ABCT
ASSOCIATION FOR BEHAVIORAL AND COGNITIVE THERAPIES

ISSN 0278-8403
VOLUME 33, NO. 4 • APRIL 2010

the Behavior Therapist

Contents

President's Message

Behavioral Medicine: Looking Forward

Frank Andrasik, *University of West Florida*

We know from large-scale epidemiological investigations (such as the Epidemiologic Catchment Area, the National Comorbidity Survey and its Replication, and the World Health Organization World Mental Health Survey, to name just a few) that mood disorders, anxiety disorders, and substance-related disorders are highly prevalent and clearly warrant the ongoing attention of cognitive and behavioral clinicians and researchers. Such has been and rightly will continue to be a major focus of our members and the offerings at our annual conferences. In my last column (Andrasik, 2010), I endeavored to shine a light on some areas that I believe may warrant a renewed focus by members of ABCT. I singled out the general field of behavioral medicine, tracing its roots within our society and at large. This column takes yet another look at behavioral medicine, discussing more specific aspects I believe are worthy of further consideration and additional pursuit by our clinicians and researchers.

I begin by examining the 10 leading causes of death in the United States, Canada, and worldwide, drawing upon the most current available data. This information is summarized in Table 1, wherein all ages and both genders have been combined. In this Table, I have calculated the percentage each category represents of the total to facilitate cross-comparisons.

Several things most stand out: (a) in North America (U.S. and Canada) coronary heart disease and cancer account for the vast majority of deaths—indeed, these two conditions alone account for about one-half of all deaths; (b) world-

the Behavior Therapist

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

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

Change of address: 6 to 8 weeks are required for address changes. Send both old and new addresses to the ABCT office.

ERRATA

For Volume 33, Issue 3

p. 45 (Table of Contents): The second author is missing from the Clinical Forum article entitled "Learning Theory Aspects of the Interpersonal Discrimination Exercise in Cognitive Behavioral Analysis System of Psychotherapy." The correct authors are Peter Neudeck, Dieter Schoepf, and J. Kim Penberthy.

p. 63: Walther et al. (2008). The correct publication year is 2009. The full reference is: Walther, H., Berger, M., & Schnell, K. (2009). Neuropsychotherapy: Conceptual, empirical and neuroethical issues. European *Archives of Psychiatry and Clinical Neuroscience, 259*(Suppl. 2), 173-182.

INSTRUCTIONS *for* AUTHORS

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

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

Submissions must be accompanied by a Copyright Transfer Form (a form is printed on p. 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:

Drew A. Anderson, Ph.D.
SUNY–Albany
Dept. of Psychology/SS369
1400 Washington Ave.
Albany, NY 12222

{continued from p. 69}

wide, coronary heart disease remains the number one cause of death, and the Global Burden of Disease 2004 study (available from the World Health Organization) predicts this will remain so for the next 20 years, or through 2030; (c) every condition listed is linked to at least one health risk behavior, with the single behavior of smoking being associated with approximately one-half of the 10 leading causes of death.

The Global Burden of Disease 2004 report projects that smoking will account for about 10% of all deaths worldwide in 2030, increasing from a total number of deaths of 5.4 million in 2004 to about 8.3 million in 2030. This same report predicts the top 5 causes of death worldwide in 2030 will remain basically the same as they are now—coronary heart disease, cerebrovascular disease (stroke), chronic obstructive pulmonary disease, lower respiratory infections (mainly pneumonia), and road traffic accidents. The burdens and costs to society (and the individual) will increase as people live longer with chronic medical conditions. For example, spending on healthcare in the U.S. for 2009 is expected to consume 17.6% of the gross domestic product. Healthcare expenditures have grown at a faster rate than the economy overall since the 1960's, such that the U.S. devotes more of its dollars to healthcare than other developed countries.

Thus, the door is wide open for members in our society to bring their considerable expertise to address these significant health problems. We have the knowledge base to address the health risk behaviors that contribute to these leading causes of death (e.g., stopping smoking; improving diet by reducing intake of sodium and fat while increasing intake of fiber, vitamins, and following dietary guidelines; increasing physical activity; promoting safe behaviors when driving by wearing seatbelts, appointing a designated driver when imbibing; moderating substance use; reducing stress; regulating exposure to sun; adhering to recommended treatments; to name just a few).

The healthcare community in general seems to have a fascination for developing cures and managing the health conditions listed above, and such is true for behavioral medicine. This intense focus on tertiary (and secondary) prevention has come at the expense of primary prevention. Stephen Weiss (1985) long ago illustrated this point in the following fictional account:

> This reminds me of the story of the little village by a river in which one day were heard the cries of a drowning man floating down the river. Through heroic effort, the villagers managed to save him. The next day the villagers spotted two more people floating along in similar straits. They too were rescued. Gradually more and more people were discovered floating down the river. The villagers began to devise increasingly innovative means of rescuing them. Specially fitted boats, trained observers, and safety nets were organized—the villagers became increasingly adept at rescuing potential drownees. The numbers continued to increase, however, threatening to overwhelm the resources of the village. Although very proud of their rescue capabilities, the villagers realized they could not continue to cope with the problem with their present systems. Then, and only then, did someone propose, "Why don't we walk upriver to find out who or what is throwing all these people into the river in the first place?" (p. xi)

The above account, unfortunately, seems almost closer to truth than to fiction. For those persuaded to give behavioral medicine increased attention, I hope this brief column has provided some food for thought ("food" that is high in nutritional content and low in preservatives and filler).

References

Andrasik, F. (2010). Behavioral medicine: Back to the future. *the Behavior Therapist, 33*, 45-47.

Weiss, S. M. (1985). Foreword: The case for worksite health promotion. In G. S. Everly, Jr., & R. H. L. Feldman (Eds.), *Occupational health promotion: Health behavior in the workplace* (pp. ix-xv). New York: Wiley.

. . .

Correspondence to Frank Andrasik, Ph.D., University of West Florida, Dept. of Psychology, 11000 University Parkway, Pensacola, FL 32514; fandrasik@uwf.edu

***Table 1*. Ten Leading Causes of Death, Represented as a Percentage of the Total**

10 Leading Causes of Death	United States[1]	Canada[2]	Worldwide[3]
Coronary Heart Disease	26.0	22.4	12.2
Malignant Neoplasms	23.1	29.3	2.3[a]
Stroke & Other Cerebrovascular Diseases	5.7	6.1	9.7
Chronic Lower Respiratory Diseases	5.1	4.6	7.1
Accidents, Unintentional Injury	5.0	4.1	2.2[b]
Diabetes Mellitus	3.0	3.4	
Alzheimer's Disease	3.0	2.5	
Influenza & Pneumonia	2.3	2.5	
Nephritis	1.9	1.6	
Septicemia	1.4		
Intentional Self-Harm		1.6	
Chronic Obstructive Pulmonary Disease			5.1
Diarrhoeal Diseases			3.7
HIV/AIDS			3.5
Tuberculosis			2.5
Prematurity & Low Birth Weight			2.0

Note. [1]Source: National Vital Statistics System, National Center for Health Statistics, CDC, year 2006; [2]Source: Statistic Canada, year 2005; [3]Source: World Health Organization, year 2004; [a]Limited to trachea, bronchus, and lung cancers; [b]Limited to road traffic accidents.

Behavioral Parent Training: Is There an "App" for That?

Deborah J. Jones, *University of North Carolina at Chapel Hill*, Rex Forehand, *University of Vermont*, and Laura G. McKee, Jessica Cuellar, and Carlye Kincaid, *University of North Carolina at Chapel Hill*

It is certainly not true that everyone owns an iPhone (yet!), but rare is the individual who has not heard the commercials with the catchy phrase, "There is an 'app' for that." For many, "apps," or applications, may be synonymous with the iPhone. So familiar are iPhone applications that a full-page advertisement is now being run in national newspapers with the headline, "Introducing 16 apps that need no introduction." So, what exactly is an "app"? "Apps" are simply software programs that most recently have become synonymous with those developed for download to a range of smartphones (e.g., Blackberry, iPhone, Droid). "Apps" involve a variety of functions, depending on the particular program, with some more sophisticated than others. For example, there is now an application for tracking packages with an express carrier. Another application allows one to check whether an item is in stock at a popular retailer. Still another application not only gives directions to a ubiquitous coffee shop, but also allows the user to add money to a customized card before arriving. There are literally applications available to manage almost every aspect of one's life, but what about parenting? . . . Is there an "app" for that?

Although unlikely to be highlighted on the famous "There is an 'app' for that" commercials, there are many applications that have been developed that are related to the field of behavior therapy. Simply typing "psychology" into the iPhone "App Store" yields hundreds of related applications, ranging from one that assesses the user's personality to another that aims to boost happiness in times of stress. A more narrow search for "behavior therapy" yields far fewer applications; however, there are still many of relevance, including applications that target the fear of flying, help to better manage time, assist with assertiveness training, and even an application that guides recording automatic thoughts and labeling cognitive errors.

There are also "apps" that focus on issues of relevance to behavioral parent training for child disruptive behaviors. There are less applied applications like the one to help parents assess their own parenting style, an exercise that parallels, although certainly less rigorous, the assessment phase of behavioral parent training. There are also more practical applications, including several designed to guide parents through the use of time-out. When the child's behavior merits a time-out, the parent can click on the child's name, which they have previously entered, and the application will tell them how long the time-out should last based on the child's age (which was also previously entered) and serve as a timer. To our knowledge, there is no available empirical data that would tell us whether such an application was helpful to parents or not. Are parents who use the time-out application more effective with the time-out procedure and, therefore, more likely to stick with it, than parents who do not? Our educated guess is that although the various time-out applications at first glance may seem helpful to parents, they have little impact on parent's competence in their use of time-out or confidence in carrying out the procedure. That is, the most difficult part of time-out for parents is likely not calculating the number of minutes the time-out should last or even finding a timer. Rather, the more difficult part of time-out for parents is determining whether time-out is the most appropriate consequence to use at a particular time: then, if it is, remembering the time-out sequence, remaining calm but firm during its administration, and utilizing the consequence consistently. These are not simple things for parents to learn and success requires significant in- and out-of-session practice—a commitment to which the barriers often seem insurmountable to many parents.

