ABCT
ASSOCIATION FOR BEHAVIORAL AND COGNITIVE THERAPIES

ISSN 0278-8403
VOLUME 37, NO. 1 • JANUARY 2014

the Behavior Therapist

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President's Message

Social Networks: Much Older Than You May Think

Dean McKay, ***Fordham University***

Most of us currently enjoy the use of a wide range of social networks. We have come to these through the use of Facebook, Twitter, Tumblr, LinkedIn, ResearchGate, BuzzNet, Flickr, FourSquare, Pinterest, to name just a few. As of this writing (on November 18, 2013), there were 199 social networking sites listed on Wikipedia, and these were just the active ones. There was an additional list of 16 now-defunct social network sites.

Our reliance on social networking sites has been characterized as a new phenomenon, with its emergence really taking hold with Facebook. However, social networking in its most general form has been with us for far longer and our current electronic social media methods have primarily hastened the pace at which the networking happens. Communities relying on different social networks (i.e., centralized, cliques, decentralized) have emerged over the ages, generally with an aim of facilitating transfer of information. Some communities retain their social network approach, even when they move to a new community. For example, Rasmussen, Chu, Akinsulure-Smith, and Keatley (in press) showed that West African immigrants relied on four levels of social networks in resolving parent-child and intimate partner conflicts. These naturally occurring styles of problem resolution were departures from the approaches employed more generally in the

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Published by the Association for
Behavioral and Cognitive Therapies
305 Seventh Avenue - 16th Floor
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Subscription information: *the Behavior Therapist* is published in 8 issues per year. It is provided free to ABCT members. Nonmember subscriptions are available at $40.00 per year (+$32.00 airmail postage outside North America).

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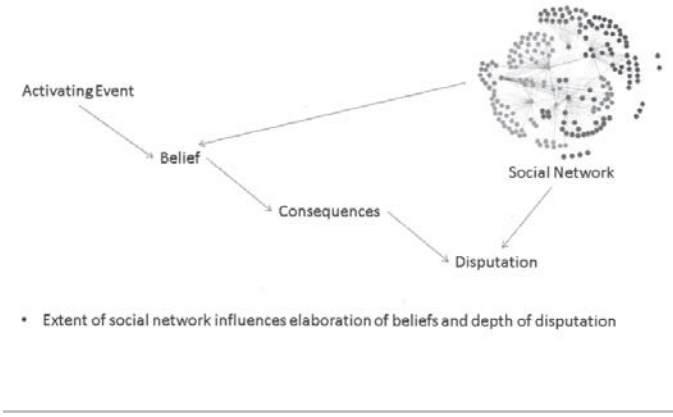

Fig. 1. Influence of social networks on cognitive therapy

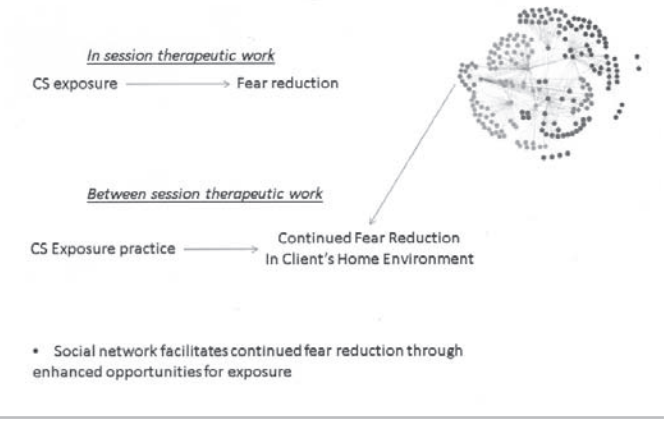

Fig. 2. Influence of social networks on exposure therapy

community (the study was conducted in New York City). Direct service providers coming in contact with members of this immigrant group would need to understand the social hierarchy system in order to best determine how to assist in problem solving. Having an understanding of the social networks clients form therefore facilitates the way in which other interventions may be implemented.

The study of social networks has evolved significantly since the advent of social networking sites on the Internet. Networks operate in many different forms, and there is a growing science to study networks (for detailed coverage, see Scott, 2012). If you are a visual person like I am, social network analysis is quite compelling because it relies, in part, on graphical displays of social contacts and their interconnectedness. As noted above, social networks operate in many communities. Networks such as these, and in a wide range of formats, have operated to great benefit in communities throughout the ages. One trip to Mesa Verde in Colorado offers visitors a peek into how communities relied on social networks to survive in an otherwise inhospitable setting (high altitude desert, with dwellings built into sheer cliff walls) as a means to make the most of what the land had to offer. Here, early cliff-dwelling communities developed networks to communicate with other tribes by leaving markings (petroglyphs) to convey information about available resources and tribal boundaries, as well as to communicate cultural and religious information (for more information on the science behind determining interpretations of North American petroglyphs, see Schaafsma, 1985).

The Science

Cognitive-behavior therapy can greatly benefit from better understanding social networks. Clinicians often inquire about their client's social life. However, these inquiries tend to be informal, and do not highlight the ways these social connections influence behavior and cognitions. It is difficult to fully appreciate how our social networks may shape our behavior. Start with the possibility that a client has a particularly impoverished social network.[1] This could lead to a limited range of potential ideas and concepts upon which to draw when developing interventions. Imagine developing a behavioral experiment for a client with elevated thought-action fusion. One exercise might involve wishing for something terrible to happen to another person within a narrow time-limited period. While it is likely the client understands this thought-event relationship is unlikely, the absence of a social network may make this behavioral experiment a challenge since the client would lack an adequate pool of potential individuals to imagine for the exercise.

Depth of social network contributes to the ability to devise effective challenges to prevailing thoughts associated with distress. This is because many patterns of thought are predicated on having social networks, and points of reference to other ways of coping, where the language used to endorse dysfunctional beliefs is varied. For example, having an extensive social network contributes to the material to draw upon in devising behavioral experiments, developing disputations, and facilitating imagery. Indeed, the richness of the social networks people have, regardless of social support, may be predictive of wellness, possibly even response to treatment. Schwartz et al. (2013) showed that social networks influence language used (i.e., people living at high altitudes discuss the mountains more frequently) and individual characteristics influence the choice of words to describe their experiences. Schwartz et al. go on to suggest that an active social network could be associated with greater emotional stability.

This is an as-yet unexplored possibility for how to advance our understanding of CBT. While I have offered conjecture about how this may work, the empirical tests have yet to be conducted. In Figures 1 and 2 I offer a preliminary speculation of points of influence for social networks in cognitive therapy and exposure-based behavior therapy. This is clearly intended as a speculative starting point for considering how social networks may impact CBT.

Social Networks and ABCT

We inherently appreciate social networks. One great illustration is the use of the ABCT list serve. CBT is widely understood to be an efficacious approach to treatment (Hofmann et al., 2012). Unfortunately, we also understand that CBT is not widely practiced, even if widely endorsed by a range of therapists and sought by many clients. ABCT's list serve illustrates well the

[1]To be completely clear, social networks are distinguished from social support. Within a social network, an individual (or, in the parlance of social network analysis, an *actor*) has contact with other individuals, but they do not necessarily serve as resources. Social support typically includes the degree that one feels they are cared for by others and/or has assistance from others.

concept of social networks and the effort to broaden our social networks. Here we see regular postings seeking qualified CBT practitioners in different communities. I've not posted there too often, but I have observed that while there are often requests for suggestions in big markets with many highly qualified CBT therapists (i.e., Boston, New York, Los Angeles), there are also postings seeking therapists in smaller markets (i.e., Rochester, NY). Frequently CBT therapists are identified in these smaller markets, and the individuals named are not members of ABCT.

This means that the list serve is a potential untapped resource for increasing our membership and, by extension, enhancing the ways clients can receive effective treatment. In effect, this is a call for ABCT to actively increase the depth and diversity of our social network, beyond the current technological methods such as Facebook and Twitter, but through direct contact with providers who really belong in our organization but are not currently.

I hope this column serves as an opportunity to begin discussing social networks, broadly conceived, in order to promote our profession.

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Clinical Forum

A How-to Guide for Conducting a Functional Analysis: Behavioral Principles and Clinical Application

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A functional analysis (FA) is an individualized assessment aimed at understanding the factors underlying a particular behavior (Sturmey, 1996). FA can be used to identify clear and reliable relationships between the natural environment and behavior (i.e., environment-behavior relationships). Following its introduction in the literature by Skinner (1953), the first explicit and thorough application to clinical pathology was undertaken by Kanfer and Saslow (1965), who articulated that the FA also could serve as a diagnostic procedure to inform therapeutic intervention. FA approaches historically have utilized a very straightforward A(ntecedent) – B(ehavior) – C(onsequence) framework and have adhered to a reasonably strict behavioral perspective. To emphasize the role of the individual (i.e., including one's thoughts, feelings, emotions, and/or physiological responses) in this conceptualization of FA, Goldfried and Sprafkin (1976) proposed the Stimulus-Organism-Response-Consequence (SORC) model to elaborate upon previous versions of the FA (Goldfried & Sprafkin; for a description see also Nelson & Hayes, 1986; Nelson-Gray & Farmer, 1999). This expanded approach has been used by some to present the FA from a more cognitive perspective with a focus on the "O" as a causal variable.

Several well-constructed theoretical pieces outline the core components of an FA aimed at understanding psychopathology (e.g., O'Brien & Haynes, 1995; Yoman, 2008), and these are essential primers for anyone interested in a comprehensive understanding of FA. However, these pieces are highly technical, focus largely on core theoretical issues, and seem to be aimed at clinicians with a behavioral orientation and a fairly advanced knowledge of behavioral principles underlying FA. Although we acknowledge the important contribution of these pieces, there is a need for a complementary piece focused on practical, straightforward clinical application of FA techniques across a range of theoretical perspectives and familiarity with behavioral principles.

