

the Behavior Therapist

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President's Message

Behavioral Medicine: Back to the Future

Frank Andrasik, *University of West Florida*



My first AABT (our name back then) conference was in the late 1970s, and I still remember the excitement, enthusiasm, and optimism that permeated the convention. Although many topics resonated for me, the one that captured my interest (and continues to hold it) was behavioral medicine. It was around this time that the seeds of behavioral medicine were taking root. This period was marked by many discussions (and a couple of landmark conferences sponsored by Yale University, Yale University School of Medicine, The National Academy of Sciences, and NIH-National Heart, Lung, and Blood Institute) devoted to defining and demarking the boundaries for this burgeoning field. This AABT conference included a distinguished panel of experts who were asked to address a common set of issues. To the question, "What is behavioral medicine?" Dr. Michael Cataldo of Johns Hopkins gave my favorite reply—"Whatever I am doing at the moment." Such was the promise and potential of behavioral medicine. The movement had such force and momentum, that key leaders soon felt a need to launch an independent society, the Society of Behavioral Medicine (SBM), which continues to date.¹

¹ It is interesting that the membership of this group mirrors our society in many respects. For example, psychologists constitute the largest membership category, with students and trainees representing the next largest member category. However, SBM has a larger array of disciplines, many unlikely to belong or attend our conference (anthropologists, epidemiologists, health educators, physiologists).

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

Submissions must be accompanied by a Copyright Transfer Form (a form is printed on p. 24 of the January 2008 issue of *tBT*, or contact the ABCT central office): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Submissions via e-mail are preferred and should be sent to the editor at drewa@albany.edu. Please include the phrase *tBT submission* in the subject line of your e-mail. Include the first author's e-mail address on the cover page of the manuscript attachment. By conventional mail, please send manuscripts to:

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Behavioral medicine flourished within our organization in those days. But, somewhere along the way, behavioral medicine lost its mojo within AABT. The Behavioral Medicine SIG, established in the mid-70s, withered on the vine and disbanded in the early 1980s. However, in 2003 it saw a resurgence. Such has seemingly been the case for other hot areas within AABT/ABCT (mental retardation and developmental disabilities, addictive disorders, severe psychopathology, to name just a few). Maybe it would be instructive to recap the events leading to the emergence of behavioral medicine, to help see if it merits a renewed or greater focus by members of our society. I chose this area for discussion, not because I believe it is the most important. No, that is clearly not the case. I chose it because it is an area for which I have the greatest knowledge. In fact, I plan to address other important endeavors in a future column.

To begin this dialogue, I call upon Dr. W. Stewart Agras, one of the founding fathers of behavioral medicine, our 20th president, and one of my personal heroes. (I could just as easily have called upon the wisdom of Dr. John Paul Brady, one of the 10 founders of AABT and our 5th president.)

Dr. Agras' historical overview, prepared as one of the lead papers in the first special issue devoted entirely to behavioral medicine in the *Journal of Consulting and Clinical Psychology*, succinctly summarized how and why this new field had come of age. To the question of why now, he gave but one answer:

The development has been spurred by the confluence of several overlapping interests. These include the existence of a relevant body of basic biobehavioral research promoted largely by the field of psychosomatic medicine; the rise of an applied behavioral science that is seemingly effective in a number of areas and that was catalyzed by behavior therapy and applied behavior analysis; by developments in epidemiology with the isolation of specific risk factors for illnesses of various kinds; and the growing interest in the prevention of illness spurred by the runaway costs of caring for the sick. (Agras, 1982, p. 798)

Psychosomatic medicine, long a dominant force, at this time was being overtaken largely because of its limited focus (descriptive) and failure to develop and evaluate effective treatments. This lack of emphasis on intervention, Agras pointed out, served to widen the gap between researchers and clinicians.

Clinicians were left without a solid basis for planning interventions and researchers were not always addressing the most relevant issues. What individuals are best suited to address this limitation? I submit that we are. Early in my career I remember reading the seminal paper of Dr. Mary McDill Sexton (1979), one that clearly showed the intimate linkage between a handful of behaviors and mortality/morbidity and ushered in the new concept of "behavioral epidemiology." I was particularly struck by one of her concluding statements: "The way of life determines the way of death." The behaviors identified back then continue as the leading behavioral risk factors (e.g., smoking, poor diet, physical inactivity, excessive drinking). What society contains the largest number of clinicians and researchers with the knowledge to address these problematic behaviors? I submit it is ABCT. Dr. Agras specifically mentioned the importance of behavior therapy (perhaps now he would say behavioral and cognitive therapy) and applied behavior analysis as catalysts to behavioral medicine. These evidence-based approaches stood in sharp contrast to the then prevailing approaches (chiefly psychodynamic). One has only to examine the past and current membership rosters of AABT/ABCT to see that our members were (and continue to be) the leaders and innovators in these areas.

Dr. Agras perhaps foresaw the magnitude of the shift away from AABT to SBM and other societies, when he stated:

Unfortunately, societies and journals tend to narrow their focus over time. It is not clear how this can be avoided, since one of the factors promoting narrowness is the specialization necessary for the conduct of research and the acquisition of new knowledge. However, we should recognize that the dissociation of basic and applied research will be fatal to the development of behavioral medicine. (Agras, 1982, p. 799)

The above led me to question why we are not more involved in behavioral medicine (as well as other areas mentioned above).

Consider our mission statement:

The Association for Behavioral and Cognitive Therapies is an interdisciplinary organization committed to the advancement of a scientific approach to the understanding and amelioration of problems of the human condition. These aims are

achieved through the investigation and application of behavioral, cognitive, and other evidence-based principles to assessment, prevention, and treatment.

Consider the current definition of behavioral medicine, obtained from the SBM website:

Behavioral medicine is the interdisciplinary field concerned with the development and integration of behavioral, psychosocial, and biomedical science knowledge and techniques relevant to the understanding of health and illness, and the application of this knowledge and these techniques to prevention, diagnosis, treatment, and rehabilitation.

Note the similarities in focus. Note, more importantly, the impressive wisdom and expertise of our members and our insistence upon empiricism. Can we do more? Can we play a larger role? Should we play a larger role in areas such as behavioral medicine? If you agree, be guided by the words of Dr. Neil Miller, another pioneer of behavioral medicine, who stated at one of the early conferences, "Be bold in what you attempt, cautious in what you claim."

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One-Session Treatment for Snake-Fearful Individuals: An Open Trial Evaluating Short-Term Outcomes

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**Note.* This manuscript was completed in partial fulfillment of the first author's master's thesis. During this time, the first author suffered a long and difficult battle with cancer; a battle that ultimately took her life prior to completion of this manuscript. The remaining authors assisted in the completion of this manuscript for publication consideration, and we also wish to express our appreciation for the support provided by Jill's fellow lab members: Maria Karekla, Megan Kelly, Carlos Finlay, Tiffany Fusé, Dean Acheson, Velma Barrios, Erica Moses, Kristin Herzberg, and Chris Berghoff. This paper is a testament to Jill's courage.

Approximately 25 million people in the United States present with specific phobias (Thorpe & Salkovskis, 1997) and an additional 60.2% of the general population demonstrate intense subclinical levels of anxiety and fear of specific objects (Eaton, Dryman, & Weissman, 1991). Although specific phobias are the most prevalent of all anxiety disorders and tend to run a chronic course if left untreated, they are also the most treatable. Studies consistently show that exposure therapy is the treatment of choice for specific phobias, and treatment typically spans 4 to 12 weeks. However, this may result in a significant burden on the client's time and resources and may be unnecessarily long (Öst, 1989). A large body of other work suggests that specific phobias may be treated effectively in a single 3-hour session, such as is the case in One-Session Treatment (OST), with a positive response rate of 76% or better (for a recent review of treatment outcome studies, see Zlomke & Davis, 2008).

OST is essentially a form of massed exposure developed by Lars-Göran Öst used to treat specific phobias (Öst, 1989). With in-vivo exposure and participant modeling as its foundation, OST also utilizes psychoeducation, verbal and physical reinforcement contingencies, and cognitive restructuring techniques to treat phobias in what is typically a 3-hour, single therapy session (Zlomke & Davis, 2008). In contrast to following a formal linear hierarchy, OST structures in-vivo exposures as a series of behavioral experiments with the goals of promoting habituation and extinction, eliciting and challenging maladaptive cogni-

tions, and preventing behavioral and cognitive avoidance (Zlomke & Davis).

A large body of research supports the efficacy of OST in reducing fear and anxiety symptomatology associated with several subtypes of specific phobia, with many studies demonstrating large effect sizes and clinically significant change (Zlomke & Davis, 2008). Generally, results indicate that OST is successful in decreasing behavioral avoidance during behavioral activation tasks (BATs) as well as symptoms of fear, anxiety, and maladaptive cognitions as measured by a variety of self-report measures.

Specifically, OST has been used successfully to treat arachnophobia, with significant improvements noted across several domains, including behavioral avoidance, physiological reactivity, and both self-reported and observer-rated symptomatology (Hellstrom & Öst, 1996; Öst, 1989; Öst, Salkovskis, & Hellstrom, 1991). Likewise, at least one study has shown that OST may be effective for injection fears, with outcomes successfully maintained 1-year post-treatment (Öst, Hellstrom, & Kaver, 1992). Similar good outcomes of OST have been reported for claustrophobia (Öst, Alm, Brandberg, & Breitholtz, 2001) and fear of flying (Öst, Brandberg, & Alm, 1997). More recently, Haukebo and colleagues (2008) found that both one- and five-session treatments of dental phobia were equally effective at reducing avoidance and changing cognitions, findings which were also maintained at follow-up.

Though such findings are encouraging, it remains unclear whether outcomes of single-session exposure also generalize to other specific phobia targets, such as snake fear. At this juncture, there is good reason to

speculate that exposure is a robust intervention that ought to work across a range of feared objects and situations (Richard & Lauterbach, 2007). Yet, it is nonetheless worthwhile to evaluate that speculation more systematically. The central aim of the present study was to evaluate the short-term effectiveness of a single-session exposure treatment for snake-fearful individuals. Overall, we anticipated that a single session of exposure therapy would be effective in reducing participants' fear of snakes as indexed across behavioral and self-report evaluative domains.

Method

Participants

The sample consisted of 43 snake-fearful female undergraduate volunteers ($M_{age} = 19.16$, $SD = 2.98$) who received up to 4 hours course credit for their participation. The decision to exclude men was guided by research showing that females are overrepresented in the phobic clinical population and are more fearful of snakes relative to males (e.g., Costella, 1982). Thus, because females provide a more accessible and more fearful population, males were excluded from the study. The ethnic distribution of the sample was as follows: 47% Caucasian, 14% African American, 9% Hispanic, 9% Asian American, and 21% either biracial or of a different ethnicity.

Prescreening Assessment

A structured phone interview using a modified brief version of the Anxiety Disorders Interview Schedule-IV (ADIS-IV; Brown, DiNardo, & Barlow, 2001) was used to screen potential study candidates for any past or present medical or psychological problems. Participants were excluded if they reported: (a) angina, asthma, cardiovascular problems, hypertension, epilepsy, or the possibility of being pregnant; (b) meeting ADIS-IV diagnostic criteria for an Axis I psychological disorder other than specific phobia, including regular use of controlled substances (e.g., marijuana, stimulants), current depression, and/or suicidal ideation; or (c) reporting past or present treatment for a psychological problem other than specific phobias, including use of prescribed psychotropic medications for such problems. Participants were also excluded if they reported that their fear of snakes was less than 60 on a scale ranging from 0 = no fear to 100 = extreme fear (Mohlman & Zinbarg, 2000), or if they successfully completed a pretreatment behav-

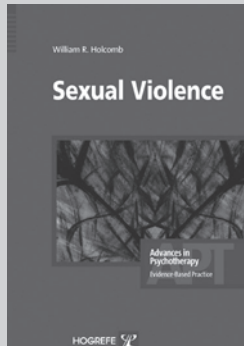
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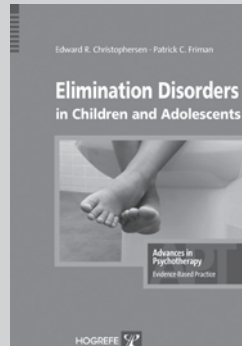
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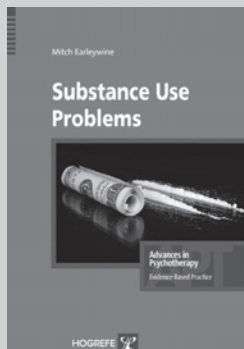
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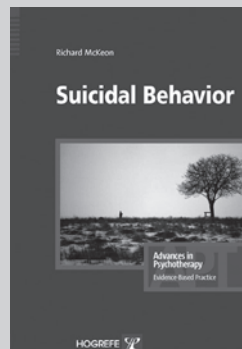
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ioral approach task (BAT) (i.e., were able to pick up a live snake from its container).

