An Appetite for Evidence

Bruce F. Chorpita, UCLA

Building on more than 50 years of treatment development and empirical testing, our field has increasingly turned its attention to the dissemination and scaling of those treatments (e.g., McHugh & Barlow, 2010). If the products of our science are going to transform communities and lives, this evolving emphasis is critical. However, my experience implementing EBTs in communities over the last 20 years suggests that, despite these emerging pursuits, we face a great risk, which is the widespread tendency in our field to conflate EBTs with evidence itself. Like it or not, we know there is a substantial and mature literature documenting unfavorable perceptions and attitudes towards EBTs among many individuals who must use them regularly (e.g., Aarons, 2005; Addis & Krasnow, 2000); this is very important research, and my experiences in community mental health have often corroborated those findings. The great concern arises, however, when we then make the inference that anyone who does not like EBTs must not like evidence. That has not been my experience at all; in fact, it has been quite the contrary.

EBTs are not evidence. They are structures or vehicles that deliver a piece of the evidence base to guide behavior of one or more individuals in a therapeutic context. Our laboratory has shown that when we ask about EBTs and evidence separately, providers like evidence, but not always the EBTs in which the evidence is packaged (Bontrager et al., 2009). We have also found that the packaging itself is responsible for a significant amount of the variance in negative attitudes (Reding et al., 2014). Some EBTs are quite popular; others less so.
ABCT

Annual Meeting of Members

NOTICE TO MEMBERS:
This year the Annual Meeting of Members is scheduled for Saturday, November 23, from 12:30 – 1:30 p.m. in L504-505, Lobby Level of the Marriott Marquis Atlanta.

53rd Annual Convention November 21–124, 2019

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.

Submissions must be accompanied by a Copyright Transfer Form (which can be downloaded on our website: http://www.abct.org/Journals/?m=mJournal&fa=TB T): submissions will not be reviewed without a copyright transfer form. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to tBT do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Kate Wolitzky-Taylor, Ph.D., at KBTaylor@mednet.ucla.edu. Please include the phrase tBT submission and the author’s last name (e.g., tBT Submission - Smith et al.) in the subject line of your e-mail. Include the corresponding author’s e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.
Humans have an appetite for evidence. This is not the place for a formal and comprehensive review of the cognitive and clinical science literature behind that claim, but the notion is not controversial. When faced with a goal, people would like to know things that could facilitate or hinder the pursuit of that goal. They want relevant evidence. Pilots want to know the weather. Restaurant diners want to know what is on the menu and how much it will cost. Automobile drivers want to know how much fuel they have left and where they might stop if needed. But, alas, the interface for getting the evidence plays a key role. Those same drivers might also want to know if their tires are safely inflated or their oil level is appropriate, but if it requires getting out, opening tire valves or raising the hood, kneeling and bending, then the effort could be too great and many will simply drive on.

My experience and research in community mental health systems has been no different: practitioners, policymakers, and administrators want to know as much as they can about how best to help people with mental health challenges, but the way that evidence is delivered can have dramatic effects. In a series of studies, in which we are examining how providers and supervisors use evidence in clinical care, we are finding that evidence use is dramatically increased when the “packaging” suits the preferences and skill level of the user (e.g., Becker et al., in press). We have also observed skill levels changing over time such that when we offer an evidence resource (e.g., a protocol, tool, or guide) to a provider, we are eventually met with requests for a more complex version of the resource, i.e., one that exposes the next layer of evidence. For example, one component of our intervention uses graphical reports to supervision teams to summarize the engagement level of a single youth receiving care, along five scale dimensions, banded with red (concerns), yellow (caution), and green (no concerns) zones for rapid interpretability. Before long, providers wanted to know subscales within the five subscales and requested more features on the report with more item-level data to tell the “why” behind the “how bad.” It made the report more complex, to the point where we do not think it would have been acceptable at the launch of the study. We have started calling this evolving preference an appetite for evidence, and now we see it everywhere.

We don’t need to teach anyone to like evidence. On the contrary, if we give someone a little, in a format they prefer, and it proves useful, they will probably ask for more. A little can go a long way, especially if we consider the preferences, competencies, and responsibilities of the user (cf. Lyon & Koerner, 2016). But if we were to stop there, we could very likely go down different blind alleys: those of simplification, decoration, or re-platforming (e.g., moving from books to mobile phones). For example, there is an emerging trend in dissemination science calling for pragmatic and simple intervention designs—fewer procedures, fewer sessions, fewer decisions. This makes intuitive sense, and I have encountered this perspective in my collaborations in India, where we must build interventions that can be delivered by nonspecialists. But providers’ appetite for evidence forces us to think seriously about extensible architectures (Chorpita, Daleiden, & Weisz, 2005). Extensibility is the ability of a resource to add or remove features without changing the fundamental underlying design, and it can be immensely powerful.

My colleagues and I deliberately use the phrase “appetite for evidence,” because appetites can and do build over time. Respecting this principle makes a critical difference in how interventions are assembled. For example, instead of developing simple, brief, or easily accessible interventions to facilitate dissemination and scaling, we would build interventions that are simple and brief for those users or contexts demanding simplicity, but that expose features for users who have developed mastery or encounter edge cases that do not fit the simpler versions.

More generally, the search for a “perfect interface” or “best design” for individuals to be guided by evidence is likely to be a false hope (see Chorpita & Daleiden, 2018). Human diversity is a foundation in our field, as is the notion that human capacities and competencies change with experience. A call for merely shifting to simpler designs, then, is akin to the claim that flip phones are more scalable than smartphones. Smartphones are extensible. They can start with just a few apps or functions (e.g., SMS or phone calls), but can add many features without needing fundamental redesign or replacement. And ultimately, they deliver more of the evidence for which people often develop an appetite (e.g., weather, news, or traffic reports). So, in fact, what we might really need are interventions that are far more complex, but whose complexity is hidden from the user until the simple features are mastered and new features are needed or desired. Appreciating this principle could substantially change the way interventions are designed and could move the field toward new models for fluent, coordinated, and strategic use of evidence in clinical care. Imagine treatments that get more sophisticated over time, but without changing their underlying structure. Imagine treatments that keep their new users from becoming anxious while they keep their experienced users from feeling bored or underresourced. Imagine treatments that can rapidly update relevant components as new research findings emerge. Now imagine that working examples already exist. If you are eager to know whether they are effective, then your appetite for evidence is building. I look forward to serving up that next layer at our November convention.

References


**Disclosures:** I am employed full-time as a Professor in the Department of Psychology at UCLA, and I am also President and Partner/Owner of PracticeWise, LLC, a behavioral health consulting corporation.

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**Next Webinar (9/19)**

David Rosmarin, Ph.D.

“Spirituality/Religion & CBT: What Clinicians Need to Know”

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**AT ABCT**

**From Your Executive Director: What Your Leadership and Staff Are Working on to Serve You Better**

Mary Jane Eimer, Executive Director

It is time to renew your membership now so you can attend the Atlanta Convention at the lowest rates and vote in the November election. And, yes, the elections have been changed from the usual April to November. Remember, when you vote, we reinforce you with an “I Voted” sticker. Vote in advance or vote at the convention: you get a sticker!

When you renew, be sure to take a minute to look at your membership record. We’ve added fields for additional languages spoken, for telehealth, and for treating chronic medical conditions. One of our 2020 initiatives is to link with other associations that focus on a chronic disease and are looking for therapists for their clients. We also made changes to how you record how you spend your time. Knowing how you spend your time helps the leadership and staff make better decisions. Plus, we’ve spent some time to ensure that our questions relating to ethnicity are sensitive and inclusive. If we overlooked any categories, please let me know.

If you take referrals, are you listed in our expanded Find a CBT Therapist directory? It is the most frequently visited page on our website. If you are licensed, you definitely want to be included. Our Clinical Directory and Referral Issues Committee is paying attention to how our referral stacks up to the competition. They believe we are holding our own, and we hope the public is finding you. You may note that annually we add new fact sheets or update existing ones. Some fact sheets have been translated into Spanish. Fact sheets are free and you are encouraged to download them and recommend them to colleagues. If we are missing a title or you would like to write a fact sheet, please let me know. We would be most appreciative of your help in expanding our library of fact sheet offerings!

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Registration is open for the November 21–24 Annual Convention in Atlanta. Now is a good time to register for ticketed sessions. Of course, we offer continuing education credits. If you are a student, check our web page for student volunteer opportunities. We will be using two hotels this year: the Marriott Marquis and the Hyatt Regency. Please book your room directly with the hotel. We do not use a housing agent. By your staying in one of our convention hotels, you help offset meeting room rental fees. We appreciate your support! And, you help us avoid housing fraud, which is a big problem for associations when scammers attempt to coerce you into booking through them for cheaper hotels. For those of you flying to Atlanta, you may want to see if our arrangement with Delta offers any discounts. Use Meeting Event Code [NY2UE].

ABCT has been offering a nursing room at the Annual Convention for several years. Those babies are up and moving and we are ready to welcome them to our 2019 child-care program. Arrangements have been made Thursday through Sunday for children aged 6 months to 12 years. Visit our convention page for details.

We have been turning our attention to helping undergraduates decide which path is right for them for a career in psychology. Shannon Blakey, our Student Membership Committee Chair, has been working with Deborra Bell and Karen Christoff, organizers of our Getting Into Graduate School panel for Friday afternoon of the Atlanta Convention. Leading up to the convention, prospective students can watch a video prepared by member Samantha Moshier that explains the difference between a Ph.D. and Psy.D., along with a good rationale for some prospective students to consider becoming a research assistant prior to applying to graduate school. Plans are under way to expand our video series. Immediately following the panel, students will be able to meet and greet recruiters from various programs. New this year, we will also have graduate students available to answer undergraduates’ questions. If you are a faculty member seeking students, remember to include your listing in ABCT’s Graduate Mentor Directory. It helps students identify prospective schools and mentors by highlighting the research interest and expertise of the faculty member. Take a look. Your entry is free, and we send you automatic reminders annually for updates.
We are coming into the membership/convention season of ABCT. A very busy and exciting time for your Central Office staff. If you have questions, please do not hesitate to contact us. We value your support and participation. We are committed to making your ABCT experience beneficial and positive. Looking forward to seeing many of you in November.

Until next time!

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LETTER TO THE EDITOR

Transgender Care at the Veteran’s Health Administration: Reply to Lee and Goldstein (2019)

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We were pleased to see Lee and Goldstein’s article “Gender-Affirming Services in Treatment of Transgender Patients: Understanding Gender Variance and Current Issues” in the June 2019 issue of the Behavior Therapist. This article underscored the importance of gender-affirming therapy for transgender and gender-diverse people. This is an essential message for providers who offer treatment to gender minority people, particularly given the structural stigma associated with a DSM-5 diagnosis of Gender Dysphoria (APA, 2013), which can be a prerequisite for medical interventions (e.g., hormone therapy, surgical intervention). The authors also discussed the structural stigma associated with the Department of Defense’s (DoD) “Don’t Ask; Don’t Tell” policy as well as bans of transgender military service.

It is important to recognize that the Veterans Health Administration (VHA) and DoD have separate policies regarding transgender and gender-diverse persons. VHA has never banned treatment for sexual and gender minority veterans. VHA’s Directive (2018), “Providing Health Care for Transgender and Intersex Veterans,” has been in place since 2011 and requires all VHA staff to provide a welcoming and affirming environment. Although transition-related surgical procedures are not included in the medical benefits package, eligible transgender and gender-diverse veterans can receive mental health services, hormone therapy, prosthetic support, vocal coaching, presurgical care and evaluations, and postoperative care for complications of surgery. VHA policy also requires that staff use the veteran’s preferred name and pronouns and that veterans are treated based upon their self-identified gender identity, including room assignments and bathroom use. When challenges arise, each VHA facility has a LGBT Veteran Care Coordinator who can assist the veteran in getting access to care in a gender-affirming environment.

While changes in policy do not immediately change culture, especially in such a large health care system as VHA, most of the literature cited by Lee and Goldstein (2019) as describing transgender veterans’ experiences in VHA relied on data collected soon after the 2011 publication of the directive on care for transgender and intersex veterans and well before educational efforts in best practices for transgender care were under way. Education is essential because very few providers (both within VHA and outside) have ever received professional training in transgender health. Education efforts have included online resources that are available 24/7, including three online courses on transgender health. VHA has also sponsored a more intensive, interactive live training (via video conferencing) on interdisciplinary care for transgender veterans (Kauth et al., 2015; Shipherd et al., 2016), which has been completed by 819 VHA providers at 149 sites. In addition, any VHA provider can access national expert consultation on the treatment plan for a transgender veteran (with the veteran’s consent) through their electronic medical chart (Shipherd, Kauth, & Matza, 2016). To date, 1,192 consults have been completed. This system allows providers who are less experienced
in transgender health and those who are treating complex case to receive an experienced interdisciplinary team’s consultation. Also, every VHA facility now has an LGBT Veteran Care Coordinator who is tasked with assisting sexual and gender minority veterans in accessing affirming care (Kauth & Shipherd, 2016; VHA Directive, 2018). Finally, a recent online survey of lesbian, gay, and transgender veterans who use VHA reported that most transgender veterans felt comfortable discussing their gender identity with their provider (Kauth, Barrera, & Latini, 2018). This study also noted a trend in surveys of LGBT veterans toward respondents feeling more welcome in VHA. Of course, more work is needed.

It is unsurprising that data collected from transgender veterans prior to the implementation of these systemic changes reflected dissatisfaction with VHA services. However, the VHA system is evolving and continuing to strive to be the health care system of choice for all veterans, including transgender veterans.

References

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Navigating Accusations of Sexual Violence: What Everyone Ought to Know and Do

Dean G. Kilpatrick and Christine Hahn, National Crime Victims Research and Treatment Center and Medical University of South Carolina

SEXUAL VIOLENCE (SV) has always been a part of human history and remains a major public health, mental health, criminal justice, and public safety problem in the United States (Black et al., 2011). Few SV cases result in victim/survivors making public accusations (Rennison, 2002), and most receive scant attention, but a few become highly publicized, generally when the alleged assailant or the victim/survivor is a celebrity, politician, or other public figure. High-profile accusations constitute only a small fraction of all SV cases, but they have an outsized impact on public discourse, policy debates, and expectations of other victims/survivors about what will happen if they make an accusation.

When an accusation of SV is made, no fair-minded person argues that the accused should forfeit their constitutional right to the presumption of innocence. Likewise, any fair-minded person agrees that the accuser has equally legitimate rights to fair treatment, protection, and a presumption that they are telling the truth until there is clear evidence that they are not. Unfortunately, there is a long history of treating accusations of SV with great suspicion, assuming that many accusations of SV are false, and believing that many of those making accusations must be “crazy,” vindictive, avaricious, or promiscuous (Edwards et al., 2011). There are also widely held beliefs that well-mannered, normal-looking, accomplished people with good character in other aspects of their lives are unlikely to have committed SV. Further, many SV cases occur when one or both parties have consumed prodigious amounts of alcohol or other drugs (Lorenz & Ullman, 2016), so it is also important to have a better understanding of the impact that such consumption has on ability to consent and memory of what happened. In short, having better information about the true nature of SV and the potential impacts of heavy alcohol and drug consumption is essential to sorting out accusations of SV in a thoughtful way.

Understanding how SV is defined, having accurate information about its scope, nature, the impact that SV has on victims/survivors, and the extent to which many widely held stereotypes and myths about SV are accurate is essential. The purpose of this paper is to: (a) describe public health vs criminal justice approaches towards understanding and addressing SV; (b) review how the subset of SV incidents constituting the crime of rape are defined in the criminal code and the evolution of those definitions over time; (c) present national data about the prevalence and nature of rape and how those data address common stereotypes about rape; (d) discuss the impact of heavy alcohol and/or drug use on capacity to consent and remember what happened during a period of heavy consumption; and (e) suggest steps that everyone can take to address America’s SV problem. This review focuses primarily on SV involving female victim/survivors and male perpetrators, although it is essential to
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remember that not all victim/survivors are girls/women, and not all perpetrators are men (Black et al., 2011).

**Public Health Versus Criminal Justice Approaches Towards Understanding SV**

Two main approaches to understanding, defining, measuring, and addressing SV are (a) the public health approach and (b) the criminal justice approach (Kilpatrick, 2004; National Research Council, 2014). From the public health perspective, SV is defined by the Centers for Disease Control and Prevention (CDC) as “a sexual act committed against someone without that person’s freely given consent” (Basile, Smith, Breiding, Black, & Mahendra, 2014). This definition indicates that SV occurs on a spectrum and includes some incidents that are violations of moral standards, sometimes harmful, but generally not violations of the criminal code (e.g., verbal sexual harassment, verbally pressuring someone to have sex until they give in) as well as incidents that are felony crimes with substantial penalties. The public health approach also emphasizes the physical and mental health consequences of SV, SV prevention, and the recognition that all SV incidents are problematic, harmful, and morally unjustifiable, even if an incident is not a crime.

The criminal justice approach focuses exclusively on SV acts that are violations of the criminal code (e.g., forcible rape [FR]/attempted FR, drug or alcohol-facilitated rape [DAFR]/attempted DAFR, and incapacitated rape [IR]/attempted IR). Although criminal code definitions of these crimes differ across jurisdictions (e.g., Tracy et al., 2012), FR typically involves nonconsent, use of force or threat of force, and some type of unwanted sexual penetration of the victim’s anus, vagina, or mouth. DAFR involves perception by victims that the perpetrator deliberately gave drugs to them and/or tried to get them drunk, and the victim was passed out or awake but too drunk or high to know what they were doing or to control their behavior, and some type of unwanted sexual penetration occurred. In other words, consent in cases of DAFR is impossible because the victim is too intoxicated or incapacitated to be capable of consenting. IR cases involve situations in which the victim voluntarily consumed alcohol or drugs, was too intoxicated or impaired to be capable of giving consent, and sustained some type of unwanted sexual penetration. Most criminal code definitions of FR, DAFR, and IR define attempted rape as an incident in which the perpetrator is unsuccessful in obtaining nonconsensual sexual penetration. A simplified way of describing these criminal code definitions is that rape/attempted rape is having or attempting to have sex with someone who doesn’t say yes, is forced to say yes, or isn’t able to say yes because she is too intoxicated or incapacitated to be capable of saying yes.

**The Lingering Impact of Historical Rape Laws on Evaluating Rape**

In contrast to the views of many, “sex crimes law derives from a historical background of bias against women” (Tracy et al., 2012, p. 4), and “this historical view of rape and its categorization as a property crime also perpetuated the belief that women lie about being raped” (Tracy et al., p. 5). Tracy and colleagues note that several rules and requirements applied only to rape cases and not to other types of violent crimes (e.g., requiring prompt reporting, physical injuries, examination of victim’s sexual history and character, and cautionary instructions by the judge that called for extra scrutiny of the victim’s testimony and allegations). Cautionary instructions were derived from influential 17th century English jurist Lord William Hale, who presided over witch trials and also thought that jurors were inclined to believe allegations of rape and that women often made false accusations of rape. He concluded that protection of defendants’ rights required that women’s testimony that they were raped be given special scrutiny. Laws in most states in the U.S. required judges to give jurors these cautionary instructions: (a) rape is a charge that is easily made; (b) rape is a charge that is difficult for the defendant to disprove; and (c) the testimony of the victim requires more careful scrutiny than testimony of other witnesses in the trial (Morris, 1988). Such cautionary instructions do not exist for other types of crimes, so this is an example of a special bias in the legal system against women who allege they have been raped. Although cautionary instructions have been removed from the laws of most states, this legacy lives on. There is still intense skepticism of women who make accusations and a strong belief in many quarters that men accused of rape are so vulnerable that they deserve special treatment that is not afforded to those accused of other crimes.

**Stereotypes About Rape: What Do the Data Say?**

The APA Dictionary of Psychology defines stereotype as follows: “A set of cognitive generalizations (e.g., beliefs, expectations) about the qualities and characteristics of the members of a group or social category. Stereotypes simplify and expedite perceptions and judgments, but they are often exaggerated, negative rather than positive, and resistant to revision even when perceivers encounter individuals with qualities that are not congruent with the stereotype” (VandenBos, 2007). If stereotypes about rape are based on inaccurate data, this can influence how accusations of rape are evaluated. Here are common stereotypes about rape: rape is rare; rape only happens to adults; assailants are typically strangers, not people you know; most rapes are reported to police; most rape victims sustain substantial physical injuries; rapes not involving substantial force or threat of force have minimal impact on victims’ mental health; and many innocent men are falsely convicted and incarcerated due to false accusations (Edwards et al., 2011; Lonsway & Fitzgerald, 1994).

**Victimization Survey Data Addressing Rape Stereotypes**

To examine stereotypes about rape, data are needed about all rape cases, not just cases reported to police or from victims who seek services. The best source of information including all cases is a victimization survey. Briefly described, this involves locating a probability sample of the population of interest and interviewing respondents about potential rape experiences using behaviorally specific questions measuring the legal elements of the crime (Kilpatrick, 2004; Kilpatrick, 2010; National Research Council, 2014); thereafter, data about case characteristics are obtained. Some surveys also gather data about post-traumatic stress disorder (PTSD) and related disorders, whether victims sought health or mental health services, and victim concerns. Due to stigma attached to rape and concerns about disclosure and being blamed (Kilpatrick et al., 2007; Weiss, 2010; Zinzow & Thompson, 2011), so many individuals are reluctant to disclose these experiences. Maximizing privacy and confidentiality during data collection is essential.

Our research group conducted five large national victimization surveys, two of which were with national household probability samples of adult women 18 years and older (i.e., the National Women’s Study
[NWS] and the National Women’s Study-Replication [NWS-R]). These surveys were funded by the Centers for Disease Control and Prevention, National Institute on Drug Abuse, and National Institute of Justice, and more than 7,000 adult women were surveyed.

We will examine the accuracy of rape stereotypes using data primarily from the NWS and NWS-R. The methodology is described in detail elsewhere (Kilpatrick et al., 2007; Kilpatrick, Edmunds, & Seymour, 1992; Kilpatrick & Resnick, 2012; Resnick et. al., 1993), but the NWS interviewed a national household probability sample of 4,008 U.S. adult women from 1989–1991, and the NWS-R interviewed 3,001 U.S. adult women in 2006. The NWS survey measured only FR, but the NWS-R survey measured DAFR and IR as well as FR. Each type of rape had unwanted anal, oral, or vaginal sexual penetration. Data were gathered about lifetime rapes and rapes that occurred within the past year. Unless otherwise noted, data addressing rape stereotypes are from invited testimony given at a U.S. Senate Committee on the Judiciary Subcommittee on Crime and Drugs hearing titled Rape in the United States: The Chronic Failure to Report and Investigate Rape Cases (Kilpatrick, 2010), the NWS-R, and a paper describing changes over 15 years from the NWS to the NWS-R (Kilpatrick & Resnick).

Stereotype One: Rape Is Rare

The lifetime prevalence of FR was 13% in the NWS and 16% in the NWS-R, an increase of 27% in the lifetime prevalence of FR over the 15 years between these two surveys. Based on the NWS-R FR estimate and 2005 Census data on the number of adult women in the U.S. population, approximately 18 million female adults in the U.S. had experienced a FR. Past-year FR prevalence was 0.71% in the NWS and 0.74% in the NWS-R. Lifetime prevalence of DAFR and IR in the NWS-R was 5%, and past-year prevalence was 0.42%. Lifetime prevalence of any rape in the NWS-R was 18%, indicating that approximately 20.2 million adult women in the U.S. have been victims of rape. Past-year prevalence of any rape in the NWS-R was 0.94%, indicating that approximately 1.1 million adult women in the U.S. are raped each year.

These findings were confirmed by findings from the CDC National Intimate Partner and Sexual Violence Survey that reported a lifetime prevalence of rape or attempted rape of 21% and a past-year prevalence of 1% (Smith et al., 2018). Findings consistently indicate that rape is far from rare. It happens to about one woman in five throughout her lifetime and to more than 1 million adult women every year. Based on these data, stereotype one is clearly not accurate. Given the magnitude of our rape problem, it is also clear that a large number of assailants must be out there to have committed so many rapes.

Stereotype Two: Rape Only Happens to Adults

Both the NWS and the NWS-R found that most FR cases happened before victims were age 18 (62% in the NWS and 55% in the NWS-R). NWS-R estimates were that 30% of all DAFR/IR cases happened when victims were under age 18. The CDC survey reported that 43% of the first rapes/attempted rapes happened before age 18 (Smith et al., 2018). Clearly, this stereotype is not accurate. Female children and adolescents are at risk of being raped, and it should not be viewed as an anomaly if a girl says she was raped or if a woman says she was raped when she was a girl.

Stereotype Three: Most Assaulters Are Strangers

Both the NWS and the NWS-R found that strangers, defined as someone the victim had never seen before or did not know, were a small fraction of all assailants in FR cases (22% in the NWS and 11% in the NWS-R). More than 8 out of 10 DAFR/IR cases in the NWS-R involved assailants known well by the victim. This stereotype is exceptionally inaccurate because the vast majority of assailants are someone the victim knows. When a woman says she was raped by someone she knows, this is the norm, not something that should raise suspicion because it was not a stranger. Also, concerns about the lack of reliability of eyewitness identifications have little relevance when the victim is identifying someone she already knows.

Stereotype Four: Most Rapes Are Reported to Police

Both the NWS and the NWS-R found that only a small percentage of FR cases were reported, 16% in the NWS and 18% in the NWS-R. Although there was a small increase in reporting over the 15 years between the two surveys, 82% of the FR cases were still unreported. Reporting was even lower for DAFR/IR cases; only 10% were reported. This stereotype is clearly not supported by data, and the low reporting rate is concerning. It is essential to identify why victims are so reluctant to report.

Stereotype Five: Most Rape Victims Sustain Substantial Physical Injuries

In most FR cases, victims received either no physical injuries (70% in NWS and 48% in NWS-R) or only minor physical injuries (24% in NWS and 34% in the NWS-R). Serious physical injuries were rare (4% of FR cases in the NWS and 16% in the NWS-R). DAFR/IR cases were even less likely to produce serious physical injuries (only 6% in NWS-R). Seventy percent of these cases resulted in no physical injuries, and 23% sustained only minor injuries. This stereotype received no empirical support. This is quite important because the expectation is that women who are really raped are obligated to put up fierce resistance that causes substantial injuries. If victims are not physically injured, many assume that their allegation is false.

