

the Behavior Therapist

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INSTRUCTIONS FOR AUTHORS

The Association for Advancement of Behavior Therapy publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy. ■ **Feature articles** that are approximately 16 double-spaced manuscript pages may be submitted. ■ **Brief articles**, approximately 6 to 12 double-spaced manuscript pages, are preferred. ■ **Feature articles** and **brief articles** should be accompanied by a 75- to 100-word abstract. ■ **Letters to the Editor** may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages. Please contact the Editor or any of the Associate Editors for guidance prior to submitting series, special issues, or other unique formats. All submissions should be in triplicate and formatted according to the *Publication Manual of the American Psychological Association, 5th edition*. Prior to publication, authors will be asked to provide a 3.5" diskette containing a file copy of the final version of their manuscript. Authors submitting materials to *the Behavior Therapist* do so with the understanding that the copyright of published materials shall be assigned exclusively to the Association for Advancement of Behavior Therapy. **Please submit materials** to the attention of the Editor: George F. Ronan, Ph.D., Department of Psychology, Central Michigan University, Mount Pleasant, MI 48859.

Obituary

Lizette Peterson-Homer (1951-2002)

Michael C. Roberts, *University of Kansas*

The scientific and clinical profession of psychology lost a major contributor, friend, and colleague on July 18, 2002, when Lizette Peterson-Homer died at age 51. Although she had been through some trials with her health over the last several years, Lizette's passing was unexpected and far too soon. She was the quintessential scientist-practitioner as a behavior therapist, consummate collaborator, dedicated teacher, prized mentor and model, loving mother, wife, and supportive friend to many—all roles reflecting strongly held values in her professional and personal life. Her work, which targeted preventing harm and injury, enhancing children's development and securing their safe futures, and helping mothers achieve parenting goals, was continuous with her personal roles as mother, daughter, wife, and sister. Indeed, many will remember her office answering machine message in which she listed the names by which she was known in her multiple roles—Lizette Peterson, Lizette Peterson-Homer, and Lizette Homer—and that she was one and the same person. Lizette successfully melded aspects of her professional and personal life into a meaningful congruency.

Lizette married her graduate school classmate and statistical consultant for her dissertation, psychologist Andrew Homer. They collaborated on multiple projects, including joint publications, a loving marriage, and two children, Kestrel and Geddes. Kes is an undergraduate at the University of California, Santa Cruz, and Ged is a high school student in Columbia, Missouri.

Born in 1951 into an academic family, Lizette received her B.S. degree from Utah State University in 1973, an M.S. (1975) and Ph.D. (1978) from the University of Utah, working with Donna Gelfand and Don Hartmann. She completed her clinical psychology internship at the Salt Lake Veteran's Administration

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Hospital. Lizette rose through the profes-
sional ranks at the University of
Missouri-Columbia starting as an assist-
ant professor in 1978. The university rec-
ognized her excellence several times, hon-
oring her with the Chancellor's Award for
Outstanding Research and Creativity in
the Behavioral and Social Sciences and the
Frederick A. Middlebush Endowed Chair
for a 5-year appointment in 1988. She
was later appointed to lifetime awards of
the Byler Endowed Chair in 1998 and
Curator's Professor in 2001.

She received the Significant Research
Contribution Award from the Society of
Pediatric Psychology in 1988 for her out-
standing work in preventing childhood
injuries and preparing children for hospi-
talization and surgery. In 1997, the APA
Division of Clinical Psychology honored
her with its award for Distinguished
Scientific Contribution to Clinical
Psychology. Lizette was a fellow in the
American Psychological Association and
the American Association of Applied
and Preventive Psychology and an
esteemed member of the Association for
Advancement of Behavior Therapy, the
Association for Behavior Analysis, and
the Society for Research in Child
Development. She never rested on her
laurels, but continued to contribute as a
superb researcher and theoretician over
time.

These honors and awards were given in
recognition of an extensive set of publica-
tions, conference presentations, and
grants. Her innovative and scientifically
sound clinical research received exception-
al support from a variety of federal fund-
ing agencies such as National Institute of
Child Health and Human Development
(NIH) and the Maternal and Child Health
Bureau (HRSA). She conducted systemat-
ic investigations into coping of hospital-
ized children, analysis and prevention of
children's injuries, recovery from cesarean
delivery, psychosocial development
among children of alcoholic parents, and
prevention of child abuse and neglect.
Her articles were published in the major
outlets for the field overlapping pediatric
psychology, behavior analysis and therapy,
and child development.

Lizette authored and edited three
books: *Prevention of Problems in Childhood:
Psychological Research and Applications* (with
Michael Roberts, 1984, Wiley-
Interscience), *Child Development and
Psychopathology* (with Donna Gelfand,
1985, Sage), and *The Pediatric Psychologist:
Issues in Professional Development and Practice*
(with Cynthia Harbeck, 1988, Research
Press). Additionally, she was frequently
invited to contribute chapters to hand-
books and edited volumes on issues relat-
ed to her research. Lizette also served the
profession extensively through the publi-

cations committees of AABT and Society
of Behavioral Medicine and on task forces
for several organizations, including activi-
ties in mentoring women professionals
early in their careers.

Lizette was passionate about her work
and the realities of life for the people she
was trying to understand and help. In
1997, for example, while trading ideas on
injury control, she whipped off an e-mail
to this writer about parental supervision
and reducing injuries: "I think you know
all of my pet peeves here—we don't know
what constitutes adequate supervision, we
don't support parents in providing it, we
act like barriers will save the world and
they won't, plus we can't even effectively
legislate for them when we know they
work (just read Peterson and Roberts,
American Psychologist, 1992, article)!"

In a note upon receiving word about
her cherished appointment as the editor-
elect of the *Journal of Consulting and
Clinical Psychology*, Lizette wrote, "I obvi-
ously have very strong feelings about the
many directions in which our field must
be led and I am fortunate to know many
of the leaders who will contribute to this
process. I look forward to my term as an
opportunity to advance my knowledge of
future leadership and future changes in
the area. I do feel a unique allegiance
toward this entire process." She held this
kind of passion for life, her work, and her
family.

Lizette was the consummate editor,
both in official positions and as a sought-
after reviewer of others' work. During her
career, she served as editor of *Behavior
Therapy* (1989-1992) and founding editor
of *Cognitive and Behavioral Practice*
(1993-1995) and as associate editor of the
Journal of Consulting and Clinical Psychology,
Health Psychology, and *Behavior Therapy* as
well as on numerous editorial boards and
frequent guest editing stints. She co-
edited a book series published by
Kluwer/Plenum Academic entitled
"Issues in Clinical Child Psychology." She
frequently excused her extensive editing
with a notation that "the hardest desire to
resist is the urge to edit another person's
work." Lizette rarely resisted that urge
and so many others benefited. Her edi-
tor's letters were so constructive and sup-
portive that numerous authors noted they
truly appreciated getting manuscripts
rejected by her and probably should have
written thank-you notes.

Writing was, indeed, her particular
passion. Her amazing vita is filled with
her professional articles, chapters, and
books. She also wrote poetry, vignettes of
her life, short stories, and novels. She most
often wrote, not on a computer, or even in
cursive handwriting, but in a legible print
on yellow tablet sheets. Pencil and paper
were more amenable to correspondence

and thoughtful commentary while pedaling on her stationary bicycle, sitting at the pool with her daughter, or waiting with her son to fall asleep at night. Occasionally, she would drop a hint about her mystery novels and worry this writer with the implication that he might be described in it. In writing and in person, her wry sense of humor buoyed many spirits, even during the tough patches of her own life. Her extraordinary volume of writing, translated into print, covers the wide theoretical, empirical, and clinical realms of psychology and her own personal experiences of a humane life.

The legacy of this superb professional will also be reflected in the careers of the many students and postdoctoral fellows

she mentored. Their contributions are enhanced under her tutelage. Her vita is replete with multiple co-authorships on articles and chapters that might have taken more time and effort, but gave valuable experience to her junior colleagues. However, in letters and conversation (and on her departmental Web site), she noted she learned as much from her students as they might learn from her.

Lizette's contributions and importance of her work to numerous areas of psychology have had and will continue to have wide-ranging and enduring influence. Her work on child abuse and injury prevention programs for children and families was particularly creative and attended to significant problems in today's society. It has

advanced injury prevention and family interventions across the country. Her caring and commitment to the improvement of human lives was evident in all her publications, teaching, research, and clinical activities.

A memorial graduate scholarship has been established in the name of Lizette Peterson-Homer in the Department of Psychological Sciences, 210 McAlester Hall, University of Missouri-Columbia, Columbia, Missouri 65211. ✍

Obituary

A Brief Recollection of My First Encounter With Lizette

Alan Kazdin, *Yale University*

Many wrinkles ago, I was editor of a journal to which Lizette had submitted a manuscript. The manuscript was reviewed in the usual way. Based on the reviewers' comments and my own reading, I sent a detailed editorial decision letter explaining the reasons why her manuscript could not be accepted for publication in the journal. Lizette wrote back a very lengthy letter asking me to reconsider the decision. So far the story is rather mundane. Who among us has not either done this or thought about doing this because the editor and his or her set of reviewers missed the point? But this is precisely where the story begins.

Lizette prepared the most thoughtful, circumspect, and thorough letter. The letter recognized the merit in each of the reviews, countered key points gently, and reflected on the editorial process and its strength and limitations. Appeal letters, as these are sometimes called, are not at all rare and the letters vary in the extent to which they are defensive, wildly offensive, righteous, dismissive, or superficial. I say this with some authority, I think, not because I have seen so many of such letters, but because I routinely incorporate each of these ingredients into my own appeals to editors who continue to reject my manuscripts.

Lizette wanted her manuscript to be reconsidered, a minor feature of this story. My own policy in journal editing is to always (or almost so) reconsider a manu-

script if the author appeals a decision. The review process has blemishes and imperfections, just as many of the studies that are submitted to it. Consequently, it is unwise to view a verdict as final if the author is willing to revise the manuscript thoroughly, to address key points raised in the reviews, and to have the manuscript undergo a completely fresh review. As for this part of the story, the manuscript was reconsidered and eventually accepted.

I mention all of this to convey a feature about Lizette evident in this first encounter. How the appeal was made by Lizette was quite special both from a scholarly and interpersonal perspective. The letter she wrote was so sensitive to different sides of the issues and remarkable in thoroughness that I asked (begged) her to accept a position as associate editor. Fortunately, she agreed. I hasten to add there were no surprises in her editing. She was marvelous. Her editorial decision letters provided the care and thoroughness evident in her original appeal letter to me.

Her associate editor days passed long ago and she moved to edit journals, including her most recent appointment as editor-elect of the *Journal of Consulting and Clinical Psychology*. Many of us have reviewed manuscripts for Lizette as editor and have seen her skills in action. Many of us have received editorial decision letters from her and invariably some of these have been letters rejecting our manu-

scripts. In my own experience, it was easy to concede (at least privately to myself) that her editorial decision letters rejecting my manuscripts were much more scholarly, balanced, carefully prepared, and worthy of publication than the study I had submitted to her.

Editors and the journal review process are frequently maligned. Much of this is deserved and, perhaps in some circumstances, understated. There have been sophisticated analyses of the process and research on factors (e.g., about authors, hypotheses and findings of the study) that contribute to whether a paper is or is not accepted. Knowing the journal editing side of Lizette has given me a different view of these weighty matters. A major problem with the journal review process is that there are not enough people who approximate the skills, sensitivity, care, and thoughtfulness that Lizette routinely displayed. What she added to the integrity of the process not only improved the work of those to whom her letters were directed but also set a standard to which our science and scientific publication ought to strive.

