rapaport, M. H., Pollack, M., Wolkow, R., Mardekian, J., & Clary, C. (2000). Is placebo response the same as drug response in panic disorder. *American Journal of Psychiatry*, 157, 1014-1016.
- Siev, J., & Chambless, D. L. (2007). Specificity of treatment effects: Cognitive therapy and relaxation for generalized anxiety and panic disorders. *Journal of Consulting and Clinical Psychology*, 75, 513-522.
- Siev, J., Huppert, J. D., & Chambless, D. L. (2009). The dodo bird, treatment technique, and disseminating empirically supported treatments. *the Behavior Therapist*, 32, 69-76.
- Telch, M. J., Schmidt, N. B., Jaimez, L., Jacquin, K. M., & Harrington, P. J. (1995). Impact of cognitive-behavioral treatment on quality of life in panic disorder patients. *Journal of Consulting and Clinical Psychology*, 63, 823-830.
- Wampold, B. E., Imel, Z. E., & Miller, S. D. (2009). Barriers to the dissemination of empirically supported treatments: Matching messages to the evidence. *the Behavior Therapist*, 32, 144-155.

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Letter to the Editor

To Kill a Dodo Bird

Stefan G. Hofmann, *Boston University*, and Jeffrey M. Lohr, *University of Arkansas*

We have read with great interest the article “Barriers to the Dissemination of Empirically Supported Treatments: Matching Message to the Evidence,” by Wampold, Imel, and Miller (2009) published in *the Behavior Therapist*. The authors provide a well-written and scholarly discussion on the issue of treatment specificity and the dodo-bird verdict. Much of the authors’ argument rests on the meta-analyses by Siev and Chambless (2007) and Wampold et al. (1997).

Not unusual for meta-analytic arguments, the authors might have missed some important evidence that contradicts their own presumptions. We observed in our own meta-analysis clear evidence that is incompatible with the dodo-bird conjecture (Hofmann & Smits, 2008). In our own meta-analysis, we examined high-quality randomized controlled trials examining the efficacy of CBT for various anxiety disorders. We found that (a) CBT is more efficacious than credible control treatments; (b) the various CBT protocols differ in their efficacy depending on the disorder they target; and, most important for this discussion, (c) CBT is disorder-specific because CBT for anxiety disorders primarily changes anxiety symptoms but to a much lesser degree depression symptoms.

The last finding should pose a particular challenge for proponents of the dodo-bird verdict because treatment specificity directly falsifies the dodo-bird conjecture. In this context, it is important to define the term *treatment specificity*. It can refer to (a) *specificity of treatment content*, (b) *specificity of treatment efficacy*, (c) *disorder-specificity of treatment*, or (d) *specificity of treatment mechanism*. In the case of specificity of treatment content, specific procedures are included to target the disorder or dysfunctions for which treatment is sought. This involves the identification of “active ingredients” and requires consideration of component-controlled experimental analyses (Lohr, DeMaio, & McGlynn, 2003). In the case of specificity of treatment efficacy, one has to show that treatment T1 is more efficacious than treatment T2 for treating a specific disorder. This form of specificity is

of limited theoretical importance because it tells us very little about the active ingredients or the mechanism of treatment change. Heuristically more useful is to examine the disorder-specificity of a treatment. In this case, a treatment T1 may be more efficacious than T2 for treating symptoms S1 but not for treating symptoms S2. Even more informative is the specificity of the treatment mechanism because this provides information about the mediation variables that are involved in a specific treatment.

Efficacy studies alone are not overly informative for this particular discussion because they neither prove nor disprove the dodo-bird conjecture. However, this conjecture is incompatible with data supporting *disorder-specificity of treatment* and also *specificity of treatment mechanism*. Our meta-analysis of CBT trials for anxiety disorders yielded a pooled effect size (Hedges’ g) of 0.73 (95% confidence interval, 0.88-1.65) for continuous anxiety severity measures and 0.45 (90% confidence interval, 0.25-0.65) for depressive symptom severity measures. Because the confidence intervals are nonoverlapping, these data suggest that CBT for anxiety disorders is treatment specific. In contrast, the dodo-bird conjecture predicts that symptoms of anxiety and depression improve similarly well (or poorly).

These data are in line with the meta-analysis by Siev and Chambless (2007) demonstrating disorder-specificity of CBT, because CBT and relaxation therapy were efficacious for generalized anxiety disorder, but CBT was more efficacious than relaxation therapy for treating symptoms of panic disorder. Wampold et al. (2009) tried to make the case that the results of Siev and Chambless’ (2007) meta-analysis were biased because of one particular study with very strong effects. However, using a different approach and evidence base, our meta-analysis supports the conclusion by Siev and Chambless.

Wampold et al. (2009) might argue next that the control conditions in our meta-analysis do not consist of bona fide interventions. However, most—if not all—of the comparison treatments included in the Hofmann and Smits (2008) trials include

bona fide interventions. These treatments include supportive counseling, relaxation treatments, and anxiety management. In a separate meta-analysis, we (Smits & Hofmann, 2009) examined the uncontrolled effect size of these control treatments and found an average effect size of Hedges' $g = 0.45$ (95% confidence interval, 0.35-0.46). There was no evidence for publication bias, nor was there a significant relationship between the effect size and diagnostic group, study year or number of treatment sessions. In addition, these treatments were associated with a relatively low attrition rate. Again, these data contradict the argument that the control treatments in the Hofmann and Smits (2008) meta-analyses are biased in favor of CBT.