Stereotype Six: Rapes Without Substantial Force or Threat of Force Do Not Produce Mental Health Harm

The NWS-R found that FR, DAFR, and IR all substantially increased risk of several mental disorders, including PTSD and major depression. Lifetime PTSD was higher among victims versus nonvictims of FR (40% vs 15%), DAFR (46% vs 16%), and IR (39% vs 16%). The same was true for past 6-month PTSD among FR victims (24% vs 6%), DAFR victims (29% vs 8%), and IR victims (26% vs 8%). Lifetime prevalence of major depression among FR, DAFR, and IR respectively were 34%, 33%, and 34%. Past 6-month prevalence of major depression among FR, DAFR, and IR victims respectively were 24%, 27%, and 27%. These data suggest that DAFR and IR are equally harmful with respect to risk of PTSD and major depression, so this stereotype is not supported. DAFR and IR are not lesser forms of real rape with respect to mental health harm. Also, more than one out of four rape victims had current PTSD or depression, documenting substantial unmet mental health treatment needs.
Stereotype Seven: False Accusations of Rape Often Result in Innocent Men Being Falsely Convicted and Incarcerated

Evidence indicates that this stereotype is not supported by data (Lisak et al., 2010). Prior to specifically addressing false allegations per se, it is important to provide context by discussing the massive attrition that results in only an extremely small fraction of all rape cases resulting in guilty verdicts and incarceration. As previously noted, victimization survey data from the NWS-R indicate that 10% of DAFR/IR cases and 18% of FR cases were reported to police. Using a conservative estimate that 1% of adult women experience a rape or attempted rape each year, we project that approximately 1.27 million of the 127 million adult women in the U.S. are raped each year. Based on NWS-R findings, approximately 30,000 of these women were raped more than once per year, so there are approximately 1.3 million rape cases per year, 471,100 of which were DAFR/IR and 829,000 of which were FR. The combined reporting rate for all FR and DAFR/IR cases was 15.1%, so we project that approximately 196,300 of the total 1.3 million rape cases were reported.

Few studies track what happens to rape cases after they are reported, but a recent NIJ-funded project did so in six jurisdictions over a 3-year period (Morabito, Williams, & Pattavina, 2019). Only 544 cases out of 2,887 sexual assault cases reported by female victims to law enforcement resulted in arrests (19.2%); charges were filed in only 363 cases (12.6% of all reported cases); only 189 cases resulted in guilty verdicts (6.5% of all reported cases); and only 164 of those with guilty verdicts were incarcerated (6.3% of all reported cases). If we apply these attrition estimates to the NWS-R estimates of rape cases described above, we project that arrests occur in approximately 37,690 cases (2.9% of all 1.3 million rapes), and charges would be filed in approximately 24,734 cases (1.9% of all 1.3 million rapes). Only 12,760 cases result in guilty verdicts (less than 1% of all 1.3 million rape cases), and only 12,367 result in incarceration (.00951% of all 1.3 million rapes). In other words, only 9.51 cases per 1,000 rape cases result in incarceration, so cases in which defendants are exonerated due to deliberate false allegations has to be a small fraction of this small fraction of all cases.

Having established the massive magnitude of the guilty-assailants-go-free problem, what about the false allegation problem? Many define that term as meaning that someone deliberately fabricated an account of an event that never happened. However, it can also mean that the gist of what the person described was true, but a portion of it turned out not to be accurate (e.g., a rape actually occurred, but the victim mistakenly identified the wrong person as the assailant). How to determine whether an allegation is false is challenging. Is an allegation false if there is insufficient evidence to meet the probable cause standard to make an arrest? How about if evidence isn’t sufficient to obtain a criminal conviction, which requires meeting a guilt beyond a reasonable doubt standard? In both these situations, the fact that there was not sufficient evidence to arrest or convict does not mean that allegations were false. In other

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words, it is not appropriate to conclude that an allegation is false solely on the basis of failure to report, lack of an arrest, failure to prosecute, or failure to obtain a conviction. Likewise, anecdotes about a few high-profile cases in which false accusations were apparently made demonstrate that false allegations are possible but do not constitute systematic data about the prevalence of the false allegation problem.

Since 1989, the National Registry of Exonerations (NRE; https://www.law.umich.edu/special/exoneration/Pages/browse.aspx) has compiled a systematic database of cases in which defendants have been convicted of major crimes and then cleared of all charges. As of March 26, 2019, there are 2,413 exonerations in the NRE database, 323 of which are exonerations of men convicted of sexual assaults of adults. For each case, the NRE identifies whether five non-mutually exclusive contributing factors were involved in the exoneration. Out of the 323 documented sexual assault exoneration cases since 1989, here is the breakdown of contributing factors: mistaken identity (n = 217; 67%); perjury or false accusation (n = 135; 42%); official misconduct (n = 123; 38%); false or misleading forensic evidence (n = 97; 30%); and false confession (n = 27; 8%).

These data have several important implications. First, it is noteworthy that 323 documented cases of exoneration over a 30-year period is an extremely small proportion of the extremely small proportion of all rape cases each year that result in guilty verdicts and incarceration (i.e., approximately 9.51 cases per 1,000 total rapes). Admittedly, the actual number of defendants who have been falsely convicted is likely much greater than those who have been officially exonerated, but even if the number was 10 times higher (i.e., 3,230), this would be a tiny fraction of all defendants currently incarcerated for sexual assault in the U.S. (n = 165,000; Wagner & Sawyer, 2018), not to mention the more than a million new rape cases that have occurred each year over the past 30 years. Second, two thirds of exoneration cases resulted from mistaken identification of the defendant, a situation that is unlikely to occur in the 80%-plus of all rape cases in which the victim knows who the assailant is before the rape happens. Third, perjury or false allegation was a factor in only 135 documented sexual assault exonervations over a 30-year period, or an average of 4.5 per year.

It is also highly likely that well-documented racial and economic disparities in criminal justice system treatment of racial minority and poor versus rich defendants is a serious disadvantage to minority defendants without the resources to mount a vigorous, expensive public relations and legal defense that only rich defendants can afford. In particular, the NRE data indicate that African-Americans are stranded by witnesses of a different race is a major factor in exonerations (Gross, Possley, & Stephens, 2017).

Fourth, by any measure, the problems of nonreporting, failure to make arrests, failure to indict, and failure to obtain convictions related to SV occurs far more often than false allegations. Nevertheless, it is a tragedy when any innocent man is falsely accused and convicted of rape, but it is an equal tragedy when a rape victim is not believed, does not get justice, and guilty rapists go free because we incorrectly believe that it is common for victims to make false allegations.

The Impact of Heavy Alcohol and/or Drug Use on SV

By definition, DAFR and IR cases occur when the victim has either involuntarily or voluntarily consumed a sufficient amount of substances to render him or her too impaired or incapacitated to consent. Many DAFR, IR, and FR cases happen when both parties have consumed large amount of alcohol or other drugs. When allegations are made, having a clear memory of what happened is important for the victim, and it is equally important for the person accused of rape to recall the event in order to refute the charges.

Alcohol consumption influences central nervous system functioning. When consumed in large amounts, alcohol can affect memory, causing alcohol-induced memory blackouts (Goodwin, 1995; Hingson, Zha, Simons-Morton, & White, 2016). Blackouts occur during periods of heavy alcohol consumption and consist of total or partial amnesia for behaviors engaged in during that period because events cannot be encoded into long-term memory and cannot be recalled at a later time. Blackouts may be total, in which the person has no memory for anything that happened during the period of heavy drinking, or partial, in which the person has fragmentary gaps in memory for what happened during the period of heavy drinking. During a blackout period, the person is ambulatory and may be moving and conversing with other people, but is not passed out. Also, during the drinking episode, people can remember things for a few minutes, but events are not coded into long-term memory. Blackouts only occur at high blood alcohol concentration (BAC) levels, but not everyone with high BAC levels experiences blackouts (Hingson et al., 2016). Blackouts are most likely to occur during periods of high-intensity binge drinking when BAC levels increase rapidly.

Many teens and young adults have patterns of alcohol consumption sufficient to produce high BAC levels. The Monitoring the Future survey of U.S. high school seniors reported that 10.5% had consumed 10–14 drinks on at least one occasion and 6% had consumed 15 drinks or more in the past 2 weeks (Patrick & Schulenberg, 2014). The 2017 National Survey on Drug Use and Health (Center for Behavioral Health Statistics and Quality, 2018) found that 25% of Americans 12 and older were binge drinkers. This included 5% of adolescents and 37% of young adults between the ages of 18 and 25, and it is reasonable to assume that any binge drinker is at some risk for experiencing a blackout. Hingson and colleagues (2016) provide extremely relevant data about blackouts in a national cohort of young adults 1 year post high school. Fourteen percent of all respondents and 20% percent of the 68% who had consumed any alcohol within the past 6 months had experienced a blackout. Binge drinking within the last month occurred among 41% of the entire sample and among 75% of those who consumed any alcohol. Blackouts were a high specificity marker for many other alcohol-related problems including hangovers, getting behind in school or work, doing something that they regretted later, arguments with friends, and seeing a doctor for an overdose. Independent predictors of blackouts were frequency of being drunk, female gender, age when first drunk, and frequency of binge drinking.

In summary, binge drinking and blackouts are not rare, so blackouts may be a factor in memory problems often associated with rape allegations that involve heavy drinking by one or both parties. Complete or partial blackouts could account for a victim’s poor memory for details of what happened but can also account for the accused not recalling having made unwanted sexual advances to someone who could not or did not consent. In situations with a credible accuser and a credible defendant exhibiting righteous indignation over having been accused, a blackout in the latter is one of the few ways to make sense of this discrepancy.
What Can We Do to Address America’s SV Problem?

Despite increased awareness of SV prevalence, rates of SV have not significantly decreased, and the majority of SV victims do not access health services or report SV to law enforcement (Black et al., 2011; Kilpatrick et al., 2007; Smith et al., 2018). Addressing SV requires a fundamental change in which everyone takes responsibility for creating a culture that acknowledges incidents of SV for what they are, supports people who disclose SV, and understands that it is everyone’s responsibility to discourage acts that promote SV. Alcohol or other drugs are involved in the majority of incidents of SV (Lorenz & Ullman, 2016), so it is essential to address the intersection of substance use and SV because this poses great risk of victimization for women and of committing a criminal act for men who fail to get true consent. There is also a critical need to improve investigation and prosecution of SV cases involving DAFR/IR (Scalzo, 2007). Finally, there is an urgent need for coordinated, systematic, and integrated programming efforts across education, health care, and criminal justice systems to respond to this public health crisis.

Based on a meta-analysis of 5,917 women who had an experience meeting the legal definition of rape, 60% did not label what happened as rape (Wilson & Miller, 2016). Nonacknowledged SV is especially problematic because not believing SV is serious enough to report is a primary reason women do not seek services following SV (Kilpatrick et al., 2007), despite post-rape PTSD, depression, alcohol misuse, and sexual revictimization being associated with nonacknowledged SV (Blayney, Hequembourg, & Livingston, 2018; Littleton, Axsom, & Grills, 2009; Wilson & Miller, 2016). Public education about the legal definitions of SV, particularly DAFR and IR, are needed so people and communities identify rape as a crime.

Victims of SV must disclose to others in order to receive tangible and emotional support. The primary reasons people do not disclose incidents of SV to mental health and medical professionals, law enforcement, and social support are concerns of people learning about the SV, shame, and fear of being blamed and not believed (Cohn et al., 2013; Weiss, 2010; Zinzow & Thompson, 2011). The public can help mitigate the impact of SV on survivors because, unlike formal support (e.g., law enforcement; medical professionals), most victims tell at least one person they know about SV (Kilpatrick et al., 2007). The best thing for people to do during SV disclosures is to communicate belief that the SV is not the person’s fault and recognize the profound impact of SV (RAINN, 2019). The public needs to be educated on effective responses to disclosures of SV, especially SV that involves substance use, because normalization of heavy drinking and sexual behaviors while intoxicated in American culture may result in mislabeling SV as relatively harmless “drunken sex” as opposed to a morally unacceptable criminal act. Moreover, drunkenness is rarely a successful defense in criminal cases, so teaching men that they engage in excessive alcohol consumption at their own peril is essential. This type of education has the potential to not only reduce the risk of SV victimization for women but also to reduce the risk of SV perpetration for men who misread cues and think an
unwilling woman is consenting when she is not or could not consent. As the old rape prevention saying goes, "If you had to guess, she didn’t say yes!"

A crucial step to combating SV in America is promoting the message that SV is unacceptable and that everyone must be actively involved in preventing and responding to SV. Misogynistic statements and behaviors are not simply "locker room talk"; they serve to maintain and excuse SV. Rape myth acceptance, adherence to traditional gender roles, and exposure to misogynistic peer messages are associated with SV perpetration (McNaughton Reyes et al., 2015), less willingness to intervene when witnessing SV (Leone & Parrott, 2018; McMahon, 2010), and greater risk of misperceiving women’s behavior as sexual interest (Jacques-Tiura, Abey, Parkhill, & Zawacki, 2007). Instead of focusing on individual factors that increase risk for perpetration and victimization, we should emphasize changing rape-supportive social norms that occur at a community level.

There is compelling evidence that educational messages about SV and bystander-based intervention are associated with changes in attitudes, increased willingness to intervene when witnessing SV, and reduced rates of SV (Coker et al., 2016; Jouriles et al., 2018). Initiatives to address SV must target adolescents and integrate education on safe-sex practices, consent, and substance use during sexual activity. In 2017, 40% of high school students reported having sex, and 19% had used substances during the last time they had intercourse (CDC, 2018). Continued efforts should be placed on empowering youth to form peer groups with healthy norms related to sex and substance use, make thoughtful decisions regarding their own sexual and substance use behaviors, discuss sexual activity with partners, and acknowledge that incidents of DAFR/IR are crimes, not simply regretted sexual experiences.

The CDC and NIH have made several recommendations that educational, health care, and legal systems can take to combat SV (Dills, Fowler, & Payne, 2016; Kilpatrick et al., 2007). Many of these recommendations are relevant for behavioral therapists, including: promoting trauma-informed care among a range of personnel that interact with SV victims and perpetrators including judges, police, mental health providers, and educators; implementing health screening for SV in health care settings; increasing access to anonymous reporting options and free post-assault medical services; and improving access and efficacy of secondary prevention of post-assault mental health outcomes.

**Conclusions**

Russian author Leo Tolstoy said, "Everyone thinks of changing the world, but no one thinks of changing himself." Addressing America’s SV problem requires each of us to change by educating ourselves about SV, applying what we know when allegations of SV are made, and recognizing that the criminal justice system is designed primarily to protect the rights of the accused, not the rights of victims. We must not tolerate a rape-supportive culture or anyone who has sex with someone who does not or cannot consent. We must extend our sense of due process, fair play, and justice to the accused as well as the accused. We must recognize that committing SV is morally wrong even if it is not a crime or if evidence is insufficient to obtain a criminal conviction. Institutional systems have historically supported rape stereotypes, rape culture, traditional gender norms, and a criminal justice system that remains particularly biased against rape victims. We must use research data to guide individual, system, and community responses to SV allegations.

Mainly, everyone should remember that (a) one in five women experience rape that predominantly occurs during adolescence and emerging adulthood; (b) most people do not report SV to law enforcement or seek services immediately following SV due to legitimate barriers, especially the lack of acknowledgment of SV, fear of being blamed, and fear of being not believed; (c) false allegations of SV, although tragic when they do occur, are rare and typically involve misidentification in stranger rape cases, which are far less common than rape perpetrated by known assailants; (d) the majority of people who experience SV tell at least one person about it and responding to a disclosure of SV by communicating that it is not the person’s fault could decrease chronic mental health problems related to SV that ultimately increase public health care costs; (e) alcohol or other substances are involved in the majority of incidents of SV and DAFR/IR result in similarly high rates of PTSD and other mental health outcomes compared to physically forced rape. All adolescents should receive education on SV, providing information that debunks rape myths, challenges traditional gender norms, and creates healthy peer norms related to sexual consent and substance use. Finally, we must quit making excuses for those who do not obtain freely given consent, however accomplished they may be in other aspects of their lives.

**References**


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Disquiet in Nosology: A Primer on an Emerging, Empirically Based Approach to Classifying Mental Illness and Implications for Training

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Prevailing Mental Health Nosologies: A Caution
Paul Meehl (1986) warned more than 30 years ago of a “scientific malignancy” worth recalling: the tendency by some to reify diagnoses, as though the criteria that operationalize a disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM; APA, 2013) describe its essence. Diagnoses, instead, are open constructs.¹ Most of us, when pressed, easily acknowledge the difference. The core motivation behind the National Institute of Mental Health’s Research Domain Criteria (Cuthbert & Insel, 2013) underscores this point. Yet when not pressed, too often the criteria can slip into becoming the disorder. It would be unfair to blame DSM for this habit (cf. Kraemer, Kupfer, Clarke, Narrow, & Regier, 2012), yet its operationalization of criteria risks making us forget that articulating a useful mental health nosology remains ongoing.

Prevailing classification approaches have other problems. Disorders are presumed distinct, yet the predominance of comorbidity raises obvious questions about the validity of their borders (e.g., Brown, Campbell, Lehman, Grisham, & Mancill, 2001; Kessler, Chiu, Demler, & Walters, 2005; Ormell et al., 2015; Teesson, Slade, & Mills, 2009). Or, categories can have marked heterogeneity, such that two individuals with the same diagnosis have entirely different sets of symptoms (Clark, Watson, & Reynolds, 1995; Hasler, Drevets, Manji, & Charney, 2004; Zimmerman, Ellison, Young, Cheilinski, & Dalrymple, 2015). Reliability is often too low (Chmielewski, Clark, Bagby, & Watson, 2015; Regier et al., 2013), and evidence overwhelmingly suggests psychopathology falls along a continuum, with no clear zones of rarity (Wright et al., 2013). Finally, it is not always clear from surveys how clinically useful clinicians find the prevailing nosology beyond its relevance for billing (First et al., 2018).

Despite these concerns, nosology remains foundational for anyone whose work intersects with mental health (Blashfield & Burgess, 2007). At minimum, it gives us a lingua franca to talk about symptoms and how they present. But ideally it would do so much more: it would guide our treatments, forecast the course of illness, and create a foundation for research into the causes of illness (Mulholl-Sweatt, Lengel & DeShong, 2016). For students in training, DSM’s lexicon, and the assumptions behind it, get woven into their curriculums and shape conceptualizations of psychopathology (e.g., Amazon ranks DSM second in psychology reference books, only behind the American Psychological Association’s style manual).

Next-Generation Approach
DSM’s hegemony over classification has overshadowed an accelerating body of research happening in the wings of mental health, largely driven by psychologists: quantitative nosology. At its core, this approach creates a data-driven, empirically based classification. It starts with diverse arrays of highly homogenous signs and symptoms of mental health problems (e.g., dysphoric mood). Statistical procedures like factor analyses and hierarchical agglomerative clustering are then used to organize elements into increasingly more heterogeneous, higher-order constructs based on patterns of association.

This method is hardly new: Thomas Moore in the 1930s analyzed the intercorrelations among 32 signs and symptoms related to psychosis to understand how they could be more parsimoniously grouped into higher-order factors. Many others, notably Achenbach and colleagues (Achenbach, 1966; Achenbach, Ivanova, & Rescorla, 2017), followed suit with increasing sophistication and precision (Kotov, 2016).

The most recent large-scale effort in this movement toward empirically based classification emerged in the spring of 2015. Forty scholars working in the area of quantitative nosology started a consortium (now close to 100 members) devoted to articulating an empirically based quantitative nosology of mental illness. Their initial proposed model—the Hierarchical Taxonomy of Psychopathology (HiTOP; Kotov et al., 2017)—provides a marked departure from nosology systems like DSM.

HiTOP: A Primer
HiTOP’s empirically based model remains a work in progress (remember Meehl’s admonitions!) and the consortium is actively working to revise the model as new evidence emerges (Krueger et al., 2018), but major, replicated contours of this nosology are already clear. The model is hierarchical, with homogenous signs, symptoms, and traits at the bottom. There are over 100 of these dimensions, and they consist of symptom components, such as insomnia, and traits, such as submissiveness. These are organized into higher-order components that are increasingly broad until one reaches what is called the spectra level—of which there are six (i.e., Internalizing, Somatoform, Thought Disorder, Disinhibited Externalizing, Antagonistic Externalizing, and Detachment). Above this, one can aggregate higher all the way up to a general factor (i.e., so-called “p-factor;” Caspi et al., 2014). Figure 1 presents portions of the model, reprinted and revised with permission.

How does this differ from the DSM? With traditional nosology, symptoms related to depression, generalized anxiety disorder, and social phobia, to take one example, constitute three putatively distinct categories of mental illness. In contrast, with HiTOP they all fall under the rubric of an internalizing spectrum. A provider can focus on this higher-level spectrum, recognizing that all three syn-

¹This can be debated, of course (see Wakefield, 2004).
dromes share elements. Or, one can cascade down the model, with, for example, depression and generalized anxiety symptoms coalescing under a “distress” subfactor and social phobia hewing more closely to a “fear” subfactor. Or one can cascade even further down, focusing on highly homogenous symptoms or traits, such as suicidality.

Unlike DSM, HiTOP does not delineate a “one size fits all” boundary between “illness” and “not illness,” a feature supported by years of taxometric research (Haslam, Holland & Kuppens, 2012). Rather, clinical decisions are guided by ranges of severity on each dimension of the model. Until work validates these in different populations, they can remain statistical (e.g., 2 SD below the mean), such as with intelligence testing, or can be tailored to the needs and resources available within a given setting or population. Kotov et al. (2017) reviews evidence supporting the model, while Ruggero et al. (2018) provides a description of its integration into clinical care.

**HiTOP May Advance Research and Treatment**

HiTOP proposes to accelerate mental health research (Conway et al., 2019). Use of continuous dimensions, as opposed to categories, has well-known benefits for statistical power of research to detect effects (Cohen, 1983). Compared to categorical phenotypes, dimensional ones double the power to predict a variety of clinical outcomes (Kotov et al., 2019) and produce more “hits” in genetic research (Otowa et al., 2016), for example.

But the hierarchical structure in and of itself provides a novel framework for pursuing pathophysiologicals. Mechanisms, or outcomes, may operate at different levels of this mental illness hierarchy, from broad and diffuse effects to more narrow and specific ones. HiTOP’s hierarchy provides one map to different levels that may be relevant, and at minimum new phenotypic targets on which to test proposed mechanisms. Already, work in genetics, neurobiology, and psychosocial contexts point to how recent findings in these fields may better align with models like HiTOP compared to traditional nosology (Conway et al., 2019).

HiTOP also proposes potentially greater clinically utility (Ruggero et al., 2018). Dimensions are more reliable than traditional categories (e.g., 15% increased reliability in meta-analyses; Markon, Chmielewski, & Miller, 2011) and may be preferred over categories by clinicians (Morey, Skodol, & Oldham, 2014). Moreover, HiTOP higher-level spectra may have increased diagnostic power, for example predicting suicide attempts, future psychopathology and other clinical outcomes more than disorder-specific variation alone (Eaton et al., 2013; Kim & Eaton, 2015). HiTOP may also better align with treatment planning. Early evidence suggests clinician-prescribing practices track more closely to a HiTOP-based model compared to a DSM one (Waszczuk et al., 2017). Similarly, emerging transdiagnostic approaches to the treatment of mental health (e.g., Barlow et al., 2017) align well with HiTOP’s conceptualization of upper-level spectra that share features and potential etiologies. Finally, HiTOP provides flexibility to adapt clinical ranges based on their purpose.

![HiTOP model](image_url)

**Fig. 1.** HiTOP model (reformatted and revised with permission from Kotov et al., 2017). Note. Not all of the model components, traits and related disorders are presented.
rather than requiring one-size-fits-all cut-offs common to DSM, removing from nosology their reification that are not empirically based (e.g., five of nine symptoms because five is more than half). None of these advantages guarantee HiTOP’s clinical utility, but they provide impetus for testing its utility and tackling the major challenge of training students on this new nosology.

Training Implications

A caution against casually introducing any new nosology, particularly one based on dimensions, would be its implications and cost for training given the major investment already made in the use of DSM (First et al., 2005). Although a major concern for fields less accustomed to dimensional models (e.g., psychiatry), students in psychology are already well-trained in working with conceptualizations and measures consistent with HiTOP (e.g., MMPI-2-RF, NEO-PI-3, PAI; Ben-Porath & Tellegen, 2008/2011; Costa & McCrae, 2010; Morey, 2007). Nevertheless, a shift toward HiTOP would impact courses related to foundational knowledge (i.e., psychopathology, assessment, and treatment planning), as well as functional competencies in the application of HiTOP via practicum and internship or residency experiences.

We field tested training in HiTOP at one of the author’s (JLC) own universities to better appreciate the feasibility of weaving HiTOP into foundational parts of a curriculum. An assessment instructor (JLC) spoke with two members from the HiTOP consortium (RK and CJR) about the model. They provided training material, including slides for instruction. The instructor then developed curricular components for the three foundational knowledge areas. During the psychopathology component, the HiTOP model was overviewed in class after introduction of DSM. During the structured interviewing component, challenges of a DSM approach to assessment and case conceptualization were presented, including concerns about reliability, heterogeneity, and comorbidity. The HiTOP model was presented as an emerging alternative that resolved some of these problems, although remained untested with respect to its clinical utility. The lecture component concluded by overviewsing a list of measures routinely taught in the course and used in practicum that are consistent with a HiTOP approach to case conceptualization. Finally, during treatment planning instruction, the HiTOP model was briefly reviewed, again drawing some content from the expert slides, before engaging in hypothetical clinical decision-making exercises (e.g., using the HiTOP framework to identify the salient spectra that will become the focus of a transdiagnostic treatment; e.g., Barlow et al., 2017; Lundhal, Kunz, Brownell, Tollefon, & Burke, 2010).

Integration of HiTOP into these training components was seamless from the instructor’s perspective and end-of-course satisfaction evaluations suggest the material was well-received by students. Foundational HiTOP knowledge was assessed as part of the midterm exam in the assessment course with all students meeting the threshold for at least adequate accuracy (70% or greater). Sequencing of HiTOP’s introduction (first psychopathology, then assessment, and finally treatment planning) flowed intuitively and was consistent with the larger curriculum. Given that the model includes many DSM-like constructs, albeit broken into smaller (symptom component) or larger (spectra) units in a hierarchical fashion, it was feasible to teach students the DSM categories for practical and perhaps temporary purposes, while familiarizing them as well with evidence-based hierarchical models.