Here we aim to provide an expanded FA framework that is consistent with the core components of FA, but that also allows for the collection of additional individual information that can be conceptualized in the FA from multiple perspectives. To illustrate this framework, we present a hypothetical case study using a patient with clinically relevant substance use, mood problems, and life stressors. Our aim is to provide a straightforward, clear set of strategies for conducting an FA that offers both structure and flexibility across a range of behaviors, settings, and clinician characteristics (e.g., theoretical orientation, familiarity with behavioral principles).

Conducting an FA

In this section, we outline several key components of the proposed FA format, including problem behavior, triggers, thoughts, feelings, positive consequences of problem behavior, negative consequences of problem behavior, alternative behavior, positive consequences of alternative behav-

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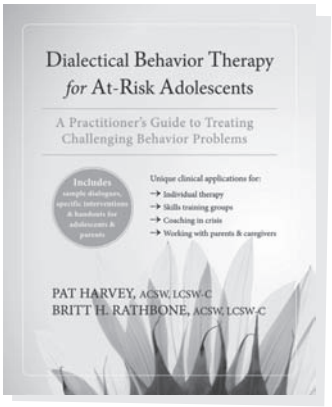

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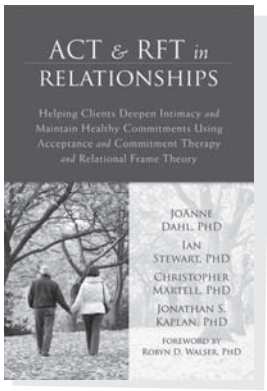

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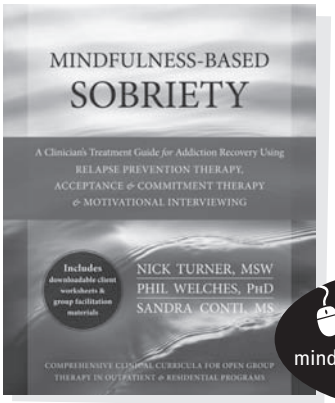

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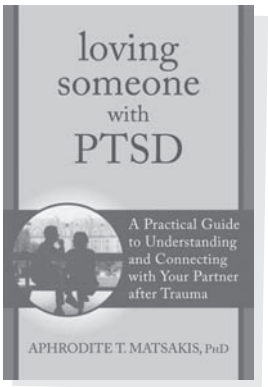

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ior, and negative consequences of alternative behavior. We outline several steps to provide a guide for clinicians conducting an FA across these key components. Using these steps, we then move to a clinical example with a completed FA template.

Step 1: FA Rationale

The first and perhaps most important step in conducting an FA is the provision of a strong rationale for its use. Doing so requires that the therapist understand the basis of FA from their particular theoretical perspective and can outline this rationale in a clear and nontechnical manner. In the section below, we provide a sample template that can be used (and modified) to articulate the FA rationale based upon differing theoretical perspectives, settings, and presenting problems.

THERAPIST SCRIPT

"What we are going to work on together is a strategy by which you can understand the causes of your behavior, or, said differently: 'Why you do the things you do.' This first key part involves selecting something you do that you would consider to be a problem behavior. In trying to understand this problem behavior we next take a good look at the situations in your life that lead up to you doing this problem behavior. We call these situations triggers because they can trigger you to act a certain way. For instance, if the situations around you are more positive, you may be more likely to think, feel, and react in a positive manner. If they are negative, then you may be more likely to have negative thoughts, feelings, and reactions. We will also focus on the consequences of the problem behavior, both in terms of what good and bad things may happen after you engage in it. Finally, we will discuss other possible behaviors that you might be able to turn to in that moment that may have different positive and negative consequences. By examining triggers and consequences of your behavior in certain situations, we can develop other plans for those situations and help you to make better choices in the situations you do end up in. Does this sound ok?"

Step 2: Problem Behavior

Following the rationale, it is important to move to the overt behavior that is core to one's experience of distress. This problem behavior can at times be the presenting problem; however, other distressing or problematic behaviors the patient considers important also may be utilized. To isolate a problem behavior, certain questions, such as "What types of behaviors do you think brought you into treatment?" "What types of behaviors do you want to either better understand or change in the future?" or "What types of negative behaviors have you been engaging in recently that you want to focus on?" may be helpful. This presenting problem is the starting point, although this may in fact change after going through the FA (i.e., when the patient may not have had insight into what behavior is truly contributing to impairment). Although it can be helpful to spend time at the start of the FA dedicated to truly understanding the clinical problem behavior of interest, it is also important to acknowledge that the patient may not want to do a very difficult FA right at the start of treatment. In such cases, it's also possible to start with a less pressing or severe problem to provide the patient with a "warm-up" so he/she becomes comfortable with the process before moving on to a more difficult FA.

Step 3: Triggers (Distal, Recent, and Proximal)

Once the target problem behavior is isolated, focus is shifted to the trigger. In identifying triggers, a key goal is to pinpoint what came right before the problem behavior (i.e., what triggers were temporally proximal). Asking questions such as, "What was the situation?" and "What happened right before the behavior occurred?" are relevant to help patients pinpoint triggers. This often points to a specific person, place, situation, or event (e.g., my friend insulted me, I got bad news about my family, etc.), which can be thought of as the *proximal* trigger.

Unfortunately, in many approaches to FA, the focus on triggers typically stops at the proximal level, highlighting only the triggers in that moment with clear perceived causality. However, it is also important to acknowledge the integral role of triggers that occurred at some temporal distance, which we refer to here as the *recent trigger* if it occurred in the near past or the *distal trigger* if it occurred in the more distant past. Recent and particularly distal triggers, unlike proximal triggers, may not be very close in time to the problem behavior but may be instrumental in creating a context by which the patient experiences the proximal trigger (i.e., not contiguously but still possibly contingently relevant). To identify recent and distal triggers, the therapist may ask if this situation resembles a similar situation from the distant or more recent past and/or ask if there are other ongoing stressors that may be contributing to the patient's response in this situation. The therapist also may have obtained relevant information doing the initial intake regarding events that may be acting as recent and distal triggers that could be referenced at this point. For example, a recent and distal trigger for a patient with a clinical problem behavior related to angry outbursts may include growing up in a household in which the patient consistently saw his father lashing out at his mother when he was upset (distal), compounded by several rocky weeks in his current relationship (recent). This represents a history for this patient in which very early on he saw how one can turn to aggression for immediate relief combined with a generally high level of relationship stress. In this scenario, the likelihood of the patient engaging in screaming in response to a proximal trigger, such as an insult delivered by his spouse, is increased by the existence of the distal and recent triggers. It also should be noted that distal and recent triggers also could be unrelated to the behavior problem and instead more general (e.g., a history of abuse or poor attachment to caregivers for distal and a general high level of stress for recent), which may differ based upon theoretical orientation.

Steps 4 and 5: Thoughts and Feelings

Following from the trigger, the patient is instructed to consider both his/her thoughts (e.g., "After you received the bad news or your friend insulted you, what were you thinking? What was going through your mind?") and feelings ("What emotions did you experience when this negative event happened?"). As best as possible, it is important to have the patient acknowledge the automaticity that often occurs from the trigger to behavior, and to consider how thoughts and feelings are occurring in between—especially if the patient reports little awareness of their occurrence.

One constructive way to discuss thoughts and feelings is to consider feelings as the emotional impact of the trigger and thoughts as "directions" the patient is following in the effort to cope with the feelings being experienced. For example, following entry into a threatening situation and the fears that result, a patient diagnosed with PTSD may have the thought, "I need to get out of this situation before I lose it," which can be conceptualized as a self-prescribed direction to leave the threatening situation to ameliorate the fear experienced. In this

way, thoughts can reflect the development of a strategy to cope with the trigger.

For some patients, genuine feelings may be particularly difficult to elicit. When difficulty arises, useful follow-up questions can address why engagement in the problem behavior seemed so urgent and necessary at the time; this may involve asking what would have happened had the patient not engaged in the problem behavior (e.g., Would the feeling have gotten worse? Would it have dissipated on its own?). Feelings are again discussed in a subsequent section of the FA on consequences, specifically to pinpoint feelings that may occur as a result of either engaging in or not engaging in the problem behavior.

Addressing thoughts and feelings in an FA can involve considering these variables as "causal" from a more cognitive perspective or "collateral" from a more behavioral perspective. Interestingly, despite this important theoretical caveat that underlies how the therapist conceptualizes the role of thoughts and feelings and interprets the results of the FA for treatment planning purposes, the actual FA work done with the patient differs little regardless of which perspective is taken. From a cognitive perspective, this could be used to later challenge causal irrational beliefs or other forms of dysfunctional cognitions, and from a behavioral perspective to understand the subjective impact of the environment experienced by the individual. Even with this clear difference in framework, it again is important to note that the actual work with the patient would largely be the same.

Step 6: Positive/Negative Consequences

Following the problem behavior, the next step is to focus on "positive" and "negative consequences" (i.e., What happens right after the behavior? What positive and negative things may result from engaging in this behavior?). This can be both a change in others or the situation (e.g., my friend stops insulting me) or more internal consequences (e.g., I stop feeling sad). Before moving to a discussion of positive and negative consequences, we outline what we term the "consequence conundrum," where an FA can reveal that the negative and positive consequences of a behavior can have a very different impact on a patient's behavior than would seem readily obvious.