In addition to these arguments, we would like to point out that a number of recent studies provide evidence for cognitive mediation of CBT effects for a variety of disorders, including panic disorder (Hofmann et al., 2007), social anxiety disorder (Hofmann, 2004; Smits, Rosenfield, Telch, & McDonald, 2006), obsessive-compulsive disorder (Moore & Abramowitz, 2007), depression (Kaysen, Scher, Mastnak, & Resick, 2005; Tang, DeRubeis, Beberman, & Pham, 2005), and pain (Price, 2000), to name only a few. These data provide additional evidence against the dodo-bird conjecture.

We hope that future debates concerning the dodo-bird verdict (we would like to eliminate this term, as indicated in our title), treatment specificity, and mechanism

of treatment change include a more balanced discussion that considers all available data, even those that seem to contradict one's own assumptions.

References

- Hofmann, S. G. (2004). Cognitive mediation of treatment change in social phobia. *Journal of Consulting and Clinical Psychology, 72*, 392-399.
- Hofmann, S. G., & Smits, J. A. J. (2008). Cognitive-behavioral therapy for adult anxiety disorders: A meta-analysis of randomized placebo-controlled trials. *Journal of Clinical Psychiatry, 69*, 621-632.
- Hofmann, S. G., Meuret, A. E., Rosenfield, D., Suvak, M. K., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2007). Preliminary evidence for cognitive mediation during cognitive behavioral therapy for panic disorder. *Journal of Consulting and Clinical Psychology, 75*, 374-379.
- Kaysen, D., Scher, C. D., Mastnak, J., & Resick, P. (2005). Cognitive mediation of childhood maltreatment and adult depression in recent crime victims. *Behavior Therapy, 36*, 235-244.
- Lohr, J.M., DeMaio, C., & McGlynn, F.D. (2003). Specific and nonspecific treatment factors in the experimental analysis of behavioral treatment efficacy. *Behavior Modification, 27*, 322-368.
- Moore, E. L., Abramowitz, J. S. (2007). The cognitive mediation of thought-control strategies. *Behaviour Research and Therapy, 45*, 1949-1955.
- Price, D. D. (2000). Psychological and neural mechanisms of the affective dimension of pain. *Science, 288*, 1769-1772.
- Siev, J., & Chambless, D. L. (2007). Specificity of treatment effects: Cognitive therapy and relaxation for generalized anxiety and panic disorders. *Journal of Consulting and Clinical Psychology, 75*, 513-522.
- Smits, A. J., & Hofmann (2009). A meta-analytic review of the effects of psychotherapy control conditions for anxiety disorders. *Psychological Medicine, 39*, 229-239
- Smits, J. A. J., Rosenfield, D., Telch, M. J., & McDonald, R. (2006). Cognitive mechanisms of social anxiety reduction: An examination of specificity and temporality. *Journal of Consulting and Clinical Psychology, 74*, 1203-1212.
- Tang, T. Z., DeRubeis, R. J., Beberman, R., & Pham, T. (2005). Cognitive changes, critical sessions, and sudden gains in CBT for depression. *Journal of Consulting and Clinical Psychology, 73*, 168-172.
- Wampold, B. E., Imel, Z. E., & Miller, S. D. (2009). Barriers to the dissemination of empirically supported treatments: Matching messages to the evidence. *the Behavior Therapist, 32*, 114-155.
- Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "All must have prizes." *Psychological Bulletin, 122*, 203-215.

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Letter to the Editor

The Dodo Bird—Again—and Again

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The "dodo bird" argument, as many people know, has been around since 1975, and there have been countless rebuttals throughout the late 80s and 90s, sometimes presented as special sections of journals. Now it is coming up again (see Siev, Huppert, & Chambless, 2009, and Wampold, Imel, & Miller, 2009) because Bruce Wampold is presenting it in a scholarly manner (much to his credit), with yet another set of meta-analyses. But the question to ask is why the dodo bird has never gained any traction even in the early years before the rise of evidence-based practice

and the appearance of thousands of positive clinical trials demonstrating superiority of psychological treatments carefully tailored to presenting psychopathology compared to some good alternatives? One reason is that the primary methods used are retrospective re-analyses of other work using meta-analytic procedures. But these procedures are notoriously subject to distortion with just the slightest tweaks (see Dieckmann, Malle, & Bodner, 2009) and manuscripts meta-analyzing the exact same data sets examined by Wampold are making their way to publication from evidence-based treatment (EBT) types showing very

different findings from Wampold's latest efforts. And, of course, numerous meta-analyses exist showing efficacy of EBTs compared to credible active controls. The main consequence of reading all of these analyses is that most people will fall asleep. For this reason I don't trust any meta-analysis conducted by anyone with an agenda, and this includes treatment developers as well as Bruce Wampold, and neither should anyone else. For example, Wampold (with more kudos for full disclosure) is very clear about his personal experience with and strong allegiance to individual long-term psychotherapy (see, for example, Wampold, 2001). This is reminiscent of a similar allegiance-related agenda reported by Gene Glass of Smith and Glass (1977) fame when he noted:

