

# *the* Behavior Therapist

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### *President's Message*

## The Year in Review

Frank Andrasik, *University of Memphis*



It hardly seems possible that this is my final column as President of our ABCT. By the time this reaches your inbox, our annual meeting in San Francisco will have passed, the gavel will have been handed to our new President, Debra Hope (and I can think of no one better to accept the handoff), and I will have been put out to pasture as Past-President. Naturally this sets the occasion to recap the year. In my prior columns I have focused on our main priorities and accomplishments, making some gentle pushes to expand our boundaries, for behavioral medicine in particular. So many wonderful things are always going on behind the scenes that I wish space permitted me to draw all of them to your attention. However, I can mention only a few. I do want to thank all of the talented, hard-working members who, along with our excellent in-house staff, toil away behind the scenes day in and day out to make ABCT the vibrant, exciting, and growing organization it is. Did I say growing? Yes, as we recently achieved another milestone: 5,088 members. While many societies are struggling to keep their member bases, we continue to grow. We must be doing something right. Kristene Doyle, Hilary Vidair, Todd Smitherman, their committee members, and our staff receive much of the credit for this growth.

So, here is a quick recap of some of our many other accomplishments during the year. As you will see, many of the items listed below are designed to further one of our overarching goals—dissemination.

*{continued on p. 151}*

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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](mailto: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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*{continued from p. 149}*

ABCT's Self-Help Book of Merit program, under the watchful eye of Chair Jonathan Abramowitz, now has 30 books approved by the Board for listing on our website. These books cover a wide range of disorders. Our work continues as we research what the Committee and the Board feel are excellent examples of evidence-based treatment.

The Academic Training Committee, chaired by Kristalyn Salters-Pedneault, is aiding our dissemination efforts in other important ways, first by making course syllabi available to members. A novel initiative, recently approved by the Board, seeks to help the medical community find knowledgeable resources for teaching CBT, training that is now mandated. We anticipate this Medical Educator Directory to be much valued. For those of you who teach, don't forget to participate in our online Mentor Directory. Sustained effort has been directed towards getting *Cognitive and Behavioral Practice* approved for indexing by Medline. We were informed it would be discussed in October. We are keeping our fingers crossed for the outcome. Thank you,

Dara Friedman-Wheeler and Elizabeth Grosch, for shepherding this through the arduous review process.

Our journals continue to grow in stature, thanks to the capable editorial oversight of Tom Ollendick and Mauren Whittal. Our newsletter just keeps getting better and better under the leadership of Drew Anderson and his editorial team. Mitch Prinstein and his web crew are continually updating web offerings and linking ABCT with other sites to increase our web traffic (two examples are [psychcentral.com](http://psychcentral.com) and [effectivechildtherapy.com](http://effectivechildtherapy.com)). Other members are working to ensure accuracy in Wikipedia content pertaining to CBT, updating and adding new fact sheets (which now total about 40 titles on a variety of topics), developing podcasts, abstracting segments of interest from our video archives for more general release, and expanding our Find-a-Therapist offerings, to name just a few.

What is in the offing? Here is a quick peek.

As regards dissemination, our work is just beginning. Our next Strategic Planning Retreat is scheduled for May of next year. Although the agenda is yet to be

developed, you can bet considerable time will be spent discussing ways to further our dissemination efforts and ways to generate new sources of revenue to ensure we are around to carry out our dissemination plans. We will also plan for our 50th anniversary in 2016. Planning meetings are typically held every 3 years, but we postponed our 2010 planning meeting because of the considerable time and resources we needed to devote to co-hosting the World Congress in Boston. We will have devoted much of Board meeting time in San Francisco preparing for this planning meeting. Look to future presidential columns for updates from Debra Hope.

I close by once again thanking you for allowing me the privilege and honor of serving as your President. I wish Deb, our newly elected office holders, our newly appointed coordinators and chairs, and those continuing in these roles, a most successful new year.

. . .

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# The Mainstream News Media, Cognitive-Behavior Therapy, Psychodynamic Therapy, and Psychopharmacology: An Illustration Using *The New York Times*

Dean McKay, *Fordham University*

Have you read the news? If you have, you may have noticed that cognitive-behavior therapy (CBT) does not get a lot of press when it comes to scientific reporting in widely available newspapers and other print media. You may have also noticed that on the rare occasions that CBT does appear in the press, it is frequently deemphasized or cited as an adjunctive treatment to medication. If you follow mental health treatment in the news, you may have observed that, in contrast to CBT, medical and psychodynamic approaches enjoy far wider coverage, and in general with more favorable perspectives. In fact, compared to other forms of mental health treatment, CBT receives very little coverage overall. Psychopharmacology advertising permeates the television airwaves as well as frequent appearances in major publications, not just news outlets. Correspondents for major news networks are exclusively medical doctors, with notable examples including Dr. Mehmet Oz (on major network television, varying by market) or Dr. Sanjay Gupta (on CNN). As far as representation of mental health professionals, there are very few (i.e., Dr. Phil McGraw) and there are certainly worthwhile debates to be had as to whether empirically supported and efficacious treatments are adequately represented by these media personalities. There are important questions about whether the public is well served by these self-identified experts and the proliferation of “life coaches” or “psychotherapists” who appear in major media outlets and offer advice that is not substantiated by empirical findings.

One could adopt the position that CBT’s absence from the newspapers is not much of a concern. After all, newspapers and other print media have been declared dead or dying for the past decade, so why should we care that our approach to treatment is not getting any press. On an individual level, all

the CBT-oriented clinicians I know are very busy professionals (I can safely say I personally know a lot, although not necessarily a representative group, of CBT practitioners). So who is being harmed by the lack of coverage? The contrasting view, however, is that news will live on even if newspapers die, and we have an obligation to ensure that CBT is properly depicted in the media. And while many of us are very busy, how many are also frustrated by the degree that CBT is deemphasized relative to medication, which in turn sends a message to clients that, when change occurs, it can be attributed to drugs rather than therapy? How many are dismayed at the positive press given to approaches that suffer serious limitations in empirical support while CBT is ignored? Therefore, accurate coverage in the media is essential for our profession and for the public. The purpose of this paper is to describe the scope of the problem, contrast it with coverage of other mental health treatments, and offer some remedies for this problem.

With all the sources of information available, it is a challenge to fully appreciate the ways in which CBT is covered in the media. One way is to examine the coverage in a major newspaper or other outlet that reaches a wide and diverse audience. I hypothesized that there would be limited coverage in the *New York Times* (as a regular reader for the past 20 years, I was expecting limited coverage based solely on my exposure to very few articles related to CBT). Since this is intended to be a starting point for illustrating the scope of the problem in media coverage, the analysis of media coverage of CBT has been limited to the *New York Times* for this article.

## Method

For the purposes of this article, I examined the *New York Times*, which is acknowledged to be a paper of record for the United States. This search was for all articles dating

back to 1981, the earliest year for which entire articles are available on nytimes.com. Search terms were “cognitive-behavior therapy,” “cognitive therapy,” “behavior therapy,” “psychodynamic,” “psychoanalytic,” and “psychopharmacology.” Additional search terms related to other major therapeutic approaches were “interpersonal therapy,” “mental health treatment,” and “supportive therapy.” These last three search terms resulted in very few articles, and virtually all overlapped with the other major search terms. Therefore, the discussion of the search results will be restricted only to the terms related to CBT, psychodynamic therapy, and psychopharmacology.

## Results

### *Cognitive-Behavior Therapy*

When using the search term “cognitive-behavior therapy,” “cognitive therapy,” or “behavior therapy,” there were a total of 58 citations that appeared in the *New York Times* website as of this writing (September 24, 2010). This number reflects articles that depict the use of therapeutic interventions after excluding letters, book reviews, or obituaries. The first of these articles appeared in 1986 (Boffey). This article, appearing 24 years ago, depicted CBT as a new treatment, and listed it alongside interpersonal psychotherapy as equally effective in treating depression. Since that time, a wide range of articles have appeared discussing the efficacy of CBT in the treatment of other psychological conditions. Surveying these articles, 43 (approximately 75%) either compared or contrasted CBT to medication, and uniformly CBT was described as a new (or newer) form of therapy.