Finally, it is common for students to learn how to apply cut scores along recognized continua, such as with IQ or use of T-scores common to many measures. Thus, students were taught to think about diagnostic cut scores for psychopathology diagnosis in the same way: diagnostic thresholds are indicators not of people who can be classified as qualitatively different from the healthy, but of relative severity on continua that suggest varying need for treatment. These experiences remain anecdotal, but they demonstrate the feasibility of weaving HiTOP training into existing psychology program curriculums. Importantly, this exercise found that HiTOP training could be integrated without major cost (from additional texts or new measures) and without radical changes to the core curriculum.

Conclusions

How we classify mental illness is foundational for psychologists, carrying profound implications for the research and treatment of mental illness, as well as training of future psychologists. Prevailing approaches lack the empirical support often called for (Krueger et al., 2018) and suffer shortcomings, including reification, less than desired reliability, and questions about the validity of proposed categories. Quantitative nosology generally, and HiTOP as the latest synthesis of these models in particular, offers a departure from prevailing nosologies, with arguably more empirical support. Dimensions, not categories, are organized hierarchically. This new model’s flexibility provides novel targets and a powerful framework for research, and may better align with treatment. Training remains a challenge for the broader mental health field, but HiTOP can already be integrated intuitively into psychology training curriculum.

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It is with sadness that we inform you that David Teisler, our Director of Communications and Deputy Director, lost his wife, Mary Anne, to cancer August 6. We know that many of you have worked with David in the past and thought you might be interested to know that friends have established a [GoFundMe](https://www.gofundme.com/TeislerFund) account. If you are so inclined to make a donation, here is the link: [https://www.gofundme.com/TeislerFund](https://www.gofundme.com/TeislerFund)
Introducing an Adolescent Emotion Dictionary: Preliminary Clinical Utility of an Adapted “Ways to Describe Emotions” Handout Series for Dialectical Behavior Therapy for Adolescents

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A CENTRAL FEATURE of borderline personality disorder (BPD) is emotional dysregulation (Linehan, 1993). Dialectical Behavior Therapy (DBT) was created to address the core symptoms of BPD in adults (Linehan, 1993). One primary component of this intervention is improving emotional competence—that is, identifying, experiencing, and regulating emotions. In fact, one of the four didactic-skill modules (Emotion Regulation) in the adult DBT model is dedicated to this purpose (Linehan, 2014). For adolescents participating in a DBT skills group, the “Ways to Describe Emotions” handouts (Emotion Regulation Handout 6; Linehan, 2014, pp. 214–223) aid in the recognition of prompting events, internal experiences and body sensations, cognitive interpretations, and action urges associated with 10 common emotion “families”: anger, fear, disgust, envy, jealousy, happiness, love, sadness, shame, and guilt (Linehan, 2014). The content of these handouts was developed, in part, from results of a cluster analysis that identified common emotions and emotional experiences (Shaver, Schwartz, Kirson, & O’Connor, 1987) and nicely map onto other content within the Emotion Regulation skills module (e.g., model of emotion; Linehan, 2014).

Within our DBT clinic, this 10-page collection of handouts has become colloquially known as the “Emotion Dictionary” and is regularly reviewed and shared with clients at various stages of treatment to aid their understanding of and to explore their emotional experiences. The somewhat analogous handout provided to teens and their caregivers in DBT for Adolescents (DBT-A) consists of a list of 37 emotion words (i.e., “Short List of Emotions,” Emotion Regulation Handout 3; Rathus & Miller, 2014, p. 335). This abbreviated version highlights that people have many different, changing, and time-limited emotions that are important to recognize and label (Rathus & Miller, 2014). As our initial trial of a single module developed its DBT-A program, our clinicians quickly realized that the “Short List of Emotions” handout was too brief for some clients and families.

One family participating in DBT-A, in particular, struggled to understand, identify, and separate some of the emotions on this list. They eagerly asked for a more in-depth resource on the various aspects of emotions (e.g., prompting events, physiological experiences, action urges) we were discussing in the Emotion Regulation module. The adult DBT “Emotion Dictionary,” which we initially shared with them, was too much information to effectively digest and apply. In a regular Goldilocks conundrum, our team explored other existing resources for this family and delved into various emotion-learning tools, including those developed for people with affect regulation difficulties. Results were a combination of too simplistic (e.g., too few emotions), limited (e.g., utilized facial expressions only), or immature (e.g., childlike images, fonts utilized).

While these options were likely important and effective tools in the environments for which and the clients for whom they were created, they were not effective in our specific context. Thus, we sought to create an “Adolescent Emotion Dictionary” with age-appropriate content, age-appropriate presentation, and clinical utility within and beyond the specific context of our DBT-A program.

* Authors contributed equally; the order of authorship was chosen randomly.

Summary and Goals of the Current Study

Identifying and understanding one’s emotional experience is pivotal to DBT, regardless of age. Therefore, the goal of the current study was to (a) develop an Adolescent Emotion Dictionary for adolescents within the context of a DBT-A program and (b) pilot it in a DBT-Linehan Board of Certification, Certified DBT Program to determine preliminary clinician-reported clinical utility in supporting emotion regulation skills development for adolescents and their parents/caregivers.

Method

Instrument Development

The set of adolescent emotion handouts (i.e., Adolescent Emotion Dictionary; see Figure 1 for the Anger handout; all handouts follow the same format) was devised and originally developed by the first authors to be developmentally appropriate in both content and appearance as well as DBT-A-compatible. The authors utilized adolescent language and jargon, when appropriate, and limited the amount of content on any given emotion “family” to one page. This also comprised including a greater number of core emotions beyond those commonly found in child-oriented emotional learning materials (e.g., mad, sad, glad, and afraid) and more specific elements of emotional experiences (e.g., synonyms, possible prompting events, internal, cognitive, and behavioral experiences) as opposed to merely facial expressions and corresponding labels.

The resulting Adolescent Emotion Dictionary attempts to convey information visually and centers around a blank graphic of a person. Content is organized like an info-graphic or a worksheet to encourage interactive engagement (e.g., coloring, drawing a facial expression). The person, in the center, first experiences a prompting event, then explores interpretations within a “thought bubble,” while internal experiences are oriented within the body and outward expressions are depicted outside of the body. The authors intentionally limited the number of examples given to balance depth and breadth of explanation with ease of comprehension. Blank lines and a blank figure are provided to allow clinicians and clients to personalize the information and make it interactive, should one choose.

To ensure the resulting Adolescent Emotion Dictionary was DBT-A-compatible, authors first mapped selected content from the adult DBT “Ways to Describe...
Emotions” handouts (Emotion Regulation Handout 6; Linehan, 2014, pp. 214–223) onto the previously described visual format. Included were similar emotion words, prompting events, interpretations, internal experiences, and outward expressions of the emotion. Specific content was selected based on the considerations of both age-appropriate content and presentation previously described. Subsequently, each of the 10 emotion “families” included in the original adult handouts was adapted for inclusion in the resulting Adolescent Emotion Dictionary. That is, one-page handouts were created for each emotion “family.”

Adaptations to the original adult handouts were made to enhance the clarity of the information as well as the applicability to adolescents; these changes were guided by clinical judgment. Several universal alterations were made across all 10 emotion terms. First, all 10 overarching emotion terms were identified as “families” (e.g., anger family) and were included in noun form (e.g., anger, fear, happiness). Basic definitions of these terms were generated by the authors and included alongside selected synonyms for clarity. Definitions included a combination of general, layperson dictionary definitions and emotion-focused psychological resources (e.g., Greenberg & Pajonk, 1998) guided by clinical judgment. Brevity and clarity were prioritized in this process.

Second, common prompting events were adapted from both the Emotion Regulation Handout 6: Ways to Describe Emotions and Emotion Regulation Handout 8A: Examples of Emotions that Fit the Facts (Linehan, 2014). Resulting prompting events all “fit the facts” (i.e., could precipitate the indicated emotion without judgment, interpretation, or thinking mistake). These were selected for their relevance to common adolescent experiences and considerations of visual clarity.

Third, interpretations of the events were selected based on applicability to adolescents and were phrased and presented as thoughts (i.e., in quotations). Interpretations that both potentially “fit the facts” and represent thinking errors were included intentionally. This allowed for additional discussion between clinicians and clients regarding the complex connections between interpretations, emotions, and additional emotion regulation skills.

Fourth, internal physiological experiences and outward expressions/actions were selected. A limited number of each was chosen for simplicity and space. Again, language was adjusted to be developmentally appropriate (e.g., “blood boiling” was provided as an internal experience of anger; see Figure 1) and congruent with adolescent experiences. Potentially unique experiences and expressions associated

![Fig I. Excerpt of Adolescent Emotion Dictionary.](image)

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with particular emotions were prioritized, though overlapping descriptions were included (e.g., breathing difficulty included in fear, sadness, guilt, and jealousy handouts) as well as to highlight the intersecting nature of various emotional experiences.

Last, information regarding emotional after effects from the adult “Ways to Describe Emotions” handouts was omitted. This was done to prioritize the information presented (i.e., definition, synonyms, prompting events, interpretations, internal experiences, and external expressions) and limit overcrowding of content on each handout. After effects are also explained and included in the model of emotion handouts in the Emotion Regulation skills module (i.e., Handouts 5–7; Rathus & Miller, 2014), including the practice exercise for the weekly skills lesson.

Participants
The current study utilized survey data collected from nine licensed clinicians and master’s and doctoral student clinicians-in-training (hereafter: clinicians) in a DBT-Linehan Board of Certification, Certified DBT Program™ independent DBT practice clinic.

Procedure
After its development, the Adolescent Emotion Dictionary was distributed to clinicians at the independent practice clinic for initial evaluation of content and utility. Feedback was reviewed and integrated into a second draft of the Adolescent Emotion Dictionary by the first authors. These handouts were then distributed to clinicians again, and clinicians were asked to consider using the Adolescent Emotion Dictionary during their DBT-A multifamily skills groups and during individual therapy sessions with adolescent and adult clients. This updated version of the tool was distributed to families in two separate DBT-A multifamily skills groups during the Emotion Regulation skills module as part of the DBT-A program. Approximately 1 month later, clinicians completed a brief questionnaire to more formally assess their perceptions of the clinical utility of the handouts.

Measures
As described above, clinicians completed a brief questionnaire regarding their perceptions of the clinical utility of the Adolescent Emotion Dictionary. The questionnaire included six Likert-scale items with anchors at 1 (Not at all/Significantly less) and 5 (Very much/Significantly more) and two open-ended questions. See Figure 2 for questionnaire content.

Results
Data were collected from nine clinicians (n = 9). Results from the Likert-scale questions indicated that clinicians would be very likely to use the Adolescent Emotion Dictionary handouts with both adolescent (M = 4.89, SD = 0.33) and adult (M = 4.67, SD = 0.33) clients in the future. Results suggested the handouts were easy to understand (M = 4.67, SD = 0.50) and comprehensive (M = 4.33, SD = 0.50). Compared to the adolescent “Ways to Describe Emotions” handouts, clinicians indicated that the adolescent handouts were easier to
understand ($M = 4.44$, $SD = 0.53$) in the context of DBT-A and as comprehensive ($M = 3.44$, $SD = 0.73$) as the adult version. Clinicians also rated the clinical utility of the handouts above average ($M = 3.67$, $SD = 0.58$).

Responses to the open-ended questions were completed by a subset of clinicians. Three clinicians ($n = 3$) responded to Question 5b, which asked about sharing the Adolescent Emotion Dictionary with clients and their clients’ response. Responses indicated preliminary support that the tool was useful and well-received. See Figure 3 for complete responses to this item. Question 8, which asked the respondents for their thoughts about the tool, was completed by six of the clinicians ($n = 6$). Qualitatively, these clinicians highlighted that they appreciated the “visual nature” of the handouts and stated that they were “clear, clean,” “useful and comprehensive,” and “easier to understand the different components of an emotion [than the adult version].” A suggestion to include emotion faces was also provided. See Figure 4 for complete responses to this item.

Discussion

Preliminary Clinical Utility

Current findings demonstrate the preliminary clinical utility of the Adolescent Emotion Dictionary to provide and supplement psychoeducation about the labels, prompting events, common thoughts, internal experiences, and outward expressions associated with 10 different “emotion families.” Responses from adult and adolescent DBT providers demonstrate that this tool provides age-appropriate content in an appealing, digestible, visually based format and can supplement DBT emotion regulation skills teaching with adolescents and adults. Open-ended responses indicate feasibility of use of the Adolescent Emotion Dictionary in both multifamily skills group and individual therapy formats. Clinicians also appreciated the streamlined content and visual presentation of material.

One clinician recommended that “emotion faces (images)” be included. The first authors weighed the appropriateness of this recommendation, and we decided against making this amendment for several reasons. First, we were concerned that providing a single image of each emotion would be overly simplistic and ultimately too limiting for the adolescent population for whom we developed this tool. Second, we wanted to allow clients to draw on or color the image of the person to promote interaction with the tool itself and to best capture individual differences. For example, some adolescents may experience a “typical” angry face with a frown and furrowed brow, whereas others may experience a neutral face associated with the “cold shoulder” or “shutting down.” This also allows for an opportunity to explore and self-validate one’s unique experience of specific emotions.

Last, we wanted to promote interaction and discussion between clients and clinicians while using this tool, allowing for greater flexibility in applications. For example, a clinician might wish to employ videos, books, magazine clippings, and/or in vivo role-plays with clients to demonstrate a range of facial expressions that could represent each emotion. As described below, further development or adaptation of this tool for other populations in the future may benefit from including emotion faces within the tool.

Potential Applications

These results suggest the Adolescent Emotion Dictionary may be useful in other contexts and with additional diagnostic populations, especially given the possibility for personalization. In particular, this tool may assist with the development of emotional competence among diagnostic groups that struggle with emotion identification in themselves and others. These may include teens with neurodevelopmental disorders (e.g., autism spectrum disorder, attention deficit/hyperactivity disorder), anxiety disorders, and/or those with difficulties with empathy (e.g., conduct disorder).

Given the developmental level of the content included, the Adolescent Emotion Dictionary presented here may better serve or augment the learning of adults with cognitive or learning difficulties compared to the adult DBT “Ways to Describe Emotions” handouts. Additionally, with preliminary use in both individual therapy and skills group settings, the Adolescent Emotion Dictionary may be particularly well-suited for integration into middle- and high-school-based social and emotional education programs. Finally, the tool may lend itself to adaptation for use with younger children, as well.

Limitations

The current project was limited in several important ways. Sampled clinicians do not represent an impartial sample, as all practice within the same DBT clinic in which the Adolescent Emotion Dictionary was created. Thus, all clinicians share a principal clinical modality, and, thus, their views may or may not align with another sample of clinicians. While the included sample represented a variety of training levels and terminal clinical degrees, participants were largely White. This study is also limited by the small sample size. Results, therefore, must be interpreted within this context and considered preliminary.

Additionally, researchers utilized a self-created assessment measure that lacked item specificity. While this was appropriate given the preliminary stage of development of the Adolescent Emotion Dictionary, additional testing with more targeted item content (e.g., measure structure, clarity of specific items or elements) is warranted. Last, while the outcome questionnaire asked clinicians to compare the Adolescent Emotion Dictionary to the “Ways of Describing Emotions” handouts, the latter was not provided for direct comparison. It was assumed that all clinicians were familiar with this set of handouts, as it is regularly utilized within general clinic practice. Future research should consider exploring a direct comparison of content between the two tools.

Considerations of Process and Future Directions

Considering that others may also work to develop supplemental tools for DBT or other established treatments, there were several factors that facilitated what we believe to be successful execution of this project. First, our DBT team, including all authors, maintains a shared and comprehensive understanding of DBT. This includes underlying DBT theory, DBT and DBT-A manuals and materials, and adherent DBT clinical practice. This allowed for a shared knowledge base and effective collaboration between clinicians at various levels of training. As a result, the final tool is grounded in both theoretical knowledge and practical experience, promoting its complementarity to existing DBT and DBT-A materials.

The second factor that supported this project included utilizing a developmental perspective with a specific target: adolescent emotional competence. This necessitated collaboration between clinicians with training across developmental stages (e.g., adult, adolescent, and child) and expertise (e.g., DBT, BPD, autism spectrum disorder). This also required a willingness to think creatively regarding both content and visual-spatial presentation of material. As a result, the Adolescent Emotion Dic-
Thank you for giving the Adolescent Emotion Dictionary a try! We are curious how you found it and would appreciate any feedback and thoughts you have. Scale: 1 = Not at all, 3 = Neutral, 5 = Very much (unless otherwise stated).

1. How easy to understand did you, as a clinician, find the Adolescent Emotion Dictionary, overall?  
   1 2 3 4 5

2. How easy to understand, compared to the adult emotion dictionary ("Ways to Describe Emotions," Emotion Regulation Handout 6), did you find the Adolescent Emotion Dictionary? (1 = Significantly less, 3 = Neutral, 5 = Significantly more).  
   1 2 3 4 5

3. How comprehensive was the information provided on the Adolescent Emotion Dictionary?  
   1 2 3 4 5

4. How comprehensive, compared to the adult emotion dictionary ("Ways to Describe Emotions," Emotion Regulation Handout 6), did you find the Adolescent Emotion Dictionary? (1 = Significantly less, 3 = Neutral, 5 = Significantly more).  
   1 2 3 4 5

5. If you shared the Adolescent Emotion Dictionary with adult/adolescent clients  
   a. Please rate the clinical utility.  
      1 2 3 4 5 N/A

   b. Please describe your client’s response to the Adolescent Emotion Dictionary (e.g., seemed interested, was willing to engage, prompted discussion):

6. How likely are you to use the Adolescent Emotion Dictionary with adolescent clients in the future?  
   1 2 3 4 5

7. How likely are you to use the Adolescent Emotion Dictionary with adult clients in the future?  
   1 2 3 4 5

8. What did you think about the Adolescent Emotion Dictionary (i.e., what did you like, what elements were useful, what could be improved)?

Fig. 2. Questionnaire provided to the clinicians.

Fig. 3. Responses to Question 5b, "If you shared the Adolescent Emotion Dictionary with adult/adolescent clients... please describe your client's response to the Adolescent Emotion Dictionary (e.g., seemed interested, was willing to engage, prompted discussion)."

Fig. 4. Responses to Question 8, “What did you think about the Adolescent Emotion Dictionary (i.e., what did you like, what elements were useful, what could be improved)?”
ing feedback from additional pilot testing, next stages of research will include more directly exploring the clinical utility of the Adolescent Emotion Dictionary from a variety of nonclinical and clinical samples. Ultimately, the research team is seeking broad dissemination of an efficacious, age-appropriate therapeutic tool to bolster the development of emotional competence for adolescents and their family members. Evidence from this study provides initial support that the Adolescent Emotion Dictionary may be a promising option to this end.

References


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The authors would like to recognize the clinicians, clinicians-in-training, and staff at the Center for Behavioral Medicine for their invaluable participation in and support of the current study. This project was presented at the International Society for the Improvement and Teaching of Dialectical Behavior Therapy annual meeting by the lead authors under the title, “The Clinical Utility of an Adapted ‘Ways to Describe Emotions’ Set of Handouts for Dialectical Behavior Therapy for Adolescents (DBT-A).”

The authors declare that they have no conflict of interest.

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When are Exams Conducted? Usually at APA and ABCT annual conferences, and other locations on a case-by-case basis.

Note: At the annual ABCT conference in November, a free Q & A workshop is conducted for those who want more information about board certification.
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As the 2019 Program Chair, I welcome you to our 53rd Annual Convention with enthusiasm and hope that this year brings us one step closer to our mission and the goals that bind us together. ABCT is committed to enhancing public health and well-being through the application of science, and that promise is reflected in our theme for 2019: “Wisdom of Purpose and Perspective: Extending the Social Impact of Cognitive Behavioral Science.” Working in leadership at a state Medicaid program, I am immersed each day in decisions that drive the social impact of our collective work on a systems level. In Virginia we are implementing a radical redesign of our system to create an evidence-based, trauma-informed, and prevention-oriented array of behavioral health services to our members, who even with expansion are largely women and children. The work of translating scientific findings to policy and regulation is not one that our graduate training traditionally prepares us for, and I believe we have opportunities in organizations such as ours to support the development of critical skills in this area towards expanding our impact. I have brought the passion that fuels me in my work as a public servant to this role as your Program Chair, and it has been my honor to serve our organization in this way.

Developing a program around this theme has been timely as we are convening in a state that has recently passed legislation significantly limiting women’s reproductive rights. Many within our organization have voiced concern for the impact of these regulations, our meeting occurring in this state context, and the rights and experiences of women both in our organization and in our world. As Program Chair, it has been my role to work with our committee to consider how we can address these concerns within the relatively relevant program we have sought to create over the past year.

We have some exciting programming specific to the impact of CBT on public health. We are humbled to be joined this year by both international and domestic experts who have made large-scale impact on service systems and vulnerable populations. Dr. Sonja Schoenwald, a trailblazer in the dissemination and implementation of treatments for youth into complex community-based settings, will translate into 21 languages other than English. More than 75,000 practitioners have been trained in its delivery. He will be speaking with us on his transformational body of work and future opportunities for social impact.

Following the passing of the abortion legislation in Georgia this summer, we worked creatively with our committee to develop an additional invited panel to bring attention to the pressing issue of using psychological science to responsibly inform and advocate policy and regulation development, with special attention to the local context here in Atlanta. We are so grateful for the fast, flexible, and thoughtful efforts of our esteemed colleague and long-time ABCT member Dr. Lynn Bufka, the Associate Executive Director for practice research and policy at the American Psychological Association, and support from our Local Arrangements Chair, Dr. Leah Farrell-Carnahan. This panel will include a diversity of speakers, including women’s rights advocates representing the local climate who will address the topic “Realizing ABCT’s Mission in a Politicized World.”

Finally, in his presidential address, Dr. Bruce Chorpita will speak to us about maximizing the reach of cognitive and behavioral science through strategic coordination of individuals, institutions, and industries.

This year you will notice that we have made some innovations in our program process:

• This is the first year that we have offered child care services at our convention, and we thank the ongoing advocacy of the Women’s Issues SIG and the on-the-ground work of Stephen Crane, ABCT’s Convention Service, for this addition. We are committed to making ABCT an inclusive experience for members who are caregivers and travel to the convention with their families. For the 4th year, we will have a lactation room available for nursing and pumping attendees.

• We invite you to join us for an Instagram-worthy moment at our Mission Wall near registration, where we all have an opportunity to share how your work enhances health and well-being. Contribute, post, and share to social media with the hashtag #ABCT2019Impact.

• For the first time ever, you will be able to VOTE at the convention! We hope that this will significantly raise our voting participation rates. Look for details in the registration area.

• Submitters noticed that the Cadmium system had several updates this year, including the ability for you to send notices to co-authors for them to complete their own information in the site. We also worked with great care to revise the categories for submission this year, to assure equity so that each Special Interest Group had an aligned category. We also have edited the key words for the program and encourage you to think of these as hashtags that mark a label for each submission to ease the identification of content relevant to your interests.

• The forests of the world rejoice, as this is the first year that we will not have a printed program book and will ask that you rely on the PDF version available, the convention planner, and the smartphone application for navigation of this experience.

• We are also testing out a new poster template, developed and made internet viral by a psychology trainee. This new template is intended to improve the presenter and attendee experience, and we will be looking closely at your feedback on this to determine future directions.
• We are grateful to the esteemed Dr. Judith Beck, who will be providing a workshop on CBT for depression worth 3 CEUs on Sunday, for free! This session will be geared towards students but all are welcome.

It has been my privilege to serve as your Program Chair this year, and I am grateful to my mentor Dr. Bruce Chorpita and the ABCT Board for entrusting me with these duties. I would like to extend a special note of appreciation to Dr. Cameo Stanick, an ABCT colleague turned dear friend, for her support as program assistant. Further, Dr. Chorpita deserves an extra helping of thanks as he rolled up his sleeves (as always) and stepped in to support me during one of the most demanding periods of work when Dr. Stanick had a family emergency. I also would like to thank Dr. Kiara Timpano (2018 Program Chair) and Dr. Katharina Kircanski (Coordinator of Convention and Education Issues and 2017 Program Chair) for their validation and camaraderie. This year I celebrate my 15th year at ABCT and I have to thank Dr. Mike Southam-Gerow for first encouraging me to attend and for his steady support and keeping me laughing for nearly half my life now. This program comes to you via the substantial efforts of virtually hundreds of our members who have contributed to its creation. This includes first the 2019 Program Committee for their expertise, careful reviews, and flexibility during the peer review process. This year we surpassed last year’s record number of reviewers, with over 350 members participating in the peer review process and 126 “Super Reviewers,” and we simply would not have a convention without their dedication and service. I also thank the chairs of the Convention and Education Issues Committee for their tireless work and exceptional job developing this year’s excellent program: Brian Baucom (AMASS), Lauren Weinstock (Workshops), Courtney Benjamin Wolk (Master Clinician Seminars), Cole Hooley (Research & Professional Development), Christina Boisseau (Institutes), and Shannon Wittey-Stirman and Dan Cherón (2020 Program Chair and Assistant Program Chair). I have worked for years with ABCT’s central office, particularly during my tenure as Chair of the Women’s SIG as we worked to implement a lactation room. However, I have never been so closely tied to Mary Jane Eimer and the central office team—especially the steadfast Stephen Crane—who showed devotion to developing the best convention possible. Finally, I am forever grateful to my husband, Geoff, and my two young daughters, who have cheered me on and patiently tolerated the many hours that I spent in dedication to ABCT this year.

We hope that you experience this as an engaging convention that inspires new scientific collaborations that increase our collective impact! Thank you for joining us in Atlanta.

**NOTE**

*Program details such as educational objectives, session level, fees, presenter credentials, and number of CE credits that can be earned may be found in the program book on ABCT’s website. Program subject to change.*

**Convention Itinerary Planner**

The pages that follow provide an overview of the ticketed sessions and general sessions that will be part of the 2019 convention in Atlanta, GA. In order to learn more details about the sessions, including full descriptions and times, skill levels, and learning goals, please utilize the Itinerary Planner. Feel free to access the Itinerary Planner at ABCT’s website at www.abct.org/conv2019. To view the entire convention program—including SIG meetings, poster sessions, invited addresses—you can search by session type, date, time, presenter title, category, or keyword, or you can view the entire schedule at a glance. (Keep in mind, this year the program book will only appear online: there will be no physical program book onsite in Atlanta.) After reviewing this special Convention 2019 insert, we hope you will turn to the online Itinerary Planner and begin to build your ultimate ABCT convention experience!

