Accelerated Behavioral Medicine

Low-Cost, High-Volume, Quality-Controlled Care

Michael Maliszewski, Ph.D.

The face of health care has changed radically over the past decade, especially with regard to managed care. These changes have been particularly acute in many states, ranging from California to Massachusetts, but are now extending into virtually all parts of the country. The rise in numbers of health maintenance organizations (HMOs) and preferred-provider organizations (PPOs), with their accompanying restrictive mandates for delivery of services, has concerned practitioners who provide health care services. The original goal of these groups was to attempt to curtail the rising increase in medical costs. However, while the profits of these cost-containment organizations have been quite high, there have been reports that both patients and health care providers have perceived a simultaneous decrease in quality of service delivery.[1–5]

One area of health care that has been significantly affected by these changes is mental health. Psychiatrists, psychologists, social workers, and allied health professionals have been impacted by these newer approaches to treatment. Not only do these professionals need the approval of insurance providers; the caregivers are also limited by the number of visits allowed and the form these interventions can take (e.g., composition of testing protocols, number of individual or group sessions) as defined by the form of monetary reimbursement. Requests are often made for additional reports to justify continuation of treatment, which adds additional, burdensome work for the practitioner. In other areas, primary care physicians and various medical groups are rewarded with financial incentives for reducing the number of patient return visits to their offices and outside referrals to psychiatry, which they may perceive as now falling within their own capable domain of treatment. The increased popularity displayed by managed care to "carve outs" (i.e., selective referrals to specific group providers who are assigned to cover all mental health care for a particular population, often at a capitated risk) does little to instill confidence that patient care will improve.[6,7]

Furthermore, few would argue that the profits made by HMOs or PPOs have in any way trickled down to the direct care provider who feels his or her income and patient pool steadily shrinking. And it is unlikely that these trends will change in the near future.[8] The issue that comes clearly to mind, then, is how can one comply with health care trends and mandates to decrease costs but, at the same time, increase the quality, efficiency, and efficacy of psychiatric interventions. It is argued here that one direction will be a model that accomodates high-volume, low-cost, efficient and quality-controlled care.

Beyond Media Promotion: Is There a True Model of Success?

The media has played a significant role with many groups and organizations in establishing and maintaining public attention, given the increasingly competitive efforts to procure patients in the shrinking marketplace. The more visible institutions and individuals rely heavily upon some form of advertising, generally arguing for more innovative and unique approaches to treatment. Proponents of these approaches claim positive outcomes in research studies, clinical trials, and patient self-reports that have been published in both the scientific and the popular literature. All of this appears to be quite impressive. However, despite these highly favorable claims, in reality, few HMOs, PPOs or insurance companies have encouraged specific mental health groups directly to refer clients on any large scale because of their positive outcomes or cost-containment effects. (This is evident when the more publicized treatment programs are compared to any other "generic" groups that delivers comparable services). Nor have the effects of these alleged unique programs allowed cost savings to be passed along directly to the patients or health care providers. It is argued here that the present state of affairs stems from one major fact: Despite claims to the contrary, virtually all of the models available to deliver mental health services are based upon a current yet conventional model of psychiatry and psychology that has now existed for more than 75 years. This includes such classic features as the 50-minute psychotherapeutic "hour," major diagnostic measures and psychologic tests (e.g., Minnesota Multiphasic Personality Inventory, Rorschach) and direct face-to-face interactions in testing and therapy. While other areas of medicine, such as cardiology, vascular surgery, and orthopedic surgery, have accommodated themselves to the need for more effective and efficient methods of delivery, mental health practitioners continue to follow an early twentieth century paradigm, which has not yet been strongly challenged to any extensive degree.

Accelerated behavioral medicine has redefined the entire spectrum of service delivery.

Setting Up a New Working Model: Acclerated Behavioral Medicine

In the health care revolution, there is now a closer alliance between psychotherapy and mainstream medicine. Contrasted with earlier methods in psychology is the newer field of behavioral medicine, which has developed as a legitimate and respected discipline with an extensive body of literature supporting its efficacy in the treatment of a wide variety of medical conditions.[9–12]

Despite data supporting cost containment, efficacy, and patient satisfaction as an alternative to strict medical/surgical and pharmacologic interventions,[13–19] there has been no real shift *en masse* by insurance companies to insist on the use of techniques found in behavioral medicine. In part, this stems from the clinician being forced to provide alleged unorthodox techniques of delivery in an orthodox format, the referral generally coming from a primary care physician (PCP) or health care organization. The customary delivery format consists of time-set 50 minute/hourly sessions, weekly sessions over an 8- or 10-week period, and sessions scheduled separately in a different setting and time from the PCP visit.

