

the Behavior Therapist

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PRESIDENT'S MESSAGE

Staying on Mission

Bruce F. Chorpita, *UCLA*



HOW LONG HAVE YOU BEEN a member of ABCT? If the answer is less than 50 years, then maybe it won't be so easy to answer this next question: What is the mission of ABCT? Now, don't go look it up. Just pause for a moment

and ask yourself what you think it is. For many years, I thought I knew the mission of ABCT, but when ABCT's 50th anniversary recently inspired me to look it up, I was surprised. I had vaguely thought the mission was to promote cognitive behavior therapy, or to do cognitive behavioral research and share it at the convention in symposia, posters, or workshops. It turns out that the mission is far more than I had imagined.

So here it is: ABCT's mission is the "enhancement of health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through the global application of behavioral, cognitive, and biological evidence-based principles." There is a lot there, but the core of our mission is enhancement of health and well-being. There is no geographical limit given, so presumably this applies to everyone on earth, and I suppose to wherever future humans establish their celestial habitats. Our mission is to make everyone, everywhere, now and in the future, have healthier, better lives. One could easily call that mission grandiose. But I would argue that anything smaller in scope would diminish our collective sense of meaning and purpose—the very thing that motivates so many of us to do what we do. So

[continued on p. 3]

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JANUARY 31

Working with Military Service Members and Veterans: Assessment and Cultural Competency 101

— Ari Lowell, Ph.D. & Marco Bongioanni, LMHC

- 11 am–12:30 pm Eastern | 10 am–11:30 pm Central
9 am–10:30 am Mountain | 8 am–9:30 am Pacific

Military veterans and service members currently serving are seeking community mental health in greater numbers than ever before. Yet, many community providers lack awareness and understanding of military culture, and may not feel competent to adequately assess their problems and needs. This webinar provides a basic overview of military culture, to include examination of its explicit and implicit elements, how to interact with military veterans and service members, as well as a review of key assessment areas, techniques, and strategies.

\$30 for ABCT members

\$45 for nonmembers

INSTRUCTIONS for AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

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let's get comfortable with it, and let's tell others when they ask us what our work is really all about. We labor to enhance health and well-being.

As you can see, our mission statement also says plenty about how we should achieve that mission, by "advancing scientific understanding," and through "global application of behavioral, cognitive, and biological evidence-based principles." Those strategies are quite broad and open to many interpretations, which is probably a good thing. It means that among our thousands of members, we can take different approaches to achieving our mission, whether through training, practice delivery, policy development, basic or applied research, treatment development, assessment, evaluation, administration . . . the list goes on and on.

It wasn't always this way. In our organization's earliest years, the work was necessarily more unified—a collective demonstration that behavior therapy was an effective approach in the face of the contemporary alternatives. It was an era of intense focus, both on building a scientific methodology appropriate to the domain and to the accumulation of empirical findings that helped establish the mainstream acceptance and recognition of behavior therapy.

As ABCT has grown, however, its pursuits have become increasingly specialized and differentiated, a normal evolution of accumulating knowledge. We now have many special interest groups (SIGs), and they are healthy and robust. Each area of our discipline has new developments and achievements every year. And specialization is important: increasingly, our most important discoveries occur at the most granular levels of detail, whether they involve neurobiological underpinnings, organizational features in implementation contexts, or nuanced variations in treatment delivery.

But our increasing specialization also now carries risks of fragmentation. That is, it is more difficult than ever to keep the "view from the sky," to envision how our members' accomplishments work together to create a constellation of real-world solutions that improve health and well-being on a grand scale. By renewing a focus on our highly ambitious mission, we now have an opportunity to strategically coordinate our many specialist pursuits—to enable our members' professional and personal efforts to add up to more than the sum of the parts. We can improve health and well-being more successfully if we increase cross-specialty communication and reflection.

This year will include a variety of ideas that I hope will get us thinking more along these lines. A prime example involves our voter participation. High voting rates are often an indication of collective engagement, and there is room for improvement. In the hopes of increasing participation, 2019 will be the year that we all vote twice—our elections for 2020 will occur in April as they always have, but for 2021 and beyond, we will permanently move the voting to our convention month. Thus, we will all be able to vote at the Atlanta convention in November, where we can wear our "I voted" stickers proudly.

The 2019 convention theme itself is about increasing our impact and serving our mission. Accordingly, our invited keynote speakers will not only be asked to showcase their ideas but also to comment on our impact as an organization. Convention submissions that are especially thematic and mission-relevant will now be identified as such in the program. And even informal activities will be given a fresh look: a "fun run" that has been hosted off-program for nearly a decade by the Dissemination and Implementation Science SIG will now be listed in the program, open to the entire membership (with accommodations for all levels of ability), with a plan

for annually rotating leadership across all SIGs that are interested. Any opportunity to cross-pollinate among our members is going to be leveraged.

Initiatives outside the convention week are planned as well for 2019. The Board is considering more think tanks to examine the role of technology, industry, and dissemination science in boosting our impact. There will be a paper in *the Behavior Therapist* discussing diverse career pathways to accomplish our mission. There is the newly created ABCT Champions initiative (see Knudsen, Gutner, & Chorpita, 2019, this issue) to better connect our work with high-impact individuals in the community, and ABCT's Board will consider similar adjustments for our other traditions and initiatives as well.

I hope 2019 will be exciting and invigorating, bringing our mission into better focus so that we can connect our everyday work to the work of all of our other members and to the individuals and communities we have pledged to serve. Thank you for your time and continued dedication to the enhancement of health and well-being. I look forward to a year of renewed emphasis and purposeful reflection on the work we do together.

Reference

- Knudsen, K., Gutner, C., & Chorpita, B. F. (2019). Recognizing champions: Increasing the scope and impact of evidence-based therapies. *the Behavior Therapist*, 42, 4.

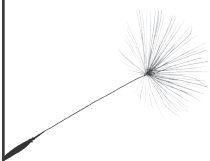
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Recognizing Champions: Increasing the Scope and Impact of Evidence-Based Therapies

Kendra Knudsen, *UCLA*

Cassidy Gutner, *Boston University School of Medicine*

Bruce F. Chorpita, *UCLA*

DATING BACK TO THE EARLY 1960s, studies of technological change emphasized that champions—charismatic people who informally emerge to actively push innovations forward—are key to overcoming their organization’s sociopolitical resistance and transforming it to an advantage (Schon, 1963). Champions thus play a critical role in the dissemination or diffusion of new ideas, practices, or technologies, and in some cases, champions may even facilitate the advancement, refinement, or evolution of those innovations. Because the membership of ABCT has long been comprised primarily of treatment developers, researchers, and service providers, we share a special interdependence with champions, who are typically not treatment developers, formal evaluators, or even straightforward practitioners or end-users. Thus, for our organization to deliver fully on its mission of improving health and well-being, we must not only be able to identify the champions who facilitate our collective efforts, but also be willing to honor them for their unique and far-reaching impact. It is time to recognize ABCT’s champions.

Within the last decade, it has become widely accepted that champions are critical to effective behavioral health implementation. As summarized in Damschroder’s Consolidated Framework for Implementation Research (CFIR), “champions” are widely considered one of several dozen important influences driving effective implementation (Damschroder et al., 2009). Since the CFIR was first articulated, there has been a notable increase in the use of the term “champions” in behavioral health publications, with currently more than 200 behavioral health-related publications using the term. Of these, nearly 75% have been written in the last decade, with most of those published within the last 4 years, compared with the previous 30 years combined (Miech et al., 2018). Despite growing attention to champions in evi-

dence-based mental health care, there are few large-scale initiatives to find, connect with, and celebrate them. This article therefore seeks to articulate the key features of champions—who they are, how they act, and why they are effective—so that we can both commend and build on their energy and influence.

How Champions Diffuse Innovations

To appreciate how champions are crucial in promoting implementation of evidence-based interventions, we must first consider the dynamics of innovation adoption more generally. An innovation is an idea, product, or practice that has both novelty and value (Runco & Jaeger, 2012). An innovation can fail due to inertia, fear of criticism, cynicism about its utility or “stickiness,” and lack of attention to fostering its early-stage development (Chakrabarti, 1974). Forces that help spread innovations are considered to be on a continuum that ranges from pure diffusion (i.e., spontaneous, informal, decentralized and likely to occur through horizontal organizational structures or via peer-mediation) to pure, active dissemination (i.e., planned, formal, centralized and most often occurring through vertical hierarchies or via top management; Helfrich, Weiner, McKinney, & Minasian, 2007). One of diffusion’s primary mechanisms is interpersonal influence through social networks (Rogers, 2003), i.e., the pattern of friendship, counsel, communication, and advocacy among members of a social system (Valente, 1996). A social system’s functional groups (e.g., agency staff and management, policymakers, and clients) often collectively interact to decide whether to adopt an innovation. According to one model, the degree of an innovation’s success can be considered to rely on five steps: (1) stimulation (something sparks awareness of system’s need for the innovation), (2) initi-

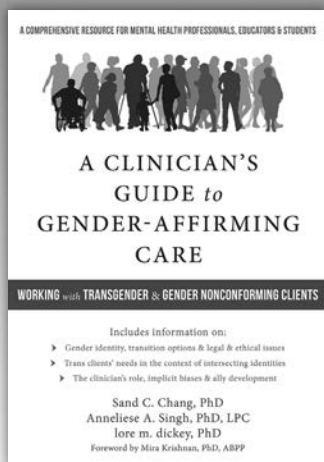
ation (someone increases attention to the innovation), (3) legitimation (those who represent the system’s norms and values sanction the innovation), (4) decision (top management commits resources to adopt the innovation), and (5) execution (groups implement the innovation; Bailey, Rogers, & Shoemaker, 1974). Numerous researchers have proposed similar models outlining steps relevant to diffusion and/or implementation (Aarons, Hurlburt, & Horwitz, 2011; Rogers, 1995, 2003).

According to Chakrabarti (1974), champions act as a link between these steps. Applying an understanding of the system’s specific problems and context, champions stimulate awareness of need across the groups within the system. In the early development phase, they translate the innovation into a valuable action plan, packaging it in a form appropriate to the system and its members. Having the social power and willingness to take risks, champions tactfully market the innovation to develop cross-functional coalitions within the system. Champions can tailor an especially persuasive message owing to (a) their considerable breadth of experience, personality and interests; (b) their awareness of the system’s unique demographic, structural, and cultural features; and (c) their knowledge of the innovation’s complexities. Often through sheer force of will and enduring energy, champions can push their message to those with formal authority to commit system resources. Finally, champions coordinate and problem-solve across functional groups to help drive the effort forward to its success, i.e., implemented by all significant people and considered to be “routine” (Damschroder et al., 2009; Helfrich et al., 2007; Miech et al., 2018; Rogers, 2003) or a “social fact” (Goodman, Bazerman, & Conlon, 1980).

Who Are Champions of ABCT?