### *Psychodynamic Therapy*

A reasonable follow-up question to the scope and adequacy of CBT coverage in the media is whether other mental health treatments are handled in the same way. In the case of the *New York Times*, we see that this is not the case. Again, searching the *New York Times* site using “psychodynamic” or “psychoanalytic” as search terms revealed 79 articles. Of these 18 were letters, obituaries, or book reviews, and surprisingly, one political editorial and one political news analysis. This leaves a total of 61 articles relating to the more general psychodynamic approach to therapy. In contrast to those covering CBT, these generally did not compare psychodynamic therapy to medication. In fact, only 17 compared or contrasted psychodynamic approaches to medication (approxi-

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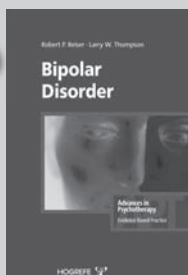
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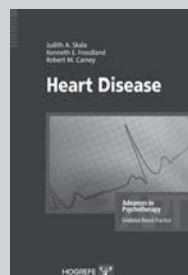
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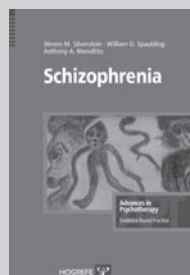
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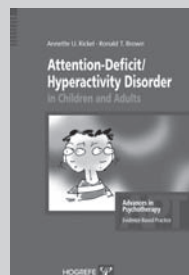
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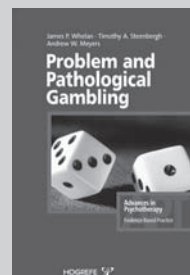
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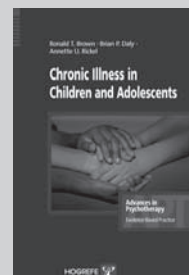
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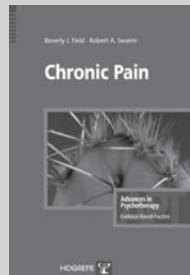
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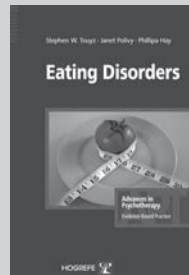
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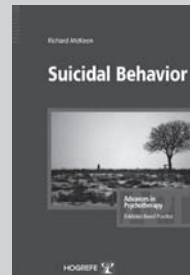
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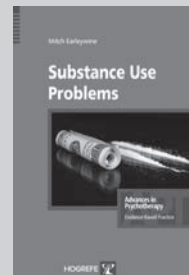
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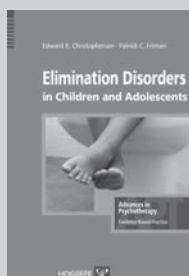
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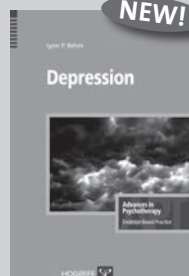
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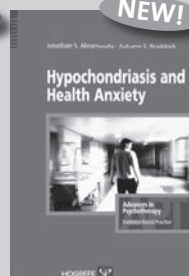
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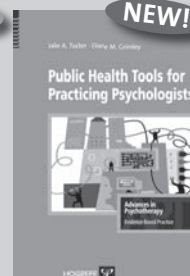
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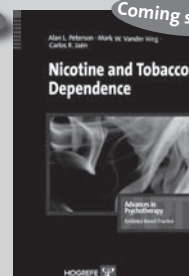
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mately 28%). Further, several recent articles in this group highlighted benefits of psychodynamic therapy in the title, or devoted the entire article to the approach. For example, one article covered a study examining psychodynamic treatment for panic disorder (Carey, 2007). Another reported on a recent meta-analysis published in *JAMA* (Leischenring & Rabung, 2008) showing favorable outcome for psychodynamic therapy (Carey, 2008).

### Psychopharmacology

Using this term alone results in 161 articles when searching the *New York Times*. Although this is not the only source of articles related to medical approaches to mental health treatment that might be referenced in the *Times*, allow me to restrict it to this single term since it clearly isolates articles expressly related to mental health treatment, and provides adequate balance to the other two areas covered whereby there were few available search terms. Of the 161 articles identified, 53 were letters, obituaries, book reviews, industry news items, political news analyses, or wedding announcements (where one or the other to-be betrothed listed psychopharmacologist as the profession), leaving 108 articles related to psychopharmacology. Unlike the coverage of either CBT or psychodynamic treatments, the coverage of psychopharmacology was generally centered on the nature of illnesses different medications treat, recent efficacy trials, or their use with other treatments. This is not surprising: Medication articles in general focus on conditions and efficacy as the implementation of drug therapy is commonly understood by the public, but the range of conditions each specific pharmacologic agent treats may be less known. These articles, as a group, typically raised the medication issue early.

### Discussion

The results of this brief search analysis of the *New York Times* illustrate several important issues that CBT faces in the media. First, it is rare to see articles devoted to CBT that do not contrast the approach with medication, and note limitations in CBT that medication can help to overcome. In short, CBT, when portrayed favorably, is not shown to be adequate as a stand-alone treatment. This stands in contrast to the available evidence. Chambless and Ollendick (2001) discussed the controversies surrounding empirically supported treatment and listed the protocols that met criteria for well-established empirically supported, probably efficacious, and promising treatments, with the majority arising from CBT-based approaches. CBT is also typically referred to as a “new” approach to treatment. This too reflects an inaccuracy—only one article cited when CBT was developed in order to reflect its more mature status (Goode, 2000). As an organization that was formed for the express purpose of advancing CBT (hence its former name, Association for Advancement of Behavior Therapy), we are now enjoying our 44th year. This would make CBT “new” only in glacial or evolutionary terms.

To be fair, the contrast with medication is part of a larger national orientation toward pharmacological treatment. For example, the National Institute of Mental Health (NIMH) stresses medication approaches in the treatment of anxiety disorders, and until recently to the exclusion of CBT (Taylor, McKay, & Abramowitz, 2010). Nonetheless, the bias toward medical treatments in the media extends beyond interventions condoned by NIMH. To illustrate, recently the *New York Times* ran a cover story on the potential efficacy of hallucinogens for a wide range of psychiatric disorders, including obsessive-compulsive disorder, posttraumatic stress disorder, and several addictions (Tierney, 2010).

When CBT is covered, where is the emphasis? While my account is not intended as a comprehensive scientific rendering of the available literature, the results are not encouraging. Of the limited articles appearing in the *New York Times* related to CBT, one gives CBT the shorthand “talk therapy,” whose title would appear to extol the virtues of the approach for child and adolescent depression (Carey, 2007). The article did not otherwise describe the methods underlying CBT. The use of the generic label “talk therapy” conflates CBT in the public eye with traditional psychotherapy and diminishes the unique place it occupies in the scientific literature. Another article describes the life lessons gained from depression (Lehrer, 2010), and only after more than 70% of the article (covering 7 linked pages) is CBT mentioned, helpfully in a favorable comparison against medication.

It would appear that the scope of the problem, overall, is considerable. The media tends to ignore CBT and its scientific merits. On the rare occasions it is covered, it is recommended as an adjunct to medication, or is described late in the article. While this was culled from only a single newspaper, it is reasonable to make this conclusion more broadly, given the enormous impact of the *New York Times*.

While the coverage of CBT has been generally inadequate with respect to efficacy, the outlook for psychodynamic therapy remains better, even if the approach is possibly in decline. For example, just as with coverage of CBT, there are articles that bury any discussion of psychodynamic therapy in the latter portion. However, unlike CBT, there are several recent examples where psychodynamic approaches are lauded, with little or no mention of medication or CBT as alternative methods. Interestingly, whereas psychodynamic therapy enjoys favorable coverage in the *New York Times*, some articles highlight the difficulties faced by psychodynamically oriented practitioners, despite negligible negative citations regarding the approach (i.e., Goode, 1999). Prior to the appearance of this aforementioned article, I could find no articles sounding a death knell to psychodynamic therapy. It did anticipate, however, by 2 full years, an influential paper detailing the difficulties that psychodynamic practitioners face in the marketplace and in scholarly circles (Bornstein, 2001).

