

the Behavior Therapist

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President's Message

Media, Science, and Cognitive-Behavior Therapy

Dean McKay, Fordham University

*When The New York Times scratches its head, get
ready for total baldness as you tear out your hair.*

—CHRISTOPHER HITCHENS



Science reporting in the media can be the source of considerable frustration. For example, how often have you thought that science reporting was oversimplified, and/or overly alarming? How often have you heard contradictory science reports occurring within days of one another? In a thorough evaluation of the factors contributing to this, one would identify problems in science education, public interest in small and easy-to-digest findings, and, in all likelihood, a proneness by the media for sensationalism. However, when it comes to how CBT is reported upon, it appears that change is slowly taking place, and in a positive direction.

A few years ago I reported in these pages on media biases in how CBT was presented compared to psychoanalytic approaches and psychopharmacology (McKay, 2010). At that time, my concerns were significant. My survey of the available articles in *The New York Times* suggested that CBT was mischaracterized, underreported, and/or unfairly lumped together with other approaches that had lower efficacy rates. CBT was also reported consistently as a new therapy, despite these same reports presenting methods that have been available for well over 40 years, at least since the founding of ABCT. By the time I completed my article, my reaction

[continued on p. 55]

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- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100- word abstract.
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was largely consistent with how Hitchens suggested one would be when reading the newspaper of record for the United States.

In the intervening years since my survey, it appears that the situation has been improving for how CBT is portrayed in the media. In my admittedly unscientific follow-up search of *The New York Times* for the past 12 months (as of this writing, on January 30, 2014), I found 11 articles in which CBT was featured.¹ But in my estimation, what was more striking was that some of these articles emphasized the need for consumers to seek out “evidence-based treatments” (i.e., Brown, 2013). This is a marked change from 2010, when the picture I observed was fairly bleak.

Where Are Things Going?

Progress in how CBT is presented to the public via the media is indeed encouraging, if we rely on *The New York Times* as a guide. Nonetheless, we cannot afford to be complacent. While the media portrayal has improved, if *The New York Times* is any guide, it is unfortunately just one outlet in an ever-expanding network of sources clients may rely upon in learning about treatment. To illustrate, *Psychology Today* has several blogs written by mental health professionals. One in particular has included questionable assertions about the research base for psychotherapy, especially CBT (Shedler, 2013). The blog post in question here, in my estimation, suggested that treatment as usual (that is, a general common factors approach) is sufficient. The justification for this assertion stems from a single study that suggested CBT practitioners routinely depart from established therapy manuals when delivering care (Waller, Stringer, & Meyer, 2012). The blog post author goes on to imply that the departures CBT-oriented therapists take invariably involve approaches that might be more traditionally psychodynamic in nature. This is the kind of discourse that serves to confuse an already ill-served public when it comes to receiving sound recommendations for care.

Now before I continue, allow me to provide a bit of full disclosure. I have disagreed with Dr. Shedler in the public square previously, as have other members of ABCT. In one exchange Shedler (2010) asserted that a general, common factors approach to treat-

ment is sufficient and that the empirically supported treatments were no better than treatment as usual. This drew a series of critical comments. Anestis, Anestis, and Lilienfeld (2011) noted that Shedler was highly selective in his review of the literature in drawing his conclusions. I noted that Shedler overlooked the absence of validated mechanisms in general psychotherapy, and that a common factors approach did not leave clinicians with guidelines should treatment fail (McKay, 2011). Tryon and Tryon (2011) noted that common factors were part of any good therapeutic enterprise at a minimum, and so any treatment should advance beyond the efficacy of general psychotherapy, which CBT succeeds in accomplishing. Thombs et al. (2011) noted that Shedler's examination of existing meta-analyses was flawed because of an uncritical acceptance of the available studies, rather than a more careful parsing of the findings from well-controlled trials of psychodynamic therapy. Shedler, in his reply (2011), asserted, “Over the past two decades or so, a ‘master narrative’ has emerged in the academic world that psychodynamic therapy has somehow been disproven and that CBT has been scientifically tested against it and found superior. In the prevailing academic climate, the steadily accumulating scientific evidence for psychodynamic therapy has been repeatedly overlooked.” He goes on to suggest that several of the commenters (myself included) were falsely holding themselves up as objective purveyors of truth.

I use the example of Shedler's *Psychology Today* blog to illustrate that there are individuals with platforms that reach a large number of individuals who can either mischaracterize or erroneously report on how CBT works or what our research suggests. The need to meet the challenge inherent in media and public portrayals of CBT is not trivial, and not just for the public who seek therapy. Our own colleagues, particularly those who see CBT as a viable treatment modality but who were trained in other traditions, will benefit from exposure to better information about its efficacy. By creating a public perception of CBT that more closely matches the scientific evidence (and differentiates it from other nonempirical approaches), we may increase the desir-

ability of training in our treatment methods. This in turn will hopefully have the effect of increasing the likelihood that clients receive empirically supported interventions.

It is here that I would like to share an anecdote. In my years as a practitioner, I have had many clients who have reported receiving non-empirically-based therapy before coming to my office. Worse, many of these same clients knew the kind of treatment that was appropriate for their condition, went to providers who claimed they could and would conduct this form of treatment, only to later offer excuses for why it was not applicable in the client's particular case. Informally, I will note that this unique subgroup of clients typically did their due diligence and asked prospective clinicians if they had been properly trained in the methods of therapy they sought. The clinicians all “passed” the client interview and were able to substantiate that they had indeed received some form of training (typically workshops). And yet, these clients did not receive the treatment they sought—but they had the kind of savvy to know what they needed. How many more lack this information?² And how many, if they could, would in turn pressure their clinicians to seek out the right kind of training? Media portrayals of the need for scientifically informed therapy would increase the odds that more savvy clients would question the treatment they receive and alter the behavior of clinicians.

What Can We Do?

How should we address this persistent, albeit improving, problem in how our approach to treatment is presented to the public? Back in 2010 I recommended adopting two broad strategies, one proactive and one reactive. The proactive one involves deliberate outreach to media sources to get the message out about efficacious treatment. We clearly need more of that. The other, reactive, approach involves responding to the inaccurate portrayals we may receive in the media. The blog post I mentioned above (and a few others by that same author) was met with a litany of comments that challenged his assertions. This approach can be frustrating, time consuming, and combative. However, I would stress that while you may not change any minds of those who respond directly to the comments, the comments are also read by others who are unlikely to post any replies at all. In short, the effort will not likely be wasted.

¹In my 2010 survey, I had noted that psychopharmacology coverage in *The New York Times* included marriage announcements. I am happy to report that I identified one marriage vow announcement in the past year where one of the to-be betrothed self-identified as a CBT therapist. For that I say “bravo!”

²An important reminder: As a service to the public, ABCT has a series of fact sheets available on their website that describe treatment for different conditions.

The reactive approach is necessarily problematic without other proactive measures. It ensures a defensiveness that can be unhelpful. So allow me to add to my recommendations articulated in 2010. When we talk among ourselves, such as during the annual conference, the scientific foundations reign supreme. It's wonderful to share ideas with like-minded colleagues who understand the importance of a scientific foundation for intervention development. But it can also be an echo-chamber. Rarely are there attendees at our annual convention who need convincing of the need for scientific bases of intervention. What is necessary now is a technology for speaking to non-scientific-minded mental health providers. While we are enthusiastically scientifically oriented in our approach to treatment delivery, my own experience has been that observing improvement when applying an empirically grounded approach is also profoundly gratifying. It would behoove us to highlight the dramatic emotional and functional benefit CBT bestows on clients, including the depiction of case illustrations. When case illustrations are yoked to scientific presentations of clinical interventions, clinicians show greater interest in receiving training (Stewart & Chambless, 2010). The media routinely does this now to make their point for a wide

range of topics. After all, that is the very point of so-called "man on the street" interviews. If we were to start doing this, it would connect the part we do so well (appeal to each other's heads) with an aspect we do less well (speak to the each other's hearts). Interestingly, there were no case illustrations as part of the 11 *New York Times* articles over the past year that described CBT's efficacy. Perhaps I am now getting greedy in my desire to see improved CBT coverage in the media. Nevertheless, the impact of coverage will be far better if the outcomes can be made more vivid through real-life illustrations.