**Increasing the World’s Therapeutic Intelligence Through Strategic Alignment of Individuals, Institutions, and Industries**

**Bruce F. Chorpita, Ph.D., UCLA**

Saturday, November 23, 5:15 p.m. - 6:30 p.m. Atrium Ballroom B&C, Atrium Level

*Participants earn 1 CE credit*

The focus for ABCT this year is purposeful reflection on how we can better achieve the mission of health and wellness through cognitive behavioral science. I will begin by outlining the landscape that must be crossed to achieve that mission, noting where our current resources and strategies encounter seemingly unmanageable complexity. On the other hand, an inventory of our strengths will show that we know more than at any time in human history about how to address mental health challenges and that we have unprecedented technological capabilities to organize and deliver that knowledge to where it is needed. Accordingly, I will articulate a framework of Coordinated Strategic Action as a way to organize people and evidence to make efficient use of these historic capabilities to meet these extraordinary challenges, with working examples and empirical findings from mental health systems and interventions. Finally, in the spirit of our organization’s behavioral intellectual rebellion, I will call for us to reflect on the contingencies or “token economies” in which we, our organizations, and our industries operate, to ask what we can do to engineer a society with greater capability of engaging in healthy and therapeutic behavior for ourselves and those around us.
THURSDAY, 8:30 a.m. - 5:00 p.m.

CIT 1 | Applying Exposure Principles to the Treatment of Depression: Exposure-Based Cognitive Therapy

+ Participants earn 7 continuing education credits

Adele M. Hayes, Ph.D., *University of Delaware*
Charlotte Yasinski, Ph.D., *Emory University School of Medicine*

Antidepressants and psychotherapy are only about 50% effective, and recurrence rates are as high as 90% by the third episode. Holtzheimer and Mayberg (2011) urge a rethinking of depression as a persistent tendency to become “stuck in a rut” when negative mood states are activated. Treatment must therefore disrupt the processes associated with entering and staying in that rut. Exposure-based cognitive therapy (EBCT) integrates cognitive behavioral therapies for depression with principles of exposure, emotional processing, and inhibitory learning from the treatment of anxiety disorders. EBCT targets key factors that maintain depression (unproductive processing, avoidance, and impaired reward sensitivity and processing). It also facilitates their more adaptive counterparts (constructive emotional processing, distress tolerance, and the ability to sustain and process positive emotions), which together can serve inhibitory functions to prevent relapse. Exposure principles are applied in: (a) weekly narratives to facilitate processing of depressive material, (b) mindfulness exercises to promote distress tolerance, (c) imaginal exposure exercises to facilitate constructive processing of memories related to defectiveness, worthlessness, and failure, and (d) exposure exercises to activate and process positive emotions and related fear and avoidance. CIT participants will learn techniques to reduce depression-maintaining processes and promote emotional processing and inhibitory learning.

THURSDAY, 8:30 a.m. - 5:00 p.m.

CIT 2 | Integrative Behavioral Couple Therapy: Acceptance and Change in Couple Therapy

+ Participants earn 7 continuing education credits

Andrew Christensen, Ph.D., *UCLA*
Brian D. Doss, Ph.D., *University of Miami*

Integrative Behavioral Couple Therapy (IBCT) is an evidence-based approach to the treatment of couples developed by Andrew Christensen and the late Neil S. Jacobson. IBCT is integrative in that it brings together the twin goals of emotional acceptance and behavior change. Also, it integrates a variety of treatment strategies under a consistent behavioral theoretical framework. In this session, Christensen will describe the theoretical notions that distinguish IBCT from traditional and cognitive behavioral couple therapies. Then he will describe the four stages of treatment: assessment, feedback, active intervention, and termination. He will illustrate some of the assessment and treatment strategies with videotaped examples of couples in IBCT. He will also briefly describe the empirical support for IBCT. Brian Doss will describe the translation of IBCT into an online version (OurRelationship.com). Doss will describe and illustrate the three main phases of the intervention captured by the acronym OUR: observe, understand, and respond. He will then discuss two nationwide clinical trials that demonstrate the effectiveness of the intervention. He will conclude with discussion of the integration of the online program with in person therapy.

THURSDAY, 8:30 a.m. - 5:00 p.m.

CIT 3 | Working With Anxious Youth: Clinical Strategies Within Empirically Supported Treatment

+ Participants earn 7 continuing education credits

Philip C. Kendall, Ph.D., ABPP, *Temple University*

This CIT will provide an initial description of the theory that guides the intervention and an overview of the nature, symptoms, and experience of anxiety in youth. We will consider when anxiety is developmentally reasonable and when it is disordered. Cognitive, behavioral, family (parenting), and emotional factors will be addressed.

The bulk of the CIT will address intervention strategies. Each of the strategies (e.g., coping modeling, changing self-talk, affect education, exposure tasks) will be described in detail and illustrated with case examples and some video illustrations. A flexible implementation of the manual-based approach will be described and encouraged.

Sample videos of actual sessions and reenacted sessions will be available to be played and discussed, and small groups of CIT participants will have an opportunity to engage in a role-play activity.

Research outcomes that inform decisions regarding the provision of clinical services for anxious youth will be considered and these findings highlight both (a) what we know and (b) what we do not yet know about the treatment of anxiety disorders in youth.
Designed for clinical practitioners, discussions and display of specific intervention techniques.

**THURSDAY**

**Institute 1 | 8:30 a.m. - 5:00 p.m.**
✦ Participants earn 7 continuing education credits.

**Desirable Difficulties: Optimizing Exposure Therapy for Anxiety Through Inhibitory Learning**
Jonathan S. Abramowitz, Ph.D., University of North Carolina at Chapel Hill
Ryan J. Jacoby, Ph.D., Massachusetts General Hospital/ Harvard Medical School
Shannon M. Blakey, Ph.D., VA Mid-Atlantic Mental Illness Research, Education & Clinical Center (MIRECC)/Durham VA Health Care System

**Institute 2 | 8:30 AM - 5:00 PM**
✦ Participants earn 7 continuing education credits.

**Motivational Interviewing for Health Behavior Change**
Nate Mitchell, Ph.D., Spalding University
Daniel McNeil, Ph.D., West Virginia University
Trevor Hart, Ph.D., Ryerson University

**Institute 3 | 1:00 PM - 6:00 PM**
✦ Participants earn 5 continuing education credits.

**Written Exposure Therapy: A Brief Treatment for PTSD**
Denise Sloan, Ph.D., Boston University School of Medicine & National Center for PTSD
Brian Marx, Ph.D., Boston University School of Medicine & National Center for PTSD

**Institute 4 | 1:00 PM - 6:00 PM**
✦ Participants earn 5 continuing education credits.

**Treating OCD in Children and Adolescents: A Cognitive Behavioral Approach**
Martin E. Franklin, Ph.D., Perelman School of Medicine at the University of Pennsylvania

**Institute 5 | 1:00 PM - 6:00 PM**
✦ Participants earn 5 continuing education credits.

**Tricking Coyote: Cutting-Edge Strategies for Harnessing Motivation and Achieving Goals**
Michael W. Otto, Ph.D., Boston University

**Institute 6 | 1:00 PM - 6:00 PM**
✦ Participants earn 5 continuing education credits.

**Anxiety and Emerging Adults: Incorporating Caregiver Involvement and Enhancing Exposures in the Treatment of Adolescents and Young Adults With Anxiety Disorders**
Anne Marie Albano, Ph.D., Columbia University Medical Center
Shannon Bennett, Ph.D., Weill Cornell Medicine
Lauren Hoffman, Psy.D., Columbia University Medical Center
Schuyler Fox, B.A., Columbia University Medical Center

**Institute 7 | 1:00 PM - 6:00 PM**
✦ Participants earn 5 continuing education credits.

**Parent-Child Interaction Therapy: A Robust Intervention for Early Childhood Mental Health**
Cheryl B. McNeil, Ph.D., West Virginia University

**Institute 8 | 1:00 PM - 6:00 PM**
✦ Participants earn 5 continuing education credits.

**Supervision Essentials in CBT**
Cory F. Newman, Ph.D., Perelman School of Medicine at The University of Pennsylvania
Danielle A. Kaplan, Ph.D., New York University School of Medicine

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**Advanced Methodology and Statistics Seminars**

*A special series of offerings for applied researchers, presented by nationally renowned research scientists. TICKETED SESSIONS*

**THURSDAY**

**AMASS 1 | Thursday, November 21, 8:30 a.m. - 12:30 p.m.**
✦ Participants earn 4 continuing education credits.

**Open Science Practices for Clinical Researchers: What You Need to Know and How to Get Started**
Jessica Schleider, Ph.D., Professor of Social and Quantitative Psychology, Stony Brook University
Michael Mullarkey, M.A., University of Texas at Austin

**AMASS 2 | Thursday, November 21, 1:00 p.m. - 5:00 p.m.**
✦ Participants earn 4 continuing education credits.

**Incorporating Intensive Measurement and Modeling Into Clinical Trials**
Jonathan Butner, Ph.D., Professor of Social and Quantitative Psychology, University of Utah
Master Clinician Seminars  TICKETED SESSIONS

These seminars involve the presentation of case material, session videotapes, and discussion to enable participants to further understand the application of cognitive and behavioral techniques.

FRIDAY

MCS 1 | 9:00 a.m. - 11:00 a.m.  
✦ Participants earn 2 continuing education credits  
You Are Not Supposed to Feel That Way: Making Room for Difficult Emotions  
Robert Leahy, Ph.D., American Institute for Cognitive Therapy

MCS 2 | 1:00 p.m. - 3:00 p.m.  
✦ Participants earn 2 continuing education credits  
Evidence-Based Assessment and Treatment of Bipolar Disorder and Mood Dysregulation in Youth and Early Adulthood  
Mary A. Fristad, ABPP, Ph.D., The Ohio State University  
Eric A. Youngstrom, Ph.D., University of North Carolina at Chapel Hill

MCS 3 | 3:30 p.m. - 5:30 p.m.  
✦ Participants earn 2 continuing education credits  
Appetite Monitoring in Individual and Family-Based Healthy Weight Coaching  
Linda W. Craighead, Ph.D., Emory University

MCS 4 | 8:30 a.m. - 10:30 a.m.  
✦ Participants earn 2 continuing education credits  
Helping Suicidal Teens Build Lives Worth Living: Key Elements to Orienting and Committing Teens to DBT  
Alec L. Miller, Ph.D., Cognitive & Behavioral Consultants, LLP

SATURDAY

MCS 5 | 8:30 a.m. - 10:30 a.m.  
✦ Participants earn 2 continuing education credits  
In-Depth Analysis of the Unified Protocol in Clinical Practice: Transdiagnostic Case Conceptualization and Application  
Todd J. Farchione, Ph.D., Center for Anxiety and Related Disorders, Boston University  
Shannon Sauer-Zavala, Ph.D., Center for Anxiety and Related Disorders, Boston University

MCS 6 | 11:00 a.m. - 1:00 p.m.  
✦ Participants earn 2 continuing education credits  
CBT for Body Dysmorphic Disorder  
Fugen A. Neziroglu, Ph.D., ABPP, BioBehavioral Institute

MCS 7 | 2:00 p.m. - 4:00 p.m.  
✦ Participants earn 2 continuing education credits  
Integrating Motivational Interviewing With CBT Interventions to Maximize Client Outcomes  
Sylvie Naar, Ph.D., Wayne State University  
Steven Safren, Ph.D., ABPP, University of Miami

MCS 8 | 8:30 a.m. - 10:30 a.m.  
✦ Participants earn 2 continuing education credits  
Comprehensive Behavioral Intervention for Tics  
Douglas W. Woods, Ph.D., Marquette University  
Michael B. Himle, Ph.D., University of Utah

Workshops  TICKETED SESSIONS

Workshops provide up-to-date integration of theoretical, empirical, and clinical knowledge about specific issues or themes

FRIDAY

Workshop 1 | 8:30 a.m. – 11:30 a.m.  
✦ Participants earn 3 continuing education credits  
Risk Reduction Through Family Therapy: An Evidence-Based Treatment for Co-occurring Substance Use Problems and PTSD Among Adolescents  
Carla K. Danielson, Ph.D., Medical University of South Carolina  
Zachary W. Adams, Ph.D., Indiana University School of Medicine

Workshop 2 | 8:30 a.m. – 11:30 a.m.  
✦ Participants earn 3 continuing education credits  
How to Apply Cognitive Behavioral Principles to Transgender Care: An Evidence-Based Transdiagnostic Framework  
Colleen A. Sloan, Ph.D., VA Boston Healthcare System and Boston University School of Medicine

Danielle S. Berke, Ph.D., Hunter College, City University of New York

Workshop 3 | 11:00 a.m. – 2:00 p.m.  
✦ Participants earn 3 continuing education credits  
Regulation of Cues Treatment: Using Appetite Awareness Training and Cue-Exposure  
Dawn M. Eichen, Ph.D., University of California, San Diego  
Kerri N. Boutelle, Ph.D., University of California, San Diego

Workshop 4 | 11:00 a.m. – 2:00 p.m.  
✦ Participants earn 3 continuing education credits  
Emotion Regulation Training for Alcohol Use Disorders: Helping Clients to Manage Negative Emotions  
Kim S. Slosman, LMHC, University of Buffalo  
Clara M. Bradizza, Ph.D., University of Buffalo  
Paul R. Stasiewicz, Ph.D., University of Buffalo
Workshop 5 | 12:00 p.m.- 3:00 p.m.
✦ Participants earn 3 continuing education credits

**When Time Matters: A Process-Based Approach for Delivering Powerful Brief Interventions**
Kirk Strosahl, Ph.D., HeartMatters Consulting, LLC
Patricia J. Robinson, Ph.D., Mountainview Consulting Group

Workshop 6 | 12:00 p.m. – 3:00 p.m.
✦ Participants earn 3 continuing education credits

**Assessment and Case Conceptualization of Disgust in Anxiety Disorders and OCD**
Dean McKay, Ph.D., Fordham University

Workshop 7 | 3:00 p.m. - 6:00 p.m.
✦ Participants earn 3 continuing education credits

**ACT for Life: Using Acceptance and Commitment Therapy to Prevent Suicide and Build Meaningful Lives**
Sean M. Barnes, Ph.D., Rocky Mountain MIRECC
Lauren M. Borges, Ph.D., Rocky Mountain MIRECC
Nazanin Bahraini, Ph.D., Rocky Mountain MIRECC
Robyn D. Walser, Ph.D., VA National Center for PTSD

Workshop 8 | 3:00 p.m. – 6:00 p.m.
✦ Participants earn 3 continuing education credits

**Functional Analysis in Process-Based CBT**
Stefan G. Hofmann, Ph.D., Boston University
Steven C. Hayes, Ph.D., University of Nevada, Reno

**SATURDAY**

Workshop 9 | 8:30 a.m. – 11:30 a.m.
✦ Participants earn 3 continuing education credits

**Practical and Effective Treatment Methods for Functional Deficits in Children and Teens With ADHD: Paths to Improving Home and School Functioning**
Richard Gallagher, Ph.D., New York University School of Adolescent Psychiatry
Jenelle Nissley-Tsiopinis, Ph.D., Children’s Hospital of Philadelphia
Margaret Sibley, Ph.D., Florida International University

Workshop 10 | 8:30 a.m. – 11:30 a.m.
✦ Participants earn 3 continuing education credits

**Supervision and Clinical Case Consultation Strategies: Guided Discovery, Strengthening the Supervisory Relationship, and Experiential Teaching Techniques**
Scott H. Waltman, Psy.D., Brooke Army Medical Center
Brittany C. Hall, Ph.D., UT Southwestern Medical Center
Lynn McFarr, Ph.D., UCLA Medical Center & CBT California

Workshop 11 | 8:30 a.m. – 11:30 a.m.
✦ Participants earn 3 continuing education credits

**Trauma-Informed Mindfulness: Integrating Mindfulness-Based Practices Into Psychotherapy With Traumatized Clients**
Terri L. Messman-Moore, Ph.D., Miami University
Noga Zerubavel, Ph.D., Duke University Medical Center

Workshop 12 | 8:30 a.m. – 11:30 a.m.
✦ Participants earn 3 continuing education credits

**Designing and Implementing Contingency Management Interventions for Health Behaviors**
Carla Rash, Ph.D., University of Connecticut Health
Jeremiah Weinstock, Ph.D., Saint Louis University

Workshop 13 | 12:00 p.m. – 3:00 p.m.
✦ Participants earn 3 continuing education credits

**A Transdiagnostic Approach to Exposure-Based Treatment: A Memory-Centric Perspective**
Jasper A.J. Smits, Ph.D., University of Texas at Austin
Mark B. Powers, Ph.D., Baylor University Medical Center
Michael W. Otto, Ph.D., Boston University

Workshop 14 | 12:00 p.m. – 3:00 p.m.
✦ Participants earn 3 continuing education credits

**Self-Practice and Self-Reflection: Developing Personal and Professional Mastery of Acceptance and Commitment Therapy Through Self-Practice of Core ACT Processes**
R. Trent Codd III, Ed.S., Cognitive-Behavioral Therapy Center of WNC, P.A.
Dennis Tirch, Ph.D., The Center for Compassion Focused Therapy
Laura Silberstein-Tirch, Psy.D., The Center for Compassion Focused Therapy
Joann Wright, Ph.D., ACT One
Martin Brock, MSC, M.A., University of Derby

Workshop 15 | 12:00 p.m. – 3:00 p.m.
✦ Participants earn 3 continuing education credits

**Means Safety Counseling for Suicide Prevention**
Craig J. Bryan, Psy.D., National Center for Suicide Studies

Workshop 16 | 12:00 p.m. – 3:00 p.m.
✦ Participants earn 3 continuing education credits

**Case Formulation and Treatment Planning in Dialectical Behavior Therapy**
Jennifer Sayrs, Ph.D., Evidence Based Treatment Centers of Seattle
Shireen L. Rizvi, Ph.D., Rutgers University
General Sessions

Clinical Roundtables, Mini Workshops, Panel Discussions, Symposia, and Research & Professional Development are part of the general program: no tickets are required. Participants earn 1.5 continuing education credits.

■ CLINICAL ROUNDTABLES

Adaptations for Assessments and Increased Impact of Evidence Based Treatments for Individuals With Autism Spectrum and Co-Occurring Disorders

Moderator: Daniel L. Hoffman, ABPP, Ph.D., Long Island Jewish Medical Center/Zucker Hillside Hospital
Panelists: Susan White, Ph.D., The University of Alabama
Lauren Moskowitz, Ph.D., St. John’s University
Matthew Lerner, Ph.D., Stony Brook University
Valerie Gaus, Ph.D., Private Practice
Connor Kerns, Ph.D., University of British Columbia

Athlete Mental Health: Strategies for Engaging Stakeholders in Identification and Treatment

Moderator: Christopher Stanley, Ph.D., Florida Gulf Coast University
Panelists: Katherine Rovtar, Clemson University
Bailey J. Nevels, Ph.D., Clemson University
Ashley Hansen, M.A., Saint Louis University
Diana Rancourt, Ph.D., University of South Florida

Beyond Standard CBT: Innovative Developments in Behavioral Interventions for Eating Disorders

Moderator: Loren Prado, M.S., Center for Dialectical and Cognitive Behavioral Therapies
Panelists: Christina Wiernnga, Ph.D., University of California, San Diego
Stephanie Knatz Peck, Ph.D., UCSD Eating Disorder Treatment Center
Mima Simic, M.D., Maudsley Centre for Child and Adolescent Eating Disorders
Nicholas R. Farrell, Ph.D., Rogers Behavioral Health
Leslie Karwoski Anderson, Ph.D., UC San Diego Eating Disorders Center

Beyond the Office: Benefits, Challenges, and Considerations for the Use of Telehealth in Diverse Clinical Settings

Moderator: Amanda R. McGovern, Ph.D., McGovern Psychotherapy, LLC
Panelists: Erin K. Engle, Psy.D., Columbia University Medical Center
Caitlin B. Shepherd, Ph.D., Smith College
Nicholas Crimarco, Ph.D., Columbia University Medical Center
Elliot Kamienetzky, Ph.D., My OCD Care

Challenges of Treating Traumatized Adolescents: Successes, Failures, and the Value of Good Old-Fashioned Case Conceptualization

Moderators: Elissa J. Brown, Ph.D., St. John’s University
Carla K. Danielson, Ph.D., Medical University of South Carolina
Panelists: Chelsea N. Grefe McCann, Psy.D., UPMC Children’s Hospital of Pittsburgh
Colleen Lang, Ph.D., Behavioral Wellness of NYC
Komal Sharma-Patel, Ph.D., St. John’s University

Clinical Challenges and Opportunities for Family Involvement in the Treatment of Adult Psychopathology

Moderator: Melanie S. Fischer, Ph.D., Institute of Medical Psychology, University Hospital, Heidelberg
Panelists: Donald H. Baucom, Ph.D., University of North Carolina at Chapel Hill
Steffany Fredman, Ph.D., Pennsylvania State University
Barbara S. McCrady, Ph.D., University of New Mexico
David Miklowitz, Ph.D., Director, Child and Adolescent Mood Disorders Program, UCLA Semel Institute for Neuroscience and Behavior
Karen H. Petty, Ph.D., Couples and Family Clinic, Ralph H. Johnson VA Medical Center; Medical University of South Carolina

Clinical Considerations for Culturally Tailored Couple Care With Underserved Groups

Moderator: Kimberly Z. Pentel, M.A., University of North Carolina at Chapel Hill
Panelists: Anthony L. Chambers, Ph.D., Family Institute at Northwestern University, Center for Applied Psychological and Family Studies
Kristina Coop Gordon, Ph.D., University of Tennessee, Knoxville
Shalonda Kelly, Ph.D., Rutgers University, Graduate School of Applied and Professional Psychology
Sarah W. Whitton, Ph.D., University of Cincinnati

Embracing the Dialectics in the Implementation of Dialectical Behavior Therapy in the Veterans Health Administration

Moderators: Christine A. Way, LCSW, William S. Middleton Memorial Veterans Hospital
Laura Meyers, ABPP, Ph.D., Orlando VAMC
Panelists: Sara J. Landes, Ph.D., Central Arkansas Veterans Healthcare System
Ren F. Stinson, ABPP, Ph.D., Minneapois VAMC
Elizabeth Chapman, MSW, Ann Arbor Veterans Healthcare System
Jeanette R. DeVevo, LCSW, US Department of Veteran Affairs, Phoenix
Melanie S. Harned, ABPP, Ph.D., VA Puget Sound Health Care System

Exposures Gone Awry: Rallying and Recuperating From Unforeseen, Unanticipated, and Uncommon Blunders!