I left the University of Wisconsin in 1965 with a brand new Ph.D. in . . . statistics and a major league neurosis. Luckily, I found my way into psy-

chotherapy that year . . . and never left it until eight years later. . . . I was so impressed with the power of psychotherapy as a means of changing my life and making it better that by 1970 I was studying clinical psychology . . . the weight of academic opinion at that time derived from Hans Eysenck's frequent and tendentious reviews . . . that proclaimed psychotherapy as worthless . . . I found this conclusion personally threatening—it called into question not only the preoccupation of about a decade of my life but my scholarly judgment (and the wisdom of having dropped a fair chunk of change) as well. I read Eysenck's literature reviews and was impressed primarily with their arbitrariness. . . . I wanted to take on Eysenck and show that he was wrong: psychotherapy does change lives and make them better. (Glass, 2000)

Only independent and impartial groups such as the National Institute for Health and Clinical Excellence (NICE) in the U.K. utilizing their sophisticated methods, and the Agency for Healthcare Research and Quality (AHRQ) within the U.S. Department of Health and Human Services

(HHS), and other similarly composed impartial policymaking bodies are capable of producing credible analyses, and produce them they have. But even these need replication. More importantly, look at the implications of the dodo bird. Is there any clinician out there who really believes that you can use exactly the same procedure with, say, someone with chronic schizophrenia, specific phobia, bipolar disorder, or OCD as long as it's a "bona fide" treatment that both patient and therapist believe in? So client-centered therapy would work as well for cognitive deficits in schizophrenia as would cognitive remediation therapy, and as well with OCD as ERP? The fundamental reason this argument has never gained traction is because it just plain doesn't make sense no matter how the clinical trials are reinterpreted. And it's also easy to sit back and "pick off" any new study and conclude that it's not "perfect." But to really prove the dodo-bird thesis, the proponents would need to do the hard work of conducting their own trials constructing "bona fide" treatments and comparing them to well-established active treatments using equivalence analyses, not just claiming that "no findings" (the null hypothesis) prove anything.

References

- Dieckmann, N. F., Malle, B. F., & Bodner, T. E. (2009). An empirical assessment of meta-analytic practice. *Review of General Psychology, 13*(2), 101-115.
- Glass, G. V. (2000). *Meta-analysis at 25*. Retrieved November 25, 2009, from <http://glass.ed.asu.edu/gene/papers/meta25.html>
- Siev, J., Huppert, J., & Chambless, D. L. (2009). The Dodo bird treatment technique, and disseminating empirically supported treatments. *the Behavior Therapist, 32*, 69-76.
- Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*(9), 752-760.
- Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Hillsdale, NJ: Lawrence Erlbaum.
- Wampold, B. E., Imel, Z. E., & Miller, S. D. (2009). Barriers to the dissemination of empirically supported treatments: Matching messages to the evidence. *the Behavior Therapist, 32*, 144-155.

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Letter to the Editor

More on the Brain Disease Model of Mental Disorders

Steven Taylor, *University of British Columbia*, Dean McKay, *Fordham University*, and Jonathan S. Abramowitz, *University of North Carolina*

Deacon and Lickel (2009) offer compelling arguments as to why an eliminative materialism approach to mental disorders, such as those promulgated by major funding bodies like NIMH, is misguided, empirically inadequate, and potentially harmful to consumers of mental health services. Eliminative materialism states that psychological conditions, such as depression, can be simply reduced to brain conditions, such as dysregulated neurotransmission. Eliminative materialism has been roundly discredited by philosophers of mind because, among other things, it neglects psychosocial factors—for example, the effects of aversive environments such as those involving poverty, discrimination, or

threats to the physical integrity of oneself or loved ones (Searle, 1992).

NIMH Director Thomas Insel called for the development of "cure therapeutics" of mental disorders (Insel & Scolnick, 2006), which is apparently a funding priority of NIMH. His proposed research program is a largely biological endeavor in the spirit of eliminative materialism. But are there any leading researchers in the field of psychopathology who seriously endorse eliminative materialism as a viable explanation of psychopathology? Likely not, except perhaps for extreme biophiles. Kenneth Kendler, a leader in the field of biological and genetic factors in psychopathology, cogently criticized a variant of eliminative materialism that he called "GeneTalk"; that is, the claim that disorder X can be simply ex-

plained by gene Y. Kendler concluded that this approach is misguided because, among other things, it ignores the importance of the environment and gene-environment interactions (Kendler, 2005). Insel's call for research on "cure therapeutics" is unrealistically simplistic because it overemphasizes biological research to the neglect of environmental (e.g., psychosocial) factors.