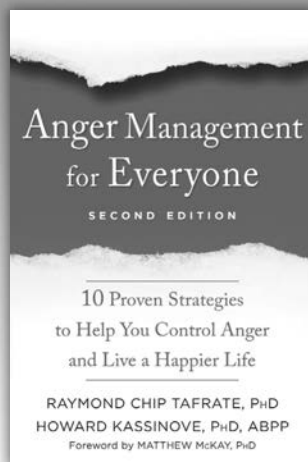
In the context of ABCT and its mission to impact health and well-being, champions are those individuals who support, facilitate, diffuse, or implement our core strategic assets of evidence-based treatments. It follows that understanding how champions succeed in their role will help us to increase the scope and impact of evidence-based therapies. Past studies highlight three necessary elements of the champion’s role in our particular context:

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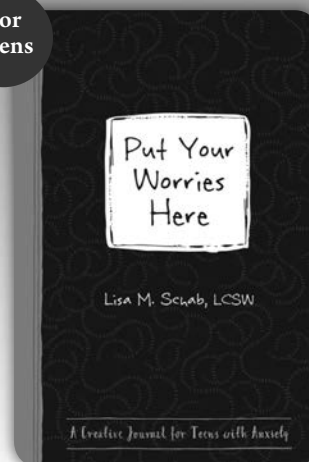
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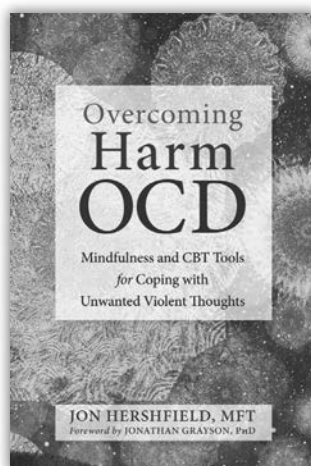
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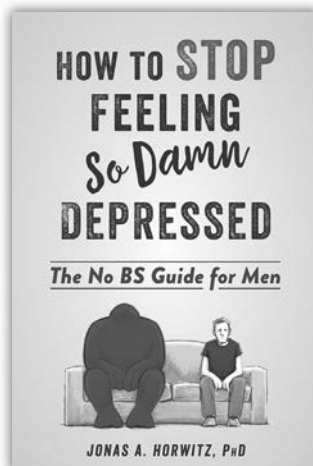


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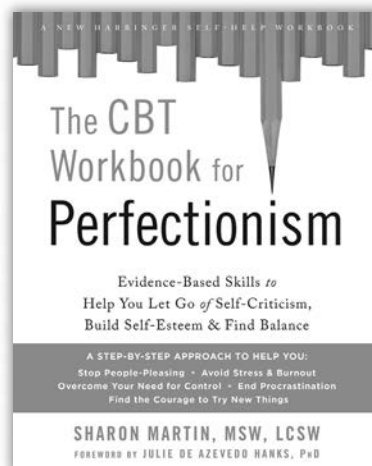
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1. Champions Recognize the Potential Application and Impact of Evidence-Based Interventions

With respect to facilitating adoption or implementation of evidence-based treatment, champions have a clear strategic vision of the innovation's advantages and limitations (Chakrabarti, 1974). They identify, interpret, reframe, and recodify new knowledge of the evidence-based intervention(s); link it with their own existing knowledge of the local context; and recognize its potential application and impact (Helfrich et al., 2007). The knowledge that underlies innovation is neither objective nor obvious; rather, it is socially constructed, regularly contested, and frequently negotiated among the members of the social system (Helfrich et al.). Champions can benefit this negotiation process by using data to persuade peers (Miech et al., 2018) and positively develop its shared meaning within the social system (Markham, 1998; Miech et al.). Champions do this by expressing a compelling vision of the innovation's potential, encouraging others to generate creative ideas and solutions to problems, and expanding innovation team members' capabilities (Howell & Higgins, 1990). By fitting the innovation within the system's existing values, goals, skills base, supporting technologies, and functionality, champions increase the likelihood of its success (Rogers, 2003).

2. Champions Go Beyond Their Formal Job Requirements Within an Organization to Relentlessly Promote the Innovation, Even at the Risk of Reputation

Systems and protocols in large organizations are often in place to keep the status quo and minimize risk. To promote innovation, champions should have strength of conviction and courage to break from the convergent thinking and habits that are the norm in large, well-established mental health service organizations. They often need to have the energy and persistence to overcome organizational resistance or indifference. In the face of frequent obstacles and the possibility of failure, champions are willing to accept risk (Damschroder et al., 2009; Howell & Higgins, 1990). The regular screening and gate-keeping mechanisms of organizations often require a hierarchical chain of command. Champions spontaneously emerge, unsolicited and personally committed to the innovation, going beyond their daily job requirements (Schon, 1963), often beyond their formal role in the organiza-

tion and above the hierarchical chain (Chakrabarti, 1974). It is worth noting that the champion is neither reckless nor overly cautious, but rather, courageous—willing to engage in purposeful action, even though it is not always comfortable or easy.

3. Champions Actively Lead Positive Social Change

Central to the role of champions is their ability to influence others to support the innovation (Thompson, Estabrooks, & Degner, 2006). A systematic review of the literature indicates that champions are often politically savvy, personable, credible, respected, and well-liked (Miech et al., 2018). Champions enact social change by actively utilizing their social power and by serving as role models. In addition to relevant measures of personality (e.g., charisma; achievement, and propensity for innovation), champions score significantly higher on self-reported measures of leadership behaviors (e.g., frequency and variety of influence attempts) compared with non-champions who are similar in age, salary, technical knowledge, organizational level, and formal role requirements (Howell & Higgins, 1990). Using cooperative (rather than confrontive) leadership strategies (Markham, 1998), champions network across organizational boundaries (Miech et al., 2018) and use power centers to legitimize their actions (Chakrabarti, 1974). Champions lead and manage teams; engage in team-based planning, training, and goal-setting; track progress; and provide feedback on the innovation to ensure its success (Miech et al.).

Champions may occur at various organizational levels, including but not limited to: (a) "foot soldiers," who manage and operate details at the ground level; (b) middle management, who have the hearts of providers and the ears of top management; and (c) system leaders, who advocate to constituents to implement policies.

Who Are Not Champions?

To recognize champions, it helps to know the boundaries that separate similar roles. Roles that are sometimes confused with champions include "opinion leaders," formally appointed internal "implementation leaders," "change agents," "knowledge brokers," and "boundary spanners" (for definitions, see Damschroder et al., 2009; Lomas, 2007; Thompson et al., 2006). These roles often unite with the champion role through a recognition that knowledge access, communication, and social interac-

tion support innovation adoption (Rogers, 2003). These roles sometimes differ from champions by location (external vs. internal to the organization), appointment (formal vs. informal), level of influence (specific vs. broad), and duration (terminal vs. ongoing). The primary differentiator of champions from the other roles is a visionary quality, overwhelming enthusiasm, and willingness to risk reputation (Thompson et al.).

How to Recognize Champions

It is still widely believed that innovation "either finds a champion or dies" (Schon, 1963). Consistent with this adage, we report that there is moderate to strong empirical support for the effectiveness of champions in behavioral health interventions, increasing the odds of an innovation's successful implementation to as high as fourfold (Miech et al., 2018). Without the daily support of champions, many of our effective interventions would fail to reach those in need. Because ABCT has not traditionally sought out champions, and because they often are not within our own ranks, we realize that champions are often overlooked when we choose to recognize exceptional individuals each year. Thus, to honor the critical role that champions play in disseminating evidence-based interventions, the ABCT Awards Committee has initiated a new award: ABCT's Champions of Evidence-Based Interventions. The purpose is to honor outstanding individuals outside of ABCT who have shown exceptional dedication, influence, and social impact through the promotion of evidence-based interventions. If you know of individuals who you feel advance the mission of ABCT through their clinical, administrative, policy, or research-related work, we hope that you will take the opportunity to nominate, so that we can formally recognize their meaningful contribution to our collective mission. Information about the initiative, this year's recipients, and now to nominate can be found by visiting the ABCT awards page (<http://www.abct.org/Awards/>) and clicking the CHAMPIONS link.

As ABCT seeks to increase its influence and impact on promoting health and well-being on the broadest scale, we will need to nurture the critical interdependence we have with champions in the community. We simply cannot be our own champions—so it is time to honor those on whom we depend so much to help ABCT improve

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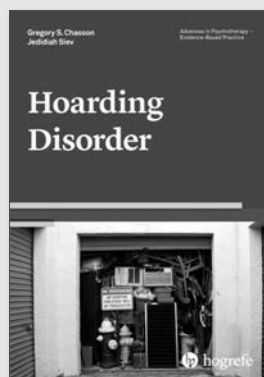
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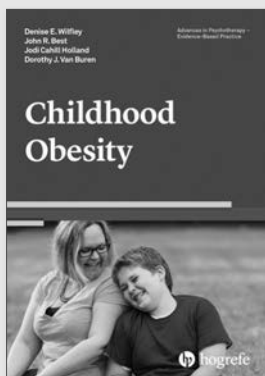
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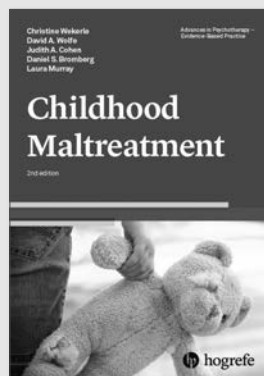
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References

- Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health*. <https://doi.org/10.1007/s10488-010-0327-7>
- Bailey, F. G., Rogers, E. M., & Shoemaker, F. (1974). Communication of innovations: A cross-cultural approach. *Man*. <https://doi.org/10.2307/2800105>
- Chakrabarti, A. (1974). The role of champion in product innovation. *California Management Review*, 17, 58-62. <https://doi.org/10.2307/41164561>
- Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*. <https://doi.org/10.1186/1748-5908-4-50>
- Goodman, P. S., Bazerman, M., & Conlon, E. (1980). Institutionalization of planned organizational change. *Research in Organizational Behavior*.
- Helfrich, C. D., Weiner, B. J., McKinney, M. M., & Minasian, L. (2007). Determinants of implementation effectiveness: Adapting a framework for complex innovations. *Medical Care Research and Review*. <https://doi.org/10.1177/1077558707299887>
- Howell, J. M., & Higgins, C. A. (1990). Champions of Technological Innovation. *Administrative Science Quarterly*. <https://doi.org/10.2307/2393393>
- Lomas, J. (2007). The in-between world of knowledge brokering. *BMJ (Clinical Research)*. <https://doi.org/10.1136/bmj.39038.593380.AE>
- Markham, S. K. (1998). A longitudinal examination of how champions influence others to support their projects. *Journal of Product Innovation Management*. <https://doi.org/10.1111/1540-5885.1560490>
- Miech, E. J., Rattray, N. A., Flanagan, M. E., Damschroder, L., Schmid, A. A., & Damush, T. M. (2018). Inside help: An integrative review of champions in healthcare-related implementation. *SAGE Open Medicine*. <https://doi.org/10.1177/2050312118773261>
- Rogers, E. M. (1995). *Diffusion of innovations*. New York: The Free Press. <https://doi.org/citeulike-article-id:126680>
- Rogers, E. M. (2003). *Diffusion of innovations theory*. New York: The Free Press. <https://doi.org/10.1111/j.1467-9523.1970.tb00071.x>
- Runco, M. A., & Jaeger, G. J. (2012). The standard definition of creativity. *Creativity Research Journal*, 24(1), 92-96. <https://doi.org/10.1080/10400419.2012.650092>
- Schon, D. (1963). Champions for Radical New Inventions. *Harvard Business Review*, 41, 77-86.
- Thompson, G. N., Estabrooks, C. A., & Degner, L. F. (2006). Clarifying the concepts in knowledge transfer: A literature review. *Journal of Advanced Nursing*. <https://doi.org/10.1111/j.1365-2648.2006.03775.x>
- Valente, T. W. (1996). Social network thresholds in the diffusion of innovations. *Social Networks*. [https://doi.org/10.1016/0378-8733\(95\)00256-1](https://doi.org/10.1016/0378-8733(95)00256-1)

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NEWS

A Review of and Insights From Matthew Nock's Invited Address: "Using New Technologies to Better Understand, Predict, and Prevent Suicidal Behavior"

Amy R. Murrell, *University of North Texas*

ACCORDING TO RECENT REPORTS from the Centers for Disease Control and Prevention (CDC), suicide is the 10th leading cause of death in the U.S., resulting in approximately 45,000 deaths in 2016. Perhaps more troubling, that same year, suicide was the second leading cause of death in individuals aged 10 to 34 (CDC, 2016). There are clear emotional, social, and financial costs associated with suicide. According to the CDC, in 2013, suicide accounted for approximately \$51 billion of the fatal injury costs in the U.S. (Florence, Haegerich, Simon, Zhou, & Lou, 2015). Predicting who will attempt and success-

fully complete suicide could reduce these costs dramatically.

There are a number of factors that have long been identified as predictors of suicide. As examples, suicidal ideation (Evans, Hawton, Rodham, & Deeks, 2005); previous attempts (Brent et al., 2009); having a substance use disorder or another disorder that involves agitation and/or impulsivity (e.g., PTSD; Nock, Hwang, Sampson, & Kessler, 2010); displaying repeated nonsuicidal self-injury (Scott, Pilkonis, Hipwell, Keenan, & Stepp, 2015); and social factors like often being, or feeling, alone (You, Van Orden, & Conner, 2011) increase risk for

suicide attempts. However, there is still a long way to go with respect to specific prediction of suicide attempts with discrimination from suicidal ideation or nonsuicidal self-injury (Nock et al., 2010; Tuisku et al., 2014). Understanding and prediction of suicidal behavior is necessary before prevention can occur.

Speaker Information

Perhaps this is why ABCT asked Matthew Nock to give an invited address at its 52nd Annual Convention in Washington, DC. He is an expert in the field of suicidology. Dr. Nock, who is a Professor of Psychology at Harvard University, received his Ph.D. in Clinical Psychology at Yale University, after completing his internship at Bellevue Hospital and the New York University Child Study Center. His research focuses on suicide and self-harm and innovative, multidisciplinary methods to examine these phenomena—in efforts to clarify, predict, and influence them. He has been awarded multiple grants, both through private foundations (e.g., Chet and Will Griswold Suicide Prevention Fund) and federal agencies, such as the National Institutes of Health and the U.S. Army. Dr.