These exclusionary criteria were employed in order to reduce any risk of possible medical complications, risks arising from handling a live snake and snake-related stimuli, and also to control for adequately high levels of fearful responding to snake or snake-related stimuli. Of the 209 participants screened, 166 (79%) were denied participation for meeting one or more of the above exclusionary criteria, with the vast majority (84.3%) of exclusions resulting from an inadequate initial fear of snakes. Consistent with rates reported by Agras, Sylvester, and Oliveau (1969), 46 of the 209 participants screened (or 22%) showed more than moderate fear of snakes. And, of these, data from 3 participants were lost due to experimenter error, yielding 43 participants who completed the full intervention.

Pretreatment Self-Report Measures

A battery of well-established and psychometrically sound anxiety-related measures were administered before treatment to assess for individual differences in levels of anxiety and their possible relation to phobic arousal and treatment response: (a) the Anxiety Sensitivity Index (ASI; Peterson & Reiss, 1993) is a 16-item questionnaire designed to assess fear of anxiety-related symptoms. The ASI has a high degree of internal consistency (alpha coefficients from .82 to .91; Peterson & Reiss) and stable test-retest reliability over a 3 period ($r = .71$; Maller & Reiss, 1992); (b) the Anxiety Control Questionnaire (ACQ; Rapee, Craske, Brown, & Barlow, 1996) is a 30-item measure designed to assess perceptions of control over potentially threatening internal and external events and situations associated with anxious responding. Rapee and colleagues (1996) found this measure to have good psychometric properties (alphas from .80 to .89; test-retest, $r = .88$); and (c) the Spielberger State-Trait Anxiety Inventory Form-Y (STAI-S-T; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) is comprised of two 20-item scales, each of which is designed to measure either state or trait anxiety. These measures have been used extensively in both clinical and non-clinical populations and have demonstrated good reliability and validity (alphas = .86 to .95 in adult and college student samples; test-retest reliabilities range from $r = .71$ to .86; Spielberger et al., 1983). The trait version of the scale (i.e., STAI-T) was administered as part of the pretreatment battery

and the STAI-S scale was administered both pre- and posttreatment.

BAT

A BAT was administered pre- and post-treatment (see Öst et al., 1991). The BAT included the following tasks, arranged by increasing difficulty: (1) approaching a container that housed a live snake, (2) opening the lid, (3) reaching a hand into the container, (4) touching the snake, (5) picking up the snake, (6) removing the snake from the container, and (7) holding the snake for 30 seconds. The behavioral and subjective scores obtained from this measure were based on the last step completed, and ranged from 0 = *refused to enter the room* to 12 = *held the snake for more than 30 seconds* (behavioral) and 0 = *not at all distressed* to 100 = *very distressed* (subjective).

Treatment Self-Report Measures

Using 100 mm visual analogue scales, participants made written evaluative ratings prior to the onset of each level of the exposure hierarchy, and evaluative ratings again following completion of each exposure task, and these ratings included the following domains: (a) anxiety level (0 mm = *not at all anxious* to 100 mm = *extremely anxious*); (b) sense of safety (0 mm = *not at all safe* to 100 mm = *extremely safe*); and (c) degree of improvement while completing the exposure tasks (0 mm = *no improvement* to 100 mm = *extreme improvement*). Following treatment, participants were asked to rate the perceived benefit of the treatment (0 mm = *not at all beneficial* to 100 mm = *extremely beneficial*).

Persons suffering from specific phobias experience many of the same symptoms that characterize panic attacks, particularly when confronting a feared object or situation (Craske, 1991; Forsyth & Eifert, 1996). Therefore, prior to treatment, participants completed the Diagnostic Symptoms Questionnaire (DSQ; Rapee, Sanderson, McCauley, & Di Nardo, 1992). The DSQ asked participants to predict which DSM-IV panic sensations they would experience during the treatment and how intense the sensations would be (0 = *not at all felt* to 8

= *very strongly felt*). After treatment, participants completed the DSQ again, but this time the focus was on how they actually felt during treatment, rather than on their predictions.

Procedure

Participants meeting inclusion criteria completed a consent form, followed by the pretreatment questionnaires, including the DSQ. Next, participants completed the pretreatment BAT and were asked to indicate on a scale from 0 to 100 (0 = *no fear* to 100 = *extreme fear*) how fearful they were immediately upon completion of the highest step achieved. Following the BAT, the therapist¹ seated participants in a comfortable recliner chair in a treatment room, provided detailed instructions about the remaining procedures, and initiated the treatment protocol.

The treatment procedure utilized in the present study followed a one-session therapist-directed exposure treatment (Öst, 1989, 1991, 1997), lasting 2.5 to 3.0 hours, which combined therapist modeling and graduated exposure to feared snake-related stimuli. Upon arrival for treatment, participants were informed that the purpose of exposure treatment was to provide them with the opportunity to confront their feared stimulus (i.e., snake) in a safe and controlled way. As suggested by Öst and Ollendick (1999), participants were instructed that teamwork was necessary during treatment and that both the therapist and the client were responsible for achieving a good outcome. Participants were informed that nothing unplanned would occur during treatment and that the therapist would first describe each level of the exposure hierarchy, then demonstrate it, and finally give the participant an opportunity to perform the task. All participants were subsequently informed of the efficacy of the treatment, specifically that 89% of individuals with animal phobias demonstrate significant improvement following completion of treatment and that 93% maintain their gains 1 year after treatment completion (Öst, 1997). Participants were given oppor-

¹ One therapist (first author) conducted exposure sessions for all participants. Prior to the onset of this treatment study, the therapist had one year of supervised clinical experience with cognitive-behavior therapy. In addition, the therapist had corresponded with Dr. L.G. Öst, the originator of the one-session exposure treatment for phobias (Öst, 1989), and the fourth author (the supervisor for this treatment study) while constructing the present treatment design to assure treatment quality. The procedures used in the present treatment study were manualized consistent with procedures outlined by Öst (1989).

tunities to voice questions or concerns before the treatment was initiated.

Initially, participants were shown several pictures of snakes, each illustrating different colored and textured snakes, and were asked to choose the one that produced the most anxiety. The therapist then placed the selected picture 91.4 cm from participants and instructed them to look at the picture for 2 minutes, focusing the entire time on all aspects of the snake. After 2 minutes, the therapist asked participants to describe how much anxiety was elicited during the task (0 = *not at all anxious* to 100 = *extremely anxious*). The therapist then asked participants to look at the picture for another 2 minutes and elicited another anxiety rating. This process was repeated until a 50% pre- to postexposure decrease in anxiety was noted.

The same procedure was carried out for the remaining levels of the exposure hierarchy, which included a closer view of a different snake picture, watching a videotape of active snakes, observing a real caged snake (45.7 cm, nonvenomous, black-and-white-striped California King) from a distance of 213.4 cm, observing a live caged snake situated at a distance of 30.5 cm, handling a realistic looking rubber snake, touching the outside of the live snake's container, reach-

ing one hand into the snake's container and touching the snake, and, finally, holding the snake with the aid of the therapist. Treatment was terminated after the participant successfully removed the snake from the container and held the snake for up to 2 minutes. Immediately following treatment, all participants completed a second BAT, STAIS, DSQ, and an assessment of perceived benefit.

Data Analysis

In order to assess the impact of the intervention on behavioral and evaluative indices of functioning, a series of repeated measure ANOVAs were conducted on pre- and posttreatment scores. Where appropriate, within subject factors included extent of change within each level of the exposure hierarchy and extent of change over time (pre- to posttreatment). Also when appropriate, significant omnibus effects were followed by comparisons using paired-sample *t*-tests. To control for familywise error rate, reported alpha levels were adjusted using the Holm's modified Bonferroni procedure (Keppel, 1991). In accordance with Cohen's suggestion (1988), partial eta squared (η_p^2) was adopted as a measure of effect size

(large effect > .14, medium effect = .06, small effect = .01).

Results

Pretreatment Questionnaires

Pretreatment anxiety-related measures (ASI, ACQ, STAIT) fell within normal limits for a nonclinical population.

BAT

As anticipated, participants completed more tasks ($M = 11.91$, $SD = .37$) and reported less subjective distress ($M = 17.60$, $SD = 18.83$) during the posttreatment BAT relative to the number of tasks completed ($M = 6.93$, $SD = 1.50$) and subjective ratings of distress ($M = 75.00$, $SD = 14.68$) observed during the pretreatment BAT. This was supported by significant main effects of time on number of BAT tasks completed, $F(1, 42) = 470.96$, $p < .001$, $\eta_p^2 = .92$ (large effect size) and subjective ratings of distress during the BATs, $F(1, 42) = 391.61$, $p < .001$, $\eta_p^2 = .90$ (large effect size).

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Treatment Self-Report Measures

As expected, pretreatment anxiety levels ($M = 32.07$, $SD = 23.43$) reduced significantly overall relative to posttreatment anxiety ($M = 14.52$, $SD = 18.87$), as supported by a significant main effect of time, $F(1, 42) = 56.48$, $p < .001$, $\eta_p^2 = .58$ (large effect size). Additionally, a significant two-way interaction of anxiety pre- and postexposure (for each level of the hierarchy) by time was found, $F(8, 336) = 12.74$, $p < .001$, $\eta_p^2 = .24$. As anticipated, this interaction was due to a greater reduction in anxiety at the end of the hierarchy level (average difference pre-post = -23.74 , $SD = 25.57$) relative to the beginning of the hierarchy level (average difference pre-post = -13.62 , $SD = 23.17$); though this contrast emerged only as a nonsignificant trend, $t(42) = -1.97$, $p = .056$.

As hypothesized, participants' sense of safety posttreatment ($M = 81.60$, $SD = 21.68$) significantly increased overall relative to pretreatment ($M = 19.59$, $SD = 18.70$), as supported by a significant main effect of time, $F(1, 42) = 116.63$, $p < .001$, $\eta_p^2 = .74$ (large effect size). Additionally, a significant two-way interaction of sense of safety pre- and postexposure (for each level of the hierarchy) by time was observed, $F(8, 336) = 5.01$, $p < .001$, $\eta_p^2 = .11$ (medium-to-large effect size). As expected, this interaction was due to an increase in participants' sense of safety at the end of the hierarchy level (Average difference pre-post = 55.36 , $SD = 30.02$) relative to the beginning of the hierarchy level (average difference pre-post = 32.95 , $SD = 32.23$), $t(42) = 4.31$, $p < .001$.

Finally, and similar to the findings for anxiety levels and sense of safety, degree of improvement posttreatment ($M = 47.43$, $SD = 22.01$) was significantly greater overall relative to pretreatment predicted degree of improvement ($M = 12.36$, $SD = 14.48$), as supported by a significant main effect of time, $F(1, 42) = 148.16$, $p < .001$, $\eta_p^2 = .78$ (large effect size). Additionally, a significant two-way interaction of degree of improvement pre- and postexposure (for each level of the hierarchy) by time was observed, $F(8, 336) = 6.49$, $p < .001$, $\eta_p^2 = .14$ (large effect size). As anticipated, this interaction was due to an increase in participants' degree of improvement at the end of the hierarchy level (average difference pre-post = -53.50 , $SD = 27.41$) relative to the beginning of the hierarchy level (average difference pre-post = -38.12 , $SD = 24.39$), $t(42) = 2.96$, $p = .005$.