Moderator: Simon A. Rego, ABPP, Psy.D., Montefiore Medical Center/Albert Einstein College of Medicine
Panelists: Anne Marie Albano, ABPP, Ph.D., Columbia University
Martin Franklin, Ph.D., Rogers Memorial Hospital
Adam Radomsky, Ph.D., Concordia University
Maureen L. Whittal, ABPP, Ph.D., Vancouver CBT Centre/University of British Columbia

Foundations and Flexible Applications of Behavioral Activation in Clinical Context

Moderators: Katherine Crowe, Ph.D., NYU Langone Health
Carolyn Spiro-Levitt, M.A., NYU Langone Health
Panelists: R. Eric Lewandowski, Ph.D., NYU Langone Health
Jessica Jenness, Ph.D., University of Washington
Kathryn DeLonga, Psy.D., Mood Brain & Development Unit, National Institute of Mental Health
Christopher R. Martell, ABPP, Ph.D., University of Massachusetts-Amherst
Elizabeth McCauley, Ph.D., University of Washington

**Improving Access to CBT in Rural Canada: Challenges and Opportunities**
**Moderator:** Amanda Lints-Martindale, Ph.D., University of Manitoba
**Panelists:** Amanda Lints-Martindale, Ph.D., University of Manitoba
Jolene Kinley, Ph.D., University of Manitoba
Shelley Goodwin, Ph.D., Dalhousie University
Jennifer Richards, Ph.D., IWK Health Centre

**Increasing Diversity in Clinical Training**
**Moderators:** Jenna B. Teves, Ph.D., Ralph H. Johnson VA Medical Center
Karen H. Petty, Ph.D., Couples and Family Clinic, Ralph H. Johnson VA Medical Center; Medical University of South Carolina
**Panelists:** Aleja Parsons, Ph.D., New York University
Shawn Jones, Ph.D., MHS, LCP, Virginia Commonwealth University
Vickie Bhatia, Ph.D., Edward Hines Jr. VA Hospital
Nicole Cammack, Ph.D., Washington, DC, VA Medical Center
Delisa Brown, Ph.D., Medical University of South Carolina

**Intensive CBT for Youth With Anxiety and OC Disorders: Special Considerations for the Design and Delivery of Treatment**
**Moderator:** Taylor Wilmer, Ph.D., McLean Hospital
**Panelists:** Shannon Bennett, Ph.D., Weill Cornell Medicine
Sarah H. Morris, Ph.D., Bradley Hospital
Kendra L. Read, Ph.D., University of Washington School of Medicine & Seattle Children’s Hospital
Michelle Rozenman, Ph.D., University of Denver
Lindsey Bergman, Ph.D., UCLA Semel Institute for Neuroscience & Human Behavior

**Optimizing Success in Delivery of Trauma-Focused Treatments With Patients With Borderline Personality Disorder**
**Moderators:** Sarah C. Voss Horrell, Ph.D., Salem VA Medical Center
Ren F.ustin, ABPP, Ph.D., Minneapolis VA Medical Center
**Panelists:** Lea Didion, Psy.D., US Department of Veterans Affairs
Laura Meyers, ABPP, Ph.D., Orlando VA Medical Center
Sara J. Landes, Ph.D., Central Arkansas Veterans Healthcare System
Melanie S. Harned, ABPP, Ph.D., VA Puget Sound Health Care System

**Practicing CBT With Religious Patients From Christian, Muslim, and Jewish Communities**
**Moderator:** Amy Weisman de Mamani, Ph.D., University of Miami
**Panelists:** David H. Rosmarin, ABPP, Ph.D., McLean Hospital/ Harvard Medical School
Shadi Beshai, Ph.D., University of Pennsylvania
Jeremy Cummings, Ph.D., Southeastern University

**Psychologists in Pediatric Medical Settings: Extending the Reach of Evidence-Based Treatment**
**Moderators:** Corinne Catarozoli, Ph.D., Weill Cornell Medicine, New York Presbyterian Hospital
Rebecca Lois, Ph.D., New York University School of Medicine
**Panelists:** Lara Brodzinsky, Psy.D., Hasensfeld Children’s Hospital at NYU Langone
Laura Reigada, Ph.D., City University of New York, Brooklyn College and the Graduate Center
Christopher Smith, Ph.D., Samaritan Family Medicine
Joslyn Kenowitz, Ph.D., Nemours/A.I. DuPont Hospital for Children

**The Application of Dialectical Behavior Therapy to Youth in Residential Care Settings in Norway’s Northern Region: Lessons and Early Findings**
**Moderator:** André M. Ivanoff, Ph.D., Columbia University & Linehan Institute
**Panelists:** Henry Schmidt, III, Ph.D., Bufetat Region Nord, Håvård Johansen, B.S., Bufetat Region North, Kristin Presteng, B.S., Bufetat, Region Nord

“The Way You Make Me Feel”: Transtheoretical Approaches to Addressing Emotions in Couple Therapy
**Moderator:** Alexandra Wojda, B.A., University of North Carolina at Chapel Hill
**Panelists:** Donald Baucom, Ph.D., University of North Carolina at Chapel Hill
Christina Balderrama-Durban, Ph.D., Binghamton University
Andrew Christensen, Ph.D., UCLA

### MINI WORKSHOPS

* Participants earn 1.5 continuing education credits

**Behavioral Activation for Adolescents**
Allison LoPilato, Ph.D., Emory University School of Medicine
Edward Craighead, ABPP, Ph.D., Emory University

* Participants earn 1.5 continuing education credits

**Bringing ERP from the Classroom to the Treatment Room: A Guide for Students and New Therapists to Motivate Patients to Do ERP**
Patrick B. McGrath, Ph.D., Amita Health Alexian Brothers

* Participants earn 1.5 continuing education credits

**Building the Effective Workforce of the Future: A Comprehensive Model for Training Students in Evidence-Based Practice for Youth Mental Health**
Charmeke K. Higa McMillan, Ph.D., University of Hawaii at Hilo
Teri Bourdeau, Ph.D., PracticeWise, LLC
Kimberly Becker, Ph.D., University of South Carolina
Bruce F. Chorpita, Ph.D., UCLA

* Participants earn 1.5 continuing education credits

**CBT Express for Young Patients: Bite-Sized Versions of Conventiona...**
Robert D. Friedberg, Ph.D., Palo Alto University
Jessica M. McClure, Psy.D., Cincinnati Children’s Hospital Medical Center
Participants earn 1.5 continuing education credits

**CBT for Addictions: Customizing Your Strategies to Meet the Needs of People from Diverse Backgrounds**
Bruce S. Liese, ABPP, Ph.D., University of Kansas Medical Center

Participants earn 1.5 continuing education credits

**CBT for Looming Vulnerability Distortions in Anxiety**
John Riskind, Ph.D., George Mason University

Participants earn 1.5 continuing education credits

**CBT With Sexual and Gender Minorities**
Jeffrey M. Cohen, Psy.D., Columbia University Medical Center
Matthew D. Skinta, ABPP, Ph.D., Private Practice
Debra A. Hope, Ph.D., University of Nebraska-Lincoln

Participants earn 1.5 continuing education credits

**How to Integrate Mindfulness Into a CBT Framework**
Robert K. Hindman, Ph.D., Beck Institute for Cognitive Behavior Therapy
Judith S. Beck, Ph.D., Beck Institute for Cognitive Behavior Therapy

Participants earn 1.5 continuing education credits

**Integration of Multiculturalism and CBTs for People of Color With Anxiety**
Jessica Graham-LoPresti, Ph.D., Suffolk University
Tahirah Abdullah, Ph.D., University of Massachusetts, Boston
Amber Calloway, Ph.D., University of Massachusetts, Boston

Participants earn 1.5 continuing education credits

**Overcoming Challenges in the Therapeutic Relationship**
Judith S. Beck, Ph.D., Beck Institute For Cognitive Behavior Therapy

Participants earn 1.5 continuing education credits

**Recovery-Oriented Cognitive Therapy for Schizophrenia**
Aaron P. Brinen, Psy.D., Drexel University College of Medicine

Participants earn 1.5 continuing education credits

**Sports, Superheroes, Star Wars and Beyond: Strategies for Teaching CBT Principles to Anxious Youth and Making Therapy Fun**
Sandra Pimentel, Ph.D., Montefiore Medical Center
Janina Scarlet, Ph.D., Center for Stress and Anxiety Management

Participants earn 1.5 continuing education credits

**Strategic Pressure for OCD: When All Else Fails**
Jonathan Grayson, Ph.D., Grayson LA Treatment Center for Anxiety & OCD

Participants earn 1.5 continuing education credits

**Stronger than OCD: Engaging Youth in Exposure and Ritual Prevention Treatment**
Anthony Puliafico, Ph.D., Columbia University Medical Center
Joanna Robin, Ph.D., Westchester Anxiety Treatment Psychological Services

Participants earn 1.5 continuing education credits

**Using Digital Tools to Facilitate CBT for Insomnia Treatment With Veterans**
Pearl A. McGee-Vincent, Psy.D., National Center for PTSD, VA Palo Alto Health Care System
Carolyn J. Greene, Ph.D., National Manager for Mental Health Web Services, VA
Christi S. Ulmer, Ph.D., VA Center of Innovation; Duke University School of Medicine
Katherine E. Miller, Ph.D., Department of Veterans Affairs

Participants earn 1.5 continuing education credits

**The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Children: Applications for Anger and Irritability**
Sarah M. Kennedy, Ph.D., University of Colorado School of Medicine

Participants earn 1.5 continuing education credits

**Treating Impulsive, Addictive, and Self-Destructive Behaviors**
Pегgiee Wupperman, Ph.D., John Jay College/The Graduate Center/City University of New York

**PANEL DISCUSSIONS**

Participants earn 1.5 continuing education credits

**Advocacy in Action: Psychologists’ Role in Advocacy to Improve the Health of Marginalized Populations**
Moderator: Colleen A. Sloan, Ph.D., US Department of Veterans Affairs
Panelists: Brian A. Feinstein, Ph.D., Northwestern University
Anu Asnaani, Ph.D., University of Pennsylvania
Abigail W. Batchelder, Ph.D., Massachusetts General Hospital/ Harvard Medical School & Fenway Health
Jae A. Puckett, Ph.D., Michigan State University
William Spaulding, Ph.D., University of Nebraska, Lincoln

Participants earn 1.5 continuing education credits

**Anxiety-Focused PCIT: Innovations in the Treatment of Early Childhood Anxiety Disorders**
Moderator: Cheryl B. McNeil, Ph.D., West Virginia University
Panelists: Steve Mazza, Ph.D., Columbia University Medical Center
Anthony Puliafico, Ph.D., Columbia University Medical Center
Steven Kurtz, ABPP, Ph.D., Kurtz Psychology Consulting
Jonathan Comer, Ph.D., Florida International University
Donna Pincus, Ph.D., Child Center for Anxiety and Related Disorders, Boston University
Andrea M. Chronis-Tuscano, Ph.D., University of Maryland

Participants earn 1.5 continuing education credits

**Bridging Anxiety, OCD, and Psychosis to Address Overlapping Symptoms and Provide Evidence-**
Participants earn 1.5 continuing education credits

**CBT in the Media: Strategies for Communicating Cognitive Behavioral Science Effectively**

**Moderators:** Ilana Seager van Dyk, M.A., The Ohio State University
Gwilym Roddick, The Ross Center

**Panelists:** Jonathan Abramowitz, Ph.D., University of North Carolina at Chapel Hill
Charity A. Davidsonson, Ph.D., Mercer University College of Health Professions
Jennifer Buchholz, MA, UNC Chapel Hill
Rachel Waford, Ph.D., Emory University Rollins School of Public Health
Jordan E. Cattie, Ph.D., Emory University School of Medicine

**Participants earn 1.5 continuing education credits**

**Cognitive-Behavioral Interventions for Substance Use Disorders: Challenges and Future Directions**

**Moderators:** Korine Cabrera, B.S., Clark University
Kathleen M. Palm Reed, Ph.D., Clark University

**Panelists:** Robert Miranda, Ph.D., Brown University Center for Alcohol and Addiction Studies
Paola Pedrelli, Ph.D., Harvard Medical School, Massachusetts General Hospital
Christina S. Lee, Ph.D., Northeastern University
Andrea Taylor, Ph.D., University of Texas Health Science Center, McGovern Medical School

**Participants earn 1.5 continuing education credits**

**Community Violence: Promoting Change by Bridging Science, Training, Policy, and Practice**

**Moderator:** Tommy Chou, M.S., Florida International University

**Panelists:** Marc S. Atkins, Ph.D., University of Illinois at Chicago
Sonya Dinizulu, Ph.D., University of Chicago
Stacy Frazier, Ph.D., Florida International University
Michael A. Lindsey, M.P.H., Ph.D., M.S.W., Silver School of Social Work, New York University
Greta Massetti, Ph.D., Center for Disease Control and Prevention Division of Violence Prevention

**Participants earn 1.5 continuing education credits**

**Cultural Insiders: Ethics, Research, Training, and Practice for Investigators of Color Working in Diverse Communities**

**Moderators:** Jacqueline O. Moses, M.S., Florida International University
Tommy Chou, M.S., Florida International University

**Panelists:** Heather A. Jones, Ph.D., Virginia Commonwealth University
Kelsie H. Okamura, Ph.D., State of Hawaii Child and Adolescent Mental Health Division
Rosaura Orengo-Aguayo, Ph.D., Medical University of South Carolina
Erlanger A. Turner, Ph.D., University of Houston-Downtown
Miguel Villodas, Ph.D., San Diego State University

**Participants earn 1.5 continuing education credits**

**Designing Interventions People Will Use: An Introduction to User-Centered Design**

**Moderator:** Emily G. Lattie, Ph.D., Northwestern University Feinberg School of Medicine

**Panelists:** Alex R. Dopp, Ph.D., University of Arkansas
Andrea K. Graham, Ph.D., Center for Behavioral Intervention Technologies, Northwestern University
Ashley Knapp, Ph.D., Northwestern University
Pauli Lieponis, M.A., Actualize Therapy
Kathryn Ringland, Ph.D., Northwestern University

**Participants earn 1.5 continuing education credits**

**Ensuring Cultural Humility Across Clinical Research Designs**

**Moderators:** Rachel R. Ouellette, M.S., Florida International University
Jacqueline O. Moses, M.S., Florida International University

**Panelists:** Miya Barnett, Ph.D., University of California, Santa Barbara
Stacy Frazier, Ph.D., Florida International University
Omar G. Gudiño, ABPP, Ph.D., University of Kansas
David A. Langer, ABPP, Ph.D., Suffolk University
Jessica LoPresti, Ph.D., Suffolk University

**Participants earn 1.5 continuing education credits**

**Extending the Reach of CBT Through Community, Industry, and Neuroscience Partnerships**

**Moderator:** Angela Fang, Ph.D., Massachusetts General Hospital/Harvard Medical School

**Panelists:** Cassidy A. Gutner, Ph.D., Boston University School of Medicine
Amanda Baker, Ph.D., Massachusetts General Hospital/Harvard Medical School
Philippe R. Goldin, Ph.D., University of California, Davis

**Participants earn 1.5 continuing education credits**

**Facing Fear the Right Way: What We Know and Need to Learn About Maximizing Exposure Outcomes**

**Moderators:** Joseph K. Carpenter, M.A., Boston University
Hayley E. Fitzgerald, M.A., Boston University

**Panelists:** Michelle Craske, Ph.D., UCLA
Michael Otto, Ph.D., Boston University
Participants earn 1.5 continuing education credits

**Having Faith in Acceptance-Based Science: Are the Spiritual Foundations of Mindfulness Compatible With Behavior Therapy?**

**Moderator:** Alexander L. Chapman, Ph.D., Simon Fraser University

**Panelists:** Emily Cooney, Ph.D., Yale School of Medicine
Philippe R. Goldin, Ph.D., UC Davis
Stefan G. Hofmann, Ph.D., Boston University Center for Anxiety and Related Disorders
Lynn C. Waelde, Ph.D., Palo Alto University; Stanford University School of Medicine

Randy Wolbert, M.S.W., Behavioral Tech, LLC

Participants earn 1.5 continuing education credits

**How Will Progress Continue After the Grant Ends? The Role of Purveyor Organizations in Sustainable Dissemination of Evidence-Based Programs**

**Moderators:** Margaret E. Crane, M.A., Temple University
Philip Kendall, Ph.D., Temple University

**Panelists:** Matthew Sanders, Ph.D., University of Queensland
Eric Daleiden, Ph.D., PracticeWise
Allen R. Miller, Ph.D., Beck Institute for Cognitive Behavior Therapy
Dennis D. Embry, Ph.D., PAXIS Institute

Ceth Ashen, Ph.D., C. Ashen Consulting

Participants earn 1.5 continuing education credits

**Implementing and Sustaining Evidence-Based Practice for Serious Mental Health Conditions: Georgia’s Recovery-Oriented Cognitive Therapy Initiative**

**Moderators:** Paul M. Grant, Ph.D., Perelman School of Medicine at the University of Pennsylvania
Ursula Davis, Georgia State University

**Panelists:** Paul M. Grant, Ph.D., Perelman School of Medicine at the University of Pennsylvania
Monica Johnson, Georgia Department of Behavioral Health and Developmental Disabilities
Terri Timberlake, Ph.D., Georgia Department of Behavioral Health and Developmental Disabilities
Jessica Austin, LCSW, Georgia State University

Christian S. Hildreth, Psy.D., Central State Hospital
Lynne Deigert, Behavioral Health Services of South Georgia

Participants earn 1.5 continuing education credits

**Making CBT an Alternative to Medication at Scale: Emerging Pathways for Increasing the Accessibility of Evidence-Based Psychological Treatments**

**Moderator:** Michael Otto, Ph.D., Boston University

**Panelists:** Jenna R. Carl, Ph.D., Big Health
Steve D. Hollon, Ph.D., Vanderbilt University
Michelle Craske, Ph.D., UCLA
Jonathan Comer, Ph.D., Florida International University
R. Kathryn McHugh, Ph.D., McLean Hospital/Harvard Medical School

Participants earn 1.5 continuing education credits

**Jumping Off the Academic Track: Extending the Social Impact of CBT in Unique Careers**

**Moderator:** Illyse Dobrow DiMarco, Ph.D., North Jersey Center for Anxiety and Stress Management

**Panelists:** Illyse Dobrow DiMarco, Ph.D., North Jersey Center for Anxiety and Stress Management
Jonathan Fader, Ph.D., Union Square Practice/SportStrata

Participants earn 1.5 continuing education credits

**Levering Technology to Support Personalized Care: Applying User-Centered Design, Citizen Science, and Machine Learning Algorithms to Digital Interventions**

**Moderator:** Stephen Schueller, Ph.D., University of California, Irvine

**Panelists:** Adrian Aguilera, Ph.D., UC Berkeley
Naomi Pollock, LCSW, AbleTo, Inc.
Lauren A. Rutter, Ph.D., McLean Hospital/Harvard Medical School

Participants earn 1.5 continuing education credits

**Tell You About Navigating Caregiver Challenges**

**Moderators:** H. Gemma Stern, B.S., Rutgers University
Emily Badin, B.A., Rutgers University
Tom Hildebrant, Psy.D., Icahn School of Medicine at Mount Sinai

Cheryl B. McNeil, Ph.D., West Virginia University
Anthony Puliifico, Ph.D., Columbia University Medical Center

Participants earn 1.5 continuing education credits

**Integrating Community-Based Projects in the Training of Clinical Scientists for Social Impact**

**Moderator:** Lauren A. Stuts, Ph.D., Davidson College

**Panelists:** Lauren A. Stuts, Ph.D., Davidson College
Taryn A. Myers, Ph.D., Virginia Wesleyan University
Elizabeth Dalton, Ph.D., Elizabethtown College
Susan Wenze, Ph.D., Lafayette College
Cheri A. Levinson, Ph.D., University of Louisville

Participants earn 1.5 continuing education credits

**Making Our Science Palatable to the Hungry Public: Embracing the Power of Social Media**

**Moderator:** Daniel L. Hoffman, ABPP,

Amelia Aldao, Ph.D., Private practice
Kenneth R. Weingartd, Ph.D., Pear Therapeutics
Paula Wilbourne, Ph.D., Sibly
Participants earn 1.5 continuing education credits

Parenting Gender Diverse Youth: Setting a Research and Clinical Agenda
Moderators: T. Zachary Huit, M.A., University of Nebraska-Lincoln
Katie Meidinger, M.A., University of Nebraska-Lincoln
Panelists: Ashley Austin, Ph.D., Barry University
Shelley L. Craig, Ph.D., M.S.W., University of Toronto
Diane Chen, Ph.D., Ann & Robert H. Lurie Children’s Hospital of Chicago/Northwestern University Feinberg School of Medicine
Arlene Noriega, Ph.D., Morehouse School of Medicine

Participants earn 1.5 continuing education credits

Research Recruitment Strategies for “Hard to Reach” Populations: A Panel to Share Lessons Learned and Tangible Takeaways
Moderator: Lanay M. Mudd, Ph.D., National Institutes of Health
Panelists: Lisa A. Uebelacker, Ph.D., Brown University & Butler Hospital
Jennifer L. Huberty, Ph.D., Arizona State University
Lauren Weinstock, Ph.D., Brown University & Butler Hospital

Participants earn 1.5 continuing education credits

Responding to #FakeNews With #RealScience: How to Disseminate Clinical Science to the Media
Moderator: Illyse Dobrow DiMarco, Ph.D., North Jersey Center for Anxiety and Stress Management
Panelists: Illyse Dobrow DiMarco, Ph.D., North Jersey Center for Anxiety and Stress Management
L. Kevin Chapman, Ph.D., Private Practice
Mitchell Prinstein, Ph.D., University of North Carolina, Chapel Hill
Simon A. Rego, ABPP, Psy.D., Montefiore Medical Center/Albert Einstein College of Medicine
Yael C. Schonbrun, Ph.D., Albert Medical School of Brown University

Participants earn 1.5 continuing education credits

So You Want to Train People From Different Professions in CBT . . . Now What?
Moderator: Barbara Kamholz, ABPP, Ph.D., VA Boston HCS/ Boston University School of Medicine
Panelists: Pooja Dave, N/A, Ph.D., CHA/Harvard Medical School
Cory F. Newman, ABPP, Ph.D., Perelman School of Medicine at the University of Pennsylvania
Gail Steketee, Ph.D., Boston University
Shona Vas, Ph.D., University of Chicago

Participants earn 1.5 continuing education credits

Social Justice Advocacy: What It Is, Why It Matters, and How to Help Psychology Fellows Integrate It Into Their Professional Identity and Practice
Moderators: Emily Treichler, Ph.D., VA San Diego MIRECC/UC San Diego
Jennifer N. Crawford, Ph.D., VA San Diego Healthcare System/UC San Diego
Panelists: Robyn L. Gobin, Ph.D., University of Illinois at Urbana Champaign
Kirsten A. Gonzalez, Ph.D., The University of Tennessee, Knoxville
Erica Lee, Ph.D., Emory University School of Medicine
Wayne G. Siegel, ABPP, Ph.D., University of Minnesota

Participants earn 1.5 continuing education credits

Successful Career Paths for the Scientist-Practitioner: A “Branching Pipeline” Approach to Retaining Women in Clinical Psychology
Moderator: Jennifer W. Malatras, Ph.D., SUNY Albany
Panelists: Julia M. Hormes, Ph.D., SUNY Albany
Ilana R. Luft, Ph.D., St. Louis Children’s Hospital, Washington University School of Medicine
Julie N. Morison, Ph.D., HPA/LiveWell
Julie L. Ryan, Ph.D., William James College
C. Alix Timko, Ph.D., University of Pennsylvania

Participants earn 1.5 continuing education credits

Supporting Graduate Students of Color: How to Identify and Overcome Barriers to Success in Predominantly White Institutions
Moderator: Alexandria N. Miller, B.S., B.A., Suffolk University
Panelists: Joaquin Borrego, Jr., Ph.D., Pacific University
Matthew J. Taylor, Ph.D., University of Missouri-St. Louis
Stevie N. Grassetti, Ph.D., West Chester University of Pennsylvania
Ana Bridges, Ph.D., University of Arkansas, Fayetteville
Jenny Phan, B.A., Loyola University Chicago
Roselee Ledesma, B.A., University of Arkansas

Participants earn 1.5 continuing education credits

Telehealth and mHealth: Innovations and Challenges in Clinical and Research Applications Across Private Sector, VA, and DoD Settings
Moderator: Jessica Stern, Ph.D., NYU Langone Health Steven A. Cohen Military Family Clinic
Panelists: Ariane Ling, Ph.D., NYU Langone Health Steven A. Cohen Military Family Clinic
Gina Raza, Ph.D., Puget Sound Healthcare System; Virginia Tech-Carilion School of Medicine
Jessica Watrous, Ph.D., Naval Health Research Center

Participants earn 1.5 continuing education credits

The MAP Toolkit for Enhancing the Connections Between Science and Practice: Common Elements and Much More
Moderator: Kimberly D. Becker, Ph.D., University of South Carolina
Panelists: Brad J. Nakamura, Ph.D., University of Hawaii at Manoa
Cameo Stanick, Ph.D., Hathaway-Sycamores Child and Family Services
Adam Bernstein, Ph.D., PracticeWise
Michael Southam-Gerow, Ph.D., Virginia Commonwealth University
Angela Chiu, Ph.D., Weill Cornell Medicine
Alyssa Ward, Ph.D., Department of Medical Assistance Services
Participants earn 1.5 continuing education credits

The Role of Cognitive Behavioral Science in Addressing Individual and Systemic Constraints to Evidence-Based Practice in the Changing Health Care Marketplace
Moderator: Kathleen M. Palm Reed, Ph.D., Clark University
Panelists: Kathleen M. Palm Reed, Ph.D., Clark University
Kerrie Toole, LICSW, MSW, Castlebrook Counseling Services, Inc.
Zachary Rosenthal, Ph.D., Duke University
Lauren Weinstock, Ph.D., Brown University & Butler Hospital

Participants earn 1.5 continuing education credits

Training Master’s-Level Clinicians in Evidence-Based Cognitive-Behavioral Practice
Moderator: Matthew Capriotti, Ph.D., San Jose State University
Panelists: Deah Abbott, M.A., Georgia State University
Matthew Capriotti, Ph.D., San Jose State University
Daniel Houlihan, Ph.D., Minnesota State University Mankato
Elena Klaw, Ph.D., San Jose State University
Caleb W. Lack, Ph.D., University of Central Oklahoma
Sarah Nadeau, M.S., MFT, San Jose State University

Participants earn 1.5 continuing education credits

Translating Research Findings to Clinical Practice: Out of the Echo Chamber, Into the Marketplace!
Moderator: Robert D. Friedberg, ABPP, Ph.D., Palo Alto University
Panelists: Mary A. Fristad, ABPP, Ph.D., The Ohio State University Wexner Medical Center
Sara J. Becker, Ph.D., Center for Alcohol and Addictions Studies Brown University School of Public Health
Torrey A. Creed, Ph.D., Perelman School of Medicine at the University of Pennsylvania
Susmita Pati, M.D., Stony Brook University School of Medicine & Stony Brook Children’s Hospital

Participants earn 1.5 continuing education credits

Treatment Engagement of Youth With Suicide Risk From Under-served Communities
Moderators: Cindy Chang, B.A., Rutgers University
Sara Ghassemzadeh, B.A., Rutgers University
Panelists: Shireen L. Rizvi, ABPP, Ph.D., Rutgers University
Kristin Scott, Ph.D., Children’s Health, University of Texas at Southwestern
Betsy D. Kennard, Psy.D., University of Texas Southwestern Medical Center at Dallas
Ethan Mereish, Ph.D., American University
Pamela End of Horn, LICSW, M.S.W., US DHHS Indian Health Service

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A Transdiagnostic, Stepped Care School Counselling System: The PRIDE Program in India
Chair: Vikram Patel, Ph.D., Harvard Medical School
Discussant: Bruce Chorpita, Ph.D., UCLA

Participants earn 1.5 continuing education credits

A Translational Approach to Suicide Risk Assessment: Novel Methodologies With Implications for Diverse Populations and Settings
Co-Chairs: Kenneth J.D. Allen, Ph.D., Alpert Medical School of Brown University
Brooke Ammerman, Ph.D., University of Notre Dame
Discussant: Christine B. Cha, Ph.D., Teachers College, Columbia University

Participants earn 1.5 continuing education credits

Act Well Your Part: Using Theater to Disseminate Evidence-Based Practices to Treat Core Deficits in Autism Spectrum Disorder
Chair: Matthew Lerner, Ph.D., Stony Brook University
Discussant: Susan White, Ph.D., The University of Alabama

Participants earn 1.5 continuing education credits

Addressing Violence, Abuse, and Trauma Throughout the Socioecological Model
Chair: Melanie D. Hetzel-Riggin, Ph.D., Penn State Erie, The Behrend College
Discussant: Emily Dworkin, Ph.D., University of Washington School of Medicine

Participants earn 1.5 continuing education credits

Advances in Perinatal Mental Health: Extending the Reach of Cognitive-Behavioral Science to an Understudied, Vulnerable Population
Co-Chairs: Samantha N. Hellberg, B.A., University of North Carolina at Chapel Hill
Jonathan Abramowitz, Ph.D., University of North Carolina at Chapel Hill
Discussant: Sheila Crowell, Ph.D., University of Utah

Participants earn 1.5 continuing education credits

ALACRITY Centers: Innovative Collaborations and Strategies for Research With Potential to Transform Practice
Chair: Joel T. Sherrill, Ph.D., National Institute of Mental Health/NIH
Discussant: Joel T. Sherrill, Ph.D., National Institute of Mental Health/NIH