Nock has authored approximately 250 scientific papers and chapters. His work has been recognized in the form of a number of awards, including an early career award from ABCT and a very impressive MacArthur "Genius" fellowship in 2011.

Review and Insights From the Invited Address

As I have written a couple of papers on nonsuicidal self-injury, I was quite familiar with Matthew Nock's work, and we had exchanged a few emails in the past. I have always been impressed with the way he makes complex topics easily accessible, and I was excited to hear his talk. He began by reviewing some of the statistics on leading causes of death and noting how suicide is high among them. In this talk, and again later, he discussed how there are probably more people who complete suicide than are counted. This is because there are a number of deaths listed as accidental from causes including injury, poisoning, and other unexplained circumstances, which may actually be suicides. Then he walked the audience through some of the common

risk factors, noting that for the last 50 years, little has changed in our knowledge base about predicting suicide. He pointed out that the lack of progress was likely tied to the fact that we are generally using the same assessment measures that we were back then. He used some clever slides to illustrate this point (and get a good laugh).

Dr. Nock then made the argument that we have gaps in our understanding due to slowed advancement in technology, or rather use in available technology. He listed three opportunities for moving forward in terms of improving our clarification of suicide risk: (a) designing methods that combine known risk factors such as family history of suicide and biological factors that increase suicidal behaviors, (b) devising new markers of suicide risk, and (c) gathering data on imminent risk. He stated that the first point is already possible owing to currently available electronic records, social media, and complex statistical models. With respect to all three opportunities, we know that the first year after a hospitalization is a high-risk time for an attempt, so targeting those individuals in

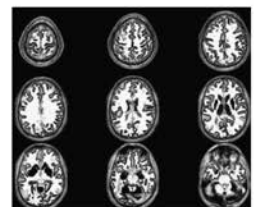
that time frame may help increase accuracy of prediction.

This was the point in the talk at which Dr. Nock started introducing his recent line of work with ecological momentary assessments. He talked a good deal about a series of studies primarily conducted by one of students (Kleiman et al., 2017; Kleiman & Nock, 2018). He stated that these studies indicated that suicidal thoughts often fluctuate throughout the day and well-known predictors of suicidality (e.g., loneliness) also vary in short periods of time and therefore are not good predictors of short-term change in ideation.

He further noted that prediction is greatly decreased if we rely solely on self-report. People are highly motivated to keep suicidal ideation and plans hidden from others, suicidal thoughts are transient, and people who are suicidal may lack an awareness that they are in that state while they are experiencing it. Dr. Nock expressed that 78% of people who attempt suicide have actively denied suicidal ideation in a short time period beforehand.

I reacted pretty strongly to this percentage, which I had never heard before. It sad-

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dened me, because I started thinking how it might be possible that our clients are not sharing their ideation with us, and that they may be even avoiding it themselves. I shared this statistic with my students, who were at the conference but not the talk, and they all had a different reaction . . . relief. They said it relieved them to know that there was truly nothing that they could have done preventatively. I wonder how many people reacted strongly to that figure in one way or another.

I almost immediately had another strong reaction. Dr. Nock brought up using the Implicit Association Test (IAT) to look at pairing death with good stimuli. He presented data that provided evidence that adults who made this pairing more quickly and with fewer errors, contradictory to most of our learning histories, were more likely to make suicide attempts; further, this prediction was greater than using previous attempts, clinical diagnoses, clinician or patient prediction of risk, or self-injury as predictors, and the finding was replicated in a second, adolescent sample. Likewise, the pairing of the word *life* with the word *me* was weakened in people with suicidal thoughts and behaviors.

I have also done some work using the IAT and a closely related measure, the Implicit Relational Procedure, or the IRAP. So, I believe that implicit measures have some utility, but I am also aware of their controversial use. Some researchers (e.g., Blanton et al., 2009) have concerns about the IAT's psychometric properties. One of the largest concerns about the IAT has to do with how sensitive the measure is to context and extraneous variables that are unrelated to the relationships of interest (Olson & Fazio, 2004). I wondered about these issues, just briefly, as I did my best to stay in the present moment and listen well. I had questions such as these: the IAT stimuli referenced life and death, not suicide, specifically, so could the context of being in the hospital recently affect these results? Were physical illnesses assessed and statistically controlled? What about religion and spirituality—were those controlled? These IAT findings raised a lot of questions for me as an audience member, and made me want to seek out studies, and perhaps even design one or two. That felt like the mark of a good talk—and Dr. Nock was not even halfway through.

He took a little bit of time to note that asking about suicide in research does not cause harmful effects to individuals, and then he moved into the portion of his talk about real-world suicide assessment and

prediction. First, he noted that only one-tenth of current studies look at a 30-day or less period from risk assessment to outcome follow-up (Kleiman & Nock, 2018). He then explained that many studies have a follow-up period of up to 10 years. He displayed a table that showed the follow-up from a number of studies and it became obvious that the follow-up periods were, on average, much longer than would be clinically relevant. If you find out that a participant attempts suicide 5 years after you collect data, are you really predicting anything meaningful when so much life has happened?

Dr. Nock moved into a discussion of a topic that was highly clinically relevant: digital phenotyping. He described the methods and results of the Kleiman et al. study (2018). In this study smartphones were used to measure suicidal thinking dynamically, in order to capture micro-level change. This was done in order to decrease recall biases, to observe behavior in natural settings, to test theories, and to provide chances for prevention. Adults who had either attempted suicide in the past year or who had disclosed recent suicidal ideation were asked about desire to kill themselves, strength of intention to kill themselves, and strength of resistance to suicidal urges via messages on their phones, four times per day. Five distinct phenotypes emerged based on mean intensity and variability. Perhaps not surprisingly, those with the highest mean and lowest variability were the individuals most likely to have a recent suicide attempt.

Dr. Nock then elaborated more on the ecological momentary assessments that were called for in the Kleiman and Nock (2018) study. He talked about using passive data from GPS systems, text and call logs, and phone or tablet application use measures. These would be used to correlate with suicidal ideation. For example, if someone is not making calls or texting others, we would expect social isolation to be a risk factor and thus correlate positively with ideation in an individual who has a history of suicidal behaviors, or other risk factors. Dr. Nock also mentioned how biological risk factors could be monitored in similar ways. As an example, movement, or lack thereof, could be measured with an accelerometer. People who do not move much at all, and people who are agitated, both may be at risk for suicidal ideation. Skin temperature, heart rate variability, and other biomarkers that correlate with suicidal thoughts and behaviors can easily be tracked. Dr. Nock also mentioned an

app named Koko that can be used to increase the efficiency of checking in on someone in a potential crisis situation. A randomized control trial indicated that using this service led to a 45% increase in the reported use of crisis services.

Again, Dr. Nock got another big laugh talking about how much has changed since he was in graduate school doing direct face-to-face intervention. It really did become clear that use of technology is the future. That the use of tablets and smartphones and web interfaces does help clinical researchers get more data quickly and with much more ecological, and perhaps more predictive, validity is clear. However, it raises some big questions. Dr. Nock moved the final part of his invited lecture in that direction. First, he mentioned the big challenges having to do with dissemination: for example, how do we deliver this information—that we, as researchers, are still learning—to clinicians and to patients. Second, he raised a question about specificity: Which assessments and treatments are best for which patients? Third, he noted that there are huge ethical implications associated with these technological advances. What if you text an adolescent and they tell you that they are seriously contemplating suicide, with a plan, and you have a tracker that tells you their location: What is your responsibility? Because Internet signals may not always be strong or reliable, and thus you may not know in the moment the participant texts that they are suicidal—is it enough to inform the consented participant of this unreliability, and does it relieve you of responsibilities to find them and do safety checks? When do you draw the line saying you have enough data about prediction to stop a study and begin to intervene using what you have learned? What about monitoring people in general? What are the ethical concerns about knowing how much someone walks or texts?

This was another point in the talk in which I began to have strong thoughts and feelings. I decided that I was glad that it was Matthew Nock and his students doing this work instead of me. I very much respect Dr. Nock, his lab, and their work. I have learned a good deal from reading their papers over the years. I am glad that I attended this invited address.

Overall Conclusion

Suicidal thoughts and behaviors are a large social health problem (Florence et al., 2015). A major challenge to understanding and predicting them to date is that previous

studies have treated them as if they do not fluctuate and therefore have used inappropriately lengthy follow-up periods (Kleiman & Nock, 2018). Dr. Nock and his collaborators have begun to use technology, such as smartphones and wearable biosensors, to gather data in real-time (e.g., Nock, Prinstein, & Sterba, 2009). There are advantages to this technology use in terms of efficiency, use of crisis services, and improved understanding of form and function of suicidal and nonsuicidal self-injury. Some large ethical questions are raised, and all of us should be considering them as we each encounter technological advances and—very likely—patients who have suicidal thoughts and behaviors. Dr. Matthew Nock's invited address did a very nice job of summarizing this important task, and I feel better equipped to understand and predict suicidal behavior after attending. Perhaps prevention is a lofty goal. Again, I say, I am glad Dr. Matthew Nock and his team on working on it.

References

- Blanton, H., Jaccard, J., Klick, J., Mellers, B., Mitchell, G., & Tetlock, P. E. (2009). Strong claims and weak evidence: Reassessing the predictive validity of the IAT. *Journal of Applied Psychology*, 94(3), 567–582. <https://doi.org/10.1037/a0014665>
- Brent, D. A., Greenhill, L. L., Compton, S., Emslie, G., Wells, K., Walkup, J. T., ... Turner, J. B. (2009). The treatment of Adolescent Suicide Attempters Study (TASA): Predictors of suicidal events in an open treatment trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48(10), 987–996. <https://doi.org/10.1097/CHI.0b013e3181b5db64>
- Centers for Disease Control and Prevention. (2016). *Leading causes of death*. Retrieved from <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>
- Evans, E., Hawton, K., Rodham, K., & Deeks, J. (2005). The prevalence of suicidal phenomena in adolescents: A systematic review of population-based studies. *Suicide and Life-Threatening Behavior*, 35(3), 239–250. <https://doi.org/10.1521/suli.2005.35.3.239>
- Florence, C., Haegerich, T., Simon, T., Zhou, C., & Luo, F. (2015). Estimated lifetime medical and work-loss costs of emergency department-treated nonfatal injuries—United States, 2013. *Morbidity and Mortality Weekly Report*, 64(38), 1078–1082. <https://doi.org/10.15585/mmwr.mm6438a5>
- Kleiman, E.K., & Nock, M.K. (2018). Real-time assessment of suicidal thoughts and behaviors. *Current Opinion in Psychology*, 22, 33–37. PMID: Pending; PMCID: N/A
- Kleiman, E.M., Turner, B.J., Fedor, S., Beale, E.E., Huffman, J.C., & Nock, M.K. (2017). Examination of real-time fluctuations in suicidal ideation and its risk factors: Results from two ecological momentary assessment studies. *Journal of Abnormal Psychology*, 126(6), 726–738. PMID: 28481571; PMCID: N/A
- Kleiman, E. M., Turner, B. J., Fedor, S., Beale, E. E., Picard, R. W., Huffman, J. C., & Nock, M. K. (2018). Digital phenotyping of suicidal thoughts. *Depression and Anxiety*. <https://doi.org/10.1002/da.22730>
- Nock, M. K., Prinstein, M. J., & Sterba, S. (2009). Revealing the form and function of self-injurious thoughts and behaviors: A real-time ecological assessment study among adolescents and young adults. *Journal of Abnormal Psychology*, 118(4), 816–827. PMID: 19899851; PMCID: PMC5258190



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Nock, M. K., Hwang, I., Sampson, N. A., & Kessler, R. C. (2010). Mental disorders, comorbidity and suicidal behavior: Results from the National Comorbidity Survey replication. *Molecular Psychiatry*, 15(8), 868–876. <https://doi.org/10.1038/mp.2009.29>

Olson, M. A., & Fazio, R. H. (2004). Reducing the influence of extrapersonal associations on the Implicit Association Test: Personalizing the IAT. *Journal of Personality and Social Psychology*, 86(5), 653–667. <https://doi.org/10.1037/0022-3514.86.5.653>

Scott, L. N., Pilkonis, P. A., Hipwell, A. E., Keenan, K., & Stepp, S. D. (2015). Non-suicidal self-injury and suicidal ideation as predictors of suicide attempts in adolescent girls: A multi-wave prospective study. *Comprehensive Psychiatry*, 58, 1–10. <https://doi.org/10.1016/j.comppsy.2014.12.011>

Tuisku, V., Kiviruusu, O., Pelkonen, M., Karlsson, L., Strandholm, T., & Marttunen, M. (2014). Depressed adolescents as young adults—Predictors of suicide attempt and non-suicidal self-injury during an 8-year follow-up. *Journal of Affective Disorders*, 152–154, 313–319. <https://doi.org/10.1016/j.jad.2013.09.031>

You, S., Van Orden, K. A., & Conner, K. R. (2011). Social connections and suicidal thoughts and behavior. *Psychology of Addictive Behaviors*, 25(1), 180–184. <https://doi.org/10.1037/a0020936>

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STUDENT FORUM

Self-Care in Clinical Psychology Trainees: Current Approach and Future Recommendations

Jessica Campoli and Jorden A. Cummings,
University of Saskatchewan

TRAINING TO BECOME a clinical psychologist is a demanding and competitive endeavor. Clinical psychology trainees need to monitor and manage numerous stressors, ranging from the academic and evaluative aspects of training, to the personal and interpersonal characteristics of the trainee and the training environment. Pressure to succeed in academia is a common stressor, as training is replete with academic challenges in addition to heavy workloads, long hours, and exhaustion (Badali & Habra, 2003; Rummell, 2015). Pressure to perform well academically becomes even more challenging as trainees learn novel clinical skills and are constantly evaluated (Skovholt & Trotter-Mathison, 2011).