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Clinical Training Update

A Model for Implementation of Cognitive Therapy in Community Mental Health: The Beck Initiative

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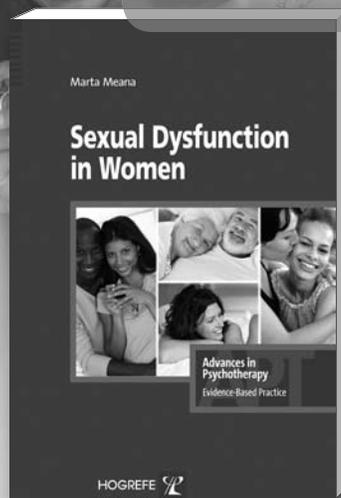
Aaron T. Beck, *Perelman School of Medicine, University of Pennsylvania*

The Patient Protection and Affordable Care Act (ACA) is now in full force, creating long-overdue opportunities to grow the capacity of mental health systems and meet the pressing needs of individuals served by community mental health. As of January 1, 2014, mental

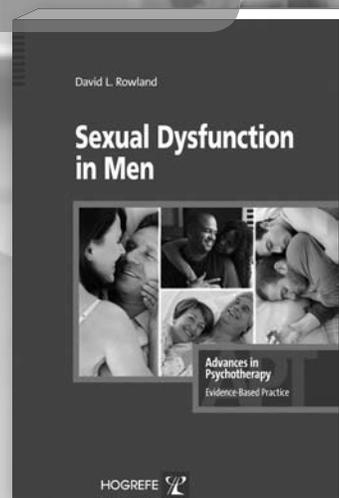
health conditions and substance use disorders fall under the broad Essential Benefits package of services under the ACA, receiving parity protection in comparison with medical and surgical benefits (H.R. 3590-111th Congress: Patient Protection and Affordable Care Act, 2009). While

each state determines the specific benefits, coverage for mental health and substance abuse services has substantially increased with the ACA, and, as a result, funding for treatment services will likely expand. A challenge to capitalizing on the ACA opportunity, however, is the underdeveloped state of evidence-based practices (EBPs) in community mental health. Unlike physical health services, for which there is a robust functioning system, the delivery of evidence-based mental health services is less well developed. However, efforts to implement EBPs in community mental health have moved to the forefront in the past decade, and these efforts may be even more important in the context of the ACA. The Beck Initiative is a collaborative clinical, educational, and administrative partnership that has successfully implemented cognitive therapy (CT) across a diverse group of community mental health care providers (agencies). This paper presents the Beck Initiative's goals, training model, and outcomes to date, so that it might serve as a successful model for implementation for other networks.

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Goals of the Beck Initiative

The Beck Initiative was established in 2007 as a partnership among the Aaron T. Beck Psychopathology Research Center of the University of Pennsylvania (UPenn), the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), DBHIDS network providers, and the children, adolescents, and adults receiving services in this large, urban behavioral health system. Although the Beck Initiative has successfully broadened its partnership to include several other city- and state-wide mental health systems, this paper focuses on the original Philadelphia Beck Initiative. The Beck Initiative partners share two key goals: to improve outcomes for people receiving services in the DBHIDS system, and to contribute to the implementation science literature. In order to meet those goals, the Beck Initiative pursues the following aims: (1) to promote hope, autonomy, and engagement in constructive activity for individuals served in

the network; (2) to establish CT as a standard practice of care for people served in the network; (3) to promote the sustained implementation of CT into the network; (4) to improve the professional lives of front-line staff in this system; (5) to conduct program evaluation to examine the feasibility, outcomes, and sustainability of high-quality CT in the community; (6) to utilize CT as a roadmap for delivering recovery-oriented care; and (7) to serve as a model for other large mental health systems.

Training Protocol and Procedures

The network's evolving priorities have prompted adaptation of the training, applying core CT concepts to diverse populations and levels of care (for a discussion of the importance of real-time adaptations to meet the needs of diverse stakeholders, see Chorpita, Daleiden, & Collins, 2013). CT has been implemented in settings as diverse as outpatient clinics, residential settings, schools, homelessness outreach teams,

Assertive Community Treatment (ACT) teams, addictions and methadone-assisted treatment clinics, and extended acute care units. Trainings are tailored for the level of care and the population served, including diverse age ranges (adults, families, youth) and presenting problems (e.g., depression, addiction, schizophrenia, recent incarceration). The training protocol retains the flexibility to adapt as the DBHIDS priorities evolve, growing out of the ACCESS model (Stirman et al., 2010; see Table 1).

Step 1: Assess, Adapt, Engage

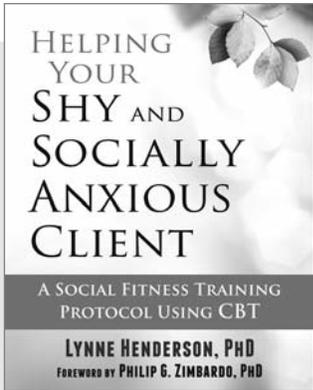
Engagement as a focus. The first step of the ACCESS model is to promote engagement through the assessment of stakeholder needs, goals, and readiness for change. Through this process, stakeholders are engaged in the process of planning and adapting the training for the provider's needs, as well as engagement in the actual training process, beginning with the Beck Initiative's first contact with the provider. When DBHIDS selects priority areas (e.g., specific levels of care or services for specific populations) for CT training, a Request for Applications (RFA) is released to encourage active provider engagement in the selection process. Providers of the targeted services may submit a proposal with a description of their ability and commitment to participate in the training program and sustained practice. The RFA process was instituted in the 2013-14 training year as a strategy for increasing active participation and engagement of administration. Prior to this, invitations for participation were based on the DBHIDS priorities without any initial expression of interest or effort by the providers. Shifting to a competitive process was an effort to increase the perceived value of participation by the agencies, as well as an attempt to identify providers with some internal motivation for participation. Based on anecdotal observation of the 2013-14 selection process, these efforts have indeed resulted in greater demonstrated investment among administrators. In their RFA responses, providers are strongly encouraged to make participation voluntary for staff, so the application also solicits a statement from each staff member whose participation is proposed, indicating whether their participation is by choice. This caveat was based on previous feedback that indicated that mandatory participation dampened their enthusiasm, even among clinical staff who were otherwise eager for CT training. The strength of the RFA submissions is evaluated by the Director of the Beck Initiative

Table 1. Implementation of CT Using the ACCESS Model

Stage	Intensive Model	Milieu Model
Assess and adapt	Stakeholders (e.g., administrators, supervisors, clinicians, individuals in recovery) are engaged in the process of planning and adapting the training for the provider's needs.	
Convey the basics	Intensive workshop is held for clinicians to build knowledge from basic CT concepts through case conceptualization and intervention planning.	Intensive workshop is held for milieu clinical staff to create a CT-informed therapeutic culture.
Consult	Weekly consultations are held to help clinicians apply CT knowledge to help individuals in recovery move toward their goals, through intervention planning, tape review, and case conceptualization.	Weekly consultations are held with instructors who model use of CT skills for clinical staff and provide feedback to clinical staff about their developing skills.
Evaluate work samples	Audio recorded CT sessions are evaluated for CT competency at 3- and 6-months postworkshop, as well as completion of training requirements (workshop, program evaluation measures, at least 85% of consultation meetings).	Completion of training is evaluated, including all workshops, program evaluation measures, and at least 85% of consultation meetings.
Sustain	Sustained practice of CT is supported through access to a web-based training to build CT skills in additional clinicians, scheduled ongoing support for trained groups, recertification expectations for clinicians, booster training, and quarterly meetings for trained provider groups.	
Study outcomes	Evaluate number of behavioral health professionals trained, retention in training, achieved competency, rates of recertification, and differential outcomes in web-based and live training.	

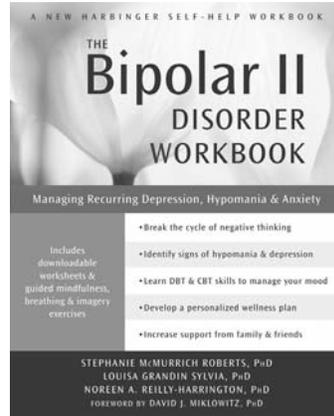
Note. The Intensive and Milieu training models may be implemented individually or together within a provider context. Adapted from Stirman et al. (2010) with permission.