For behavioral researchers this is important because the denigration of our subject matter by funding bodies seriously impairs our investigation of the variables that we regard, with good reason, as being important in understanding psychopathology. As Deacon and Lickel (2009) point out, there are important and sometimes harmful practical consequences. There are other important consequences that were not mentioned by Deacon and Lickel that we would like to highlight. This concerns a booklet recently published by NIMH intended to educate the public about the nature and treatment of obsessive-compulsive disorder (OCD; NIMH, 2009). Given the debilitating nature of OCD, and the difficulty many sufferers have in identifying appropriate treatment resources, the dissemination of accurate educational materials is vital for helping consumers make informed choices

about health care. We were concerned to see that the NIMH booklet offered distorted advice about treatment options. The booklet offers the following advice to consumers:

There is help for people with OCD. The first step is to go to a doctor or health clinic to talk about symptoms. People who think they have OCD may want to bring this booklet to the doctor, to help them talk about the symptoms in it. The doctor will do an exam to make sure that another physical problem isn't causing the symptoms. The doctor may make a referral to a mental health specialist. Doctors may prescribe medication to help relieve OCD. It's important to know that some of these medicines may take a few weeks to start working. Medications can be prescribed by M.D.s (usually a psychiatrist) and in some states also by clinical psychologists, psychiatric nurse practitioners, and advanced psychiatric nurse specialists. Check with your state's licensing agency for specifics. The kinds of medicines used to treat OCD are listed below. Some of these medicines are used to treat other problems, such as depression, but also are helpful for OCD.

- antidepressants,
- anti-anxiety medicines, and
- beta-blockers.

Doctors *also may* ask people with OCD to go to therapy with a licensed social worker, psychologist, or psychiatrist. This treatment can help people with OCD feel less anxious and fearful. (p. 4, emphasis added)

The booklet overstates the role of medication. It gives the misleading impression that medications are the only first-line treatments and that “therapy”—presumably a reference to behavioral or cognitive-behavioral therapy (CBT)—is simply an adjunct to medication. There is ample evidence that behavior therapy and CBT, as stand-alone treatments, are just as efficacious as medications (Abramowitz, Taylor, & McKay, 2009). Such findings have emerged from studies funded by NIMH. Indeed, a recent NIMH-funded study showed that CBT was efficacious even for OCD patients who failed to respond to an adequate course of pharmacotherapy (Simpson et al., 2008).

Contemporary practice guidelines, such as those published by the American Psychiatric Association and by the Royal

College of Psychiatrists, make it abundantly clear that behavioral or cognitive-behavioral interventions are first-line treatments, even as stand-alone interventions (e.g., American Psychiatric Association, 2007; National Institute for Health and Clinical Excellence [NICE], 2006). For children and adolescents with OCD, it has been recommended that CBT is the initial treatment of choice, and that medication should be only considered if there has been an insufficient response to CBT (NICE, 2006). The following quotations illustrate these practice guidelines.

In choosing a treatment approach, the clinician should consider the patient's motivation and ability to comply with pharmacotherapy and psychotherapy. CBT and serotonin reuptake inhibitors (SRIs) are recommended as safe and effective first-line treatments for OCD. (American Psychiatric Association, 2007, p. 11)

Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT ... because these treatments appear to be comparably efficacious. ... Adults with OCD with severe functional impairment should be offered combined treatment with an SSRI and CBT. (NICE, 2006, p. 232)

Children and young people with OCD with moderate to severe functional impairment... should be offered CBT ... If psychological treatment is declined by children or young people with OCD ... or they are unable to engage in treatment, an SSRI may be considered with specific arrangements for careful monitoring for adverse events. (NICE, 2006, pp. 232-233)

The NIMH booklet does not reflect contemporary practice guidelines. Instead, it gives the distorted impression that people suffering from OCD must take medication, and that “talk therapy” is simply an adjunct to medication. As such, the booklet does not serve the best interests of the public. We notified Dr. Insel of our concerns and hope that our empirically informed suggestions can counterbalance the biocentric emphasis in the booklet. We gather that our suggestions are currently under consideration by the unnamed authors of the OCD booklet. As Deacon and Lickel amply demonstrate, a biocentric emphasis may hinder rather than help our clients or patients overcome their

problems. Clearly, should take precedence over the ideologies about the causes of mental disorders.

References

- Abramowitz, J. S., Taylor, S., & McKay, D. (2009). Obsessive-compulsive disorder. *The Lancet*, 374, 489-497.
- American Psychiatric Association (2007). *Practice guideline for the treatment of patients with obsessive-compulsive disorder*. Arlington, VA: Author.
- Deacon, B. J., & Lickel, J. L. (2009). On the brain disease model of mental disorders. *the Behavior Therapist*, 32, 113-116.
- Insel, T. R., & Scolnick, E. M. (2006). Cure therapeutics and strategic prevention: Raising the bar for mental health research. *Molecular Psychiatry*, 11, 11-17.
- Kendler, K. S. (2005). “A gene for...”: The nature of gene action in psychiatric disorders. *American Journal of Psychiatry*, 162, 1243-1252.
- National Institute for Health and Clinical Excellence. (2006). *Obsessive-compulsive disorder*. London: British Psychological Society and the Royal College of Psychiatrists.
- National Institute of Mental Health. (2009). *When unwanted thoughts take over: Obsessive-compulsive disorder*. [Brochure]. Washington, DC: Author. Retrieved December 9, 2009, from <http://www.nimh.nih.gov/health/publications/when-unwanted-thoughts-take-over-obsessive-compulsive-disorder/complete.pdf>
- Searle, J.R. (1992). *The rediscovery of the mind*. Cambridge, MA: MIT Press.
- Simpson, H.B., Foa, E.B., Liebowitz, M.R., Ledley, D.R., Hupert, J.D., Cahill, S., et al. (2008). A randomized controlled trial of cognitive-behavioral therapy for augmenting pharmacotherapy in obsessive-compulsive disorder. *American Journal of Psychiatry*, 165, 621-630.