There are many facets of Lizette to praise and to remember, and my comments do not address those that will be most near and dear to her family and close personal friends. My professional contacts, beginning with the one I highlight here, merely note an instance of her uniqueness, but no doubt they stand for characteristics that pervaded many areas of her personal and professional life. What a privilege to know her, to have contact with her, and to stand in awe and emulate some of the skills and sensitivities she brought to her work. Her loss is terrible and terribly painful. ✍

The Role of the Media and Primary Care in the Dissemination of Evidence-Based Parenting and Family Support Interventions

Matthew R. Sanders and Karen M. T. Turner, *Parenting and Family Support Centre, University of Queensland*

Several recent comprehensive reviews have documented the efficacy of behavioral family intervention (BFI) as an approach to treating children and their families (Lochman, 1990; McMahon, 1999; Sanders, 1996, 1998; Taylor & Biglan, 1998). There is clear evidence that BFI can benefit children with disruptive behavior disorders, particularly children with oppositional-defiant disorders, and their parents (Forehand & Long, 1988; McMahon & Wells, 1998; Webster-Stratton, 1994). The empirical basis of BFI is strengthened by evidence that the approach can be successfully applied to many other clinical problems and disorders, including attention-deficit/hyperactivity disorder (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992), persistent feeding difficulties (Turner, Sanders, & Wall, 1994), recurrent pain syndromes (Sanders, Shepherd, Cleghorn, & Woolford, 1994), anxiety disorders (Barrett, Dadds, & Rapee, 1996), autism and developmental disabilities (Schreibman, Kaneko, & Koegel, 1991), achievement problems, habit disorders, and common childhood problems (see Sanders, 1996; Taylor & Biglan, 1998, for reviews of this literature). Parenting and family-oriented interventions have also been increasingly used with parents of adolescents at risk of drug abuse, conduct problems and delinquency, attention-deficit disorder, eating disorders, depression, and chronic illness (Dishion & Andrews, 1995; Irvine, Biglan, Smolkowski, Metzler, & Ary, 1999).

Meta-analyses of treatment outcome studies of BFI often report large effect sizes (Serketich & Dumas, 1996), with

good maintenance of treatment gains (Forehand & Long, 1988). For instance, treatment effects for children have been shown to generalize to school settings (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991) and to various community settings outside the home (Sanders & Glynn, 1981). Parents participating in these programs are generally satisfied consumers (Webster-Stratton, 1989). Additionally, BFI has been found to reduce maternal depression and stress, increase parental satisfaction and efficacy, and reduce marital conflict over parenting issues (e.g., Nicholson & Sanders, 1999; Sanders, Markie-Dadds, Tully, & Bor, 2000; Sanders & McFarland, 2000; Webster-Stratton, 1998).

Despite the fact that family-based interventions are effective in the treatment of many common childhood behavior problems, these interventions are not widely available in the community and therefore make a negligible impact on the prevalence of children's behavior difficulties. This article examines the role of a population strategy targeting the media and professionals in primary care services (e.g., family doctors, child health nurses, teachers, child care workers, and allied health professionals) as part of a comprehensive parenting and family support system to improve the health status and well-being of children. An overview of the Triple P-Positive Parenting Program is provided as a model for a multilevel system of intervention for preventing and managing childhood emotional and behavioral problems. The levels of intervention are detailed in terms of their increasing intensity and narrower reach

according to families' individual needs, cost-effectiveness, and flexible delivery formats. Drawn from the Triple P model, the first three levels of intervention are discussed in detail as they differ from traditional mental health service delivery for parents and children and rely on media and primary care settings as vehicles to promote families' access to parenting information and support. Research that has begun to test the impact of these media and primary care programs in reducing child behavior problems and improving parents' skills and sense of competency is also summarized. Finally, some of the benefits and challenges involved in developing media programs and training primary care practitioners to prevent mental health problems, provide early intervention services, and refer patients for additional mental health services are discussed.

The Importance of Dissemination

There has been general acknowledgment of the gap that exists between clinical research in psychological interventions and the practices of clinicians in the field (Fixsen & Blase, 1993; Taylor & Biglan, 1998; Wilson, 1997). Despite the evidence for BFI and the trend for managed care, cost-effective practice, and accountability (Task Force, 1995), empirically supported intervention programs have not achieved widespread use in clinical practice (Stolz, 1981; Task Force, 1995; Wilson, 1995). Effective dissemination of empirically supported interventions to clinicians in the community has been lacking (Barlow, Levitt, & Bufka, 1999), and families presenting to clinical services commonly do not receive these interventions (Taylor & Biglan, 1998; Webster-Stratton & Taylor, 1998). Many services continue to use ineffective, nonempirically supported psychotherapeutic interventions or nonevaluated parenting and family support programs (Webster-Stratton & Taylor). In fact, only the minority of children with identifiable conduct problems receives any form of treatment (Zubrick et al., 1995).

While scientific debate has turned to the importance of implementing empirically supported interventions, research has primarily focused on efficacy studies, with less attention to effectiveness studies, and little attention to the evaluation of training and dissemination methods (Barlow & Hofmann, 1997). Effective dissemination is critical for evidence-based research to have any significant community impact. Traditional dissemination strategies like scientific publications and professional meetings have many limits, such as clinicians' poor access to or use of scientific journals, and brief information from pro-

EDITORIAL NOTE: The AABT Committee on Public Education and Media Dissemination is responsible for efforts to educate and inform the public regarding issues encompassed by behavior therapy and for responding to requests from media representatives to the association. This article is the second in a series of articles by the committee, with the goal of providing information about educating the public on behavior therapy, including communicating with and through the media. The committee is pleased that Matthew R. Sanders and Karen M. T. Turner agreed to write an article about their use of the media and primary care providers in the important parenting and family support work they do in Australia.

AABT members with an interest in getting involved in activities of the committee and/or the AABT Media and Community Connection program are encouraged to contact David Hansen, Chair of the Committee (dhansen1@unl.edu), or Mary Jane Eimer, Executive Director of AABT (mjeimer@aabt.org).

—David J. Hansen, *Chair, AABT Committee on Public Education and Media Dissemination*

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fessional meetings having little impact on clinical practice (Backer, Liberman, & Kuehnel, 1986). We contend that a population health perspective on family intervention is required that involves the explicit recognition of the role of the broader ecological context of parenting (e.g., Biglan, 1995; National Institute of Mental Health, 1998). Such an approach is more likely to change parenting practices and thereby reduce the prevalence of problem behavior in children.

A Population Approach to Family Intervention: The Triple P–Positive Parenting Program

Approaches to prevention are typically conceptualized as falling into one of three categories: universal, selective, or indicated (Mrazek & Haggerty, 1994). A universal prevention strategy targets an entire population (e.g., national, local community, neighborhood, or school); selective prevention programs refer to strategies that target specific subgroups of the general population that are believed to be at greater risk than others for developing a problem (e.g., low-income families, young single mothers); and indicated preventive

interventions target high-risk individuals who are identified as having detectable problems, but who do not yet meet diagnostic criteria for a behavioral disorder (e.g., disruptive and aggressive children).

The Triple P–Positive Parenting Program is a multilevel parenting and family support strategy developed by the authors and colleagues at the University of Queensland in Brisbane, Australia. The program aims to prevent severe behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills, and confidence of parents. It incorporates universal, selective, and indicated interventions organized across five

TABLE 1: THE TRIPLE P MODEL OF PARENTING AND FAMILY SUPPORT

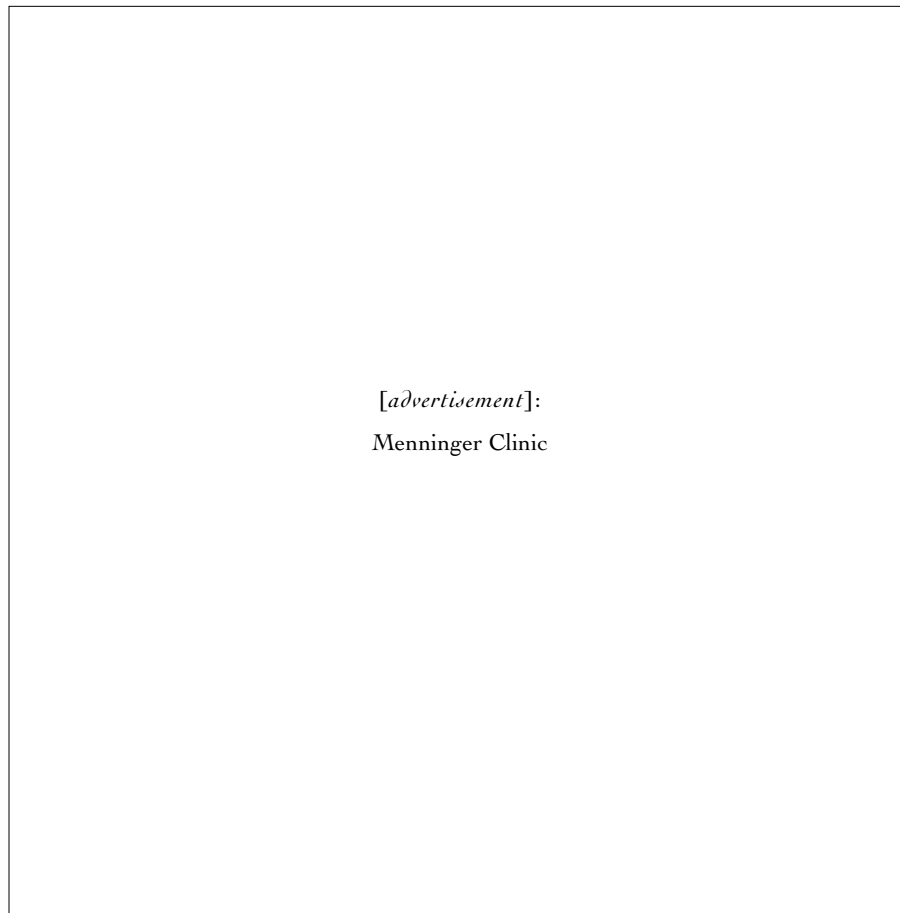
Level of Intervention	Target Population	Intervention Methods	Possible Target Areas
1. <i>Universal Triple P</i> Media-based parenting information campaign	All parents interested in information about parenting and promoting their child's development.	A coordinated information campaign using print and electronic media and other health promotion strategies to promote awareness of parenting issues and normalize participation in parenting programs such as Triple P. May include some contact with professional staff (e.g., telephone information line).	General parenting issues; common, everyday behavioral and developmental issues.
2. <i>Selected Triple P</i> Information and advice for a specific parenting concern	Parents with specific concerns about their child's behavior or development.	Provision of specific advice on how to solve common child developmental issues and minor child behavior problems. May involve face-to-face or telephone contact with a practitioner (about 20 minutes over two sessions) or (60-90 minute) seminars.	Common behavior difficulties or developmental transitions, such as toilet training, bedtime problems.
3. <i>Primary Care Triple P</i> Narrow focus parenting skills training	Parents with specific concerns about their child's behavior or development who require consultations or active skills training.	A brief program (about 80 minutes over four sessions) combining advice with rehearsal and self-evaluation as required to teach parents to manage a discrete child problem behavior. May involve face-to-face or telephone contact with a practitioner.	Discrete child behavior problems, such as tantrums, whining, fighting with siblings.
4. <i>Standard Triple P</i> <i>Group Triple P</i> <i>Self-Directed Triple P</i> Broad focus parenting skills training	Parents wanting intensive training in positive parenting skills. Typically targets parents of children with more severe behavior problems.	A broad focus program (up to 12 one-hour sessions) for parents requiring intensive training in positive parenting skills and generalization enhancement strategies. Application of parenting skills to a broad range of target behaviors, settings and children. Program variants include individual, group, or self-directed (with or without telephone assistance) options.	Multiple child behavior problems; aggressive behavior; oppositional-defiant disorder; conduct disorder; learning difficulties.
5. <i>Enhanced Triple P</i> Behavioral family intervention	Parents of children with concurrent child behavior problems and family dysfunction.	An intensive, individually tailored program (up to 11 one-hour sessions) for families with child behavior problems and family dysfunction. Program modules include home visits to enhance parenting skills, mood management strategies, stress coping skills, and partner support skills.	Concurrent child behavior problems and parent problems (e.g., relationship conflict, depression, stress).

levels on a tiered continuum of increasing strength (see Table 1).