### Remedies for the Problem

As I developed this article, I was surprised at just how little our field is covered

**Table 1. Search Results From the *New York Times* (1981–2010)**

Search Terms	Articles descriptive of approach or related to efficacy	Term appears in other articles
“Cognitive behavior therapy” “cognitive therapy” “behavior therapy”	58	12
“Psychoanalytic therapy” “Psychodynamic therapy” “Psychopharmacology”	61 108	18 53

in a major news outlet like the *New York Times*. Bear in mind that not only is this a newspaper of record that is widely read across the United States and the world, it has a weekly science section, and regularly covers scientific findings in its main section. So what are we to do, short of identifying a CBT cultural icon, list our primary therapeutic orientation in wedding announcements, or cause a political crisis that involves our specialty?

One recommended approach is to respond promptly to limited or inadequate coverage of CBT via letters to the editor of different publications. This sounds obvious, but the number of letters I counted in my searches suggests this is less widespread than would be expected. The value of adopting such a regular response system is newspaper and other media editors will have CBT in mind when it is raised in future articles, and there may be an increased inclination to cover the approach more fairly.

While the letter-writing approach is helpful, it is necessarily reactive and does not provide a long-term remedy to how CBT is presented in the public, and could hamper dissemination efforts. McHugh and Barlow (2010) recently highlighted the difficulties in disseminating empirically supported treatment, in particular via programmatic implementation through state and federal agencies. The media may serve as a means to prepare providers to accept an empirically supported approach if it is covered vigorously and actively by practitioners who espouse the treatment methods. This is essentially a grass-roots perspective whereby practitioners are more likely to seek out the necessary training, and the public are more likely to be adequately informed consumers regarding CBT. Therefore, a proactive approach would be to advocate that local, state, and provincial psychological associations advance CBT in the public sector, which in turn would lend greater credence to media outlets of the appropriateness of CBT. In some states this may turn out to be more of a challenge than it might appear. Sticking with the New York theme, a recent article by the current President of the New York State Psychological Association (NYSPA) appeared in the association newsletter (*NYSPA Notebook*) where traditional psychoanalytic therapy was strongly advocated, despite the limited empirical evidence (Northrup, 2009). Indeed, in psychodynamic circles the lack of specific mechanisms is a selling point that has recently been vigorously advanced as a justification for psychodynamic therapy (Shedler,

2010). This means that a major approach to therapy that has limited established efficacy over CBT and virtually no support for a major mechanism (symptom substitution) is also extolled by its practitioners for these very same attributes (McKay, in press). So, it would appear that in order to gain the necessary traction with the wider audience of practitioners, the message has to be delivered frequently and forcefully.

Other proactive grass-roots efforts at disseminating the efficacy of CBT would involve direct contact between providers and other medical professionals who might otherwise simply recommend psychotherapy. Some examples include dissemination of brochures that describe CBT that would be placed in patient waiting rooms (such as the already available Fact Sheets that ABCT produces); descriptive flyers for posting in hospital and clinic settings whereby CBT is briefly described in order that clients may request a specific and empirically supported approach to treatment; and contacting public relations personnel at hospitals and clinics in order that local, state, and national media may receive better information regarding CBT.

One additional recommendation would involve contacting newspaper and other media outlets regarding articles related to CBT and its efficacy. In light of the coverage accorded CBT in a major outlet like the *New York Times*, it is reasonable to assume that many editors of different outlets have limited knowledge or awareness of CBT and its scope of efficacy; if the approach is known, it may be to a very limited extent. This may not be a barrier in that there is a large representation of empirical articles in the scientific literature that supports the use of CBT. Further, while CBT does not have its own division in the American Psychological Association (unlike both Psychodynamic therapy, in Division 39, and Psychopharmacology, in Division 28), we enjoy very high representation in Division 12 (Clinical) and in Section III of Division 12 (Society for a Science of Clinical Psychology). There are many other professional organizations in which the membership is heavily tilted toward CBT (i.e., Society for Behavioral Medicine; American Psychological Society). Therefore, the range and scope of possible topics for which CBT could be covered in the media is vast, and there are numerous professional groups in addition to ABCT that could serve as strong representatives of the approach. This would lend far greater legitimacy to any news report documenting CBT's efficacy.

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The purpose of this article was to highlight how CBT is portrayed in the media. It is important to note that this analysis is limited by the restriction to the *New York Times*. However, based on this analysis, it seems safe to conclude that its coverage is "light" and does not go far enough in promoting its efficacy. This is particularly salient in contrast with other mental health treatment methods, where coverage is more extensive, or at the very least, more favorable. This does not include portrayals in film or other media, but primary news and science media. It is my hope that we can begin to look to ways of increasing our exposure in different media outlets to reach a wider audience and inform the public to a greater extent. Increasingly, consumers seek our brand of treatment, and in this way, CBT practitioners have accomplished a great deal. However, oftentimes prospective clients only know the initials, and have heard it is effective. But in the presentations provided in the news, it appears likely that many clients cannot appreciate the full range of efficacy of CBT, or have diminished expectations when it is considered adjunctive to other mental health approaches.

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## Recommendations From Community Experts on the Development of Implementation Strategies for Embedding Evidence-Based Treatments in Community Settings

Valeri O. Anukem, *Western Psychiatric Institute and Clinic*, Joyce E. Blackburn, *Allegheny Children's Initiative*, Colleen D. Gianneski, *Family Services of Butler Memorial Hospital*, Amy D. Herschell, *University of Pittsburgh School of Medicine*, Carol A. Hughes, *C. A. Hughes and Associates*, Meghan M. Probst, *Sarah A. Reed Children's Center*, Meghan E. Shaver, *Western Psychiatric Institute and Clinic*, and Patricia R. Taylor, *Partners for Quality, Inc.*

Current research suggests that although a large number of consumers receive mental health treatments in community-based mental health agencies, evidence-based treatments (EBT) remain underutilized in community settings (Street, Niederehe, & Lebowitz, 2000). Many reasons have been cited for this divide, including that trainings for EBT have not been empirically informed or supported (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). Sanders and Murphy-Brennan (2010) agree that there is a significant need for EBT training to be more efficient and effective, and explain that policymakers currently solicit the advice of "expert advisory panels" in order to determine the most efficient way to implement EBTs. Experts can provide great insight; however, there seem to have been fewer efforts to solicit the recommendations of the community practitioners who are participating in EBT training. Community-based practitioners likely can add a valuable perspective to EBT training given that they often know their communities, consumers, and constraints better than treatment developers, researchers, or other outside experts.

A training development workgroup meeting was held as a component of a grant funded by the National Institute of Mental Health (K23 MH074716) that is focused on the collaborative development and testing of a theoretically and empirically informed training protocol for an EBT. A total of eight people participated in the 16-hour workgroup: four clinician/supervisors representing four community-based mental health agencies (JEB, CDG, CAH, MMP), one training director from a large mental

health agency (PRT), one experienced EBT trainer (MES), the principal investigator (ADH), also an experienced EBT trainer, and the research assistant (VOA) of the project. Community partners involved in this workgroup had been participating in the larger project (K23 MH074716), Project Connect: Connecting Research and Practice, for a variable amount of time ranging from a few months to 6 years. Due to the aims of the larger project, the PI originally approached the included agencies because they had been identified as providing a large amount of behavioral health services to children in child welfare by their county child welfare administrators. Care also was taken to ensure that agencies serving rural and urban populations were included and that each agency was located in a different county because Pennsylvania is a state where there is considerable variability in behavioral health policy across counties (e.g., managed care companies vary by county). The following is a compilation of specific recommendations from community partners on EBTs, their trainings, and suggestions on ways to incorporate such treatment models and trainings into community-based mental health agencies.

### *Develop a Supportive, Learning-Centered Environment Within the Community-Based Mental Health Agency*

The importance of the larger organizational context in an EBT implementation process has been highlighted by several researchers (e.g., Aarons, 2006; Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009; Glisson et al., 2008). A positive organizational culture likely contributes to lower therapist turnover and increased sus-

tainability for a new program (e.g., Glisson et al.). Implementation models that consider therapist, client, and organizational variables are often the most successful in supporting change of therapist behavior (i.e., improving therapist adherence, competence, and skill; Beidas & Kendall, 2010).