Behavioral Parent Training: Engagement and Retention

Years of accumulated data suggest that behavioral parent training, which includes time-out as well as other skills (e.g., rewards, ignoring, giving effective instruction), works—parenting behavior improves and, in turn, child behavior problems decline (see Eyberg, Nelson, & Boggs, 2008; Kazdin, 2000, for reviews). As highlighted elsewhere (Prinz & Sanders, 2007), numerous obstacles preclude many families from accessing empirically supported behavioral parent training programs (e.g., lack of knowledge that such programs exist; limited availability of trained clinicians). Even if a family is referred to a clinician who is trained to offer behavioral parent training, most empirically supported programs are relatively time-intensive, requiring both in- and out-of-session practice, a commitment that may be daunting to many already stressed families (Prinz & Sanders, 2007). The potential burden of this investment cannot be underestimated (Ingoldsby, in press; Prinz & Sanders, 2007) and is a primary challenge to the effectiveness of behavioral parent training. Inadequate engagement in behavioral parent training leads to family attrition, which has been estimated to be more than one-fourth of parents in parent training research (Forehand, Middlebrook, & Rogers, 1983; Sanders, Markie-Dadds, & Tully, 2000). Failure to engage in services also decreases the likelihood that parents who do continue to attend will adequately learn effective parenting skills (e.g., Jensen et al., 1999; Nock & Ferriter, 2005). Parental lack of confidence and competence in the new skills increases the likelihood that both parents and children will return to old patterns of behavior (i.e., the coercive cycle proposed by Patterson; see Granic & Patterson, 2006; McMahon & Forehand, 2003).

So, what are the consequences of parents failing to engage in, and ultimately dropping out of, parent training programs? Many of the children whose parents seek treatment are on the "early starter pathway," which is associated with the worst prognosis for youth (see McMahon & Forehand, 2003). This pathway is characterized by the onset of relatively less serious conduct problems in the preschool and early childhood years, most notably noncompliance, and progression without treatment to increasingly serious conduct problems (e.g., aggression, stealing, substance use) throughout childhood, adolescence, and adulthood (Calkins & Keane, 2009; Frick &

Viding, 2009). Parents play a critical role in the early starter model with regard to how they respond to early noncompliant behaviors and are considered a primary mechanism by which children accelerate along an early starter pathway (McMahon & Forehand). As a consequence, behavioral parent training is a treatment of choice for early starter pathway families (Granic & Patterson, 2006; McMahon & Forehand). If parents fail to engage in, and ultimately drop out of, parent training, children will be at a substantially higher risk for remaining on a pathway to serious conduct problems (e.g., McMahon & Forehand).

Promoting Engagement and Retention: The Role of Technology

Given the public health importance of treating early starter pathway youth and their families, what strategies have been used to enhance parental engagement and, in turn, increase the likelihood that they will be retained in the program a sufficient length of time to benefit from the skills training? As summarized elsewhere (Ingoldsby, in press), previous strategies include the following: appointment reminders (e.g., Watt, Hoyland, Best, & Dadds, 2007), identifying and overcoming barriers to treatment (e.g., McKay, Stoewe, McCadam, & Gonzales, 1998), monetary incentives (e.g., Heinrichs, 2006), building relationships and addressing resistance prior to therapy (e.g., Szapocznik et al., 1988), family support (e.g., Miller & Prinz, 2003), and motivational techniques (e.g., Nock & Kazdin, 2005; Sterrett, Jones, Zalot, & Shook, in press).

While some of these approaches have shown promise for improving the engagement of families, others have yielded fewer, if any, gains (Ingoldsby, in press). Moreover, the programs that show promise largely represent the development of new programs designed to explicitly address the issue of engagement (e.g., Szapocznik's Strategic Structural Systems Engagement; Nock & Kazdin's Participation Enhancement Intervention); in contrast, little attention has been given to innovative enhancements for existing behavioral parent training programs. We propose that one particularly innovative approach for moving the field forward is the inclusion of technological enhancements to existing parenting programs.

How can advances in technology help? Alan Kadzin (2008), the former President of the American Psychological Association and ABCT and a well-known researcher in the field of behavioral parent training, noted there is a relatively untapped potential of various telecommunication technologies to enhance the effectiveness of treatments by maintaining connections with clients beyond the walls of the therapy room. Importantly, smartphones integrate the benefits of a wide range of technologies (i.e., telephone, computer, electronic organizer) into a portable and relatively cost-effective hand-held device, allowing users wireless access to phone, e-mail, web, and videos. Users are able to synchronize and transfer information between their smartphones and other technologies (e.g., internet, computers, etc.), send and receive email and text messages, and even send and receive video.

Can technology increase parental engagement in behavioral parent training and, in turn, prevent parent dropout? Self-Determination Theory (SDT; Ryan & Deci, 2000) would suggest that it can. SDT posits that human motivation falls along a continuum. The least self-determined motivation, external motivation (i.e., the propensity to engage in a particular behavior to satisfy an external requirement), falls at one end of the continuum (e.g., court-mandated parenting classes), while the most self-determined motivation, intrinsic motivation (i.e., the tendency to engage in a behavior due to the pleasure of and interest in the behavior itself), falls at the other (e.g., enjoying new parenting skills; Deci & Ryan, 2002; Ryan & Deci, 2000). Importantly, intrinsic motivation is considered the most likely to fulfill the most basic of psychological needs: autonomy (i.e., need for control), competence (i.e., need for effectiveness), and relatedness (i.e., need for relationships). Given that intrinsic (autono-mous) behaviors are most likely to meet individual psychological needs and, in turn, are most likely to be maintained over time, autonomy and support for autonomy have been considered critical to behavior change interventions (e.g., Williams, Lynch, & Glasgow, 2007).

Building upon SDT (Ryan & Deci, 2000), the incorporation of smartphone technology into parent training can potentially enhance engagement and retention in several ways. First, smartphones could afford therapists the opportunity to provide more support to parents by providing intervention options outside of the therapy setting (e.g., home). Therapists could provide additional out-of-session information to the families about the program (e.g., sample skills video to watch on smartphones; text message reminders about skills practice). In addition, families could receive more informed feedback from therapists based on their out-of-session practice of skills (e.g., daily assessments, weekly check-ins, videotaped skills practice). By increasing the family's relationship with the therapist, as well as the accessibility of the program to the family, smartphones could enhance the parents' overall positive feelings about the behavioral parent training program. Although initially the smartphone may promote greater reliance on the therapist (i.e., less autonomy), the increased opportunity for connection and practice could afford a means for parents to feel more competent in the use of the new skills both in and out of session and to reach criterion on each of the parenting skills more quickly (i.e., more autonomy) (e.g., Williams et al., 2007). In turn, parents may require fewer sessions to reach criterion on each of the new skills.

Relative to the potential advantages, prior research suggests that incorporating smartphones into existing parent training programs should produce little additional family burden. Estimates of burden are not yet available for behavioral parent training in particular; however, research using cellular phones with other difficult-to-engage groups (e.g., homeless, HIV-infected) suggests a high level of satisfaction, including programs that ask participants to carry phones at all times and to receive calls at random intervals (Collins, Kashdan, & Gollnisch, 2003). In addition, when cellular phones are used, the majority of participants (95%) complete the intervention, again suggesting the burden of the technology is minimal (Alemagno et al., 1996).

Economic burden must also be considered. It would be remiss to ignore the potential costs (e.g., cost of smartphone, service plan) or practical issues (e.g., service coverage) associated with using smartphones. Importantly, industry estimates suggest that 40 million smartphones or wireless enabled personal data assistants (PDAs) were being used by Americans in 2009 (CTIA, 2009). The increase in smartphone use, occurring at the same time that the sales of cellular phones more generally is on the decline, has been attributed to economics (Lohr, 2009). Smartphones bundle the advantages of other types of technology, affording the user the opportunity to make telephone calls, text, and access the web. Furthermore, most Americans live in areas with multiple wireless service providers (CTIA, 2009). As more of these and other companies provide smartphone options, prices have begun and will continue to drop, leading to more accessibility across income levels. In fact, technology experts

have suggested that the next wave of users will be lower-income consumers because they can acquire the benefits of the Internet without the operating system or cable package required for at-home use of a desktop computer (Noyes, 2007). Thus, in the near future, smartphones may well be an economical and readily available way to promote engagement and retention.

Conclusions

So, back to the question: Is there an "app" for behavioral parent training? The answer currently is "no," but theory, research, and decreasing costs suggest that will soon change. In anticipation of the decreasing cost and growing use of smartphones, now is the time to begin to capitalize on and to empirically test the utilization of smartphones for enhancing the engagement and retention of families in behavioral parent training programs. Consistent with Kazdin's (2008) call for more attention to technology innovations, as well as a similar call by the National Institute of Mental Health (2003), we are currently developing the components of an application for the iPhone aimed at increasing the engagement and retention of parents in one well-established behavioral parent training program, Helping the Noncompliant Child (HNC; McMahon & Forehand, 2003).