Level 1, a universal parent information strategy, provides all interested parents with access to useful information about parenting through a coordinated media and promotional campaign using print and electronic mass media and user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies. This level of intervention aims to increase community awareness of parenting resources, promote parents' receptivity to participating in programs, and create a sense of optimism by depicting solutions to common behavioral and developmental concerns. Level 2 is a brief, 1- to 2-session primary care selective intervention providing anticipatory developmental guidance to parents of children with mild behavior difficulties. Level 3, a more intensive, 4-session selective intervention, is designed for parents of children with mild to moderate behavior difficulties and includes active skills training for parents. Level 4 is an intensive 8- to 10-session individual or group training program for parents of children with more severe behavioral difficulties. Level 5 is a 5- to 11-session enhanced BFI program for families with parenting difficulties complicated by other sources of family distress (e.g., relationship conflict, parental depression, or high levels of stress). It builds on Level 4, with additional modules targeting home practice of parenting skills, coping skills, and partner support skills.

This tiered, multilevel strategy recognizes that there are differing levels of dysfunction and behavioral disturbance in children and adolescents, and parents have differing needs and desires regarding the type, intensity, and mode of assistance they may require. The system is designed to maximize efficiency, contain costs, avoid waste and overservicing, and ensure the program has wide reach in the community (see Figure 1). The program targets five different developmental periods from infancy to adolescence, and within each developmental period the reach of the intervention can vary from broad (targeting an entire population) to narrow (targeting only high-risk children). The multidisciplinary nature of the program involves the better utilization of the existing professional work force in the task of promoting competent parenting.

Triple P's media and primary care strategy, as part of a larger system of intervention, aims to change the ecological context of parenting. It does this by normalizing parenting experiences (particularly the process of participating in parent education), breaking down parents' sense of social isolation, increasing social and emotional support from others



in the community, and validating and acknowledging the importance and difficulties of parenting. It also involves actively seeking community involvement and support in the program by the engagement of key community stakeholders (e.g., community leaders, government agencies, corporations, schools, and voluntary organizations).

Developing Effective Media Interventions

Rationale for Media Interventions

One way to disseminate effective parenting interventions more widely is by using the mass media. The mass media play an important role in providing health information for the general public (Egger, Donovan, & Spark, 1993), and television acts as the primary vehicle for mass media in today's society. Television has been shown to have the capacity to influence awareness and to change attitudes, beliefs, and behaviors, making it potentially one of the most powerful educational resources available at the present time (Hofstetter, Schultze, & Mulvihill, 1992; Zimmerman, 1996). For example, evidence from the public health field has shown that televised media strategies can successfully increase community aware-

ness of the risk and protective factors impacting upon health and well-being, promote health-preserving behaviors such as abstaining from drinking alcohol when driving, and be instrumental in modifying potentially harmful behaviors such as cigarette smoking, poor diet, and lack of exercise (Biglan, 1995; Sorenson, Emmons, Hunt, & Johnston, 1998).

Although the mass media have been used widely in the health promotion field, little is known about resulting effectiveness in the field of family intervention.

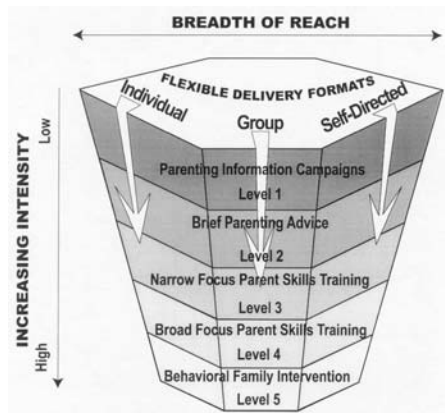


Fig 1. TRIPLE-P MODEL OF GRADED REACH AND INTENSITY OF PARENTING AND FAMILY SUPPORT SERVICES

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There are several potential advantages of using media strategies such as television as an information source for parenting and family issues. Mass media have a pervasive influence on modern families. For example, adults watch approximately 3 hours of television per day (Nielsen, 1998); 47% of adults rate television as the best medium for accurate and reliable news; 61.8% choose to obtain news and information from television; and 79.6% report it to be the most influential advertising source (Federation of Australian Commercial Television Stations, 1995).

Media-based parent education programs have the advantage of being able to be accessed in the privacy of the home by a large proportion of the population, some of whom, such as parents living in rural and remote locations, may otherwise be difficult to reach. As an early intervention/prevention strategy, they have the potential to significantly decrease costs associated with accessing professional services. Alternatively, they may assist parents to recognize early warning signs of behavioral and emotional problems in children and encourage them to seek professional advice early when a minimal level of intervention may be sufficient to address recent-onset, discrete child behavior problems (Sanders & Markie-Dadds, 1996). Moreover, media-based parent education programs can promote and increase community awareness of effective parenting strategies and understanding of the role family relationships play in the health and well-being of young children (Sanders, 1999). Media interventions of this type have the capacity to create a social milieu that is supportive of parent education and family change (Flay, 1987), which can be used to counter alarmist, sensationalized, or parent-blaming messages (Sanders). An added advantage of such programs is that any behavioral change achieved is likely to be attributed to one's own efforts (Flay), thus increasing parents' feelings of personal competence.

To be most effective as a mechanism of behavior change, rather than operating purely as a strategy for raising public awareness, it has been argued that a media intervention needs to not only provide information about the problem behavior but also provide practical advice about how to deal with it effectively (Andrews, McLeese, & Curran, 1995; Flay & Burton, 1990; Owen, Bauman, Booth, Oldenburg, & Magnus, 1995). For example, Parloto, Green, and Fishman (1992) found that efforts to teach mothers about the general principles of nutrition were less successful in changing infant feeding patterns than programs that pinpointed food-related behaviors and gave specific skills-based information, such as teaching mothers how to adequately prepare their

infant's food. Similarly, for the mass media to be a successful vehicle for the promotion of effective parenting skills and the modification of parental behavior, information about functional strategies for promoting competence in children and for dealing with problem behavior needs to be provided. Behavior change then requires parents to adopt a self-regulatory approach that involves self-monitoring, self-identification of personal strengths and weaknesses, and personal goal setting (Halford, Sanders, & Behrens, 1994; Webster-Stratton, 1992).

Triple P in the Media

A universal Triple P prevention strategy was recently developed to include a media campaign on parenting based around a television series, *Families*, which was shown in prime time on a commercial television network in New Zealand. The 13-episode (30 minutes per episode) series was in an "infotainment" style to ensure the widest reach possible for Triple P. Such programs are very popular and, according to ratings data, frequently attract around 20% to 35% of the viewing audience (Nielsen, 1997). The series used an entertaining format to provide practical information and advice to parents on a variety of common behavioral and developmental problems in children as well as other parenting issues. The main segments included the following: a feature story, which presented brief discussions on a number of family issues (e.g., school involvement and the role of fathers in the family); a segment in which a celebrity family discussed a range of issues about their family; family health care tips; animal care and integrating the pet into family life; interesting facts about the current state of families in society; and a Triple P segment.

A 5- to 7-minute Triple P segment each week enabled parents to complete a 13-session Triple P intervention at home. The Triple P segments provided brief examples of the causes of child behavior problems from a social learning perspective; provided information on how to monitor child behavior; and presented clear guidelines for using a range of parenting strategies designed to encourage desirable behavior in children (e.g., descriptive praise, positive attention), prevent problems from occurring (e.g., providing engaging activities), and manage difficult behavior (e.g., rule setting, directed discussion, planned ignoring, and the provision of clear instructions backed up by logical consequences, quiet time or time-out). These strategies were integrated into parenting plans for common problems (e.g., whining, disobedience, aggression and temper tantrums), for promoting children's development (e.g., encouraging

creativity and involvement in sport, and helping with homework), and for managing developmental issues (e.g., cooperative play, sleeping difficulties, and eating difficulties). In addition, each Triple P segment presented a modeled demonstration of suggested strategies.

A cross-promotion strategy using newspapers, posters, and magazines was also used to prompt parents to watch the program and inform them of how to contact a Triple P telephone information line for more information about parenting. The Families fact sheets (specifically designed parenting tip sheets providing a back-up self-help strategy based on the information from the Triple P segment) were also available by writing to a Triple P center, calling the Triple P information line, or through a retail chain store.

To evaluate whether this form of media intervention could have a significant impact on family functioning, Sanders, Montgomery, and Brechman-Toussaint (2000) randomly assigned 56 mothers with children aged between 2 and 8 years either to a media intervention or wait-list control group. Mothers in the intervention group were given the television series, in the format of videos and tip sheets. These mothers watched two episodes of the series (in their own home) each week, at a time convenient to them, and read the relevant tip sheets. Mothers in the control group received no intervention for 6 weeks. As predicted, mothers in the media condition reported significant reductions in child behavior problems posttreatment in comparison to the control group. Reductions occurred in both the intensity of problem behavior and the number of problems that mothers were experiencing with their child. The percentage of children from the control condition falling in the clinical range for problem behavior did not change from pre- to postintervention, yet there was a significant decrease in the percentage of children from the media condition who fell in the clinical range—from 46% prior to the intervention to 14% remaining in the clinical range following the intervention. Mothers in the media condition also reported an increased sense of competence and satisfaction in their parenting abilities relative to mothers in the control group. Anecdotally, many mothers reported that the realization they were doing some things “the right way” was one of the most salient outcomes of the program. A strong trend was also indicated for mothers in the media condition to demonstrate a reduction in dysfunctional parenting styles (e.g., laxness, overly harsh discipline, nagging) relative to the mothers in the wait-list condition. Although the upfront cost of establishing a media-based intervention program such as Families is

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substantial, the reach may be wide and the long-term benefits to individuals and the community may far outweigh these initial costs.

As Triple P has been disseminated more widely in the community, different kinds of media activities have been used to promote the program. These activities have included the broadcast of Triple P positive parenting tips (60 to 120 seconds each) on community radio stations, a weekly newspaper column on positive parenting, editorial and feature articles on the program, 30-second television commercials promoting the five key principles of positive parenting (a safe, engaging environment; a positive learning environment; assertive discipline; reasonable expectations; and taking care of ourselves as parents), positive parenting inserts in school newsletters, public lectures and presentations by Triple P staff, and news and current affairs stories on network television. Triple P has been featured on the Australian version of *60 Minutes* as well as on several other current affairs programs. These programs have generally tracked one or more children through an intervention program and have promoted strong public interest. Activities such as these provide examples of ways in which the media can be used to promote program awareness, which in turn can create

demand for evidence-based programs. Our experience has been that it is important to develop appropriate referral networks and back-up services for more intensive interventions prior to the commencement of a media campaign.

For some families, exposure to the media is the only participation they will have in a parenting program. Hence, designing a media campaign with thematically consistent, practical, and culturally appropriate messages is critical to ensure acceptance and maximum impact. This may be accomplished by ensuring key themes (e.g., importance of preemptive anticipatory parenting, consistency, positivity) occur in the media. The practical usefulness of information can be enhanced by using footage that demonstrates key skills and competencies. Cultural acceptability of parenting advice can be checked through reference groups and by surveying different ethnic groups.