State anxiety decreased from pre- ($M = 41.67$, $SD = 8.89$) to posttreatment ($M = 25.26$; $SD = 6.19$), as supported by a significant main effect for time, $F(1, 42) = 139.08$, $p < .001$, $\eta_p^2 = .78$ (large effect size). In addition, participants also reported fewer *DSM-IV* panic symptoms ($M = 7.81$, $SD = 7.96$) as well as decreased intensity of symptoms ($M = 2.16$, $SD = 2.60$) posttreatment relative to the number ($M = 18.35$, $SD = 9.66$) and intensity ($M = 6.02$, $SD = 7.27$) of symptoms reported pretreatment. This was supported by significant main effects of time on number of *DSM-IV* panic symptoms reported, $F(1, 42) = 61.89$, $p < .001$, $\eta^2 = .60$ (large effect size), and intensity of reported panic symptoms $F(1, 42) = 319.24$, $p = .002$, $\eta^2 = .21$ (large effect size). Finally, participants reported benefitting appreciably from the treatment ($M = 84.98$, $SD = 15.91$).

Discussion

The purpose of the present study was to evaluate the efficacy of a one-session exposure treatment for snake-fearful individuals. Consistent with previous findings (Gostestam, 2002; Öst et al., 1991, 1997, 2001), participants completed more tasks on the posttreatment BAT and reported decreased anxiety while doing so, relative to the pretreatment BAT. Similarly, state anxiety was reduced at the end of the treatment, as were the number and intensity of reported panic symptoms.

In terms of evaluations conducted throughout the exposure hierarchy, anxiety decreased overall from pre- to posttreatment. However, only a trend towards significant reduction was noted for anxiety levels within each level of the hierarchy. An inspection of the means and standard deviations suggests that this nonsignificant finding may be due to the large variance of scores pre- and postexposure as participants repeated exposure tasks within a rung of the hierarchy. Nonetheless, this will be an important area to consider in future investigations.

As expected, both perceived safety and degree of improvement increased from pre- to posttreatment, as well as within each level of the hierarchy. The fact that participants' sense of safety progressively increased is particularly important in the context of outcomes in exposure therapy. Specifically, these outcomes support contemporary accounts of exposure processes, where the emphasis is on exposure as an opportunity for new learning, and specifically new safety learning (Richard & Lauterbach,

2007). This new safety learning may have contributed to the overall successful outcomes noted above; however, evaluating this domain more closely in the context of OST would certainly be worthwhile for future investigations.

Lastly, and perhaps most importantly, participants reported benefitting greatly from the treatment. Collectively, these data support the short-term efficacy of single-session exposure therapy for snake fearful individuals. As other authors (e.g., Öst, 1996) have noted, OST seems to be the treatment of choice for specific phobias, but the intervention could certainly benefit from further refinement and continued investigation.

Other authors have presented various directions for future research, including the need for more rigorously controlled trials, investigation of mediators and moderators of treatment outcome (Zlomke & Davis, 2008), and further elucidation of the mechanism of action in OST (Öst et al., 1991). In addition to these important lines of research, it seems relevant to consider other areas as well. While the treatment success rates seen in trials of OST for specific phobias are among the highest in the field, some individuals fail to improve. Understanding predictors of treatment success will be an important avenue for future research. In addition, while the research suggests that OST is well-tolerated, it would be helpful to explore whether attrition rates could be further reduced. One possible way to accomplish this might be through the introduction of a values-based exposure protocol (i.e., one that is less focused upon symptom reduction and more aimed at helping individuals to perform activities they have disengaged from due to the distress of their phobias).

Before concluding, we wish to point out several limitations of the study that warrant consideration. First, findings from the current project should be interpreted with caution given that the methodology employed was more in keeping with that of an open trial and thus suffers from the limitations and caveats that accompany such preliminary work. In particular, the lack of a comparative condition limits the impact of any potential findings due to the inherent threats against validity. However, the effect sizes of all assessed indices in the current study are comparable (and are much larger in the case of the BATs) to effect sizes of comparative OST outcome trials calculated by Zlomke and Davis (2008) in their recent review. While a direct examination cannot be made given the limits of the current

study, the large effect sizes suggest that the outcomes in the current paper are robust and would likely be replicable within the context of a more rigorously controlled trial.

It should also be noted that sample size was relatively small and limited to snake-fearful women. Our decision to restrict the sample to women was largely pragmatic and guided by epidemiological data showing that women not only tend to be more fearful of snakes relative to men, but also are overrepresented in the clinical population of persons suffering from specific phobias (Bourdon et al., 1988; Costello, 1982). Even then, few individuals met study inclusion criteria for snake fear in the present study (see Agras et al., 1969). This is not surprising given that cues and contexts for specific phobias are often readily avoided, and thus do not typically result in the same degree of functional impairment compared to syndromal and subsyndromal forms of other anxiety disorders (Barlow, 2001). A next obvious step for future research of this type would be to evaluate the efficacy of one-session exposure therapy in a sex-balanced sample of persons meeting diagnostic criteria for specific phobia of snakes, and perhaps to include additional indices of fearful responding (e.g., methods to detect attentional bias and capture).

Lastly, we wish to point out that the present findings are obviously limited to acute treatment response, and it is unclear, given the absence of extended follow-up, whether participants would maintain treatment gains in the long-term. Nonetheless, previous research utilizing one-session exposure therapy has shown favorable long-term outcomes at 6 months and 1 year (Hellstrom, Fellenius, & Öst, 1996; Öst et al., 1992, 1997; van den Hout, Tenney, Huygens, & de Jong, 1997).

In summary, the findings from the current study support the efficacy of OST for snake-fearful individuals. Furthermore, this work adds to a growing body of research supporting the use of time-limited behavioral treatments for phobias and other anxiety disorders.

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Integrating Sexual Interventions and Psychosexual Skill Exercises Into Cognitive-Behavioral Therapy

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Over the past 20 years there has been very impressive growth in both clinical and research programs centered on cognitive-behavioral approaches to couple therapy. This expansion has led to the creation of sophisticated models of understanding and assessment of communication patterns, the development of problem-solving strategies and conflict resolution techniques, and the prediction of successful and unsuccessful marriages (Epstein & Baucom, 2002; Gottman, 1994; Snyder & Whisman, 2003). However, it appears that cognitive-behavioral researchers and clinicians have often ignored, and at times almost avoided, dealing with issues of sexual function and dysfunction. The two major exceptions to this general lack of attention regard issues of sexual trauma (Comptom & Follette, 2002) and the impact of extra-dyadic involvements (Snyder, Gordon, & Baucom, 2007). However, sexual functioning is often a primary difficulty among individuals and couples seeking treatment, and clients would benefit from the greater attention to the topic by CBT researchers and clinicians.

This conceptual/clinical paper focuses on reintroducing sex therapy interventions and psychosexual skill exercises into CBT with individuals and couples. Sex therapy is best conceptualized as a subspecialty within couple therapy (McCarthy & Thestrup, 2008), and sexual problems are therefore best understood, assessed, and treated from a couple perspective (Aubin & Heiman, 2004). In this paper we present the classic PLISSIT model for treating sexual concerns and dysfunction (Annon, 1974), provide a few specific examples of behavioral exercises that may be incorporated into treatment, and outline major categories of male and female sexual dysfunction of which all CBT therapists should be aware.

While a full review of the classic PLISSIT model is beyond the scope of this article, in brief, it proposes a hierarchical approach to treatment, where each level is thought to represent a stage of treatment

with increasing depth. The model conceptualizes a four-dimensional approach to clinical intervention for sexual concerns, outlined as follows:

- P — Permission Giving
- LI — Limited Information
- SS — Specific Sexual Suggestions
- IT — Intensive Sex Therapy

The first phase is focused on validating sexuality as an important topic affecting both couple functioning and individual well-being, and invites the open discussion of sexual topics. The second aims to provide realistic expectations and norms regarding sexual function and dysfunction. The third focuses on behavioral intervention and the teaching of psychosexual skill exercises. Finally, the fourth stage turns the focus to broader couple concerns that may be contributing to sexual dysfunction.

In interpreting this model, cognitive-behavioral clinicians are strongly encouraged to address sexuality by providing accurate sexual information and by helping the client develop positive, realistic sexual expectations of him/herself and of the relationship. Rather than being value-neutral (which is neither possible nor genuine), the clinician is encouraged to assume a prosexuality stance. This includes asserting that sex is a good thing in life and that sexuality is a positive, integral part of being a man or a woman. It should be conveyed that the challenge for any individual, whether 18 or 68, in a relationship or single, straight or gay, is to express sexuality so it can contribute significantly to an individual's well-being and couple satisfaction, without being the dominant focus of the relationship. In couple sex, the prime role of sexuality is to energize the relationship bond and enhance feelings of desire and desirability (McCarthy & McCarthy, 2009).

Providing positive, realistic sexual information that is both scientifically valid and provides relevant clinical guidelines should be a forte of CBT. Our culture has gone

from one extreme of sexual ignorance, inhibition, and denial to the opposite extreme of sensationalism, unrealistic sexual performance demands, and intimidating sexual expectations. Examples of this latter extreme include the performance expectation that intercourse should last at least 30 minutes, that it is imperative that the woman orgasm first, and that "G-spot" and multiple orgasms are superior (Metz & McCarthy, 2010). Further, pro-erection medication advertisements and other media praising its benefits pledge a return to the totally predictable erections of youth and perfect intercourse performance, as well as the assumption that loving, sexually functional couples have a wonderful experience every time (Baglia, 2005).

Since the Sex in America study (Laumann, Gagnon, Michael, & Michaels, 1994), there has been a dearth of high-quality epidemiological sex research in the U.S. (Leiblum, 2007), although there continues to be important evidence-based work on sexual dysfunction, particularly at the Kinsey Institute (Heiman, 2007). However, sociological studies, research from Canada and Europe, and clinical studies do provide a reliable base for helping individuals and couples create positive, realistic sexual expectations. For example, such research has shown:

1. The average length of a sexual encounter is 15 to 45 minutes, with intercourse itself involving 2 to 7 minutes. Few couples have intercourse extending longer than 12 to 15 minutes (Metz & McCarthy, 2003).
2. Female orgasmic response is more variable and complex than male orgasmic response (different, not better or worse), few women are orgasmic at each couple sex encounter, and the new mantra of healthy sex is desire, pleasure, and satisfaction rather than the pass-fail performance criterion of orgasm (Heiman, 2007).
3. The medicalization of male sexuality has been accepted by both professionals and the public even though based on poor scientific evidence. In reality, among successful Viagra, Cialis, and Levitra users, 65% to 85% of the time the medication results in successful intercourse. The dropout rate is extremely high, caused by unrealistic expectations and the failure to integrate the medication into the couple style of intimacy, pleasuring, and eroticism (Metz & McCarthy, 2004).
4. Less than 50% of sexual encounters among loving, sexually satisfied couples re-

sults in the ideal scenario of mutual desire, arousal, and orgasm (Frank, Anderson, & Rubinstein, 1978). Couple sex is inherently variable and flexible in terms of both function and meaning. This includes that 5% to 15% of encounters are dissatisfying or dysfunctional. Helping couples accept the multiple roles and meanings of sexuality promotes a positive, realistic Good Enough Sex model (Metz & McCarthy, 2007b).

5. Approximately 20% of married couples and 33% of nonmarried couples who have been together more than 2 years fall into a nonsexual relationship, defined as being sexual less than 10 times a year (Laumann et al., 1994).

These findings highlight the need to provide realistic sexual guidelines for clients presenting with sexual concerns or dysfunction. A crucial concept to convey in that process is that sex is an interpersonal experience of sharing pleasure rather than an individual sexual performance. The challenge for all couples, regardless of sexual orientation or marital status, is to integrate intimacy and eroticism into their ongoing relationship (Perel, 2006). Unfortunately, the great majority of clinical work has been focused on heterosexual, married couples. There is a great need for CBT researchers and clinicians to expand work with homosexual and cohabiting couples.

Specific Sexual Interventions and Psychosexual Skill Exercises

Sexual interventions and exercises are the core focus of this article and are the PLISSIT model's third dimension. Few cognitive-behavioral clinicians adopt sex therapy as a primary intervention modality (Peterson, Dobbins, Coleman, & Razzock, 2007), but integrating sexual interventions and exercises into traditional CBT treatment programs is a natural fit. Most importantly, it meets the therapeutic needs of individuals and couples.

The most commonly adopted therapeutic intervention is to place a temporary prohibition on intercourse to reduce performance anxiety and to encourage the couple to engage in nondemand pleasuring (Althof, 1998). Although this can be a valuable learning—that not all touch needs to end in intercourse and orgasm—unless integrated into a change strategy to address specific sexual anxieties and inhibitions, it has little therapeutic impact. Specifically, this intervention may not address the most common sexual dysfunction for women and a source of conflict and dissatisfaction for

couples—inhibited sexual desire (hypoactive sexual desire disorder).