Through the use of iPhones, we plan to utilize several strategies with parents that have been used in behavioral parent training, as well as other interventions, including the following: to upload printed HNC materials from the manual; to conduct between-session telephone check-ins with parents (e.g., McMahon & Forehand, 2003); to provide parenting skill video demonstrations (e.g., Sanders et al., 2000; Webster-Stratton, 1994); to email and text message reminders regarding skills practice (e.g., Andersson, Strömgren, & Ström, 2002; Celio, Winzelberg, Dev, & Taylor, 2002); and to conduct daily assessments of skills practice (e.g., Fung, Menassis, & Kenny, 2002). In addition, iPhones will provide the opportunity for parents to videotape their daily in-home skills practice for review with the therapist, providing increased opportunity for therapist observation and feedback on progress on each of the skills. Of importance, our aim is not to replace weekly telephone check-ins or face-to-face weekly sessions with the therapist; rather, the iPhone will allow us to integrate the advantages of multiple technologies into one portable device to enhance parental engagement in the program by forging a virtual connection between the parent, the HNC program, and the therapist.

Beyond engaging the participating parent, usually the mother, iPhones also can help to assess and include in treatment other adults and family members (e.g., coparents) assisting the mother with parenting. Given that these coparents are unlikely to attend the intervention sessions (McMahon & Forehand, 2003), we plan to use iPhones to promote their involvement in several ways: to text-message reminders to parents that coparents should be using the skills as well; to gather information on the extent to which coparents are also practicing the skills at home; to encourage mothers to share videos of skills demonstrations with coparents; and ask mothers to videotape coparents' skills practice.

There are several aims to this initial pilot investigation. First, our goal is to examine the extent to which families who we already know may have difficulty engaging in behavioral parent training utilize the iPhone-enhanced HNC components of treatment.

Therapists will have a record of whether or not each participating family is completing the daily assessments on the iPhone, as this information will be directly uploaded to a therapist spreadsheet when the family completes the iPhone survey. Families will also be asked to bring their iPhones to session each week, so the therapists will know via a counter embedded in the videos the extent to which the videos have been watched, how many times they have been watched, and whether or not families have videotaped their skills practice. Finally, families will have an opportunity at the end of treatment to complete a consumer satisfaction questionnaire that will assess satisfaction with the iPhone intervention components, as well as recommendations for improvements that would better meet family needs.

Asking mothers to videotape their own skills practice using the iPhone may seem like a potential challenge. However, small tripods that have been designed for use with the iPhone are now available and are relatively easy to use, suggesting that once we show parents how to set up the phone and start and stop the video, this may actually be a relatively easy way for them to get informed therapist feedback on their daily skills practice. Importantly, the consumer satisfaction questionnaire, as well as weekly therapist-mother interaction, will provide more definitive information on the feasibility of all aspects of the iPhone intervention components. Our hypothesis, however, is that parents will engage in these relatively brief mini-assessments and interventions, which, coupled with the daily reminders, standard weekly telephone check-in, and standard weekly session, will yield higher levels of engagement throughout the course of treatment, fewer sessions to reach behavioral criterion for each of the HNC skills, and reduction in dropout from the program. Furthermore, we will examine if co-parents (e.g., fathers, grandmothers) of mothers engage more in the HNC treatment program, increasing the likelihood that mothers will feel supported and remain engaged, eventually benefitting their children, as well as identify any obstacles to co-parent engagement in the iPhone intervention components (e.g., watching skills videos, videotaping their own skills practice) that could guide the improvement of the eventual application. Finally, we will conduct cost-effectiveness analyses, which we expect will show that the costs of iPhones will be outweighed by the benefits (e.g., fewer sessions to reach criterion for the acquisition of the parenting skills).

Once the component parts of the application are tested as a package and, assuming their use is supported, and modifications are made consistent with family feedback, the next step will be to develop the "app" that can complement the HNC manual, providing an additional resource for therapists and the families with whom they work. While our focus is on the use of an HNC application to enhance engagement and retention of families in behavioral parent training, the components of the application likely have utility in their own right as well (e.g., streamlined assessment strategies, increased opportunity for therapist observation of skills practice; efficient strategies to remind parents about skills practice). And maybe, someday, one of those commercials will say, "Behavioral parent training . . . there is an 'app' for that."

References

Alemagno, S.A., Cochran, D., Feucht, T.E., Stephens, R.C., Butts, J.M., & Wolfe, S.A. (1996). Assessing substance abuse treatment needs among the homeless: A telephone-based interactive voice response system. *American Journal of Public Health, 86*, 1626-1628.

Andersson, G., Strömgren, T., & Ström, L. (2002). Randomized control trial for internet-based cognitive therapy for distress associated with tinnitus. *Psychosomatic Medicine, 64*, 810-816.

Calkins, S.D., & Keane, S.P. (2009). Developmental origins of early antisocial behavior. *Development and Psychopathology, 21*, 1095-1109.

Celio, A.A., Winzelberg, A., Dev, P., & Taylor, C.B. (2002). Improving compliance with online structured self-help programs: Evaluation of an eating disorder prevention program. *Journal of Psychiatric Practice, 8*, 14-20.

CTIA. (2009, October 7). *CTIA–The Wireless Association® Announces Semi-Annual Wireless Industry Survey Results.* Retrieved from http://www.ctia.org/media/press/body.cfm/prid/1870.

Collins, R.L., Kashdan, T.B., & Gollnisch, G. (2003). The feasibility of using cellular phones to collect ecological momentary assessment data: Application to alcohol consumption. *Experimental & Clinical Psychopharmacology, 11*, 73-78.

Cunningham, C.E., Bremner, R., & Boyle, M. (1995). Large group community-based parenting for families of preschoolers at risk for disruptive behavior disorders: Utilization, cost effectiveness, and outcome. *Journal of Child Psychology and Psychiatry, 36*, 1141-1159.

Deci, E.L., & Ryan, R.M. (Eds.). (2002). *Handbook of self-determination theory research*. Rochester, NY: Rochester University Press.

Eyberg, S.M., Nelson, M.M., & Boggs, S.R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child & Adolescent Psychology, 37*, 215-237.

Forehand, R., Middlebrook, J., & Rogers, T. (1983). Dropping out of parent training. *Behaviour Research and Therapy, 21*, 663-668.

Frick, P.J., & Viding, E. (2009). Antisocial behavior from a developmental psychopathology perspective. *Development and Psychopathology, 21*, 1111-1131.

Fung, D.S., Manassis, K., & Kenny, A. (2002). Web-based CBT for selective mutism. *Journal of the American Academy of Child & Adolescent Psychiatry, 2*, 112-113.

Granic, I., & Patterson, G.R. (2006). Toward a comprehensive model of antisocial development: A dynamic systems approach. *Psychological Review, 113*, 101-31.

Heinrichs, N. (2006). The effects of two different incentives on recruitment rates of families into a prevention program. *The Journal of Primary Prevention, 27*, 345-365.

Hutchings, J., & Webster-Stratton, C. (2004). Community-based supports for parents. In M. Hoghughi & N. Long (Eds.), *Handbook of parenting: Theory and research for practice* (pp. 334-351). Thousand Oaks, CA: Sage.

Ingoldsby, E.M. (in press). Review of interventions to improve family engagement and retention in parent and child mental health programs. *Journal of Child and Family Studies*.

Jensen, P.S., Arnold, L.E., Richters, J.E., Severe, J.B., Vereen, D., & Vitello, B. (1999). A 14 - month randomized clinical trial of treatment strategies for attention deficit hyperactivity disorder. *Archives of General Psychiatry, 56*, 1073-1086.

Kazdin, A.E. (2000). Treatments for aggressive and antisocial children. *Child and Adolescent Psychiatric Clinics of North America, 9*, 841-58.

Kazdin, A.E. (2008). President's column: Ensuring that our findings have impact. *Monitor on Psychology, 39*, 5-6.

Lohr, S. (2009, June 9). *Smartphone rises fast from gadget to necessity*. Retrieved from http://www.nytimes.com/2009/06/10/technology/10phone.html.

McKay, M.M., Stoewe, J. McCadam, K., & Gonzales, J. (1998). Increasing access to child mental health services. *Health and Social Work, 23*, 9-16.

McMahon, R. J., & Forehand, R. (2003). *Helping the noncompliant child: A clinician's guide to effective parent training* (2nd ed.). New York: Guilford.

Miller, G.E., & Prinz, R.J. (2003). Engagement of families in treatment for childhood conduct problems. *Behavior Therapy, 34*, 517-534.

National Institute of Mental Health. (2001). *Blueprint for change: Research on Child and Adolescent Mental Health Council's Workgroup on Child and Adolescent Mental Health Intervention*

Development and Deployment. (DHHS Publication No. CG 031-591). Washington, DC: US Government Printing Office.

Nock, M.K., & Ferriter, C. (2005). Parent management of attendance and adherence in child and adolescent therapy: A conceptual and empirical review. *Clinical Child and Family Psychology Review, 8*, 149-166.

Nock, M.K., & Kazdin, A.E. (2005). Randomized controlled trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology, 73*, 872-879.

Noyes, K. (2007). *Smartphones vs. dumbphones: No contest*. Retrieved from http://www.technewsworld.com.

Prinz, R.J., & Miller, M.K. (1994). Family-based treatment for childhood antisocial behavior: Experimental influences on dropout and engagement. *Journal of Consulting and Clinical Psychology, 62*, 645-650.

Prinz, R.J., & Sanders, M.R. (2007). Adopting a population-level approach to parenting and family support intervention. *Clinical Psychology Review, 27*, 739-749.

Ryan, R. M., & Deci, E.L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*, 68-78.

Sanders, M.R., Markie-Dadds, C., Tully, L.A. (2000). The Triple P-Positive Parenting Program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology, 68*, 624-640.

Sterrett, E., Jones, D.J., Zalot, A., & Shook, S. (in press). A pilot study of a brief motivational intervention to enhance parental engagement: A brief report. *Journal of Child and Family Studies*.