Participants earn 1.5 continuing education credits

All the Skills, All the Time: Lessons Learned From Dialectical Behavior Therapy Intensive Outpatient, Partial Hospitalization, and Residential Programs
Chair: Emily Cooney, Ph.D., Yale School of Medicine
Discussant: Lorie Ritschel, Ph.D., University of North Carolina Chapel Hill School of Medicine

Participants earn 1.5 continuing education credits

Am I Good Enough? The Role of Self-Evaluation in the Context of Body Image and Disordered Eating
Chair: Laurel D. Sarfan, M.A., Miami University
Discussant: Drew Anderson, Ph.D., University at Albany, State University of New York
Participants earn 1.5 continuing education credits
**Anxiety Sensitivity and Substance Use: Associations and Novel Treatment Approaches**
*Co-Chairs: Amanda Raines, Ph.D., Southeast Louisiana Veterans Health Care System*
Nicholas Allan, Ph.D., Ohio University
*Discussant: Julia Buckner, Ph.D., Louisiana State University*
Participants earn 1.5 continuing education credits
**Applying Acceptance and Commitment Therapy to the Treatment of Domestic Violence, Stalking, and Sexual Misconduct**
*Chair: Erika Lawrence, Ph.D., The Family Institute at Northwestern University*
Discussant: Miriam Ehrensaft, Ph.D., Duke University
Participants earn 1.5 continuing education credits
**Barriers and Facilitators to Implementing Evidence-Based Interventions for Sleep Problems**
*Chair: Jessica C. Levenson, Ph.D., University of Pittsburgh School of Medicine*
Discussant: Sairam Parthasarathy, M.D., University of Arizona
Participants earn 1.5 continuing education credits
**Behavioral Health Treatment Needs, Entry, and Outcomes Among Justice-Involved Individuals**
*Co-Chairs: Mandy D. Owens, Ph.D., VA Puget Sound Health Care System*
Kelly E. Moore, Ph.D., East Tennessee State University
*Discussant: Raymond DiGiuseppe, Ph.D., St. John’s University*
Participants earn 1 continuing education credit
**Beyond Academic Impairment: Additional Risk for College Students With ADHD**
*Co-Chairs: Anna Garner, B.A., University of Northern Iowa*
Elizabeth Lefler, Ph.D., University of Northern Iowa
*Discussant: Andrea M. Chronis-Tuscano, Ph.D., University of Maryland*
Participants earn 1.5 continuing education credits
**Beyond Symptom Remission: Using CBT to Empower Youth to Achieve Normative Developmental Milestones**
*Chair: Renae Beaumont, Ph.D., Weill Cornell Medicine, New York Presbyterian Hospital*
Discussant: Cynthia Suveg, Ph.D., University of Georgia
Participants earn 1.5 continuing education credits
**Bridging the Gap: Addressing Barriers and Improving Access to Evidence-Based Psychotherapy**
*Co-Chairs: Gabriella Ponzini, B.A., West Virginia University*
Shari Steinman, Ph.D., West Virginia University
*Discussant: Bethany Teachman, Ph.D., University of Virginia*
Participants earn 1.5 continuing education credits
**Brief, Technology-Mediated Interventions to Expand the Reach of Cognitive-Behavioral Therapies**
*Chair: Jessica L. Schleider, Ph.D., Stony Brook University*
Discussant: Stephen Schueller, Ph.D., University of California, Irvine
Participants earn 1.5 continuing education credits
**Building the Capacity of Primary Care Providers and Improving Experiences for Families: Findings From Trauma-Informed Training, Collaborative Care, and Specialized Medical Home Efforts**
*Chair: Elizabeth A. Miller, Ph.D., University of Pittsburgh School of Medicine*
Discussant: David J. Kolko, Ph.D., University of Pittsburgh School of Medicine
Participants earn 1.5 continuing education credits
**Change That Matters: What, Why, and How Meaningful Change Happens in CBT for Anxiety-Related Disorders**
*Chair: Jesse McCann, B.S., University of Pennsylvania*
Discussant: Anu Asnaani, Ph.D., University of Pennsylvania
Participants earn 1.5 continuing education credits
**Chronic Medical Illness and Anxiety/Depression**
*Co-Chairs: Arielle Horenstein, M.A., Temple University*
Andrew H. Rogers, M.A., University of Houston
*Discussant: Daniel W. McNeil, Ph.D., West Virginia University*
Participants earn 1.5 continuing education credits
**Chronic Pain and Substance Use: Toward an Understanding of Psychological Vulnerabilities**
*Co-Chairs: Katherine McDermott, B.A., Florida State University*
Andrew H. Rogers, M.A., University of Houston
*Discussant: Gordon Asmundson, Ph.D., University of Regina*
Participants earn 1.5 continuing education credits
**Cognition and Emotion in Self-Injury and Suicide: Evidence for Novel State and Trait Risk Markers Using Objective Assessment Methods and Intensive Longitudinal Designs**
*Chair: Kenneth J.D. Allen, Ph.D., Alpert Medical School of Brown University*
Discussant: Brooke Ammerman, Ph.D., University of Notre Dame
Participants earn 1.5 continuing education credits
**Cognitive and Electrophysiological Advances in Anxiety and Related Disorders**
*Co-Chairs: Hani Zainal, M.S., Pennsylvania State University*
Michelle G. Newman, Ph.D., Pennsylvania State University
*Discussant: Kiara Timpano, Ph.D., University of Miami*
Participants earn 1.5 continuing education credits
**Cognitive Behavioral Science Beyond the Psychotherapy Room: Identifying Mental Health Disparities and Barriers to Care to Enhance Health and Well-Being Among Diverse and Vulnerable Medical Populations**
*Co-Chairs: Amelia Stanton, Ph.D., Harvard Medical School/Massachusetts General Hospital*
Miryam Yusufov, Ph.D., Dana-Farber Cancer Institute
Participants earn 1 continuing education credit

**CBT in Global Mental Health: Trials and Implementation**  
Chair: Laura Murray, Ph.D., Johns Hopkins University  
Discussant: Lucy Berliner, M.S.W., University of Washington, Seattle

Participants earn 1 continuing education credit

**Collaborating With Community Partners to Deliver Evidence-Based Practice and Increase Access to Care for Individuals With ASD Across the Life Span**  
Chair: Judy Reaven, Ph.D., JFK Partners, University of Colorado Anschutz Medical Campus  
Discussant: Laura G. Anthony, Ph.D., Children’s Hospital Colorado, University of Colorado Anschutz Medical Campus

Participants earn 1.5 continuing education credits

**Community-Based Mental Health and Trauma-Focused Service Provision for Children and Adults With ASD**  
Chair: Connor Kerns, Ph.D., University of British Columbia  
Discussant: Ann Garland, Ph.D., UC San Diego, School of Medicine

Participants earn 1 continuing education credit

**Considering Parenting in a Cultural Context: Class, Ethnicity, and Gender**  
Chair: Deborah J. Jones, Ph.D., UNC Chapel Hill  
Discussant: Robert J. McMahon, Ph.D., Simon Frasier University, British Columbia; BC Children’s Hospital, Vancouver

Participants earn 1.5 continuing education credits

**Context Matters: Sociocultural Considerations for Psychosis Risk and Early Psychosis**  
Chair: Emily He, M.A., Clark University  
Discussant: Amy Weisman de Mamani, Ph.D., University of Miami

Participants earn 1.5 continuing education credits

**Cost-Effectiveness of CBT: Critical Information for Dissemination and Implementation**  
Chair: Alessandro S. De Nadai, Ph.D., Texas State University  
Discussant: Eric A. Storch, Ph.D., Baylor College of Medicine

Participants earn 1.5 continuing education credits

**Creating a National Resource Center for Victims of Mass Violence: Addressing Mental Health Response and Consequences**  
Chair: Angela Moreland, Ph.D., Medical University of South Carolina  
Discussant: Dean Kilpatrick, Ph.D., Medical University of South Carolina

Participants earn 1 continuing education credit

**Cultural and Contextual Factors Affecting Individuals With Schizophrenia-Spectrum Disorders**  
Chair: Daisy Lopez, B.A., University of Miami  
Discussant: David Penn, Ph.D., University of North Carolina at Chapel Hill

Participants earn 1 continuing education credit

**Cultural Competence and Evidence-Based Practice in Training and Provision of Care in Diverse Societies**  
Chair: Vaishali Raval, Ph.D., Miami University  
Discussant: Terri Messman-Moore, Ph.D., Miami University

Participants earn 1.5 continuing education credits

**Current Practices and Future Directions in Addressing School Refusal**  
Co-Chairs: Scott E. Hannan, Ph.D., & Elizabeth Davis, Ph.D., Institute of Living  
Discussant: Micco Jamie, ABPP, Ph.D., Private Practice/Harvard Medical School

Participants earn 1.5 continuing education credits

**Does How We Implement an EBT Matter? Measuring the Process of Therapy**  
Chair: Jenelle Nissley-Tsiopinis, Ph.D., Children’s Hospital of Philadelphia  
Discussant: Anne Marie Albano, ABPP, Ph.D., Columbia University

Participants earn 1.5 continuing education credits

**Eating Disorders, Self-Injury, and Suicide: Common Pathways, Mechanisms, and Functions**  
Co-Chairs: Kathryn Fox, M.A., Harvard University  
Shirley Wang, B.A., Harvard University  
Discussant: Smith April, Ph.D., Miami University

Participants earn 1.5 continuing education credits

**Efficacy and Feasibility of Integrating Evidence-Based Treatment and Support Into Schools: Four Approaches From the United States and Japan**  
Chair: Chelsey Bowman, Ed.M., Boston University  
Discussant: Thomas Ollendick, Ph.D., Virginia Polytechnic Institute and State University

Participants earn 1.5 continuing education credits

**Emerging Research Among Military Couples: Novel Investigations and Unique Considerations**  
Chair: Feea Leifker, M.P.H., Ph.D., University of Utah  
Discussant: Steven Sayers, Ph.D., University of Pennsylvania / CMC VA Medical Center (Philadelphia)

Participants earn 1 continuing education credit

**Emotion Socialization Matters: Delving Into the Complexities of the Relations Between Emotion Socialization and Youth Internalizing and Externalizing Symptoms**  
Chair: Laura G. McKee, Ph.D., Georgia State University  
Discussant: Erin Tully, Ph.D., Georgia State University

Participants earn 1.5 continuing education credits

**Empowering Patients With Direct-to-Consumer Marketing for Evidence-Based Psychotherapies**  
Chair: Casey A. Schofield, Ph.D., Skidmore College  
Discussant: Robert D. Friedberg, ABPP, Ph.D., Palo Alto University

Participants earn 1.5 continuing education credits

**Evidence-Based Treatments to...**
Participants earn 1.5 continuing education credits

Evidence-Based Treatments in Low-and Middle-Income Countries: Adapting Treatments to Meet Local Needs
Chair: Lauren C. Ng, Ph.D., Boston University
Discussant: Jessica F. Magidson, Ph.D., University of Maryland, College Park

Participants earn 1.5 continuing education credits

Exercise Your Mind and Body: Boosting Physical Activity and Cognition in Severe Mental Illness
Co-Chairs: Abigail C. Wright, Ph.D., Massachusetts General Hospital
Julia Browne, M.A., University of North Carolina at Chapel Hill
Discussant: Kim Mueser, Ph.D., Boston University

Participants earn 1.5 continuing education credits

Expanding Impact: Addressing Co-occurring and Complicating Factors During Evidence-Based Treatments for PTSD
Chair: Shannon M. Blakey, Ph.D., VA Mid-Atlantic MIRECC/Durham VA Healthcare System
Discussant: Denise Sloan, Ph.D., National Center for PTSD

Participants earn 1.5 continuing education credits

Expanding the Impact of Youth Evidence-Based Mental Health Care Through Parents
Chair: Vanesa Ringle, M.S., University of Miami
Discussant: Jill Ehrenreich-May, Ph.D., University of Miami

Participants earn 1.5 continuing education credits

Exposure Therapy: From Bench to Bedside
Chair: Joanna L. Kaye, M.S., VA San Diego Healthcare System
Discussant: Michael Southam-Gerow, Ph.D., Virginia Commonwealth University

Participants earn 1.5 continuing education credits

Extending Research on the Interrelation of Interpersonal and Emotional Dysfunction Within Borderline Personality Disorder
Chair: Kim Gratz, Ph.D., University of Toledo
Discussant: Jennifer Cheavens, Ph.D., The Ohio State University

Participants earn 1.5 continuing education credits

Extending Suicide Research to the Most Marginalized Subgroups of Sexual and Gender Minority Individuals
Co-Chairs: Brian A. Feinstein, Ph.D., Northwestern University
Cindy Chang, B.A., Rutgers University
Discussant: Mitchell Prinstein, Ph.D., University of North Carolina, Chapel Hill

Participants earn 1.5 continuing education credits

Extending the Impact of Professional Training: Innovative Models to Support Clinician Competence
Chair: Kimberly A. Hepner, Ph.D., RAND Corporation
Discussant: Donna Sudak, M.D., Drexel University

Participants earn 1.5 continuing education credits

Extending the Reach of Therapeutic Interventions: Technology-Based Interventions for Risky Substance Use
Co-Chair: Julia Buckner, Ph.D., Louisiana State University
Katherine Walulevich-Dienst, B.A., Louisiana State University
Discussant: Clayton Neighbors, Ph.D., University of Houston

Participants earn 1.5 continuing education credits

Extending the Wisdom and Purpose of Mindfulness Across Couple and Families
Chair: Katherine A. Lenger, M.A., University of Tennessee, Knoxville
Discussant: Kristina Coop Gordon, Ph.D., University of Tennessee, Knoxville

Participants earn 1.5 continuing education credits

Families as a Source of Resilience for Youth Facing Stressors: Extending the Reach and Relevance of Family-Based Interventions
Chair: Nada M. Goodrum, M.A., Medical University of South Carolina
Discussant: Deborah J. Jones, Ph.D., University of Carolina, Chapel Hill

Participants earn 1.5 continuing education credits

Fear and Anxiety about Chronic and Acute Pain: Mechanisms, Emotion Regulation, and Psychosocial Factors
Chair: Daniel W. McNeil, Ph.D., West Virginia University
Discussant: Gordon Asmundson, Ph.D., University of Regina

Participants earn 1.5 continuing education credits

Fidelity Assessment in Usual Care Settings: Implications for Implementation of Evidence-Based Treatment Models
Chair: Craig E. Henderson, Ph.D., Sam Houston State University
Discussant: Sara J. Becker, Ph.D., Center for Alcohol and Addictions Studies
Brown University School of Public Health

Participants earn 1.5 continuing education credits

From Laboratory to Clinic: Mechanism-Focused Treatment of Borderline Personality Disorder
Chair: Julianne Wilner Tirpak, M.A., Boston University
Discussant: Kim Gratz, Ph.D., University of Toledo

Participants earn 1.5 continuing education credits

From the Ground Up to the Sky: Spanning the Arc of Implementation Supports
Chair: Rachel E. Kim, Ph.D., Judge Baker Children’s Center
Discussant: Shannon Dorsey, Ph.D., University of Washington
Participants earn 1.5 continuing education credits

Harnessing Clinical and Cognitive-Behavioral Science to Improve the Rigor of Paraprofessional Mentoring Interventions
Co-Chairs: Matthew Hagler, M.A., University of Massachusetts; Boston Samuel D. McQuillin, Ph.D., University of South Carolina
Discussant: Jean Rhodes, Ph.D., University of Massachusetts, Boston

Participants earn 1.5 continuing education credits

How Can I Help This Angry Patient? Developments in the Understanding and Treatment of Dysregulated Anger
Chair: Claire Cassiello-Robbins, M.A., Boston University Center for Anxiety and Related Disorders
Discussant: Raymond DiGiuseppe, Ph.D., St. John’s University

Participants earn 1.5 continuing education credits

Identity Concealment: Reasons, Consequences, and Associations With Mental and Physical Health
Chair: Courtney Beard, Ph.D., McLean Hospital/Harvard Medical School
Discussant: Steven Safren, Ph.D., University of Miami

Participants earn 1.5 continuing education credits

Impacts of Relationship Transitions on Romantic Relationship Quality and Individual Well-Being
Chair: Charlie Huntington, B.A., University of Denver
Discussant: Howard Markman, Ph.D., University of Denver

Participants earn 1.5 continuing education credits

Improving PTSD Treatment Access and Retention: Insights and Outcomes From the First 3 Years of the Warrior Care Network’s Intensive PTSD Treatment Programs
Chair: Philip Held, Ph.D., Rush University Medical Center
Discussant: Alan L. Peterson, ABPP, Ph.D., University of Texas Health Science Center at San Antonio

Participants earn 1.5 continuing education credits

Improving the Delivery and Reach of CBT: The Role of Emerging Technology
Chair: Amanda Edwards-Stewart, Ph.D., Psychological Health Center of Excellence
Discussant: Carolyn Greene, Ph.D., University of Arkansas for Medical Sciences

Participants earn 1.5 continuing education credits

Improving Treatment Outcome With Clinical Decision-Making Tools
Chair: Jacqueline Persons, Ph.D., Oakland Cognitive Behavior Therapy Center
Discussant: Philip Kendall, Ph.D., Temple University

Participants earn 1.5 continuing education credits

Improving Treatments for Hoarding Disorder: From the Laboratory to the Clinic
Chair: Kiara Timpano, Ph.D., University of Miami
Discussant: Randy Frost, Ph.D., Smith College

Participants earn 1.5 continuing education credits

Increasing Diversity in Clinical Research: Reaching New Populations and Developing Diverse Workforces
Chair: Xieyining Huang, M.S., Florida State University
Discussant: Esther C. Park, B.A., Florida State University

Participants earn 1.5 continuing education credits

Individualized Assessment and Treatment: What Wisdom Does Ecological Momentary Assessment Offer to Clinician and Client Stakeholders?
Co-Chairs: Thomas Rodebaugh, Ph.D., Washington University in St. Louis Madelyn Frumin, B.A., Washington University in St. Louis
Discussant: Bethany Teachman, Ph.D., University of Virginia

Participants earn 1.5 continuing education credits

Innovations in Translating CBT for Depression From the Lab to the Clinic
Chair: Roecklein A. Kathryn, Ph.D., University of Pittsburgh
Discussant: Michael A. Young, Ph.D., Illinois Institute of Technology

Participants earn 1.5 continuing education credits

Innovative Strategies to Overcome Barriers to Care for Children With Selective Mutism
Chair: Brian E. Bunnell, Ph.D., Medical University of South Carolina
Discussant: Deborah Beidel, Ph.D., University of Central Florida

Participants earn 1.5 continuing education credits

Interpersonal Relationships Among Marginalized Populations: Implications for Mental Health and Treatment
Chair: Sarah Carter, Ph.D., VA Puget Sound Health Care System
Discussant: Sarah W. Whiton, Ph.D., University of Cincinnati

Participants earn 1.5 continuing education credits

Interventions for Suicidality: How Good Are They, and How Can We Improve Them?
Co-Chairs: Joseph Franklin, Ph.D., Florida State University Jessica Ribeiro, Ph.D., Florida State University
Discussant: Zachary Rosenthal, Ph.D., Duke University

Participants earn 1.5 continuing education credit

Irritability in Childhood: Measurement, Predictive Utility and Treatment
Chair: Jeffrey D. Burke, Ph.D., University of Connecticut
Discussant: Amy K. Roy, Ph.D., Fordham University

Participants earn 1.5 continuing education credits

Lab-based Acquisition and Extinction of Conditioned Disgust: Novel Methods and Clinical Implications
Co-Chairs: Hannah Berg, B.A., University of Minnesota Shmuel Lissek, Ph.D., University of Minnesota
Discussant: Bunmi Olatunji, Ph.D., Vanderbilt University
Participants earn 1.5 continuing education credits

Labels Matter: The Role of Sexual Assault Perceptions in Risk and Outcomes
Co-Chairs: Emily Bernstein, B.S., University of Central Florida
Amie R. Newins, Ph.D., University of Central Florida
Discussant: Patricia A. Resick, Ph.D., Duke University Medical Center

Participants earn 1.5 continuing education credits

Learning from Social Situations: Translating Research on Mechanisms to Reduce the Burden of Social Anxiety
Chair: Miranda L. Beltzer, M.A., University of Virginia
Discussant: Stefan G. Hofmann, Ph.D., Boston University Center for Anxiety and Related Disorders

Participants earn 1.5 continuing education credits

Lessons Learned From Peer- and Lay Health Worker–Delivered Evidence-Based Interventions in Underserved Settings Locally and Globally
Co-Chairs: Jessica F. Magidson, Ph.D., University of Maryland, College Park
Mary B. Kleinman, M.P.H., University of Maryland, College Park
Discussant: Steven Safren, Ph.D., University of Miami

Participants earn 1 continuing education credit

Long-Term Effects of Youth Depression Prevention Programs: Patterns, Moderators, and Effects on Parental Depression
Chair: Karen Schwartz, M.S., SDSU/UC San Diego Joint Doctoral Program in Clinical Psychology
Discussant: V. Robin Weersing, Ph.D., SDSU-UC San Diego Joint Doctoral Program in Clinical Psychology

Participants earn 1.5 continuing education credits

Markers of Internalizing Disorders in Youth: The Interplay Between Cognitive, Psychophysiological, and Affective Processes
Chair: Michelle Rozenman, Ph.D., University of Denver
Discussant: V. Robin Weersing, Ph.D., SDSU-UC San Diego Joint Doctoral Program in Clinical Psychology

Participants earn 1.5 continuing education credits

Maternal Depression, Parenting Behavior, and Interventions: Relation to Children’s Outcomes
Co-Chairs: Judy Garber, Ph.D., Vanderbilt University
Katherine Cullum, M.A., Emory University
Discussant: Sherryl Goodman, Ph.D., Emory University

Participants earn 1.5 continuing education credits

Maximizing the Public Health Impact of Cognitive Behavioral Science Through Improving Consumer Engagement
Co-Chairs: Davielle Lakind, Ph.D., University of South Carolina
Alayna L. Park, M.A., UCLA
Discussant: Kimberly D. Becker, Ph.D., University of South Carolina

Participants earn 1.5 continuing education credits

Mental Health Interventions in Schools: Examining Multiple Ecological Levels of Intervention
Chair: Tara Kenworthy, M.A., University of South Carolina
Discussant: Tara Mehta, Ph.D., University of Illinois at Chicago

Participants earn 1.5 continuing education credits

Mindfulness- and Acceptance-Based Approaches With Marginalized Communities
Chair: Jennifer H. Martinez, M.A., University of Massachusetts Boston
Discussant: Lindsey M. West, Ph.D., Augusta University

Participants earn 1.5 continuing education credits

Mindfulness, Compassion, and CBT Interventions for Mood and Anxiety Disorders: Brain and Behavioral Investigations of Therapeutic Change
Chair: Philippe R. Goldin, Ph.D., University of California, Davis
Discussant: Stefan G. Hofmann, Ph.D., Boston University Center for Anxiety and Related Disorders

Participants earn 1.5 continuing education credits

Misophonia (Selective Sound Sensitivity): Clinical Characteristics and Cognitive-Behavioral Conceptualization
Chair: Dean McKay, Ph.D., Fordham University
Discussant: Joanna J. Arch, Ph.D., University of Colorado, Boulder

Participants earn 1.5 continuing education credits

Moderators and Mediators in Adult Anxiety and Obsessive-Compulsive Disorders
Chair: Nathaniel Van Kirk, Ph.D., McLean Hospital/Harvard Medical School
Discussant: David Tolin, Ph.D., Institute of Living

Participants earn 1.5 continuing education credits

More than Meets the Eye: Implications of Virtual Reality for Improving and Disseminating Anxiety and Depression Treatment
Chair: Anne Marie Alban, ABPP, Ph.D., Columbia University
Discussant: Muniya Khanna, Ph.D., Children’s Hospital of Philadelphia

Participants earn 1.5 continuing education credits

Moving Effective Treatment for PTSD to Primary Care
Chair: Jeffrey Cigrang, Ph.D., Wright State University
Discussant: Jeffrey L. Goodie, ABPP, Ph.D., Uniformed Services University of the Health Sciences

Participants earn 1.5 continuing education credits

Moving From Efficacy to Effectiveness With High-Quality Implementation of Interventions for Children With ADHD
Chair: Julie Sarno Owens, Ph.D., Ohio University
Chair: Amori Y. Mikami, Ph.D., University of British Columbia
Discussant: Marc S. Atkins, Ph.D., University of Illinois at Chicago

Participants earn 1.5 continuing education credits

Network Models Advancing the Understanding of Psychopathology
Chair: Michael A. Young, Ph.D., Illinois Institute of Technology
Discussant: Richard J. McNally, Ph.D., Harvard University
**Participants earn 1.5 continuing education credits**

**New Directions in Learning Research: Clarifying Psychopathological Risk and Identifying Treatment Targets**

Co-Chairs: Adam Jaroszewski, M.A., Harvard University
Emily E. Bernstein, M.A., Harvard University
Discussant: Michelle Craske, Ph.D., UCLA

**Participants earn 1.5 continuing education credits**

**New Directions in the Treatment of Suicidal People**

Chair: Kelly Zurorski, Ph.D., Harvard University
Discussant: Mitchell Prinstein, Ph.D., University of North Carolina, Chapel Hill

**Participants earn 1.5 continuing education credits**

**Novel Preventive Intervention Strategies for Couples and Families: Extending the Reach and Social Impact of CBT to Promote Relationship Quality and Adult and Child Well-Being**

Chair: Allen W. Barton, Ph.D., University of Georgia
Discussant: Scott Stanley, Ph.D., University of Denver

**Participants earn 1.5 continuing education credits**

**Novel Treatments for Affective Disorders: Leveraging Biological and Psychological Indicators for Treatment Personalization**

Chair: Alicia Meuret, SMU
Discussant: W. Edward Craighead, ABPP, Ph.D., Emory University

**Participants earn 1.5 continuing education credits**

**Novel Ways to Recruit and Increase Uptake Into Digital Mental Health Interventions**

Co-chairs: Emily G. Lattie, Ph.D., Northwestern University Feinberg School of Medicine
Ashley Knapp, Ph.D., Northwestern University
Discussant: Evan Forman, Ph.D., Drexel University