The preferred therapeutic strategy is to address desire issues directly. The core of sexual desire is building positive anticipation and developing cognitions of deserving to experience sexual pleasure at this time in your life and in this relationship. Each person is responsible for his/her sexual desire and they function as an intimate team to implement exercises that enhance comfort, attraction, trust, and build individual and couple sexual scenarios. In addition, the couple engages in exercises to “build bridges to sexual desire” and experiment with using partner interaction arousal, self-entrancement arousal, and role enactment arousal (McCarthy & Metz, 2008).

Specific interventions and exercises can address the common male and female sexual dysfunctions. Contrary to popular belief, when couples stop being sexual it is almost always the man's decision, made unilaterally and conveyed nonverbally (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994). The most common cause is the man's reaction to a sex dysfunction; he has lost his comfort and confidence with erections, intercourse, and orgasm (Metz & McCarthy, 2010). The healthy cycle of positive anticipation, pleasure-oriented sex, and a regular rhythm of sexual expression becomes replaced by the dysfunctional cycle of anticipatory anxiety, tense and failed intercourse performance, and frustration, embarrassment, and avoidance (McCarthy & McCarthy, 2003).

Male Sexual Dysfunction

The most common male dysfunction is premature ejaculation (Metz & McCarthy, 2003). The “do it yourself” techniques commonly recommended on the Internet are to reduce arousal by wearing two condoms, masturbating before couple sex, and/or focusing on anti-erotic thoughts such as how much money you owe or your mother-in-law. These techniques can have the iatrogenic effect of causing erectile dysfunction, inhibited desire, or couple alienation. The preferred therapeutic strategy is to approach learning ejaculatory control as a couple task, learn self-entrancement arousal, identify the point of ejaculatory inevitability, practice with masturbation and/or partner manual stimulation, gradually introduce different intercourse positions and movements, and establish realistic sexual expectations (Metz & McCarthy, 2003).

A second common male concern, erectile dysfunction, is the major cause of inhibited desire and sexual avoidance (Metz & McCarthy, 2004). Conceptualization of the etiology and treatment of erectile dysfunction presents a good example of the medicalization of the field of sexual health. Previously, it was believed that the vast majority of erectile dysfunction was caused by psychological or relationship problems, but since 1998 the pendulum has swung to the opposite extreme (Rowland, 2007). The current belief, among both the lay public and medical communities, is that erectile dysfunction is typically medically caused and treatment is generally a stand-alone medical intervention. In fact, estimates suggest that 90% of cases of erectile dysfunction are treated with a pro-erection medication, such as Viagra, Levitra, or Cialis (Althof, 2006). For more difficult cases, treatment might be even more extreme, including penile injection, and for the most severe cases a penile prosthesis. In truth, erectile dysfunction is a good example of a multicausal, multidimensional problem that is best approached from a psychobiosocial model, with assessment, treatment, and relapse prevention following a couple approach (Metz & McCarthy, 2004). A medical intervention (if employed) needs to be integrated into a couple style of intimacy, pleasuring, and eroticism rather than asking the drug to do more than it can do. Psychosexual skill exercises include the “wax and wane” of erection, use of multiple stimulation to high arousal in both non-intercourse and intercourse sex, and the partner guiding intromission (McCarthy & McCarthy, 2009).

Perhaps the most important intervention is to adopt the Good Enough Sex model, which suggests that that 85% of encounters will flow to intercourse and when they do not to transition (without panicking or apologizing) to an erotic, nonintercourse or sensual, cuddly scenario (Metz & McCarthy, 2007b). Accepting a variable, flexible approach to erection and intercourse is a major challenge for the man, a challenge made easier by his partner since this is congruent with female sexual socialization and experiences. The variable, flexible approach is just as relevant whether or not he is using a pro-erection medication (McCarthy & Fucito, 2005).

Ejaculatory inhibition is the least known and most poorly understood male sex dysfunction. It is very rare in its most severe form, total inability to ejaculate intravaginally, but in the intermittent, secondary form it affects as many as 15% of men over

the age of 50 (Hartmann & Waldinger, 2007). The man often mislabels this as an erectile dysfunction because he loses his erection after 2 to 10 minutes of intercourse. In reality, he loses his erection because he is unable to establish an erotic flow to orgasm, becomes frustrated and “runs out of gas” (Perelman, 2004). In assessing, treating, and preventing relapse, it is crucial to assess psychological factors (especially his openness to using all erotic resources), biological factors (especially side effects of medications and poor health habits/fitness), and relational factors (especially whether he views the woman as his intimate, erotic friend). The most common interventions are (a) transition to intercourse at high levels of erotic flow, (b) use multiple stimulation during intercourse, and (c) identify and use “orgasm triggers” during intercourse (Metz & McCarthy, 2007a).

In examining and treating male sex dysfunction, the dimensions that determine the severity and impact on individuals and couples include cognitions (“I am a failure as a man” vs. “My body functions differently now”), emotions (shame vs. acceptance of sexual variability), and behavior (avoidance vs. embracing a variable, flexible couple sexuality). While biological and sexual functioning factors are very important, it is the psychological factors that best explain why some men and couples with sexual function problems experience sexual distress while others with the same problems successfully deal with the issue as an intimate team (McCarthy & Metz, 2008).

Female Sexual Dysfunction

Many of the PLISSIT concepts and interventions described for male sex dysfunction are applicable to female dysfunction, but there are gender-specific concerns that need to be addressed. Perhaps the most helpful concept in understanding female desire problems is that of “responsive sexual desire” (Basson, 2007). Desire problems are the most common female concern and cause most couple distress (Weeks, 2004). This new model recognizes that female desire is not driven primarily by erotic fantasy, a need for orgasm, or rapidity of response, but rather by complex touch, emotional, and relational factors. Rather than the woman feeling second class in a desire competition, she develops and accepts her “sexual voice,” which is more complex and variable than male desire.

The same concept applies to female orgasmic response—it is neither better nor worse than male orgasmic response but is

more variable and flexible. The best estimate is that one in three regularly orgasmic women are never or only seldom orgasmic during intercourse (Heiman, 2007). So the most common male complaint (that the woman cannot orgasm during intercourse) is actually a normal variation, not a sex dysfunction (Sugrue & Whipple, 2001). In addition, the great majority of women (over 80%) have a variable orgasmic response pattern rather than being orgasmic at each couple encounter (Foley, Kope, & Sugrue, 2002). Another important empirical finding is that only 1 in 4 women have the same orgasmic pattern of men—a single orgasm during intercourse not needing additional stimulation. The majority of women who are orgasmic during intercourse utilize multiple stimulation, and approximately 15% have a multi-orgasmic response pattern, usually with manual or oral stimulation (Heiman, 2007).

As outlined by the PLISSIT hierarchy, the first step of any therapeutic intervention must therefore be permission-giving to enhance acceptance of variability and flexibility of female sexuality and providing scientific information and personally relevant guidelines to establish positive, realistic expectations. Following this step, the clinician can focus on specific interventions and exercises. The most helpful desire interventions are to enhance female and couple receptivity with comfort, attraction, and trust exercises. She can develop and initiate her favorite bridges to sexual desire with her preferred way to set the stage for a sexual encounter (mood, time, external cues), initiate (verbal or non-verbal), how and when to transition from sensual to erotic stimulation, preferred arousal/orgasm pattern (before, during, or after intercourse), how and when to transition to intercourse (high vs. moderate levels of arousal, as well as who leads the transition and guides intromission), and establishing satisfying afterplay scenarios (typically, the most ignored part of the sexual encounter).

The most important intervention for arousal and orgasm is to understand if her preference is for mutual vs. taking turns scenarios; multiple vs. single stimulation; manual, oral, intercourse, rubbing, or vibrator stimulation; use of partner interaction, self-entrancement or role enactment arousal; orgasm before, during, or after intercourse. Through exploration of preferences she can find permission to honor her own sexual voice rather than reacting to her partner’s or society’s sexual performance criterion.

The problem of female sexual pain has also been totally revolutionized in the past decade (Binik, Bergeron, & Khalife, 2007). It is now classified as a pain disorder rather than a sex dysfunction. For the most common cases, the interventions/exercises are the woman (especially women over 45) accepting the difference between subjective and objective arousal and using a water-based hypoallergenic lotion prophylactically, guiding intromission at high levels of erotic flow, and using intercourse positions and movements that are comfortable and function. In chronic, severe cases a team approach with a gynecologist, couple therapist, and the most important team member—a female physical therapist with a subspecialty in female pelvis musculature—is optimal (Bergeron, Meana, Binik, & Khalife, 2003).

Couple Sexual Function and Satisfaction

Lindau and colleagues’ groundbreaking study of sex and aging (2007) makes clear that sexual satisfaction is much more than objective sexual function. In integrating sexual interventions and psychosexual skill exercises into cognitive-behavioral individual and couple therapy, it is crucial that the clinician reinforce a variable, flexible approach to sex desire, pleasure, and satisfaction rather than the potentially iatrogenic approach of perfect intercourse and orgasm performance (Foley et al., 2002).

Sexual issues and concerns are very common among both individual and couple clients. At a minimum, the cognitive-behavioral clinician can actively engage in permission-giving, provide scientifically accurate information, help develop personally relevant guidelines, and help the individual and couple establish positive, realistic sexual expectations. Additionally, using relevant sexual interventions and exercises can improve both general and sexual outcomes. With chronic, complex sexual dysfunction, a referral for sex therapy is appropriate. The goal of sexuality interventions is to help individuals and couples value sexuality so that it can contribute to relational vitality and satisfaction.

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Learning Theory Aspects of the Interpersonal Discrimination Exercise in Cognitive Behavioral Analysis System of Psychotherapy

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Pavlov and Skinner are sitting on your shoulders in every psychotherapy/pharmacotherapy session you administer.

—J. P. McCULLOUGH, JR.

The Cognitive Behavioral Analysis System of Psychotherapy (CBASP) manual for treating chronic depression (Keller et al., 2000; McCullough, 2000, 2003, 2006) is strongly disorder oriented and contains techniques for changing the patient's perception as well as his or her behavior. Based on Skinner's (1953) model of operant learning, Piaget's (1971/1963) model of cognitive development, and the Person × Environment model by Bandura (1967), the CBASP is a theory-driven psychotherapy from the third generation of behavior therapy models. Due to the weight that McCullough's multidimensional approach puts on the disturbed person-environment relationship and the resulting deficient ability to act, the patient's core pathology (i.e., the maladjusted way of experiencing the world and the maladjustment with respect to social interaction) becomes the focus of therapy. CBASP's therapeutic strategies can be divided into interventions that have "bottom-up" or "top-down" effects that help the patient to learn in a systematic way to apply proactive, goal-directed, and socially acceptable behavior on his or her social and material environment (Schoepf, 2007). On the one hand, from a bottom-up point of view, a behavioral response to a "person-environment" condition will occur more reflexively if the psycho-physiological activation of limbic and limbic-cortical structures is strong. On the other hand, from a top-down point of view, a modulation of the perceptual and mnemonic processing gradients that is caused by cortical networks has the effect that the interference of those parts of information that do not

match the behavioral response is enhanced, thereby facilitating reflexive behavior once more. As Hofmann and Asmundson (2008) have pointed out, new psychotherapeutic approaches ("third-wave therapies"), such as Acceptance and Commitment Therapy (Hayes, 1999) and the CBASP, have to demonstrate a strong link between their theoretical model and how the therapy is applied in practice. In other words, it is imperative that the specific mechanisms underlying the therapeutic methods of new psychotherapies are clearly elucidated. The aim of this conceptual paper is to describe the impact of learning mechanisms on a specific CBASP method called the Interpersonal Discrimination Exercise (IDE).

Top-Down and Bottom-Up Processing Techniques in CBASP

Perception is the processing of information that is acquired through one of the senses (sight, hearing, smell, taste, touch). This information about the structure of the physical world is used for the adaptive control of behavior. Thus, perception and behavior are closely connected. According to the psychology of perception, there are two different types of processes or ways of stimulus recognition: bottom-up and top-down. In the case of bottom-up processing, a specific property of the stimulus is detected; the specific stimulus properties are then combined into more complex forms until final stimulus recognition takes place. This explains why bottom-up processing is sometimes referred to as "passive" (perception). By contrast, in top-down processing, (perceptual) hypotheses about the stimulus as a whole are formed (expectations and prior knowledge); then specific properties are selected and tested, and, finally, stimulus recognition occurs. Top-down processing is referred to as "active" (behavior).