This level of intervention may be particularly useful for parents who have sufficient personal resources (i.e., motivation, literacy skills, commitment, time, and support) to implement suggested strategies with only brief parenting advice. However, a media strategy is less likely to be effective on its own for parents who have a child with a severe behavioral disorder or where a parent has few of the

resources listed above, is depressed, in a conflictual relationship, or suffering from major psychopathology. In these instances a more intensive form of intervention is needed. Conversely, media interventions may be an ideal maintenance strategy for families with multiple problems who have already received successful intensive interventions.

The effective use of the media depends on a host of other factors, including the development of good working relationships with media personnel, the availability of suitable time slots to reach the target audience, and the high cost of some media productions. Our approach to working with the media has also involved being prepared to reach an agreement with producers about how the subject matter will be treated. For example, the media's search for emotionally arousing material can lead to the depiction of children with behavior problems in pejorative terms (e.g., brats, monsters, future delinquents). We frequently point out the hazards and inaccuracies of depicting children in this way. On the other hand, if parents choose to represent their children in a particular way, it is their decision. Our concern has been how reporters and script writers choose to represent families and children. The potential for bad publicity needs to be weighed against the overall advantages of favorable media coverage of parenting issues. Our experience with the media has generally been a very positive one that has enabled many important issues concerning the well-being of children and parents to be publicly aired.

Primary Care as a Setting for Prevention and Early Intervention

Rationale for Primary Care Interventions

The last decade has seen an increasing emphasis on treating mental health problems at the primary care level (Giel, Koeter, & Ormel, 1990). A large number of pediatric consultations deal with parental concerns about children's behavior, development, or school achievement (Christopherson, 1982, 1983; Oberklaid, Dworkin, & Levine, 1979; Taylor & Biglan, 1998; Triggs & Perrin, 1989). A recent parenting survey showed that family doctors were the professionals most frequently consulted by caregivers of children with an emotional or behavioral problem (Sanders, 1999). Similarly, the Western Australian Child Health Survey showed that 65% of parents of children with behavioral and emotional problems consulted a doctor during a 6-month period, yet only 2% saw a mental health specialist (Zubrick et al., 1995). Although

primary care professionals are well-positioned to provide parenting support, they are commonly underresourced and undertrained for the detection of child behavior problems and the provision of effective mental health programs for children and families.

In a national U.S. survey of over 2,000 parents with children under 3 years of age, Young, Davis, Schoen, and Parker (1998) highlighted parents' concerns and the information they would like to receive from their pediatric physician or nurse. The majority of parents reported having a regular source of pediatric health care, which met their child's health needs, yet many were not satisfied with the help they received with regard to understanding their child's growth, development, or care. Fewer than one quarter had talked with their pediatric clinician about discipline or promoting their child's development. Parents who received this type of information were significantly more satisfied with their pediatric clinician than those who had not. A majority of parents (79%) reported a desire for more information from their pediatric clinician in at least one of six areas of child rearing (i.e., newborn care, sleep patterns, crying, toilet training, discipline, and encouraging early learning). These data suggest that personalized advice, in the context of an ongoing supportive relationship, is the need being expressed by parents.

As they have regular contact with young families, primary care services can undertake several important tasks to promote children's mental health. Early detection of significant deviations from normal development and provision of advice to parents seeking information about developmental issues can become part of routine well-child care. Provision of brief behavioral counseling for child behavior problems and increased access to early intervention for dysfunctional family interaction patterns could help to prevent later, more serious problems. Primary care service providers can be supported to perform a triage function for the appropriate referral of moderate to severe child behavior problems to specialized services and be better informed about available mental health services in the community. This helps match intervention strength to individual family needs and ensures the limited funds available for specialist mental health services are directed where they are most needed. In the long term, widespread implementation of such preventive primary care interventions could function to decrease the number of children requiring specialist mental health services. Through this type of primary care strategy, parent education and support in preventing and managing childhood emotional and behavioral problems become an

integral part of family health care provision.

Triple P in Primary Care Settings

Three recent trials have assessed the impact of Triple P interventions in primary care settings. The first (Williams, Zubrick, Silburn, & Sanders, 1997) examined the effectiveness of specialized training and implementation of a group format intensive parenting skills training program (Level 4 Group Triple P; Markie-Dadds, Turner, & Sanders, 1997; Turner, Markie-Dadds, & Sanders, 1998) by primary care staff. The program was administered as a selective prevention demonstration project to reduce the prevalence of conduct problems at a population level. The target population was all parents of 3- to 4-year-old children living in a metropolitan area with high socioeconomic disadvantage and high child-abuse notification rates. The intervention was relatively brief—four, 2-hour group sessions and four 15- to 30-minute individual telephone consultations. The program was successful in reducing dysfunctional parenting from twice the population average to general population levels and significantly reduced disruptive behavior problems in the children of participating families. Results were maintained at 12- and 24-month follow-up.

The second (Sultana, Matthews, De Bortoli, & Cann, 2000) involved a randomized controlled trial comparing two brief parenting interventions (Level 2 and 3 Triple P; Turner, Sanders, & Markie-Dadds, 1999) implemented by maternal and child health nurses, in comparison to a wait-list control condition. The study aimed to evaluate the impact of the Level 2 intervention (involving self-administration of written parenting advice following a 15-minute consultation) in comparison to the Level 3 intervention (involving four brief consultations supported by written and videotape parenting advice). Participants were 50 families of children aged between 18 months and 6 years with a recent-onset, mild-to-moderate behavior problem. Results showed that Level 3 intervention produced significant reductions in child behavior problems and increases in appropriate discipline practices in comparison to the wait-list control condition. Moderate positive parent and child outcomes were achieved by families in the Level 2 intervention; however, results did not differ significantly from the wait-list control condition. The Level 3 intervention proved superior to Level 2 on one measure of child behavior problems (Parent Daily Report Checklist; Chamberlain & Reid, 1987) and in reducing conflict between parents over parenting.

The third, a study being conducted by the authors (Turner & Sanders, 2001), is a randomized controlled effectiveness trial examining the impact of Level 3 interventions conducted as part of routine practice by nurses in two community child health centers. It was hypothesized that, in comparison to a wait-list control group, families receiving the brief intervention would show a greater reduction in dysfunctional parenting practices and a reduction in parenting stress. It was also hypothesized that these changes would moderate a decrease in the targeted child behavior problem(s). Thirty families presenting to community child health clinics requesting information or advice about child behavior problems or developmental issues (for children between 2 and 6 years of age) participated in the study. The children of participating families were at risk of, but not yet displaying, severe pathology. Preliminary results show that, in comparison to the wait-list condition, families receiving the intervention exhibit a significant decrease in dysfunctional parenting strategies, a significant increase in mothers' sense of parenting competence, and a significant decrease in reports of problem child behavior (again on the Parent Daily Report Checklist). These results are maintained 6 months following completion of the program.

Results from these trials provide support for the efficacy of primary care staff in offering brief, early parenting support, resulting in improved parenting practices and reduced child problem behavior. However, the introduction of a coordinated parenting support strategy may represent a significant change of role for many primary care practitioners. We advocate an approach that views changing professionals' consulting practices as a complex interaction between the quality of the intervention, the quality of the skills training for practitioners, the posttraining environment, and the practitioner's feelings of self-efficacy in implementing the program. This is a model currently being examined by the authors in a survey of over 1,000 professionals following training in Primary Care Triple P (Turner & Sanders, 2001). Preliminary results from this trial have identified a number of barriers for primary care staff in delivering the program following training. Common barriers include integration of the program with their usual caseload or responsibilities, access to supervision, and proficiency in implementing the program, such as keeping parents on track and covering session material in the scheduled time (Turner & Sanders, 2000). These issues can be of particular concern for professionals who are unused to consulting in a particular way (e.g., conducting group programs, scheduling repeat appoint-

ments). Where the mode of delivery and/or content of a new program varies markedly from a professional's comfort zone, there may be a greater need for support in the workplace through the provision of appropriate resources, training, and supervision.

Our approach to dissemination of Triple P, which has been applied in a statewide contract funded by the Queensland Health Department (Markie-Dadds, Brechman-Toussaint, & Sanders, 2000), includes the adoption of an ecological perspective. This approach to dissemination involves providing information and technical support to supervisors or managers (e.g., orientation briefings, procedures guidelines, regular updates); consultative back-up to practitioners (e.g., troubleshooting, training, e-mail question-and-answer forum); correct information about the program (e.g., clarification of expectations, correcting misperceptions); periodic reviews of an agency's implementation (e.g., identification of strengths and barriers at each site, review of progress toward performance indicators); assistance to mobilize political support and advocacy (e.g., briefings to policy advisers and ministers, suggestions for gaining media coverage, regular updates to key stakeholders); support in establishing supervision networks (e.g., provision of guidelines, identification of a coordinator, support to overcome administrative obstacles and process issues); and support for the availability of flexible work hours.

Conclusions

If only a small proportion of children with significant mental health problems has contact with mental health services (Zubrick et al., 1995), there are obviously significant barriers to service utilization. Several steps can be undertaken to improve community awareness of parenting issues and enhance service provision. Greater community education through the mass media regarding parenting issues can directly influence parenting practices and may optimize early help seeking (Vasquez-Barquero, 1990). To improve detection rates, optimal training for primary care professionals should focus on increasing awareness of the nature and prevalence of mental health problems in their patients, and the characteristics of high-risk groups (Giel et al., 1990; Vasquez-Barquero). Finally, increasing the skills of primary care practitioners in brief prevention and early intervention programs and establishing appropriate referral and liaison mechanisms with specialist mental health services (Cotton, 1998; Kramer, Simonsick, Lima, & Levav, 1992; Nicholson, Ffrench, Oldenberg, & Connelly, 1997) would help to ensure

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optimal care for patients presenting with mental health, behavioral, or social concerns.

The more effective use of the media and primary care services represents a potentially important vehicle through which increased access to evidence-based parenting and family interventions can be achieved. Access to effective interventions is an important consumer issue, with implications for equity and social justice. The appropriate use of the media is one means of educating the public about best available treatments for child and family problems. This process can exert some pressure on professionals to adopt more efficacious practices. Parent consumers are potentially extremely powerful advocates for better services for children and families. The media can also have a direct function of educating professionals, who, like parents, are exposed to media messages.

As noted earlier, primary care services are well placed to offer parenting support in the community, through early detection of problems, provision of advice to parents about developmental issues, provision of empirically supported prevention and early intervention programs for mild to moderate child behavior problems, and appropriate referral to specialist services for moderate to severe problems. As the majority of pediatric clinicians do not feel adequately prepared to provide such a service (Oberklaid et al., 1979; Young et al., 1998), primary care professionals need better training and access to high-quality, well-researched information resources to use in consulting with parents about developmental and behavioral issues (Taylor & Biglan, 1998).

Commonly expressed concerns are that the provision of training to primary health care practitioners to deliver parent training will reduce the role of specialist mental health practitioners, and that families will be harder to work with if there has been an unsuccessful, less intensive intervention. Our experience has been rather different. Through relevant training, primary care practitioners develop knowledge of the type and intensity of intervention indicated and are more inclined to implement early interventions and make appropriate referrals to other professionals as required. If primary care professionals develop better detection strategies and are more aware of local services, it is likely that mental health services will be better accessed by families in need of specialist services while less severe cases are dealt with appropriately in self-directed and primary care prevention programs. Examination of the number and nature of referrals from primary care settings may clarify this issue.

There is a need for innovative dissemination research that examines how to optimize the application of psychological science knowledge on persuasive communication to promote better parenting practices through media interventions and existing service providers. Most of the research on health communication has not examined relationship issues within the family. Similarly, relatively few studies have systematically evaluated parenting interventions delivered through primary care services or the optimal means of dissemination to such service providers. Controlled studies examining variables that influence practitioner adoption and accurate implementation of evidence-based parenting and family interventions must be seen as a priority in the field.