### *Involve Supervisors Early and Keep Them Actively Involved Throughout the Implementation*

Supervisors are a valuable, but sometimes overlooked, resource. Supervisors' knowledge of their own agency, community, and resources (Paterniti, Pan, Smith, Horan, & West, 2006) is likely just as important to an implementation initiative as the training itself. Supervisors are often able to appreciate the value in a new initiative and convey that importance to supervisees through informal and formal interactions as an opinion leader (e.g., supervision meetings; Budman & Armstrong, 1992; Dariotis, Bumbarger, Duncan, & Greenberg, 2008).

Implementation initiatives should consider the unique needs and position of supervisors, and accordingly, should have separate components for supervisors. For example, information should be provided to supervisors on how to: (a) integrate the training and treatment into their context, (b) motivate staff to participate in training, (c) supervise the EBT, and (d) train new clinicians as they are hired. In addition to participating in training with clinicians, supervisors should be consulted on the development of the implementation initiative structure (when possible) and be provided with information about the training and treatment as early as possible in the process.

### *Assess Clinicians' Attitudes, Knowledge, and Skills Prior to Training*

In community settings there are often varying levels of education, experience, knowledge, skill, and interest in new approaches among clinicians. It should not be assumed that because a clinician has a graduate degree that he or she can provide an EBT with minimal training (Budman & Armstrong, 1992). There is an amazing amount of heterogeneity among clinicians, which is valuable and necessary in agencies given the heterogeneity among clients who are seen in community settings. However, heterogeneity among clinicians may be an obstacle to the implementation of an initiative if the implementation initiative does not account for differences across clinicians. For example, some clinicians may have con-

siderable training in treatment approaches that are less structured and directive than most EBTs. Completing a pre-implementation assessment of clinicians' experience, knowledge, skill, and interest would help to: (a) provide a baseline assessment, (b) inform the trainer of these differences, which would allow him or her to fit training to the current learning level, and (c) help clinicians to set goals, which could result in an increase in their level of commitment (Budman & Armstrong). It also may be beneficial to assess each clinician's readiness to incorporate an EBT into their current style of treatment delivery. If a clinician is not comfortable changing their current delivery style, consumer outcomes for a new initiative may be negatively affected (e.g., Dariotis et al., 2008).

#### *Work to Ensure That Clinicians Enter Training With Similar Levels of Knowledge and Readiness*

When learning any new model, there is core, knowledge-based content that needs to be learned. Most implementation initiatives involve instructor-led, workshop-style trainings. One alternative to presenting all knowledge-based content within an instructor-led training is to assign knowledge-based work prior to training. This can help to ensure that clinicians enter training with similar levels of knowledge. Pretraining work can help to shorten instructor-led trainings and/or allow more time for sessions to incorporate active learning strategies like role-play, feedback, and skill demonstration. To promote pre-work completion, it may be necessary to attach contingencies to the assigned work (e.g., a person can not enter into the training without verification of completion of the assignments or until he or she has passed a knowledge exam).

It may be helpful for administrators to meet individually with their staff and supervisors to speak with them about training expectations, their level of commitment, and to proactively address questions or concerns with the implementation of a new initiative. This type of meeting will help clinicians to know the expectations of the initiative prior to its implementation so that they can make an informed choice about participating in training and set their own goals and expectations accordingly (Bowen & Martens, 2009). This can even take the form of a commitment contract.

#### *Understand the Community Agency's Criteria for a Good Trainer*

When implementing an initiative in a community agency, it may be useful to consider what trainer characteristics are valued. Often, in a university setting, publications, grants, and awards highlighting a level of recognition as an expert academic are valued. However, community agencies may value practical experience over academic accomplishments. It is often easier to relate to a trainer who you feel "gets it" and has "walked in your shoes." This may call for a trainer who is well balanced in both research and current applied experience or who is more clinically focused. It also likely will be helpful for the trainer to understand the social context of the organization and the larger community. The trainer must possess strong communication skills such that he or she is able to listen, take in questions, and provide practical, clinically- and community-relevant feedback.

#### *Understand the Community Agency's Criteria for a Good Training*

Community agencies may have different motivations for implementing new initiatives and often value initiatives that aid in fulfilling requirements imposed by local legislation, referral sources, and/or funding sources. Understanding these motivations and requirements will likely help the success of the initiative. For example, insurance companies, courts, and other government agencies (e.g., Child Protective Services) give referrals to and request evaluations from community agencies. If the EBT training helps to satisfy some of these requirements, it can enhance the commitment to the EBT. For example, government agencies often consider whether the community agency's treatments improve family functioning (or similar outcomes). They may take into account if treatment produces a noticeable decrease in aggression or prevents escalation of problem behavior. If part of the EBT training initiative helps the community agency find reliable ways to measure such outcomes, it will help to embed the EBT into the organization by making it useful in fulfilling requirements. Similarly, if possible, continuing education credits, including ethics, should routinely be offered as part of an EBT training initiative.

#### *Begin Training at Optimal Times in the Year and Allow for Continual Entry, Exit, and Reentry Into the Training*

Implementation efforts may be influenced by events that cannot be controlled by the clinicians or the trainer (e.g., pregnancies, health concerns, family caregiving) that influence clinicians' availability for parts of the training. When feasible, the implementation plan should account for possible breaks in clinician's availability for training so that people can easily enter, exit, and re-enter the implementation initiative.

Additionally, there are certain times of the year when people might naturally be more available for training. Implementation efforts during the summer and holiday times may be difficult due to the high rates of travel and vacation. Ideal times to start training are the fall season, between September and November (a time generally correlated with the beginning of the school year) or between January and April.

#### *Consider the Pros and Cons of In-Person Versus Technology-Supported Trainings*

Given the various forms of technology-supported communication that are now available (e.g., videoconferences, live lectures or web casts), it may be difficult to discern which would be the most useful for implementation initiatives. Although technological advances may offer several advantages (e.g., cost-effective, available anytime, anywhere), the technological sophistication of the organization and clinicians must be considered. For example, some agencies have a limited number of computers or phones, older computers that often run slow or freeze, or limited Internet access that blocks unknown addresses, so they would not be able to fully benefit from such trainings. In addition, these forms of trainings can be perceived as impersonal and monotonous, causing a disinterest in training altogether. Organizations and clinicians (at least initially) may prefer in-person training and may value the personal and interactive experience.

#### *Hold Frequent Short Trainings Instead of Infrequent Long Trainings*

When deciding on the structure of an implementation initiative, it is important to consider the productivity of the agency and individual clinician. Often clinicians must work a given number of billable hours to maintain agency productivity. Implementation of a new initiative takes away from billable hours. It would be ideal for agency administration to reduce productivity

demands for the training period; however, that is not always fiscally possible. Therefore, it may be helpful to abbreviate training days (e.g., 9:00 A.M. – 2:00 P.M.) so that clinicians have time to see clients. Also, to save time for clinicians, it may be beneficial to train at the agency instead of an alternate location. Rather than full training days, it may be helpful to hold fewer hours of training over an extended period (e.g., 2 hours once a week for a month). However, these recommendations place a notable burden on the trainer.

### ***Break Content Down Into Smaller Pieces and Teach Content Step-by-Step***

When learning a new EBT, it may be beneficial to take a step-by-step approach rather than providing a large amount of information at one time. Each EBT contains multiple pieces of content and skills that might be challenging to new learners. In addition to content, there are skills such as incorporating an active, directive therapy approach; using specific assessment tools to guide treatment; and collecting and monitoring program data that all have to be refined over time. Implementing a new initiative gradually by first training on a component, allowing practitioners to master those components, then moving on to the next portion of the training may result in more efficient mastery of the EBT.

As behavior therapists know, just as a person cannot learn to play tennis by watching a match, it stands to reason that clinicians cannot learn to provide a treatment by passively listening to a lecture or by watching others (Budman & Armstrong, 1992). It is useful to incorporate as much interactive learning as possible. Also, if clinicians personally and successfully practice the skills, they may be better able to teach the skills to their clients. For example, if the clinician has used breathing exercises for his own emotion regulation, then he may be better able to teach this skill to a client.