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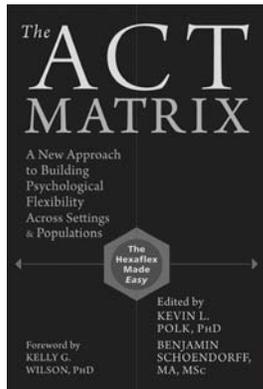
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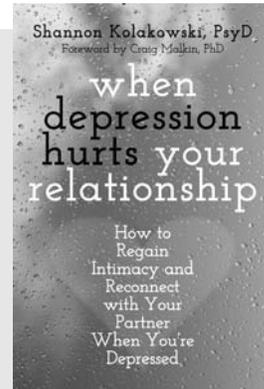


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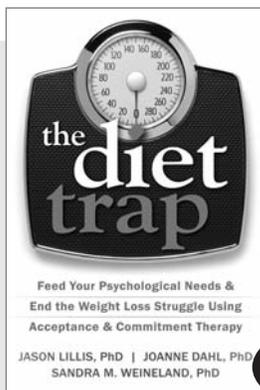
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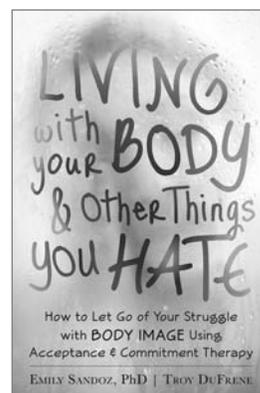
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(the first author) and DBHIDS representatives, and the final selection is approved by the Commissioner of DBHIDS (third author).

Selected providers are notified and three initial events are planned for each provider. First, the agency administrative contact (e.g., Chief Executive Officer, Director of Clinical Services), members of the clinical staff (typically one or more supervisors), the Director of the Beck Initiative, two post-doctoral level Beck Initiative instructors, and a DBHIDS representative meet to review the components of the training plan, develop a time line, and resolve any challenges. Further information is gathered about the provider's mission, clientele, and treatment context. For example, school-based services often emphasize group therapy with briefer individual sessions and crisis management, whereas residential services may capitalize on milieu staff in daily contact with individuals receiving services. Gathering information about the provider allows the instructors to begin to tailor the training to these characteristics.

Next, an operational meeting is held with the participants at the provider's site so that instructors can experience the treatment context. Instructors share information about training specifics, elicit feedback about the fit between the training model and participants' needs, and address any questions or hesitations. Open feedback is encouraged directly by limiting the attendance to the participant group, as administrative presence could inhibit the expression of questions or concerns. This early opportunity for open discussion was prompted by early training experiences in which clinicians who were hesitant to participate remained disengaged until their hesitations were openly discussed. Instructors describe training as a partnership between the instructors and participants, in which the instructors bring CT expertise and participants bring expertise in the provider's mission, consumers, and strategies. The instructors are mindful that participants are professionals who strive to provide good care, which requires a different approach and set of sensitivities than one might have while training new professionals. Baseline program evaluation data are also gathered in the operational meeting to evaluate and improve the effectiveness and acceptability of the Beck Initiative training as the program progresses.

The provider then holds a kickoff celebration for participants, their colleagues and supervisors, other staff and employees, board members, individuals receiving ser-

vices, and others. Refreshments are provided and speakers, including the CEO or Director of Clinical Training, the DBHIDS liaison, the Director of the Beck Initiative and instructors, and other stakeholders share their enthusiasm about the training endeavor. The celebration sets a tone of respect for the commitments made, as well as solidifying the intentions to increase the likelihood that they will translate to behavior (Godin, Belanger-Gravel, Eccles, & Grimshaw, 2008).

Instructors also work with participants throughout to develop strategies to engage individuals in CT services. For example, a participant may say, "I'm learning a new approach called cognitive therapy, and when I thought about who might be a great candidate to try it out, you came to my mind. Could we talk about what that therapy would be like, and whether you would be interested in trying it?" Participants then orient the person to CT (e.g., session structure, the cognitive model) and ask for feedback about participation. Informational flyers to orient individuals to CT are also available and are often located in the provider waiting rooms.

Step 2: Convey the Basics

Training models. The two main training approaches may be implemented independently or together, based on the needs of the provider. The intensive training model aims to build therapist CT competency to the level expected of clinicians in clinical trials of CT. The milieu training model aims to build familiarity with CT concepts, intervention, and conceptualization for clinical staff who are not in traditional therapist roles. The differentiated approaches were developed in response to the evolving priorities of DBHIDS, which in turn reflect the diversity of behavioral health settings. Early training cohorts focused on services in which a traditional therapy-hour model was used (e.g., outpatient clinics) and the intensive training model was developed to meet their needs. Subsequent training cohorts also included services in which the traditional therapy hour was not the focus of services (e.g., residential services for people experiencing chronic homelessness) or in which coordination of adjunctive services were essential (e.g., school-based services with individual and group therapy plus in-classroom support), so the milieu model was developed as an alternative or additional approach.

Although either training model may focus on a specific presenting problem, as in

the case of methadone-assisted treatment clinics, training for generalist settings is now transdiagnostic. Early trainings focused on depression and suicide ideation as a vehicle for teaching CT skills, but the feedback indicated that participants inferred from this approach that CT was only useful for depression and suicide. Thereafter, trainings were adapted to focus on diverse presentations. The instructors facilitate this adaptation by presenting CT principles and engaging participants to jointly consider ways in which the principles apply to specific individuals.

Intensive training model. The intensive training moves from workshop to group consultation, and then to internal group consultation. Therapists are not taught a manual; rather, they are taught the principles behind the manuals so that CT can be delivered with both flexibility and fidelity (Kendall & Beidas, 2007). This model is appropriate for participants whose job responsibilities include delivery of individual therapy that is reimbursable within the DBHIDS network. Within most levels of care, therapists are required to have at least a master's degree in social work, counseling, or related field, but in addictions services, bachelor's-level therapists are also eligible for reimbursement and are therefore included in intensive training.

Typically, intensive training model groups include 6 core participants and 2 alternates. To successfully complete the program, core participants must (a) participate in all 22 workshop hours and at least 85% of the 6-month consultation meetings; (b) maintain at least four to five CT training cases; (c) submit at least 15 recorded sessions for review (with appropriate consent/assent); (d) complete all program evaluation measures; and (e) demonstrate sustained CT practice after completion of the training through ongoing participation in internal consultation groups and recertification every 2 years. Alternates participate in the workshop and may join the consultation group if a core participant leaves (e.g., due to turnover). Alternates are encouraged to rejoin the core participants after 6 months when the group moves to internal consultation and apply for a certificate of competency (see below).

Intensive workshops, consisting of 22 hours over four to five weekly meetings, begin with the basics of CT and build through complex case conceptualization and intervention planning. Information is presented through interactive methods including didactics, demonstrations, role-plays, paired practice, and discussion of

audio examples (for an example, see Creed, Reisweber, & Beck, 2011). Participants practice the new CT skills between meetings and discuss these experiences in the subsequent workshop. By the end of this phase, the goal is for participants to share a common language and understanding of CT concepts. In addition to core and alternate participants, administrators, supervisors, psychiatrists, or other clinical staff who will not be core participants or alternates are also encouraged to attend.

Milieu training model. Milieu training builds familiarity with CT concepts, intervention, and conceptualization for nontherapist clinical staff. These goals are reached through use of workshops and supported practice. When paired with an intensive training, the goal of the milieu training is for participants to support the CT delivered by intensive training participants (Chang, Grant, Luther, & Beck 2013; Riggs, Wiltsey-Stirman, & Beck, 2012). When delivered independent of an intensive training, the goal is to create a CT-informed therapeutic culture where staff use a common, evidence-based approach to create consistency among their therapeutic interactions. Milieu CT trainings have been suc-

cessfully implemented in settings as varied as residential programs for persons experiencing chronic homelessness, inpatient extended acute care units, ACT teams, and schools. As in the intensive training model, participants are taught the CT model and principles to be delivered with flexibility and fidelity (Kendall & Beidas, 2007) rather than a manualized intervention. Milieu trainings include all staff in the therapeutic milieu to shift the context to one that is guided by CT. Milieu participants' job roles have included case managers, outreach workers, mental health workers, nurses, certified peer specialists, recovery coaches, administrators, occupational therapists, psychiatrists, and behavioral health workers.