As such, clinical psychology trainees often experience high levels of stress during their training that can affect their mental and physical health, with some studies conducted in the United States and the United Kingdom showing that 73% to 75% of psychology graduate students report high stress levels from their clinical training (Cushway, 1992; Stafford-Brown & Pakenham, 2012). Similarly, clinical psychology students report disconcerting rates of mental health concerns. In a large survey of clinical and counseling psychology graduate students in the U.S., approximately 49% of the sample reported three or more symptoms of anxiety, and about 39% of students reported five or more symptoms of depression (Rummell, 2015). Approximately 35% of students reported clinically significant symptoms of both anxiety and depression (Rummell, 2015). In a sample of students from psychology graduate programs across Canada, 33% of students reported clinically significant symptoms of depression and 6% reported depressive symptoms that reached the threshold for clinical impairment (Peluso, Carleton, & Asmundson, 2011). What is more alarming is that the prevalence of these symptoms is greater than that found in the gen-

eral population (American Psychiatric Association, 2013; Kessler et al., 2003). Moreover, stress can also negatively affect numerous physical systems of the body (American Psychological Association, 2016). Substantial numbers of trainees also report physical health complaints that occur at concerning rates. For example, more than half of doctoral students in clinical and counseling psychology report physical health symptoms (e.g., headaches, back pain) at least biweekly, which is more than double the prevalence in the general population (Rummell, 2015).

Given the high levels of stress and associated health concerns in this population, self-care is increasingly recognized as a core competency in clinical psychology training across accreditation bodies including Canada (i.e., Canadian Psychological Association [CPA]) and the U.S. (i.e., American Psychological Association [APA]). However, when comparing the frequency with which students from nonpsychology health disciplines (e.g., nursing, occupational therapy) use self-care, students in professional psychology (e.g., clinical, school, and counseling) engage in less self-care (Ayala, Ellis, Grudev, & Cole, 2017; Stark, Hoekstra, Hazel, & Barton, 2012). Thus, our field's current approach to self-care is likely not as effective as needed. Here we review the benefits of self-care on both personal and professional functioning and the consequences of not using self-care, discuss why current approaches are problematic, and we conclude with key recommendations for how clinical psychology programs can better promote effective self-care among students.

Self-Care

The concept of self-care is generally understood as the engagement in behaviors that are self-selected by a person that help to maintain and/or promote health, professional functioning, and a balance

between one's personal and professional life (Brucato & Neimeyer, 2009; Lee & Miller, 2013). It is often described as a multidimensional concept that involves several domains of well-being and thus an endless array of strategies, which range from basic behaviors that benefit health (e.g., oral hygiene) to context-specific strategies to reduce stress and burnout and promote health (e.g., meditation).

Benefits of Self-Care on Health and Professional Functioning

If self-care is used effectively, it can mitigate clinical psychology students' perceived stress levels, and protect against mental and physical health concerns (Myers et al., 2012; Shen-Miller et al., 2011). Self-care habits (e.g., sleep and exercise) account for 24% of the variance in stress levels among psychology graduate students (McKinzie, Altamura, Burgoon, & Bishop, 2006). Moreover, the benefits of self-care on health are not activity-specific (Colman et al., 2016). Teaching students to succeed in self-care during their training may also help them to flourish in their future careers as clinical psychologists. For example, being in a positive emotional state

during therapy can have an important influence on the process and outcome of therapy (Chui, Hill, Kline, Kuo, & Mohr, 2016). On the other hand, therapists who do not use self-care appropriately can reduce the effectiveness of their clinical work since they are at a greater risk of higher levels of negative affect (e.g., frustration, depression, fatigue).

Self-Care as an Ethical Imperative

In the context of clinical psychology, self-care becomes even more important given the responsibility that psychologists have for caring for others; if psychologists do not attend to their own needs, it is challenging to help others effectively and ethically (Dattilio, 2015). If left unmanaged, chronic stress can develop into burnout, which refers to physical and psychological exhaustion (often resulting from professional demands) that exceeds an individual's perceived resources (Ishak et al., 2013). In turn, burnout predicts poor ethical judgment (e.g., a decline in objectivity and blurred boundaries) and suboptimal care practices (e.g., disinterested in client issues and needs; APA, 2010; Barnett & Cooper, 2009; Carter & Barnett, 2014;

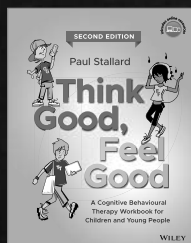
Skovholt & Trotter-Mathison, 2016). The effects of burnout clearly put psychologists at risk of violating ethics principles. Therefore, self-care is not just an indulgence or a leisure activity for when a person has the time, but should be an essential part of his or her professional identity and can preserve the integrity of professional and ethical practice (Carter & Barnett, 2014).

Barriers to Self-Care and Long-Term Impact

The largest reported hindrance to self-care reported by psychology students is a perceived lack of time (e.g., reported in about 71% of students; El-Ghoroury et al., 2012). The second most frequently reported barrier to self-care is financial constraints (approximately 47%; El-Ghoroury et al.). Another barrier to self-care, specifically utilizing mental health services, is confidentiality (i.e., fear that one's supervisor or other faculty would find out that they were attending therapy; Dearing, Maddux, & Tangney, 2005; El-Ghoroury et al.).

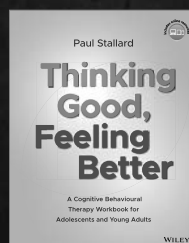
The ineffective use of self-care among clinical psychology trainees becomes even more problematic given that this pattern of

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behavior can continue to transpire throughout their careers. Similar to that reported by trainees, some of the most frequently reported barriers to self-care for psychologists include lack of time and concerns with confidentiality (APA, 2010). Psychologists can ignore early-warning signs of burnout and can underestimate the importance of self-care and impact that stress can have on their work (Walsh, 2011). In a survey of 260 clinical psychologists, 59% of psychologists reported that they failed to seek therapy when they believed they would have benefited from it (Bearse, McMinn, Seegobin, & Free, 2013). While more research is needed to determine the relation between earlier self-care patterns with later outcomes, it seems likely that establishing healthy ways to cope with stress during training can likely pave the way for effective self-care during an individual's career.

Importance of Program Culture and Promotion of Self-Care

Another barrier to self-care is the culture of training programs. In an APA survey of clinical psychology graduate programs, over 60% of students reported that their training program did not promote self-care (Munsey, 2006). Findings that are more recent show that less than half (approximately 41%) of clinical psychology doctoral programs in the U.S. made at least one written reference to self-care in the clinical training area and/or general program handbook (Bamonti et al., 2014). Direct discussion of stress or burnout occurred infrequently; rather, program brochures included ambiguous statements about self-care, which often referred to mental health services for students who are already experiencing concerns (Bamonti et al.). This discourse implies that self-care is something that “people with problems” do once they are impaired, rather than conveying self-care as a professional activity that all clinical psychologists should regularly engage in. Moreover, it stigmatizes those who “need” self-care by creating an us (healthy, not in need of self-care) versus them (impaired, needing self-care to recover) training program culture.

Not offering adequate self-care promotion within training programs not only fails to teach trainees how to flourish, but it impacts their self-care utilization. In a survey on 262 doctoral clinical psychology students from APA-accredited programs, students who perceived their program to have a greater emphasis on self-care tended

to engage in self-care more frequently (Goncher, Sherman, Barnett, & Haskins, 2013). Furthermore, program faculty and clinical supervisors can have a powerful influence over the self-care behaviors of those around them (Dearing et al., 2005).

Our Current Problematic Approach to Self-Care: Limited, Reactive, and Ambiguous

There are three downfalls of the current culture and education on self-care in clinical psychology training programs. First, as discussed above, training programs pay an insufficient amount of attention to self-care, either by failing to emphasize it, model it for students, or teaching students how use it effectively. Second, the approach advocated is often reactive, leaving self-care to the individual trainees' discretion. In turn, programs often directly advise self-care after adverse consequences have occurred, including remediation (Carter & Barnett, 2014; Elman & Forrest, 2004). This views self-care as a student's responsibility rather than a program's collective responsibility and frames it as a solution to a problem, not a means of preventing them. This reactive approach stands in contrast to the proactive approach that ethical codes (e.g., CPA, APA) advocate. Third, there is a “shopping list presentation of self-care strategies and recommendations” (Pakenham, 2015a, p. 407) wherein trainees are presented with a menu of activities. According to this checklist approach, self-care strategies are viewed as universal across people. What is missing here is an emphasis on how self-care activities might integrate with a person's values, needs, preferences, and life context (e.g., time) and how to incorporate the individual characteristics of the person to create a sustainable self-care plan.

A Revamped Approach: Preventative, Individualized, and Assertive

The literature offers us valuable guidance on how to improve our self-care approach. Three themes, which address micro (i.e., individual) and macro (i.e., cultural) levels, inform more fully our understanding of how to improve our approach: being preventative, individualized, and assertive.

Guiding Principle 1: Self-Care Is Preventative

A preventative approach to self-care—applied to all students irrespective of stress

levels—is imperative (Barnett & Cooper, 2009; Pakenham, 2015a). Indeed, clinical psychology trainees in Australia report that they would find it beneficial to have self-care training offered during the first semester of the first year of training (Pakenham, 2015c). Instilling the importance of self-care and helping trainees to develop sustainable plans during training is especially advantageous because this is when professional identities develop and thus can help to set the stage for future self-care behaviors after graduation (Barnett & Cooper, 2009; Pakenham, 2015b), which positions the next generation of clinical psychologists to avoid the personal and professional problems that have challenged our field. Furthermore, this normalizes self-care by framing it as something all psychologists need to do.

Guiding Principle 2: Self-Care Is Individualized

To create a sustainable and workable self-care plan, strategies should be adapted to the person and situation (Campoli & Cummings, 2018a; Skovholt & Trotter-Mathison, 2011). Trainees' own values and preferences need to drive their self-care because what one person considers self-care might be unenjoyable, or even stressful, for another (Pakenham, 2015b) and research does not find activity-specific benefits to self-care (Colman et al., 2016). Advising trainees to individualize their self-care plans allows them to select those activities that best suit their values (Hayes, Levin, Plumb-Villardaga, Villatte, & Pistorello, 2013). Since values are freely chosen, they are intrinsically motivating (Trindade, Ferreira, Pinto-Gouveia, & Nooren, 2016) and make it more likely that people will consistently engage in that pattern of behavior due to the positive consequences of value-consistent living. Over time, the value-based actions become rewarding and thus serve as reinforcement for future behaviors that serve those values (Dahl & Lundgren, 2006). In contrast, when behavior is based on factors other than a person's values, such as avoidance or social compliance, this does not reinforce the behavior (Hayes et al., 2013). Research evaluating self-care interventions emphasizing individualized self-care choices influenced by values (e.g., Pakenham, 2015b; Pakenham, 2015c) has shown that, relative to the control group, participants who received the intervention showed reduced stress, greater self-compassion, and the ability to build rapport with clients. Results of another trial showed that partic-

ipants found this self-care training helpful in developing habits (about 74% of participants reported at least 1 behavioral change) and greater self-care efficacy (Pakenham, 2015c).