**Participants earn 1.5 continuing education credits**

**Onward, Together! Patient-Centered Research to Expand the Impact of Behavioral Treatments for Tourette Syndrome**

Chair: Matthew Capriotti, Ph.D., San Jose State University
Discussant: Amanda Talty, Tourette Association of America

**Participants earn 1.5 continuing education credits**

**Oppressed Identities and Healing: Streamlining Intervention Targets and Coping**

Chair: Broderick Sawyer, Ph.D., Behavioral Wellness Clinic
Discussant: Broderick Sawyer, Ph.D., Behavioral Wellness Clinic

**Participants earn 1.5 continuing education credits**

**Outcome Data and Implications of a Novel, Optimization-Focused Cognitive-Behavioral Intervention Focused on Destigmatizing Mental Health**

Chair: Brad Donohue, Ph.D., University of Nevada Las Vegas
Discussant: Al Light, M.S., Cirque du Soleil

**Participants earn 1.5 continuing education credits**

**Participatory Action in Research: Building Interventions From the Ground Up**

Chair: Grace Lee Simmons, B.S., The University of Alabama
Discussant: Brad J. Nakamura, Ph.D., University of Hawaii at Manoa

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**Partnership With Families in Therapy: Leveraging Family Processes in the Treatment of Anxiety Disorders**

Chair: Ryan Jacoby, Ph.D., Massachusetts General Hospital
Discussant: Eric Storch, Ph.D., Baylor College of Medicine

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**Pre-Loss Grief in Family Members of Cancer and Dementia Patients: A Theoretical and Empirical Examination of PLG Leading to an Evidence-Based Intervention**

Chair: W. Edward Craighead, ABPP, Ph.D., Emory University
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**Qualitative and Mixed Method Research on ADHD Treatment: The Importance of Stakeholders’ Perspectives**

Chair: Anne Morrow, M.S., Nova Southeastern University
Discussant: Gabriela A. Nagy, Ph.D., Duke University Medical Center

**Participants earn 1.5 continuing education credits**

**Recruitment, Engagement, and Retention of Underrepresented Groups in Bio-Behavioral Research: Lessons Learned and Recommendations for Investigators**

Chair: Gabriela A. Nagy, Ph.D., Duke University Medical Center
Discussant: Carla Rash, Ph.D., University of Connecticut

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**Reframing Behavioral Addictions as Reinforcer Pathologies: Implications for Theory and Practice**

Chair: Samuel F. Acuff, M.S., The University of Memphis
Discussant: Carla Rash, Ph.D., University of Connecticut

**Participants earn 1.5 continuing education credits**

**Relationship Health Across Diverse and Underserved Communities: Connecting Theory and Practice to Inform Therapeutic Processes for Couple Distress**

Co-Chairs: Judy Biesen, M.A., University of Notre Dame
Binghuang A. Wang, M.S., Binghamton University, State University of New York
Discussant: Emily Georgia Salivar, Ph.D., Nova Southeastern University

**Participants earn 1.5 continuing education credits**

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**Participants earn 1.5 continuing education credits**

**Religion and Spirituality in Couple Relationships: Building a Foundation for Expansion of Couple Therapy Research and Practice to Religious Couples**
Participants earn 1 continuing education credit
Remote Interventions With Couples: Using Technology to Extend our Reach
Chair: Steven Sayers, Ph.D., University of Pennsylvania / CMC VA Medical Center (Philadelphia)
Discussant: Brian Doss, Ph.D., University of Miami

Participants earn 1.5 continuing education credits
Responding to Stress Early in Life: Bench-to-Bedside Implications for Regulating Emotions
Co-Chairs: Jennifer Pearlstein, M.A., University of California, Berkeley
Victoria E. Cosgrove, Ph.D., Stanford University School of Medicine
Discussant: Patricia Brennan, Ph.D., Emory University

Participants earn 1.5 continuing education credits
Response to Treatment for Adolescent Depression: Pathways to Efficient and Personalized Psychotherapy
Co-Chairs: Molly Adrian, Ph.D., University of Washington
Jennifer B. Blossom, Ph.D., Seattle Children’s/UW School of Medicine
Discussant: Elizabeth McCauley, Ph.D., University of Washington

Participants earn 1 continuing education credit
Risk and Resilience Factors in Racial and Ethnic Minority Populations
Chair: Ana Martinez de Andino, M.S., Emory University School of Medicine
Discussant: Sierra Carter, Ph.D., Georgia State University

Participants earn 1.5 continuing education credits
Serving the Underserved: Victories and Challenges in Global Dissemination of EBPs for Underserved Communities
Co-Chairs: Kevin Narine, B.A., University of Pennsylvania
Jeremy Tyler, Psy.D., University of Pennsylvania
Discussant: Shannon Wiltsey-Stirman, Ph.D., National Center for PTSD and Stanford University

Participants earn 1.5 continuing education credits
Social Media for Social Good: Using Social Media to Deliver Cognitive and Behavioral Interventions to Adolescents and Young Adults
Chair: Danielle Ramo, Ph.D., Hopelab
Discussant: Patricia Cavazos, Ph.D., Washington University in St. Louis

Participants earn 1.5 continuing education credits
Social Media: Friend or Foe? Investigating the Effects of Social Media on Mood, Body Image, and Internalizing Disorders
Chair: Allison D. Altman, M.A., University of California, Berkeley
Discussant: Melissa Hunt, Ph.D., University of Pennsylvania

Participants earn 1.5 continuing education credits
Strategies to Increase Caregiver Involvement in Treatment: Novel Workforces, Delivery Models, and System Reforms to Reach Underserved Populations
Chair: Miya Barnett, Ph.D., University of California, Santa Barbara
Discussant: Marc S. Atkins, Ph.D., University of Illinois at Chicago

Participants earn 1.5 continuing education credits
Suicidality in Underrepresented Populations
Chair: Ana Rabasco, B.A., Fordham University
Discussant: Richard Liu, Ph.D., Alpert Medical School of Brown University

Participants earn 1.5 continuing education credits
Suicide Prevention: From Biomarkers to Intervention Implementation
Chair: Courtney Wolk, Ph.D., University of Pennsylvania
Discussant: Matthew Nock, Ph.D., Harvard University

Participants earn 1.5 continuing education credits
Technology-Based Mindfulness Interventions: Development, Patterns of Use, and Clinical Impact
Chair: Colleen Conley, Ph.D., Loyola University Chicago
Discussant: Moria J. Smoski, Ph.D., Duke University

Participants earn 1.5 continuing education credits
Technology-Based Targeted Prevention of Post-Sexual Assault Substance Use and Mental Health Symptoms
Co-Chairs: Emily Dworkin, Ph.D., University of Washington School of Medicine
Amanda Gilmore, Ph.D., Medical University of South Carolina
Discussant: Angela Moreland, Ph.D., Medical University of South Carolina

Participants earn 1.5 continuing education credits
The Feasibility of Exposure Therapy for Eating Disorders
Chair: Jamal H. Essayli, Ph.D., Penn State College of Medicine
Discussant: Carolyn B. Becker, Ph.D., Trinity University

Participants earn 1.5 continuing education credits
The Influence of Time of Day on Psychopathology and Implications for in-the-Moment and Personalized Interventions
Co-Chairs: Caroline Christian, B.S., The University of Louisville
Peter D. Soyster, B.A., University of California at Berkeley
Discussant: Aaron Fisher, Ph.D., University of California, Berkeley

Participants earn 1 continuing education credit
The Integration of Religion/Spirituality Into Culturally Informed, Cognitive-Behavioral Mental Health Treatments
Chair: Kayla K. Thayer, Ph.D., Nova Southeastern University
Discussant: Stevan Lars Nielsen, Ph.D., Brigham Young University

Participants earn 1.5 continuing education credits
The Interpersonal Regulation of Emotion Within Couples Coping With Unique Stressors
Chair: Steffany Fredman, Ph.D., Pennsylvania State University
Discussant: Brian R. Baucom, Ph.D., University of Utah
Participants earn 1.5 continuing education credits

**The Neuroscience of Hoarding and OCD: Predictors of Treatment-Response, Decision Making, and the State vs Trait Debate**

*Chair: Amitai Abramovitch, Ph.D., Texas State University*

*Discussant: Dean McKay, Ph.D., Fordham University*

Participants earn 1.5 continuing education credits

**The Oxford Cognitive Approach to Understanding and Treating Persecutory Delusions**

*Co-Chairs: Daniel Freeman, Ph.D., Psy.D., University of Oxford*

*Emma Cernis, Psy.D., University of Oxford*

*Discussant: Louise Isham, Psy.D., University of Oxford*

Participants earn 1.5 continuing education credits

**The Process of Improving Care in Community Settings**

*Chair: Courtney Wolk, Ph.D., University of Pennsylvania*

*Discussant: Rinad Beidas, Ph.D., University of Pennsylvania*

Participants earn 1.5 continuing education credits

**The Treatment of Anxiety in Autism Spectrum Disorder (TAASD) Trial: Clinical Characteristics and Outcomes**

*Chair: Connor Kerns, Ph.D., University of British Columbia*

*Discussant: Susan White, Ph.D., University of Alabama*

Participants earn 1.5 continuing education credits

**The Wisdom of a Good Night’s Sleep: Sleep Disturbance as a Mechanism and Target of Treatment in Depression and Anxiety**

*Chair: Y. Irina Li, M.A., University of Rochester*

*Discussant: Michael L. Perlis, Ph.D., University of Pennsylvania*

Participants earn 1.5 continuing education credits

**Therapeutic Potential of Oxytocin for Improving Social-Cognitive Processes and Behavior in PTSD and Substance Use Disorders**

*Chair: Lauren M. Sipple, Ph.D., National Center for PTSD*

Discussant: Angela Fang, Ph.D., Massachusetts General Hospital/Harvard Medical School

Participants earn 1.5 continuing education credits

**To Approach, Avoid, or Both? Towards an Improved Characterization of Positive and Negative Valence Systems in Eating Disorders**

*Chair: Erin E. Reilly, Ph.D., University of California, San Diego*

*Discussant: Katherine Schaumberg, Ph.D., University of Wisconsin, Madison*

Participants earn 1.5 continuing education credits

**Transdiagnostic Approaches in the Aetiology and Treatment of Anxiety Disorders**

*Co-Chairs: Muriel A. Hagenaar, Ph.D., Utrecht University*

*Iris M. Engelhard, Ph.D., Utrecht University*

*Discussant: Dirk Hermans, Ph.D., KU Leuven*

Participants earn 1.5 continuing education credits

**Transdiagnostic Implications of Parent’s Socialization of Children’s Emotions and Child Differences in Vulnerability**

*Chair: Julia D. McQuade, Ph.D., Amherst College*

*Discussant: Andrea M. Chronis-Tuscano, Ph.D., University of Maryland*

Participants earn 1.5 continuing education credits

**Transgender and Gender Diverse Health: Minority Stress, Coping, and Implications for Cognitive Behavioral Science**

*Chair: Jae A. Puckett, Ph.D., Michigan State University*

*Discussant: Ethan Mereish, Ph.D., American University*

Participants earn 1.5 continuing education credits

**Translating Research Findings Into Practical Tools for the Assessment of Mechanisms and Barriers in Real-World Treatment for OCD**

*Co-Chairs: Jennie M. Kuckertz, M.S., San Diego State University/University of California, San Diego*

*Nathaniel Van Kirk, Ph.D., McLean Hospital/Harvard Medical School*

*Discussant: Thröstur Björgvinsson, Ph.D., ABPP, McLean Hospital’s Behavioral Health Partial Program/Harvard Medical School*

Participants earn 1.5 continuing education credits

**Treatment Fidelity Assessment: Developing Efficient Measurement Tools**

*Chair: Nicole B. Gumport, M.A., University of California, Berkeley*

*Discussant: Shannon Dorsey, Ph.D., University of Washington*

Participants earn 1.5 continuing education credits

**Trigger Warnings! Are They Helpful, Harmful, or Neither?**

*Chair: Richard J. McNally, Ph.D., Harvard University*

Participants earn 1.5 continuing education credits

**Understanding and Modifying Cognitive Control and Processing Biases in Depression**

*Chair: Leanne Quigley, Ph.D., Ferkauf Graduate School of Psychology, Yeshiva University*

*Discussant: Christopher Beevers, Ph.D., The University of Texas at Austin*

Participants earn 1.5 continuing education credits

**Understanding Barriers to Engaging Traditionally Underserved Populations in Mental Health Services**

*Chair: Alayna L. Park, M.A., UCLA*

*Discussant: Stanley Huey, Ph.D., University of Southern California*

Participants earn 1.5 continuing education credits

**Understanding Exercise Approach-Avoidance Behavior in Women to Inform Feasible Transdiagnostic Intervention Development**

*Co-Chairs: Samantha G. Farris, Ph.D., Rutgers University*

*Kathryn A. Coniglio, B.A., Rutgers University*

*Discussant: Brandon Alderman, Ph.D., Rutgers University*

Participants earn 1.5 continuing education credits

**Understanding Relationship Functioning and Dynamics to Serve Diverse and Underserved Sexual Minority Individuals**
Invited Addresses

Friday, November 22 | 11:00 a.m. – 12:00 p.m.
Lifetime Achievement Address

Imagine Being Accused of Scientific Fraud!
Linda C. Sobell, Ph.D. ABPP, Nova Southeastern University
Mark B. Sobell, Ph.D. ABPP, Nova Southeastern University

Friday, November 22 | 12:30 - 1:30 p.m.
Invited Address 1

Building the Workforce to Deliver Psychological Therapies Globally
Vikram Patel, Ph.D., Harvard Medical School

Saturday, November 23 | 12:30 - 1:30 p.m.
Invited Address 2

Transforming the Lives of Children, Parents, and Communities: Accomplishments and Future Opportunities
Matthew R. Sanders, Ph.D., University of Queensland, Brisbane
Research and Professional Development

Participants earn 1.5 continuing education credits

Applying for F31 Predoctoral or F32 Postdoctoral Fellowship Awards
Chair: Becky Kinkead, Ph.D., Emory University School of Medicine
Speakers: Lou Ann Brown, Ph.D., Emory University School of Medicine
Becky Kinkead, Ph.D., Emory University School of Medicine

Participants earn 1.5 continuing education credits

Careers in Clinical Psychology: Which Path Makes Sense for Me?
Chair: Jedidiah Siev, Ph.D., Swarthmore College
Sabine Wilhelm, Ph.D., Harvard Medical School; Massachusetts General Hospital
Matthew Nock, Ph.D., Harvard University
Jonathan B. Grayson, Ph.D., The Grayson LA Treatment Center for Anxiety & OCD
Barbara Kamholz, ABPP, Ph.D., VA Boston HCS & BU School of Medicine

Participants earn 1.5 continuing education credits

Developing Your Research Career: NIH Training and Career Development Funding Opportunities
Chair: Lanay M. Mudd, Ph.D., National Institute of Mental Health
Speakers: Ashley Tipton, Ph.D., National Institute of Mental Health
Lisa Uebelacker, Ph.D., Brown University & Butler Hospital
Christina M. Laberto, Ph.D., Massachusetts General Hospital/Harvard Medical School
Ivan W. Miller, Ph.D., Brown University
Ana M. Abrantes, Ph.D., Brown University
Lanay M. Mudd, Ph.D., National Institute of Mental Health
Lauren Weinstock, Ph.D., Brown University & Butler Hospital

Participants earn 1.5 continuing education credits

Improving Support for Parents During Psychology Training
Chair: Gabriela Khazanov, Ph.D., Corporal Michael J. Crescenz VA
Speakers: Stevie N. Grassetti, Ph.D., West Chester University of Pennsylvania
Keith D. Renshaw, Ph.D., George Mason University
Lauren Weinstock, Ph.D., Brown University & Butler Hospital
Lynn McFarr, Ph.D., Harbor-UCLA Medical Center & CBT California
Jedidiah Siev, Ph.D., Swarthmore College
Contributor: Aleshea Young, M.A., University of Hartford

Participants earn 1.5 continuing education credits

It Never Hurts to Ask! Strategies to Negotiate Academic Job Offers
Chair: Shona N. Vas, Ph.D., The University of Chicago
Speakers: Andrea K. Graham, Ph.D., Northwestern University Feinberg School of Medicine
Fabiana S. Araujo, Ph.D., University of Chicago
Shona N. Vas, Ph.D., University of Chicago

Participants earn 1.5 continuing education credits

Living as a Scientist-Practitioner: How to Conduct Research in Your Clinical Practice
Chair: Jacqueline B. Persons, Ph.D., Oakland CBT Center
Speakers: Travis L. Osborne, ABPP, Ph.D., Evidence Based Treatment Centers of Seattle
Andrew White, Ph.D., Portland DBT Institute
R. Trent Codd III, Ed.S., Cognitive-Behavioral Therapy Center of WNC, P. A.

Participants earn 1.5 continuing education credits

The Power and Promise Individual Participant Data: Developing A Clinical Trial Repository for Pediatric OCD
Chair: David H. Barker, Ph.D., Bradley Hasbro Children’s Research Center
Speakers: Scott N. Compton, Ph.D., Duke University
Jennifer B. Freeman, Ph.D., Alpert Medical School of Brown University
Kristen M. Benito, Ph.D., Bradley Hospital
David H. Barker, Ph.D., Bradley Hasbro Children’s Research Center

Participants earn 1.5 continuing education credits

Values-Based Self-Care: Creating a Professional Self-Care Plan that Will Stick
Chair: Jorden Cummings, Ph.D., University of Saskatchewan
Speakers: Jessica Campoli, B.A., University of Saskatchewan
Jorden Cummings, Ph.D., University of Saskatchewan

Spotlight Research

All Spotlight Research sessions are 1.5 continuing education credits

How Can We Develop Therapeutic Interventions to Reduce the Harmful Effects of Adverse Childhood Experiences? A Modular, Multifocal, Trauma-Informed Solution
Chair: Arnon Bentovim, M.D., Fellow of Royal College of Psychiatrists UK
Panelists: Cameo Stanick, Ph.D., Hathaway-Sycamores Child and Family Services

Implicit Anti-Black Bias Predicts Black Mortality Rates
Chair: Monnica T. Williams, Ph.D., University of Connecticut
Panelists: Jamilah R. George, University of Connecticut
Terence Ching, University of Connecticut

Toward a Dimensional Taxonomy of Perseverative Thought
Chair: Kiara Timpano, Ph.D., University of Miami
Panelists: Lauren Hallion, Ph.D., University of Pittsburgh
Marc Coutanche, Ph.D., University of Pittsburgh
Jutta Joormann, Ph.D, Yale University
Susan Kusmierski, B.A., University of Pittsburgh
M. Kathleen Caulfield, B.A., University of Pittsburgh

Training Family and Caregivers in CBT for Psychosis-Informed Skills Within the Context of a CBTp Provider Network
Chair: Sarah L. Kopelovich, Ph.D., University of Washington School of Medicine
Panelists: Bryan Stiles, M.A., University of Washington School of Medicine
Maria Monroe-DeVita, Ph.D., University of Washington School of Medicine
Kate Hardy, Ph.D. Stanford University
Doug Turkington, M.D, Newcastle University
Co-Author: Samantha Davis, BFA, University of Washington
Special Invited Panels

FRIDAY, NOVEMBER 22 | 9:00 a.m. – 10:30 a.m.
Atrium Ballroom B & C, Atrium Level
1.5 CE Credits

Increasing Impact of Cognitive Behavioral Therapies: Why Public Health?

Moderator: Sonja Schoenwald, Ph.D., Oregon Social Learning Center
Panelists:
Ileana Arias, Ph.D., Centers for Disease Control and Prevention
Craig Thomas, Ph.D., Centers for Disease Control and Prevention
Richard Puddy, Ph.D., MPH, Centers for Disease Control and Prevention

This invited session explores the intersection of public health principles and essential services with the conference theme of extending the social impact of cognitive behavioral science. Sonja Schoenwald facilitates a guided discussion among a panel from Atlanta-based, U.S. Centers for Disease Control and Prevention that includes, Ileana Arias, Ph.D., Craig Thomas, Ph.D., and Richard Puddy, Ph.D., MPH. Topics addressed include: public health foundational concepts, the benefits of adopting a public health perspective; what’s needed (and limitations) for interventions to work on the ground in a wide variety of potentially diverse and challenging contexts; and illustrations of comprehensive public health strategies that span the continuum from individual to population health. Success stories and battle scars will be highlighted from across a range of strategies that impact health (from individual behavioral science interventions to wide-scale policy interventions), all the while taking into account implementation factors. Come experience how ABCT as an organization and as a collection of individuals can gain a public health perspective on scaling solutions to increase the impact of cognitive behavioral science.

SATURDAY, NOVEMBER 23 | 10:30 a.m. – 12:00 p.m.
Atrium Ballroom B & C

Realizing ABCT’s Mission in a Politicized World

Moderator: Lynn F. Bufka, Ph.D., American Psychological Association
Panelists:
Laura D. Seligman, Ph.D., University of Texas Rio Grande Valley
Anita Brown, Ph.D.,
Megan Gordon-Kane, Feminist Women’s Health Center
Lauren Thompson, Ph.D., McKendree University
Brandon Gaudiano, Ph.D., Brown University

ABCT is “committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevent and treatment of human problems through the global application of behavioral, cognitive, and biological evidence-based principles.” How can ABCT as an organization and individual ABCT members leverage this mission and knowledge to inform public policy and legislation? Members may be energized by recent issues—such as Georgia’s restrictive abortion laws—but enhancing the health and well-being of others through the application of evidence-based principles extends to many domains. Panelists will address the realities of policy development in our modern era and discuss the best strategies for ensuring that science appropriately informs the process. Panelists will also address the challenging realities of working within divisive and partisan politics to find solutions that advance health and well-being. Challenges include “fake news,” the public’s lack of understanding of science, attempting to advance multiple priorities that require political goodwill, “irrational” decision making, and working within the legal and ethical bounds of the organization and our disciplines. Panelists include Dr. Laura Seligman, an active member of ABCT’s Women’s SIG; Dr. Anita Brown, an advocate for psychology within the state of Georgia; Dr. Lauren Thompson, a historian specializing in law and health; Ms. Megan Gordon-Kane, an advocate for state-level reproductive justice policies from Atlanta-based Feminist Women’s Health Center; and Dr. Brandon Gaudiano, an expert in science and pseudoscience. The panel will be moderated by Dr. Lynn Bufka, who oversees policy and research development for professional practice at the American Psychological Association.
## Special Interest Group Meetings

Attendance at an ABCT Special Interest Group meeting is a wonderful networking opportunity. The SIGs focus on a diverse range of topics, including treatment approaches, specific disorders or unique populations. SIGs are open to ABCT members only, so be sure to join or renew your membership. The Friday-night Cocktail Party/SIG Exposition, 6:30 PM – 8:30 PM, is a fabulous chance to get an overview of ABCT’s SIG Program in a friendly, networking atmosphere. All SIG meetings will take place in the Hyatt Regency.