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Ready for Reno?



Now that you have sent in your Convention registration form, reserved a flight to Reno, called the hotel for a room (and will remember to bring the confirmation number with you), you can make your Convention experience even better by:

Participating in the Networking Lunch

Friday, 12:30–1:45 P.M., Reno Ballroom
Tickets will be available on site.

A great way to meet colleagues who share your concerns. Table facilitators will get the ball rolling by introducing the subject and surveying the participants for areas to be shared. The emphasis will be on sharing your thoughts, knowledge, and expertise.

Attending the Awards Ceremony

Friday, 5:15–6:15 P.M., Crystal Ballroom 3 /4
Honor AABT members who have given their time and energy to help shape the field and the Association.

Dancing the Night Away

Saturday, 9:00 P.M.–1:00 A.M., Reno Ballroom
Join friends for a drink and some laughs.
And, if time allows,

Visiting Lake Tahoe

Sunday from 12:30 to 5:30 p.m.
Tour the north rim of this natural wonder with a professional guide.
See ticket information in Program.
Deadline for reservations is November 3.

Behavior Therapy and the Medicalization of Male Sexuality

Barry A. Bass, *Towson University*

The replacement of the medical model with the behavioral model will have a place of honor in the books yet to be written about 20th-century abnormal psychology. The medical model of the mid-20th century posited that symptoms of psychopathology were simply that: symptoms of a deeper underlying psychological disorder. Proponents of this paradigm cautioned nonbelievers to dare not treat symptoms directly, lest the underlying disease process reemerge in the form of new and perhaps even worse symptoms (Bookbinder, 1962). Having fought and defeated the 20th century version of the medical model (see Bandura, 1969), behavior therapists are now being coaxed into adopting a new, improved version of the discredited model.

The 21st-century version of the model might more appropriately be labeled the medicalization paradigm. This new and improved version implies that because medical treatment is so effective, the underlying psychosocial causes of abnormal behavior have become much less relevant, thereby making psychological assessment an unnecessary luxury. As the media headlines news that research on impotence upsets the idea that it is usually psychological (Stipp, 1987, p.1), we, as well as the public, are led to believe that uncovering the conditions or reinforcers maintaining problem behaviors has become an unnecessary waste of time and effort. Why bother with a functional analysis of behavior if, instead, we can skip directly to a medical treatment for the upset?

Arguing that psychological therapy is time consuming, many psychiatrists and other medical professionals advocate the use of medications over therapy for the treatment of erectile dysfunction (Morgentaler, 1999). It is interesting that the medical establishment originally argued against using brief, behavioral treatments, fearing that such intervention would result in no more than a short-lived, quick fix. Now, ironically, the new medicalization model, in this era of managed health care, is being touted for possessing those very same qualities for which behavior therapy had been previously criticized, mainly its brevity and efficiency.

But why preach to the choir? Surely members of AABT, if no one else, realize that a thorough assessment of the current conditions and reinforcers maintaining any problem behavior is an important first step in the development of an effective treatment protocol. Although the behavioral paradigm posits no necessary link between etiology and treatment, many believe that surgical procedures or medications with potentially deleterious side effects are best avoided when other, less invasive treatment options are available. Surely, those of us reading this journal do not need to be reminded of the dangers inherent within the medicalization model and of the importance of a thorough functional analysis of behavior.

Or perhaps we, too, need reminding. All too often I hear my behavior therapy colleagues expounding the virtues of prescription privileges for psychologists. Without going into the merits of that debate, it is behavior therapy's thunderous silence over the medical co-opting and the consequent medicalization of male sexuality that is of concern here. In spite of the fact that one of behavior therapy's major contributions to the psychological literature has been the successful treatment of erectile dysfunction (Carey, Wincze, & Meisler, 1993; Heiman & Meston, 1997; Mohr & Beutler, 1990), medical and pharmacological interventions are now seen by the public (Toufexis, 1988; Walton, 1993), as well as by many medical and mental health professionals (Manecke & Mulhall, 1999), as the first-line treatments for that disorder.

The rationale for, as well as the advantages of, a medical/pharmacological treatment for male sexual dysfunction are being packaged and delivered to the public by a coalition of medical, pharmaceutical, and other commercial interests that I have labeled elsewhere the *sexual performance perfection industry* (Bass, 2001). Among the founding members of this industry are the American Urological Association, Pfizer Pharmaceuticals (the manufacturer of Viagra), self-help groups started by urologists such as Impotents Anonymous, entrepreneurs who develop and market sex aids such as vacuum pumps and penile implant prostheses, and the mass media, which provide the endless

supply of newspaper and magazine articles written to feed the public's appetite for the latest scientific sexual breakthrough. This industry has won a major public relations coup by convincing many of us that good sex happens when a man inserts a rock-hard penis into a woman's appropriately lubricated vagina and then moves it around in there for a suitable amount of time (Bass, p. 337). The industry's definition of good sex thereby changes the basic nature of a sexual encounter from one of intimacy and pleasure to one of achievement and performance.

This attempt by the sexual performance perfection industry to restrict the definition of sex to performance and intercourse should not be viewed as simply a benign, self-serving deception. This definition of sex, put forth by an industry in which sildenafil (Viagra) is held out as nothing less than the medical breakthrough of the century, represents a phallocentric and iatrogenic orientation to human sexuality. Tiefer (1986), in a similar vein, has written that the medical establishment's pursuit of the perfect penis has resulted in an approach to sex that is both sexist and homophobic. The message communicated in the media by this pervasive medicalization of male sexuality is, in effect, an industry-supported advertisement that serves to provide a steady supply of new customers for the products of a multimillion-dollar industry. It is a message intended to create feelings of inadequacy and to remind us that we do not measure up and that we never will unless we become regular consumers of the industry's products.

But the truth—a truth that we behavior therapists were among the first to recognize—is that the reason so many individuals experience disappointing sex has very little to do with one's medical status (Bass, 1994). In fact, it has been argued that even for those men with documented organic injury or disease known to interfere with genital functioning, it is the psychological distress associated with not measuring up, rather than the physiological limitations imposed upon these individuals by their medical conditions, that is causing most of their sexual disturbance (Bass, 1986; Ellis, 1976). In the majority of cases, ignorance, anxiety, and, more often than not, an inability to communicate openly and honestly with our sex partners contribute to problems with sex (Zilbergeld, 1992).

And because biology is not the culprit, treatments that focus on a pump, an injection, a surgical implant, or even a blue pill are likely to be misguided and misdirected. To put it concisely, sexual distress, even when seen in conjunction with physiological impairment, is primarily the

result of the unrealistically high sexual performance standards promulgated by the sexual performance perfection industry. It is these unattainable standards, rather than our sexual functioning, that need modification. And that is the message that behavior therapy has been broadcasting for the past 30 years. Yet our 20th-century message is not being heard in the medicalized 21st century.

In addition, the data on the prevalence of organic versus psychogenic causes of sexual dysfunction reported in professional sources and then disseminated to the public by the mass media have changed dramatically over the years. Thus, when physicians had few medical interventions at their disposal, the professional literature (as well as the media) reported that over 90% of all men presenting with erection concerns were experiencing something then called psychogenic impotence (Bancroft, 1982). However, as the availability of medical, surgical, and pharmacological treatments has increased, so have the estimates of the organic causes of erectile dysfunction. Now it is not uncommon to read that there is an organic cause underlying erectile dysfunction in more than 80% of men affected by the disorder (Morgentaler, 1999, p. 1713).

Thus, the current conventional wisdom seems to be that all men presenting with sexual concerns should first be evaluated medically to rule out any neurological, vascular, or other biochemical causes before beginning an expensive regimen of psychological treatment. In spite of the fact that for over 20 years the time-limited behavioral treatment of sexual dysfunction has been shown to be both effective as well as inexpensive (Heiman & Meston, 1997), psychotherapy is nonetheless frequently portrayed in the media as an expensive, long-term process.

All of this is not meant to demean the important role that our physician col-

leagues will continue to play in the diagnosis and treatment of male (and female) sexual dysfunction. However, as behavior therapists we have a duty to communicate to our colleagues, as well as to the public, our concerns about the deleterious effects of the current milieu, which encourages us to see all of human sexuality through the lens of the sexual performance perfection industry.

In brief, sexual dysfunction is the inevitable consequence of our futile efforts to attain sexual performance perfection. Only when we effectively communicate that message—the message that attempting to achieve sexual perfection is itself a recipe for sexual failure and disappointment—are we likely to serve as an effective counterbalance to those forces in society committed to utilizing medical intervention to address issues that are most often nonmedical in nature.

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Awards & Recognition

presentation

Come celebrate the accomplishments of your colleagues at AABT's 8th Annual Awards Ceremony, Friday, November 15, 5:15-6:15 P.M., in Crystal Ballroom 3 & 4, at the Annual Convention in Reno. In addition to these award winners, we will also acknowledge:

- ♦ *Elsie Ramos Student Poster Award Recipients*
- ♦ *AABT members who responded professionally to 9/11*
- ♦ *ADAA Career Development Travel Award Recipients*
- ♦ *Mark B. Sobell to receive the Jellinek Memorial Award*



LIFETIME ACHIEVEMENT

Leonard Krasner, Ph.D.,
Stanford University School of Medicine

OUTSTANDING CLINICIAN

Marvin R. Goldfried, Ph.D., SUNY, Stony Brook

OUTSTANDING SERVICE TO AABT

Barry Lubetkin, Ph.D., and **Steven T. Fishman, Ph.D.**,
Institute for Behavior Therapy, New York City

OUTSTANDING TRAINING PROGRAM

Psychology Internship and Postdoctoral Programs
at Wilford Hall Medical Center, **Robert K. Klepac, Ph.D.**,
Director of Psychology Training

DISTINGUISHED FRIEND TO BEHAVIOR THERAPY

Anne Fletcher, for her book *Sober for Good*

VIRGINIA ROSWELL DISSERTATION AWARD

Sudie Back, M.A., University of Georgia

NEW RESEARCHER AWARD

Allison Harvey, Ph.D., University of Oxford

AABT

Reading Grade Level and Readability of Behavior Treatment Programs for Individuals With Developmental Disabilities

Gerald F. McKeegan, Ayonda E. Lanier, Angela D. Adkins, Jennifer L. Amato, Ericka N. Elkins, and Sarah B. Lugar, *Western State Hospital*, and Nirbhay N. Singh, *Medical College of Virginia of the Virginia Commonwealth University*

Written informational materials have become an important aspect of clinical treatment and training in many health care service delivery systems. These materials can be beneficial to consumers, trainees, and staff in the various health fields, but they are often not fully understood (Humfress & Schimdt, 1999). Reading level and readability are two critical aspects of whether written materials are understood. Reading level is the instructional level of written materials, whereas readability is the ease with which an individual can understand or comprehend the materials. In some cases, informational materials are written at the appropriate reading level of the intended audience, but may still be difficult for them to understand because of low readability (Adkins & Singh, 2001; Slaten, Parrott, & Steiner, 1999). Given that over 300 million Americans are functionally illiterate and can barely read printed materials written at an 8th-grade level or above (United States Department of Education, 1986), both reading grade level and readability become important variables in the utility of informational materials.

Studies of patient education materials have shown that most are written well above the reading levels of the population for which the materials are intended. For example, O'Farrell and Keuthen (1983) found that the median reading level of behavior therapy self-help manuals required greater reading capability than can be expected, given that 35% of the adult population in the United States has not completed 12 years of schooling. In another study, Davis et al. (1993) found readability levels of patient education materials and forms for inpatients in substance abuse programs to be 3 to 13 grades above the reading grade levels of the target population. Similar findings have been reported in other areas of patient care (e.g., Kirkpatrick & Mohler, 1999; J. Singh, 1995, 2000).