Milieu instructors often take an experiential approach, beginning with basic case conceptualization to help participants understand a given person's behavior in the milieu (Riggs et al., 2012). Specific interventions are planned as a way to shift that behavior, and participants are encouraged to practice the interventions in their interactions with the individual. Experiences with the intervention are reviewed and built upon with new interventions and people re-

ceiving services in the milieu. Short workshop meetings are typically held over 2 to 3 months, providing opportunity for practice and application of new skills. By the end of the workshops, the goal is for the milieu participants to be able to interact with persons receiving services in a cohesive, consistent, CT-informed manner, and when coupled with an intensive training, to be able to support the skills built in individual sessions. For example, an ACT team lead clinician may share her case conceptualization of a man receiving services with the team, including the man's belief that he is "broken." The team nurse may use that conceptualization as a framework to understand the man's reluctance to take medication. ("Why bother? Nothing can help me. I'm too messed up.") The nurse may work with him to examine whether that belief is as accurate as it might initially seem to him, and whether the belief is helping him to move closer to his goals.

Step 3: Consult

Intensive training model. When the intensive model workshop ends, core participants shift to weekly 2-hour consultation meetings with the instructors. In each meeting,



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participants share session audio to be discussed by the group (facilitated by instructors). Additional didactics are presented on interventions and techniques in which the participants are building competency, as well as other topics by participant request (e.g., interventions for specific presenting problems, integration of family in sessions). Case conceptualizations are developed and refined, then used to guide intervention planning. The instructors, active in the early consultation meetings, slowly move to the background as the group becomes more peer-led.

During this phase, four key personnel meetings are also attended by the administrative point person, the instructors, the DBHIDS liaison, the Beck Initiative director, and a participant liaison nominated by the participant group. These meetings provide an opportunity for discussion of progress, successes, challenges, and any needed problem solving.

By the end of the group consultation phase, a group facilitator is identified within the participant group. That individual must demonstrate competency in CT, be willing to take on a facilitator role, and complete 4 additional training hours in group facilitation. At the end of the 6-month group consultation, responsibility for the group transitions to the provider, with the expectation that the group will continue to meet weekly (1 hour) or biweekly (2 hours) to support sustained practice through peer consultation.

Milieu training model. Application of the skills is supported by 6 to 8 months of weekly on-site consultation with the instructors who observe participants and provide feedback, model skills with persons receiving services in the milieu setting, participate in team meetings to help integrate CT into the team's approach, and provide further information as needed. As in the intensive model, four key personnel meetings are held during this phase with discussions centered on progress, challenges, and successes. By the end of the consultation phase, a point person is identified within the cohort. Milieu participants are not expected to continue to meet biweekly, because unlike a group of therapists, providers rarely have regular supervision-like expectations for milieu staff. Sustained practice of the learned CT skills is encouraged in team meetings and clinical interactions, and the instructors are available for additional support as needed.

Step 4: Evaluate Work Samples

Intensive training model. Core participants identify an audio recording from the midpoint (3 months postworkshop) and end (6 months postworkshop) of the consultation phase to be rated by the instructors using the Cognitive Therapy Rating Scale (CTRS; Beck & Young, 1980, 1988). Item scores, a total score, and detailed feedback on each of the 11 items are provided to participants as a measure of their progress toward competency in CT (see Creed et al., 2013, for details). The gold-standard for CT clinical trials (CTRS total score ≥ 40 ; Shaw et al., 2009) is used to indicate competency in the Beck Initiative. A baseline audio (recorded prior to training) is also rated for program evaluation, but scores and feedback are not provided to the participants.

Three different certificates can be earned by Beck Initiative participants in the intensive training model based on their participation and demonstrated competency on the CTRS. Alternates who complete the workshop are eligible for a certificate indicating that they have "completed a 22 hour workshop in Cognitive Therapy in Community Mental Health settings." Core participants who complete all of the participation requirements are eligible for a certificate indicating that they have "completed an intensive training in Cognitive Therapy in a Community Mental Health setting." Core participants who complete all of the participation requirements and also earn at least a total score of 40 on the CTRS are eligible for a second certificate indicating that they have "demonstrated competency in Cognitive Therapy in a Community Mental Health setting." Alternates who join the internal consultation group after the 6-month consultation then submit a recorded therapy session and earn at least a total score of 40 on the CTRS are also eligible for the "demonstrated competency" certificate. Each certificate is recognized within the DBHIDS network as an indicator of familiarity and skill level in CT.

The milieu training model. Beck Initiative milieu participants may earn a certificate indicating that they have "completed a milieu training in Cognitive Therapy in a Community Mental Health setting" upon completion of the training program if they complete all program evaluation measures, and attend all workshop meetings and at least 85% of the consultation meetings held during their scheduled work hours.

Step 5: Sustained Practice

Training and implementation of an EBP, in the absence of a plan for maintained practice, may be destined for a very limited impact (Scheirer, 2005; Stirman et al., 2012). A number of sustainability elements have been incorporated to support the maintained practice of CT over time, including web-based training, scheduled support for ongoing groups, recertification expectations, booster training, and quarterly meetings for the trained provider groups.

Employee turnover can be a challenge to sustaining services, and as Beck Initiative graduates left the provider or advanced into roles with less clinical contact, the need to replenish the internal groups became clear. Greater penetration of CT was also desirable, both within a provider (training more than the core and alternate participants) and across providers (reaching more providers in an efficient and effective way). In 2011, a 22-hour web-based training (WBT) was launched with these goals in mind, presenting the material from the live workshops through detailed PowerPoint slides and videotaped role-play examples. Access to the WBT was offered to therapists employed by providers who had moved to the internal group consultation phase of the intensive training model. Newly participating therapists completed the online training in lieu of the workshop training, then joined the ongoing consultation group of their trained peers. The peer group meetings served the same purpose for the WBT participants as the initial 6-month consultation served for the original training group.

WBT participants who met the criteria outlined for intensive training model participants (completion of all 22 hours of didactic learning, participation in at least 85% of ongoing consultation meeting for 6 months, submission of 15 training case audio recordings, demonstrated competency on the CTRS) were then eligible for a certificate indicating that they "demonstrated competency in Cognitive Therapy in a Community Mental Health setting." In addition, each provider group that moved into the internal consultation group phase retained a generic provider login so that the ongoing groups could access the WBT as a resource. In February 2014, an updated WBT (WBT 2.0) will be released, reflecting updates to the training materials and the advancing technology in online learning. WBT 2.0 relies much less on participants reading material, and instead includes voice-over of content, interactive activities

and games, broader video examples, and downloadable therapy materials.

The internal consultation groups also receive regular support from the Beck Initiative. Every 6 to 8 weeks, a Beck Initiative instructor participates in the internal consultation meeting, offering additional information about requested topics, feedback about audio or case conceptualization, support for the group facilitator, or other tasks as needed. However, providers who have demonstrated success in sustaining CT may therefore not need this level of regular contact from the Beck Initiative, and as each training year adds to the number of providers receiving this support, the resources required to offer regular support have become unsustainable. Therefore, plans are being finalized to transition successful providers to a more independent status wherein support is available upon request but no longer scheduled by default. Providers who have not yet reached this level of independence will continue to receive support, with the aim of helping them to develop independence.

Even among the skilled, drift from the model may be found over time (Waller, 2009). Therefore, certificates of CT competency require renewal every 2 years. To apply for recertification, a therapist must (a) participate in at least 85% of internal group consultations during the 2-year period; (b) complete 4 CT- or CBT-related continuing education credits during the 2-year period; and (c) submit a recorded therapy session (with the permission of the person being recorded) demonstrating competency in CT as rated on the CTRS. Prior to the provider's recertification date, a Beck Initiative instructor offers a 4-hour on-site booster training to refresh therapists on the specifics of CT and the CTRS. These boosters are often provided during two consecutive internal group consultation meetings to minimize burden on the therapists.

All CT-trained providers, including their administration, supervisors, Beck Initiative graduates, and those interested in joining the Beck Initiative, are invited to participate in a Beck Initiative quarterly meeting four times per year. These meetings provide an opportunity for administration and graduates to refresh their enthusiasm and fine-tune their skills, for networking among providers delivering CT for the people they serve, and a preview of CT and the Beck Initiative for individuals interested in joining. Quarterly meetings begin with updates on the Beck Initiative, including newly participating or graduating providers, upcoming RFAs, and other news. Next, a group

discussion is facilitated among the stakeholders. For example, group feedback about the WBT was solicited to shape the WBT 2.0, and providers have shared strategies for integrating CT principles into their documentation. Finally, a clinical exercise is used to refresh or sharpen participants' CT skills.

Step 6: Study Outcomes: Preliminary Findings

Since 2007, The Beck Initiative has delivered 44 training programs to 35 provider agencies, including 13 child-focused programs, 12 programs for individuals experiencing chronic homelessness, 9 general adult outpatient programs, 4 addictions-services programs, 3 ACT teams, 2 extended acute care units, and 1 program focused on gay, lesbian, and transgender adults.