Guiding Principle 3:

Self-Care Is Assertive

If trainees are taught early on about how to identify their own self-care needs, this sets them up for “assertive” self-care (Skovholt & Trotter-Mathison, 2016, p. 127), which calls for professionals to develop a greater self-awareness of their needs and to commit to enriching their selves to help others more effectively (Skovholt & Trotter-Mathison). Assertive self-care calls for people to have self-awareness of their own needs and to use this knowledge to drive them towards self-care strategies that improve their well-being. In addition, assertive self-care also calls for people to persist in following through with self-care when challenges arise (e.g., not enough time, competing demands). In a grounded theory study on the process of developing effective self-care habits from the perspective of health trainees, Campoli and Cummings (2018b) found that, to follow through with using self-care when it was difficult, students advocated for their own self-care needs by being assertive with others (e.g., supervisors, colleagues, family). Being assertive with others was a strategy that developed from participants using self-knowledge about why self-care mattered in their own lives, and then using this as internal motivation to “stand up” for their self-care needs (Campoli & Cummings, 2018b). Assertive self-care sets students up for success for both when they are doing well with balancing training and other demands, but also when it becomes challenging to take care of themselves.

Supervisors and professors can play a crucial role in helping trainees to identify their self-care needs and facilitate assertive self-care. For example, supervisors and faculty can encourage students to monitor and/or reflect on how they are doing regularly. Simultaneously, as students uncover not only how they are doing, but what their individual self-care needs are, supervisors and professors should support and encourage students to experiment with different self-care strategies until they find what “works” for them. For example, allowing students to experientially engage in self-care strategies as part of course work and/or practica can help them to tailor their self-care plans. By individually defining self-care plans early on, clinical psy-

chology trainees can develop a foundation of self-care practices that they can build on as needed throughout their career. Moreover, this helps to create a culture of self-care that views it as an ongoing process (e.g., via trial and error). In addition, supervisors and faculty should support students advocating for their self-care needs by welcoming open discussions about how they are doing with balancing their self-care needs with training demands. They can also model and role-play how to effectively be assertive with others. In addition, training students in interpersonal skills training (e.g., such as those used in treatment paradigms like dialectical behavior therapy) may be effective in equipping them with the necessary skill set to develop assertive self-care. Trainees should be encouraged to draw on their clinical skill sets to communicate effectively with others about their self-care needs. Similar to how trainees would assist their clients to advocate for their needs unapologetically—but also with respect—trainees should use their interpersonal skill sets to have what are often difficult conversations with others about their own boundaries and needs.

In sum, research and scholarly discussion encourage us to move away from an individualistic solution to self-care that provides limited and one-size-fits-all information in a reactionary manner. Instead, we are called to move toward an approach that emphasizes prevention and individualized self-care solutions. In turn, this assists people to use self-care assertively by using their understanding of themselves and their needs to create a sustainable plan.

Recommendations for Clinical Psychology Programs

Clinical psychology training programs can play a pivotal role in helping to implement the above approach to self-care training. As stated earlier, the culture of self-care within training programs impacts trainees’ self-care utilization. Regular modeling and education from programs on how to use self-care regularly and when obstacles arise helps to integrate self-care into students’ emerging professional identities and thereby set in place a positive self-care trajectory. First, to instill a greater emphasis on prevention, programs must incorporate self-care as a program value and explicate how this value is being met by the program (e.g., evaluation of self-care prevention methods). If self-care is to become a core competency for psychologists (and we believe it should), then

accreditation bodies (e.g., CPA, APA) should also include self-care training as an evaluative component of programs (Bamonti et al., 2014; Barnett & Cooper, 2009). Developing specific criteria helps to not only keep programs accountable, but it can be used to evaluate the extent to which a program is meeting its own training goals (e.g., is a program training students to thrive or to reactively respond to stress to avoid burnout?).

Second, we recommend that programs offer experiential learning activities to help trainees learn which strategies work best for them. Rather than providing generic information about self-care in a top-down fashion, students must be engaged participants who not only use their own preferences and values to inform their self-care practices, but who can have an impact on their program’s self-care initiatives. While research finds an added benefit of including personal values into a self-care plan, beyond the impact of basic education about self-care alone (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007), few opportunities incorporate trainees’ values or encourage exploration of strategies. This negates the individuality of each trainee and misses an important opportunity for trainees to learn more about themselves as people and professionals.

Third, when developing and evaluating self-care interventions, researchers and programs should include the voices and perspectives of students. For example, programs should elicit feedback from students about what they would like to see in self-care training. By building such interventions from the bottom-up, we can more effectively develop self-care training interventions that mirror what trainees—the users of these programs—need. In addition, the student voice should be considered a pivotal form of feedback on the effectiveness of self-care interventions.

Fourth, we encourage clinical supervisors to use the supervisory relationship to instill the importance of self-care and/or to explore self-care values. While little research explicates strategies to use during supervision to support supervisee wellness, the literature suggests the following avenues: debriefing after stressful clinical casework, supporting students to attend to their self-care needs, and assessing a student’s workload in the context of other personal and/or professional demands (Howard, 2008). In addition, research suggests that a supervision style that builds on the trainees’ strengths and personal resources is useful for helping to build the

student's resilience and for conveying the importance of self-care (Howard, 2008). Future research is needed to evaluate how one's supervision style can impact a supervisee's perception and utilization of self-care.

Fifth, supervisors and faculty in clinical psychology programs play a crucial role in creating a cultural shift through their everyday interactions with trainees. Specifically, faculty and supervisors should model, welcome, and provide opportunities for students and staff to engage in open and transparent conversations about self-care. For example, biweekly roundtable discussions about how to identify when to use self-care, brainstorming sessions about self-care strategies and how to integrate self-care into one's daily routine can foster a more effective self-care culture. In addition, it is imperative that faculty members and practicum supervisors model the effective use of self-care, not only by demonstrating that they too engage in self-care (or starting to engage in self-care if they do not!), but also by supporting their students to do so. For example, faculty and clinical supervisors should help their students to create and implement individualized self-care plans. Since our self-care needs are not static, faculty and/or supervisors should also regularly check in with their students to provide support and guidance in modifying their existing self-care plans, for example, during monthly laboratory meetings and/or during individual or group supervision. In addition, during periods of heavy clinical or academic workloads, faculty and clinical supervisors should help trainees to take care of themselves during these stressful moments and provide support in modifying their self-care plans so that they are feasible given new demands and clinical training contexts. In implementing self-care regularly and in the face of several competing demands, faculty and supervisors should provide praise to students who regularly engage in self-care, as they would for other clinical and/or academic accomplishments. By having all parties invested in self-care (students and faculty), a clear and consistent message is given: "Self-care is a critical skill to be learned during graduate school and practiced across one's career" (Bamonti et al., 2014, p. 259).

Sixth, beyond training environments, psychologists can play an important role in helping organizations and programs develop a "professional greenhouse," environments that are ideal for growth (Skovholt & Trotter-Mathison, 2011). A

professional greenhouse encapsulates four aspects: (a) leadership that promotes a healthy balance between helping the self and others, (b) support from others, (c) mentoring others, and (d) having fun (Skovholt et al., 2001). For example, clinical practica could teach trainees how to cultivate a professional greenhouse in organizational settings. Not only does this allow for clinical engagement, but it also advances our understanding about how organizational and system factors influence self-care utilization. Overall, clinical psychology programs are in a unique position to move the self-care agenda forward in both training and organizational contexts; there are several outlets for getting started in shifting toward preventative, individualized, and assertive self-care.

Call to Action: An Opportunity to Meet the Needs of Clinical Psychologists

Some of the biggest changes that clinical psychology trainees wish to see in their programs is a greater emphasis on self-care, including education on self-care plans, support from faculty, and having self-care modeled by clinical supervisors and/or faculty (Pakenham, 2015c; Rummell, 2015). Considering this need, along with our ethical responsibility to engage in self-care, finding ways to promote an effective self-care culture is crucial for meeting our ethical responsibilities, for helping others, and ultimately to flourish as a discipline. However, to enact change and a true cultural shift, this requires the spirit of self-care to be reflected by multiple parties: individuals, programs, organizations, and professional bodies.

In sum, the pressure to perform well in multiple domains (clinical, academic, research) necessitates that clinical psychology trainees use self-care effectively. Our current solution to integrating self-care requires advancement, as it is not only limited, but when it does occur, it is not preventative and does not teach trainees how to identify their own self-care needs. We advocate for an approach to self-care that is preventative, tailored to user needs, and assertive. To enact cultural changes in our discipline, we must intervene at the training level by educating and engaging our future generation of psychologists not only on how to survive, but how to thrive. Given the large number of lives that each clinical psychologist touches, moving towards effective self-care training that attends to psychologists as people has the potential to have a ripple effect on countless individuals and families.

References

- American Psychological Association. (2010). *Survey findings emphasize the importance of self-care for psychologists*. Retrieved from <http://www.apapracticecentral.org/update/2010/08-31/survey.aspx>.
- American Psychological Association. (2016). *Stress effects on the body*. Retrieved from <http://www.apa.org/help-center/stress-body.aspx>.
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Ayala, E. E., Ellis, M. V., Grudev, N., & Cole, J. (2017). Women in health service psychology programs: Stress, self-care, and quality of life. *Training and Education in Professional Psychology, 11*, 18-25. doi:10.1037/tep0000141.
- Badali, M. A., & Habra, M. E. (2003). Self-care for psychology students: Strategies for staying healthy and avoiding burnout. *Psynopsis: Canada's Psychology Newspaper, 25*(4), 14.
- Bamonti, P. M., Keelan, C. M., Larson, N., Mentrikoski, J. M., Randall, C. L., Sly, S. K., ... McNeil, D. W. (2014). Promoting ethical behavior by cultivating a culture of self-care during graduate training: A call to action. *Training and Education in Professional Psychology, 8*, 253-260. doi:10.1037/tep0000056.
- Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology: Science and Practice, 16*, 16-20. doi:10.1111/j.1468-2850.2009.01138.x.
- Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research & Practice, 44*(3), 150-157. doi:10.1037/200311182.
- Brucato, B., & Neimeyer, G. (2009). Epistemology as a predictor of psychotherapists' self-care and coping. *Journal of Constructivist Psychology, 22*, 269-282. doi:10.1080/10720530903113805.
- Campoli, J., & Cummings, J. (2018a). *A grounded theory study on developing the identity of a person who does self-care*. Manuscript in preparation.
- Campoli, J., & Cummings, J. (2018b). Developing the identity of "someone who does self-care": a grounded theory study of health-care trainees. *International Journal of Qualitative Methods, 17*(1), 7.
- Carter, L. A., & Barnett, J. E. (2014). *Self-care for clinicians in training: A guide to psychological wellness for graduate students in psychology*. New York, NY: Oxford University Press.
- Chui, H., Hill, C. E., Kline, K., Kuo, P., & Mohr, J. J. (2016). Are you in the mood? Therapist affect and psychotherapy