### ***Incorporate Skills Assessments and Feedback Throughout Training***

Feedback on skills learned is often one of the most important components of an implementation initiative. Feedback provides reinforcement for skills accurately displayed and facilitates the improvement of others. Additionally, a formal skills assessment is useful in order to track the progress of each clinician. However, one major skill assessment at the end of implementation can be anxiety provoking and stressful for clinicians.

It may be beneficial to build skill assessments into the implementation at various stages of the process. For example, skill check-outs could be built into existing role-play exercises. When possible, skills should be assessed on current cases. Video-recording and/or audio-taping clinician sessions can provide an ideal way of assessing their skills as they actively use them. This will also enable the trainer to give feedback as the session is reviewed. Given the amount of time it could take to perform these assessments individually for a large group of clinicians, it may be beneficial to build in peer-to-peer consultation by dividing clinicians up into pairs or groups for peer assessments and feedback in order to ensure that every clinician consistently receives these components. With this format, clinicians can have an opportunity to share their experiences and receive feedback. This can also foster a community within the agency where clinicians view each other as support for the implementation of the treatment. If the skills check is part of the implementation process, it will allow for a continuous evaluation of progress without the pressure of an intimidating large exam at the conclusion of implementation.

### ***Include Job Aids***

An obstacle to the implementation of an initiative may be the training materials. Often the manuals developed for various EBTs are dense and academically focused. Given the mobility of community clinicians, it may be difficult to carry such manuals from session to session. It may be challenging to adhere to the manual if the clinicians have to spend time finding each session within the manuals.

Consider including an abbreviated reference or prompt that outlines each session's goals and key concepts so clinicians can use the handout as a quick reference to stay organized and refer back to it as necessary (Dariotis et al., 2008). It may be useful to also include handouts that can be incorporated into each session to help clinicians and clients structure their sessions. If job aids are included, it may be beneficial to incorporate a component into the implementation process that teaches clinicians how to effectively use and incorporate the job aids, and one that teaches supervisors to integrate the handouts into their agency standards and supervision sessions. Other helpful job aids include sample treatment goals and plans as well as progress notes.

### ***Provide Clinicians With Ongoing Support Following the Completion of the Training***

Due to the uniqueness of every client, unforeseen questions often arise as clinicians work with various clients. Ongoing contact from an expert trainer can facilitate continued learning and application (Dariotis et al., 2008; Herschell et al., 2010). In addition, it may be useful to have at least one identified expert or lead clinician within the agency who will serve as the intermediate resource responsible for answering questions in between external trainer follow-ups. This could be a supervisor or a clinician who was previously trained on the treatment. This can allow the agency to become self-sufficient and could result in less need for the external trainer. A monthly "booster session" with the trainer could provide a forum for keeping clinicians updated with new EBT innovations as well as for providing clinicians the opportunity to ask questions (both general questions and ones specific to their cases) and learn the different styles of others through case presentation and conceptualization (Budman & Armstrong, 1992).

In summary, these recommendations from community partners are meant to reflect the community's perspective (which is often underreported in the EBT implementation literature) and to highlight some factors worthy of considering when planning and conducting an EBT implementation initiative. While we might have once hoped that EBT implementation would be simple, it is now clear that to be successful, the implementation process must be active, include several core components that impact multiple levels of the mental health delivery system (Fixsen, Blasé, Naoom, & Wallace, 2009), and involve strong collaborative partnerships between academic and community stakeholders. There is also some evidence to suggest that an implementation initiative that results in routine use of the innovation (in this case an EBT) will likely take 2 to 4 years to complete (Fixsen et al., 2009).

Notable is that many of the recommendations provided are complex, time-consuming, and (perhaps) logistically challenging. They also are based on clinical wisdom, rather than science, which is a significant weakness. Much could be gained by establishing a stronger research base for the implementation of EBTs (e.g., Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Sholomskas, Syracuse-Siwert, et al., 2005). EBT implementation is difficult, in part, because it involves a "soft technology" (Hemmelgarn, Glisson, & James, 2006)

and often requires therapists to significantly change their behavior. EBT implementation also requires an ongoing and effortful commitment to a more evidence-based culture that recognizes the value in collecting data and using it to guide decision making (Chaffin, 2006). Given the possible challenges for community-based clinicians, it seems particularly important to listen to and incorporate their feedback on one component of implementation: training.

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## Research Forum

# Tips on Writing National Research Service Award Predoctoral Fellowship Proposals From Real NRSA Reviewers

Greg J. Siegle, *University of Pittsburgh School of Medicine*, Sheri L. Johnson, *University of California, Berkeley*, D. Erik Everhart, *East Carolina University*, and Tamara Newton, *University of Louisville*

As National Research Service Award (NRSA) training grant (F31, F30, F32) reviewers on the F12B study section devoted to Psychopathology, Developmental Disabilities, Stress, and Aging, we often see applications that conform to the “letter” of the program announcement but that receive suboptimal scores for common, preventable reasons that might be difficult to intuit before sub-

mission. Here we have assembled a collection of recommendations from NRSA reviewers that will hopefully address many of these considerations. A second goal is to highlight features of the most successful applications that we review. We have geared our comments specifically for predoctoral applicants applying for the F31 mechanism, but most of what we say also applies to the other NRSA mechanisms. There are, of

course, exceptions to most of what we have said below, and our points are probably best thought of as general characteristics of successful applications rather than hard and fast rules. Importantly, this is not an official document. It has neither been endorsed nor constructed by NIH representatives, program officers, review officers, or staff.

### Process

#### Read Up

Visit the F kiosk ([http://grants1.nih.gov/training/F\\_files\\_nrsa.htm](http://grants1.nih.gov/training/F_files_nrsa.htm)) and read the program announcement and the guidelines for how F awards are evaluated. To get a feel for what reviews are like, read the sample F critique (National Institutes of Health, 2010).

#### Write the Application With Your Mentor

It is helpful to write the application with your mentor. It is easy to spot applications into which the mentor had little input, par-

ticularly if the applicant does not seem to know the field or the mentor's work well enough. Make sure the mentor has read the application and has had time to comment on it before it goes out.

### *Plan Ahead*

Most successful F31 grants are resubmissions. Our timeline for writing a K-award (faculty career award) may be a helpful guide in preparing to write your F31 ([www.4researchers.org](http://www.4researchers.org)).

### *Biosketch*

Use your personal statement for a scientific (not the rest of your life) biography of where you have been and what your professional aims are. Ideally, it should lead directly to the proposed project and from it.

In your personal statement, differentiate yourself from your sponsor—you should be working toward a career that is not exactly the same as the sponsor's. It can have similarities, but the reviewers want to know you will not be a clone, and that you are capable of original ideas.

List in-press, submitted, and in-prep publications. Also, list your presentations separately. For an F31, you should have at least one published or in-press publication and ideally more than two, with one first authorship to be competitive. If you do not have at least two publications, this is something that should be addressed in your sponsor's letter, ideally with a plan for increasing publications. For an F32, having at least three papers is useful to be competitive.

Listing your grades and GRE scores is important, so do not omit them. Telling the reviewers the percentiles for your scores is helpful. If your grades were terrible early in your undergraduate years, you might want your sponsor to note that your circumstances, motivation, or other factors have improved.

## **Training**

### *Career Development*

Take the career development sections seriously. Your sponsor should describe your career development plan in detail in the beginning and then you should describe it at the end under "goals for fellowship and training." Both should be multiple pages, long and very explicit. The content can be virtually duplicated but from the perspectives of your advisor and you.

### *Training Activities*

Proposed training should be above and beyond that which you would otherwise receive in your graduate program. Otherwise, reviewers may think that you do not need the grant to get the proposed training. Think about specific skills that you need to go further in your career, such as advanced statistical expertise to help you with longitudinal or trials data, new ways of analyzing fMRI or psychophysiological data, training in psychopathology, and so on. If you are proposing to use a specific technology, such as fMRI, proposing to take a course or workshop in that technology—to either obtain or hone your skills as a scanning maven—can be very useful.

Ideally, the proposed training should not deviate too far beyond the skills used in the research protocol. So, if you are going to associate coursework with the proposal, it is helpful to say how you will use it in your proposed research. It is rare that including much clinical work, teaching, or graduate courses unrelated to the research in a proposal would be perceived as helpful unless such activities clearly enhance the applicant's ability to complete the proposed research.