In total, 569 community mental health care workers in Philadelphia have participated in live workshop training aimed to directly increase skills. (Close to 200 additional professionals in Philadelphia have attended other workshops to share information about CT in the network, including care managers and other DBHIDS employees.) Of those, 267 attended intensive training model workshops, and 302 participated in milieu training. The intensive training workshops include core participants, alternates, and others in clinical care roles who attended the workshop portion of training to learn about CT. Among those attendees, only the core participants were also intended to participate in the full competency training, so the numbers who attended the 6-month consultation and attempted to reach competency are smaller, but do not reflect high rates of dropout. In fact, 172 participants of the 267 in the intensive workshops have completed the full 6-month consultation and submitted audio to try to earn a certificate indicating competency in CT. Among the 95 other participants who attended workshop but did not attempt to meet competency criteria, only 1 withdrew from the program because of a desire to stop participating. The remaining individuals attended the workshop to learn about CT but never intended to participate in the 6-month consultation ($n = 63$; e.g., alternates, administrators, additional supervisors), or individuals who withdrew because they no longer met criteria for participation ($n = 32$; e.g., left the provider agency, moved to a role with no case load). In addition, 35 WBT participants have completed the online portion of the WBT

plus 6 months of internal group consultation, submitting audio for certification.

Among participants who have attempted certification, 83% of those in the live training and 71% of those in the WBT have reached a level of competence seen in clinical trials (Shaw et al., 2009). The newly launched WBT 2.0 is hypothesized to have higher rates based on the integration of newer e-learning technology, but this empirical question will be answered when sufficient comparison data are available. Similar rates of competency have been reached at the 2- ($n = 63$; 86%) and 4-year ($n = 24$; 83%) recertification point among eligible participants who have been in the Beck Initiative long enough to submit for these time points. All participants who attempted recertification began in the live training, as the WBT began too recently for WBT participants to have reached the 2-year mark.

Implications for Dissemination and Training

As a model for implementing an EBP in community mental health, the Beck Initiative offers a method for maintaining the rigor necessary for fidelity while retaining the flexibility to adapt to treatment settings and diverse behavioral health conditions. The model has grown from outpatient clinics to treatment milieus with a culture of CT, and from a depression focus to training tailored for diverse behavioral health conditions, while achieving high standards of competency similar to clinical trials (Shaw et al., 2009). These changes reflect adaptations made in response to challenges in the training and implementation efforts. The RFA process, voluntary participation for clinicians and open discussion of any hesitations, movement away from a depression focus, the intensive and milieu training approaches, web-based training, and provider transitions to independence were all initiated to overcome implementation challenges. The flexibility to make these adaptations in response to the needs of diverse stakeholders may be the biggest contributor to the success of the Beck Initiative (Chorpita et al., 2013).

An emerging development represents the ongoing spirit of this progression. As the penetration of CT into the network increases, the opportunity for the continuity of care across providers is building. A common language and approach can be shared across levels of care or providers trained in CT to facilitate a more cohesive recovery experience for an individual. Providers may

share information about a case conceptualization, goals that a person has identified or achieved, interventions that have met with success, and skills that the person has built. When this information translates across a person's treatment experiences, opportunities exist for cumulative progress rather than restarting with disparate therapeutic approach.

As the nation's community mental health systems continue to evolve in response to the mandates of the ACA (H.R. 3590–111th Congress, 2009) and growing pressure to provide broad access to EBPs, the calls for models of implementation with both flexibility and fidelity will increase. The Beck Initiative offers a collaborative approach to meeting this need for providers and networks, resulting in an increased presence of accessible evidence-based care.

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FRANK DATTILIO RECOGNIZED with AAMFT OUTSTANDING CONTRIBUTION to MARRIAGE and FAMILY THERAPY AWARD

October 26, 2013 – Frank Dattilio, Ph.D. was recognized as the 2013 Outstanding Contribution to Marriage and Family Therapy award winner by the American Association for Marriage and Family Therapy (AAMFT). The award, which recognizes exception and significant contributions to the field of marriage and family therapy, was formally given during the Association's annual conference in Portland, Oregon.

Erin Schaefer, member of the AAMFT Board of Directors and Chair of its awards committee, noted that, "[Dr. Dattilio] has been a leader in the promotion of cognitive-behavior therapy with couples and families for several decades."

Dr. Dattilio has delivered numerous lectures around the world and developed written works in 30 languages available in over 80 countries. He currently serves as a faculty member with the Department of Psychiatry at Harvard Medical School and at the University of Pennsylvania Medical School where he is responsible for training psychiatric residents in the use of marriage and family therapy techniques.

He has also made significant humanitarian contributions to underprivileged nations around the world including the donation of scholarship funds and training time.

Cloe Madanes, chair of the Board for the Council on the Human Rights of Children which Dr. Dattilio serves on, remarked, "Dr. Dattilio has devoted his life to bringing harmony to families and to the training of those who can carry on the AAMFT mission."

Conducting Research on Adolescent Suicide Attempters: Dilemmas and Decisions

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Suicide is the third leading cause of death among 10- to 24-year-olds in the United States (Centers for Disease Control and Prevention, 2010). Recent statistics from a nationally based survey of high-school students in the United States showed that 15.8% had seriously considered attempting suicide in the past year, 12.8% had made a plan about how they would attempt suicide, and 7.8% had attempted suicide one or more times (Eaton et al., 2012). Among 15- to 24-year-olds, there are approximately 100 to 200 suicide attempts for every completed suicide (Goldsmith, Pellmar, Kleinman, & Bunney, 2002) and prior suicide attempts are one of the strongest predictors of subsequent suicide attempts and suicide deaths in both adolescents and adults (e.g., Harris & Barraclough, 1997; Lewinsohn, Rohde, & Seeley, 1994; Shaffer, et al., 1996).

Currently, there are no treatments specifically targeting suicide attempts in adolescents that meet criteria for a "well-established" empirically supported treatment (APA Presidential Task Force, 2006). As a result, guidelines for managing and treating these high-risk adolescents are based on a combination of "expert opinion" and a small number of randomized and nonrandomized intervention trials (Asarnow & Miranda, in press). There are only eight randomized controlled trials (RCTs) of treatments for adolescent suicide attempters that targeted reduction in reattempts as their primary outcome. Only four of these trials yielded significant results. These interventions consisted of (a) group therapy including both cognitive-behavioral and psychodynamic techniques (Wood, Trainor, Rothwell, Moore, &

Harrington, 2001); (b) multisystemic therapy (Huey et al., 2004); (c) mentalization-based treatment (Rossouw & Fonagy, 2012); and (d) integrated CBT for comorbid alcohol abuse disorders and suicidal thoughts or behaviors (Esposito-Smythers, Spirito, Kahler, Hunt, & Monti, 2011). The group therapy approach failed to be replicated in two subsequent follow-up trials (Green et al., 2011; Hazell et al., 2009) and the other three studies have yet to be replicated. The four trials that did not yield significant decreases in suicide attempts included (a) a green card offering rapid, no-questions-asked hospital admission if requested (Cotgrove, Zirinsky, Black, & Weston, 1995); (b) a brief home-based

problem-solving intervention (Harrington et al., 1998); (c) a skills-based approach targeting problem-solving and affect management (Donaldson, Spirito, & Esposito-Smythers, 2005; and (d) a youth-nominated support team (plus a second trial using a slightly modified version of the approach; King et al., 2006, 2009). It is clear that further research is urgently needed.