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Book Review

Cooper, M., Todd, G., & Wells, A. (2009). *Treating Bulimia Nervosa and Binge Eating: An Integrated Metacognitive and Cognitive Therapy Manual*. New York: Routledge

Reviewed by Rachel A. Annunziato, *Mount Sinai School of Medicine*

T*reating Bulimia Nervosa and Binge Eating*, by Myra Cooper, Gillian Todd, and Adrian Wells, comprehensively describes a cognitive approach for addressing symptoms of binge eating and/or purging. The method presented is applicable for patients diagnosed with bulimia nervosa (BN), subthreshold BN, and a range of binge-eating presentations. Overall, the book offers a thorough rationale for adopting a cognitive conceptualization of the target symptoms; and the subsequent treatment techniques are presented in a clear, user-friendly fashion that is appropriate for clinicians with a wide range of experience.

The authors begin by providing extensive rationale for treating BN with cognitive behavioral therapy (CBT), including a review of the data supporting Fairburn, Marcus, and Wilson's (1993) well-known intervention package. However, it is noted that traditional CBT for BN results in a large percentage of patients continuing to manifest clinically significant symptoms after long-term follow-up; and that CBT for BN appears to be less effective than other extensively studied CBT protocols such as those targeting anxiety disorders. Therefore, the authors hypothesize that bolstering the cognitive aspect of standard CBT packages for BN will result in improved outcomes.

A new cognitive model, describing both the development and maintenance of BN, is offered, drawing on several influences and integrating more recently described metacognitive theory (Wells, 2000). The specific treatment targets addressed in this formulation are negative beliefs about the controllability of bingeing and the consequences of eating; positive beliefs about eating-related behaviors and cognitions; and negative self-beliefs. For those who have experience with other cognitively oriented treatments, targeting these foci will likely feel quite familiar and comfortable. At this point, the reader will perhaps wonder whether these components are added to traditional CBT for BN or if there are other dif-

ferences. The treatment does depart from Fairburn et al. (1993) in other ways as well. Food records are not employed, and rationale is offered for why this could be counterproductive. However, the frequency of purging and bingeing episodes is tracked. To perhaps assuage those who will be uncomfortable with the absence of this core technique, exceptions to the omission of food diaries are discussed. Behavioral strategies are employed (e.g., stimulus control, exposure exercises, etc.) but often they are presented as offshoots of the cognitive components. For example, exposure exercises are routinely used, and very nicely described, to test the validity of specific beliefs.

The treatment portion of the book is structured like a manual. Throughout, the reader is referred to exemplary forms, materials in the Appendix, and case examples. Prior to this, an extensive discussion of disordered eating assessment is provided, which will likely be less relevant to more experienced readers but very helpful to trainees. In addition, an overview of treatment motivation and engagement is offered. This discussion may help to determine who will or will not be appropriate for this treatment. The authors explain how to integrate the assessment data into a formulation using their cognitive model. How to present and "sell" the model to prospective patients is also very well articulated. At this point, the authors address specific treatment targets, beginning with metacognitive factors and proceeding to negative self-beliefs. In some instances the authors included "Troubleshooting" sections which I really liked. These cautions captured well difficulties I envisioned having when implementing the treatment. Finally, readiness for and the termination process itself is briefly reviewed.

Treating Bulimia Nervosa and Binge Eating has important strengths. Overall, the material is presented very clearly and interestingly. The interventions described, depending on the reader, may range from ideas that one has widely used to quite novel concepts. I felt that no matter where a stratagem fell on this spectrum, the description

and rationale were well-organized, concise, and quite feasible for one to imagine implementing. The vignettes provided greatly help in this regard. The authors are appropriately and thoroughly inspired by multiple influences and they did an excellent job concisely presenting such areas. For example, in their discussion of engagement and motivation for treatment, presentation of Prochaska and DiClemente (1982) and Miller and Rollnick's (2002) work is provided. These descriptions are tailored to clinicians with a range of prior familiarity. Considering the perspective of trainees, I believe the overviews of such areas are likely very welcoming and helpful (but not so extensive as to alienate those with more experience, in fact, to the contrary, they could be nice refreshers). Finally, the plethora of materials presented in the book is outstanding. I found the forms and other references in the Appendix to be of great interest and utility.

The lingering questions I had while contemplating my use of the treatment are in regards to its effectiveness and the relative importance and sequence of the presented techniques. The authors review data supporting the development of their model and the chosen treatment targets. However, data are not yet presented regarding the effectiveness of this approach and, of great importance, how this package compares to traditional CBT for BN. Secondly, the relative weight of treatment targets was not clear to me. For example, if a client struggles with detached mindfulness, is that critical to treatment success? It seemed as if the authors advocate a specific sequence for delivering the treatment and the order was consistent with other cognitively oriented packages (e.g., targeting core beliefs towards the end of treatment) but I was curious if they recommended flexibility here. For example, would clinical judgment prevail if a therapist felt it helpful to address core beliefs earlier or is adhering to the prescribed order of value?