At one level, negative consequences are easy for patients to consider. Consequences have a decidedly pejorative connotation to them, and not surprisingly, patients often are very quick to identify a laundry list of negative consequences, often taken from threats and punishments received. Positive consequences can be decidedly more difficult to conceptualize given the focus on a "problem" behavior. Once the patient is instructed to really consider (without judgment or guilt) "why" they engaged in the behavior, positive consequences often are acknowledged more easily. Interestingly, it is the rare case that a patient can acknowledge that the positive consequences outweigh the negative consequences, thereby making the continued engagement in the behavior a "conundrum" and quite difficult to understand.

For example, a cocaine-dependent patient may report (and believe) that the negatives of their drug use on self and family far outweigh any positives associated with using the drug. Similarly, a patient with borderline personality disorder (BPD) who engages in self-harm as an emotion-regulation strategy may be able to acknowledge that the negative consequences of self-harm and the distress caused to those around them outweigh any positive consequences of this behavior. Finally, a patient diagnosed with social phobia may engage in social avoidance and isolation despite acknowledging that the resulting negative consequences on their social support system and overall well-being overshadow the positive consequences of this behavior.

Each example above—spanning three different psychological disorders—demonstrates the patient who understands that the magnitude of the negative consequences of the problem behavior outweighs the positive consequences, and yet who engages in the behavior anyway. This discrepancy can lead the individual to feel weak, illogical, or even immoral, because there are moments of action that completely undermine their aspirations at other moments. In such cases an FA can be especially useful to help the patient understand why, in one particular moment, the negative behavior feels right and makes sense as their best option—even if in all other moments it makes little sense. Thus, a goal of FA is to move away from having a patient feel badly about themselves based on their inability to stop a behavior that has more apparent negatives than positives and to instead focus at a functional level on why the positive consequences of the problem behavior may be more impactful for the individual in the moment.

In particular, an FA can be useful for addressing this issue with an analysis of how we often place excessive emphasis on certain characteristics of consequences, including the *magnitude* (size/intensity of the consequence) and *duration* (how long the consequence lasts), and discount the immediacy (how quickly the consequence arises) and certainty (how likely the consequence will occur). This picture is in line with perspectives such as delay discounting (see Bickel & Johnson, 2003) and can be illustrated with a substance use example focusing on how the negative consequences are typically of high-magnitude and prolonged duration, but are low in both immediacy and certainty.

For instance, there are serious, long-term, and often permanent consequences of chronic heavy drinking, yet the problems do not emerge immediately and are not guaranteed at any given time. In contrast, the positive consequences of substance use largely have the opposite qualities, characterized by low magnitude and limited duration but with clear and high levels of immediate and certain benefits. In this way, the immediate relief and relaxation experienced as a result of intoxication is a consequence that is less intense and long lasting in comparison to liver damage, yet occurs more immediately and with greater certainty (see Table 1 for a depiction).

Table 1. "Consequences Conundrum": A Depiction of Positive and Negative Consequences of Problem Behavior and Their Properties

	Problem Behavior (e.g., substance use)	
	-- Consequences (e.g., legal issues, health impairments)	+ Consequences (e.g., drug high, reduction in stress)
Magnitude	High	Low
Duration	High	Low
Immediacy	Low	High
Certainty	Low	High

Demonstrating the distinct qualities of these consequences, in particular highlighting why the negative behavior is so appealing in the moment, can often be a validating experience for patients in understanding why they continue to feel compelled to engage in a behavior that has such damaging, long-lasting consequences.

Our experience is that the patient finds great personal reflection and enlightenment in changing the dialogue rather than focusing on "why do I do something when the value of the negatives clearly outweighs the value of the positives?" to a focus on what ways the positives of the problem behavior actually do seem more valuable than the negatives in the immediate context. Finally, presenting the negative and positive consequences in this way offers a smooth transition to identifying alternative behaviors. Importantly, the alternative, healthier behavior must capture the positives of the unhealthy behavior to some degree to be considered as a reasonable alternative. By refocusing on what is appealing about the behavior we are trying to change, we are more likely to discover behaviors the patient may actually turn to in that context.

Step 7: Alternative Behavior and Associated Positive/Negative Consequences

As indicated above, the discussion of the characteristics of positive and negative consequences transitions into a discussion of alternative behaviors, particular ones that capture the positive aspects of the problem behavior (i.e., in terms of immediacy and certainty) yet with fewer long-term negative consequences. The alternative behavior section of the FA encourages the patient to think about what they could have done instead in that specific situation, and it is recommended to together generate as many ideas as possible, emphasizing that no idea here is right or wrong, and there will likely not be one "right answer" as a perfect alternative behavior. Additionally, the patient can offer suggestions of positive behaviors they may already be turning to in that situation from time to time. In sum, the goal at this step is to develop a list of other options of behaviors, with a particular focus on behaviors that share the positive qualities of the problem behavior in terms of immediacy and certainty, and that all ideas do not necessarily need to be new alternative behaviors.

A focus on alternatives converges on an important question: If the patient had done the alternative behavior instead, what might have happened in terms of both negative and positive consequences? In the example of substance use to relieve stress, this patient may have focused on alternative behaviors such as physical exercise, meditation, job-seeking, or other healthy behaviors that would have provided some immediate stress relief. Although we limit our discussion here to assessment, it is notable that the discussion of alternative behaviors in the FA can be very useful for transition to treatment planning and aligns nicely with many cognitive and behavioral interventions.

Step 8: Clarifying Overlap Across Components of the FA

Although when conducting an FA there is some effort to separate its different components for ease of comprehension and to isolate a particular problem behavior, the patient is likely to realize that there is considerable overlap across FA components. As one might expect, this realization could be confusing for the patient. For instance, while we provide evidence of thoughts and

feelings as FA components in their own right, they also can be negative consequences of a problem behavior or even triggers for that problem behavior. Additionally, it is quite common for consequences of one problem behavior to then serve as triggers of a subsequent problem behavior. In the initial presentation to the patient, the independent aspects of these components of the FA may be important to emphasize, but over time the interdependence is also important in its own right to illustrate how behavior patterns may emerge and be sustained.

FA Case Study

In this next section, we provide a case study of the application of FA to a patient with clinically impactful substance use, mood problems, and life stressors (see Table 2 for a visual depiction of the FA using a basic handout that could be utilized in therapy). In the case study we aim to emphasize the flexibility and adaptability of the FA approach. It should be noted that we do not provide any reference to the rationale presented to the patient, as this is addressed above in the patient script; however, in this case, the rationale was provided at the start of the FA according to the script provided.

Presenting Problem

Mr. Y was a 34-year old Caucasian male who presented to his mental health practitioner (MHP) noting depressed mood in the past 2 months, elevated substance use (tobacco and alcohol), as well as some functional impairment related to reduced work attendance and productivity. Mr. Y was married with a 3-year-old daughter. He also noted recent conflict at home, which he mentioned was largely due to his wife feeling that he was not doing his share of household and child-care-related responsibilities, as well as her frustration with his alcohol and tobacco use, which she noticed had increased recently.

FA as an Assessment in the Initial Session

The FA began with an assessment of the core problem behaviors. When asked about the most troubling behaviors, the patient immediately focused on substance use. Specifically, about 2 months ago, Mr. Y reported that he started stopping at a local convenience store on his way home from work once per week. He would pick up a pack of cigarettes and a six-pack of beer, which would last him throughout the week. A month later, it quickly became twice per week, then three times per week.

First, the FA focused on *proximal triggers* (i.e., "What happens right before you go to the convenience store/or use?"), which the patient could identify with reasonable ease, including stressful events at work and home. More specifically, events during the day included conflict with a particular person at work—someone who became a constant reminder of his lower status at his job. On these days, Mr. Y found it incredibly difficult to not smoke throughout the day or stop on his way home. Additionally, when he would return home, often late to pick up his daughter at child care or without the dry cleaning, this would fuel increased conflict with his wife, particularly when she would smell smoke on his breath and clothes.

Next, and somewhat more difficult, the patient was asked to identify *recent triggers*, or events that occurred within the recent past that might have influenced his substance use. While the client struggled momentarily with generating these triggers, he was able to note somewhat recent events, including being demoted at work 6 months ago. Furthermore, he reported that he concealed his demotion from his wife, which represented another recent trigger.

Finally, the patient was asked to consider any *distal triggers* from his past that set the stage and created the context for his response to these events, specifically any memories or events from his past that he feels contribute to his substance use. The patient found these to be the most difficult triggers to generate. However, in addition to the proximal and recent triggers, the patient was able to identify many more distant events, such as recalling being told he would never amount to anything by his father. This memory in particular stuck out to him.

The MHP then examined the thoughts associated with the proximal, recent, and distal triggers. Specifically, for proximal triggers, the MHP asked Mr. Y to try to imagine being back in that moment during the most recent experience of the proximal trigger (e.g., "The last time you interacted with that employee at work, what were you thinking? What was going through your mind?"). Mr. Y indicated that anytime he interacted with this employee, regardless of the type of interaction, he would often have thoughts such as, "I shouldn't have to be doing this," "I am too good for this," "I didn't use to be on this level, I am a failure."