Szapocznik J., Perez-Vidal, A., Brickman, A.L., Foote, F.H., Santisteban D., Hervis, O., & Kurtine, W.M. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology, 56*, 552-557.

Watt, B.D., Hoyland, M., Best, D., & Dadds, M.R. (2007). Treatment participation among children with conduct problems and the role of telephone reminders. *Journal of Child Family Studies, 16*, 522-580.

Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology, 62*, 583-593.

Williams, G.C., Lynch, M., Glasgow, R.E. (2007). Computer-assisted intervention improves patient-centered diabetes care by increasing autonomy support. *Health Psychology, 26*, 728-734.

. . .

Funding for this project was provided by NIMH 1R34MH082956-01A1. Additional support was provided by NICHD 5T32HD049325 (Training Grant in Research in Black Child Development) and NICHD 5T32HD007376 (Human Development: Interdisciplinary Research Training).

We wish to acknowledge Joel Sherrill, Program Chief, Child and Adolescent Psychosocial Intervention Program, for his guidance on this project; to our colleagues at Research Triangle International, Amanda Honeycut, Olga Khavjou, and Eric Finkelstein for their contributions to the cost-effectiveness analyses; and to Robert J. McMahon, University of Washington, for his comments on an earlier draft of this article.

We also extend our sincerest appreciation to our technology consultant, Greg Newey, Research Technology Solutions, for his guidance and assistance with the development of our iPhone intervention components (gnewey@restechsol.com).

Correspondence to Deborah J. Jones, Ph.D., Department of Psychology, UNC Chapel Hill, CB #3270, Chapel Hill, NC 27599; djjones@email.unc.edu.

Clinical Forum

How Can We Close the Gap Between Clinical Practice and Research?

Marvin R. Goldfried, *Stony Brook University*

As a graduate student in the late 1950s (!), I was subjected to a schizophrenic experience. The courses on learning, perception, and research methodology clearly spelled out the message that conclusions about behavior and the change process needed to be backed by empirical evidence. By contrast, the clinical courses, involving projective techniques and psychoanalytic therapy, contained "conclusions" not backed by any evidence whatsoever. And all of this was shortly after it was recommended that clinical psychologists should be trained according to the Boulder model, where the goal is to function as both a clinician and researcher. You can imagine my excitement when I learned that Paul Meehl, perhaps the most distinguished empirically minded clinician at the time, was going to visit our program. And if that wasn't exciting enough, I was invited to be among a small group of graduate students that went to dinner with him. This indeed was a rare treat, especially since I read virtually everything Meehl had written, and had enormous respect for his insights on research, practice, and the philosophy of science. At one point during the evening, someone asked him the question about the extent to which his clinical work was informed by research. Without any hesitation, he replied: "Not at all."

As someone who was struggling to adopt the identity of scientist-practitioner, I left this memorable dinner disheartened. I don't think I ever fully recovered. The challenge of how we can close the gap between research and practice has stayed with me for all these years, and because I am attracted to challenges—my experiential colleagues would probably say it's more "unfinished business"—I have continued to be intrigued with the integration of practice and research. To be sure, the situation is far better than it was in the past. Still, there continues to remain a gap between research and practice. It is in my role as President of the Society of Clinical Psychology, Division 12 of APA, that I have begun an initiative to build a two-way bridge between research and practice—and where the input of you, the reader, is very much needed. More about that later.

Throughout most of my professional career, I have lived in both the clinical and research worlds. Much of my teaching, research, and writing has placed me at the academic end of the spectrum. However, my continued involvement in clinical training and supervision, and my part-time practice of psychotherapy, have all kept me in close touch with clinical reality. I am writing this article now because I believe that, more than ever before, the current demands for accountability need to be addressed from an integrated clinical-research perspective.

The Link Between Research and Practice

Sociologists and philosophers of science have made an important distinction between the questions to be studied and the methods of studying them. During the initial phase—the context of discovery—we have the "problem finders," who identify the important research questions that are likely to advance the field (Wilkes, 1979). Once these issues are identified, we move to the verification phase, where the "problem solvers" investigate the empirical status of those phenomena that have been identified by the front-line observers. In the case of particularly successful researchers, we see both these activities occurring within the same individual. An excellent example is Neal Miller, one of the field's most respected researchers. In a candid commentary on how he approached research problems, he confessed to using his intuition before designing a study with tight or elaborate experimental controls: "During the discovery or exploratory phase . . . I am quite free-wheeling and intuitive—follow hunches, vary procedures, try out wild ideas, and take short-cuts" (Miller, cited in Bergin & Strupp, 1972, p. 348). Only after this does he conduct well-controlled studies to investigate the problem. Thus, his goal at first is to convince himself that the phenomenon exists. Having done that, his goal becomes that of convincing his colleagues.

In considering the relationship between psychotherapy practice and research, I have viewed clinical work as providing us with the context of discovery. Working with clients directly and discussing clinical cases with supervisees not only provides the challenge of translating general research findings to the individual case at hand, but also can afford one the opportunity to witness firsthand the ever-varying parameters of human behavior and the change process. In my own role as therapist, the "problem finder" in me has been able to garner clinical hypotheses that I went on to study under better-controlled research conditions.

In the 1970s, when behavior therapy began to recognize the importance of cognitive factors for understanding and changing human functioning, it was in the clinical setting that such recognition began (Goldfried & Davison, 1976). Specifically, it was the result of practicing behavior therapists experiencing difficulties in using the originally available behavioral interventions that led to the incorporation of more cognitive procedures. Only later did research findings offer confirmation of what originally had been observed clinically.

The scientist-practitioner model is important in that it keeps us honest as clinical researchers. Without an ongoing clinical base, it is all too easy to get caught up in studying research trends and fads than in investigating something that is useful to the practicing clinician.

Building a Two-Way Bridge Between Research and Practice

Since my days as a graduate student, I have held on to the goal of building a bridge between practice and research that can allow for movement in both directions. As stated some years ago, there is an invaluable convergence between research and practice:

> The experience and wisdom of the practicing clinician cannot be overlooked. But because these observations are often not clearly articulated . . . [and] . . . may be unsystematic or at times idiosyncratic . . . it is less likely that these insights can add to a reliable body of knowledge. The growing methodological sophistication of the researcher, on the other hand, is in need of significant and . . . [clinically] . . . valid subject material. [In short], our knowledge about what works in therapy must be rooted in clinical observations, but it must also have empirical verification. For the researcher and clinician to ignore the contributions that each has to make is to perpetuate a sys-

tem in which no one wins. (Goldfried & Padawer, 1982, p. 33)

Although the current generation of outcome research (i.e., randomized clinical trials) has reached a very high level of methodological sophistication, a number of my empirically oriented colleagues and I have been concerned about the unforeseen implications it may have for clinical practice (e.g., Goldfried & Wolfe, 1996). Because such internal validity is sometimes achieved at the expense of external, clinical validity, our concerns have been that the methodological constraints associated with such research may translate into clinical constraints for the practicing therapist—such as insurance companies limiting the number of sessions to those used in clinical trials.

The idea that clinicians can provide input for researchers often works better in theory than in practice. There unfortunately is a long history of tension between clinicians and researchers, even to the point of outright antagonism. For example, one clinician came to the conclusion that it is only feasible to carry out research in psychotherapy if it is done "in the mechanical way that is so fashionable among many of our colleagues who are too frightened and too inept to establish an interpersonal relationship of the therapeutic variety with the patient" (Lehrer, 1981, p. 42). Many clinical researchers have comparable disdain for practitioners, viewing them as being totally disinterested in research findings and more involved in doing what feels comfortable for them.

For practitioners more favorably disposed to clinical research, an important issue becomes that of time and motivation. This point has been underscored by Borkovec, who has been actively involved in enlisting the cooperation of therapists into a practice-research network (Goldfried, Borkovec, Clarkin, Johnson, & Parry, 1999). The initial motive that many of these practitioners had for participating in the network was a desire to reconnect with their scientific roots. Although that prompted them to join the group initially, Borkovec has acknowledged that their motivation wanes, and more creative methods of keeping them involved are needed (e.g., financial incentives, continuing education credit). Parry, who has been involved in a comparable practice-research network in the United Kingdom, has similarly underscored the difficulty in maintaining ongoing motivation.

There are numerous realistic limitations that simply do not make it feasible for the practitioner to conduct the kind of process and outcome research that currently characterizes the field. The current model of clinical trials necessitates a large number of participants and is often feasible only with external funding and collaboration among several researchers. Even if the practitioner had learned research methodology during his or her training, much of it is likely to have undergone changes and refinements since that time. Psychotherapy process research, which often most closely parallels the clinical interests of practitioners, is often far too labor-intensive to be feasible in a clinical setting where a certain number of contact hours must be met.

However, a way that clinicians can provide an invaluable contribution to the research process is by providing feedback to clinical researchers regarding how well empirically supported or evidence-based interventions work in actual practice. When a drug has been approved by the FDA on the basis on randomized clinical trials, and is subsequently used for treatment, a mechanism exists for providing feedback about how well it fares in the real clinical setting. Thus, practitioners can file incident reports to the FDA when they encounter problems in the use of any given drug in clinical practice. Within the field of psychotherapy, the practitioner can readily provide similar feedback to researchers. One way this can be implemented is within the context of continuing education workshops, which often present advances in treatment based on available research findings. After attending such workshops, clinicians can report their experience as to how well these empirically based procedures work in real clinical settings, and what changes might need to be made and studied in order to enhance their effectiveness.

With pressures for accountability coming from insurance companies, and with the field making attempts to document empirically supported therapies, there appears to be a renewed opportunity in forming collaboration between researchers and clinicians. Perhaps more than ever before, this climate is more conducive to having clinicians become more actively involved in the research process. Because of the realistic factors that limit practitioners' ability to conduct the kind of research now done by clinical researchers, their research involvement must take a different form.