These findings prompted us to look at the reading level and readability of behav-

ior treatment plans because they are written by psychologists or behavior analysts and implemented by others, such as direct care staff, teachers, and parents. Treatment plans based on behavior analytic principles are useful in treating and managing the behavioral excesses and deficits of individuals with developmental disabilities in both institutional and community settings (Kazdin, 2000; N. Singh, 1997). The research literature is replete with impressive demonstrations of the utility and cost-effectiveness of behavioral methods with people who are developmentally disabled.

One must appreciate, however, that the data reported in behavioral journals are from controlled studies where the interventions are more than likely carried out by well-trained and highly educated research assistants and the fidelity of the interventions is closely monitored by the senior researcher, usually a doctoral-level psychologist. The result is that there is a gap between the effects of behavioral interventions in the research literature and what occurs in everyday applied settings.

Given the reality of most institutional settings, where written behavioral interventions are employed, the interventions are not implemented consistently as prescribed. The result is that the effectiveness of the behavioral plan is less than optimum. Reasons for the inconsistent implementation of behavioral plans have been attributed to staff shortages and deficits in knowledge of behavioral principles on the part of staff responsible for implementing the plans.

Another, often overlooked, factor may be the readability of the written behavior plans interacting with the reading level of the staff responsible for implementing the plans. In our experience, people responsible for writing the treatment plans are professionals with college degrees who have specialized training in behavioral principles; the staff responsible for implementing the treatment plans typically have a high school education and minimal

training in behavioral principles. We suspect that if a behavioral plan cannot be easily understood, there is little motivation for the direct care staff to persevere in implementing it. To better help persons responsible for implementing the plans, it is important for the behavioral treatment plans to be written in such a way that allows readability levels to be congruent with the reading level of the staff.

Are behavior treatment plans written at the reading level of the staff who implement them? In a recent study, A. Singh (1999) assessed the readability of behavior treatment plans implemented in an inpatient psychiatric hospital. Clinical psychologists trained in behavior analysis developed these plans for direct care staff to implement when individuals with mental illness engaged in target behavior problems, such as aggression and property destruction. When assessed on the Readability Assessment Instrument (RAIN; J. Singh, 1994), most did not reach the criteria for acceptable levels of readability. Indeed, given an overall criterion of 80% for acceptability, the mean for these treatment plans was only 58%.

We were interested in assessing whether a similar situation exists in the area of developmental disabilities, where behavior plans are ubiquitous.

Sample

We randomly selected 67 behavior treatment plans from three facilities for people with developmental disabilities and analyzed the reading level and readability of these plans. We defined reading level as the instructional level of written materials and readability as the ease with which a person can comprehend the materials. Certified behavior analysts developed these plans under the supervision of a doctoral-level behavior consultant. Standard behavioral case formulation, based on functional assessment and other relevant data, were used to develop the plans.

Procedures and Instruments

We used the SMOG formula (McLaughlin, 1969) to determine the reading level of each behavior plan. This formula is designed for evaluating the reading level of educational materials that can be read independently by a patient or family member in the absence of assistance from a teacher or instructor (Richardson & Morgan, 1994). It can be used to derive a reading grade level of the materials being evaluated by: (a) counting three sets of 10 sentences from the beginning, middle, and end of the text; (b) counting all the words that have three or more syllables; (c) calculating the square

root of this number; and (d) adding 3 to the square root.

We used the RAIN to assess the readability of the behavior plan. RAIN was developed for assessing the readability of patient education materials and has been found to be an easy-to-use instrument for this purpose (Kirkpatrick & Mohler, 1999). It includes eight text variables and several subvariables in its definition of readability. Overall, readability can be assessed on 14 variables, depending on the appropriateness of each variable for the text being assessed. We used the guidelines established in the RAIN manual to determine acceptable readability on each variable. In addition, we used a scoring criterion of 80% for overall acceptable readability (Kirkpatrick & Mohler).

Interrater Reliability

In addition to the primary person who rated each of the 67 behavior plans on each of the two instruments, a second person also rated 17 (25%) randomly selected plans. Interrater agreement on the RAIN was calculated by dividing the number of agreements by the number of agreements plus disagreements and multiplying by 100. The interrater agreements on the 17 plans ranged from 86% to 100%, with an average agreement of 99.6%. An exact agreement method was used to calculate the interrater agreement on the SMOG. The interrater agreement on the SMOG was 100%.

Results

The range of reading grade levels was from 12.2 to 16.7, with the median being 14.1. The mean grade level required to read the plans was 14.12 ($SD = 1.03$). That is, all behavior treatment plans were written at a level that was above the 12th grade of high school; 91% ($n = 61$) would have required reading levels commensurate with 1 to 4 years of undergraduate studies.

The readability of the 67 behavioral treatment plans was assessed on 12 of the 14 variables used in the RAIN. Two variables, illustrations and adjunct questions, were not applicable to this set of materials. These 2 variables are important aspects of training staff in the understanding of the interventions that are contained in the behavioral plan but are not part of the written product. In our experience, staff training in implementing specific behavior treatment plans is done separately and usually before the plan is implemented. None of the treatment plans met all 12 criteria. A closer inspection of the data showed that 3 plans met 7 criteria, 6 met 8, 34 met 9, and 24 met 10 criteria. Overall, the readability criteria met by the

behavioral treatment plans ranged from 58% to 83%, with a mean of 76%. If the overall acceptability score of 80% is used, 24 (35.8%) of the 67 behavioral treatment plans obtained an acceptable readability score.

Discussion

The average reading grade level of the behavior treatment plans was too high and the overall readability level was too low. Given the low levels of reading abilities in the general population and the low educational levels of direct care staff in institutions for people with developmental disabilities (Rousseau & Foshee, 1981; Zaharia & Baumeister, 1978), the reading levels of the 67 behavior treatment plans that were evaluated needed to be lowered significantly, with some by as much as 10 grade levels so as to match the median reading grade level of direct care staff in institutions.


The behavioral plans could have been edited to make them more readable. Professionals, especially those trained in behavior analysis, who write behavior treatment plans in institutions need to be mindful of making the plans easier to read and understood by the staff who will implement them. Indeed, we recently demonstrated that increasing the readability of behavioral treatment plans enhances their effectiveness in terms of treatment outcomes (Adkins, Singh, McKeegan, Lanier, & Oswald, in press).

It has been our experience that, in many instances, solid behavioral treatment plans derived from a comprehensive functional assessment result in failure because direct care staff are often not adequately trained in implementing the behavioral procedures. In addition, staff may have motivational difficulties in implementing a behavioral plan, as written, because of the ecological conditions in which they typically work (e.g., staff shortages, more than one individual at a time needing behavioral intervention). Our data suggest that behavioral psychologists may actually compound these problems by a lack of attendance to the readability of their written programs. Obviously, this is one area where behavioral clinicians can easily alter their own behavior by writing treatment plans at a readability level that is commensurate with the reading level of the staff that implements them. Such a simple change that increases the user-friendliness of the treatment plans may not only enhance treatment outcomes for the individuals being treated, but also increase collaboration among clinicians and direct care staff.

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Letter to the Editor

A Description of a Rapid Desensitization Procedure

Michael H. Palmer, *North Tier Counseling, Towanda, PA*

I read with interest "A Treatment for Paruresis or Shy Bladder Syndrome" (Weil, 2001), which detailed the treatment of shy bladder syndrome with breath holding to boost CO₂ levels using Wolpe's reciprocal inhibition model. This paper was of particular interest to me as I have been using breath holding to treat a variety of anxiety conditions over the last several years.

My first patient was a 31-year-old Caucasian female who presented at the HMO where I was working in the late 1980s. Her next-door neighbor had ax-murdered his wife and then blown up his house, killing himself and destroying the property, by turning on the gas stove. The patient's presenting complaint was of an intrusive visual image of her then-deceased neighbor coming after her with an ax. While she knew intellectually that this was not possible, she found the recurring image quite distressing. Her sleep was diminished and she appeared anxious. In an effort to bring immediate relief to this distraught young woman, I developed a rapid desensitization procedure as follows: She was briefly trained in Subjective Distress Units (SUDS; 0 to 10) and a description of the distressing image was elicited. I asked her to close her eyes as I represented a description of her feared image. She was instructed to signal me by wiggling her finger when she was able to visualize this scene vividly. A SUDS rating was then obtained. She was then instructed to continue to visualize the picture in her mind's eye as she took and held a deep


breath. She was asked to hold her breath while I counted to 20. At the count of 20, she was instructed to let her breath out and relax. After approximately 15 more seconds had passed, a second SUDS rating was obtained.

This procedure was repeated 31 times in the first session, with SUDS ratings dropping from 9 to 3 by the end of the session. Presented scenes were embellished as we proceeded. As she was initially seen on a Friday, she was sent home with instruction to hold her breath for 20 seconds whenever the image popped back into her mind.

She was seen again the following Tuesday and 23 repetitions of the procedure were performed, with her ultimate SUDS rating dropping to 2. She was scheduled for a third session a week later but called and canceled, reporting significant symptomatic relief to obviate additional appointments. A 6-month follow-up phone call confirmed satisfaction with treatment and no additional difficulties.

I have since used the procedure with dozens of patients with OCD and with a variety of social fears. My observation is that it is particularly useful with anxiety disorder patients who are upper-chest breathers.

Reference

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PRESIDENT RICK HEIMBERG ANNOUNCES

AABT LISTSERVE

AABT launched its listserv in July. It already has over 600 members signed up and corresponding on a variety of issues. It's easy to sign up! Please make sure the central office has your e-mail address (send it to rpark@aabt.org and Rosemary Park, AABT's Membership Services Manager, will update your record).

Then simply go to our Web site, www.aabt.org, click on JOIN AABT, and you will see the listserv in the menu. Click on LISTSERVE and follow the easy instructions.

I would personally like to thank Lynn Marcinko, Ph.D., AABT Listserv Coordinator, Director of Cognitive Therapy Clinic, Assistant Professor, Dept. of Psychiatry, Harbor UCLA Medical Center, and her students, Brittany Burchfield, M.A., and Marie K. Lee, M.A., who will serve as Assistant AABT Listserv Coordinators. Without them, we would not be offering this service. Special thanks to President-Elect Jacqueline B. Persons, Ph.D., for getting the ball rolling.

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Keynote: Aaron Beck, PhD

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Preregistration
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PREREGISTER for the 2002 Convention in Reno!

Registration forms can be found in the program book and on our Web site at www.aabt.org

Comment on Barry Lubetkin's Personal Narrative Regarding September 11

Norman C. Weissberg, *Brooklyn College, CUNY*

As a member of the Disaster Mental Health Team of the Nassau County (New York) Chapter of the American Red Cross, I would like to comment on Lubetkin's (2002) article in the issue of *the Behavior Therapist* devoted to AABT's response to September 11.

First, I note many parallel experiences: To the best of my knowledge, I too was the only AABT member on the Nassau County team; I too "worked" the airport, providing support and counseling to both airline personnel and passengers, albeit under Red Cross auspices; I too lamented the absence of appropriate handouts; and I too observed mental health professionals and others engage in questionable practices in their well-intentioned efforts to assist victims of this tragedy. What prompts this comment, however, is my concern that Lubetkin's observations and recommendations do not sufficiently distinguish between immediate postdisaster interventions and those that may appropriately be applied weeks or months post-disaster. With respect to the former, our job as psychologists is not to provide therapy; it is to administer "psychological

first-aid" (Litz, Gray, & Adler, 2001). That is, rather than intervening with exposure and cognitive restructuring techniques, our task is to offer comfort and support, to depathologize people's reactions to severe stress, to listen empathically to whatever story victims wish to tell, to encourage them to talk with family and friends, and to provide triage. These services often are delivered in noisy, crowded, somewhat chaotic public settings—a far remove from the private offices in which traditional therapy is provided. Moreover, in the immediate aftermath of a disaster, most of our interactions with those affected are brief, one-time encounters—a shorter period of time than even the briefest of brief cognitive-behavioral interventions (cf. Ruzek, 2002).