Research on suicide attempters presents multiple challenges for investigators, which likely accounts for the lack of needed research in this area (Iltis et al., 2013; Linehan, 1997; Pearson, Stanley, King, & Fisher, 2001). Challenges include management of the significant anxiety associated with working with suicidal individuals, perceived liability risks for investigators, the need for sufficient expertise and resources to monitor and treat suicidal subjects, and the large sample sizes needed for sufficient statistical power to detect between-group differences in suicide-related outcomes (Pearson et al., 2001). In this article, we discuss ways to address these issues based on our experiences conducting the Collaborative Adolescent Research on Emotions and Suicide (CARES) study, the first RCT of Dialectical Behavior Therapy (DBT) that specifically targets adolescent suicide attempters with current high suicide ideation. Our goal is to facilitate additional research in this understudied area by offering suggestions that reduce the stressors and concerns associated with studying highly suicidal adolescents. First, we provide a brief description of the CARES study. Next,

Table 1. Inclusion and Exclusion Criteria for the CARES Study

Inclusion Criteria	Exclusion Criteria
Elevated suicide ideation within the past month	Acute psychiatric or medical symptoms (e.g., traumatic brain injury, substance dependence requiring inpatient detoxification) that would interfere with the adolescent's ability to participate in outpatient psychotherapy and/or study assessments
History of at least one lifetime suicide attempt	Adolescent is court-ordered to treatment
Recurrent intentional self-injury: <ul style="list-style-type: none"> • History of at least 3 intentional self-injuries, one within 12 weeks of referral to the study 	IQ score less than 70
Presence of at least 2 BPD criteria besides the recurrent intentional self-injury criterion	
12 to 18 years old	
At least one family member or responsible adult agrees to participate in assessment and treatment	

we review multiple roadblocks that are likely to be encountered when working with this population and strategies for addressing them.

CARES Study

The CARES study is a multisite RCT being conducted at the University of Washington, Seattle Children's Hospital, Harbor-UCLA Medical Center, and the University of California, Los Angeles. A total of 170 adolescents will be enrolled in the study across sites. Inclusion and exclusion criteria are shown in Table 1. Adolescents who meet study inclusion criteria are randomly assigned to receive 6 months of either DBT or Individual and Group Supportive Therapy (IGST). Outcome assessments are conducted at 3, 6, 9, and 12 months. The primary outcome variable is suicide events (suicide, suicide attempts, or emergency department visit or inpatient hospitalization for suicidality). Assessments also incorporate a number of domains that are associated with increased risk of suicide attempts, including multiple measures of psychopathology (e.g., mood and anxiety disorders, PTSD, psychosis, substance abuse, and borderline personality disorder traits), difficulties with emotion regulation, impulsivity, social adjustment, coping skills, and family functioning. Potential mediators of treatment outcomes, such as increased emotion regulation and decreased family conflict, will also be examined. At present, we have enrolled approximately two-thirds of the sample.

Research on Suicidal Adolescents: Dilemmas and Decisions

Selection of an Experimental Condition

Two factors are needed in selecting an experimental treatment for study. First, the treatment to be studied needs to have enough preliminary evidence to warrant an RCT. Second, there has to be a need for another study, i.e., the study must be designed to provide new information. DBT was selected because of its known efficacy with suicidal adults (Koons et al., 2001; Linehan, Armstrong, Suarez, & Allmon, 1991; Linehan et al., 2006; Verheul et al., 2003). However, no RCTs on DBT have been conducted with adolescents selected for high suicidality. This is a problem due to the fact that DBT is already being widely provided to adolescents in clinical settings in the absence of data on efficacy. A number of pilot trials of DBT adapted for adolescents have been conducted demonstrating the feasibility and promise of DBT for the adolescent

population (Fleischhaker et al., 2011; Katz, Cox, Gunasekara, & Miller, 2004; Rathus & Miller, 2002; Woodberry & Popenoe, 2008). What is missing is a sufficiently powered RCT of DBT for adolescents selected due to previous and current high suicidality. In sum, based on the strength of the data demonstrating the efficacy of DBT with suicidal adults, the promising results obtained in small studies of DBT with suicidal adolescents, and the widespread dissemination of DBT for adolescents in response to clinical need, without support from a RCT, it is clear that an RCT of DBT with adolescent suicide attempters is justified and is a critical next step in research on adolescent suicide prevention.

Selection of a Control Condition

An optimal control condition needs to be safe, potentially effective, and desirable to participants. In one large-scale study of treatment for adolescent suicide attempters, researchers were unable to conduct an RCT as planned due to youth and parents' unwillingness to be randomized to the study conditions (which included CBT, medication, and CBT plus medication; Brent et al., 2009). Because we were interested in maximizing internal validity, we used an active treatment control condition in which we could control for as many aspects of treatment delivery as possible. As there currently are no evidence-based treatments for suicidal adolescents, there was no clear choice of a control treatment (Spirito, Stanton, Donaldson, & Boergers, 2002). We selected IGST based on prior studies showing that supportive therapy led to decreases in suicidality (defined as suicidal ideation with a plan or a suicide attempt) equivalent to CBT and systemic behavior family therapy in a sample of depressed adolescents (Brent et al., 1997) and was equivalent to CBT in decreasing suicidal ideation and attempts in a sample of adolescent suicide attempters (Donaldson et al., 2005). Supportive therapy techniques were also shown to be the most commonly reported elements of TAU in a sample of adolescent suicide attempters (Spirito et al., 2002). Client-centered therapy has also been used as a comparison group in multiple RCTs that examined trauma-focused CBT with traumatized youth (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Knudsen, 2005). In order to enhance internal validity, IGST is designed to control for key treatment elements such as hours of treatment provided, treatment modalities provided (e.g., both individual

and group therapy), therapy dropout policies, therapist expertise, and availability of supervision.

Recruitment of High-Risk Adolescents

Although suicide is a leading cause of death among adolescents, it occurs at a relatively low base rate in the general population. Hence, large samples are needed for sufficient statistical power to detect between-group differences in suicidal behaviors. Moreover, it is important that researchers use a sample at high risk for suicide so that enough suicidal behaviors occur during the study to compare groups on suicide-related outcomes (Linehan, 1997). In the CARES study, the need for a large sample size was addressed by conducting a multisite study. In order to ensure that we recruited a sample at high risk of engaging in suicidal behavior, we based our inclusion criteria on documented risk factors for suicide and suicide attempts in adolescents (see Table 1). Finally, over time, we established strong referral networks with settings that were likely to treat highly suicidal adolescents, such as inpatient units, residential treatment programs, emergency rooms, psychiatric mobile response teams, and community-based clinics. To the best of our knowledge, we have recruited one of the highest risk samples of suicidal adolescents to date.

How to Safely Manage Suicide Risk

Working with such a high-risk sample requires responsible suicide risk management protocols for both experimental and control conditions. However, the use of intensive risk protocols across study conditions must also be balanced with the scientific concern of reducing power to detect between-group differences (Pearson et al., 2001). Further complicating the matter is the lack of ability to accurately predict which individuals will ultimately die by suicide. Taking into account these multiple concerns, in order to ensure responsible risk management that was consistent with the two treatments provided, we created separate, detailed risk-management protocols for each condition. Given that there are no standard suicide risk-management protocols that are used uniformly across clinical settings in the United States, both risk-management protocols utilized in this study are likely to be superior to TAU, provide manualized safety monitoring and risk management, and are consistent with ethical and legal requirements for the protection of human subjects.

Clinicians providing IGST follow the risk-management procedures outlined in the American Academy of Child and Adolescent Psychiatry's Practice Parameters for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior (Shaffer & Pfeffer, 2001). They are provided with extensive training on how to assess suicide risk and on the standard safety precautions to be reviewed with both youth and parent (e.g., removal of lethal means, increased parental monitoring, provision of telephone numbers of local emergency services) that are recommended in the practice parameters. They are also provided with guidance on how to perform these procedures while staying within the nondirective, client-centered approach of the treatment model. Youth and parents are also given the telephone numbers of local and national suicide hotlines that are available for 24-hour, 7-day-per-week crisis management.

In the DBT condition, therapists follow DBT assessment and treatment protocols for suicidal individuals, including the Linehan Risk Assessment and Management Protocol (LRAMP; Linehan, 2009). The LRAMP is a semistructured assessment checklist that guides clinicians through an extensive list of risk factors for imminent suicide and enables him/her to conduct and document a comprehensive risk assessment that addresses liability concerns. It also assists the clinician in determining and justifying his/her course of action (e.g., recommending hospitalization or not) and in creating a safety plan. The LRAMP is completed in the first session with a new client and subsequently completed at any time during treatment when the client reports self-injury, a suicide attempt, an increase in suicidal urges, or threatens suicide. As part of the standard DBT protocol, therapists also provide clients and parents with 24-hour, 7-day-a-week telephone coaching within limits, with the goal of learning to use DBT skills in both suicidal and nonsuicidal crises. In the absence of any data that hospitalization is an effective treatment for suicidality (for reviews, see Bridge et al., 2006; Gould et al., 2003), DBT has a strong preference for avoiding hospitalization for suicidal individuals and rarely suggests inpatient care, although it is not prohibited if it is needed. Although DBT promotes the use of coping skills instead of psychotropic medication (replacing pills with skills) to manage negative emotions, it also includes a rescue medication protocol. In particular, the DBT therapist recommends immediate treatment with medications in the following two instances, both of

which have been shown to be predictors of imminent suicide: (a) severe insomnia combined with escalating agitation or suicide ideation (Bernert & Joiner, 2007; Fawcett, 2013; Linehan, 1981) and (b) a severe psychotic episode (Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Hor & Taylor, 2010).