Mr. Y more quickly offered numerous feelings associated with the trigger, including that he was experiencing frustration and disappointment in himself during his day at work, particularly regarding growing financial concerns (i.e., "I feel useless. I feel inadequate. I feel like a failure"), and Mr. Y reported that this built up throughout the day as he continued to interact with this specific individual. This, in turn, becomes a trigger for drinking and smoking after work (i.e., "Then it seems almost impossible to not stop at the store on my way home. It's like I can't stand it. I can just taste the beer and cigarette as I leave work, it's all I

Table 2. Example of a Completed FA Handout From Initial Assessment Session

Trigger (Distal, Recent, & Proximal) - Memories of father being critical (distal) - Demotion at work (recent) - Interactions with irritating co-worker (proximal)	**Thoughts** - I am a failure - I shouldn't have to be dealing with this - I am above this	**Feelings** - Frustration - Disappointment - Inadequacy - Worthlessness
Problem Behavior - After work, go to a convenience store to pick up cigarettes, beer	**Problem Behavior Positive Consequences** - Feel relieved after drinking and smoking a cigarette - Something to look forward to at the end of the day - Provides a distraction from other worries	**Problem Behavior Negative Consequence** - Late to pick up daughter - Wife gets angry after she smells smoke on clothing - Feel frustrated getting yelled at - Spend too much on cigarettes and beer
Alternative Behavior - Go straight to day care - Run when I get home	**Alternative Behavior Positive Consequences** - Feel responsible - Wife doesn't get angry - Feel healthy - Less urge to drink at home - Can relax with my family	**Alternative Behavior Negative Consequence** - Don't get benefits of drinking and smoking - Feel frustrated as I pass the convenience store - Feel irritated when picking up my daughter

want."). Next, the FA moved to consequences after a synthesis/recap of the discussion of thoughts and feelings. This dialogue between the MHP and Mr. Y is described below.

Recap of Thoughts/Feelings and Discussion of Consequences:

MHP: Okay, so it sounds to me like the interactions with this employee at work make you have certain thoughts related to being inadequate or a failure, and this person has become a trigger or a reminder of your demotion 6 months ago. It sounds like in line with these thoughts, you start to feel inadequate and even worthless. Does this sound accurate?

Mr. Y: Yeah, definitely.

MHP: It also sounds to me like it reminds you of other times in your past when you felt worthless and inadequate, such as when your father told you that you would never amount to anything. Then, the only thing that makes the situation feel tolerable is turning to alcohol and cigarettes. Does this also sound accurate?

Mr. Y: Yes, unfortunately it does.

MHP: So, after you stop at the store and pick up beer and smoke a cigarette, then what?

Mr. Y: Well, it does help, I have to admit. I like drinking, and weirdly, I never thought I would, but I really like smoking; it just makes me feel more relaxed and able to focus on what I should have been focused on in the first place.

MHP: So smoking and drinking provides some relief. It makes you feel better after a day of feeling down and like a failure from interacting with this person. What happens next?

Mr. Y: Well, that's when another problem comes about. Stopping often makes me late to pick up my daughter at day care. So, by the time I get home, my wife is angry because she knows I picked up Lucy late, and she can usually smell the smoke on my clothes. So, I get home to just get yelled at, and then I just want to drink and smoke more. Sometimes I can resist that urge, it's easier than the after work one, but sometimes I just can't help it. I make up an excuse to go to the grocery store or the gas station just to go out for a smoke.

MHP: Okay, so it sounds to me like there are some positive consequences from stopping at the convenience store after work, like that initial relief that the smoking and drinking provides, but that it also brings with it some negative consequences, like being late to get your daughter and then your wife getting angry. This, in turn, fuels an even greater desire to engage in these same behaviors. I want to focus on that time period right after work, when you get in your car to go home. What else could you do?

Mr. Y: Well, I could just drive another route and go directly to my daughter's day care. That would probably solve everything.

MHP: Okay, what are some other ideas? Let's try to think of as many as possible.

Mr. Y: That's probably it. It seems so obvious.

MHP: So okay, that's one option. But going straight to child care may not pro-

vide the same relief that the smoking and drinking offers. It sounds like you really need something when you walk out that door to improve your mood after a long day of feeling badly. What else brings you that same relief?

Mr. Y: Well, seeing my daughter does, so I do think that could be a good option. I also really like running. That's something that brings me a ton of relief immediately as long as I don't overdo it.

MHP: Okay, so running could be a good option, but you may not have time for that either right after work. Could you run later in the night?

Mr. Y: Yes, I think I could.

MHP: Okay, so that gets us started with a few options. Together we'll continue to think of other behaviors you can turn to and set a plan to make it easier to do these new behaviors.

Summary

The FA was a useful assessment tool in the first session to identify proximal, recent, and distal triggers for the patient's substance use, associated thoughts and feelings, as well as positive and negative consequences of the substance use. The FA revealed that the proximal and recent triggers were the work interactions following his demotion and at-home conflict with his wife. The FA also revealed the relative sequencing of the disorders. It seemed that the depression came first and the substance use later escalated in response to a worsening of mood and more proximal triggers.

Additional Uses of the FA Throughout Treatment

At this point it's worth noting that the FA should not be limited to the start of therapy. Indeed, the FA can be used for additional problems as they are addressed through the course of therapy. Additionally, the FA can be used to address barriers to therapy as they impact intervention efforts. For example, if a patient is noncompliant with homework assignments, this noncompliance can be a target behavior beginning the FA with the identification and discussion of particular triggers for noncompliance and then moving through the other parts of the FA as discussed above.

Conclusions

Given its structure yet flexibility, we believe that FA may be an incredibly practical and useful strategy to provide a complement to diagnostic assessments focused more on the structural aspects of psychopathology, with great potential for understanding the nature of the problem behavior and for jump-starting treatment planning. In some cases, FA may be useful as an intervention on its own to improve understanding and guide behavior change; in addition, it may also be incredibly useful to guide activity planning, scheduling, or problem-solving according to more of a behavioral perspective and/or cognitive restructuring according to a cognitive perspective based upon what is highlighted in the FA. Additionally, the focus on recent and distal triggers may enable greater understanding of longstanding patterns for a patient and may also be useful to guide efforts for relapse prevention.

One important goal was to help make the FA more accessible across a range of therapeutic approaches and theoretical orientations. Regarding the latter point, we encourage therapists to consider how they apply their own theoretical framework to the implementation of the FA. For example, a therapist from a cognitive perspective might be inclined to consider an emotional consequence of a problem behavior as causal in its role as a trigger for a future behavior. In contrast, a therapist from a behavioral perspective might work with the patient to identify the same information, but always return to the overarching environmental context to address causality. Moreover, while FA is not highly utilized outside of cognitive and behavioral orientations, we believe the approach outlined here is sufficiently flexible such that it need not be limited to therapists from those orientations. In this way, we believe that this framework allows therapists across multiple perspectives to identify a range of rich clinical information, while placing it firmly in their own theoretical framework. We have aimed to present this guide in a comprehensive and detailed fashion to increase ease of use, but at the same time it is meant to be flexible and serve merely as a starting point for integrating FA principles into practice. As we aim to highlight throughout, we hope this framework is one that is applicable and useful across theoretical perspectives, clinical settings, and types of problematic behavior.

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Clinical Forum

Implementing a Mindfulness-Based Stress Reduction Program in the Community: Lessons Learned and Suggestions for the Future

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Over the last several years, there has been a burgeoning interest in the role of mindfulness in psychological interventions (Baer, 2003). Growing evidence suggests that mindfulness-based treatments (MBTs) are associated with enhanced ability to manage attention and memory (e.g., Hölzel et al., 2007, 2011; Jha, Krompinger, & Baime, 2007; Kilpatrick et al., 2011) and increased activation of brain areas associated with the processing of positive affect and improved immune function (Davidson et al., 2003). Germane to the current review, MBTs have been shown to have beneficial effects on a wide range of medical and psychiatric conditions in adults (e.g., Goldin & Gross, 2010; Grossman, Niemann, Schmidt, & Walach, 2004; Hofmann, Sawyer, Witt, & Oh, 2010; Jain et al., 2007; Keng, Smoski, & Robins, 2011; Ramel, Goldin, Carmona, & McQuaid, 2004; Vøllestad, Sivertsen, & Nielsen, 2011) and children and adolescents (e.g., Biegel, Brown, Shapiro, & Schubert, 2009; Semple, Lee, Rosa, & Miller, 2010). A recent meta-analysis of 39 randomized and nonrandomized trials found a moderate to large pre-post treatment effect for the reduction of anxiety ($g = 0.63$, $p < .01$) as well as depression ($g = 0.59$, $p < .01$; Hofmann et al., 2010). In addition, the findings from this meta-analysis suggest that the gains from MBTs are generally maintained several months after treatment (Hofmann et al.).

Although many current behavioral treatment packages include a mindfulness component (e.g., Acceptance and Commitment Therapy [ACT], Hayes, Strosahl, & Wilson, 1999; Dialectical Behavioral Therapy [DBT], Linehan, 1993; Emotion Regulation Therapy [ERT], Mennin & Fresco, in press), John Kabat-Zinn was the first to develop a codified, secular meditation training program (Kabat-Zinn, 1982) and his mindfulness-based stress reduction (MBSR) remains unique in its consistent focus on mindfulness training as primary ingredient rather than treatment component. MBSR is also distinctive in its feasibility for cost-effective treatment delivery and dissemination: It is an 8-week course that can be delivered to groups of up to 20 to 25 participants by one to two trained instructors and facilitated by use of audio materials and daily homework practice. The program has been disseminated successfully over the past three decades to different types of practitioners across 44 states and 30 countries. It has also shown ease of implementation across a variety of settings, including hospitals, community clinics, and, most recently, schools (Saltzman & Goldin, 2008). An iteration of MBSR including a cognitive therapy component was developed for the prevention of depressive relapse (Mindfulness Based Cognitive Therapy [MBCT]; Segal, Williams, & Teasdale, 2002). Segal and colleagues found that training in MBCT resulted in decreased likelihood of depression relapse among patients with three or more previous depressive episodes (Teasdale et al., 2000). More recently, Semple and colleagues (2010) showed that MBCT for children can lead to reductions in attention problems and anxiety symptoms.