- process. *Journal of Counseling Psychology*, 63, 405-418. doi:10.1037/cou0000155.
- Colman, D. E., Echon, R., Lemay, M. S., McDonald, J., Smith, K. R., Spencer, J., ... Swift, J. K. (2016). The efficacy of self-care for graduate students in professional psychology: A meta-analysis. *Training and Education in Professional Psychology*, 10, 188-197. doi:10.1037/tep0000130.
- Cushway, D. (1992). Stress in clinical psychology trainees. *British Journal of Clinical Psychology*, 31, 167-169. <http://dx.doi.org/10.1111/j.2044-8260.1992.tb00981.x>.
- Dahl, J., & Lundgren, T. (2006). *Living beyond your pain: Using acceptance and commitment therapy to ease chronic pain*. Oakland, CA: New Harbinger.
- Dattilio, F. M. (2015). The self-care of psychologists and mental health professionals: A review and practitioner guide. *Australian Psychologist*, 50(6), 393-399. doi:10.1111/ap.12157.
- Dearing, R. L., Maddux, J. E., & Tangney, J. P. (2005). Predictors of Psychological Help Seeking in Clinical and Counseling Psychology Graduate Students. *Professional Psychology: Research and Practice*, 36, 323-329. doi:10.1037/0735-7028.36.3.323.
- El-Ghoroury, N., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology*, 6, 122-134. doi:10.1037/a0028768.
- Elman, N. S., & Forrest, L. (2004). Psychotherapy in the remediation of psychology trainees: Exploratory interviews with training directors. *Professional Psychology: Research and Practice*, 35, 123-130. doi:10.1037/0735-7028.35.2.123.
- Goncher, I. D., Sherman, M. F., Barnett, J. E., & Haskins, D. (2013). Programmatic perceptions of self-care emphasis and quality of life among graduate trainees in clinical psychology: The mediational role of self-care utilization. *Training and Education in Professional Psychology*, 7, 53-60. doi:10.1037/a0031501.
- Gregg, J. A., Callaghan, G. M., Hayes, S. C., & Glenn-Lawson, J. L. (2007). Improving diabetes self-management through acceptance, mindfulness, and values: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 75, 336-343. doi:10.1037/0022-006X.75.2.336.
- Hayes, S. C., Levin, M. E., Plumb-Villardaga, J., Villatte, J. L., & Pistorello, J. (2013). Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behavior Therapy*, 44, 180-198. doi:10.1016/j.beth.2009.08.002.
- Howard, F. (2008). Managing stress or enhancing wellbeing? Positive psychology's contributions to clinical supervision. *Australian Psychologist*, 43, 105-113. doi:10.1080/00050060801978647.
- Ishak, W., Nikraves R., Lederer S., Perry R., Ogunyemi D., & Bernstein C. (2013). Burnout in medical students: a systematic review. *The Clinical Teacher*, 10(4), 242-245. doi:10.1111/tct.12014.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., & Merikangas, K. R., ... Wang, P. S. (2003). The epidemiology of major depressive disorder: Results from the national comorbidity survey replication (NCS-R). *Journal of the American Medical Association*, 289, 3095-3105.
- Lee, J. J., & Miller, S. E. (2013). A self-care framework for social workers: Building a strong foundation for practice. *Families in Society*, 94(2), 96-103. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc10&NEWS=N&AN=2013-13154-006>.
- McKinzie, C., Altamura, V., Burgoon, E. & Bishop, C. (2006). Exploring the effects of stress on mood, self-esteem, and daily habits with psychology graduate students. *Psychological Reports*, 99, 439-448. doi:10.2466/PRO.99.2.439-448.
- Munsey, C. (2006). Questions of balance. *Gradpsych*, 4(4). Retrieved from <http://www.apa.org/gradpsych/2006/11/c-over-balance.aspx>.
- Myers, S. B., Sweeney, A. C., Popick, V., Wesley, K., Bordfeld, A., & Fingerhut, R. (2012). Self-care practices and perceived stress levels among psychology graduate students. *Training and Education in Professional Psychology*, 6, 55-66. doi:10.1037/a0026534.
- Pakenham, K. I. (2015a). Comment on "The self-care of psychologists and mental health professionals" (Dattilio, 2015). *Australian Psychologist*, 50(6), 405-408. doi:10.1111/ap.12145.
- Pakenham, K. I. (2015b). Investigation of the utility of the acceptance and commitment therapy (ACT) framework for fostering self-care in clinical psychology trainees. *Training and Education in Professional Psychology*, 9, 144-152. doi:10.1037/tep0000074.
- Pakenham, K. I. (2015c). Training in acceptance and commitment therapy fosters self-care in clinical psychology trainees. *Clinical Psychologist*, 1-9. doi:10.1111/cp.12062.
- Peluso, D. L., Carleton, R. N., & Asmundson, G. J. G. (2011). Depression symptoms in Canadian psychology graduate students: Do research productivity, funding, and the academic advisory relationship play a role? *Canadian Journal of Behavioural Science*, 43, 119-127. doi:10.1037/a0022624.
- Rummell, C. M. (2015). An exploratory study of psychology graduate student workload, health, and program satisfaction. *Professional Psychology: Research and Practice*, 46, 391-399. doi:10.1037/pro0000056.
- Shen-Miller, D. S., Grus, C. L., Van Sickle, K. S., Schwartz-Mette, R., Cage, E. A., Elman, N. S., ... Kaslow, N. J. (2011). Trainees' experience with peers having competence problems: A national survey. *Training and Education in Professional Psychology*, 5, 112-121. doi:10.1037/a0023824.
- Skovholt, T. M., & Trotter-Mathison, M. (2011). The elevated stressors of the novice practitioner. In T. Skovholt & M. Trotter-Mathison (Eds.), *The resilient* (2nd ed., pp. 79-104). New York, NY: Taylor & Francis Group.
- Skovholt, T. M., & Trotter-Mathison, M. (2016). *The resilient practitioner: Burnout and compassion fatigue prevention and self-care strategies for the helping professions* (3rd ed.). New York, NY: Routledge/Taylor & Francis Group.
- Stafford-Brown, J., & Pakenham, K. I. (2012). The effectiveness of an ACT informed intervention for managing stress and improving therapist qualities in clinical psychology trainees. *Journal of Clinical Psychology*, 68, 592-613. Retrieved from <http://dx.doi.org/10.1002/jclp.21844>.
- Stark, M. A., Hoekstra, T., Hazel, D. L., & Barton, B. (2012). Caring for self and others: Increasing health care students' healthy behaviors. *Work*, 42, 393-401. <http://dx.doi.org/10.3233/WOR-2012-1428>.
- Trindade, I. A., Ferreira, C., Pinto-Gouveia, J., & Nooren, L. (2016). Clarity of personal values and committed action: Development of a shorter Engaged Living Scale. *Journal of Psychopathology and Behavioral Assessment*, 38, 258-265. doi:10.1007/s10862-015-9509-7.
- Walsh, R. (2011). Lifestyle and mental health. *American Psychologist*, 66, 579-592. doi:10.1037/a0021769.
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Kurt Salzinger: Reflections on a Scholar, Mentor, and Mensch

Mark R. Serper, *Hofstra University*

In the beginning was the Word, and it must have been positively reinforced, because man has been talking incessantly ever since. (Salzinger, Portnoy, & Feldman, 1964, p. 845)

IF YOU DID NOT KNOW Dr. Kurt Salzinger personally or read his scholarly works, you may be under the false impression that B. F. Skinner's language acquisition theory (1957), which explained through principles of reinforcement how children learned language, was debunked, laid bare by Chomsky's caustic review. To the contrary! Kurt would avidly inform you that "the book that B. F. Skinner considered to be his most important work, namely *Verbal Behavior*, continues to be both unexamined and much maligned and therefore basically misunderstood" (Salzinger, 2008, p. 287). Kurt would also tell you that even six decades later, "had Skinner's book been more accepted by both behaviorists and cognitive psychologists, perhaps they would not have believed that behavior analysis does not allow one to talk to patients, but that one can only reinforce their nonverbal behavior" (Salzinger, 1992).

Kurt was passionate about the potential of the study of verbal behavior to make the world a better place, from helping individual patients to aiding society at large. Kurt reflected, "Yet even a little bit of thought makes clear, that particularly in complex civilizations, it is talk that produces the most important reinforcers and it is talk that allows one to avoid the most egregious consequences" (Salzinger, 1992).

Kurt directed a large portion of his research efforts to examining verbal behavior and its reinforcement in schizophrenia (e.g., Salzinger & Pisoni, 1960). Kurt contributed immensely to the application of behavioral analysis to psychological disorders. He formulated the immediacy hypothesis for schizophrenia (1970), which states that the behavior of individuals with schizophrenia is controlled primarily by immediate stimuli in the environment, to the exclusion of more distal but relevant stimuli.

Kurt also devoted some of his energies to examining operant conditioning mechanisms. He and his colleagues successfully conditioned goldfish to press a lever under varying reinforcement conditions (Salzinger, Freimark, Fairhurst, & Wolkoff, 1968) and later conditioned goldfish to make differential operant responses based on the level of pollution in the water. These studies together suggest that fish may be trained as an "early warning system" to detect unclean water (Salzinger et al., 1973). In short, his scholarly output was prolific, original, and innovative.

Kurt was born in Vienna, Austria in 1929. At 11 he fled the Nazis with his family. He lived along the way in Latvia and Japan and eventually took a boat to Seattle, finally arriving in New York after a 2-year journey. He attended the Bronx High School of Science, followed by New York University. He received his Ph.D. in Psychology from Columbia University under the mentorship of Joseph Zubin.

Beyond his scholarship, Kurt shaped our field through his leadership in many organizations, such as serving as Executive Director for Science at the American Psychological Association (APA), as President of the New York Academy of Sciences, as president of APA Divisions 1 (General Psychology) and 25 (Behavior Analysis), as President of the American Association of Applied and Preventive Psychology and the Eastern Psychological Association. In addition, over the years he worked as a professor of psychology at Hofstra University and was the director of the Hofstra clinical doctoral program. Prior to this, he was a professor at Polytechnic University of New York. The early days of his academic career were as a Principal Research Scientist at the New York State Psychiatric Institute. He received the Sustained Superior Performance Award from the National Science Foundation, the Stratton Award from the American Psychopathological Association, and the Most Meritorious Article Award from the *Journal of Behavior Therapy and Experimental Psychiatry*. In 2002, he was a Presidential Scholar for the Association for Behavior Analysis.

Despite his many accomplishments, Kurt was always approachable and kind. He was patient with students, but at the same time challenged them to think through their hypotheses more clearly. He always made time for fellow faculty and enjoyed collaborations and discussions of psychology as well as world affairs. Over a 15-year period at Hofstra I benefited almost daily from his humor, mentorship, and wisdom. We lost someone special last month. But we psychologists will continue to be inspired by Kurt's accomplishments, writings, and his legacy.

References

- Salzinger, K. (2008). Skinner's verbal behavior. *International Journal of Psychology and Psychological Therapy*, 8(3), 287-294.
- Salzinger, K., Fairhurst, S. P., Freimark, S. J., & Wolkoff, F. D. (1973). Behavior of the goldfish as an early warning system for the presence of pollutants in water. *Journal of Environmental Systems*, 3, 27-40.
- Salzinger, K., Freimark, S. J., Fairhurst, S. P., & Wolkoff, F. D. (1968). Conditioned reinforcement in the goldfish. *Science*, 160(3835), 1471-1472.
- Salzinger, K., Portnoy, S., & Feldman, R. S. (1964). Verbal behavior of schizophrenic and normal subjects. *Annals of the New York Academy of Sciences*, 105(15), 845-860.
- Salzinger, K., Portnoy, S., Pisoni, D. B., & Feldman, R. S. (1970). The immediacy hypothesis and response-produced stimuli in schizophrenic speech. *Journal of Abnormal Psychology*, 76(2), 258.
- Skinner, B. F. (1957). *Verbal behavior*. New York: Appleton-Century-Crofts.

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Nominate the Next Candidates for ABCT Office!

I nominate . . .

► PRESIDENT-ELECT (2019–2020)

► REPRESENTATIVE-AT-LARGE (2019–2022) and Liaison to Academic & Professional Issues

Name

If Not You, Who?

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

NOTE: To be nominated for President-Elect of ABCT, it is recommended that a candidate has served on the ABCT Board of Directors in some capacity; served as a coordinator; served as a committee chair or SIG chair; served on the Finance Committee; or have made other significant contributions to the Association as determined by the Leadership and Elections Committee. Candidates for the position of President-Elect shall ensure that during his/her term as President-Elect and President of the ABCT, the officer shall not serve as President of a competing or complementary professional organization during these terms of office; and the candidate can ensure that their work on other professional boards will not interfere with their responsibilities to ABCT during the presidential cycle.

This coming year we need nominations for two elected positions: President-Elect and Representative-at-Large. Each representative serves as a liaison to one of the branches of the association. The representative position up for 2019 election will serve as the liaison to Academic & Professional Issues.

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

NOMINATE Candidates for ABCT Office

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years.