Detailed safety protocols are also utilized during study assessments across both study conditions. Assessment interviewers utilize the Linehan Risk Assessment Protocol (LRAP; Reynolds, Lindenboim, Comtois, Murray, & Linehan, 2006). The LRAP includes an assessment of suicide and self-injury risk pre- and postassessment, strategies to decrease distress and related suicidal and self-injurious urges, and procedures for when to increase the level of response (e.g., escorting the subject to the hospital). Of note, there is no evidence that assessment of suicidal behavior (whether for treatment or research purposes) "primes" vulnerable individuals and leads to increased suicide risk or risk of nonsuicidal self-injury (Biddle et al., 2013; Gould et al., 2005). Given that self-harm and suicidal behaviors are inherent risks in a study that recruits expressly for highly suicidal people, and the importance of protecting our participants, the LRAP is administered as a standard part of each assessment battery. The LRAP includes a protocol for calling in a supervisor to speak with the subject before she/he is allowed to go home if the other elements of the LRAP do not sufficiently reduce distress.

Several additional steps have been taken to enhance and manage safety. The Principal Investigators (PIs) of the study are experts in working with suicidal clients, as well as in conducting large-scale clinical trials. Study PIs and clinical supervisors are available to study staff at all times for consultation regarding safety concerns. As described above, study therapists and assessors receive extensive training on risk assessment and management protocols. As required by NIH for all intervention trials, the study has a Data Safety and Monitoring Board that meets on a quarterly basis to evaluate the safety of the trial. There is also a study ombudsman designated at each site who is available to independently evaluate whether or not a subject needs to be removed from the study protocol. Because there are no evidence-based treatments for suicidal adolescents, and no data showing that hospitalization or residential treatment are superior to outpatient care (Bridge et al., 2006; Gould et al., 2003; Van der Sande et al., 1997; Waterhouse & Platt, 1990),

there is no strong rationale for pulling subjects out of the study treatment just because they become more suicidal during the study. However, if at any time an individual involved in the adolescent's treatment (e.g., the therapist, the adolescent, the parent, the supervisor, the PI) feels that he/she is not benefiting from the study treatment or is getting worse, and there is reason to believe that an alternative treatment exists that has a greater likelihood of addressing the client's needs, a meeting with the ombudsman and the family is automatically initiated. The ombudsman makes the final decision as to whether or not the youth should be removed from the study protocol.

How to Manage Anxiety

Finally, and perhaps most important, working with highly suicidal adolescents creates a great deal of anxiety among therapists and investigators. Indeed, the thought of a child dying by suicide is difficult to bear and the assessment, management, and treatment of suicidal clients are among the most stressful tasks facing clinicians (Jobes, 1995). It is critical that this anxiety is adequately addressed and managed in order to prevent it from interfering with the implementation of appropriate safety procedures (Pearson et al., 2001). For example, therapists' fears may compel them to either under- or overassess suicidality, or to deviate from study protocols, which could lead to suboptimal risk management. It is critical that the study is led by investigators and clinical supervisors who can tolerate the anxiety associated with working with suicidal adolescents and model this for others. In order to address anxiety in our research teams, we have (a) provided ongoing training and education about risk management procedures, (b) provided education about the limits of therapists' ability to predict and prevent suicides, (c) had therapists meet regularly with clinical supervisors and in teams to provide each other with support and guidance, (d) had PIs and clinical supervisors who are available 24/7 for consultation, (e) given therapists small caseloads to prevent burnout and allow time for careful management of cases, (f) provided detailed safety protocols to be followed, (g) conducted regular fidelity monitoring of therapy and assessment sessions, and (h) emphasized the critical importance of the work research team members are doing and the potential for their work to save lives in the future.

Conclusion

Adolescents who have attempted suicide are at high risk for subsequent suicide attempts and death by suicide and evidence-based treatment approaches are urgently needed. However, at present, there is a relatively small amount of treatment research that has been conducted on this population and no interventions meeting criteria for a “well-established” empirically supported treatment (APA Presidential Task Force, 2006). The lack of research studies in this area is likely due to the multiple difficulties encountered in working with a sample of highly suicidal individuals. In light of our experiences conducting the CARES study, a large RCT examining the efficacy of DBT with adolescent suicide attempters, we discussed ways to address the issues that deter researchers from conducting this research. In particular, we discussed how to select scientifically sound treatment and control groups, recruitment of high-risk adolescents, safety protocols, and managing anxiety. We hope that this article will be instructive for investigators considering doing research on this topic and will facilitate additional research.

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CBTers ASSEMBLE!!¹

Episode 1: “A Tweet for Help”

Jonathan Hoffman, *Neurobehavioral Institute*

Dean McKay, *Fordham University*

This emergency psych. response begins with a tweet, a telling indication of just how far we’ve come in minimalist communication. Honestly, is an e-mailed “cry for help” just too much to ask for these days? A superhero fast running out of pre-authorized sessions wants a consult ASAP with the CBT action team (CBT/AT). CBT/AT is for inordinately complex cases, the kind you can’t search for in PubMed. ‘Nuff said, you ask? Certainly not! He manifests characterological issues in less than 140 characters. “Need your help, fate of all humanity at stake—will you take my plan? Referred by The Watcher. S.” Says it’s a crisis, but doesn’t want to incur any out-of-pocket expenses. Classic.

Even with the Affordable Healthcare Act (ACA), we’re so far out of network that Professor X couldn’t locate us with his telepathic powers enhanced by Cerebro and set to scan managed care databases, and no, there isn’t any superhero courtesy. He doesn’t like this therapeutic stance; he’s used to continuous reinforcement schedules, VIP style. We won’t play his little entitlement games, the ability to travel faster than light doesn’t translate into any “specialized” care in this clinical setting.² After trying to wheedle us into being “one-time providers”—the only contingency we’ll “provide” on this matter is broadening his experiential tolerance for the word “no”—he says he’ll self-pay, at least for now. Our ethical standards eschew profiling based on expectancies, but he fits the demographic to a tee—sky’s the limit on the secret lair, has to have the latest intergalactic surfboard, but resents spending dime one on

clinical services. If he claims financial hardship, dollars to gluten-free doughnuts he can’t provide adequate documentation to qualify for the sliding scale. Probably will explain it’s on account of being self-employed. We’ve heard that one before. One of us says, “Superhero? Super-Ego more like it!” Inside joke. We both giggle like grad students before qualifying exams.

We obtain his informed consent for treatment and this transcript; ‘natch, we get both his superhero and alter ego signatures, in case he claims he’s got dissociative identity disorder and asks for a refund after services are rendered. It’s happened before (cf. Frank & Lee, 1989), and we have now incorporated these additional safeguards after careful legal consultation and thorough examination of our local and interstellar HIPAA regulations. Well, anyway, he makes a big fuss about confidentiality, but protests way too much for us to validate. Most superheroes “say” they want to keep things on the down low, even have “secret identities,” but somehow they always manage to show up for the intake in full regalia. S. is no exception. He glides into our waiting room striking a yoga pose on a shiny glazed plank gratuitously hovering two feet off the ground, “Humble Warrior” no less. As if! We have never seen so much overcompensating this early, worse even than the narcissistic CEO who showed up in an armed-to-the-teeth suit of iron he desperately wanted us to believe he designed with no help from the legion of MIT brainiacs he has on the payroll. Meanwhile, our new consult has limited mindfulness, lacks inhibitory mechanisms, and craves attention, impulsively going for the negative kind if he can’t get the posi-

tive. Problem for him is he needs us more than we need him and he knows it. He’s seen the evidence base, recognizes we’re board certified in CBT from ABPP to boot.

CBT/AT: So you’re the Surfer, eh?

S: What gave it away, that I’m literally shining metallic or that I’m riding a board that’s levitating in thin air violating basic laws of physics? If that’s an example of a cognitive behaviorist’s “powers” of observation, maybe I’d be better off seeking another theoretical perspective. Come to think of it, can you suggest an energy therapy practitioner who DOES take my insurance?