Anatomical correlates to bottom-up processes include the brain stem and the basal forebrain (affect-driven attention). Top-down processes can be represented in the dorsolateral or the prefrontal regions as well as the anterior cingulate gyrus and the basal cerebral cortex (given sufficient sensorial stimulation or individually developed goals).

The CBASP manual for treating chronic depression comprises bottom-up as well as top-down strategies of treatment. Generally speaking, top-down techniques guide the therapeutic work from the patient's rather general or global descriptions to more concrete individual situations. They are used in order to encourage formal operational thinking and behavior. Bottom-up techniques are designed to lead the patient from the concrete therapeutic situation to interpersonal situations which resemble the therapeutic situation. The goal of these techniques is to help the patient modify adverse interactions or relationship patterns with the help of the therapist's use of Disciplined Personal Involvement (Schoepf, 2007). One important bottom-up technique is the IDE. The IDE is used to address/heal developmental trauma arising from negative experiences with maltreating significant others. The therapist demonstrates to the patient that the therapist's behavior in so-called "hot spots," or individual interpersonally difficult situations in session, stands in contrast to the experienced behavior of significant others in the patient's life. By applying this technique the therapist puts the deeply personal nature of the therapist-patient relationship into the foreground of therapeutic efficacy as both a moderator variable of in-session acquisition learning and an alternative to therapist neutrality.

The Early-Onset Chronically Depressed Patient Behaves Differently

In *Treating Chronic Depression With Disciplined Personal Involvement*, McCullough (2006) compares the social-cognitive-emotional functioning of the early-onset chronically depressed patient with the cognitive-emotional organization of children during their preoperational stage of development (Piaget, 1981). The deficit in cognitive-emotional development is thought to result from a multidirectional combination of the following factors: genetically caused dispositions, personality factors, recurrent experiences of helplessness when interacting with the significant others and early experiences of loss and/or chronic

neglect. According to a biologically predetermined person-environment "vicious circle," the patient has not had a sufficient quantity of reinforcing social events available in the appropriate motivational state to accelerate the development of his cognitive-emotional organization. Instead, stimulus learning of stressful encounters with the significant others has dominated social adaptive action-outcome learning. As a consequence, social misbehavior and a pattern of negative interactions interfere with getting social rewards that are otherwise available. A disturbance of the dynamic person-environment interaction is associated and social interaction is experienced as subjectively dissatisfying and is therefore avoided. Necessary adaptation does not occur and the adversities of life cannot be dealt with in adequate ways. With respect to the person-environment relationship, the implications are as follows. As shown in Figure 1, the patient and his or her perceptions are disconnected from the interpersonal world. The interpersonal efforts of others are unable to penetrate the barrier as depicted in Figure 1. The patient is caught in an "emotional time warp": his or her present condition is characterized by past conditions and predicted future conditions. Interpersonal feedback does not reach the patient and change in the behavior of others is not recognized. Ultimately, emotional change does not occur in the patient. Not only is the patient unable to cognitively separate him- or herself from the situational context, the patient's behavior is also unaffected by the concrete situation (Figure 1).

The patient doesn't react to others but, in a self-referential manner, only to him- or herself. This is illustrated in Figure 1 by the parallel arrows moving in opposite directions between the domains of "cognitive disconnection/non-situational-directed behavior" and "psychological reactivity." Because new interpersonal information is unable to penetrate the system and because the patient is unable to change the situational context, painful memories, traumata, and other emotional scars reverberate in the patient's subjective experience. This results in old physiological reactivity patterns affecting thoughts and behavior and vice versa. During the IDE, the patient can learn to end the "emotional time warp" and connect to the present environment.

The Importance of the Transference Hypothesis for the IDE

In order to perform an IDE, it is necessary to first develop a transference hypothesis. Transference hypotheses are deduced using the "Significant Others History" (SOH) technique in CBASP. McCullough (2000, 2006) assumes four transference areas of interaction that, from the perspective of developmental psychology, play an important role in the patient's relationship with significant others. His theoretical considerations concerning the transference hypothesis refer to the concept of "tacit knowledge" (Polanyi, 1966) and the idea of "reasoning based on implicit causal theories" (Nisbett & Wilson, 1977). In accordance with these assumptions, learning processes and instrumentally learned interpersonal rules developed during toxic developmental conditions may have caused implicit attentional and expectational shifts. These shifts have helped the patient as "emotional surviving strategies" to decrease the contact with interpersonal events that are expected to have negative outcomes. Correspondingly, automatic conditioned patterns of interpersonal behavior are elicited and executed regularly in "hot spot" situations. This rigidly ruled behavior usually does not correspond to the present situation, arouses stress, and provides the patient with a social disadvantage. Specifically, McCullough (2000) describes working with the construct of transference as an exercise in "focused attention." The transference hypothesis differs from Freud's concept of transference in that it can be actively acted out in session with the therapist and then processed within the IDE. The four transference areas in which "hot spots" occur are:

1. Interpersonal intimacy (either felt by the patient or the therapist).
2. Emotional needs of the patient toward the therapist.
3. Mistakes the patient has made (e.g., not doing his or her homework or being unable to solve problems presented during therapy sessions).
4. Negative affects of the patient toward the therapist.

After conducting SOH, a transference hypothesis is worked out during the first few sessions, taking the form of an "if-then" connection. Then, from the transference area most relevant to the patient, a causal theoretical inference (transference hypothe-

sis) is deduced by the therapist and the patient (see examples at McCullough, 2006). An example of this might be: "If I make mistakes during therapy, the therapist is going to dislike, punish, or humiliate me." The transference hypothesis then becomes important in the IDE because it defines the starting point or interpersonal hot spot. Careful and correct identification of transference hypotheses is essential. If an incorrect or irrelevant hypothesis is developed, the IDE will not work effectively.

Administration of the IDE

Three phases are carried out consecutively during the IDE. The IDE starts with the "negative phase," which occurs during initiation of the hot spot or typical area of interpersonal dysfunction. For example, when the patient has forgotten to do his or her homework for the session, the therapist might ask: "What would the significant other have done if you had told her that you've forgotten your homework?" In the "negative phase," the following is likely to happen: The patient starts recalling a typical past interpersonal interaction with one or two of his maltreating significant others

in a similar situation. Then he has to describe the negative consequences caused by the behavior of his significant other.

The second phase of the IDE is called the "positive phase." In this phase the patient is asked to describe his or her perception of the therapist's reactions. After this, the patient characterizes his or her feelings that have been evoked by the current incident with the therapist. The patient is then asked to compare the therapist's behavior to the recalled behavior of his or her significant others in a similar situation. The felt distress of the patient usually decreases at this moment of the exercise.

Sensitive to the timing and the magnitude of the felt decrease of distress in the last phase of the IDE (i.e., "the healing phase"), the patient is encouraged by the therapist to identify the contrast between the therapist's behavior and the significant other's behavior. The result is a felt increase of the potency of the therapist to specifically reduce interpersonal distress during the experienced "hot spot" situation and a new interpersonal reality of the therapist-patient relationship becomes meaningful to the patient.

In the course of the therapy, the patient learns to discriminate between the reactions that he or she was expecting due to negative experiences made in the past ("emotional time warp") and the therapist's actual reactions. In this way, over time, the patient will have new experiences with other people in everyday life and these experiences may be different than prior experiences of the patient. Instead of punishing the patient for a mistake, the therapist has listened carefully and has shown understanding and interest. Questions (e.g., "What made you realize that I was interested in your story?") provide the necessary intervention for the learning theory perspective of IDE to direct the patient's attention to important and relevant aspects of the therapist's behavior (properties of the stimulus; see also "bottom-up process").

It may be possible to describe the unspecific determinant known as the therapist-patient relationship in terms of learning theory and arrive at a transparent analysis. According to McCullough (2006), the positive phase of IDE already contains the mechanism of negative reinforcement. The patient's conditioned feeling of aversion is weakened by the therapist's positive reaction.

What Is Learned During the IDE?

In order to describe the learning theory aspects of IDE, it is important to recall Bouton's (2007) model of a synthetic cognitive-biological perspective on instrumental action. Bouton's model describes the way in which stimuli control behavior. The following abbreviations are used in his model:

- S^D or CS stands for discriminative (S^D signal/cue) stimulus, the conditioned stimulus in the Pavlovian model (CS).
- S^* or UCS is the biologically relevant stimulus (reinforcer), the unconditioned stimulus in Pavlov's model.
- The arrow from $R \rightarrow S^*$; UCS designates a theoretical association (i.e., an organism's knowledge) that a specific behavior leads to a (primary) reinforcer.
- OS cue denotes a context cue, informing the individual that, given the presence of a stimulus cue (S^D , CS), a specific behavior (R) leads to a reinforcer (UCS: S^*).

Combining the two models of Pavlov and Skinner results in a twofold learning process:

1. Through the relation $S^D:CS \rightarrow S^*$, the organism gains information about the

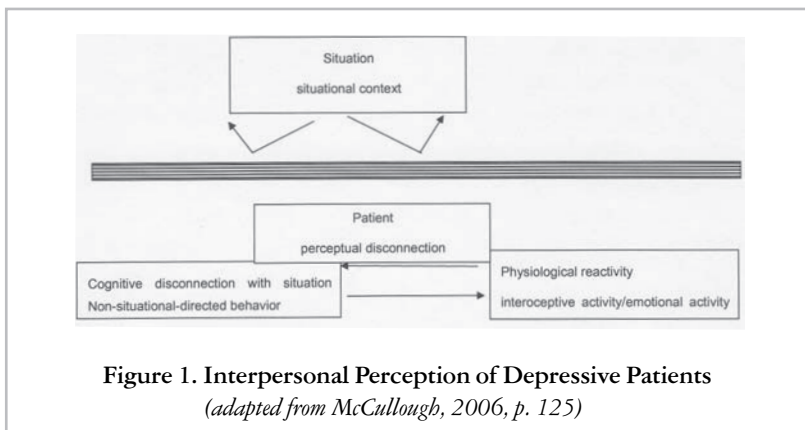


Figure 1. Interpersonal Perception of Depressive Patients
(adapted from McCullough, 2006, p. 125)

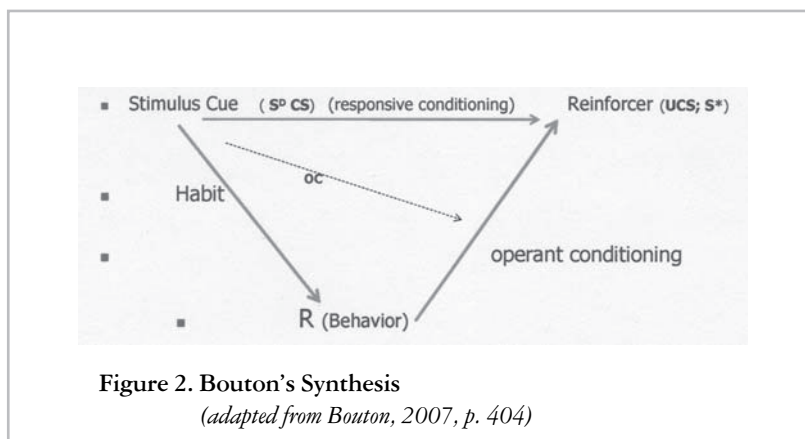


Figure 2. Bouton's Synthesis
(adapted from Bouton, 2007, p. 404)

stimulus properties of the system (Pavlov). For example: "In the presence of the mother there is safety"; or: "In the presence of the mother there is harm."

2. The $R \rightarrow S^*$ relation allows the organism to gain information about the possibilities of attaining reinforcers within the system (Skinner). For example: "Getting close to the mother results in safety"; or, "Staying away from the mother prevents harm" (avoidance).

As Bouton (2007) points out, avoidance behavior is always driven by fear. In the case of the chronically depressed patient, it is interpersonal fear that leads to interpersonal avoidance.

As we have summarized, at the beginning of therapy, the therapist defines the transference hypothesis. The following transference hypothesis will serve as an example:

"If I make a mistake in front of my therapist, she will punish me."