The ideal coursework is more than what you would already be gaining in your program, and enough that you can move ahead with your proposed research career. Both of these features should be noted. Proposed training should help you differentiate yourself from your sponsor so that you can have a different research career. So, if you are proposing to work with a clinical population and do not have explicit training and background with clinical populations, you should propose to get training in that clinical area—at least a course in the pathology (or if appropriate, psychopathology), and ideally spending time outside the research protocol with people with the pathology. Individual supervision should supplement your experiences learning about psychopathology. Experience in diagnostic interviewing seems to be particularly important for aspiring psychopathology researchers: Otherwise, the committee may suggest you will be unqualified, at the end of the day, to do independent work with clinical populations. Be careful not to overstate what you will be able to do based on your level of training (e.g., if you are not a clinical psychologist, you should likely not be assigning diagnoses of schizophrenia). Unless your primary goal is to be a statistician, if you are proposing only retrospective data analysis for your primary research pro-

ject it is useful to say that you will also have training experiences interacting with actual people, particularly doing some relevant data collection, so that when you are done it is clear you can stand on your own.

It is useful to propose skills-building activities in manuscript and grant writing. Consider including an agenda for writing papers, attending conferences, and learning skills for grant writing. Bill Gerin's (2006) *Writing the NIH Grant Proposal: A Step-by-Step Guide* is good reading in this regard.

### *Choose Your Sponsors and Consultants Carefully*

It is helpful to choose a sponsor who is an expert in the research area of the proposal, has published a bunch and, ideally, has mentored other NRSA or K-awardees. If your sponsor does not have a strong track record of mentorship, it is useful to bring on a cosponsor who does have a strong track record of mentorship. Reviewers will also expect the sponsor to have funding in the proposed research area. If the sponsor does not have that specific funding, or if the funding will end during your award period, it is worth commenting about how other existing funding (e.g., start-up funds or other mechanisms) can be used to support your work.

It is helpful for the sponsor to be local, ideally at your institution. If your sponsor is not at your institution, showing that you have a track record of working with your sponsor face to face, despite location, particularly going regularly back and forth from the sponsor's institution, can be helpful.

It is often helpful to have more consultants than just your sponsor. Ideally there should be consultants capable of advising on every aspect of your proposed work. For each sponsor/mentor/consultant you should say exactly what his or her unique (i.e., nonoverlapping) contribution will be, and specify your particular involvement with each of them. For example, if you want to use a technology that your advisor has not used in published work, seek a consultant who will train you in those methods. If your project involves studying a form of psychopathology or comorbidity that your advisor is not expert in, seek a consultant to cover that area. All consultants should be well-published in their areas.

It is often helpful to have a statistician versed in your research area as a consultant. Having the statistician read the application before it goes out, and help with writing your analysis plan gets you lots of extra bonus points.

For applicants proposing to learn neuroimaging, having a physicist and MR statistician on board as consultants can really help, ideally associated with the center where you are scanning.

### *Describe Your Interactions With Sponsors and Consultants Explicitly*

Meeting content and frequency with your sponsor, cosponsor, and other consultants should be spelled out by them and by you—and these numbers should agree. A table of meetings is helpful to convey this information to the reviewer. Ideally, the primary sponsor will be available for weekly individual meetings. If a cosponsor is at another site, provide a detailed plan not just for visiting, but how training will work during that visit. It is not sufficient to say “cosponsor will be available by phone and web meetings.” Additionally, it is best to specify the types of readings that will be involved. Include specific training toward producing manuscripts and enhancing your grantsmanship. Finally, the sponsor and cosponsor’s comments should be superlative, if possible, or at least strongly laudatory.

## **Research**

### *Hit the Public Health Relevance Hard*

How will the work you are doing help people? In other words, how will your research “translate” into improving public health-related issues? This is one strong feature on which the proposal will be judged. If you cannot answer it, neither can reviewers.

The aims should have a high likelihood of being informative; in other words, something that, if the study comes out as predicted, will lead to clinical understanding, new studies, or at least being cited by people in your field. This is particularly true for longitudinal studies, in which you want to include support for the idea that the changes you are proposing to examine over time have a high likelihood of occurring. For example, proposing a longitudinal study in which you examine how many people who are 12 to 13 years old develop hemophilia within 1 year of an initial assessment may be deemed to have low likelihood of being informative due to the low base rate of hemophilia, and poor choice of a time-window in which the disorder will develop.

If you are examining a particular developmental period (e.g., puberty or old age), make sure to (a) clearly justify that period and (b) include relevant considerations for that developmental period. For example, if

you are assessing children, will they be able to sit still for your assessments?

### *Use Your Training*

The proposed work must represent a good training experience. You should not already have the proposed skills to do all the work you are proposing, and should emphasize what you will be learning from the proposed work.

The award is about you getting the training that will help your career to go in an interesting direction. The project is a chance to use that training. As such, it is useful to make sure that you are incorporating your training into your research plan. For example, if you propose to learn a statistical technique, include that technique in your proposed analyses.

### *Aims*

It is often helpful to have no more than three specific aims (though applications with more can get a favorable review) and to fit them on one page. Reviewers want to see a simple story. This is not to say that the work will not have its complexities—rather, reviewers want to be able to understand the aims in a quick read. Remember, your application will be one of many they review, possibly at midnight after a long night of other grants. A confused reviewer can turn quickly into a grumpy reviewer, which does not bode well for scores.

The specific aims should not be dependent on each other; if hypotheses for Specific Aim 1 are not confirmed, it should still be useful to examine Specific Aim 2.

The aims should differentiate your work from your sponsor’s. In particular, they should not read just like those from a sponsor’s existing grant, as the differentiation from the sponsor may be questioned. If the overlap is large, make sure to include a statement that very clearly indicates what is new in your line of work compared to that of your sponsor.

### *Scope*

Keep it feasible—more feasible than you think you have to. F’s are often hit for being “too ambitious.” In particular, proposing a reasonably powered RCT (randomized clinical trial) which is not piggy-backed on to a sponsor’s work is often considered too ambitious. You may want to consider a nonrandomized pilot study instead. If you do propose an RCT it is helpful to have extensive documentation of feasibility and support from your mentors and consultants.

## **Fundamentals**

Never neglect the fundamentals. Reviewers will evaluate the proposed work with regard to strength of methods, and they will look for signs that you kept the fundamentals of research at the forefront of your thoughts as you confronted the many challenges inherent in designing a feasible study.

If you are choosing measures from the literature, choose strong measures. Document their psychometric properties, including reliability and construct validity. This is particularly important for observational studies, where experimental manipulation may be difficult or impossible, and the soundness of your conclusions depends on the psychometric quality with which a construct is measured. Using a measure “because our lab has used it in the past” or “because my sponsor designed it” is not an acceptable rationale. The standard is currently lower for psychophysiology and imaging (i.e., no one reports psychometrics on these), and this can be noted. Note—this recommendation should not preclude you from developing measures and tasks, but if you do, it is useful to propose to evaluate their psychometrics.

Address potential confounds. All research studies must grapple with potentially confounding variables, and reviewers know this. Explicitly identify potential confounds in your research, decide how to address them (e.g., randomization, exclusion, statistical covariates, etc.), and make your reasoning transparent.

Know the current and upcoming developments in your area. Most research areas, through cumulative efforts of multiple researchers, have developed state-of-the-science methods. Use them. And propose to get trained in them. A strong goal of the F31 mechanism is to help you to be an independent investigator in your area. If the methods you choose would only have made you a terrific investigator 10 years ago, reviewers may not support the application. Of particular note, for studies of emotion and information processing, it may be useful to include measures in addition to self-report (e.g., psychophysiology, eye-tracking, imaging, etc.).

Take care to not selectively report only the literature consistent with your hypotheses—a reviewer is bound to know of inconsistent studies if they exist. It is better to head these off at the pass than to rely on the ignorance of your reviewers.

## Things to Include

Do include analytic plan and power-analysis sections. This should not be a toy or pilot data collection project—reviewers want to see that it will be publishable at the end of the day.

Put in a time-line for what research activities will occur when.

## Marketing

Say why the proposed training and research resources are essential to making you the scientist you want to be. This is above and beyond what you would be able to get or what is typically offered for your graduate program and also above and beyond what you would otherwise do for your dissertation research. One good answer here is that the money will protect your time for research so that you do not have to teach or spend time begging on the streets.