Our group, housed in an academic medical center in a major metropolitan city, is one of the many examples of successful dissemination of MBSR. One of the authors (SE) has trained at the Center for Mindfulness at the University of Massachusetts Medical School and has been delivering MBSR courses at this institution over the past decade. The program consists of eight weekly classes, lasting 2 hours each. The course includes guided instruction in mindfulness meditation practices, gentle stretching and mindful yoga, group dialogue designed to enhance development of skills, development of mindfulness in everyday life, and daily home assignments. Participants have included members of the community as well as medical center trainees, staff, and faculty. We have previously published data suggesting participants' perceived benefit of engaging in the program, including a reduction in psychological stress and increased mindful awareness in everyday life (Evans, Ferrando, Carr, & Haglin, 2011).

However, the implementation and dissemination of MBSR is subject to the challenges common to the delivery of psychotherapeutic interventions. In this article, we seek to delineate barriers to effective delivery of a mindfulness-based treatment program to the community and to outline useful strategies to target these challenges. We draw upon anecdotal experience of implementing an MBSR program in an academic medical center over the past decade, feedback provided by participants of the program, and academic literature to illustrate pitfalls and offer potential solutions. We hope to provide strategies useful to practitioners implementing MBTs and to identify research questions that would enable further dissemination.

Managing Challenges of Treatment Delivery

With increased appeal and worldwide dissemination of MBSR programs, there is greater need for practitioners to identify and learn to manage the challenges and potential obstacles that face both practitioners delivering the class as well as participants. These include participant expectations, difficulty carving out the time for practice, presence of medical conditions, comorbid psychiatric disorders, and complex group dynamics. Some of these issues are exemplified in the feedback we have received from our group members over the years: "I didn't practice enough, however when I did, it was very valuable"; "[I] did not do homework, so I handicapped myself"; and "I wish I had attended more of the classes." We will examine each of these challenges in more de-

tail below and summarize our suggestions in Table 1.

1. Participant Expectations

One issue that may arise is the set of expectations participants bring to the class. Oftentimes, and quite understandably, group members come into class with unique attitudes and assumptions, including the hope that they will feel better, more relaxed, and even happier as a result of participating in the group. For some people, in fact, meditation may be equated with the idea of relaxation. However, the desired state of mindfulness meditation is not a void of experience or emotion. As one review on the subject notes, the goal is to cultivate an ability to experience fully, without either preoccupation with or suppression of the experience (e.g., Keng et al., 2011). For group members who seek the course in order to rid themselves of difficult-to-control, unpleasant thoughts and feelings and feel "calm," this notion requires a mind shift that can be nuanced and delicate. A reorientation by the instructor toward accepting the existence of the unpleasant thoughts, emotions, and physical discomfort without allowing these aspects to permeate oneself may be quite useful in this type of situation. This notion is clearly illustrated in Rumi's poem "The Guest House," which is read during the course of the class. It urges participants to "welcome and entertain [all emotions] . . . even if they are a crowd of sorrows."

The struggle to bring awareness and acceptance to one's experience rather than modifying it to fit a perceived expectation can become particularly pronounced when participants become disappointed in not achieving their expected state of mindfulness. A key aspect of mindfulness meditation is that it is a nonstriving process during which the practitioner becomes an impartial observer of her experiences. As Kabat-Zinn (1994) notes, "the tack we take in meditation is simply to witness whatever comes up in the mind or the body and to recognize it without condemning it or pursuing it, knowing that our judgments are unavoidable and necessarily limiting thoughts about experience." This approach is quite different from habitual processes that often involve labeling and judging experiences (e.g., "I don't like this feeling"; "This isn't working for me"). Due to the judging nature of the mind, the cultivation of a nonjudgmental stance is therefore a key skill developed in mindfulness meditation. Sometimes, however, despite the group leader's efforts to encourage curiosity and openness to all experiences (good, bad, neutral), participants may continue to have difficulty letting go of the desire for a specific meditation experience. For example, the group leader might hear the following comments in class discussion following meditation practice: "It was hard"; "My mind kept wandering and I couldn't stop it"; "I got frustrated with myself"'; "I thought I was getting better at this." On the other hand, sometimes participants make positively valenced comments—for example, "I felt so relaxed" and "My mind didn't wander so much this time." It is helpful for the instructor to remind the class that the practice of mindfulness is a process and to encourage class members to let go of judging themselves or their experiences when their minds wander.

This tendency to judge, particularly in a negative direction, can lead some members to become disheartened and even decide to give up altogether and drop the course. Others may continue but do so half-heartedly and with a certain level of pessimism. This was the case with Sarah, an elderly married housewife who struggled with an ailing husband. Sarah voiced from the very beginning, including during the orientation class, that she found meditating frustrating because her mind wandered. She repeatedly commented, "There must be something wrong with me that I can't do this." Despite reframing from the group members and leader suggesting that noticing her mind wander and attempting to bring it back to the point of focus was exactly what "doing this" was about, Sarah became anxious and discouraged with her practice, stating by the fourth week that she decided to stop practicing altogether. The group leader was unable to impart to Sarah the idea of allowing herself to observe her experiences while cultivating a nonjudgmental attitude toward the contents of her mind. Interestingly, Sarah continued to come to every class and commented to the group that she found the class discussions and the group support to be very helpful to her.

We have found that encouraging potential participants to attend an hour-long orientation prior to the start of the course is helpful to familiarize participants with the class structure and goals and to adjust any unrealistic expectations. In addition to reviewing the course parameters, some time can be devoted to meditation. This allows for participants to experience a taste of the

Table 1. Managing Challenges to Treatment Delivery

Challenge	Strategy
Managing participants' expectations	Set up orientation to familiarize participants with course expectations and mindfulness practice. Devote group discussion time to troubleshooting finding time to practice mindfulness.
Participant daily practice	Stress importance of initial formal mindfulness practice, prior to informal practice.
Participants with physical limitations	Participants remain in chair for mindfulness practice and body scan. Yoga portion can be excluded (Morone et al., 2008).
Psychiatric conditions	MBSR can be helpful for symptoms of anxiety and depression, but its efficacy as a stand-alone treatment is still limited. MBSR may be a gateway to further treatment for suffering individuals unwilling to access psychotherapy or medication.
Group dynamics	Break group into dyads for more focused discussion, then return to larger group.

process, to have the experience of their mind wandering, and to practice the skill of coming back to the breath. It is useful for the group leader to normalize the common experience of mind wandering and judgments and to remind participants that they are developing an attitude of nonjudgmental acceptance.

The orientation class may be held in a more casual environment and may be a good source of information for participants unsure about committing to the course or uncertain regarding what to expect. During the orientation and throughout the course, the group leader draws on previous participant experiences to normalize the frustration of the mind wandering and the expectation for greater focus. It is often useful to share with the group that many participants who have taken the course have had similar frustrations, especially at the beginning of the course. For participants similar to Sarah, it may be important for the group leader to have individual phone discussions to redress expectations of the mindfulness process and to do so outside the limited time of the group discussion. In addition, suggesting reading materials, such as *Wherever You Go, There You Are* (Kabat-Zinn, 1994) and *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (Kabat-Zinn, 2013), can be helpful in orienting the participant to the goal of the nonjudgmental stance.

2. Time and Commitment

Another common issue is carving out time for the daily practice. Group discussion, particularly in the earlier classes, is devoted to problem solving around when and where is a good time to practice. Finding the time to practice is a universal problem, but it can be even more challenging for some people who have particularly busy work and/or family schedules. This was the case with Marie, a young executive who joined the class with hope that practicing mindfulness and "learning to relax" would assuage some of her difficulties with infertility. Marie presented as ambitious, driven, and prone to bouts of anxiety. In the second week of class, Marie wanted to know if she could do the sitting meditation practice on the subway commuting to and from work. She mentioned finding it "nearly impossible" to devote the time to be with herself and by herself to practice.

Interestingly, Marie is not alone in trying to figure out a way of "multitasking" meditation practice. Participants have asked if it is okay to practice while commuting, running, watching TV, and resting in the sauna. While there is room in MBSR, as in other MBTs, for informal meditation practice, such as mindful eating and walking, these practices are meant to complement rather than replace the daily formal meditation practice. MBTs instruct in formal practice in order to allow participants to develop the skill set before applying it to informal settings. In addition, particularly in early stages of practicing mindfulness, individuals might be motivated to utilize mindfulness as an emotion-regulation strategy intended to reduce the intensity of negative affect and other aversive internal experiences. We find many participants who propose to couple mindfulness with another activity in the name of multitasking report experiencing much discomfort when left without the distractions of a subway or a buzzing television during formal meditation practice. Therefore, if participant Marie was intending to practice mindfulness in the subway on her way to work in order to reduce her anxiety about sitting quietly with her own thoughts and feelings, she might have paradoxically defeated the purpose of cultivating mindfulness.

Indeed, not surprisingly, those participants who are able to carve out time for the sole practice of mindfulness have mentioned finding that time to be highly rewarding. For example, Delia, a working mother with one child, struggled with the problem of finding a quiet time when she would be able to practice uninterrupted. With some experimenting, she was able to find a time she could completely devote to practice. During the weeks of the class she came to cherish this special time. We therefore recommend that, given the challenges of the practice and the issues of time, commitment, and setting, it is useful to stress these factors during the orientation class. In addition, we recommend that the group leader be aware that participants' difficulties scheduling time for meditation and their multitasking solutions may, at times, be symptomatic of experiential avoidance.