For those with cognitive proclivities, this text provides welcome additions to standard CBT for BN. The supplementary materials included by the authors to illustrate their concepts and techniques will likely serve as valuable resources for those treating disorders characterized by symptoms of bingeing and/or purging as well as some that generalize to other presentations as well. I cannot think of a book I have used recently that contains as many resources as this one. Theoretical rationale for both the core tenants and supplementary techniques is provided. The tone and scope of *Treating Bulimia Nervosa and Binge Eating* very nicely

balances the needs of readers who will have a wide range of experience, which certainly is not always an easy feat. Those who elect to employ this method will be well-prepared. It will be quite exciting to learn more as data are published on its use.

References

Cooper, M., Todd, G., & Wells, A. (2009). *Treating bulimia nervosa and binge eating: An integrated metacognitive and cognitive therapy manual*. New York: Routledge.

Fairburn, C.G., Marcus, M.D., & Wilson, G.T. (1993). Cognitive behaviour therapy for binge eating and bulimia nervosa: A comprehensive treatment manual. In C.G. Fairburn & G.T. Wilson (Eds.), *Binge eating: Nature, assessment, and treatment*. New York: Guilford.

Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. New York: Guilford.

Prochaska, J.O. & DiClemente, C.C. (1982). Transtheoretical therapy: Towards an integrative model of change. *Psychotherapy Theory and Research Practice*, 19, 276-288.

Wells, A. (2000). *Emotional disorders and metacognition*. Chichester: Wiley.

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Book Review

Klingemann, H., & Sobell, L. (Eds.). (2007). *Promoting Self-Change From Addictive Behaviors: Practical Implications for Policy, Prevention and Treatment*. New York: Springer

Reviewed by Carlo C. DiClemente, *University of Maryland, Baltimore*

In 1979 the National Cancer Institute issued a Request for Proposals that included examining the phenomenon of self-change of smoking. Researchers had been developing many different programs for smoking cessation over the years. However, data indicated that the vast majority of individuals who quit smoking did so "on their own" without the use of any formal treatments. This began a journey for many of smoking cessation behavioral scientists to understand the nature, mechanisms, and meaning of individual-initiated and sustained change of addictive behavior. Although there were some indicators that this phenomenon existed for other drugs of abuse and alcohol abuse and dependence, most clinicians and researchers of "real" addictive behaviors" (heroin, cocaine, marijuana, and alcoholism) believed self-change was a phenomenon limited to nicotine addiction and even then believed that it really could not happen with individuals who were truly addicted.

This volume offers a comprehensive view of the halting and somewhat circuitous path that led to our current understanding of self-change from all types of addictive behaviors. The editors are pioneers in the investigation of this phenomenon of self-change among individuals with serious drug and alcohol problems in multiple countries and continents. For the past 15 years both Drs. Klingemann and Sobell

have challenged some of the basic beliefs of the addiction treatment community by bringing to light the struggle of individuals who, with minimal or no assistance from treatment interventions, have been able to change successfully one or more addictive behaviors and sustain that change over time. These pioneers also have contributed to the methodological sophistication with which we now study self-change. Early studies were generally retrospective evaluations of self-reported successful change that did not use formal treatment. The field has progressed greatly over the years, taking into account severity, prior treatment, mutual help experiences, legal status, mental illness, and other complicating factors. However, it is interesting to note that in many more current studies methodological rigor falls short of the standards promoted by these researchers.

For this compendium on self-change, Harald Klingemann and Linda Carter Sobell have brought together an international group of addiction scientists and experts to explore the topic of self-change using survey data and research studies to focus on more traditional (alcohol, drug use, smoking, gambling, eating disorders) addictive behaviors and then to extend the view of self-change to new areas like stuttering and crime. Later chapters offer views of how to integrate self-change into our concepts of treatment, culture, policymaking,

and societal influences. A final chapter details the growing wealth of resources and information for assessing and promoting self-change.

The current volume represents an update of a prior work, *Promoting Self-Change From Problem Substance Abuse* (Klingemann et al., 2001), that originally brought to light the research on the existence of self-change and offered ideas and strategies to harness the power of this process and promote self-change. Initial chapters provide a wonderfully rich compendium of the state of the science of self-change. After a thoughtful overview by Sobell of the importance of the existence of self-change among addicted individuals and the many challenges to understanding and studying this experience, the next four chapters review the research, primarily in alcohol and drug abuse, from classic to current (2005) studies. The multiple reviews, however, become redundant and a bit confusing as different chapters discuss the same study in different ways. The authors of these review chapters do not seem to have communicated about what studies and in what way they would cover the research. Thus, there is some sense of déjà vu as one goes from chapter to chapter, though it is interesting to get some different perspectives. This may be a personal bias but I would also like to see more included about the experience of self-change of smoking beyond the 5-page treatment that comes in a later chapter. Smoking cessation offers a perspective on how societal, social group, and personal self-change interact and there is a growing understanding of these interactions emerging in the literature. Despite these criticisms of the early chapters, I believe that anyone who wants to know what has happened in the arena of self-change in alcohol and drug abuse research will be delighted with the breadth and depth of these reviews.