A disaster of the magnitude and scope of September 11 challenges all of our treatment paradigms. As others have noted (Foa, Hembree, Riggs, Rauch, & Franklin, 2001; Gist, 2001; Herbert et al., 2001), we must be wary of trying to do too much too soon. While providing comfort and support may not meet the criterion of utilizing only empirically vali-

dated interventions, every parent knows that that's where one begins.

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Ruzek, J. I. (2002). Dissemination of information and early intervention practices in the context of mass violence or large-scale disaster. *the Behavior Therapist*, 25, 32-36. ✍

2003 Call for Nominations

AABT is pleased to announce that the first phase of its 2003 election process is under way: the nomination of qualified full members for the positions of President-Elect (2003-2004), Representative-at-Large (2003-2006), and Secretary-Treasurer (2004-2007).

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, 2003, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to AABT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of AABT members in important policy decisions in the coming years. Contact the Nominations and Elections Chair for more information about serving AABT or to get more information on the positions. **Please complete, sign, and send this nomination form to: Attn.: Sue C. Jacobs, Ph.D., Nominations and Elections Chair, AABT, 305 Seventh Ave., New York, NY 10001.**

NOMINATE the Next Candidates for AABT Office

I NOMINATE THE FOLLOWING INDIVIDUALS FOR THE POSITIONS INDICATED:

PRESIDENT-ELECT (2003-2004)

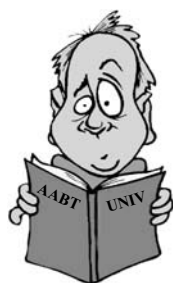
REPRESENTATIVE-AT-LARGE (2003-2006)

_____ ✍

SECRETARY-TREASURER (2004-2007)

NAME (printed)

SIGNATURE (required)



HELP AABT GROW

- SPONSOR A NEW MEMBER
- HELP US FIND LOST MEMBERS

AABT's Membership Committees Launch New Membership Campaigns

Michael Petronko, *Membership Issues Coordinator*

These graphics illustrate our initiation of a broad-based campaign to recruit new members and/or locate previous members in order to bring our census to over 5,000 in 2003. This membership drive is grounded in our belief that more effort needs to be made to champion empirically supported treatments. AABT is the organization best positioned to serve this most important function because of its broad base and interdisciplinary membership. Many of you may wonder why the open book held by the learned man in the above graphic has AABT UNIV printed on it. You may also wonder about the details of being a sponsor. Let me address both issues.

Last year, when discussing the upcoming conference in Philadelphia with my students, I opened up the conference program as if the book were a catalog of course offerings, not unlike what we have available in our university. I went through each Master Clinician, Workshop, and the like, indicating which each student should attend. It dawned on me how incredibly robust the array of top-notch scholars were, and how fortunate it was for my students (and me) to be able to learn from them all in one place.

Furthermore, it became clear how much of a bargain it was. The amount AABT charges for these kinds of activities is far less than would be the case at any university. I should add that I also attended the sessions for the same purpose. In doing this, I fantasized about what it would be like to work in such a university with so many gifted people. Thus, "AABT University" came to mind. What better concept to attract colleagues who could not only use this opportunity to advance their own skills, but whose contributions to the organization could also enhance ours?

Now, let's talk about sponsorship. The notion of being a new member's sponsor reflects many things. Among the more important is shared responsibility. Once sponsored, we would expect that the new member would become active. The organization is prepared to reward this activity for the original member and the new member. We will place the sponsor's name as well as the initiate in two separate bowls. Rick Heimberg, President, will pick a winner from each bowl during the Annual Meeting of Members. Winners will receive either a free subscription to the second journal, three videotapes of their choice or free membership for one year. One new student member and one new full member will receive both journals.

Here's how our reward program works. Each year, the Central Office maintains a listing of new members and a separate listing of members who assist in our recruitment efforts. They are listed in the October issue of *tBT* and have traditionally been given a PRESIDENT'S HONOR ROLL ribbon. This year we are changing the ribbon to reflect NEW MEMBER SPONSOR. We will now be giving out three different colors: A gold ribbon indicates 7 or more members recruited, a silver ribbon indicates 3 or more members recruited, and tan (think bronze, but the ribbon company doesn't make that color) indicates 1 to 2 members recruited. The member who recruits the most new members will be acknowledged at the Annual Meeting of Members with a "Top Recruiter" certificate and is still eligible for a prize. (Psst, heard this year's top recruiter was Mitchell Schare. Thanks for the support, Mitch.) We will be giving away four free journal subscriptions, four winners will receive their choice of three videotapes each and two free memberships.

And there's more: Each year we lose some members. Some folks change professions, retire, or leave for their own reasons. We also lose many members, especially students, because they move without leaving a forwarding address. We need your help in tracking them down. If you are interested in helping us find our lost members, please let either Stephanie Felgoise, Membership Issues Committee Chair, Mary Jane Eimer, Executive Director, or me know. We will keep track of the number who rejoin by your efforts and will enter your name and theirs for similar prizes as mentioned above.

Stop by the AABT Membership Booth if you have questions or want to get more involved.



Join us in the hunt!

Come on, we all know that AABT is home and it's to your advantage to be surrounded by the best and the brightest. Let's work together to make our goal of 5,000 in 2003!

Welcome, New Members!

The following individuals have recently been accepted as new members.

We welcome them into the Association and appreciate their support.

Full Members

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Judith Coche, Ph.D.
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Catherine C. Epkins, Ph.D.
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Members Refer 315 New Members This Year!

In appreciation, AABT will recognize them with a NEW MEMBER SPONSOR ribbon on their Annual Convention name tags. Asterisks next to the names below indicate that they were the source of 3 or more new members. Special recognition goes to Mitchell Schare for recruiting 11 new members. We thank all our members for their support. There is no higher honor they can give AABT.

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Anne Marie Albano
Nader Amir
Drew Andreson
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Sandra Azar
David Barlow
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Aaron Beck
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David Valentier
Kim Walitzer
Kathryn Walker
Lauren Warger
Frank Weathers
Allen Weg

Amy Wenzel
Sabine Wilhelm
Donald Williamson
Christine Wilson
G. Terence Wilson
Lucene Wisniewski

Mary Wong
Lester Wright
Edelgard Wulfert
Saltzberg, Judith
Robin Yeganeh
Eric Youngstrom

Claudia Zayfert
Robert Zettle
Lori Zoellner*
Michael Zvolensky

2002 Voluntary Contributors

The following members made generous voluntary financial contributions to AABT in 2002. AABT has used these funds to fuel its continuing growth by expanding its services and publications, and to further our goal of encouraging the practice, research, and recognition of behavior therapy. We sincerely thank them for their generosity.

Minoru Akagi
Anne Marie Albano
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Special Interest Groups

News of the SIGs

Andrea Seidner-Burling, *SIG Committee Chair*

Child and Adolescent Anxiety SIG-in-formation. A new Child and Adolescent Anxiety SIG-in-formation will be meeting at AABT's Annual Convention in Reno this year. Experts in the field of child and adolescent anxiety will present summaries of current issues and directions for future research. Topics include basic understanding of anxiety and developmental trajectory, innovative treatments for neglected disorders (e.g., PTSD, trauma, school refusal), and considerations for adapting treatment to community populations and complex cases. Discussion will follow the summaries to reach consensus on critical areas facing treatment and research of childhood anxiety disorders.


If you want more information about the Child and Adolescent Anxiety SIG-in-formation, please contact Jennifer Hudson at jhudson@psy.mq.edu.au; Department of Psychology, Macquarie University, Sydney, NSW, 2109, Australia; or phone at 61 2 9850 8668. If you are interested in joining this SIG, please provide her with your contact information and AABT membership status, and plan to attend their group-in-formation meeting in Reno.

Rehabilitation and Neuropsychology SIG-in-formation. A Rehabilitation and Neuropsychology SIG also is being formed. The purpose of this SIG is to bring together practitioners and researchers with shared interests in advancing empirically based clinical assessment and treatment for a variety of acute and chronic health conditions. They hope to attract members who are interested in advancing research in the etiology, course, effects, and interventions in the areas of rehabilitation and neuropsychology (chronic pain, spinal cord injury, multiple sclerosis, brain injuries, geriatric issues, disability, and social support). The SIG is particularly interested in advancing our knowledge in the application of cognitive and behavioral assessment and therapy techniques in rehabilitation and neuropsychological populations. Their mission is to disseminate research findings and to facilitate communication and networking opportunities for SIG members. The number of AABT members active in practice and research in the areas of rehabilitation and neuropsychology is growing and vibrant, and this new SIG is excited to expand professional interactions in these areas. If you want more information about

this SIG-in-formation, please contact Laura E. Dreer at dreer001@mc.duke.edu; Duke University Medical Center, 932 Morreene Road, Room 170, Durham, NC 27705; or (919) 668-2835. If interested, please provide her with your contact information and AABT membership status and plan to attend their meeting at the Reno Convention.

SIG Events at the Reno Convention.

The annual SIG Exposition and Cocktail Party will be held at 6:30 on Friday evening at the Reno Hilton. This reception is an excellent opportunity to network, view the latest research, and learn about the activities of AABT's SIGs. The posters to be presented will appear in the program addendum. Other convention activities for the SIGs include the annual meetings of the individual SIGs, as well as the SIG leader meeting. Also, there are several symposia that are being sponsored by SIGs this year. The agendas for these activities vary, so please check your program book for details.

SIG Guidelines. The SIG Guidelines have been revised and approved by the board and they will be available on AABT's Web site shortly. A copy of the new guidelines was sent via e-mail in early August to each SIG leader. If you didn't receive one, please e-mail Teresa Wimmer, AABT Staff Liaison to the SIG Program, at twimmer@aabt.org. There were several important changes to the guidelines (e.g., all SIG members must now be AABT members), so it is very important that each SIG review the new guidelines and make sure that they are in compliance with them. 

Classifieds

For classified rates and closing dates, contact Stephanie Schwartz, AABT Advertising Manager, (212) 647-1890, or via e-mail: sschwartz@aabt.org.

Positions Available

BEHAVIORAL PSYCHOLOGIST. Behavior Therapy Associates seeks cognitive-behavior therapist to join successful private practice on full-time basis. Strong background in assessment/treatment of full range of child and adolescent disorders required. Expertise in AD/HD desirable. Must have passion, combined with creativity, for self-marketing and desire to be free of managed care. Send Resume: Steven B. Gordon, Ph.D., ABPP, Behavior Therapy Associates, P.A., 35 Clyde Rd., Suite 101, Somerset, NJ 08873. Call 732-873-1212.

HUDSON RIVER REGIONAL PREDOCTORAL INTERNSHIP PROGRAM IN PROFESSIONAL PSYCHOLOGY, NEW YORK STATE OFFICE OF MENTAL HEALTH offers full time predoctoral internship positions in professional psychology for 2003-2004 in its APA-accredited program. Weekly seminars in a variety of clinical and professional areas supplement extensive supervision. Clinical assignments are to inpatient and community services programs at facilities of the New York State Office of Mental Health. Preference is given to students enrolled in APA-accredited clinical or counseling psychology programs. For further information and application materials, write to Paul Margolies, Ph.D., Training Director, Hudson River Regional Psychology Internship Program, Hudson River Psychiatric Center, 10 Ross Circle, Poughkeepsie, New York 12601-1078. You may e-mail your request to www.hrrhpjm@omh.state.ny.us.