Make sure to say how your work will be funded. This is important because the F31 mechanism does not provide research funding. Particularly if it is fMRI, say where the resources for scanning will come from.

If English is not your first language or writing is not your forte, it is very helpful to have others read through and correct your grammar, spelling, and structure. Making the grant easier to read actually helps to get a positive review.

## Responsible Conduct of Research

Take responsible conduct in research seriously. Training must be ongoing throughout the award, formal, and ideally not just online. Saying that you were trained in the past is not good enough. Providing details on course content as well as individual mentorship that will support ethics training is essential. Be specific about the frequency and duration of the training as these are explicit scoring criteria. Wherever possible, name the faculty members who will mentor you in training for responsible conduct in research, as well as the specific role(s) that they will play. Having the sponsor echo their roles in this regard can be helpful.

## Human Subjects

Be careful in describing procedures you will use for protecting human subjects. Mistakes in following these conventions can be perceived as evidence that you are not being well-trained in the procedures in your field. If it is a clinical trial, make sure to have a Data Safety and Monitoring Plan. If it has fMRI and there are women of child-bearing

age, make sure to provide for pregnancy tests.

If you are working with a clinical population, discuss limits of confidentiality and referral mechanisms if needed, and consider a certificate of confidentiality if you are asking about illegal behaviors. If you are working with a procedure that has risks or discomforts, be honest about those. If you are gathering data online, be very specific about procedures you will use to protect electronic data.

## Consultant Letters

It is useful to have letters from everyone remotely associated with your project. If you have a cosponsor, it is important to have a letter from the cosponsor. Not having letters can be interpreted as a lack of knowledge about the project or lack of involvement by the cosponsor or consultant.

You may be asked to draft letters from your consultants and referees to you as well as your sponsor's statement. Take care as you draft these letters. The letters are a big part of reviewers' determination of your consultants' belief in and commitment to you. Do not be modest—your consultants should know you, be enthusiastic about you and your project, and demonstrate that they are committing the proposed resources to help you.

Some thoughts as you review (or draft) consultant letters:

1. It is common for consultants to reiterate their understanding of their specific contributions to the applicant's research and training plans in their letters of support.

2. If you are using a consultant or sponsor's resources (e.g., their lab) it is useful for them to say they are on board with this use.

3. Chris Martin, Ph.D., has used the following sections in his letters: (a) involvement with mentee, (b) summary of mentee background, (c) mentee's appropriateness for an F31, (d) correspondence of career development plan and research proposal, (e) endorsement of collaborators, (f) commitment of mentor's resources, (g) description of mentor's resources, and (h) support for mentee.

4. The NIMH guidelines for a career award reference letter are also helpful. They state that the letter involves an evaluation of the candidate with special reference to (a) potential for conducting research, (b) evidence of originality, (c) adequacy of scientific background, (d) quality of research endeavors or publications to date, (e) commitment to health-oriented research, and (f)

need for further research experience and training.

## Biosketch Personal Statements for Sponsors, Mentors, and Consultants

The NIH biosketch requires that sponsors, mentors, and consultants include a personal statement. It is helpful to write a draft of this section for them. Here is a template Siegle has used:

The proposed research involves.... I have expertise in all of these areas, including ..., a long history investigating ..., experience with ..., and formative work in.... My work in this area began in.... I currently direct the ——— Lab, which is devoted to these themes. I have successfully administered major grants in this area and currently serve as PI or Co-I on multiple NIH grants using.... I have a strong track record of mentorship and co-mentorship of graduate students including NRSAs. Currently I mentor (number) graduate students and (number) postdoctoral fellows, of whom (number) have NRSAs. My students have regularly transitioned to prestigious postdoctoral and faculty appointments. I have and can provide the necessary resources to support (name)'s training goals.

## Responding to Pink Sheets

1. Respond to every item in the review.
2. It is rarely useful to make changes on a revision that were not specifically identified as problems in the first submission, unless they were true design weaknesses.
3. If you get comments saying there is not enough methodological detail, be particularly careful to respond to these. If there are gross methodological lapses, it can be interpreted as a lack of mentor-involvement.

## Final Thoughts

This may seem like a lot of advice. Please don't let it dissuade you. The F series is a terrific and flexible award mechanism. The committees who review them are eager to see the next generation of researchers go on to brilliant careers and NIH is committed to using the F mechanism to help them do it. So good luck writing!

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## Classifieds

**POSTDOCTORAL RESEARCH FELLOWSHIP IN THE UNIFIED PROTOCOL FOR THE TRANSDIAGNOSTIC TREATMENT OF EMOTIONAL DISORDERS (UP) AT THE CENTER FOR ANXIETY AND RELATED DISORDERS AT BOSTON UNIVERSITY.** The Center for Anxiety and Related Disorders (CARD) at Boston University invites applications for several post-doctoral research fellowships, available beginning in the summer of 2011, for work on an NIMH-supported project further establishing the efficacy of the UP. Successful candidates will be involved in both research and clinical responsibilities on this project. Extensive opportunities for manuscript preparation and additional collaborative ongoing research at CARD. The position will provide post-doctoral clinical hours and supervision necessary for licensure. Upon completion of one or two post-doctoral years, promotion to Research Assistant Professor and membership in the faculty of the Clinical Psychology Program at BU may be available. Competitive salary and fringe benefits. To apply, please send curriculum vita, letters of interest, and the names of three referees to David H. Barlow (dhbarlow@bu.edu).

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...

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## Society of Clinical Child and Adolescent Psychology and the Association for Behavioral and Cognitive Therapies

John Guerry, *University of North Carolina, Chapel Hill*

Hopefully many Division 53 readers are already aware of the new evidence-based practice website, [www.effectivechildtherapy.com](http://www.effectivechildtherapy.com). This resource, which is an ongoing collaboration between the Society of Clinical Child and Adolescent Psychology (SCCAP) and the Association for Behavioral and Cognitive Therapies, now serves as an easily accessible “bridge site” between the two associations. Please look for the new “Evidence-Based Treatments for Youth” links and logos at various places throughout the SCCAP and ABCT home pages.

The goal of [effectivechildtherapy.com](http://effectivechildtherapy.com) is to educate the general public, as well as mental health professionals and educators, about the most current empirically supported treatment options for child and adolescent mental health problems. Accordingly, website content has been partitioned into information for “The Public” and for “Professionals & Educators.” In this article we’ll briefly highlight some of the features under each category.

### The Public

Guiding the design of “The Public” portion of the website was the recognition that the informed preferences of parents, caregivers, and youths represent an essential piece of the “three-legged stool,” or movement towards evidence-based mental health practice. Potential child and adolescent clients and their families can expect to

find a growing collection of resources, including lay-friendly descriptions of common symptoms, corresponding information about likely diagnoses, hypothetical case vignettes, and links to relevant external websites. Most importantly, the bottom of each “diagnosis home page” provides a table listing “well-established,” “probably efficacious,” and “possibly efficacious” treatments. By following various table links, visitors may either read broad overviews of treatment options or learn about how evidence-based criteria is defined. Additional public sections provide informative articles related to such questions as “How to decide between CBT and medication” and “How to choose a child therapist.”

### Professionals and Educators

The available content for mental health practitioners, researchers, and educators closely parallels that found on “The Public” pages. Professionals are given an in-depth but accessible introduction to such topics as “What is evidence-based practice?” and “Myths and facts about empirically supported treatments.” The primary feature of the pages for professionals, however, is to provide a centralized library of current psychosocial treatments for various child and adolescent disorders. As with the public pages, treatments are listed in summary tables according to evidence-based criteria outlined by Chambless and Hollon (1998) and Silverman and Hinshaw (2008). But

what most clearly set the professionals’ tables apart are individual treatment pop-up windows written in most cases by the developers of each specific intervention. Interested professionals can expect to find immediate access to training information, external websites, relevant peer-reviewed journal articles, and in some cases actual treatment manuals.