What makes this most timely is that the field of psychotherapy can no longer make claims without pointing to evidence that the treatments indeed work. Although pressures for accountability have existed over the past few decades, the emphasis on empirically supported treatments, evidence-based practice, pay for performance, quality assurance, and the existence of practice guidelines have inexorably moved the field of psychotherapy toward accountability.

Providing Clinical Feedback on the Use of Empirically Supported Therapies

As noted above, the Society of Clinical Psychology, Division 12 of the APA, is committed to building a two-way bridge between research and practice. Indeed, this will be the theme of many of the presentations sponsored by the Society at the August 2010 convention in San Diego. Moreover, the Society is establishing a mechanism whereby practicing therapists can report their clinical experiences using empirically supported treatments. This is not only an opportunity for clinicians to share their experiences with other therapists, but also can offer information that can encourage researchers to investigate ways of overcoming these limitations. We are starting with the treatment of panic disorder, but will extend our efforts to the treatment of other problems at a later time.

In this initiative, I am fortunate to be working with a group of experienced, motivated, and enthusiastic researchers and practitioners who similarly have had an ongoing dedication to closing the gap between practice and research. Our committee includes Louis G. Castonguay (President of the Society for Psychotherapy Research); Marvin R. Goldfried (Past-President of the Society for Psychotherapy Research and President of Division 12); Jeffrey J. Magnavita (President of Division 29—Psychotherapy); Michelle G. Newman (Associate Editor of *Behavior Therapy* and psychotherapy researcher with expertise in anxiety disorders); Linda Sobell (Past-President of ABCT and Division 12); and Abraham W. Wolf (Past-President of Division 29). In addition to their motivation and interest, members of this group have had ongoing experience in working to close the gap between practitioners and researchers, such as Castonguay's role as Co-Chair of the National Research Practice Network; Goldfried's founding of the journal *In Session*, which includes research reviews written for the practicing clinician; Magnavita and Newman serving as Guest Editors for this journal; Sobell's collabora-

tion with therapists in designing a therapy manual and research protocol for the treatment of substance abuse (Sobell, 1996); and Wolf's professional dedication to fulfilling the model of the scientist-practitioner.

The Society is currently inviting therapists using cognitive-behavior therapy (CBT) in treating panic to share their clinical experiences about those variables they have found to limit the successful reduction of symptomatology. Although research is underway to determine if other therapies can successfully treat panic, CBT is the only approach at present that has adequate empirical support. However, in order to move from an empirically supported therapy to a treatment that works well in practice settings, we need to know more about the clinical experience of therapists who make use of these interventions. By identifying the obstacles to successful treatment, we can then take steps to overcome these shortcomings.

Therapists' responses, which will be anonymous, will be surveyed, tallied, and then posted on the Division 12 website—with links to other websites. The results of the feedback we receive from clinicians will be disseminated in all relevant professional outlets, in the hope that researchers can investigate ways of overcoming these obstacles.

I invite the reader to participate in this very exciting initiative. The survey is very brief—taking only 10 minutes—and can be found at: www.div12.org/panic.

References

Bergin, A. E., & Strupp, H. H. (1972). *Changing frontiers in the science of psychotherapy*. Chicago: Aldine-Atherton.

Goldfried, M. R., Borkovec, T. D., Clarkin, J. F., Johnson, L. D., & Parry, G. (1999). Toward the development of a clinically useful approach to psychotherapy research. *JCLP/In Session: Psychotherapy in Practice, 55*, 1385-1405.

Goldfried, M.R., & Davison, G.C. (1976). *Clinical behavior therapy.* New York: Holt, Rinehart & Winston.

Goldfried, M.R., & Padawer, W. (1982). Current status and future directions in psychotherapy. In M. R. Goldfried (Ed.), *Converging themes in psychotherapy: Trends in psychodynamic, humanistic, and behavioral practice* (pp. 3-49). New York: Springer.

Goldfried, M. R., & Wolfe, B. E. (1996). Psychotherapy practice and research: Repairing a strained alliance. *American Psychologist, 51*, 1007-1016.

Lehrer, A. (1981). Not a science. *APA Monitor, 12*, 42.

Sobell, L.C. (1996). Bridging the gap between scientists and practitioners: The challenge before us. *Behavior Therapy, 27*, 297-320.

Wilkes, J. M. (1979). *Cognitive issues arising from study in the sociology of science*. Paper presented at the Annual Meeting of the American Psychological Association, New York, September.

. . .

Correspondence to Marvin Goldfried, Ph.D., Department of Psychology, SUNY-Stony Brook, Stony Brook, NY 11794; e-mail: Marvin.goldfried@sunysb.edu

Stanley Falls Flat at the IRB

Suzy Bird Gulliver, John W. Klocek, and Laurie E. Steffen, *VISN 17 Center of Excellence* and *Texas A&M Health Sciences Center College of Medicine*

Last week, I was delighted to open my mailbox and find therein a manilla envelope addressed to me in the round print letters of my second-grade godchild. After smiling at the treasure in my hands, I opened it to find a gingerbread-shaped one-dimensional fellow accompanied by a letter in the same perfect penmanship as evidenced on the envelope. The letter introduced me to Flat Stanley, and asked that I let Flat Stanley accompany me on my travels for a week or two, take some pictures of the sites we saw, and send him back with the accompanying data. As a clinical researcher, I was completely happy to oblige. Flat Stanley accompanied me to work and to local hot spots. I documented his adventures and was happily preparing him for his return journey when it hit me—this was data. An ethical dilemma ensued as I thought about my obligations as a clinical researcher. I quickly reviewed the information that had accompanied Stanley. Was I to provide consent? What about consent for Stanley? I had no idea how participating in this research might affect me, my godchild, and Stanley. Had an IRB considered these questions?

If I had not done a good job with Flat Stanley, would my godchild suffer a decrease in her academic standing? What would happen to her social status, both real and perceived? Could I suffer guilt or some other unpleasant emotion as a result? I was already experiencing unforeseen anxiety about the results. Data had been collected, but could I still withdraw my participation? What about Flat Stanley? Who was assuring that he was being transported in a safe and secure manner? If he was bent, to whom was that to be reported? Did Stanley understand the potential risks of participation? I reviewed the photographs my postdoc had taken of Flat Stanley and me and realized that they made Flat Stanley look, well, flat. Imagine the potential harm when he got up with all the other little Flat Stanleys and my goddaughter and faced the insults.

As I was not given any information as to who to contact with questions or concerns, I decided to take it to my local IRB, confident that it would provide assistance and helpful feedback to assure all subjects could be cared for. It hasn't met yet, but in its response below the IRB wants documentation about human subjects training for all the second graders and the custodians for the Flat Stanleys.

Aunts, Uncles, Grandparents, Godparents, let this be a warning to you: The apparent simplicity of the contents of that envelope with the neatly rounded print may impose more depth than intended.

Dear Potential Investigator,

Thank you for your inquiry regarding the potential need for review of the Grade 2 project titled "Flat Stanley: A Visual and Textual Record of Recent Travels." As Chair of the IRB, I am frankly stunned at the implications of what you have presented as having occurred without the careful oversight of the institutions involved and their regulatory boards, oversight committees, and review panels.

In addition to the shocking lack of education regarding the protection of human research participants documented for the investigator of record (your godchild), the principal investigator (the teacher), and the staggeringly large number of additional members of the research team privy to the data (the entire class), there is no evidence to suggest that any of the parties to be involved in the project were actually aware of the potential benefits or complications, nor the potential for social, psychological, economic, or physical risks to participants who were mailed and others "volunteering" to appear with him in pictures. There appears to be a complete lack of any substantive rationale to exposing FS to the risks inherent in traveling across large distances in an envelope handled by the US Postal Service (e.g., unpressurized cargo holds, frequent disregard for "Do Not Fold or Bend" instructions). Neither FS nor any of the other potential participants were informed of alternative image recording modalities that might be chosen instead of photography, alternative methods of data recording, or had any assurance that the data generated would be maintained appropriately in a secure fashion. For example, if a photo featuring FS and an additional participant were to blow away during unsecured transit across campus, that picture might end up in the hands of an employer who recognizes their employee appearing to be enjoying themselves at a Cubs game on a day when they called in "sick" thus resulting in loss of employment, social ostracization, and public revelation of their sporting preferences. Was this potential risk revealed to others appearing in the photos? I suspect not.

Your godchild's age does not excuse her lack of compliance with regulations governing research. You have done the right thing in bringing this blatant disregard of the Regulations to our attention. We are certain that the interviews to be conducted by the investigatory boards I have contacted regarding this situation will be educational as well. Again, thank you for your diligence and please remember—we are here to help.

Confidentially,
The IRB

ABCT *Welcome, New Members!*

The individuals listed on the pages that follow have recently joined ABCT.