Only full and new member professionals can nominate candidates. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions. Candidates for the position of President-Elect shall ensure that during his/her term as President-Elect and President of the ABCT, the officer shall not serve as President of a competing or complementary professional organization during these terms of office; and the candidate can ensure that their work on other professional boards will not interfere with their responsibilities to ABCT during the presidential cycle. Please complete and sign this nomination form. **Only those nomination forms bearing a postmark on or before February 1, 2019, will be counted.**

Send your form to David Pantalone, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001 by **February 1, 2019**. Or email the form to membership@abct.org (Subject line: **NOMINATIONS**)

Three Ways to Nominate

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



ABCT AWARDS & RECOGNITION 2018

52nd Annual Convention | November 16, Washington, DC



Lifetime Achievement: Mark B. Sobell and Linda Carter Sobell



Outstanding Mentor: Ricardo Muñoz



Graduate Student Research Grant: Laurel D. Sarfan and Daniel P. Moriarity, honorable mention



Elsie Ramos Memorial Student Poster Award (left to right): Kristen E. Frosio, Jonah Meyerhoff, Emma Brett

far right photo:
Lillian Reuman (left) **Student Travel Award**, and Shannon Blakey (right), **ADAA Travel Award** (pictured with ABCT fellow and past-president Jonathan Abramowitz)

left photo:
Congressman Joseph Patrick Kennedy III, **Award for Science and Parity in Mental Health**, with Cassidy Gutner, Awards Chair



ABCT AWARDS & RECOGNITION 2018



Midcareer Innovator: *Shannon Wiltsey Stirman*



Outstanding Service to ABCT: Former Editors of *Behavior Therapy* (left to right) *Richard G. Heimberg, Thomas H. Ollendick, and Michelle G. Newman*



**Leonard Krasner
Student
Dissertation:
Eric Lee**



**Virgnina Roswell
Student Dissertation
Award: Gabriela
Khazanov**

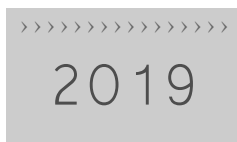


President's New Researcher: *Ryan C. Shorey*, pictured with (left) Past President *Gail Steketee* and (right) President *Sabine Wilhelm*



**Anne Marie Albano
Early Career Award:
Joseph McGuire with
Anne Marie Albano**

NOT PICTURED: **John R. Z. Abela Student Dissertation Award**, *Joanna Kim*; **Distinguished Friend to Behavior Therapy**, *Joel Sherrill*; **ADAA Travel Award**, *Martha Falkenstein*



Call *for* Award Nominations

to be presented at the 53rd Annual Convention in Atlanta, GA

The ABCT Awards and Recognition Committee, chaired by Cassidy Gutner, Ph.D., of Boston University School of Medicine, is pleased to announce the 2019 awards program. Nominations are requested in all categories listed below. Given the number of submissions received for these awards, the committee is unable to consider additional letters of support or supplemental materials beyond those specified in the instructions below. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Recent recipients of this award include Thomas H. Ollendick, Lauren B. Alloy, Lyn Abramson, David M. Clark, Marsha Linehan, Dianne L. Chambless, Linda Carter Sobell, and Mark B. Sobell. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to 2019ABCTAwards@abct.org. Include "Career/Lifetime Achievement" in the subject line.

Nomination deadline: March 1, 2019

Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Recent recipients of this award include the Doctoral Program in Clinical Psychology at SUNY Albany, Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology, the University of Nebraska-Lincoln Clinical Psychology Training Program, the Charleston Consortium Psychology Internship Training Program, and the Clinical Science Ph.D. Program at Virginia Polytechnic Institute & State University. Please complete the on-line nomination form at www.abct.org/awards. Then e-mail the completed form and associated materials as one pdf document to 2019ABCTAwards@abct.org. Include "Outstanding Training Program" in your subject heading. **Nomination deadline:** March 1, 2019

Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Recent recipients of this award include Mark S. Bauer, Vikram Patel, Benedict Carey, Patrick J. Kennedy, and Joel Sherrill. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to 2019ABCTAwards@abct.org. Include "Distinguished Friend to BT" in the subject line.

Nomination deadline: March 1, 2019

Outstanding Clinician

Awarded to members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Past recipients of this award include Albert Ellis, Marsha Linehan, Marvin Goldfried, Frank Datillio, Jacqueline Persons, Judith Beck, and Anne Marie Albano. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to 2019ABCTAwards@abct.org. Include "Outstanding Clinician" in the subject line.

Nomination deadline: March 1, 2019

Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT's mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano's core commitments. This award includes a cash prize of \$1,000 to support travel to the ABCT Annual Convention and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: (1) Candidates must be active members of ABCT, (2) New/Early Career Professionals within the first 5 years of receiving his or her doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care. Applicants should submit: nominating cover letter, CV, personal statement up to three pages (statements exceeding 3 pages will not be reviewed), and 2 to 3 supporting letters. Application materials should be emailed as one pdf document to 2019ABCTAwards@abct.org. Include candidate's last name and "Albano Award" in the subject line.

Nomination deadline: March 1, 2019

Student Dissertation Awards

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

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2018. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents (i.e., under age 18). Self-nominations are accepted or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the nomination materials (including letter of recommendation) as one pdf document to 2019ABCTAwards@abct.org. Include candidate's last name and "Student Dissertation Award" in the subject line. **Nomination deadline:** March 1, 2019

President's New Researcher Award

ABCT's 2018-19 President, Bruce Chorpita Ph.D., invites submissions for the 41st Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of \$500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent work published in high-impact journals; and promise of developing theoretical or practical applications that represent clear advances to the field.

Requirements: must have had terminal degree (Ph.D., M.D., etc) for at least 1 year but no longer than 6 years; must submit an article for which they are the first author; 3 letters of recommendation must be included; self-nominations are accepted; the author's CV, letters of support, and paper must be submitted in electronic form. E-mail the nomination materials (including letter of recommendation) as one pdf document to PNRAward@abct.org. Include candidate's last name and "President's New Researcher" in the subject line. **Nomination deadline:** March 1, 2019

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

Outstanding Service to ABCT

Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the completed form and associated materials as one pdf document to 2019ABCTAwards@abct.org. Include "Outstanding Service" in the subject line.

Nomination deadline: March 1, 2019

ABCT's 53rd Annual Convention

November 21–24, 2019 • Atlanta, GA

Preparing to Submit an Abstract

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

ABCT uses the Cadmium Scorecard system for the submission of general session events. The step-by-step instructions are easily accessed from the Abstract Submission Portal, and the ABCT home page. Attendees are limited to speaking (e.g., presenter, panelist, discussant) during no more than FOUR events. As you prepare your submission, please keep in mind:

- **Presentation type:** Please see p. 25 for descriptions of the various presentation types.

- **Number of presenters/papers:** For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The total number of speakers may not exceed 6. Symposia are either 60 or 90 minutes in length. The chair may present a paper, but the discussant may not. Symposia are presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation of treatment protocols. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.

- **Title:** Be succinct.

- **Authors/Presenters:** Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their degree, ABCT category (if they are ABCT members), and their email address. (Possibilities for “ABCT category” are current member; lapsed member or non-member; postbaccalaureate; student member; student nonmember; new professional; emeritus.)

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

- **Key Words:** Please read carefully through the pull-down menu of defined keywords and use one of the keywords on the list. Keywords help ABCT have adequate programming representation across all topic areas.

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

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

QUESTIONS?

FAQs are at <http://www.abct.org/Conventions/> > **Abstract Submission FAQs**

Thinking about submitting an abstract for the ABCT 53rd Annual Convention in Atlanta?

The submission portal will be opened from February 14–March 15. Look for more information in the coming weeks to assist you with submitting abstracts for the ABCT 53rd Annual Convention. The deadline for submissions will be 3:00 a.m. (EST), Saturday, March 16, 2019. We look forward to seeing you in Atlanta, GA!

Understanding the ABCT Convention

General Sessions

There are between 150 and 200 general sessions each year competing for your attention. An individual must LIMIT TO 6 the number of general session submissions in which he or she is a SPEAKER (including symposia, panel discussions, clinical round tables, and research spotlights). The term SPEAKER includes roles of chair, moderator, presenter, panelist, and discussant. Acceptances for any given speaker will be limited to 4. All general sessions are included with the registration fee. These events are all submitted through the ABCT submission system. The deadline for these submissions is 3:00 AM ET, Saturday, March 16, 2019. General session types include:

Symposia. *In responding to convention feedback requesting the presence of senior researchers/faculty to present papers at symposia along with junior researchers/faculty and graduate students, we strongly encourage symposia submissions to include some senior researchers/faculty as first-author presenters.* Presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. The total number of speakers may not exceed 6.

Clinical Round Tables. Discussions (or debates) by informed individuals on a current important topic directly related to patient care, treatment, and/or the application/implementation of a treatment. Examples of topics for Clinical Round Tables include (but are not limited to) challenges/suggestions for treating a certain disorder or group of patients, application of a treatment protocol or type of treatment to a novel population, considerations in applying CBTs to marginalized communities and/or minority groups. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. Clinical Round Tables are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Panel Discussions. Discussions (or debates) by informed individuals on a current important topic that are conceptual in nature, rather than pertaining directly to clinical care. Examples of topics for panel discussions

include (but are not limited to) supervision/training issues, ethical considerations in treatment or training, the use of technology in treatment, and cultural considerations in the application of CBTs. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. These are organized by a moderator and include between three and five panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

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

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

Targeted and Special Programming

Targeted and special programming events are also included with the registration fee. These events are designed to address a range of scientific, clinical, and professional development topics. They also provide unique opportunities for networking.

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

Mini-Workshops. Designed to address direct clinical care or training at a broad introductory level and are 90 minutes long.

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

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

Special Sessions. These events are designed to provide useful information regarding profes-

sional rather than scientific issues. For more than 20 years, the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training.

Special Interest Group (SIG) Meetings. More than 39 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

Ticketed Events

Ticketed events offer educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment. The deadline for these submissions is 3:00 AM ET, Saturday, February 2, 2019.

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

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

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

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

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

Research and Professional Development. Provides opportunities for attendees to learn from experts about the development of a range of research and professional skills, such as grant writing, reviewing manuscripts, and professional practice.

**ticketed
sessions**

call

53rd Annual Convention

November 21–24, 2019 | Atlanta, GA

for Ticketed Sessions

Workshops & Mini Workshops

Workshops cover concerns of the practitioner/ educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than 4 presenters. Mini Workshops address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention. Please limit to no more than 4 presenters. When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.

For more information or to answer any questions before you submit your abstract, contact **Lauren Weinstock, Workshop Committee Chair, workshops@abct.org**

Institutes

Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday. Please limit to no more than 4 presenters.

For more information or to answer any questions before you submit your abstract, contact **Christina Boisseau, Institute Committee Chair, institutes@abct.org**

Master Clinician Seminars

Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday through Sunday. Please limit to no more than 2 presenters.

For more information or to answer any questions before you submit your abstract, contact **Courtney Benjamin Wolk, Master Clinician Seminar Committee Chair, masterclinicianseminars@abct.org**

Research and Professional Development

Presentations focus on “how to” develop one’s own career and/or conduct research, rather than on broad-based research issues (e.g., a methodological or design issue, grantsmanship, manuscript review) and/or professional development topics (e.g., evidence-based supervision approaches, establishing a private practice, academic productivity, publishing for the general public). Submissions will be of specific preferred length (60, 90, or 120 minutes) and format (panel discussion or more hands-on participation by the audience). Please limit to no more than 4 presenters, and be sure to indicate preferred presentation length and format.

For more information or to answer any questions before you submit your abstract, contact **Cole Hooley, Research and Professional Development Chair, researchanddevelopmentseminars@abct.org**

Submissions will now be accepted through the online submission portal, which will be open until February 1.

Submit a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please visit www.abct.org and click on “Convention and Continuing Education.”

Submission deadline: February 1, 2019

ABCT

53rd Annual Convention

November 21–24, 2019 | Atlanta, GA

**general
sessions**

Theme:

WISDOM OF
PURPOSE AND
PERSPECTIVE:
EXTENDING THE
SOCIAL IMPACT
OF COGNITIVE
BEHAVIORAL
SCIENCE

Portal opens

February 14, 2019

Deadline

for submissions:
March 15, 2019

With ABCT now in its sixth decade, it is more important than ever to reflect on how well we are achieving our core mission of enhancing health and well-being. What can we do together to extend the reach and social impact of our vast accumulation of scientific knowledge? How can we produce healthy, therapeutic behavior on a grand scale? The purpose of this call is to engage us in ongoing reflection, commitment, and the effortful habit of evaluating our accomplishments in terms of this high-level goal of reducing mental health burden and improving lives; in other words, to measure our work against our mission.