CBT/AT: Let’s bring the focus back to you. When you contacted us, you expressed urgently needing our help.

S: I don’t need anything, much less urgently. *[dramatic pause]* I command the Power Cosmic.

CBT/AT: So then what brings you here, besides your surfboard?

S: Look bub, if I want snarky comments, I’ll go over to DC and talk to Bane. That joker’s always contextualizing to justify himself. Uses analogies and metaphors nobody understands or cares about, no coherent value system to unpack. Fancies himself a “Third Waver,” about the only thing he ever waves is an unregistered firearm. But back to me, you keep making me go off on tangents. Here I am because . . . I just care too much. Get too enmeshed, always gotta be the good egg. So, I’ve got a super friend who’s in a real pickle, stuck at the precontemplation stage—refractory to psychopharmacological approaches, can’t stay consistent with his PMR. No therapeutic wilderness program will touch him with a 30-foot branch!

I chill wit’ a buncha other superheroes with dysfunctionalities too. Sometimes we do jobs together, sometimes it’s like we aren’t even aware each other exists. Yet, we’re all improbably connected. Every so often I get the funny feeling that all of our actions are being operantly conditioned by an omniscient entity that’s calling all the shots beyond free will and dignity, only making the obligatory cameo appearance from time to time.³ Marvelous, isn’t it? You know, I can refer you lots of customers if you play your cards right.

¹Dear reader, be advised that this article contains obscure “fanboy” references that may not reach .05 statistical significance for some, OK virtually all, ABCT members.

²There are protocols being developed now that handle mutants with supra-light speed. We are hoping to enlist heroes with similar abilities and pro homo-sapiens leanings to deliver the protocols to our predecessors when they bend time at their will.

³We are concerned about S’s potential for paranoid ideation. Seems the “omniscient entity” to which he refers “revealed” himself at least once that is well documented (Lee & Kirby, 1964).

Sure I can't get you on my insurance panel?

CBT/AT: About the friend you mentioned. . .

S: OK, OK. Here goes: When this bozo I'm talkin' bout gets all ticked off, his size like quadruples, his clothes shred, and his IQ—I suppose you eggheads would say his EQ too—drops to the statistically deficient level. He gets into these rages, often sans identifiable triggers, literally turns green, starts regressively verbalizing in two-word sentences, and smashes everything in sight to a pulp.

Then, after nothing's left to clobber, I mean mangle, he takes giant leaps to who knows where. When he wakes up, he's practically naked. Can't remember anything, gets all socially phobic. It's very embarrassing, and I'm not even mentioning the potential liability issues. Worse, he's a doctor, well maybe a Ph.D.—no offense—an' he started this whole mess doin' some stupid N of 1 research about Gamma Rays that went haywire. No IRB, no reversal of conditions, nothing, like he thinks all the other scientists are beneath him. Now we're not even sure he graduated from an accredited program.

CBT/AT: I think I recall hearing about this friend of yours. Wasn't there an incident a long time ago at Alkali Lake, in Canada, involving him?

S: Wow, you hear of one hyper-steroidal rage and you overgeneralize to everyone, like you never heard of cognitive biases??? That guy at Alkali Lake had retractable adamantium claws, a barber with an uncanny sense of humor, and, listen up, HE WASN'T GREEN! [*S. throws head back in faux annoyance*].⁴

CBT/AT: Why is this so important to you?

S: Never mind all that. Look, can you design a Comprehensive Behavioral Intervention Treatment plan for him, or what?

CBT/AT: [*He's really grilling us hard—like we've never seen good eye contact before.*] We get the picture, what's your friend's name? [*As if we didn't know.*]

Diagnostic Impressions and Initial Reactions

Okay, initial and raw responses: what's the dealio in this case? Is the "friend" the real patient or just the poor patsy, er, "Identified Patient?" Does S. have a hidden agenda? Lotsa questions, no diagnostic formulation so far, but it's not as if some clerk who won't give us their last name is limiting the number of sessions available in a specified time period. We have seen this kind of presentation before (Parker & Watson, 1999), but those were case illustrations, and besides, those clients had severe arm and neck trauma from spider bites. If there's an acceptance and commitment to attending therapy on a regular basis, then we're gonna get some closure. Believe it.

Our treatment team begins to consider transdiagnostic possibilities. Clearly, S. has emotion regulation problems he does not "own," and like so many that struggle with managing their affective states, perhaps his "friend" has this challenge too, without the interplanetary itinerary. We begin to examine our caseloads, wondering if a group will turn out to be the best modality to start all concerned with in order to build skills for their subsequent courses of solution-focused individual psychotherapy. Raising S.'s acceptance of his own issues paralleling those of his alleged "friend" will task us, as will be overcoming his anticipated self-sabotaging efforts to evade the rigors of the interpersonal dynamic, but your friendly neighborhood CBT/AT is up for it. BTW, if

you think forming a suitable group for these sorts of patients would be difficult, think again. Just earlier this week one of our consultants met with another colossus with "issues"—this one covered in large fantastical orange rocks—who was interested in "meeting like-minded others." Also, on our wait-list was a man who called himself a Russian mutant (talk about self-esteem problems!) who could also convert his skin to metal at will. He said his name was Piotr, which we determined was a fake. I mean, really, how pretentious! "Piotr" said he was sent by Magneto, but we doubt the veracity of this self-serving explanation (see Kane & Cockrun, 1975). We consider this group evidencing such interesting adaptations that we immediately began to develop plans for a case paper, manualized treatment guide to follow, feeling optimistic that it would be appropriate for *Cognitive and Behavioral Practice*, maybe even as part of a special issue on modifying treatment for clients with bizarre ideation and genetic mutations.⁵ A nagging concern, what are the existing guidelines for conducting cybertherapy with a humanoid senselessly posturing on a surfboard? No doubt our State Licensing Board will be able to provide clarity on this matter if indeed it arises.

Episode Next

Mo' background details, mo' problems. *In the ensuing installment, the CBT/AT finds time in their busy schedule to do a diagnostic work-up for an over-controlled homeless scientist, his unpredictably expansive 1200 lb. emerald-hued alter ego, or both. Whatever, going forward a credit card's on file and there's a charge for missed sessions not cancelled within 24 hours, unless of course they have a semiplausible explanation. After all, it's a practice, not a business.

As Stan Lee, the Original Gangsta of psychological dissemination, says—"Excelsior!!!"

* The work of the CBT/AT is supported by a generous grant from SHIELD, Behavioral Sciences Section, and the kind forbearance of our colleagues.

* You have the data. In accord with the CYA risk management policies strongly suggested by our attorneys at highly disproportionate hourly rates, we encourage you to forward your clinical impressions and recommendations, i.e. know-it-all comments, regarding patient S.'s initial presentation to Dr. Reed

⁴We checked later and felt a certain vindication that news accounts confirmed that the incident at Alkali Lake did indeed involve the green-muscl'd hero in question as well as a clawed mutant with remarkable restorative abilities. If we knew this at the time of our consultation, our own "here-and-now" focus would have been shelved to deliver a sharp rebuke; not helpful for therapeutic alliance, sure, but man, was S. smug. See Thomas and Lee, 1974, for the news account.

⁵We received a separate invitation to contribute our unique treatment protocol to a special dedicated issue of a different journal, but it was an open-access publication. The guest editor (D. "Doc" Sampson) claimed it would be well cited, but we had our doubts when it was accompanied by a request to participate in a by-invitation-only symposium to be held on Asgaard, with a hefty prepayment for publication of the article in the conference proceedings in addition to the journal itself. Our suspicions deepened when all correspondence from Sampson went straight to our spam filter. We hope we don't face Odin's wrath when we try to publish elsewhere, but we are working on a limited grant here and can't spare the funds to pay for open access or for the conference.

Richards, Baxter Building, 42nd & Madison, New York, NY. Best you not check on his license to practice.

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Youngstrom et al.
Cognitive and Behavioral Practice
doi: 10.1016/j.cbpra.2013.12.005

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“[John] Dewey held that the reflex arc was not merely a stimulus and response, but a totality of behavior and that the arc did not really have a beginning and end but that the phenomenon was *circular*. The end of an arc was also the beginning of another arc.”

Harold H. Anderson
“Circular Behavior”
In Wolff & Precker (Eds.) (1952)
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mayor = mair • how = heaow • bagels = beggles • phone = phoon • water = wooter • about = uh-bowt = uh-beowt

If you have other examples of Philadelphia-speak, send them along to Mary Ellen at mebrown@abct.org