FULL MEMBERS

Jason Bacchiochi
Sudie E. Back
Monty Baker
Jacques P. Barber
Christopher Barry
Andrea Garitee Batton
Michelle Beard
Victoria Lemle Beckner
Jamie D. Bedics
Kathy R. Berenson
Noelle Margit Berger
Michele Berk
Andrew Bertagnolli
Karine Berthou
Raymond M. Biersbach
Marsha T. Blank
Frederic C. Blow
Helena Borg
Kerri N. Boutelle
Melinda Carlisle Brackett
Arthur Brand
Cindy L. Brody
Lauren Brookman-Frazee
Sam F. Broughton, Jr.
Dity J. Brunn
Randy S. Burke
Page Burkholder
Elsa Busch
Meghan L. Butryn
Mattias Carlsson
Corey Carr
Jay Carruthers
James W. Carson
William Casey
Candice Cattan
Dawn K. Catucci
Suma P. Chand
Susanna Chang
Rhea M. Chase
Erica M. Chin
Kelly R. Chrestman
Lauren E. Christian
Mary Clair
Norma Coffin Olvera
Oshra Cohen
Miguel A. Colon Sr.
Amy L. Copeland
Betsy Corrin
Clare Cosentino
Laura J. Cramer-Berness
Rebecca C. Croff
Bryan Michael Davidson
Shannon Davis
Joanne Davis
Stephanie Landrum Dean
Lara Degen
John E. Desrochers
Melanie Dirks
Haleh Eghrari
Sue Ei
Nabil Hassan El-Ghoroury
Ian M. Evans
Peter Farvolden
Egeria E. Ferrer
Pam Flint
Teresa Mary Flynn
Christine E. Foertsch
Mia Foley
Arlene Foreman
Joel T. Foster
Kenneth A. Frank
Susanna G. Friedlander
Michele Galietta
Marilyn Garcia
Andrea Garry
Christopher Germer
Michael Giantini
Kimberly Gilbert
Nancy Gordon
Ian Gotlib
Jeffrey Greeson
Beth J. Halpern
Charles Dean Hamad
Jim Harbin
Emily Johnston Hardcastle
Thomas H. Harrell
Rebecca Hazen
Daniel R. Hilliker
Roberta Hoffman
Tamika Jarrett Howell
Julian Hughes
Catherine Hutter
Emily Frelinghuysen Israel
M. Hope Jackson
Shantelle Richardson Jacobs
Theresa Marie Jaworski
Monique Johnson
Christopher Jones
Deborah Juarbe Rey
Andrew Kahn
Monique Kahn
Stephen Kaplan
Steve Katsikas
Denise Kearns
Kristi Ketz
Jean Kim
Ji-Hae Kim
Ronit Kishon
Marc Kleber
Birgit Kleim
David H. Klemanski
James Klosky
Russell Kolts
Nikolaos Konstantakos
Ethan Kross
Alexis Kuerbis
Denise E. Laframboise
Rebecca S. Lamm
David A. Lane
Huynh-Nhu Le
Leslie Lenox
Gloria Leo
Lesley A. Lewis
Laurie R. Lewis
Michael Likier
Matthew Lippman
William Long
Weili Lu
Barry S. Lubetkin
Victoria Lusk
M. Kathleen B. Lustyk
Katherine L. Lynch
Steven J. Lynn
Mary F. Macedonio
James MacKillop
Carole M. Marciano
Patricia Marino
Amy D Marshall
Nancy Maruyama
Pamela Mason
Patty E. Matz
Catherine B. Maxwell
Elizabeth McCauley
Michael R. Mecozzi
Daniel Scott Merwin
Jane Metrik
Suzanne Meunier
Nancy Miller
Robert Miranda
Shoshana Mirvis
Katherine J. Mitchell
Julie N. Mogan
David C. Mohr
Suneeta Monga
Daniela Montalto
Antonella Montano
Phoebe S. Moore
Tracy E. Moran
Melodee Morrison
Laura Mufson
Brian E. Mundy
Jordana Muroff
Leah Ann Murphy
Berkeh Nasri
Maria Nazarian
Andrea Neal
Reo Newring
Jack B. Nitschke
Margaret A. O'Connor
Miyako Oguru
Stephanie O'Leary
Laura Oliff
Heather A. O'Mahen
Kaori Osawa
Michael V. Pantalon
Anthony Papa
Coralee Perez Pedrogo
Tara Sophia Peris
Michael Lloyd Perlis
Sean G. Perrin
Shari Lynn Pescatore
Linda Pfiffner
Elisabeth S. Pollio
Sheryl Prenzlau
Jeslina J Raj
Cynthia Ramirez
Bernard Prange
Mary Ellen B. Raposa
James Reich
Noreen Reilly-Harrington
Bernice Mednick Reinharth
Heidi S. Resnick
Brendan A. Rich
Jonathan Richard
Laura Richardson
Mark L. Roberts
Angela C. Roddenberry
Angela Romeo
Daniel Romer
Diana M. Ronell
Heidi Ronfeldt
Arabelle Margaret Rowe
Lesia M. Ruglass
Peter Sakuls
Merilyn M. Salomon
James M. Sardo
Denise L. Schaffer
Lindsay S. Schenkel
Sabine Petra Schmid
Brandon Schultz
Erica Scioli
Diane J. Shea
Karen Sheridan
Timothy Silverman
Alan Silverman
Anna Simpson
Cecilia Sjoden
Amer Smajkic
Jeffery D. Snarr

Lauren Solotar
Shannan Sonnicksen
Gabriela Livas Stein
Melissa Altman Stein
Sharon H Stephan
Dr. Sherry Stewart
Heather Stone
Jacqueline Summers
Liv Svirsky
Jean M. Thaw
Christina Rose Thomas
Henrik Tingleff
Samuel Tobler
Mary Tramontin
Ingrid Mariana Trujillo Ruano
Mehmet Hakan Turkcapar
Julia Turovsky
Jose David Useda
Alethea A Varra
Sally J. Vavala
Mildred Vera
James A. Vermilyea
Kristofer Vernmark
Jennice Vilhauer
Ariel Vite
Martha Wadsworth
Barry M. Wagner
John R. Wagner
Rheeda L. Walker
Andreas Wallstedt
Cortney S. Warren
Beverley B. Watkins
Daniel N. Weiner
Elin S. Weinstein
Jessica Hirsh Weiss
Rebecca Weston
Daniel J. Whitaker
Shawn Whooley
Denise E. Wilfley
Joseph James Williams
Keith Edward Williams
Seth Jonathan Wintroub
Gisela Wisung
Sharon J. Witkin
Matt S. Wofsy
Jami Young
David Yusko
Denis L. Zavodny
Angela Marcia Zolow

NEW PROFESSIONAL

Salvatore Alfano Jr.
Margareta Almer
Emma B. Arons
Dominique Belisle
Arva Bensaheb
Tania Borda
Kristen Allyn Borg
Roberta Borzi
Kimberly Dienes
Siobhan O'Leary Evarts
Megan Flynn
Jeanne M. Gabriele
Chris Hakala
Tanya H. Hess
Renee Hoekstra
Archana Jajodia
Michele Kofman
Olubukonla O. Kolawole
Hoin Kwon
Smadar Leiserowitz
Bryan Aberin Mendiola
Michael G. Messina
Colette A. Miesse
Jason Morrison
Heather Murray
Aesoon Park
Autumn M. Paulson
Adria N. Pearson
Elizabeth Ramquist
Demi Rhine
Mitchell Rodier
Stacey Rosenkranz
James Ross
Melanie Santos
Jason Seacat
Meghan Searl
Crescent Seibert
Clint C. Stankiewicz
Denise D. Walker
Sherry Muterspaugh Walling
Robert A. Zambrano

POST-BACCALAUREATE

Jennifer Barnes
Lauren M. Borgs
Rachel Jordan Brooks
Bonnie Brown
Jackie Bullis
Erin Suzanne Burger
Mary Kathryn M Cancilliere
Michelle Christine Capozzoli
James Y. Choi
Ignacio Simon Contreras
Jennifer Cowie
Colleen Marie Cowperthwait
Cristina Teresa del Busto
Charlene Ann Deming
Haley Ann Carroll Douglas
Christopher Michael Dudek
Anthony Ecker
Tera Leigh Fazzino
Whitney Francis
Danielle Francois
Meredith Lynn Friedson
Janine Galione
Stephanie Marie Gorka
Leila Guller
Ana M. Gutierrez-Colina
Dianna Hidalgo
Alex Holdaway
Sarah Anne Hostetter
David Houghton
Jared Israel
Chungwon Kim
Rachel E. Kim
Tammi R.A. Kral
Lillian Krantz
Jimeka Leonard
Katarzyna Liwski
Cynthia A. Luethcke
Luke Madrigal
Elizabeth Marks
Luana Marques
Katherine D. McCarthy
Andrew McClintock
Joseph McGuire
Natasha Mehta
Andrew Roberts Menatti
Sarah Anne Moore
Andrea Marie Nave
Maryann Elizabeth Owens
Shairy C Pabon
Alexandra Hayah Jellinets Perloe
Josh L. Peter
Michael Reding
Cara Suzanne Remmes
Christina Frances Rosenthal
Lindsey S. Sankin
Nomara Santos
John Charles Solheid
Megan Spencer
Michelle S. St. Paul
Katie Lyn Stoudt
Ika Szendro
Hed Tamir
Alicia Irene Tarry
Mari Trefry
Lindsay Anne Vuchetich
Frances Wang
Whitney Elizabeth Waugh
Rachel Wechsler
Jaclyn Sara Weisman
Jessica A. Weissman
Melinda Welch
Deni White
Jesse L. Wilkinson
Matt Woodward
Davor Nicholas Zink

STUDENT

Leah Maria Adams
Amanda C. Adcock
Samantha Adelsberg
Fabian Daniel Agiurgioaei Boie
Alina Agiurgioaei Boie
David L. Albright
Ahmad Alhadi
Jennifer Allen
Jaclyn Blake Alper
Sarah Altman
Kristin Gem Anderson
David M. Anderson
Corinne M. Anton
Megan Apperson
Elizabeth M. Archer
Kimberly A. Arditte
Michael Scott Arthur
Rebecca Ashare
Teresa Au
Emily Anne Baggett
Bryann R. Baker
Noah Baker
Rachel Baldwin
Kaitlin Elizabeth Balka
Lisa Balkir
Annie Nicole Banducci
Kelly Ann Barker
Mallory Barker
Andrea L. Barrocas
Angela K. Bartholomew
Linda Lorraine Batemarco
Daniel Be
Lacey Beckmann
Cherie Olga Bedford
Shay-Lee Belik
Amanda Annette Benbow
Shana Bennett
Patrick Bennett
Shannon M. Bennett
Jessica E. Berenguer
Payal Beri
Olga Berkout
Melissa Bernstein
Johnny J. Berona
Ranjit Bhagwat
Theresa E. Bhoopsingh
Jacob Dylan Bigelow
Patrice Bilawka
Marilyn Bineau
Melissa Ann Birnbeck
Aparajita Biswas
Britney Blair
Angelo Salvatore Boccia
Jamie Rae Bolles
Jessica Bomyea
Sruly Bomzer
Albert David Bonfil
Genery DuRette Booster
Rachel Bowley
Kelsey Michael Bradshaw
Katie N. Bradshaw
Christine Erin Brady
Joseph N. Brand