3. Concurrent Medical Conditions

Participants may present with medical conditions that can pose certain challenges for both the participant and the group leader. This is certainly not to say that participants with these problems should be excluded from taking the class. In fact, Kabat-Zinn's earlier studies focused on individuals suffering from chronic pain conditions (e.g., Kabat-Zinn, 1982). Since these seminal studies, there have been numerous others demonstrating the effectiveness of mindfulness-based therapies for a wide array of medical and emotional disorders. A recent meta-analysis of randomized controlled trials of MBSR for chronic medical disease indicated the treatment had a small effect on depression ($d = 0.27$, $p < .001$) and a moderate effect on anxiety ($d = 0.47$, $p < .05$) among this difficult population (Bohlmeijer, Prenger, Taal, & Cuijpers, 2010). The eight studies comprising the analysis included the following medical conditions: cancer (2), fibromyalgia (2), heart disease (1), chronic lower back pain (1), rheumatoid arthritis (1), chronic fatigue syndrome (1).

In delivering treatment to individuals with chronic medical conditions, it is important for the group leader to assess these conditions, what impact they may have, and to assist participants in finding needed modifications. For example, in delivering MBSR to a group of older adults with chronic back pain, Morone and colleagues (2008) adapted the program to exclude the yoga component, while focusing on the body scan, sitting meditation, and walking meditation. The authors noted they excluded the yoga component because they did not have a fully developed yoga program that would be safe for all participants.

In our experience, modification to fit physical abilities has been most useful in adapting the program for individuals with medical conditions. We have been able to make such modifications for individuals even within a group with diverse physical functioning. For example, Phillip, a middle-aged male with a history of severe back trouble, had recently undergone surgery prior to taking the course and his ability to ambulate was therefore impaired. He walked slowly, with some difficulty, and used a cane to maintain his balance. Phillip had no prior history with meditation but easily engaged in the group meditations and class discussions. He remained seated in his chair for sitting meditation and the body scan. He was able to adapt a couple of the yoga poses from his chair, including a modified version of the spinal twist. Despite his physical limitations and inability to participate in some of the activities, Phillip reported significant benefit from his practice and expressed a more positive attitude and relationship toward his back pain and limitations.

4. Current Psychiatric Conditions

MBSR classes are a draw for individuals struggling with anxiety and mood symptoms and MBSR and MBCT have been found useful as adjunctive or stand-alone treatments for individuals meeting diagnostic criteria for mood and anxiety disorders. Several studies have found that adding an adjunctive course of MBSR/MBCT to medication management reduces symptoms of chronic depression (e.g., Barnhofer et al., 2009) and residual depressive symptoms (e.g., Kingston et al., 2007) as compared to medication management alone. In addition, a number of studies have found MBSR useful in symptom reduction among samples of patients with anxiety disorders, specifically generalized anxiety disorder, panic disorder, or social anxiety disorder (e.g., Evans et al., 2008; Vøllestad et al., 2011).

For example, Angela, an elderly female, appeared in class to be quiet, reserved, and at times sad and withdrawn. She was reluctant to engage in any of the group discussions but listened with a tone of interest and respect. Although she did not verbally participate in class, she always arrived early and reported that she was practicing regularly. Approximately halfway through the course, Angela approached the leader and asked to speak confidentially. She said that her beloved husband of many years had passed away about a year ago and then began to cry. Upon further discussion, it was apparent that Angela was suffering from an episode of major depression. She refused to consider a referral for therapy and/or medication but continued her regular attendance in class. During the remainder of the class, Angela continued to appear sad and quite withdrawn. Despite this, Angela appeared to benefit from group support and reported that her daily meditation practice was helpful to her. The group leader raised the possibility of a treatment referral again at the end of the last class and Angela agreed to enter into treatment for depression and complicated bereavement. With the help of grief counseling and medication, Angela was able to achieve a full remission of symptoms. She continued to practice meditation, which had become an important part of her early morning routine.

For Angela, MBSR provided a necessary gateway to seeking further treatment. It may be that MBSR has the potential to engage individuals suffering with depression and anxiety but unwilling to access psychotherapy or medication. Hofmann and colleagues (2010) identified moderate to large treatment effects from pre- to post-treatment for depressive and anxiety symptoms following a single course of MBSR. However, the data suggesting the efficacy of MBSR as a stand-alone treatment for psychiatric conditions are still limited. For those individuals who may need further treatment, MBSR can provide an initial positive therapeutic experience.

We are unaware of any data suggesting contraindication of MBSR for individuals with certain psychiatric illnesses. However, we have found that for some individuals, certain conditions may interfere with the ability to participate in the course, potentially resulting in premature termination. This was the case with Winifred, a woman in her late 20s with a long history of anorexia who came into the group significantly underweight and struggling with a number of depressive symptoms. In the group, she disclosed that she struggled with the formal meditation process due to significant mental preoccupations and found that she ate less when attempting to eat mindfully. After discussion with the group leader, Winifred left the program at Week 4 but continued in cognitive-behavioral therapy as well as psychopharmacological management.

5. Group Dynamics

While MBSR is a program that is designed and formatted to follow a class-like structure, there are nonetheless many opportunities for a variety of group dynamics to emerge. One issue that may come up is that of a monopolizing or domineering member. On the other side of the spectrum, there may be the quiet and withdrawn participant who holds back from contributing to group discussions. One example of a well-meaning but somewhat intrusive participant was Phyllis, a middle-aged woman who presented as high-spirited, energetic, enthusiastic, outgoing, and voluble. She was clearly interested and motivated and very encouraging of other members in the group. She also had a tendency to dominate discussions and, at times, would pose intrusive questions to other members.

It is up to the group leader to identify problematic behaviors in order to intervene early on. In addition to instruction, the leader sets and maintains the class dynamic. For example, at the start of the course the group leader can encourage each person to participate in group discussions and advise members to use the opportunity to be particularly "mindful" of their communication style. It is also important for the group leader to gently encourage those members who find it difficult to speak up and express their views. A useful strategy to foster communication among group members is to break the group into dyads in early sessions to talk about a particular topic and then come back to discuss their thoughts with the entire group. For example, in the first class the dyad can discuss what drew each of them to the course. This process of dyad to group discussion can have a significant impact on promoting a positive and participatory dynamic within the larger group.

Conclusion

MBTs are a popular and effective form of therapeutic treatment, with moderate to large treatment effects for the reduction of anxiety and depression (Hofmann et al., 2010). MBSR, in particular, has been favored as a short-term, easily disseminated group treatment, which has been found efficacious for psychiatric (e.g., Vøllestad et al., 2011) and medical conditions (e.g., Bohlmeijer et al., 2010). We believe that these benefits provide support for the widespread dissemination of MBSR internationally and across different settings.

In this article, we have attempted to further facilitate dissemination by outlining some of the challenges of MBSR implementation and offering potential strategies for the resolution of these difficulties. Among these challenges, we have identified unrealistic expectations for the mindfulness process, time and commitment to practice, medical comorbidities, psychiatric comorbidities, and group dynamics. With regard to course expectations and time management, we encourage the setting of realistic expectations prior to starting the course by running an orientation that includes a course description, mindfulness practice, a summary of previous participant experiences, reading recommendations, and emphasizes the time commitment requisite for the course and the openness to experience useful to reap its full benefits. In terms of comorbid medical and psychiatric conditions, we encourage the instructor to tailor the program for the needs of the specific participant and, when necessary, to further assist the participant via out-of-class phone discussions. In addition, it is helpful for the instructor to identify early on how participants interact in the group discussion, with the goals of encouraging everyone to engage and dissuading inappropriate or unhelpful suggestions. We have found that a particularly useful tactic toward achieving this goal is breaking the group into dyads

for a focused discussion before bringing everyone back together to the larger group.

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Past Presidents Series

Perspectives From Past Presidents: Research Design and Data Analysis

Alayna Schreier and David J. Hansen, *University of Nebraska-Lincoln*

This brief article is the second in a four-part series that provides recommendations on relevant literature and resources from expert researchers and clinicians: the past presidents of the Association for Behavioral and Cognitive Therapies (ABCT). Past presidents were surveyed for their perspectives on research articles, theoretical articles, books, websites, and self-help books they would recommend to members of ABCT and readers of *the Behavior Therapist*. The first article in this series, "Perspectives From Past Presidents: Foundations of Behaviorism and Studying Behavior Change" (Schreier & Hansen, 2013), can be found in the October issue of *the Behavior Therapist*. The following suggestions are resources and articles that address research design and data analysis, beginning with broad foundational texts and followed by more specific applications and valuable examples from the literature.

Campbell and Stanley's (1963) *Experimental Quasi-Experimental Designs for Research and Teaching* is a classic text that outlines a variety of research designs. Recommended by Dr. Steven Hollon, ABCT's president from 1998-1999, the book provides an overview of preexperimental, experimental, quasi-experimental, and correlational or ex-post facto research designs. Chapters on experimental design include a focus on factors that may jeopardize internal and external validity and provide suggestions for reducing such threats. Another foundational text, *Single Case Experimental Designs: Strategies for Studying Behavior Change* (Hersen & Barlow, 1976), was recommended by Dr. Michel Hersen, president from 1979-1980. The most recent edition of this book was published in 2009 (Barlow, Nock, & Hersen, 2009). The authors discuss variations of single-case designs (e.g., A-B-A, multiple baseline) for use in applied behavioral research and provide illustrative graphs to supplement their descriptions.

Briefly discussed in the previous article in this series, Sidman's (1960) Tactics of *Scientific Research: Evaluating Experimental Data in Psychology* bridges the topics of research design and evaluation of experimental data. Recommended by Dr. Debra Hope, president from 2010-2011, and Dr. David Barlow, president from 1978-1979, this influential text focuses on the active control of individual behavior, and advocates strongly for single-subject design. Dr. Barlow recommended this text for providing a theoretical basis for studying individual behavior change within the field of psychology.