It is important to note that the website [effectivechildtherapy.com](http://effectivechildtherapy.com)—which will always endeavor to reflect the current state of treatment-outcome literature—will necessarily remain a work in-progress. At present, all treatments presented in the website were based on the 10-year update of evidence-based treatments for youths appearing in the 2008 special issue of the *Journal of Clinical Child and Adolescent Psychology*. Going forward, we need your help to ensure that treatment recommendations evolve with the scientific literature. If you would like to request a change to any treatment recommendations or to the website as a whole, please follow the instructions posted on the website. Above all, please help us widely disseminate the web address among professional colleagues, interested clients and families, and the general public!

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To learn about creative options for donating to ABCT, visit our website and click on DONATE at the top of the home page, or contact us at 212.647.1890.

# Call

## for Award Nominations

The ABCT Awards and Recognition Committee, chaired by Shelley Robbins of Holy Family University, is pleased to announce the 2011 awards program. Nominations are requested in all categories listed below. Please see the specific nomination instructions in each category.

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

### Outstanding Contribution by an Individual for Clinical Activities

Awarded to members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Past recipients of this award include Albert Ellis, Marsha Linehan, Marvin Goldfried, Frank Datillio, and Jacqueline Persons. Complete the on-line nomination form at [www.abct.org](http://www.abct.org). Then e-mail the completed form to [srobbins@holysfamily.edu](mailto:srobbins@holysfamily.edu). Also, mail a hard copy of your submission to ABCT, Outstanding Clinician, 305 Seventh Ave., New York, NY 10001.

### Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Past recipients of this award include the Clinical Psychology Program at SUNY Binghamton, The May Institute, the Program in Combined Clinical and School Psychology at Hofstra University, and the Doctoral Program in Clinical Psychology at SUNY Albany. Please complete the on-line nomination form at [www.abct.org](http://www.abct.org). Then e-mail the completed form to [srobbins@holysfamily.edu](mailto:srobbins@holysfamily.edu). Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Ave., New York, NY 10001.

### Student Dissertation Awards:

- **Virginia A. Roswell Student Dissertation Award (\$1,000)**
- **Leonard Krasner Student Dissertation Award (\$1,000)**
- **John R. Z. Abela Student Dissertation Award (\$500)**

Each award will be given to one student based on his/her doctoral dissertation proposal. The research should be relevant to behavior therapy. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligible candidates for this award should be student members who have already had their dissertation proposal approved and are investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor may complete the nomination. Self-nominations are also accepted. Nominations must be accompanied by a letter of recommendation from the dissertation advisor. Please complete the on-line nomination form at [www.abct.org](http://www.abct.org). Then e-

mail the completed form to [srobbins@holysfamily.edu](mailto:srobbins@holysfamily.edu). Please include an e-mail address for both the student and the dissertation advisor. Also, mail a hard copy of your submission to ABCT, Student Dissertation Awards, 305 Seventh Ave., NY, NY 10001.

### Distinguished Friend to Behavior Therapy

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

### Career/Lifetime Achievement

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

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

### Outstanding Service to ABCT

Please complete the on-line nomination form at [www.abct.org](http://www.abct.org). Then e-mail the completed form to [srobbins@holysfamily.edu](mailto:srobbins@holysfamily.edu). Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001.

**Questions?** Contact: Shelley Robbins, Ph.D., Chair, ABCT Awards & Recognition Committee; e-mail: [srobbins@holysfamily.edu](mailto:srobbins@holysfamily.edu)

**Nominate on line: [www.abct.org](http://www.abct.org)**  
Deadline for all nominations:  
Monday, March 1, 2011

# I nominate

the following individuals for the positions indicated:

PRESIDENT-ELECT (2011-2012)

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---

REPRESENTATIVE-AT-LARGE (2011-2014)

---

---

NAME (printed)

---

SIGNATURE (required)

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## 2011 Call for Nominations

**Every nomination counts!** Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2011, will be counted.**

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

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

*Good governance* requires participation of the membership in the elections. ABCT is a membership organization that runs democratically. We need your participation to continue to thrive as an organization.

This coming year we need nominations for two elected positions: President-Elect and Representative-at-Large. Those members who receive the most nominations will appear on the ballot. In April, full and new professional members in good standing vote for the candidates of their choice to serve for 3 years. The President-Elect serves in that function from 2011 to 2012, then as President from 2012 to 2013, and then as Past President from 2013 to 2014. Each representative serves as a liaison to one of the branches of the association. The position of Representative-at-Large serves as the liaison to the Membership Issues Coordinator. This representative will review, develop, and maintain activities that service and support the members of ABCT. All full members in good standing are eligible to be nominated, and there is no limit to the number of members you can nominate for either position.

A thorough description of each position can be found in ABCT's bylaws: [www.abct.org/docs/Home/byLaws.pdf](http://www.abct.org/docs/Home/byLaws.pdf).

### Three Ways to Nominate

- Mail the form to the ABCT office (address above)
- Fill out the nomination form by hand and fax it to the office at 212-647-1865
- Fill out the nomination form by hand and then scan the form as a PDF file and email the PDF as an attachment to our committee: [membership@abct.org](mailto:membership@abct.org).

The nomination form with your original signature is required, regardless of how you get it to us.





*Are you a faculty member in a graduate program?  
Are you a student applying to graduate school?*

If so, check out the new ABCT Graduate Mentorship Directory. The Graduate Mentorship Directory is intended to provide students with an opportunity to learn which individual ABCT members regularly mentor students in their respective graduate programs. The history of psychology, and especially the history of the cognitive and behavioral therapies, is one of lineage and relationships, where professionals trace their lineage back three or four generations. This directory is not intended as an exhaustive list of graduate programs; rather, it is a list of ABCT members affiliated with programs in which they are potentially available to serve as a mentor.

### *Faculty Mentors*

It's easy to add yourself to the ABCT Graduate Mentorship Directory. Follow these simple steps and soon any potential graduate student can learn about you, your respective graduate training program, and whether or not you plan to mentor a graduate student during the next academic admission cycle.

**Step 1.** Go to the ABCT website ([www.abct.org](http://www.abct.org)) and scroll over the *Students/Early Career* tab.

**Step 2.** Click on *Mentorship Directory*

**Step 3.** Read the directions and click on the link to "List/Update Mentorship Directory"

*Note: You'll need your ABCT member number to log in.*

### *Prospective Graduate Students*

It's easy to search the ABCT Graduate Mentorship Directory to learn about potential graduate mentors and training programs. You can search based on several dimensions, including research and clinical specialties, geographic location, and training model. Because many graduate training programs use a mentor-based training model, the ABCT Graduate Mentorship Directory is a great way to quickly access information about CBT-oriented graduate faculty and academic training programs.

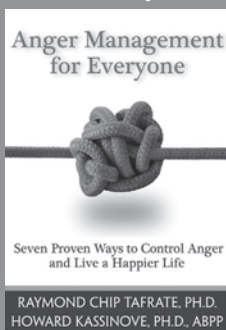
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## ABCT AWARD WINNERS

Congratulations to our 2010 ABCT Self-Help Book of Merit Award winners:  
R. Chip Tafrate, Howard Kassinove, and Tom Horvath, authors of these noteworthy client resources!



### ***Anger Management for Everyone***

#### ***Seven Proven Ways to Control Anger and Live a Happier Life***

R. Chip Tafrate, Ph.D. & H. Kassinove, Ph.D., ABPP Softcover \$17.95/240 pages

Kassinove and Tafrate bring their expertise and research-based understanding to everyone interested in controlling their anger as they show readers how to cope with life's adversity, unfairness, and disappointment. Put anger in its proper place and live a vital, happy, and upbeat life!

### ***Sex, Drugs, Gambling & Chocolate***

#### ***A Workbook for Overcoming Addictions (2nd Edition)***

A. Thomas Horvath, Ph.D. Softcover \$16.95/240 pages

An alternative to 12-step! Readers can reduce almost any type of addictive behavior — from drinking to sex, eating, and the Internet — with this practical and effective workbook. This comprehensive resource treats addictive behaviors in general, not one at a time because if you're prone to addictions, you've probably got more than one.

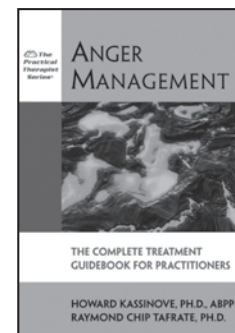
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