We encourage submissions that investigate novel ways to extend the reach of our current therapeutic processes and products, and especially the scientific knowledge behind them. Thematic examples include:

- Reaching and partnering with new and diverse populations (e.g., global mental health, underutilized behavioral health audiences, underserved communities, intersecting interests among two or more Special Interest Groups);
- Leveraging or developing new workforces or stakeholders (e.g., paraprofessional health workers, instructional models for professional training and development, supervision models for training and/or distributing expertise in health systems, scientific/mental health literacy of the general population);
- Improving knowledge delivery and the efficiency to guide behavioral health decisions (e.g., innovative protocol designs; decision support or feedback systems to inform treatment or implementation; models to better connect theory or emergent scientific findings to impending therapeutic action, personalized treatments, translation across problem or practice ontologies, such as DSM and RDoC; use of research evidence);
- Interacting with industry (e.g., the role of emerging technology; the relationship between science and entrepreneurship, between human helpers and machines; models for scaling our most effective solutions);
- Striving to solve problems that are meaningful to stakeholders (e.g., clients, therapists, mental health system administrators); dissecting our failures or the unintended consequences of our prior successes; developing extensible resources today that anticipate the world of tomorrow.

Submissions may be in the form of Symposia, Clinical Round Tables, Panel Discussions, and Posters. Submissions that are judged to be especially thematic will be recognized in the online program for the 2019 Convention.

Submission deadline: March 15, 2019

ABCT and Continuing Education

At the ABCT Annual Convention, there are Ticketed events (meaning you usually have to buy a ticket for one of these beyond the general registration fee) and General sessions (meaning you can usually get in by paying the general registration fee), the vast majority of which qualify for CE credit. See the end of this document for a list of organizations that have approved ABCT as a CE sponsor. Note that we do not offer CMEs. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit. For those who have met all requirements according to the organizations which have approved ABCT as a CE sponsor, certificates will be mailed by mid-January following the Annual Convention.

TICKETED EVENTS Eligible for CE

All Ticketed events offer CE in addition to educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment beyond the general registration fee. For ticketed events, attendees must scan in and out, and complete and return an individual evaluation form. It remains the responsibility of the attendee to scan in at the beginning of the session and out at the end of the session. **CE will not be awarded unless the attendees scans in and out.**

- **Clinical Intervention Training** One- and two-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction. Participants attending a full-day session can earn 7 continuing education credits, and 14 continuing education credits for the two-day session.
- **Institutes** Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday, and are generally limited to 40 attendees. Participants in the full-day Institute can earn 7 continuing education credits, and in the half-day Institutes can earn 5 continuing education credits.
- **Workshops** Covering concerns of the practitioner/ educator/ researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees. Participants in these Workshops can earn 3 continuing education credits per workshop.
- **Master Clinician Seminars (MCS)** The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees. Participants in these seminars can earn 2 continuing education credits per seminar.
- **Advanced Methodology and Statistics Seminars (AMASS)** Designed to enhance researchers' abilities, there are generally two seminars offered on Thursday or during the course of

the Convention. They are 4 hours long and limited to 40 attendees. Participants in these courses can earn 4 continuing education credits per seminar.

GENERAL SESSIONS Eligible for CE

There are 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. Most of the sessions are eligible for CE, with the exception of the poster sessions, Membership Panel Discussions, the Special Interest Group Meetings (SIG), and a few other sessions. You are eligible to earn 1 CE credit per hour of attendance. General sessions attendees must scan in and out and answer particular questions in the CE booklet regarding each session attended. The booklets must be returned to ABCT registration area at the end of the Convention. General session types that are eligible for CE include the following:

- **Clinical Grand Rounds** Clinical experts engage in simulated live demonstrations of therapy with clients, who are generally portrayed by graduate students studying with the presenter.
- **Invited Panels and Addresses** Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge on a broad topic of interest.
- **Mini-Workshops** Designed to address direct clinical care or training at a broad introductory level and are 90 minutes long. Mini-workshops are offered on Friday and Saturday and are generally limited to 80 attendees. Participants can earn 1.5 continuing education credits.
- **Panel Discussion** Discussions (or debates) by informed individuals on a current important topic that are conceptual in nature, rather than pertaining directly to clinical care. Examples of topics for panel discussions include (but are not limited to) supervision/training issues, ethical considerations in treatment or training, the use of technology in treatment, and cultural considerations in the application of CBTs. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. These are organized by a moderator and include between three and five panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.
- **Clinical Round Tables** Discussions (or debates) by informed individuals on a current important topic directly related to patient care, treatment, and/or the application/ implementation of a treatment. Examples of topics for Clinical Round Tables include (but are not limited to) challenges/suggestions for treating a certain disorder or group of patients, application of a treatment protocol or type of treatment to a novel population, considerations in applying CBTs to marginalized communities and/or minority groups. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their

ABCT and Continuing Education

judgment in making this decision. Clinical Round Tables are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

- **Spotlight Research Presentations** This format provides a forum to debut new findings considered to be groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute question-and-answer period allows for more in-depth presentation than is permitted by symposia or other formats.
- **Symposia** Presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. The total number of speakers may not exceed 6.

GENERAL SESSIONS NOT Eligible for CE

- **Membership Panel Discussion** Organized by representatives of the Membership Committee and Student Membership Committees, these events generally emphasize training or career development.
- **Poster Sessions** One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,400 and 1,600 posters are presented each year.
- **Special Interest Group (SIG) Meetings** More than 39 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.
- **Special Sessions** These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training. These sessions are not eligible for continuing education credit.
- **Other Sessions** Other sessions not eligible for CE are noted as such on the itinerary planner and in the program book.

How Do I Get CE at the ABCT Convention?

The CE fee must be paid (see registration form) for a personalized continuing education credit letter to be distributed. Those who have included CE in their preregistration will be given a booklet when they pick up their badge and registration materials at the ABCT Registration Desk. Others can still purchase a

booklet at the registration area during the convention. The current fee is \$99.00.

Which Organizations Have Approved ABCT as a CE Sponsor?

Psychology

ABCT is approved by the American Psychological Association to sponsor continuing education for psychologists. ABCT maintains responsibility for this program and its content. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit. For ticketed events attendees must sign in and sign out and complete and return an individual evaluation form. For general sessions attendees must sign in and sign out and answer particular questions in the CE booklet regarding each session attended. The booklets must be handed in to ABCT at the end of the Convention. It remains the responsibility of the attendee to sign in at the beginning of the session and out at the end of the session.

Social Work

ABCT program has historically been approved by the National Association of Social Workers (Approval # 886427222) for approximately 25 continuing education contact hours for the Annual Convention, though a new application is required each year.

Counseling

The Association for Behavioral and Cognitive Therapies is an NBCC-Approved Continuing Education Provider (ACEPTM) and may offer NBCC-approved clock hours for events that meet NBCC requirements. The ACEP is solely responsible for all aspects of the program.

Marriage and Family Therapy

ABCT is recognized as a California Association of Marriage and Family Therapists (CAMFT)-approved Continuing Education Provider (#133136). The ABCT Annual Convention meets the qualifications for 28 hours of continuing education credit for LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences.

CE Grievance Procedure

ABCT is fully committed to conducting all activities in strict conformance with the American Psychological Association's Ethical Principles of Psychologists. ABCT will comply with all legal and ethical responsibilities to be non-discriminatory in promotional activities, program content and in the treatment of program participants. The monitoring and assessment of compliance with these standards will be the responsibility of the Coordinator of Convention and Education Issues in conjunction with the Convention Manager. Although ABCT goes to great

lengths to assure fair treatment for all participants and attempts to anticipate problems, there will be occasional issues which come to the attention of the convention staff which require intervention and/or action on the part of the convention staff or an officer of ABCT. This procedural description serves as a guideline for handling such grievances. All grievances must be filed in writing to ensure a clear explanation of the problem. If the grievance concerns satisfaction with a CE session the Convention Manager shall determine whether a full or partial refund (either in money or credit for a future CE event) is warranted. If the complainant is not satisfied, their materials will be forwarded to the Coordinator of Convention and Continuing Education Issues for a final decision. If the grievance concerns a speaker and particular materials presented, the Convention

Manager shall bring the issue to the Coordinator of Convention and Education Issues who may consult with the members of the continuing education issues committees. The Coordinator will formulate a response to the complaint and recommend action if necessary, which will be conveyed directly to the complainant. For example, a grievance concerning a speaker may be conveyed to that speaker and also to those planning future educational programs. Records of all grievances, the process of resolving the grievance and the outcome will be kept in the files of the Convention Manager. A copy of this Grievance Procedure will be available upon request.

If you have a complaint, please contact Stephen R. Crane, Convention Manager, at scrane@abct.org or (212) 646-1890 for assistance.



A few weeks ago, ABCT initiated the "Impact Fund" to launch ideas and activities that will help CBT and evidence-based therapies have a bigger impact on communities. It is ABCT's first purely unrestricted, strategic fund. It has the potential to transform ABCT's pursuit of its mission of improving the health and well being of all people.

Consider whether you would be willing to give just \$1 per year you have been a full member (i.e., can our 10-year members give \$10, etc?). Just been a member a few years? That's great...everything will help. If you want to give more, by all means do. Consider the following:

1. **You're betting on science.** If you think science is one of the best ways to have a large-scale impact on reducing human suffering, ABCT is one of the best places to give. How we build and apply the evidence base on human behavior will improve all of our futures.
2. **A little goes a long way.** ABCT is incredibly efficient with this fund. *Fully 100% will go to strategic priorities that would otherwise not be possible. There are no management or investment fees and no overhead.*
3. **You can help with strategy.** Want a voice behind your donation? If you have opinions on how ABCT can put such a fund to best use, please chime in. Post your ideas on FB, or let the Development Committee know. Run for office!
4. **We're more than a convention.** If you have long thought of ABCT as an annual convention, think again. We're committed to social change through facilitating the best science, education, and training...all year long. We started as a movement in the 1960's, and we are a movement today—fostering the application of science in changing lives. This priority is more important than ever.
5. **Double your impact.** ABCT's president, Bruce F. Chorpita, Ph.D., **is matching the first \$1,000 of donations.**
6. **CBT folks love "behavioral experiments."** If all this sounds good, but maybe you are procrastinating, or you think it won't be worthwhile, take a mood rating, then donate, and then see how good it feels to invest in this community of members committed to the use of science to guide policy and practice. It feels great, even if can you give just a little.

→ Go to: <http://www.abct.org/Home/>

→ Click on "Donate"

→ Click on the amount you'd like to contribute. (If it's \$1 per year, you can click "other" to enter a custom amount.)

→ For item 1, pick the "Impact Fund"

→ Click "Add to cart" and check out.

Find a CBT Therapist



ABCT's *Find a CBT Therapist* directory is a compilation of practitioners schooled in cognitive and behavioral techniques. In addition to standard search capabilities (name, location, and area of expertise), ABCT's *Find a CBT Therapist* offers a range of advanced search capabilities, enabling the user to take a *Symptom Checklist*, review specialties, link to self-help books, and search for therapists based on insurance accepted.

We urge you to sign up for the *Expanded Find a CBT Therapist* (an extra \$50 per year). With this addition, potential clients will see what insurance you accept, your practice philosophy, your website, and other practice particulars.

To sign up for the *Expanded Find a CBT Therapist*, click **MEMBER LOGIN** on the upper left-hand of the home page and proceed to the ABCT online store, where you will click on "Find CBT Therapist."

For further questions, call the ABCT central office at 212-647-1890.

CBT Medical Educator Directory

Another indispensable resource from ABCT—an online directory of CBT educators who have agreed to be listed as potential resources to others involved in training physicians and allied health providers. In particular, the educators on this list have been involved in providing education in CBT and/or the theories underlying such interventions to medical and other allied health trainees at various levels. The listing is meant to connect teachers across institutions and allow for the sharing of resources.

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.
2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.
3. Training should take place or be affiliated with an academic training

facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

Please note that this list is offered as a service to all who teach CBT to the medical community and is not exhaustive.

To Submit Your Name for Inclusion in the Medical Educator Directory

If you meet the above inclusion criteria and wish to be included on this list, please send the contact information that you would like included, along with a few sentences describing your experience with training physicians and/or allied health providers in CBT to Shona Vas at svas@uchicago.edu and include the phrase "Medical Educator Directory" in the subject line.

Disclaimer

Time and availability to participate in such efforts may vary widely among the educators listed. It is up to the individuals seeking guidance to pick who they wish to contact and to evaluate the quality of the advice/guidance they receive. ABCT has not evaluated the quality of potential teaching materials and inclusion on this list does not imply endorsement by ABCT of any particular training program or professional. The individuals in this listing serve strictly in a volunteer capacity.

ABCT's
Medical
Educator
Directory

<http://www.abct.org>

[Resources for Professionals](#)

[Teaching Resources](#)

[CBT Medical Educator Directory](#)

the Behavior Therapist

Association for Behavioral
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