Dr. J. Gayle Beck, president from 2004-2005, recommended an article that similarly "helps us all to understand the philosophical basis of much of our research." Meehl (1967) discusses theory testing in the physical sciences as compared to the psychological or applied behavioral sciences. The article employs examples to outline methodological "sins" that interfere with confirmation and/or refutation of social science theories. Continuing to connect research methodology and interpretation of results, Dr. Beck also recommended an article that focuses on the use of confidence intervals and interval estimation as a method of improving the interpretation and communication of research findings (Cumming & Finch, 2005). The authors discuss the relationship between confidence intervals and statistical significance in the context of interpreting data presented graphically. Dr. Beck stated that this article is "incredibly accessible and helps us to understand that reporting effect sizes is not enough."

Communication of empirical data was also identified as an important theme by Dr. Jacqueline Persons, president of ABCT from 2002-2003. Dr. Persons recommended a chapter by Bem (1987) that provides a "thoughtful and very elegant model for writing the empirical journal article." It illustrates how to communicate the design, analysis, and interpretation of data and covers all steps from planning to writing and rewriting. The chapter includes specific suggestions and examples for each section of a manuscript and provides a variety of stylistic tips. With a similar focus on academic writing, Dr. Beck noted that her experience as an editor led her to suggest the *Publication Manual of the American Psychological Association* (APA, 2009). The sixth edition of this text provides detailed guidance on APA style, including tables and figures, along with general recommendations on the writing process.

In addition to foundational texts and articles, past presidents recommended quality research studies that have demonstrated innovative and sound methodology and data analytic techniques. Dr. Thomas Ollendick, president from 1994-1995, recommended an article by Bandura, Ross, and Ross (1961) that tests the amount of imitative learning children display following exposure to aggression, but in the absence of that aggressive model. The methodology of this article speaks specifically to increasing the precision of treatment comparisons through matched groups, and Dr. Ollendick identified the article as an example of the importance of "small innovative studies and case studies." Findings were consistent with the hypothesis that children exposed to physical and verbal aggression would imitate that behavior in a subsequent situation.

Dr. Philip Kendall, past president from 1989-1990, recommended a randomized controlled trial comparing cognitive-behavioral therapy, sertraline, a combination of the two, and a placebo in children with anxiety disorders (Walkup et al., 2008). Dr. Kendall summarized the findings of this rigorous experimental trial, noting that "CBT for anxiety in children and adolescents fared very well, with 60% of CBT treated youth meeting criteria as a treatment responder and 80% of youth responding to CBT with medications." Dr. Hollon recommended a different take on randomized controlled trials in an article by Turner, Matthews, Linardatos, Tell, and Rosenthal (2008). Through an examination of academic literature and antidepressant reviews from the FDA, the authors argue that there has been selective publication of clinical trials within the literature. While the origin of selective publication (e.g., authors, journal editors) is not addressed, the article contends that this practice may lead to biased estimates of the effectiveness of antidepressants, which may lead to adverse effects for all parties involved.

An article arguing that modern innovations in research methodology have allowed for the ability to explore previously understudied behaviors was recommended by Dr. Rosemery Nelson-Gray, ABCT

president from 1981-1982. Nock, Prinstein, and Sterba (2009) examine self-injurious thoughts and behaviors among adolescents and young adults using ecological momentary assessment methods. Participants completed both signal- and event-contingent assessments related to their self-injurious behaviors over 14 days. Results of a general hierarchical linear model suggest that suicidal thoughts occurred less frequently than nonsuicidal self-injurious thoughts, but lasted for greater amounts of time. Suicidal thoughts also led to self-injurious behavior less frequently. The authors describe the implications of these findings for evidence-based practice.

Dr. Anne Marie Albano, president from 2007-2008, recommended the texts and articles of many of the authors and past presidents noted above, including Drs. Barlow, Hollon, Kendall, and Drs. Kazdin (president 1977-1978) and Heimberg (president 2001-2002). Dr. Albano recommended that readers of *the Behavior Therapist* read "carefully conducted clinical research studies that may be small *n* or randomized controlled trials . . . that have advanced our understanding of psychopathology and clinical treatment in various modalities." As identified by Dr. Albano, the above resources on research design and data analysis have helped guide the clinical research and evidence-based practice that is currently being done within ABCT and the field of behavioral and cognitive therapy.

Past presidents have provided their expert recommendations of these seminal texts and articles for the continued education of professionals, educators, students, and readers of *the Behavior Therapist*. Further examples of quality scholarship offered by past presidents will be presented in the next article in the series, addressing assessment and evidence-based practice.

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Classified

19th annual Awards & Recognition Ceremony

Michelle G. Craske, *Outstanding Researcher*

Thomas H. Ollendick, *Lifetime Achievement*

Outstanding Training Program: *University of Nebraska-Lincoln, Clinical Psychology Training Program.* LEFT TO RIGHT, *faculty members:* Will Spaulding; Dennis McChargue; Shireen Rizvi, Awards and Recognition Chair; David J. Hansen, *Director*; Stefan Hofmann, ABCT's President; David DiLillo; Debra Hope; and Tim Nelson

Nashville Convention, November 22, 2013 | Shireen Rizvi, *Awards & Recognition Chair*

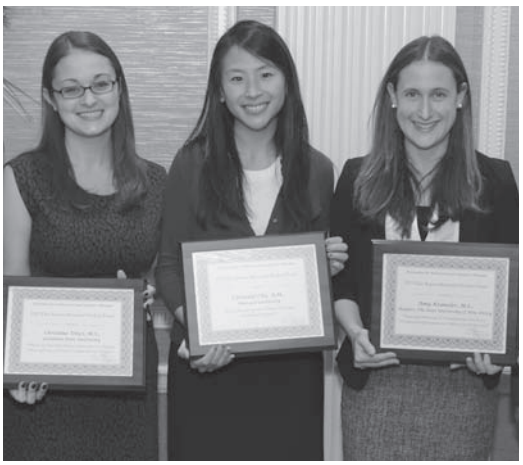
Lauren Weinstock, accepting the award for **Mark S. Bauer**, *Distinguished Friend to Behavior Therapy (with Shireen Rizvi,* left*, Awards Chair; and Stefan Hofmann,* right*, ABCT President)*

Kelly Koerner, *Outstanding Service to ABCT (with Shireen Rizvi,* left*, Awards Chair; and Stefan Hofmann,* right*, ABCT President)*

Sarah Royal, *Leonard Krasner Student Dissertation (pictured with Todd Moore, Awards Committee memeber,* left*, and Stefan Hofmann, ABCT President,* right*)*

Kaitlin Gallo, *Virginia Roswell Dissertation (pictured with Todd Moore, Awards Committee member,* left*, and Stefan Hofmann, ABCT President,* right*)*

Jesse Cougle, *President's New Researcher, with Shireen Rizvi, Awards Chair*



LEFT:

Elsie Ramos Memorial Student Poster winners (*left to right*) *Christine Vinci, Christine Cha, Amy Kranzler*

RIGHT:

Student Travel Award winner *Gillian Alcolado, with President Stefan Hofmann*

Call for Award Nominations

The ABCT Awards and Recognition Committee, chaired by Shireen L. Rizvi, Ph.D., of Rutgers University, is pleased to announce the 2014 awards program, to be presented at the 48th Annual Convention in Philadelphia. 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.

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 David H. Barlow, G. Alan Marlatt, Antonette M. Zeiss, Alan E. Kazdin, and Thomas H. Ollendick. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Career/Lifetime Achievement" in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001.

Nomination deadline: March 3, 2014

Mid-Career Innovator

This year we are introducing a new award category. Eligible candidates for the Mid-Career Innovator Award are members of ABCT in good standing who are at the associate professor level or equivalent mid-career level, and who have made significant innovative contributions to clinical practice or research on cognitive and/or behavioral modalities. The 2014 Mid-Career Innovator Award will be given in honor of Alan Marlatt. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Mid-Career Innovator" in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001.

Nomination deadline: March 3, 2014

Outstanding Mentor

This year we are seeking eligible candidates for the Outstanding Mentor award who are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. Previous recipients of this award are Richard Heimberg, G. Terence Wilson, Richard J. McNally, and Mitchell J. Prinstein. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Mentor" in your subject heading. Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Ave., New York, NY 10001.

Nomination deadline: March 3, 2014

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 The Honorable Erik K. Shinseki, Michael Gelder, and Mark S. Bauer. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.

com. Include "Distinguished Friend to BT" in the subject line. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001.

Nomination deadline: March 3, 2014

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. 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. Eligibility requirements for these awards are as follows: (a) candidates must be student members of ABCT; (b) topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined; (c) the dissertation must have been successfully proposed; and (d) the dissertation must not have been defended prior to November 2013. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/ or adolescents. Self-nominations are accepted or a student's dissertation mentor may complete the nomination. Nominations must be accompanied by a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include candidate's last name and "Student Dissertation Award" in the subject line. Also, mail a hard copy of your submission to ABCT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001.

Nomination deadline: March 3, 2014

Student Travel Award

This award is designed to recognize excellence among our student presenters and to aid in allaying some of the significant travel costs associated with presenting at the convention. Accompanying this honor will be a monetary award ($500) to be used to facilitate travel to the ABCT convention. Eligibility requirements for this award specify that nominees must be (a) speaking at the 2014 convention as a symposium presenter (i.e., first author on a symposium talk), panel participant, or moderator; (b) student members of ABCT in good standing; (c) currently enrolled as a student, including individuals on predoctoral internships in the 2014-2015 year but excluding postbaccalaureates. Information about the nomination form and application will be available following announcement of conference acceptances.

Nomination deadline: August 1, 2014

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Nominations for the following award are solicited from members of the ABCT governance.

Outstanding Service to ABCT

Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Service" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001.