To keep the research grounded in the experience of the self-changers, the editors

have included quotes and reports reflecting experiences of those who have been able to change addictive behaviors on their own. The welcome addition of these brief vignettes helps the reader understand the experience and not just the research. Unfortunately, these vignettes appear only in a couple of chapters and could have been more strategically placed throughout the other chapters as well.

The phenomenon of self-change challenges many of our views of addiction, loss of control, self-regulation, and the process of change. Many of the chapters highlight some of these issues. However, the overall perspective seems to contrast self-change and treatment change as separate entities or routes of change. This is understandable to some extent since pioneers need to establish the existence and reality of a previously understudied experience that many in the field did not believe existed—that is, the ability of addicted individuals to change on their own without treatment or assistance. However, as the field matures, it seems best to consider all change in addictive behaviors as self-change. Treatment simply enhances or supports the personal process of change. Brief interventions, motivational interviewing, and policy changes that produce significant individual change events seem to indicate the process of self-change can be influenced by events and interventions that one would consider contextual or minimal. Hopefully, as the field develops, there will be less and less of a need to dichotomize self-change and treatment change.

The importance of context in the phenomenon of self-change is highlighted in the chapter by the Klingemanns that describes hostile and favorable social climates for self-change and the one by Barker and Hunt that offers some thoughts about the cross-cultural challenges for the study and understanding of self-change among subgroups of individuals embedded in various cultural traditions and experiences. These chapters highlight the fact that we have a long way to go to understand and to control or direct self-change of addictive behaviors. However, they do offer ideas and concepts that can help us move forward to study the contextual influences on self-change and the types of policies and societal attitudes that can foster change.

As with any good book, this one leaves this reader wishing for more. I would have liked to have seen more theoretical and conceptual discussion of assumed mechanisms that influence and enable self-change. I would like to have had a more in-depth treatment of how self-change influences our understanding of addiction and our diagnostic categorization of dependence. I wanted a more integrated overview of the literature and a more detailed description of what self-change means for treatment and healthcare policy. Finally, I would like to have seen more on the interaction of social forces and personal processes. However, the value of this book is that there are chapters in which the discussion of each of these topics is highlighted and the topic explored. Clearly, there will need to be another update of this book in the future.

At present, however, many different audiences can benefit from reading this book. Researchers will benefit from reading about the scope of the research and will be challenged about directions for future research. Clinicians will be able to see the nature and scope of the addicted individual's capacity to change. Policymakers will be intrigued by the possibilities of harnessing self-change for the betterment of society. The public, that includes all of us, will be challenged to question our assumptions about addiction and change, to reflect on our attitudes about individuals engaged in addictive behaviors, and learn a little about how to promote self-change among our colleagues, friends, and families.

References

- Klingemann, H., & Sobell, L. (Eds.). (2007). *Promoting self-change from addictive behaviors: Practical implications for policy, prevention and treatment*. New York: Springer.
- Klingemann, H., Sobell, L., Barker, J., Blomqvist, J., Cloud, W., Ellinstad, T., et al. (2001). *Promoting self-change from problem substance abuse*. Dordrecht, The Netherlands: Kluwer.

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CALL FOR Workshop Submissions

44th Annual Convention | November 18–21, 2010 | San Francisco

Please send a 250-word abstract and a CV for each presenter to:

Jillian C. Shipherd, Ph.D.
Women's Health Sciences Division (116B-3)
VA Boston Healthcare System
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Boston, MA 02130
or email: Jillian.Shipherd@va.gov

CALL for PAPERS

44th Annual Convention | San Francisco

November 18–21, 2010



COGNITIVE
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Unifying
Diverse
Disciplines
With
a Common
Thread

One of the many strengths of cognitive behavioral therapy is the fact that it is flexible and can be adapted to treat a variety of problems that individuals face. This has resulted in the tremendous growth of diverse specialties that utilize cognitive behavioral principles to help people return to a healthier state of both physical and psychological functioning. While there are many specialties within the fields of physical and mental health, our shared understanding of the importance of applying evidence-based cognitive behavioral practices is a common thread that joins us together.

Opportunities to share knowledge across disciplines could be achieved through broadening the scope of our ABCT conference. As multidisciplinary treatment teams are becoming more prevalent, it is important to find avenues for increasing our communication about ways that evidence-based practices can be applied more broadly, adding to the richness of our knowledge about cognitive behavioral theory and its potential applications.

The theme of the 44th annual meeting is intended to emphasize the relevance of cognitive-behavioral theories across varied topics and disorders and across diverse health - and mental-health related professions and disciplines. We welcome submissions for research symposia, clinical sessions, and workshops focused on elucidating ways that cognitive behavioral treatments are relevant to diverse groups of professionals that work with patients.

Submissions that highlight innovative applications of cognitive behavioral treatments or submissions that help highlight ways that we can broaden our focus about the populations, settings, and disciplines in which cognitive behavioral treatments can be used are encouraged and will receive special consideration. We welcome representation in areas or from disciplines that may have been underrepresented in recent years.

Submissions may be in the form of symposia, round tables, panel discussions, and posters. Information for submitting abstracts can be found on ABCT's web site or in the February issue of the Behavior Therapist.