To change this state of affairs we can consider an alternative option: Bring the separate fields of psychotherapy and medicine together so that both areas become transformed, i.e., mainstream medicine becomes integrated more with strategies in psychotherapy and behavioral medicine, and psychotherapy becomes more medical in its scope. On a practical level, one can accomplish this by teaching primary care physicians behavioral medicine or by introducing a behavioral medicine specialist who works with physicians as an integral member of their team. It is also important that the delivery of services be overhauled to accomodate formats for interdisciplinary treatment that are less restrictive than the piecemeal, specialized forms of treatment in place today.

More recently, an approach to delivery of services in behavioral medicine with pain patients was developed that differed dramatically from the form and structure observed in other behavioral medicine programs in the United States and abroad. Currently referred to as accelerated behavioral medicine (ABM), the program has redefined the entire spectrum of service delivery. ABM was first tested and refined several years ago when I worked at the Diamond Headache Clinic in Chicago, Illinois. This clinic was the largest single site and best-known treatment center for headaches in the world and to this day continues to treat patients and publish widely in the field of headache.[20–23] The approach of ABM paralleled those utilized by physicians at this treatment center—namely to use all available strategies at one's disposal to reduce or eliminate severe headache pain as quickly as possible. However, in contrast to a "copharmacy" approach emphasized by physicians at this setting (i.e., the use of several medications concomitantly[24]), the focus of ABM centered on a variety of nonpharmacologic and nonsurgical strategies. Despite its direction away from the more invasive medical strategies, it did not serve as an exclusive alternative to mainstream medicine, but rather was presented as an additional option that complemented more orthodox methods. In this situation also, a psychologist served as a specialist in a team approach to the treatment of headaches.

The roles of psychiatry, psychology, and psychotherapy in ABM in this setting were redefined and restructured by necessity. First, three physicians at this setting treated more than 20,000 patients per year from all over the world on an inpatient (35-bed unit) or outpatient basis. There was generally a 2–3-month waiting list. To accommodate this high volume, extremely efficient methods of delivery were developed. A description of the approach used here is outlined below. A unique vantage point was also offered by a medical setting that specialized in treating a specific medical problem and that also treated an unusually large numbers of clients from diverse parts of the world. First, one was able to assess the efficacy of standard psychiatric and psychologic interventions across specific types of medical disorders (in this case, headache) in a large sample size. More subtle nuances related to demographic factors (age, gender, educational level, area/country of residence, etc.) could also be assessed in terms of efficacy of treatment, receptivity by patient, etc., which would not be apparent at smaller, more generic treatment sites. There exist only a specific number of diagnostic classifications that patients most commonly presented at such a site (e.g., tension-type, migraine, cluster; criteria outlined by the International Headache Society).[25] Hence, a distinct approach could be utilized to treat each of these normative categories with some variation to allow for individual differences within each group.

Essentially, ABM involved assessing, selecting, and modifying the repertoire of available diagnostic tests and treatment strategies identified with the field of behavioral medicine with the goals of (1) increasing the speed with which significant clinical

Patients were given some latitude to negotiate the form of treatment intervention.

and medical information could be acquired and analyzed, (2) increasing the impact of behavioral medicine strategies in effecting changes in pain, (3) reducing the time needed to deliver the services required to effect a reduction in pain, and (4) reducing the overall costs involved in delivery of these services. Headaches were generally observed to be triggered and reinforced by changes in physical movement, physiologic arousal and/or psychologic processes (e,g,, cognitive patterns, emotional reactions, etc.). Hence, with ABM, a finite number of specific techniques generally were found to be more effective than others and were used to effect more quickly psychologic and physiologic changes related to reducing pain. Among those strategies most effective were techniques aimed at modifying physiologic activation levels through diaphragmatic breathing exercises, performance of physical postures and movements, training to engage in specific time-set activities (physical and mental), teaching strategies for avoidance of intrusive cognitive and introspective processes, and adherence to more strict behavioral interventions to modify behaviors and thought patterns. The therapist's role turned out to be primarily psychoeducational in nature, defining what strategies were best to use at specific times for each patient.*

Dealing Effectively with Patients' Reactions

It is also important to note that many patients who are being treated for headache and pain often object to seeing a psychiatrist, psychologist, or psychotherapist as part of the assessment and treatment procedure. A number of reasons are often given for this objection: Patients want fast-acting interventions to alleviate their pain; patients feel that the PCP doubts the veracity of their pain; they want medical proof for their disorder; they are fearful of being judged as somatizers or hypochondriacs; they perceive that their physicians are helpless and have given up on treatment of their physical problems; or they feel themselves to be viewed as being disturbed.