The variables in Bouton's model are:

S^D , CS: Therapist

S^* ; UCS: Fear

R: Interpersonal avoidance behavior in order to reduce fear

In the negative phase of the IDE, bad feelings and thoughts are evoked in the patient through tacit knowledge. The patient remembers (experiences) negative feelings like fear, pain, and sadness in the presence of a positive stimulus. Counterconditioning according to the principle of reciprocal inhibition (Schoepf, 2007) takes place by the benevolent therapist's reaction. The goal of counterconditioning (Cover-Jones, 1924) is the substitution of an existing stimulus-response connection with a new (and better) one. Counterconditioning means that a stimulus-response connection that was established through classical conditioning is unlearned or reconditioned through conditioning with novel stimuli. The underlying mechanism is that of reciprocal inhibition (Hull, 1943; Wolpe, 1958). The feeling of aversion is weakened in the presence of a stimulus-induced positive emotion.

In the positive phase of the IDE, the therapist directs the patient's attention to his or her own behavior and draws a comparison to the behavior of the significant other (i.e., discrimination learning). The focus of the patient's attention is directed outside him- or herself, and is focused instead on the interpersonal situation and the

situational context (see Figure 1). Thus, the patient will be able to perceive interpersonal signals of the other individual in an adequate manner, and the perceptual disconnection barrier has its first cracks. Based on concrete interpersonal in-session situations with the therapist, the patient learns something new about the stimulus properties of the system. The therapist's (S^D) reaction to the patient is different from that of the significant other: Instead of punishing, he or she reacts in a positive (S^*) way. When the patient talks about a mistake (R), the therapist (S^D) is interested and open-minded. The patient makes a mistake and, instead of being punished, is complimented (S^*) for his or her openness by the therapist. This is the discrimination learning in the IDE. Moreover, through this kind of S-S learning, the knowledge about what type of behavior (R) leads to reinforcement (S^* ; UCS) changes. In order to achieve this, the therapist focuses the patient's attention directly on the stimuli (cues) that are associated with the behavior in question (e.g., tone of voice, posture, facial expressions, choice of words, exact wording).

In the healing phase of the IDE, both discriminating the behavioral aspects and contrasting the meaning between S^D ; CS = therapist's behavior and significant others, the patient becomes aware of new interpersonal possibilities. The patient learns that he or she no longer needs to behave in a fearful, hostile, submissive, or aggressive way, since his or her behavior is followed by positive consequences (S^*). The mechanism of learning theory potentially underlying discriminative learning in the positive and healing phases is called sensitization; that is, the strength of the focused social-adaptive behavior results from the repeated demonstration and creation of awareness of the eliciting stimulus (behavior of the therapist). It may help the patient to integrate traumatic relationship experiences arising from negative experiences with maltreating significant others into his self picture and to experience a new interpersonal reality of liberation.

Reducing Interpersonal Avoidance: The Role of Sensitization

Sensitization is defined as enhanced perception and increased responsiveness (response readiness) when repeatedly confronted with a certain sensory stimulus. Sensitization is a mechanism of the central nervous system that plays an important physiological role in everyday life. As a result of the repeated presentation of a specific

stimulus, an increase in response occurs. A typical increase in response is an increase of attention with respect to the stimulus cue. The better known term of *habituation* describes the opposite, meaning a decrease in response to a stimulus that is repeatedly presented. Through sensitization, we learn to pay special attention to important stimuli, rather than ignoring them. Sensitization is largely unspecific to the stimulus, which makes it different from habituation. Both mechanisms are triggered by a specific cognitive stimulus processing and they originate in certain plastic processes in the nervous system. In the literature, sensitization is mostly described as a process that is caused by harmful or noxious stimulus exposure. However, from the neurology of learning, we know that positive stimuli can also lead to sensitization (e.g., addiction memory; sensitization is a process contrary to tolerance development and it describes an increase of the potency of a substance given constant dosage \rightarrow sensitization of the dopaminergic system). Another example comes from animal training: If, for example, calling a dog becomes meaningful to the dog because the dog gets a reward for coming to the owner, the importance of the stimulus to the dog increases. Therefore, the stimulus will be met with increased attention in the future. Habituation and sensitization are forms of nonassociative learning; that is, in order for a response to occur, no association or combination of stimuli is necessary. They are both stored as knowledge in the part of the memory system called implicit (nondeclarative) memory.

Sensitization is defined as an induction procedure (caused by specific stimulus properties) and the resulting measurable responsiveness. If the induction procedure causes an appropriate response, its perpetual repetition leads to a specific learning process that causes hyperresponsivity. Applied to the IDE, the following aspects of sensitization are revealed:

If the patient is expecting the therapist to react in a dismissive or devaluating manner to his or her behavior, and if the therapist's behavior repeatedly fails to meet the patient's expectations, it can be assumed that the patient will exhibit enhanced attention and increased readiness to show the behavior in question again. Reflecting upon the therapist's behavior and contrasting it with the significant other's behavior results in the patient focusing on the therapist's behavior. What happens next is this:

The patient realizes that R (making mistakes) in the presence of S^D (therapist) does not result in punishment (UCS) but, in-

stead, leads to attention and interest (S*; UCS). The specific stimulus properties of the therapist (therapist's behavior, cues; see above) and the patient's increased willingness to show the relevant behavior again indicate the induction process and trigger sensitization. Through stimulus discrimination and the sensitization that follows, the patient is able to learn a new type of interpersonal behavior.

Case Example: Starting the Process of Sensitization in the Positive Phase of the IDE

"K, The Rowdy's Son"

K is a 54-year-old man who has suffered from depression since his childhood (early-onset depression). He grew up in a violent, chaotic family. The mother was depressed, abused alcohol, and died of liver cirrhosis. She never cared for K, or his brother, and the children could not count on her. She was weak, and was often threatened by her husband with violence. His father was also an alcoholic. He worked as a mechanic. He drank during and after work, and was physically and verbally abusive toward his wife and children when he was drunk. K's father was especially hostile to K, perhaps because K was a fearful, shy child. K left school at age 15 and never graduated. K has worked for a large company in maintenance. He has been married twice and, both times, his wives left him because of his drinking and depression. K's typical interpersonal patterns of behavior with his wives include avoiding interpersonal conflict by drinking. His wives reported that they felt that they could not get emotionally close to K. After each divorce he attended psychotherapy, but discontinued treatment as soon as his depression lifted. He appears to be fixed on a dominant hostile interaction/relation style.

The Transference Hypothesis: "If I get close to the therapist, he will hurt/abuse me"

NEGATIVE PHASE

Therapist: What was it like if you tried to get close to your father?

K: I'll give you an example. I was sitting at the table, in front of a slice of bread. I did not want to eat it. My dad stood behind me, and he came up closer and then he forced me to eat the bread.

Th: How did he do that?

K: He just said, "Eat it, eat it boy," and I ate a bit and started to choke. I didn't vomit, but I remember I was choking.

Th: How did you feel then?

K: It was like being in a straightjacket. I became frozen. Yes, fear, I felt fear.

Th: So that was what it was like to be close to your father?

K: I remember, sometimes when I was sitting on a chair he would hold my head and press it between his legs. I couldn't breathe. I would cry and beg him to stop, but he would just laugh. For him it was a funny game.

Th: So that was a game?

K: It was a violent game.

Th: What was it like to get close to your father?

K: I was afraid, afraid.

Th: Do you feel it right now?

K: Yes, I feel it, the fear and it is uncomfortable.

Th: I understand that this is tough, we can take our time. I am here with you to help you through it. OK?

K: OK, I can continue.

Th: What did you do then with your father when he would hold your head down?

K: As soon as he let me, I would run away.

Th: OK, I think I understand.

POSITIVE PHASE

Th: K, you know we just had a difficult situation here between you and me.

K: Yeah, it was hard.

Th: What did I do when you said it was uncomfortable for you?

K: You moved back. You were supportive and patient and you were still friendly.

Th: And how did you feel then?

K: I felt safer.

Th: And what did you do?

K: I moved closer to you. I could stand the uncomfortable feelings, and I could speak.

Th: Did I hurt you?

K: No, you did not.

Th: Did I do something that made it easier for you to get close?

K: Yes, you said that you were with me. You showed respect; the way you behaved was respectful.

Th: What aspects of my behavior did you realize helped you?

K: Your voice. You were not yelling or shouting. You moved back. You looked at me. You were friendly. I didn't expect that. I mean I never realized that there is a friendly aspect of closeness.

Here, the therapist's job is to direct the patient's attention to the new behavior and the consequences that it entails. In the Skinnerian sense of the word, the therapist

acts as a reinforcer for the patient, whereas, within CBASP, the therapist's behavior becomes the discriminative stimulus cue. As described earlier, the barrier shown in Figure 1 starts to crack. The patient is able to draw a connection between his or her own behavior and the situational context while the therapist focuses the patient on the relevant new stimuli, thereby starting the process of sensitization. As the patient's way of experiencing changes in the course of sensitization, old physiological patterns and cognitions are altered and a new behavior that is affected by the situation becomes possible.

In contrast to exposure therapy, where patients learn to omit their avoidance behavior (R) and experience a reduction of unpleasant symptoms resulting in decreased response readiness (habituation) and extinction, the learning process that is started during the positive phase of the IDE is that of sensitization. Therefore, the IDE can be described as a confrontation with new interpersonal behavior, in which avoidance behavior (interpersonal avoidance) is reduced.

Sensitization, IDE, and Memory

Implicit (procedural) memory is the part of memory that stores knowledge acquired through nonassociative learning, such as processes of sensitization and habituation. It is where behavior, skills, and priming processes are stored. As mentioned above, the cerebral regions involved in bottom-up processing are the brain stem and the basal forebrain. The internal reactions provoked by the signals the therapist gives off (the behavior) could be instances of so-called basic emotions (information from the environment is translated into internal codes, depending on the degree of attention) that are connected to new behavior and are stored as interoceptive stimuli. The therapist uses the detected basic emotion in the course of the therapy, making it the focus during the healing phase of IDE and using it as an action directive for the remainder of the exercise.

With regard to content, the basic emotions mentioned above are those that represent relationships with other people (relational content of emotion) and were triggered during the positive phase of IDE. We know that short-term memory and long-term memory share the same fundamental processes. Short-term and long-term sensitization lead to changes in the strength of synaptic connections between sensory and motor neurons (heterosynaptic reinforcement). In both cases, the increase is due to a heightened release of the corre-

sponding transmitter (serotonin cAMP). This is the reason why IDE should be performed several times in the course of the therapy. The aim is to achieve long-term storage and activation of important cues and emotions.

Here, the working definition of neuropsychotherapy given by Walther et al. (2008) could take place. As the authors pointed out, neuropsychotherapy is about the identification of mediators and functional targets, determination of new therapeutic routes to such targets, and the design of psychotherapeutic techniques.

Following this definition, the next step to take is to develop a rational model of the IDE that goes beyond the present theoretical considerations. By conducting therapy studies and using imaging technologies, more can be learned about the fundamental mechanisms (processes of learning and memory) that take place during an IDE. For instance, if the process of sensitization takes place during the IDE heterosynaptic reinforcement, a stronger release of serotonin cAMP should be found during the treatment. Moreover, it is predicted that after a course of IDE sessions, the ability of patients to detect and memorize emotional behavior in an adequate way should be improved. Therefore, empirical data will be needed to find neural signatures of the psychological mechanisms.

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At ABCT

Minutes of the Annual Meeting of Members

43rd Annual Convention, New York City, November 21, 2009

Call to Order

President Bob Leahy welcomed members to the 43rd Annual Meeting of Members and called the meeting to order at 12 noon. Written notice of the meeting had been sent to all members in August.

Minutes

Secretary-Treasurer George Ronan asked for any comments or corrections to the minutes from last year's meeting; hearing none, he asked for a motion to accept.

M/S/U: Minutes of the November 15, 2008, Annual Meeting of Members were unanimously accepted as distributed.