**Submission
Deadline:
March 2, 2010**

PROGRAM CHAIR: John D. Otis, Ph.D.

Call

for Award Nominations

The ABCT Awards and Recognition Committee, chaired by Shelley Robbins of Holy Family University, is pleased to announce the 2010 awards program. Nominations are requested in all categories listed below. Please see the specific nomination instructions in each category.

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

Outstanding Contribution by an Individual for Research Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions to the literature advancing our knowledge of behavior therapy. Past recipients of this award include Alan E. Kazdin in 1998, David H. Barlow in 2001, Terence M. Keane in 2004, and Thomas Borkovec in 2007. Please complete an on-line nomination form at www.abct.org. Then, e-mail the completed forms to srobbins@holyfamily.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Researcher, 305 Seventh Ave., New York, NY 10001.

Outstanding Mentor

This year we are seeking eligible candidates for the Outstanding Mentor award who are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. The first recipient of this award was Richard Heimberg in 2006, followed by G. Terence Wilson in 2008. Please complete an on-line nomination form at www.abct.org. Then, e-mail the completed forms to srobbins@holyfamily.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Mentor, 305 Seventh Avenue, NY, NY 10001.

Student Dissertation Awards:

- **The Virginia A. Roswell Student Dissertation Award**
- **The Leonard Krasner Student Dissertation Award**

Each award will be given to one student based on his/her doctoral dissertation proposal. The research should be relevant to behavior therapy. Accompanying this honor will be a \$1,000 award to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligible candidates for this award should be student members who have already had their dissertation proposal approved and are investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor should complete the nomination. Please complete an on-line nomination form at www.abct.org. Then, e-mail the completed forms to srobbins@holyfamily.edu. Also, mail a hard copy

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Distinguished Friend to Behavior Therapy

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

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include Albert Ellis, Leonard Ullman, Leonard Krasner, Steve Hayes, and David H. Barlow. Please complete an on-line nomination form at www.abct.org. Then, e-mail the completed forms to srobbins@holyfamily.edu. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement Award, 305 Seventh Ave., New York, NY 10001.

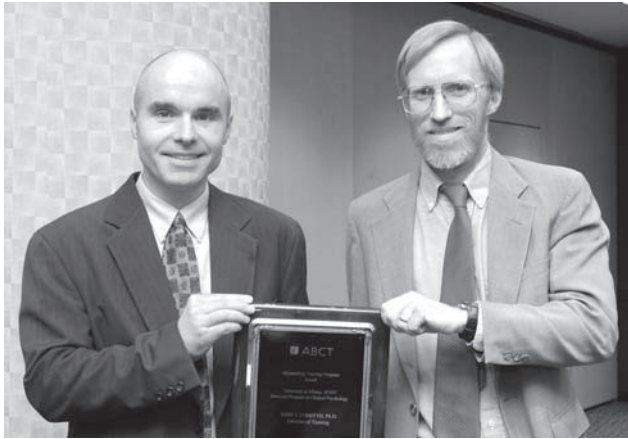
NOMINATIONS FOR THE FOLLOWING AWARD ARE SOLICITED FROM MEMBERS OF THE ABCT GOVERNANCE:

Outstanding Service to ABCT

Members of the governance, please complete an on-line nomination by visiting www.abct.org. Then, e-mail the completed forms to srobbins@holyfamily.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT Award, 305 Seventh Ave., New York, NY 10001.

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

Nominate on line: www.abct.org
Deadline for all nominations:
Monday, March 2, 2010



John P. Forsyth (*left*) receiving the Outstanding Training Program Award from David A. F. Haaga, *Awards & Recognition Chair*



Elsie Ramos Poster Award Winners (l to r) Landon Fuhrman, Thomas Armstrong, and Nisha Sethi (with Lily McNair, Chair, Elsie Ramos Poster Award)



Philip C. Kendall receiving the Outstanding Contribution by an Individual for Education/Training

43rd Annual Convention

Awards Ceremony



Lata McGinn, *Program Chair*, and Robert Leahy, *President (2008-09)*



Edna Foa receiving the Lifetime Achievement Award



Top row, l to r: Jonathan Abramowitz, Chair, Self-Help Book of Merit Committee; Martin Antony, Self-Help Book of Merit; Richard Swinson, Self-Help Book of Merit; Dennis Greenberger, Self-Help Book of Merit; Robert Leahy, ABCT President; Arthur Freeman, Outstanding Service to ABCT; Diane Logan, Virginia Roswell Dissertation; B. Timothy Walsh, Distinguished Friend to ABCT; John P. Forsyth, Outstanding Training Program (SUNY-Albany Doctoral in Clinical Psychology); Bunmi Olatunji, President's New Researcher; Sally Moore, Neil S. Jacobson Research Award • Seated, l to r: Landon Fuhrman, Nisha Sethi, and Thomas Armstrong, Elsie Ramos Poster Award; Michael Anestis, Leonard Krasner Student Dissertation; Eddie Selby, Neil S. Jacobson Research Award; Rex Forehand, Self-Help Book of Merit; Dave Haaga, Chair, Awards and Recognition

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2010 Call for Nominations

Every nomination counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2010, will be counted.**

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

Please complete, sign, and send this nomination form to Ray DiGiuseppe, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.

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