To accommodate any patient resistance to the stereotyped image of psychotherapeutic interventions and to meet the need for maximizing efficacy of ABM's comprehensive treatment approach, the following procedures and strategies were implemented:

1. Patients saw the psychologist in the same setting as their PCPs and close in time to the PCP's initial medical workup.
2. As part of their initial workups, patients were given abbreviated, unique, headache tests (specific to behavioral medicine), which took 5–10 minutes to complete. The design of these tests was to have the testees check off features that fit their make-up from a pool of test items derived from headache classifications and known to correlate with such dimensions as personality, developmental issues, interpersonal factors, and lifestyle orientation.*
3. The abovementioned tests were scored, analyzed, and discussed with the patients at the first meeting. The psychologist provided a diagnosis and outline of all treatment strategies that could be used at that time.
4. The psychologist provided information that the physician did not have time to discuss or of which the physician was unaware (e.g., behavioral correlates related to etiology and treatment).
5. Customary hourly meetings and billing sessions were abandoned. All patients were initally given a diagnostic evaluation that was charged at a set fee (regardless of the time factor involved). This was followed by the option of individual and/or group therapy sessions. Similar to the diagnostic evaluations, group sessions had a set fee structure. Efficiency of approach to interventions was stressed in individual therapy sessions so that the conventional hourly time format was generally deemed to be untenable. Rather, services here were charged "by the minute" with patients deciding with the provider how much they felt was necessary in terms of information and intervention to stop their headache pain and also what they could afford to pay. (For inpatients, the first 10 minutes of individual therapy was free). If patients genuinely felt the contributions made by the psychologist were useless or redundant, that is, simply a repetition of what they had heard before from previous providers, the fee was waived. (Two exceptions were drug addicts and sociopaths. Individuals fitting either of these profiles had investment in not having successful outcomes to treatment).
6. Patients were given some latitude to negotiate the form of treatment intervention. Group formats provided a support context for them and could also reduce costs incurred (and save the therapist considerable time). Information provided in these meetings covered topics common to all headache sufferers as well as features unique to each patient's case. More personal issues could be incorporated into private, individual therapy ses-

*Maliszewski, M. Management of the headache patient: A behavioral medicine approach, unpublished manuscript, ©1990. This paper is the only previous essay to discuss specific content of the ABM model.

A maximum of 2 ½ hours was needed to treat the most chronic and difficult cases comprehensively.

sions, fine-tuning what had not been addressed in the group sessions.[24]

7. Patients were provided with information and specific interventions unique to this program and generally not found in other behavioral medicine settings. This was achieved through clinical observations of the thousands of patients who went through this treatment program.

A remark on behavioral interventions for patients who were diagnosed accurately as having cluster headaches will serve to illustrate this point. The incidence of this specific type of headache disorder is quite small compared to other types of headaches. At this clinic site, at least 30 cluster headache patients were seen monthly. By contrast, the average neurologist seldom treats this number yearly. Derived from hundreds of clinical observations, a large number of cluster headache patients were often observed to have abrupt headache attacks at those times when there occurred a rapid drop from a high level of activation to a period of low arousal or in other instances when sufferers allowed their general activation level to remain low upon waking for even a matter of a half hour or less. Increasing activation levels (identified by other types of headache sufferers as being potentially stressful and pain inducing) often served to nullify the potential for any headache attacks. Hence, behavioral interventions were developed to increase and maintain higher levels of physiologic arousal in order to reduce headache attacks, given that meditation and relaxation-based interventions often triggered headache onset for this particular population* and patients themselves often identified psychologic strategies as not being helpful.[24] In contrast, a majority of psychologists use biofeedback and relaxation procedures as standard treatment for all types of headache.[26,27]