The president thanked the members of the Board and the leadership for their hard work. Special thanks go to Anne Marie Albano, who is rotating off as Immediate Past President; Bob Klepac, Representative-at-Large, 2006-2009; Mitchell L. Schare, Membership Issues Coordinator, 2006-2009; Joaquin Borrego, Committee on Student Members Chair, 2006-2009; Gerald Tarlow, Committee on Clinical Directory & Referral Issues Chair, 2006-2009; Philip C. Kendall, Publications Committee Coordinator, 2006-2009; Richard G. Heimberg, Editor of *Behavior Therapy*, Volumes 37-40; Brian C. Chu, Committee on Media Production Co-Chair, 2006-2009; Ellen C. Flannery-Schroeder,

Committee on Media Production Co-Chair, 2006-2009; Jennifer Block Lerner, Committee on Academic Training Chair, 2006-2009; David A. F. Haaga, Committee on Awards and Recognition Chair, 2008-2009; Lata K. McGinn, 2009 Program Chair; and Carolyn M. Pepper, Workshop Committee Chair, 2006-2009.

The President thanked the Program Committee, noting that, "We all know that to put together a program of this size takes a lot of time and dedication. This year we had 136 members help review program submissions." He thanked Anne Marie Albano, Brad Alford, Drew Anderson, Peggy Andover, David Atkins, Sonja Batten, Abbie Beacham, Carolyn Black Becker, Debora J. Bell, Kathryn Bell, Jennifer Block-Lerner, Michele Boivin, Carolyn E. Brodbeck, Elissa J. Brown, Steven Bruce, Annmarie Cano, Cheryl Carmin, Corinne Cather, Brian Chu, Mari Clements, Meredith Coles, Frank Collins, Dennis R. Combs, Jonathan Comer, James V. Cordova, Lisa Coyne, Ronda L. Dearing, Crystal Dehle, Tamara Del Vecchio, Patricia

DiBartolo, David DiLillo, Keith Dobson, Peter Donovan, Brian Doss, Greg Dubord, Jill T. Ehrenreich, Susan Evans, Martin Franklin, David M. Fresco, Dar Friedman-Wheeler, Patti Fritz, Richard Gallagher, Scott T. Gaynor, Brandon Gibb, Kathryn Grant, Kim Gratz, Amie Grills-Taquechel, Lindsay Ham, Ben Hankin, Melanie Harned, Shelby Harris, Tae Hart, Trevor Hart, James Herbert, Stefan Hofmann, Flora Hoodin, Jennifer Hudson, Emily Johnson, Jennifer Johnson, Shalonda Kelly, Robert Kern, Muniya Khanna, Brett Kuhn, Jennifer Langhinrichsen-Rohling, Robert H. LaRue, Erika Lawrence, Nicole Leblanc, Penny Leising, Luana Marques, Lynn McFarr, Lata McGinn, Dean McKay, Daniel McNeil, John R. McQuaid, Elizabeth A. Meadows, Deborah Melamed, Douglas Mennin, Alicia Meuret, Catherine Michas, Alec Miller, Todd M. Moore, Katherine Muller, Douglas Nangle, Lisa Napolitano, Tara M. Neavins, Karl Nelson, Michelle Newman, Conall O'Cleirigh, Phyllis Ohr, Bunmi O. Olatunji, K. Daniel O'Leary, Holly Orcutt, Camilo Ortiz, John Pachankis, David Pantalone, Sandra Pimentel, Donna Posluszny, Jennifer Potter, Sheila A. M. Rauch, Jennifer P. Read, Simon Rego, Mark Reinecke, Sarah Reynolds, John Riskind, Shireen Rizvi, Patricia Robinson, Ronald Rogge, Kelly J. Rohan, George Ronan, Zach Rosenthal, Kristalyn Salters-Pedneault, Bill Sanderson, Steven L. Sayers, Mitchell Schare, N. Brad Schmidt, Kathleen J. Sexton-Radek, Tamara Sher, Sandra Sigmon, George Slavich, Jasper A. J. Smits, Jennifer Snyder, Diane Spangler, Jennifer Steinberg, Gregory Stuart, Sharon Sung, Steven Taylor, Dennis Tirsch, Kimberli Treadwell, Matthew Tull, Cynthia L. Turk, Risa Weisberg, Robert Weiss, Amy E. Wenzel, Kamila White, Claudia Zayfert, and Michael J. Zvolensky. Dr. Leahy also thanked the Local Arrangements Committee for a terrific job and for making attendees feel very welcome in the Big Apple (and he hoped that everyone had received their I LOVE ABCT tattoos!). Thanks were expressed to Jan Mohlman, 2009 Local Arrangements Committee Chair, and members Rebecca Price, Alison Staples, and Dorian Hunter-Reel.

Coordinators' Reports

Membership Issues

Coordinator Mitchell Schare reported that membership is good: the organization had been experiencing a growth spurt, but the bad economy has slowed things. We currently have 4,835 members, with about

2,500 of those being full members and 2,000 student members. Our newly launched Ambassador program is under way and listed on the web. Dr. Schare stated that this will be an effective way to communicate with members and prospective members. In addition, he noted that ABCT is embracing social networking: the Facebook page is up, and Dan Hoffman, who maintains and moderates the pages, has policies and procedures in place. The Membership Committee is actively recruiting Canadian members; and we have a new membership category, the *postbaccalaureate membership*—in its inaugural year, we already have 87 postbaccalaureate members.

The Find-a-Therapist section of the website remains the most frequented, except at convention time, and the list serve is working very well. Dr. Schare stated that in our goal for members to help nurture and teach via the website, the list serve is assisting here admirably. We recently added several video web casts to our site showing how members can become involved and how to become leaders. And we offered a session on repaying loans via an NIH program, which was attended by 125 students.

Mitchell Schare added that we try to be welcoming and inclusive. To that end, we had nine international students paired with U.S. and Canadian students who are showing them the ropes and making them feel at home at the ABCT convention. Finally, ABCT currently has 37 SIGs plus 4 more in formation (Clinical Research Methods and Statistics, Technology and Behavior Change, Military Psychology, and Self Injury and Suicide).

Academic and Professional Issues

Coordinator Joann Wright reported that the Mentorship Directory, a project of the Academic Training Committee, is up on the web and being populated. She explained that rather than a listing of graduate programs, we wanted to link people with potential mentors. This, essentially, accomplishes both tasks, but focuses on the mentors. She noted that the Syllabi section on the website continues to grow. We've added a section on the web explaining how ABCT can help our members who are running for office in allied and related organizations.

She noted that Research and Facilitation Committee has a new chair, Michael Towhig; she hoped everyone enjoyed the Awards program, which everyone reports was fabulous; she's especially gratified to see the ABCT Self-Help Book of Merit pro-

gram begin and thinks the first dozen inductees are all great resources for our lay audiences to consult. She reminds us that the WCBCT2010 is coming to Boston, June 2-5; and WCBCT2013 is in Lima, Peru.

Convention and Education Issues

Reporting for Coordinator Art Freeman, Mary Ellen Brown, the Director of Education and Meeting Services, noted that Lata McGinn did an amazing job putting this event together. She emphasized that there are a lot of people here and that those people are buying lots of tickets to our events.

The Director of Education and Meeting Services reported that several of our sessions sold out and other people just couldn't get into the rooms because they were filled to capacity. She said we just can't make the rooms bigger; and we use the rooms, all the rooms, we have, and we plot the best fits based on past history.

She also noted that this was, by far, the most well-attended meeting in our history, with 4,135 attendees [ED NOTE: final numbers were 4,285 professional attendees; 4,407 attendees when including all who registered].

Sandy Pimentel, the Chair of the Continuing Education Committee, reported that Social Work Day has been a great success, and she thanked Joe Himle and Dan Beck for their efforts to make it so. She said this provided great contacts and we may try to replicate this in San Francisco. She noted that the committee is considering doing road-shows again. She encouraged members to post and utilize the on-line CE calendar.

Publications

The Coordinator, Philip Kendall, noted that his term ends and Dave Haaga will be taking over. He reported on the progress made on the priorities set by the Publications Committee:

Editor Maureen Whittal has done a magnificent job moving forward on the streaming videos showcasing therapist techniques in *Cognitive and Behavioral Practice*. We've already seen the embedded page formats (with static images, the way a reader of the print journal would see it) and sample streams are now available. Elizabeth Gosch completed the Medline application early in the year. She also developed policies, including a broad conflict of interest policy, now in place for both journals. We're a better association for this comprehensive approach.

Drew Anderson continues his fine job as editor of *the Behavior Therapist*. Next year, he will turn the reins over to Kate Gunthert.

We continue to expand our video offerings, adding to the list of audio-only and video web casts on our website. Mitch Prinstein and John Guerry, his RA, have created joint pages with Division 53 to help expand our offerings, especially related to child anxiety issues. This has been a real coup in that ABCT and SCCAP and the constituencies they serve all benefit. He pleaded that you must spend some time on the website. There's so much there, and we welcome your feedback on what's working and what we could do to improve it.

Bryce McLeod is heading up a task force exploring the future of our journals as our contract with Elsevier nears its conclusion.

Dr. Kendall concluded with a special tribute to Rick Heimberg, whose term as editor of *Behavior Therapy* ends and who leaves it in its best position in decades, with an impact factor of 2.74, and ranked 14th of 88 journals.

Executive Director's Report

The Executive Director, Mary Jane Eimer, called this a very satisfying year, reveling in the excellent member leadership the Association's enjoyed. We did very well to keep membership high in a recession year. In the same year, we converted to a new database, enabling us to do better targeted marketing and process registrations and renewals; acquire a completely new phone system; revamp our website from top to bottom; and implement electronic voting. She asked the membership to "get involved," calling it her "call to action." She said she knows of no better place to get involved, we are a nurturing environment, as you might expect from a behavioral group.

She thanked the members of her staff, including Stephanie Schwartz, the managing editor for the three periodicals and graphic designer for most of the print material you see; Lisa Yarde, who can whip any database into shape; Tonya Childers, who handles registrations and exhibits; Keith Alger, often the first voice you hear when you call the Association and often the only as he solves many of the day-to-day issues members might have; Damaris Williams, our bookkeeper, who keeps our accounts update and transparent; David Teisler, who got our podcasts up and is working even now on major contractual issues; and Mary Ellen Brown, once again, coordinating a first-rate annual convention for the ABCT.

Secretary-Treasurer's Report

George Ronan, the Treasurer, noted that the Finance Committee has several important functions, including overseeing the fiscal health of ABCT; monitoring income, expenses, and projections; ensuring funds are available for achieving specified goals; making recommendations regarding personnel; ensuring funds are invested prudently; and evaluating financial considerations related to ownership of permanent headquarters. The Finance Committee is comprised of two members selected by the Chair, Judy Favell and Mike Petronko, plus the President-Elect, currently Frank Andrasik and soon to be Deb Hope.

The Finance Committee works with staff, especially our bookkeeper, Damaris Williams, and the "big three," Mary Jane Eimer, Mary Ellen Brown, and David Teisler, to manage \$1.5M spread over more than 400 budget lines and growing. For 2009, the year ending, we're projecting total income of \$1,765,387 against expenses of \$1,777,049 for a loss for the year of \$6,865. The budget of one and three quarter million dollars is divided among three major areas: Convention has revenues of \$638,001; Membership has \$529,902; and Publications adds \$475,430, with the remainder from other areas. We are also managing restricted reserve funds of \$644,000. This year we hired a financial consultant to help us with these reserves.

Looking at the future, this year we are kicking off our Five-Year Campaign to raise \$2 million to fund our reserves, labeling the campaign "Fund the Future." And we welcome Denise Davis, Treasurer-Elect, who will coordinate gifting.

The Treasurer ended indicating that the Association enjoys sound overall financial health: we are fiscally sound; we pass yearly independent audits; we follow accepted accounting principles (GAAP); we are compliant with all state and federal regulations; our budget is transparent; we track staff time and task allocation; and, he and the committee remain cautiously optimistic during this recession.

President Leahy announced the following members would be serving the Association: Kristene Doyle, 2009-2012 Membership Issues Coordinator; Todd Smitherman, 2009-2012 Committee on Student Membership Chair; Catharine P. MacLaren, 2009-2012 Clinical Directory & Referral Issues Chair; Ray DiGiuseppe, 2009-2012, Leadership & Elections Committee Chair;

Daniel Hoffman, 2009-2012 Social Networking Committee Chair; John Otis, 2010 San Francisco Program Chair; David DiLillo, 2011 Toronto Program Chair; Kristalyn Salters-Pedneault, 2009-2012 Academic Training Committee Chair; Michael Twohig, 2009-2012 Research Facilitation Committee Chair; Shelly Robbins, 2009-2011 Awards & Recognition Committee Chair; David A. F. Haaga, 2009-2012 Publications Committee Coordinator; Tom Ollendick, Editor, Behavior Therapy; and N. Brad Schmidt, 2009-2012 Media Production Committee Chair.