{Student members, continued}

Brenda L. Bratton
Megan Brault
Ashley Braun
Lynn Marie Breckenridge
Jessica Breland
Britni-Lynne Brierly
Simone Brochard
Douglas Marshall Brodman
Maggie Hood Bromberg
Christopher W. Brown
Dana Brown
Linda F. Brown
Caroline Bliss Browne
Aaron Brownlee
Lindsey D. Bruett
Gina Luff Bruns
Bridget Marie Brush
Michelle G. Bubnik
Bianca R. Bucarelli
Nicole E. Buch
Lucy Buchholz
Sarah J. Bujarski
Caitlin Burditt
Shannon Rachel Burgert
Brian Burkett
Melissa Burnett
Karen A Burns
Lorna Busch
Kelley Busjaeger
Emily H. Callahan
William A. Campbell
Patricia Campos
Leonardo Caraballo
Erica R. Carlin
Mary Carnesale
Gabrielle S. Carson
Sarah Carter
Cassady Casey
Robert Casselman
Casey Erin Cavanagh
Maria Vital Cedillo
Elizabeth Marie Cedillos
Mark Joseph Celano
Christine Chang-Schneider
Jessica Ann Chen
Robert Chiaccio
Lauren Alexis Chilian
Alyssa L. Chimiklis
Sonoko Chinen
Kee-Hong Choi
Kim Chu
Laura Cimini
Jessica Lee Clark
Nickeisha Clarke
Katherine Carolyn Claypoole
Sara E. Clayton
Jordan Alejandro Coello
Kimberly A. Coffey
Anahi D. Collado-Rodriguez
Dan Conybeare
Elizabeth Cook
Cathy G. Cooke
Virmarie Correa-Fernandez
Amanda Hauser Costello
Daniel Cox
Cassandra Jessie Crangle
Nicholas Charles Crimarco
Kate Cuno
Gina Curcuru
Christina Dardis
Ellen Van Ingen Darling
Tatiana Davidson
Kyle Davis
Timothy L. Day
Lindsey B. DeBoer
Lindsay Anna Deling
Katherine DellaPorta
Catherine L. Dempsey
Jessica Dere
Sonya S. Deschenes
Daniel Aaron Dickson
Rachael Dillon
Shira Dinar
Eleanor Donegan
Jennifer E. Donnelly
Tanya N. Douleh
Jacquelyn Doxie
Amy Kathryn Drayton
Jessica Dreifuss
Chris M. Duggan
Otylia Marta Dulnik-Hsu
Stephanie Dunkel
Ilana Dworin
Sara Jean Dyson
Martha C. Early
Theresa Elizabeth Egan
Marie Ehrler
Efrat Eichenbaum
JoAnna Elmquist
Laura Ely
Benjamin Emmert-Aronson
Hadassa Engelsohn
Lorena Escoriaza-Socorro
Emmanuel P. Espejo
Flint M. Espil
Nicole M. Evangelista
Laura E. Fabricant
Erin Fallis
Stacey L. Farmer
Samantha G. Farris
Jeniimarie Febres
Brian Feinstein
Nicole Feirsen
Elise Nicole Feldman
Thomas Fergus
Candice Festa
Margaret Feuille
Silvia Fiammenghi
Cassie N. Fichter
Yudelki Firpo
Lauren Fisher
Ellen E. Fitzsimmons
Meir Flancbaum
Lauren Beth Flegle
William M. Folberth
Vibh A. Forsythe
Meghan Regina Fortune
Shana Franklin
Tiffany Franzo
Rachel D. Freed
Elizabeth Freeman-Bain
Mayo Fujiki
Stephanie Fung
Jami M. Furr
Jessica Lyle Gahr
Nancy K. Gajee
Michelle Lee Gallagher
Colin Jarred Gallagher
Kathryn Gallagher
Sarah K. Galloway
Daniella N. Ganger
Steve C. Garcia
Christie Gardner
Sarah Garnaat
Melissa Garner
Alexander Geboy
Dalia Gefen
Sarah Elizabeth Gilbert
Lisa Hayley Glassman
Jessica Glowacki
Heather Glubo
Amy Goetz
Ashleigh Golden
Catherine M. Golden
Debbie Gomez
Michele Lora Gonen
Ana Maria Gonzalez
Christina LeighAnn Goodwin
Eugenia I. Gorlin
Kaitlyn Rose Gorman
Adam Gottlieb
Aaron John Grace
Troy Grassi
Elisa Grechi
Joshua Robert Greco
Amanda Lea Grodewald
Kathleen Marie Grout
Nicole Nina Grubisic
Patricia A. Gruner
Benjamin Grysman
Matthew David Guelker
Jamie Lynn Guelker
Maria Gurren
Angela Maria Haeny
Jonathan Houston Hagewood
Lauren S. Hallion
Karen M. Hamill
Ashley Sierra Hampton
Sonia Handa
Jessica Handelsman
Lori Handschuh
Kristen A. Hanson
Christine Adelaide Hanson
Rob Happich
Erez Harari
Katy Harper
Lisa Harrington
Mark Louis Hatzenbuehler
Katherina Hauner
Christopher G. Hawkey
Kirsten Hawkins
Jillian Haydicky
Veronique Hayek
Jacqueline Hyland Heath
Karin E. Hendricks
Angela Herle
Brooke Hersh
Kylee J. Heston
Stephanie Hicka
Mikaela J. Hildebrandt
Kaitlin Ashley Hill
Atara D. Hiller
Marchion Hinton
Laura Sachi Hiruma
Julia Hitch
Jessica Holdren
Lyda Eugenia Holguin
Lauren J. Holleb
Courtney Alexandra Hopkins
Katie J. Horsey
Elizabeth Ann Howarth
Ashley N. Howell
Maria Howell
Lorena Hsu
Kristen Hudec
Suzanne Lorraine Huggins
Genna Faith Hymowitz
Genevieve Izzo
Janelle R. Jackiw
Stephanie Jacobs
Anna Jadanova
Danielle Jahn
Urmi B. Jani
Brantley Jarvis
Deborah Jaspen
Jenna L. Jebitsch
Sherlyn Jimenez
Kirsten Elizabeth Jimerson
Brad Joachim
Katie Ann Johanning
David P. Johnson
Megan Jones
Jeremy S Joseph
Ashley Nicole Junghans