Nomination deadline: March 3, 2014

President's New Researcher Award

ABCT's 2013–2014 President, Dean McKay, Ph.D., invites submissions for the 36th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of $500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent work published in high-impact journals; and promise of developing theoretical or practical applications that represent clear advances to the field. While nominations consistent with the conference theme are particularly encouraged, submissions will be accepted on any topic relevant to cognitive behavior therapy, including but not limited to topics such as the development and testing of models, innovative practices, technical solutions, novel venues for service delivery, and new applications of well-established psychological principles. Submissions must include the nominee's current curriculum vita and one exemplary paper. Eligible papers must (a) be authored by an individual with five years or less posttraining experience (e.g., post-Ph.D. or post-residency); and (b) have been published in the last two years or currently be in press. Submissions will be judged by a review committee consisting of Dean McKay, Ph.D., Stefan G. Hofmann, Ph.D., and Jonathan D. Abramowitz, Ph.D. (ABCT's President, Immediate Past-President, and President-Elect). Submissions must be received by Monday, August 4, 2014, and must include four copies of both the paper and the author's vita and supporting letters if the latter are included. Send submissions to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.

Submission deadline: August 4, 2014

NOMINATE ONLINE:
www.abct.org

Call for Papers on next page of this issue

47th Annual Convention | Nashville

Preparing to Submit an Abstract

ABCT will once again be using the ScholarOne abstract submission system. The step-by-step instructions are easily accessed from the ABCT home page. As you prepare your submission, please keep in mind:

• ***Presentation type:*** Please see the two right-hand columns on this page for descriptions of the various presentation types.

• ***Number of presenters/papers***: For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The chair may present a paper, but the discussant may not. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.

• ***Title***: Be succinct.

• ***Authors/Presenters***: Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their ABCT category. Possibilities are **current member**; **lapsed member** or **nonmember**; **postbaccalaureate**; **student member**; **student nonmember**; **new professional**; **emeritus**.

• ***Affiliations***: The system requires that you enter affiliations before entering authors. This allows you to enter an affiliation one time for multiple authors. DO NOT LIST DEPARTMENTS. In the following step you will be asked to attach affiliations with appropriate authors.

• ***Key Words***: Please read carefully through the pull-down menu of already defined keywords and use one of the already existing keywords, if appropriate. For example, the keyword "military" is already on the list and should be used rather than adding the word "Army." **Do *not* list *behavior therapy*, *cognitive therapy*, or *cognitive behavior therapy*.**

• ***Goals***: For Symposia, Panel Discussions, and Clinical Round Tables, write three statements of no more than 125 characters each, describing the goals of the event. Sample statements are: "Described a variety of dissemination strategies pertaining to the treatment of insomnia"; "Presented data on novel direction in the dissemination of mindfulness-based clinical interventions."

Overall: Ask a colleague to proof your abstract for inconsistencies or typos.

Understanding the ABCT Convention

The ABCT Convention is designed for practitioners, students, scholars, and scientists who come from a broad range of disciplines. The central goal is to provide educational experiences related to behavioral and cognitive therapies that meet the needs of attendees across experience levels, interest areas, and behavioral and cognitive theoretical orientations. Some presentations offer the chance to learn what is new and exciting in behavioral and cognitive assessment and treatment. Other presentations address the clinical-scientific issues of how we develop empirical support for our work. The convention also provides opportunities for professional networking. The ABCT Convention consists of General Sessions and Ticketed Events.

GENERAL SESSIONS

There are between 150 and 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. General session types include:

Invited Addresses. Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge.

Spotlight Research Presentations. This format provides a forum to debut new findings considered to be groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute question-and-answer period allows for more in-depth presentation than is permitted by symposia or other formats.

Symposia. Presentations of data, usually investigating the efficacy or effectiveness of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. No more than 6 presenters are allowed.

Panel Discussions and Clinical Round Tables. Discussions (or debates) by informed individuals on a current important topic. These are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. No more than 6 presenters are allowed.

Poster Sessions. One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,200 and 1,400 posters are presented each year.

Clinical Grand Rounds. Clinical experts engage in simulated live demonstrations of therapy with clients, who are generally portrayed by graduate students studying with the presenter.

Membership Panel Discussion. Organized by representatives of the Membership Committees, these events generally emphasize training or career development.

Special Sessions. These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training.

Special Interest Group (SIG) Meetings. More than 35 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

TICKETED EVENTS

Ticketed events offer educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment.

Clinical Intervention Training. One- and 2-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction.

Institutes. Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday, and are generally limited to 40 attendees.

Workshops. Covering concerns of the practitioner/educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees.

Master Clinician Seminars. The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees.

Advanced Methodology and Statistics Seminars. Designed to enhance researchers' abilities, they are 4 hours long and limited to 40 attendees.

ABCT

Call for Papers

Enhancing CBT by Drawing Strength From Multiple Disciplines

48th Annual Convention

Philadelphia

November 20–23, 2014

The road to the current state of scientific support for cognitive-behavioral therapy (CBT) is paved with findings from diverse empirical backgrounds. The areas that have informed contemporary practice of CBT include social psychology, developmental science, behavioral neuroscience, learning theory, and experimental cognitive science, to name a few. The result of drawing together these varied scientific disciplines has been a foundation of CBT procedures and empirically informed practice that has substantially improved the lives of our clients.

As CBT continues to advance, it is timely to revisit the scientific foundations of our specialty. It is anticipated that these disciplines may inform procedures to facilitate treatment delivery and dissemination, as well as improve on the efficacy and efficiency of CBT. Therefore, the theme of this year's conference, "Enhancing CBT by Drawing Strength From Multiple Disciplines Within the Social Sciences" is intended to showcase research that explicitly draws from varied social science areas to build upon the foundation of CBT as currently practiced. Included under this heading are methodologies that draw on modern technological advances and newer theoretical developments in the full corpus of the social and behavioral sciences. Illustrative examples include: how social psychological processes inform efforts at dissemination of CBT approaches to a wider audience of practitioners; what developmental implications result from cognitive-behavioral interventions in youth; how our knowledge of social cognition informs the implementation of CBT in diverse populations; what culturally specific factors influence the delivery of CBT; how human factors play a role in ensuring compliance with behavioral homework using smartphone technology.

We encourage submissions that explore the full range of social and behavioral science influences on the development and implementation of cognitive-behavioral methods. It is hoped that this year's conference will showcase research that illustrates how diverse scientific principles have informed CBT, and how this very same diversity continues to inform future advances in the discipline. Accordingly, areas of social science research that have been underrepresented in past conferences are especially welcome.

Submissions may be in the form of Symposia, Clinical Round Tables, Panel Discussions, and Posters. Information about the conference and for submitting abstracts will be on ABCT's website, www.abct.org, after January 1, 2014. The online submission portal will open in early February.

Deadline for submission is March 1, 2014

call for Continuing Education Sessions

48th Annual Convention | November 20–23, 2014 | Philadelphia

Please send a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please see the Frequently Asked Questions section of the ABCT Convention page at www.abct.org.

Workshops and Mini Workshops

Workshops cover concerns of the practitioner/educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than FOUR presenters.

Mini Workshops address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention.
Please limit to no more than FOUR presenters.

When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.

Barbara Kamholz, *Workshop Committee Chair*
workshops@abct.org

Institutes

Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday.
Please limit to no more than FOUR presenters.

Lauren Weinstock, *Institute Committee Chair*
institutes@abct.org

Master Clinician Seminars

Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday through Sunday.

Sarah Kertz, *Master Clinician Seminar Committee Chair*
masterclinicianseminars@abct.org

DEADLINE *for Submission : February 1, 2014*

A New Look for the ABCT Website

Starting January 16th, you're going to see a number of changes to the look and feel of our home on the web. The ABCT web committee has been working hard to revise the website along the following principles:

1. **Streamlined navigation**: We hope the new website is intuitive and user-friendly.
2. **A cleaner look**: We've added more white space and less text.
3. **Consistent structure**: We've organized the website around content categories (Journals, Convention, etc.), making it easy to orient yourself and know where to find what you're looking for.
4. **Dynamic**: We will highlight new website content as it's added and feature important CBT news headlines.

We hope you find our new website easier to use and more fun to browse!

CURRENT WEBSITE

NEWLY DESIGNED WEBSITE

now

ABCT

online

WEBINAR: Jonathan Abramowitz
Feb. 6, 11:00 A.M., EST
"Exposure Therapy for OCD Symptom Dimensions"

https://www.abct.org

in-press article

Exposure-Based Family Therapy: An Open Case Series of a New Treatment for Anorexia Nervosa

"… parents and family members are given the task in Session 1 of relating to the patient's anxiety through description of one of their own worst fears. After eliciting the worst fears from each family member, the therapist frames these fears in the context of the process of refeeding by asking individual family members to 'imagine facing [feared situation] 3 to 5 times per day for the remainder of his/her life just to live.'"

Hildebrandt et al.
Cognitive and Behavioral Practice
doi:10.1016/j.cbpra.2013.10.006

archive

"When, by chance, the neurosurgeon's electrode activates past experience, that experience unfolds progressively, moment by moment. . . . Absent from it are the sensations he ignored, the talk he did not heed."

Penfield & Roberts (1959)
Speech and Brain Mechanisms

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

NOMINATE the Next Candidates for ABCT Office

I nominate the following individuals:

PRESIDENT-ELECT (2014–2015)

_____

_____

REPRESENTATIVE-AT-LARGE (2014–2017)

_____

_____

NAME (printed)

_____

SIGNATURE (required)

_____

2014 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, 2014, 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 Christopher Martell, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.

Or email the form to membership@abct.org
Subject line: NOMINATIONS.