President Leahy announced the transition of officers: Deb Hope will serve as President-Elect, Dean McKay will serve as Representative-at-Large and liaison to Convention & Education Issues, Denise Davis will serve as Secretary-Treasurer and will take office next November, and Frank Andrasik will serve as President.

The President noted that our goals have been dissemination via *tBT*, reaching out to the media, adding benefits for our members, using the web to provide content, developing a Facebook page, looking into the possibility of, although ultimately rejecting, credentialing, and adding local communities. We've succeeded or are making great progress on all lines. He stated, "I am happy to turn the gavel over to our President, Frank Andrasik, knowing things are in such great shape."

The incoming President, Frank Andrasik, thanked now-Immediate-Past-President Leahy, saying he was honored to accept the gavel and the responsibility. He said he hopes you all think at the end of next year that you had a good year. He noted he was looking forward to the convention that John Otis would be heading in San Francisco.

Adjournment: There being no further business, the meeting was adjourned at 1:05 P.M. Eastern Standard Time. ●

World Congress of Behavioral and Cognitive Therapies

June 2–5, 2010 • Boston University

www.wcbct2010.org

The World Congress includes a diverse and exciting group of In-Congress Workshops and Master Clinician Seminars that are listed below and described in detail at www.wcbct10.org.

For full information about other events, including Pre-Congress Workshops, Invited Addresses, and general sessions please visit the website. Come join us for 4 days of exciting presentations on cognitive and behavioral therapies!

WCBCT IN-CONGRESS WORKSHOPS

Thursday

6 hours | 9:00 a.m.

Unified Protocol for the Treatment of Emotional Disorders • David Barlow, Kristen Ellard, Christopher Fairholme, Todd Farchione, Johanna Thompson-Hollands, Zofia Wilamowska, *Boston University*

3 hours | 9:00 a.m.

The Nature and Treatment of Depression in Adolescents
Cecilia Essau, *Roehampton University*

3 hours | 9:00 a.m.

Beyond the Manual: Managing the Factors That Interfere With The Effective Delivery and Acceptance of Empirically Supported Cognitive-Behavioral Therapies
Cory Newman, *University of Pennsylvania and Center for Cognitive Therapy, Philadelphia*

3 hours | 9:00 a.m.

Trichotillomania and Pathological Skin Picking: The Essentials of Assessment and Treatment • Martin Franklin, *University of Pennsylvania School of Medicine*, Nancy Keuthen, *Massachusetts General Hospital, Harvard Medical School*, and Douglas Woods, *University of Wisconsin-Milwaukee*

3 hours | 9:00 a.m.

From Report to Court: Psychology, Trauma and the Law • Sarah Heke, *Institute of Psychotrauma, East London Foundation NHS Trust, London*, and Georgina Smith, *Imperial College NHS Trust, London*

3 hours | 2:00 p.m.

Outpatient Cognitive Behavioural Therapy for Adults With Anorexia Nervosa: A Refresher Course • Glenn Waller, *King's College London and CNWL NHS Foundation Trust, London*

3 hours | 2:00 p.m.

CBT for Late Life Depression
Ken Laidlaw, *Edinburgh University*

3 hours | 2:00 p.m.

Cognitive Behavioral Therapy for Adult ADHD: An Integrative Psychosocial and Medical Approach • Russell Ramsay and Anthony Rostain, *University of Pennsylvania*

3 hours | 2:00 p.m.

An Acceptance-Based Behavioral Therapy for Generalized Anxiety Disorder and Comorbid Disorders
Sue Orsillo, *Suffolk University*, and Elizabeth Roemer, *University of Massachusetts, Boston*

3 hours | 2:00 p.m.

Cognitive-Behavioral Treatment of PTSD in Persons With Serious Mental Illness
Jennifer Gottlieb, *Dartmouth Medical School, Dartmouth Psychiatric Research Center, and Massachusetts General Hospital, Boston*, Kim Mueser, *Dartmouth Medical School and Dartmouth Psychiatric Research Center*

Friday

6 hours | 9:00 a.m.

Working With the Couple With Cluster B Spectrum Personality Disorders: Comorbidity, Crisis, and Collusion
Frank Dattilio, *Harvard Medical School*, and Arthur Freeman, *Governors State University*

6 hours | 9:00 a.m.

Implementing CBT for PTSD in Clinical Practice Using the Case Formulation Approach • Jason DeViva, *VA Connecticut Health Care System, Newington, CT*, and Claudia Zayfert, *Dartmouth Medical School*

6 hours | 9:00 a.m.

Working With Shame and Self-Criticism: A Compassion-Focused Approach
Paul Gilbert, *Mental Health Research Unit, NHS, Derby*

3 hours | 9:00 a.m.

Cognitive Behavioral Treatment of Childhood Obesity: Basis Concepts and Strategies • Caroline Braet and Ellen Moens, *Ghent University*

3 hours | 9:00 a.m.

Ending Cognitive Behavioral Treatment: When Clinical Realities Collide With Empirical Data
Deborah Dobson, *Alberta Health Services, Calgary Zone*, and Keith Dobson, *University of Calgary*

3 hours | 9:00 a.m.

Cognitive Therapy for Addiction: Motivation and Change • Frank Ryan, *University of London and CNWL NHS Foundation Trust, London*

3 hours | 9:00 a.m.

Cognitive Therapy for Challenging Problems: What to Do When the Basics Don't Work • Judith S. Beck, *Beck Institute for Cognitive Therapy and Research and University of Pennsylvania*

3 hours | 2:00 p.m.

Cognitive-Behaviour Therapy for Contamination-Related OCD: ERP and Beyond • Stanley Rachman, *University of British Columbia*, Adam Radomsky, *Concordia University*, and Roz Shafran, *University of Reading*

3 hours | 2:00 p.m.

Disrupting the Rhythm of Depression: Prevention of Relapse in Depression Using a Brief Cognitive Group Therapy • Claudi Bockting, *University Groningen*

3 hours | 2:00 p.m.

The ABCs of Case Formulation in Complicated Grief • Ruth Malkinson, *Israeli Center for REBT, Rehovot*

3 hours | 2:00 p.m.

Cognitive-Emotional Therapy With Cancer Patients • Yossi Adir, *Sheba Medical Center, Tel-Aviv*

Saturday

6 hours | 9:00 a.m.

Staying Well After Psychosis: A Cognitive Interpersonal Approach to Relapse Prevention and Emotional Recovery
Andrew Gumley, *University of Glasgow*, and Matthias Schwannauer, *University of Edinburgh*

6 hours | 9:00 a.m.

Pseudo-Neurological Disorders: Theoretical and Clinical Guide to Diagnosis and Management
David Glosser, Tsao-Wei Liang, and Christopher Skidmore, *Jefferson Hospital for Neuroscience and Jefferson Medical College, Philadelphia*

{WCBCT 2010 Workshops, Saturday, Continued}

3 hours | 9:00 a.m.
CBT for Body Dysmorphic Disorder
Fugen Neziroglu, *Bio-Behavioral Institute, Great Neck, NY, and Hofstra University*, and David Veale, *Kings College London*

3 hours | 9:00 a.m.
Cognitive Behavior Therapy for Adolescent Depression: The TADS Modular Approach
John Curry, *Duke University*

3 hours | 9:00 a.m.
Cognitive-Behavioural Systems Approach to Relationship and Sexual Problems
Mehmet Sungur, *Marmara University and Turkish Association of CBT*

3 hours | 9:00 a.m.
Case Formulation and Collaborative Empiricism: Enhancing the Use of Homework Assignments in CBT
Nikolaos Kazantzis, *La Trobe University*

3 hours | 2:00 p.m.
Implementing a Cognitive-Behavioural Group Program (Fun FRIENDS) With Young Children
Paula Barrett, *Pathways Health and Research Centre and University of Queensland*, and Kristine Pahl, *Pathways Health and Research Centre*

3 hours | 2:00 p.m.
Integrating Family Therapies Into Third Wave CBT Interventions for Addictive Eating Disorders • Phyllis Gildston, *Brooklyn College and North Shore Center, Great Neck, NY*

3 hours | 2:00 p.m.
Behavioral Couples Therapy for Alcoholism and Drug Abuse
William Fals-Stewart, *University of Rochester*, and Timothy O'Farrell, *VA Boston and Harvard Medical School*

WCBCT MASTER CLINICIAN SEMINARS

Thursday

2 hours | 9:00 a.m.
Developing and Using a Case Formulation to Guide Treatment • Jacqueline B. Persons, *San Francisco Bay Area Center for Cognitive Therapy, Oakland, and University of California, Berkeley*

2 hours | 9:00 a.m.
Four New Ways to Make Behavioral Couple Therapy Work Better • Kim Halford, *University of Queensland, St. Lucia*

2 hours | 9:00 a.m.
Rapid and Effective Treatment of Specific Phobias • Lars-Göran Öst, *Stockholm University*

2 hours | 9:00 a.m.
New Ways of Working With Delusions
Philippa Garety, *King's College London and South London & Maudsley NHS Foundation Trust, London*

2 hours | 2:00 p.m.
Cognitive-Behavioral Interventions for Disadvantaged Participants With Chronic Medical Conditions • Juan J. Sanchez-Sosa, *National University of Mexico, Mexico City*

2 hours | 2:00 p.m.
Working With Negative Cognitions in Depression: Evidence-Based and Utility-Based Strategies for Cognitive Change
Keith Dobson, *University of Calgary*

2 hours | 2:00 p.m.
Miracle Cures Do Happen: Two Examples From a Cognitive Therapy Session and an Interpersonal/Emotional Processing Session
Thomas Borkovec, *Penn State University*

Friday

2 hours | 9:00 a.m.
Group Schema Therapy for Borderline Personality: Catalyzing Change
Arnoud Arntz, *Maastricht University and Maastricht Community Mental Health Center*
J. Farrell, *Indiana University School of Medicine and Larue D. Carter Memorial Hospital, Indianapolis*

2 hours | 9:00 a.m.
Acceptance and Change in Couple Therapy
Andrew Christensen, *UCLA*

2 hours | 9:00 a.m.
Metacognitive Therapy for Adult Anxiety: Case Formulation and Meta-Level Change Techniques • Adrian Wells, *University of Manchester*

2 hours | 9:00 a.m.
Group Treatment of Anxiety Disorders in Children and Adolescents: The Cool Kids Program • Ronald Rapee, *Macquarie University*

2 hours | 2:00 p.m.
Treatment of Multiple Health Risk Behaviors: Poor Quality Diet, Inactivity, Smoking • Bonnie Spring, *Northwestern University*

2 hours | 2:00 p.m.
Illness/Wellness Management and Recovery: Current Status and Future Directions • Kim Mueser, *Dartmouth Medical School*

2 hours | 2:00 p.m.
The Clinical Side of CBT for Anxious Youth: "Tips From the Trenches"
Philip Kendall, *Temple University*

Saturday

2 hours | 9:00 a.m.
A Cognitive Behavioral Approach to Weight Loss and Maintenance
Judith Beck, *Beck Institute for Cognitive Therapy and Research and University of Pennsylvania*

2 hours | 9:00 a.m.
Attention Modification Program: An Effective and Efficient Treatment for Anxiety • Nadir Amir, *San Diego State University*

2 hours | 9:00 a.m.
The Anatomy of a Stuck Point: Challenging Specific PTSD Beliefs Within Cognitive Processing Therapy • Patricia Resick, *Boston University*

2 hours | 9:00 a.m.
Developing the Therapeutic Alliance in Adolescents With Dysfunctional Anger
Raymond DiGiuseppe, *St. John's University*

2 hours | 2:00 p.m.
Bipolar Disorder: A Family Intervention Approach • David Miklowitz, *UCLA*

2 hours | 2:00 p.m.
Cognitive Therapy for the Beginning of the End of Life: Interventions for Chronic, Progressive Illness • Jason Satterfield, *University of California, San Francisco*

2 hours | 2:00 p.m.
Beyond the Manual: How to Do Child and Family Therapy Really Well!
Mark Dadds, *University of New South Wales*

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