8. If conventional psychologic tests were used,[28] test scores/outcomes were reinterpreted and redefined in medical/behavioral terms (not psychiatric diagnoses). For example, the 1-3/3-1 MMPI code profile (elevated scales in hysteria [Hy] and hypochondriasis [Hs]), which is often found in a majority of migraine sufferers, was reinterpreted exclusively in terms of how cognitive and affective features of this orientation could trigger or reinforce headaches, providing the patient with neutral descriptors that had no psychiatric association. (As an example, Hy scores could be described in terms of a propensity to have a more intense reaction to issues or events on an emotional level; high Hs scores might describe a tendency to incorporate stress on a somatic level or respond with a somatic reaction to stressful events).
9. If desired, patients could be referred to mental health providers following the customary health care model to address additional issues (as many patients were out of state/country, those patients who requested additional interventions were given outpatient referrals to providers who practiced near where the patients lived).
10. Following from (item 7) above, however, it was recognized that outpatient referral to orthodox psychotherapists (i.e., psychotherapists who are unfamiliar with headache patients) after treatment for standard support or more indepth therapy could detract from treatment gains that were achieved at this particular setting. As examples, psychiatrists would often try to alter the clinic's copharmacy regimen to follow more closely a customary model of psychiatric medication because there was some overlap in classifications of medication used. Generally, this took the form of reducing both numbers and dosage levels of medications initially needed to achieve and maintain a pain-free status. Also, psychoanalysts and psychodynamically oriented psychologists would readdress traumatic events with patients. Reactivating memories of trauma and stress with headache patients could serve to trigger headache attacks again,[24,29]. Hence, when possible, the sensitivity of these patients to pharmacologic and psychologic changes was reviewed in advance to referred providers informing them that precipitous changes in either of these areas could lead to reemergence of headache problems.
11. A *maximum* of 2 ½ hours was needed to treat the most chronic and difficult cases (inpatient) comprehensively, providing the patients with both acute (immediate) and prophylactic intervention strategies. Less severe or complex cases could be treated in a fraction of that time. (Outpatient visits could generally average between 15 and 30 minutes). This contrasts with the typical 8–10-week format in hourly sessions that is generally pursued elsewhere.

Outcomes

With regard to for treatment outcomes, the following practical issues deserve mention:

- Studies were published verifying the overall efficacy of treatment.[24]
- Followup questionnaires were sent to patients after treatment, asking for strengths and limitations that the patients observed for themselves in the assessment and intervention pro-

Overall fees charged were observed to be far less than other behavioral medicine programs.

Resources

The American Council for Headache Education
19 Mantua Road
Mt. Royal, NJ 08061
(609) 423-0258 or (800) 255-ACHE
Fax: (609) 423-0083
Web site: http://www.achenet.org

Rocky Mountain Headache Association
1155 East 18th Avenue
Denver, CO 80218
(303) 832-6236

Florida Headache Association
2185 Keylime Drive, Suite 100
Titusville, FL 32780
(407) 269-9810

The Migraine Association of Canada
356 Bloor Street East, Suite 1912
Toronto, Ontario, Canada M4W 3L4
(416) 920-4916 or (800) 663-3557
24-hour information line:
(416) 920-4917
Fax: (416) 920-3677

Foundation Quebecois de la Migraine et des Cephalees
3587 Avenue Papineau
Montreal, Quebec, Canada H2K 4J7
(514) 529-3449
Fax: (514) 529-3492
French language services included

British Migraine Association
187A High Road
Byfleet, West Byfleet
Surrey, England, KT14 7ED
011-44-932-352468

The Migraine Trust
45 Great Ormond Street
London, England, WC1N 3HZ
011-44-071-2782676

Irish Migraine Association
P.O. Box Number 4290
Dublin 9, Ireland

Swiss Migraine Trust
Schaffhauserstrasse 21
Postfach 8042, Zurich, Switzerland

Australian Brain Foundation
National/Victoria Branch
746 Burke Road
Camberwell, Victoria, Australia 3124
011-61-3-8822203

The New Zealand Neurological Foundation Inc.
P.O. Box 68402
Newton, Auckland 1001, New Zealand
011-64-9-3798470

cedures used. This information could later be incorporated into future treatment considerations.