ASSISTANT PROFESSOR, EASTERN MICHIGAN UNIVERSITY. Tenure track position beginning Fall 2003 for Ph.D. in Psychology with specialty in Clinical Behavior Analysis and/or Behavior Therapy in a program that integrates Applied Behavior Analysis and Behavior Therapy. Requires Ph.D. from an APA accredited program, internship in APA accredited setting, and eligibility for Michigan licensure in psychology. Faculty member will participate in new doctoral program that builds on existing terminal M.S. programs in Clinical and Clinical Behavioral Psychology. Doctoral program integrates the two perspectives, as well as allows specialization in either track. Program emphasizes the scientist-practitioner training model, as well as organizational management, program development, and evaluation training. Department began accepting doctoral students in Fall, 2001, while continuing highly successful terminal M.S. Programs. Applicants should have: a) training, research and expertise in behavioral assessment and functionally derived behavioral intervention procedures; b) skill in presenting fundamental conceptual framework of behavioral psychology; c) active

participation in ABA and/or AABT; and d) publications in journals such as *JABA*, *Behavior Therapy*, *JBT&EP* or *Behavior Modification*. Successful applicants will be expected to play a major role in M.S. and Ph.D. programs and also to contribute to the undergraduate program. Competence in supervising graduate students in clinical field placements and on dissertations desirable. Preference given to candidates with expertise in organizational behavior management and/or behavioral systems as applied to mental health delivery. Screening begins on or about December 1 and will continue until finalist selected. To apply, send a letter outlining qualifications, a vita, and three letters of reference to Posting #F0321, Eastern Michigan University, 202 Boone Hall, Ypsilanti, MI 48197.

EMU enrolls approximately 24,000 students in over 100 programs. The Psychology Department has approximately 550 undergraduate majors, Masters programs in Clinical, Clinical Behavioral, and General Psychology, and a new Ph.D. program in Clinical Psychology. EMU offers an outstanding benefits package and a competitive salary, as well as a collegial work environment. The 22 full-time faculty members are active researchers with diverse interests who emphasize a teamwork-mentorship model of clinical training. Faculty have access to a wealth of research assistance and institutional support (40 doctoral fellows will be funded for four years including tuition waiver). The EMU campus is located in the Ypsilanti/Ann Arbor community, 5 miles from downtown Ann Arbor and 35 miles west of Detroit, MI, and Windsor, Ontario. We encourage women and members of minority groups to consider this opportunity and to identify themselves when applying. EMU is an Equal Opportunity Employer.

POSTDOCTORAL FELLOWSHIP IN COGNITIVE BEHAVIOR THERAPY. A Postdoctoral Fellowship position is anticipated in the Drexel Department of Psychology. Scheduled to begin July 1, 2003, this advanced training position will include activities in several clinical service programs and research projects. Areas of focus include: sexually aggressive behavior disorders, behavioral medicine, and developmental disabilities. Opportunities include training in supervisory skills, application of CBT to both behavioral medicine and forensic populations, and an elective rotation in physiological assessment. Interest in conducting research in any of these areas is desirable. Qualified candidates will be considered for adjunct faculty appointment and teaching opportunities. Fellowship goals include preparation for the ABPP exam. Successful candidates will have completed their Ph.D. or Psy.D. from an APA-accredited clinical or counseling program, with evidence of practicum/ internship experience in cognitive-behavioral psychology. Minority candidates with regard to race, gender, sexual orientation, and ethnicity are strongly urged to apply. Applications should include curriculum vitae, writing sample, statement of professional goals, and three letters of reference. Due date for materials is December 30, 2002. Send application materials to: Christine Maguth Nezu, Ph.D., ABPP, Drexel University, 245 N 15th Street - Mail Stop 515, Philadelphia, PA 19102-1192.

CHILD/ADOLESCENT PSYCHOLOGIST. Altru Health System in Grand Forks, North Dakota, is seeking to add a full-time child/adolescent psychologist to its team of ten psychologists. Primary duties include outpatient assessment and treatment of children and adolescents and some inpatient consultation. Candidates should be familiar with a wide variety of testing instruments and possess strong communication skills when interfacing with physicians or allied health professionals. Credential requirements include a Ph.D. in Clinical or Counseling Psychology with APA-accredited internship experience in behavioral medicine and immediate eligibility for North Dakota licensure.

Altru Health System is an integrated health system with 200 physicians located in eastern North Dakota and western Minnesota. Grand Forks, ND, home of the University of North Dakota, is a thriving community of 65,000 with excellent schools, safe neighborhoods and a variety of cultural activities.

Send curriculum vitae with four reference letters to Jean Keller, Altru Clinic, PO Box 6003, Grand Forks, ND 58206-6003. Fax: 701-780-6641, e-mail: jkeller@altru.org, Website: www.altru.org. Applications will be accepted until the position is filled. Equal opportunity employer.

FACULTY POSITION AT JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE IN SUBSTANCE ABUSE RESEARCH. A new faculty position at Instructor, Assistant, or Associate Professor level is available at JHUSOM. The candidate would be expected to establish a line of independent research in clinical pharmacology or substance abuse treatment research at JHUSOM. In addition, candidate would work within the Mid Atlantic Node of the National Drug Abuse Clinical Trials Network (CTN), a new national treatment-research partnership that conducts multi-site effectiveness studies of empirically based treatments for drug abuse within community treatment programs. Within the CTN, candidate would collaborate with PI, other faculty and local treatment providers to develop and direct study concepts and to help set future research directions. In addition, this position would have project coordination responsibilities within the node and nationwide for multi-site CTN studies. JHU offers a rich array of facilities and a stimulating environment to support independent research activities, while the CTN offers a unique new collaborative research platform. Position is suitable for a M.D. or Ph.D. with training and experience in substance abuse treatment and research. Academic rank and pay grade depends on experience. Candidates should send vita and letter of interest to: Maxine L. Stitzer, Ph.D., Professor of Psychiatry and Behavioral Sciences, Mid Atlantic Clinical Trials Network, Room 580, Mason F. Lord Building, 4940 Eastern Avenue, Baltimore, MD 21224. ✉



WORLD ROUNDS

V I D E O T A P E S

FOR INDIVIDUAL OR CLASSROOM USE,
THESE 1½-HOUR TAPES SHOW
THE HOW-TO OF GOOD THERAPY

Steve Hayes and Marsha Linehan are just two of the many excellent presenters at this year's convention. Each has also produced a World Rounds video for AABT (and Marsha's adding a second at the Reno Convention). These World Rounds videos feature internationally renowned clinicians demonstrating real techniques with simulated clients. It's an excellent opportunity to watch those who developed the techniques demonstrate those techniques.

Acceptance and Commitment Therapy

Steven C. Hayes, *University of Nevada, Reno*

Emphasizing experience, ACT works exclusively through process rather than content to diffuse patterns of the mind. The ultimate goal: the realization that there is no ultimate goal.

In this refreshingly different video, Hayes works with Candace, a young woman with social phobia who views her anxiety as a problem. He encourages the client to deconstruct anxiety into a set of harmless individual symptoms and meaningless words. Through the use of metaphor and sensory exercises, Hayes guides Candace to a state of acceptance of her anxiety in social situations. He strives to help her disentangle from language and, instead, promote her true intentions by "watching the chatter" of her mind without doing anything about it.

DBT for Suicidal Clients Meeting Criteria for Borderline Personality Disorder

Marsha M. Linehan, *University of Washington, Seattle*

"Suicide is always in the back of my mind." These are not words a therapist hopes to hear from a client. What happens next in the therapy session could influence your client's decision to live or die. Are you as prepared as you should be?

Marsha Linehan, master clinician and founder of Dialectical Behavior Therapy, demonstrates techniques used to persuade clients to refrain from harmful behaviors during the course of treatment. Linehan demonstrates successful negotiating and contracting for nonsuicidal behaviors, techniques to strengthen commitment to therapy, and emphasizes ways for therapists to treat clients with borderline personality disorder as humans rather than patients.

ADDITIONAL WORLD ROUNDS VIDEOS

- Tammie Ronen* Problem Behavior in Children and Adolescents
- Edna B. Foa* Imaginal Exposure
- Art Freeman* Personality Disorder
- Frank Dattilio* CBT With a Couple
- Lars Goran-Öst* One-Session Treatment of a Specific Phobia
- Ray DiGiuseppe* Redirecting Anger Toward Self-Change
- E. Thomas Dowd* Cognitive Hypnotherapy in Anxiety Management

**For a full list of all the videos available, including our historical Archives videos capturing such pioneers as Andy Salter, Joe Wolpe, and Alan Marlatt, visit us at the AABT Booth in the Exhibit Hall at the convention, or go to our Web site: www.aabt.org.*

COST PER TAPE

- Member: \$ 55.00 Nonmember: \$ 100.00 • Shipping & Handling: \$5.00 • Overseas postage: \$10.00
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AABT CLINICAL ASSESSMENT SERIES

The AABT Clinical Assessment Series is a collaboration of AABT and Kluwer Academic/Plenum Publishers, designed to simplify the lives of practitioners and researchers alike.

These handy, comprehensive guides make assessment more systematic, convenient, and completely up-to-the-minute. Focusing on key clinical areas, they offer organized, readily accessible information on assessment issues as well as the specifics of individual measures, providing reliability and validity evidence and invaluable comparisons of instruments.

These guides can be used everyday to enhance practice, facilitate research, and assist students.

These and the companion volumes in the series were developed to combat the frustration that researchers and clinicians often experience in locating assessment devices and finding evaluative information on them. Although you will be familiar with a number of the measures here, many others will either be unknown or only vaguely familiar.

Practitioner's Guide to Empirically Based Measures of Anxiety

Edited by

- Martin M. Antony, St. Joseph's Hospital and McMaster University
- Susan M. Orsillo, Boston VAMC and Boston University School of Medicine
- Lizabeth Roemer, University of Massachusetts, Boston

This remarkable compendium includes reviews of more than 200 instruments for measuring anxiety-related constructs in adults. These measures are summarized in "quick view grids," which clinicians will find invaluable. Seventy-five of the most popular instruments are reprinted, and a glossary of frequently used terms is provided.

Practitioner's Guide to Empirically Based Measures of Depression

Edited by

- Arthur M. Nezu, Drexel University
- George F. Ronan, Central Michigan University
- Elizabeth A. Meadows, Central Michigan University
- Kelly S. McClure, Drexel University

This volume provides summary tables comparing and contrasting different instruments in terms of their time requirements, suitability, costs, administration, reliability, and validity. These "quick view grids" provide a rapid method of identifying and comparing potentially useful measures.

For Content and Contributors, please visit: www.wkap.nl

List Price: \$69.95 AABT members Special Discount Price: \$49.00

To order these titles at the member's discount of 30% off the list price, visit the AABT booth or Kluwer booth at the convention or order directly from Association for Advancement of Behavior Therapy, 305 Seventh Avenue, New York, NY 10001.

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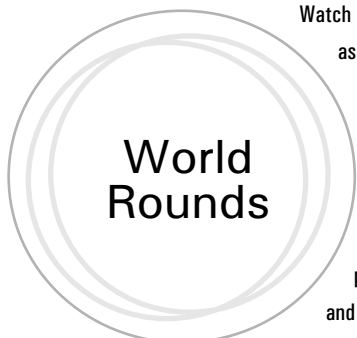
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- Patricia Resick

○ World Rounds 3

DBT for Suicidal Clients Meeting Criteria for
Borderline Personality Disorder

- Marsha M. Linehan

○ WORLD ROUNDS 4

Harm Reduction Therapy for Co-Occurring Disorders

- G. Alan Marlatt

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