{Student members, continued}

Aaron W. Kaiser
Ewa Anna Kalicka
Marie Karlsson
Lara Beth Kassoff
Ayelet Kattan
Kelly L. Katuls
Aviva M. Katz
Shaina Jill Katz
Marcia Kearns
Crystal Keath
Quinn Dione Kellerman
Mackenzie Kelly
Chris Kelly
Shian-Ling Keng
Kalianne Kenny
Yelena Kholodenko
Tatyana Kholodkov
Marcia B. Kimeldorf
Andrea S. King
Sarah C. King
Carissa Kinman
Melinda Victoria Kirschner
Michael B. Klein
Paulo Knapp
Heather Knous-Westfall
Lauren Kochanek
Margaret Fox Koepke
Darryl M. Koif
Julie Kolzet
Daniel Cameron Kopala-Sibley
Aaron Kraus
Nicole Kreiser
Jason Krompinger
Ashley Eve Kronen
Jennie Kuckertz
Lynn Kufner
Elyse Gabrielle Kupperman
Katherine G. Kusner
Abbie Kwitel
Beth LaGrange
Lauren Lane-Herman
Danielle Kathleen LaRaia
Nancy Lau
Laura Anna Lauko
Richard Jason Lawrence
Sophie Lazarus
Sarah Beth Lazer
Yuen-Shan Lee
Tiffany Lee
Ember Lee
Angela Lee-Winn
Kristin Lemaster
Yat-Ming Jude Leung
Cheri Alicia Levinson
R. Eric Lewandowski
Erin Lewis Morrarty
Betty Liao
Jason Lillis
Teresa Ann Lillis
Lincoln Lim
Stine Linden-Andersen
Oliver Lindhiem
Ariane Ling
Lindsay Liotta
Nicole Lippman
Claire Goodwin Lisco
Tannah Little
Nancy H. Liu
Howard Liu
Graciete Lo
Amanda Gloria Loerinc
Allison Love
William Lu
Christina Luberto
Kristy Ludwig
Kelly Jean Luebkert
Jessica R. Lunsford
Jordan A. Lyon
Timothy L. Lyons
Jessica Madrigal-Bauguss
Joshua C. Magee
Leanne Magee
Marisa D. Mahler
Jordan Stuart Maile
Christian P. Maile
Olivia S. Maldonado
Sarah Mandel
Nicole Neleh Manns
Jaime Marrus
Angelika Marsic
Andrea L. Martin
Caitlin Ann Martin
Jessica Martin
Lindsay M. Martin
Jennifer Honculada Martinez
Jessica Katherine Masty
Amanda R. Mathew
Ali M. Mattu
Cortney Mauer
Alexis May
Heather Mazursky
Amber Elizabeth McCadney
Charles McClure
Jennifer L. McCollum
Megan McCrudden
April R. McDowell
Briana McElfish
Tara Caitlin McGahan
Morgan Lilith McGillicuddy
Eleanor McGlinchey
Catharine A. McRoy
Jared Reginald McShall
Kate McSpadden
Joshua Luke Medjuck
Jennifer Meeter
Stacey Lawrence Colton Meier
Michael Christopher Meinzer
Kyle Menary
Chloe Valentine Menon
Abigail Merin
Liza C Mermelstein
Rachel Ann Merson
Blair Mesa
Yeraz N. Meschian
Tatyana Mestechkina
Patricia L. Metzger
Joseph Meyer, III
Nicholas Mian
Patrick Michaels
Natalie Janina Michal
Elizabeth Anne Miller
Michelle Miller
Adam Bryant Miller
Rachel Lynn Miller
Hannah Lucy Mills
Dafne A. Milne
Jacquelene Farrah Moghaddam
Ashleigh R. Molz
Jennifer Monforton
Jessica Moore
Dawn M. Moot
Erica Grace Moran
Lucas Paul Kawika Morgan
Blair W. Morris
Samantha J Moshier
Ashley Moskovich
Lauren Moskowitz
Ryo Motoya
Nataliya Moubray
Emily Mouilso
Cara Marie Murphy
Amanda Murray
Sadia Najmi
Kentaro Nakajima
Maria Narimanidze
Andrea L. Nelson
Maria Nenova
Kate Newton
Mei Yi Ng
Andrew Ninnemann
Melanie Noel
Caroline Norris
Daniel Norton
Kathryn Noth
Jeremy Novich
Sara Nowakowski
Shoshana Nusbacher
Andrew P. Oakland
Olga Obraztsova
Kelli O'Brien
Emily Ocner
Shani Ofrat
Avital Sarit Ogniewicz
Megan E. Olden
Jessica Lynn O'Leary
Carissa Orlando
Elizabeth Mary June Orr
Melissa L. Ortega
J. Alexis Ortiz
Rebecca E. Osterhout
Magdalena Anna Ostrowski
Cortney Marrissa Panzarino
Corey James Patrick
Michelle Patriquin
Ben Paul
Michelle Pavony
Nicole Juszczak Peak
Pia Pechtel
Marianne Pelletier
Livangelie Perez
Meredith L. Perlman
Lori Ann Maria Perretta
Kristen Perry
Jessica R. Peters
Nicole Tavano Peters
Trevor J. Petersen
Emma Lee Peterson
Nicholas Petikas
Jenny Petrie
Bojana Petrovic
Mark Peugeot
Ani A. Pezeshkian
Errol J. Philip
Laura Mykell Philipp
Emily M. Pisetsky
Stephanie Raye Pitts
Scott Pizzarello
Anica P. Pless
Erin Kathleen Poindexter
Gina M. Poole
Alvin Poon
Mandy Porter
Carrie Michelle Potter
Jennifer Potts
Ashley Elizabeth Powell
Patricia Nicole Prescott
Angela Maria Prieto
Cara Elisabeth Pugliese
Connor Puleo
Adriane Itode Queiroz
Leanne Quigley
Yakeel T. Quiroz
Erin M. Rabideau
Archna Randall
Lance M. Rappaport
Kathy Rasmussen
Ariel L. Ravid
Kendra Louise Read
Xoli Redmond
Nicole Redzic
Melissa Reeves
Laura C. Reilly
Michelle M. Reising
Casey Michelle Reneau

Welcome, New Members

{Student members, continued}

Alexis Resnick
Jazmin Reyes
Graham Reynolds
Sarah E. Ricelli
Kolette Michelle Ring
Michelle S. Rivera
Donald John Robinaugh
Elizabeth Jenna Robison-Andrew
Matthew Roche
Jennifer Lynn Rodman
Maria Antonia Rodriguez
Kate Rogers
Perella Rooz
Diane Rosenbaum
Anna Rosenberg
Brendon David Ross
Philippe Roy
Sarah Royal
Ian Rugg
Maria C. Russo
Elizabeth Ryan
Maria C. Saavedra
Rebecca Sachs
Deena Sadiky
Cristian Camilo Saenz Moncaleano
Mia M. Sage
Kristin Elizabeth Salber
Francisco Isaac Salgado-Garcia
Nadia Samad
Kristen Sanderson
Shivali Noel Sarawgi
Moeko Sato
Michael Thaddaus Savenelli
Julia Savina
Antonina Savostyanova
Sarah Savoy
Anne Saw
Natalie Marie Scanlon
Heather Schatten
Nicole Schatz
Brandon F. Schechter
Kate Lauren Scherzo
Erin Renee Schmidt
Benjamin Schoendorff
Frederick J. Schoepflin
Meghan Schreck
Amie R. Schry
Jessica Schubert
Elizabeth Barbara Schuster
Danielle Schwartz
Jeremy A. Sears
Abigail Carole Seelbach
Danielle K. Seigers
Mayu Sekiguchi
Joshua Semiatin
Puja Seth
Siddhi J Shah
Sharon Shatil
Jena Ann Shaw
Christina Marie Sheerin
Sean C. Sheppard
Amanda Sherman
Keri Shiels
Nina D. Shiffrin
Joshua Gregory Shifrin
Yuki Shimaoka
Philippe Shnaider
David A Shwalb
Marc Anthony Silva
Caroline Silva
Emily Ann Silverman
Lilya Sitnikov
Meredith Leigh Slish
Adrianne Sloan
Susannah Q. Smedresman
Kimberly Dawn Smith
Rose C. Smith
Jocelyn Smith
Taylor Smith
Kelly Brook Smith
Leisha J. Smith
Rachel Diane Smith
Rosa Smurra
Elizabeth Jessica Smyth
Jeneane Solz
Laura Coleman Sorensen
Michael Jonathan Sornberger
Elina Spektor
Katherine Simpson Spencer
Clare Donnelly Spillane
Amanda M Spray
Laura E. Sproch
Todd Squitieri
Amy Starosta
Amanda Stary
Zachary Ryan Stearns
Brittany Sted
Victoria Stein
Elizabeth Steinberg
Emily Rebecca Stern
Joanna R. Stern
Maria-Christina Stewart
Caroline Stewart
Nina Stoeckel
Monika Magdalena Stojek
Jocelyn Stokes
Dorian Dunn Storbeck
Madalina Laura Sucala
Aimee Sullivan
Corinne Sweeney
Patrick D. Sylvers
Yael Taler
Angelique Teeters
John Terry
Michel A. Thibodeau
Kristine Michelle Thielman
Abigail Thompson
Adrian Dion Thompson
Johanna Thompson-Hollands
Nicole Thomson
Timothy Thornberry, Jr.
Neathery Alejandra Thurmond
Yvonne Tieu
Meghan Tomb
Letitia Elizabeth Travaglini
Lindsay Rae Trent
Theresa Noel Trombly
Meagan C. Tucker
Laura B. Turner
Jodi Z. Uderman
Aisha Usmani
Charles David Valadez, Jr.
Roberto Ruiz Valdez
Christine Van Gessel
Nathaniel Van Kirk
Anna Van Meter
Michael Patrick Van Wie
Julien-Pierre Vanasse Larochelle
Marie-Anne Vanderhasselt
Alison Vargovich
Vivek Venugopal
Matthieu Villatte
Anna L. Villavicencio
Kristine Vindua
Maria Vital
Rebecca K. Vujnovic
Lisa Wajsblat
Amber Lea Walser
Yanping Wang
Kathleen Erin Watson MacDonell
Ashley L. Watts
Chiaying Wei
Christina Wei
Jason S. Weingarten
Miryam Welbourne
Elena A. Welsh
Johanna Whitney Wendell
Angela Roethel Wendorf
Julia A. West
Alyssa Kai Wheeler
Mandi White-Ajmani
Kerry Whiteman
Sarah Ramsey Williams
Jessica Marlene Williams
Caitlin Wilpone-Jordan
Jennifer Ann Wilson
Susan Marie Wilson
E. Samuel Winer
Jessica K. Winkles
Nick Wisdom
Kate S. Witheridge
Noam Wittlin
Sheri Wolnerman
Maggie Lucile Woodrum
Don Wooldridge
Abigail Lyn Wren
Kristin Wyatt
Jennifer Yardley
Ilya Yaroslavsky
Vivian M. Yeh
Yeo-Gin Yun
Ana Zdravkovic
Karen Michelle Zhang
Jiaojiao Zheng
Rupa Puri Zimmermann
Erica Zucker
Karen Beth Zwillenberg
Daniel Paul Zwillenberg

Call for Web Editor

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

Web Page Mission Statement

The Web page serves a central function as the public face of ABCT. As such, it has core functions linked to the mission and goals of the organization: facilitating the appropriate utilization and growth of CBT as a professional activity and serving as a resource and information source for matters related to CBT.

Informational and resource activities are directed toward three conceptual groups:

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

Web Page Strategy Statement

One of the broader changes in the architecture of the Web page is that our content will now come up on searches. Accordingly, we need to plan content that will bring professionals and consumers to our site. The Web editor will need to liaise with associate editors, periodical editors, committees, and SIGs for content. Such content includes:

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

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

How to Apply

ABCT members interested in applying for this position should contact David Teisler, Director of Communications, ABCT, at teisler@abct.org.

DEADLINE: May 15, 2010

the Behavior Therapist
Association for Behavioral and Cognitive Therapies
305 Seventh Avenue, 16th floor
New York, NY 10001-6008
212-647-1890 | www.abct.org
ADDRESS SERVICE REQUESTED

April is election month

www.abct.org

Let the electronic voting begin!

Remember to cast your electronic vote.
If we *do not* have your email in our system,
then we mailed you a paper ballot.
If you did not receive voting materials
in any form, please contact the central office.