- Although specific figures are beyond the scope of this paper, economic factors were also quite favorable. I had the opportunity to travel throughout the United States and western Europe and meet with other professionals at different treatment centers. Generally speaking, given the structure of ABM, overall fees charged were observed to be far less than other behavioral medicine programs (stressing a high-volume/low-cost approach).
- Given the large volume of patients and smaller number of personnel used in behavioral medicine/psychiatry (two to three full time), overall profits to direct care providers were quite high, also exceeding the income of other behavioral medicine programs. Charges to insurance companies were also noted to be significantly lower than those offered at other psychiatric or behavioral medicine centers.

[†]ABM is now being tested as part of a larger, more progressive health care format known as ASHI [SM] (Accelerated Synchronized Health care Interventions), model incorporating simultaneous delivery of several treatment interventions in an accelerated fashion, the results of which will be published elsewhere.

Conclusion

Summarizing these findings, this model speaks favorably to the goal of reducing costs to carriers and patients, yet allows providers to maintain a profitable income. It also provides more extensive treatment to a chronic medical condition (headache) that would normally warrant a specialized, team-oriented approach. If the focus of managed care continues to reinforce the idea of limiting patient visits, this integrative model can provide an alternative approach, even in situations when consideration of carve outs and capitation have to be managed more effectively (costwise and timewise).

While this ABM model wove the psychologist into a team treatment approach, it is clear that an equally successful strategy could involve teaching physicians the information and techniques needed to incorporate this component into their practices directly. Some of the aversion that many patients, some physicians, and most insurance companies have to psychotherapeutic interventions may be due, in large part, to what they perceive and has been described here as a more orthodox and prolonged model of treatment.

However, it is not argued here that ABM should be considered the exclusive alternative to more orthodox treatment models. To this end, while many patients at the Diamond Clinic received complete exposure to all available components of ABM, other patients only needed (or elected) to receive specific strategies relevant to their own cases. Some patients wanted pharmacologic interventions exclusively. Still other patients, on the other hand, elected to have (or had recommended to them) referral to providers adhering to other psychotherapeutic models based upon the complexity and history of their cases. Finally, components of ABM could also be introduced into orthodox psychotherapeutic sessions by outside providers seeking to meet the needs of headache patients *per se* better. Other fac-

The ABM model can also be used in the treatment of medical conditions other than headaches.

tors, such as formal education level, personality makeup, motivation level to change (i.e., stop headaches), geographic location, chronologic age, and economics also influenced decision making in selecting the various options available.

Nonetheless, similar to other orthodox behavioral medicine programs, it is argued that the ABM model can also be used in the treatment of medical conditions other than headaches, providing patients with comprehensive, accelerated, rigorous treatment interventions specifically fit to their needs while still allowing for the cost savings insurance carriers seek.† Future testing of accelerated treatment models in a variety of different settings among different groups of patients is warranted, given the current economic and health care trends affecting all of us as health care providers. □

References

1. Cotler, M.P. HMOs and academic medicine: Are they both deaf to patients? *West J Med* 166(2):156, 1997.
2. Deckard, G.C. Physician responses to a managed environment: A perceptual paradox. *Health Care Manage Rev* 20(1):40–46, 1995.
3. Pope, C.R. Consumer satisfaction in health maintenance organizations. *J Health Soc Behav* 19(3):291–303, 1978.
4. Wilcox, D.P., Francisco III, C.J. When cost containment interferes with clinical decisions. *Tex Med* 86(5):28–31, 1990
5. Farberman, R. As managed care grows, public unhappiness rises. *APA Monitor* 30(2):14,1999.
6. McGovern, M.P., Lyons, J.S., Pomp, H.C. Capitation payment systems and public mental health care: Implications for psychotherapy with the seriously mentally ill. *Amer J Orthopsychiat* 60(2):298–304, 1990.
7. Patricelli, R.E., Lee, F.C. Employer-based innovations in behavioral health benefits. *Prof Psychol Res Practice* 27(4):325–334. 1996.
8. American Association of Practicing Psychologists. Psychologists' incomes plummet while mental health care continues to erode. *AAPP Newsletter* 1(1):5, 1998.
9. Blanchard, E.B. Behavioral medicine and health psychology. In: Bergin, E.A., Garfield, S.L., (eds.) *Handbook of Psychotherapy and Behavior Change* (4th ed.). New York: John Wiley & Sons, 1994, pp. 701–733.
10. Cott, A., Pavloski, R.P. Behavioural medicine: A process for managing performance problems. *Canadian Psychol* 26(2):160–167, 1985.
11. Wodarksi, J.S., Wodarski, L.A., Nixon, S.C., Mackie, C. Behavioral medicine: An emerging field of social work practice. *J Health Soc Policy* 3(1):19–43, 1991.
12. Richmond, J., Berman, B.M., Docherty, J.P., et. al. Integration of behavioral and relaxation approaches into the treatment of chronic pain and insomnia. *JAMA* 276:313–318, 1996.
13. Caudill, M., Schnable, R., Zuttermeister, P., Benson, H., Friedman, R. Decreased clinic use by chronic pain patients: Response to behavioral medicine interventions. *Clin J Pain* 7:305–310, 1991.
14. Cummings, N.A. Arguments for the financial efficacy of psychological services in health care settings. In: Sweet, J.J., Rozensky, R.H., Tovian, S.M. (eds.) *Handbook of Clinical Psychology in Medical Settings*. New York: Plenum, 1991, pp. 113–126.
15. Friedman, R., Sobel, D., Myers, P., Caudill, M., Benson, H. Behavioral medicine, clinical health psychology, and cost offset. *Health Psychol* 14:509–518. 1995.
16. Hellman, C.,J., Budd, M., Borysenko, J., McClelland, D.C., Benson, H. A study of the effectiveness of two group behavioral medicine interventions for patients with psychosomatic complaints. *Behav.Med*16(4):165–173, 1990.
17. Pallak, M.S., Cummings, N.A., Dorken, H., Henke, C.J. Effect of mental health treatment on medical costs. *Mind/Body Med* 1:7–12, 1995.
18. Schneider, C.J. Cost effectiveness of biofeedback and behavioral medicine treatments: A review of the literature. *Biofeedback Self Regul* 12(2): 71-92. 1987;
19. Sobel, D.S. Rethinking medicine: Improving health care outcomes with cost-effective psychosocial interventions. *Psychosomatic Med* 57(3):234–244. 1995.
20. Diamond, S., Dalessio, D.J. (eds.) *The Practicing Physician's Approach to Headache* (5th ed.). Baltimore: Williams & Wilkins, 1992.
21. Diamond, S., Maliszewski, M. (eds.). *Sexual Aspects of Headaches*. Madison, CT: International Universities Press, 1992.
22. Diamond, S., Diamond-Falk, J. *Advice from the Diamond Headache Clinic*. New York: International Universities Press, 1982.
23. Diamond, S., Diamond, V.A. *Hope for Your Headache Problem: More Than Two Aspirin* (rev. ed.). New York: International Universities Press, 1987.
24. Diamond, S., Freitag, F.G., Maliszewski, M. Inpatient treatment of headache: Long-term results. *Headache* 26:189–197, 1986.
25. Headache Classification Committee of the International Headache Society. Classification and diagnostic criteria for headache disorders, cranial neuralgias and facial pain. *Cephalalgia* 8:91–96, 1988.
26. Diamond, S., Maliszewski, M. Relaxation and biofeedback therapy. In: Blau, J.N. (ed.) *Migraine: Clinical and Research Aspects*. Baltimore: Johns Hopkins University Press, 1987, pp. 215–221.
27. Keefe, F.J., Ward, J.A., Lefebvre, J.C. Intervention-specific response rates in behavioral treatments for chronic pain. *Mind/Body Med* 2(4):190–201, 1997.
28. Maliszewski, M. Psychological testing of the headache patient. In: Diamond, S., Dalessio, D.J. (eds.). *The Practicing Physician's Approach to Headache* (5th ed.). Baltimore: Williams & Wilkins; 1992, pp. 224–238.
29. Braun, B.G., Sachs, R.,G., Frischholz, M.A. Headaches and early child abuse. In: Diamond S, Maliszewski, M. (eds.) *Sexual Aspects of Headaches*. Madison, CT: International Universities Press, 1992, pp. 379–388.

Michael Maliszewski, Ph.D., is a consultant in psychology/psychiatry at Massachusetts General Hospital and a clinical instructor in psychology in the department of psychiatry at Harvard Medical School, both in Boston. He is also the project director for the ASHI℠ model described in this paper.

To order reprints of this article, write to or call: Karen Ballen, *ALTERNATIVE & COMPLEMENTARY THERAPIES*, Mary Ann Liebert, Inc., 2 Madison Avenue, Larchmont, NY 10538-1962, (914) 834-3100.