<table>
<thead>
<tr>
<th>SIG Name</th>
<th>Date/Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Addictive Behaviors</strong></td>
<td>Friday, 12:30p.m.- 2:00 p.m.</td>
<td>Embassy C, Embassy Level</td>
</tr>
<tr>
<td><strong>African Americans in Behavior Therapy</strong></td>
<td>Friday, 8:30a.m.- 10:00 a.m.</td>
<td>Embassy C, Embassy Level</td>
</tr>
<tr>
<td><strong>Anxiety Disorders</strong></td>
<td>Saturday, 9:30 a.m.- 11:00 a.m.</td>
<td>International North, Ballroom Level</td>
</tr>
<tr>
<td><strong>Asian American Issues in Behavior Therapy and Research</strong></td>
<td>Saturday, 11:30 a.m. – 12:30 p.m., International North, Ballroom Level</td>
<td></td>
</tr>
<tr>
<td><strong>Attention-Deficit/Hyperactivity Disorder (ADHD)</strong></td>
<td>Saturday, 4:00p.m.- 5:30 p.m.</td>
<td>Embassy C, Embassy Level</td>
</tr>
<tr>
<td><strong>Autism Spectrum and Developmental Disorders</strong></td>
<td>Friday, 10:30a.m.- 12:00 p.m.</td>
<td>Embassy C, Embassy Level</td>
</tr>
<tr>
<td><strong>Behavioral Medicine and Integrated Primary Care</strong></td>
<td>Saturday, 9:30a.m.- 11:00 a.m.</td>
<td>Embassy A, Embassy Level</td>
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<tr>
<td><strong>Behavioral Sleep Medicine</strong></td>
<td>Saturday, 4:00p.m.- 5:30 p.m.</td>
<td>Embassy A, Embassy Level</td>
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<tr>
<td><strong>Bipolar Disorders</strong></td>
<td>Saturday, 4:00p.m.- 5:30 p.m.</td>
<td>International North, Ballroom Level</td>
</tr>
<tr>
<td><strong>Child and Adolescent Anxiety</strong></td>
<td>Saturday, 2:00p.m.- 3:30 p.m.</td>
<td>Embassy D, Embassy Level</td>
</tr>
<tr>
<td><strong>Child and Adolescent Depression</strong></td>
<td>Friday, 3:30p.m.- 5:00 p.m.</td>
<td>Embassy C, Embassy Level</td>
</tr>
<tr>
<td><strong>Child Maltreatment and Interpersonal Violence</strong></td>
<td>Friday, 10:30a.m.- 12:00 p.m.</td>
<td>Embassy D, Embassy Level</td>
</tr>
<tr>
<td><strong>Child and School-Related Issues</strong></td>
<td>Friday, 8:30a.m.- 9:30 a.m.</td>
<td>Embassy C, Embassy Level</td>
</tr>
<tr>
<td><strong>Clinical Psychology at Liberal Arts Colleges</strong></td>
<td>Saturday, 4:00p.m.- 5:30 p.m.</td>
<td>Embassy D, Embassy Level</td>
</tr>
<tr>
<td><strong>Clinical Research Methods and Statistics</strong></td>
<td>Friday, 1:45p.m.- 2:45 p.m.</td>
<td>Vinings, Conference Level</td>
</tr>
<tr>
<td><strong>Couples Therapy</strong></td>
<td>Friday, 10:30a.m.- 11:30 a.m.</td>
<td>Vinings, Conference Level</td>
</tr>
<tr>
<td><strong>Couples Research and Treatment</strong></td>
<td>Friday, 9:00a.m.- 10:00 a.m.</td>
<td>Embassy F, Embassy Level</td>
</tr>
<tr>
<td><strong>Dissemination and Implementation Science</strong></td>
<td>Friday, 12:30 p.m.- 2:00 p.m.</td>
<td>International North, Ballroom Level</td>
</tr>
<tr>
<td><strong>Forensic Issues and Externalizing Behaviors</strong></td>
<td>Friday, 4:30 p.m.- 6:00 p.m.</td>
<td>Vinings, Conference Level</td>
</tr>
<tr>
<td><strong>Hispanic Issues in Behavior Therapy</strong></td>
<td>Saturday, 9:30 a.m.- 11:00 a.m.</td>
<td>Embassy D, Embassy Level</td>
</tr>
<tr>
<td><strong>Men's Mental and Physical Health</strong></td>
<td>Friday, 12:00 p.m.- 1:00 p.m.</td>
<td>Vinings, Conference Level</td>
</tr>
<tr>
<td><strong>Military Psychology</strong></td>
<td>Friday, 8:30 a.m.- 10:00 a.m.</td>
<td>Vinings, Conference Level</td>
</tr>
<tr>
<td><strong>Mindfulness and Acceptance</strong></td>
<td>Friday, 4:00 p.m.- 5:30 p.m.</td>
<td>Embassy E, Embassy Level</td>
</tr>
<tr>
<td><strong>Native American Issues in Behavior Therapy and Research</strong></td>
<td>Saturday, 2:00 p.m.- 3:30 p.m., International North, Ballroom Level</td>
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<tr>
<td><strong>Neurocognitive Therapies/Translational Research</strong></td>
<td>Saturday, 9:30 p.m.- 10:30 a.m.</td>
<td>Embassy C, Embassy Level</td>
</tr>
<tr>
<td><strong>Obesity and Eating Disorders</strong></td>
<td>Friday, 2:30 p.m.- 4:00 p.m.</td>
<td>Embassy F, Embassy Level</td>
</tr>
<tr>
<td><strong>Oppression and Resilience: Minority Mental Health</strong></td>
<td>Friday, 10:30 a.m.- 12:00 p.m.</td>
<td>Embassy B, Embassy Level</td>
</tr>
<tr>
<td><strong>Parenting and Families</strong></td>
<td>Friday, 2:00 p.m.- 3:30 p.m.</td>
<td>Embassy E, Embassy Level</td>
</tr>
<tr>
<td><strong>Psychosis and Schizophrenia Spectrum</strong></td>
<td>Friday, 10:15 a.m.- 11:45 a.m.</td>
<td>Embassy C, Embassy Level</td>
</tr>
<tr>
<td><strong>Sexual and Gender Minority</strong></td>
<td>Saturday, 2:00 p.m.- 3:30 p.m.</td>
<td>Embassy A, Embassy Level</td>
</tr>
<tr>
<td><strong>Spiritual and Religious Issues in Behavior Change</strong></td>
<td>Friday, 10:30a.m.- 11:30 a.m.</td>
<td>Embassy F, Embassy Level</td>
</tr>
<tr>
<td><strong>Student</strong></td>
<td>Friday, 9:00a.m.- 10:00 a.m.</td>
<td>Embassy D, Embassy Level</td>
</tr>
<tr>
<td><strong>Suicide and Self-Injury</strong></td>
<td>Friday, 2:00p.m.- 3:30 p.m.</td>
<td>Embassy D, Embassy Level</td>
</tr>
<tr>
<td><strong>Technology and Behavior Change</strong></td>
<td>Friday, 2:00 p.m.- 3:30 p.m.,</td>
<td>Embassy C, Embassy Level</td>
</tr>
<tr>
<td><strong>TIC and Impulse Control Disorders</strong></td>
<td>Saturday, 11:30a.m.- 1:00 p.m.</td>
<td>Embassy A, Embassy Level</td>
</tr>
<tr>
<td><strong>Women's Issues in Behavior Therapy</strong></td>
<td>Saturday, 11:00 a.m.- 12:00 p.m.</td>
<td>Embassy C, Embassy Level</td>
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</tbody>
</table>
Preregister on-line at www.abct.org. To pay by check, complete the registration form available in PDF format on the ABCT website. Participants are strongly urged to register by the preregistration deadline of October 15. Beginning October 16 all registrations will be processed at the on-site rates.

Please note: Convention Program Books will NOT be distributed. A PDF of the program book will be available and posted to the ABCT convention page. Please download the convention app to view and create your own personalized schedule.

To receive the member-discounted convention registration rate, members must renew for 2020 before completing the registration process or they must join as a new member of ABCT.

Preconvention ticketed sessions and registration for preconvention sessions will be held on Thursday, November 21 at the Atlanta Marriott Marquis Hotel. All preconvention sessions are designed to be intensive learning experiences. Preregister to ensure participation.

Registration for all PRE-convention sessions (AMASS, Clinical Intervention Seminars, Institutes) will take place in the Atlanta Marriott Marquis Hotel at the ABCT onsite registration area in the International Ballroom South, International Level.

- Thursday, November 21: 7:30 a.m. - 6:30 p.m.

General Registration

Upon arrival at the Atlanta Marriott Marquis Hotel, you can pick up the program addendum, additional convention information, and ribbons at the Pre-Registration Desk in the Atrium, Exhibition Level. If you are a member of ABCT, please vote for the 2020-2021 candidates using the computers provided.

PLEASE REMEMBER TO BRING CONFIRMATION LETTER WITH YOU TO THE MEETING.

Onsite Registration AND Preregistration pickup will be open:

- Thursday, November 21: 7:30 a.m. - 6:30 p.m.
- Friday, November 22: 7:30 a.m. - 6:30 p.m.
- Saturday, November 23: 7:30 a.m. - 6:30 p.m.
- Sunday, November 24: 7:30 a.m. - 1:00 p.m.

The general registration fee entitles the registrant to attend all events on November 21–November 24 except for ticketed sessions. Your canceled check is your receipt. Email confirmation notices will be generated automatically for on-line registrations and will be sent via email the same day you register. Email confirmations will be sent within 1 week for faxed and mailed registrations. If you do not receive an email confirmation in the time specified, please call the ABCT central office, (212) 647-1890, or email Tonya Childers at tchilders@abct.org.

You must wear your badge at all times to be admitted to all official ABCT sessions, events, and the exhibits. If you lose your badge there will be a $15 charge for the replacement.

All presenters (except for the first two presenters of ticketed CE sessions) must pay the general registration fee. Leaders of ticketed session will receive information regarding their registration procedure from the ABCT Central Office. Admission to all ticketed sessions is by ticket only. Preregistration is strongly advised as ticketed sessions are sold on a first-come, first-served basis.

Please note: NO PURCHASE ORDERS ACCEPTED.

To register, please choose one format:

Registering On-Line The quickest method is to register on-line (go to abct.org and click on the convention banner on the home-page, or go to www.abct.org/conv2019). Use this method for immediate feedback on which ticketed sessions you will be attending. To receive members‘ discounted rates, your ABCT dues must be up to date. If your membership has lapsed, use this opportunity to renew.

To get member rates at this conference, your ABCT dues must be paid through October 31, 2020. The ABCT membership year is November 1, 2019–October 31, 2020. To renew, go to abct.org or visit the membership booth on-site in Atlanta.

Registering by Fax You may fax your completed registration form, along with credit card information and your signature, to (212) 647-1865. If you choose this method please DO NOT send a follow-up hard copy. This will cause double payment. For preregistration rates, please register BEFORE the deadline date of October 15.

Registering by Mail All preregistrations that are paid by check must be mailed to ABCT, 305 Seventh Avenue, 16th Floor, New York, NY, 10001. For preregistration rates, forms must be postmarked by the deadline date of Monday, October 15. Forms postmarked beginning Tuesday, October 16 will be processed at on-site rates. There will be no exceptions. Refund Policy Cancellation refund requests must be in writing. Refunds will be made until the October 15 deadline, and a $40 handling fee will be deducted. Because of the many costs involved in organizing and producing the Convention, no refunds will be given after October 15.

Payment Policy

All fees must be paid in U.S. currency on a U.S. bank. Any bank fees charged to the Association will be passed along to the attendee. Please make checks payable to ABCT.

Exhibits, ABCT Information Booth Hours

- Friday & Saturday: 8:00 a.m. - 5:30 p.m.
- Sunday: 8:30 a.m. - 11:00 a.m.
Hotels

Marriott Marquis Atlanta
265 Peachtree Center Avenue NE
Atlanta, Georgia, 30303 USA
Telephone: (404) 521-0000

- Online reservations:

A stay at Atlanta Marriott Marquis places you in the heart of Atlanta, within a 15-minute walk of AmericasMart and World of Coca Cola. This 4-star hotel is 0.6 mi (0.9 km) from Centennial Olympic Park and 0.6 mi (1 km) from Georgia Aquarium. Free Internet, WiFi, Fitness Center, Spa, Swimming Pool, and access to concierge Level lounge for selected sleeping rooms, just steps away from MARTA Peachtree Center Station.

Sleeping Room Rate: $189 Single or Double Occupancy

Reservation Cut-off Date: October 25, 2019

Taxes: 16% plus an additional $5 per night flat State Hotel fee.

All reservations must be accompanied by a first night room deposit or guaranteed with a major credit card.

Attendees are able to book via phone with Marriott Central Reservations at 866-469-5475.

Concierge level rooms may be available with $50 surcharge.

Hyatt Regency Atlanta on Peachtree Street
265 Peachtree Street NE
Atlanta, Georgia, 30303 USA
Telephone: (404) 577-1234

- Online reservations:

Hyatt Regency Atlanta is a 30-minute train ride from the airport and a short walk to Mercedes-Benz stadium and Atlanta’s arena, convention center and top attractions. The hotel is famous for the Polaris rotating lounge and their acclaimed Chefs, who partner with 70 local farms to plate the freshest ingredients. Welcome to the landmark hotel in the heart of Atlanta. Free WiFi, Fitness Center, Seasonal Swimming Pool and business services available.

Sleeping Room Rate: $184 Single or Double Occupancy

Reservation Cut-off Date: October 24, 2019

Taxes: 16% plus an additional $5 per night flat State Hotel fee.

An early departure fee will be charged in the amount of one night’s room and tax in the event that a guest checks out before the confirmed departure date.

All reservations must be accompanied by a first night room deposit or guaranteed with a major credit card.

If the group rate is no longer available, prevailing rates may be offered for some or all of your dates.

The special ABCT Convention rates will be offered, based on mutual agreement with the Hotel, 3 days before and 3 days after the official Convention dates of November 21 – 24, 2019. The block is limited and available on a first-come basis until the block is depleted. If you are interested in upgrading your hotel accommodations, there are limited options available, at an increased rate. Contact the hotel directly.

All ABCT Convention scientific sessions will take place at the Atlanta Marriott Marquis Hotel. General registration includes panel discussions, clinical round tables, symposia, mini-workshops, and over a dozen poster sessions. SIG meetings will take place at the Hyatt Regency Atlanta on Peachtree Street. Remember to check out the limited-attendance CE events – both on Thursday and throughout the Convention on Friday and Saturday. One complimentary beverage ticket will be provided for use at the Welcoming Reception/SIG Exposition on Friday night from 6:30 p.m. to 8:30 p.m.

Stay at the Marriott Marquis Headquarters Hotel or the Hyatt Regency Atlanta to meet your friends and colleagues on the elevator, in the coffee shop, as well as in the meeting rooms. Your support of the convention hotels also helps to keep the overall expenses to a minimum.

Rooms and rates are subject to rate and room availability. Please be sure to book your reservation early!
Jennifer Cheavens is an Associate Professor and Director of Clinical Training in the Department of Psychology at the Ohio State University (OSU). Jen earned her Ph.D. in clinical psychology at the University of Kansas after completing her internship year at Duke University Medical Center (DUMC). Following her internship year, Jen completed a postdoctoral fellowship through an NIA-sponsored T32 award at the Duke Center for the Study of Aging and Human Development. After 3 years on the faculty of DUMC, Jen accepted a position at OSU and has been there since. Jen directs the Mood and Personality Studies research group at OSU, where she supervises both graduate and undergraduate researchers conducting investigations aimed at characterizing and improving treatment for disorders of emotion dysregulation, including borderline personality disorder and depression. Jen also studies ways to incorporate client strengths into treatments. She teaches both undergraduate and graduate-level courses, in addition to providing supervision in the Dialectical Behavior Therapy clinic. Jen has been recognized with a university-wide award from OSU for excellence in teaching.

For how long have you been a member of ABCT?
I’ve been a member of ABCT since 2000 (when it was AABT). I joined as a graduate student and have maintained my membership ever since.

What type of mentor do you aspire to be? Do you have a mentorship philosophy?
I aspire to be the kind of mentor who knows how to get the best out of people. In my experience, the best mentoring is in the context of a caring relationship in which your mentor knows what you want and has your best interests at heart. I believe if I am deeply invested in each of my students as people, then the rest will follow. If I know their goals, values, and priorities, then I can meet them where they are and challenge them in ways that help them move toward their goals.

What practices do you engage in that foster your mentorship style?
I try to maintain authenticity and transparency in my relationships, including my mentoring relationships. When we know each other well and like each other, it is so much easier to work together, so I spend a significant amount of time with my trainees. I have found that regular one-on-one time helps me to know them as whole people. Relatively, we as a lab celebrate professional and personal wins. When a student has a paper accepted or submits a grant or gets married or has a baby, we celebrate that together.

What are your strengths as a mentor?
My primary strength as a mentor is that I genuinely care about my students and their success. I have faith in each of them; I know they can flourish and meet their goals. I know that they are on a path in which they can be truly happy and fulfilled in their professional and personal lives. Essential to this is caring enough to deliver difficult feedback. I respect my students enough to let them know what I think and I assume they can handle feedback of all sorts—the cheerleading and encouragement, as well as the pulling for more.

Whom do you perceive to be your most influential mentors? Describe the main lessons that you have learned from your mentors.
I have been so lucky to have some truly tremendous mentors in my life. My most influential mentor, professionally, was my graduate school mentor, Rick Snyder, at the University of Kansas. Rick really emphasized the importance of giving more than you take. He believed that you should constantly be striving to make the world a better place, even in small ways. Also, he was a lifelong learner and modeled the continuous approach of new questions with a childlike curiosity. I really loved that about him.

I also have learned so much from the peer mentors in my life—the people with whom I’ve worked most closely at each stage of my career. By watching my friends and colleagues I’ve learned: you’ve got to put yourself out there; the journey is much more fun when you have your people with you; it is possible to help others and be productive; and don’t pull the ladder up behind you.

What do you tend to look for in potential mentees?
The primary attribute I look for in potential mentees is intellectual curiosity. I get very excited by new ideas and working as a team to answer questions—even when the work is tough. I really want students who find it fun to dig into the process of answering questions with me. Additionally, it is important for me to have good citizens in my research group. I look for students who are able to balance their own goals with the goals of the group. Additionally, because I have very high expectations for my students and prefer to communicate directly with them, I value mentees who are receptive to feedback and are committed to investing in their own growth.

What advice would you give to other professionals in your field who are starting out as mentors?
I think it is difficult to give broad advice on mentoring, as it is an activity that is so intertwined with one’s personality. I think it is important to develop a mentoring style that works for you. I’ve had mentors with radically different styles who each taught me some very important lessons. I also think it is probably a good idea to continue to look for examples of excellent mentoring all around you—in your mentors, your peers, your students—and then try to steal all their best stuff!

What do you enjoy doing for fun/relaxation?
I read quite a bit; I love to try new restaurants; and I really enjoy traveling. I have terrific friends from all the stages of my life and an amazing family so I try to spend as much time with those folks as possible.

Spotlight on a Mentor interviews are presented by ABCT’s Academic Training and Education Standards Committee. To read about all of our spotlighted mentors, please visit abct.org/Resources. To add your mentorship profile to the ABCT Mentorship Directory, please visit www.abct.org/mentorship/
BOOK REVIEW


New York: Guilford Press

Reviewed by Natalie Armstrong Hoskowitz, Bridgewater State Hospital

Tafrate, Mitchell, and Simourd’s new text, CBT With Justice-Involved Clients (2018), is an addition to the existing series Treatment Plans and Interventions for Evidence-Based Psychotherapy, edited by Robert L. Leahy. The overarching aim of this series is to provide clinicians with practical guides and materials for use with particular clinical issues or populations. Such an aim is easily identified throughout this newest addition proffered by Tafrate, Mitchell, and Simourd. In addition, the book’s subtitle, Interventions for Antisocial and Self-Destructive Behaviors, reinforces the goal of this text and also foreshadows for the interested reader that this book is intended to provide a framework for effective interventions with this sometimes challenging population.

Importantly, Tafrate et al. (2018) intended to create a resource for graduate-level trainees when they are first introduced to work with a justice-involved population—a resource that guides their training in a way that aligns with both best practices as well as evidence-based approaches within the ever-broadening definition of CBT. Although this is not explicitly stated in the preface section of the text, what is clear is that the authors intended this book to be used as a practical guide for clinical treatment, while fully recognizing the inherent difficulties of working with such a population. Indeed, throughout this book, the authors endeavor to remind the reader that any challenges that arise when working with justice-involved clients are a normative part of the therapeutic process and are not to be blamed on either the client or the clinician. Similarly, the authors prepare the reader for what may be considered an unusual approach to the organization of this treatment planner, in that it is “less manualized” than contemporary peer texts. However, such organization is not without appropriate justification, and again harkens back to the authors’ clear understanding of justice-involved individuals and how clinicians in training can best serve those involved with the justice system.

The book opens with two chapters within a section titled “Forensic Basics” that lays out the environment in which clinicians likely find themselves when working with justice-involved clients, as well as how CBT “fits” within such a landscape. The authors do well in distilling theories and research regarding offending behavior into digestible portions. In doing so, Tafrate et al. (2018) guide the reader into understanding how CBT principles are at work in research in these areas, and how they will be applied later in the text. The following sections, “Engagement” and “Assessment, Case Formulation, and Focus,” build upon these foundational concepts from the first two chapters. Indeed, these chapters are well-designed around the central thesis for this book (i.e., how to provide clinical trainees with an effective roadmap in working with justice-involved individuals) and provide the most essential and useful information without becoming too cumbersome and laden with extraneous material.

Subsequent sections, “Detailed Treatment Plans for Criminogenic Thinking and Antisocial Orientation” and “Detailed Treatment Plans for Harmful Lifestyle Patterns,” operate in much a similar manner. However, it is within these sections that the real meat of the book is apparent, as is the unique organizational structure initially identified in the preface. Specifically, Tafrate et al. (2018) provide the emerging clinician with practical steps to address in treatment the most crucial issues facing most justice-involved clients. Moreover, throughout this portion of the text, they also provide troubleshooting tips—that is, how to address issues that may arise when treatment does not go “according to plan.” Such a thoughtful approach suggests two important pieces of information: (a) the authors have a clear understanding of the theory and research behind working with justice-involved individuals; and (b) the authors are able to communicate such information in an effective way that also feels genuine and based in real-life experiences.

The final section, “Practice Management,” is a helpful bookend because it provides the reader with useful examples of clinical writing. In this way, readers are shown what are the most essential and important elements to include in case formulation, assessment, treatment progress, and treatment summaries. Importantly, Tafrate et al. (2018) steer clear of pejorative and charged language, thus modeling how to convey this information in a largely neutral manner. Such skill is particularly important in the context of written work, which often lasts far beyond the clinician’s physical tenure. An important lesson to learn as an emerging clinician is how to manage personal responses to challenging populations, and to do so in a way that is largely free of negative bias. Indeed, throughout the book, the authors model for graduate trainees how to identify bias when working with justice-involved clinicians, and to manage it appropriately.

The strengths of this book are many. Tafrate et al. (2018) have crafted a text that is easily readable and deeply practical. Good examples include the use of case vignettes throughout the text, which illustrate typical progress and struggles between the client and the clinician. More to this point, the authors frequently comment on the realistic difficulties that many may encounter when working with this population, taking care to highlight that the reasons for such difficulties are myriad in nature and not the fault of any one person. Additionally, the authors integrate other modalities into their treatment plan, including Motivational Interviewing and Acceptance and Commitment Therapy. Such integration reflects a central tenet of working with justice-involved clients and is at the heart of this text: although working with justice-involved clients is inherently based in CBT, therapeutic success can be maximized by utilizing supplementary evidence-based therapies when necessary. Moreover, the informative summaries, scripts, and handouts available for the clinician flow naturally from the text, and will be a helpful addition to any graduate trainee working with this population. Finally, the authors do well in providing a text that a clinical supervisor can easily follow and build upon as needed.
Future editions of the book may wish to consider providing more examples across various settings in which work with justice-involved clients is likely. For example, as the text advances, many of the examples focus on community-based settings. Although a large bulk of work with justice-involved clients occurs in the community, many trainees provide services in jails, prisons, and psychiatric facilities. Thus, additional effort likely will be required on the part of the reader when having to adapt this text to more secure (i.e., prison or inpatient) environments. Additionally, while the authors clearly articulate a focus on antisocial and self-destructive behaviors, clinical trainees will likely need more consultation with their supervisors when encountering clients with severe comorbid psychopathology and/or substance use. An inherent limitation in writing in any treatment text is the inability to capture all nuances when working with a particular population, and this text is no exception. However, the framework of the book is such that the authors provide the reader with in-text cues that seeking additional supervision on particular topics (cf. risk assessment, severe psychopathology, and substance use) will likely be helpful and warranted. Overall, this text is a useful addition to the field of forensic treatment, and it is hoped that outcome data on this intervention strategy can provide even more support for its use among clinical trainees.

Reference

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CALL FOR NOMINATIONS

Spotlight on a Researcher

ABCT’s Research Facilitation Committee is pleased to highlight innovative work being conducted by our membership through our Spotlight on a Researcher feature. Indeed, ABCT’s Spotlight on a Researcher seeks to enhance understanding of the process of research involvement among ABCT members by sharing the perspectives of established researchers. Our hope is that members who are building careers that involve research can benefit from experiences, insights, and advice shared by these researchers. Our Spotlight seeks to highlight the diversity of research being conducted by ABCT members by including perspectives across varied backgrounds, settings, paradigms, and populations.

To view previous spotlights, see our selection criteria, and to nominate a researcher, please visit: http://www.abct.org/Resources and select SPOTLIGHT ON RESEARCHERS

Past Spotlighted Researchers
Laurel Sarfan
Ken Weingardt
Shawn C.T. Jones
Web Editor

ABCT is seeking a Web Editor to assist in updating material in, and developing policies for, its website. The position is funded with an honorarium. The role principally involves helping to develop content for the website and reviewing the site and navigational structure to ensure it remains best suited to our audiences. Technological knowledge is less essential, and the Web Editor is not expected to post to the site or otherwise take on the function of a webmaster.

The following mission statement and strategy statement detail information on the proposed aims, activities, and audiences of this new website effort.

**Web Page Mission Statement**
The website serves a central function as the public face of ABCT. As such, it has core functions linked to the mission and goals of the organization: facilitating the appropriate utilization and growth of CBT as a professional activity and serving as a resource and information source for matters related to CBT.

Informational and resource activities are directed toward three conceptual groups:

- **Members**—with emphasis on providing an interface for many of the administrative functions of the organization, including conference information, dues, public listing of therapists, etc.
- **Nonmember Professionals**—to advertise the comparative efficacy, diversity of styles, and methods of cognitive-behavior therapy, with additional information on training opportunities, available syllabi, and new findings in the scientific literature.
- **Consumers**—to provide information and treatment resources on disorders and their treatment, with emphasis on the style, “feel,” and efficacy of cognitive-behavior therapy, as well as information on additional issues that consumers confront in treatment (e.g., combined treatments, relapse prevention, etc.).

**Web Page Strategy Statement**
One of the broader changes in the architecture of the website is that our content will now come up on searches. Accordingly, we plan content that will bring professionals and consumers to our site.

The Web Editor will need to liaise with associate editors, periodical editors, committees, and SIGs for content. Such content includes:

- Diagnosis-specific information pages (e.g., information on depression and its treatment)
- Efficacy information (comparative, combination treatment issues)
- The “feel” of cognitive-behavioral treatment
- CBT, BT, DBT, RET . . . what is in a name?
- Recent research findings
- Position statements—regarding issues in the field (to clarify what our organization stands for)
- Speakers bureau
- Links to publications
- Helping media find the right person to discuss a topic
- CBT curricula
- Featured therapist of the month
- Research funding available
- Learning opportunities

ABCT’s website is now a mature site, having undergone several structural revisions. There will be another following the conclusion of an evaluation of our existing database and web. We are looking for a member to help us maximize our own web’s outreach potential and grow it while maintaining structural integrity. In addition, candidates can apprentice with our current webmaster, learning the interface among Web Editor, webmaster, and central office.

**How to Apply**
ABCT members interested in applying for this position should contact David Teisler, Director of Communications, ABCT, at teisler@abct.org.

⇒ **DEADLINE for APPLICATIONS**: October 1, 2019
CALL FOR CANDIDATES

Editor of BEHAVIOR THERAPY

Candidates are sought for Editor-Elect of Behavior Therapy, volumes 53–56. The official term for the Editor is January 1, 2022, to December 31, 2025, but the Editor-Elect should be prepared to begin handling manuscripts at least 1 year prior.

Candidates should send a letter of intent and a copy of their CV to Michelle Newman, Publications Coordinator, ABCT, 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008, or via email to teisler@abct.org.

Candidates will be asked to prepare a vision letter in support of their candidacy. David Teisler, ABCT’s Director of Communications, will provide you with more details at the appropriate time. Letters of support or recommendation are discouraged. However, candidates should have secured the support of their institution.

Questions about the responsibilities and duties of the Editor or about the selection process can be directed to David Teisler at the above email address or, by phone, at (212) 647.1890.

Letters of intent MUST BE RECEIVED BY October 15, 2019.
Vision letters will be required by October 31, 2019.
The Editor will be selected at ABCT’s Board of Directors meeting in November.

Impact factors for ABCT’s journals:

Behavior Therapy: 3.243
4.221 (5 year)
23/129

Cognitive and Behavioral Practice: 1.932
2.627 (5 year)
65/129
VOTE for 2020 Officers at the Annual Convention

The 2020 ABCT election opens November 1. We have moved up the 2020 elections to November to get more of the membership involved in voting. If you renewed your 2020 ABCT membership and are a full member or new member professional, please vote. Be sure you pick up your “I Voted” sticker at the ribbon board at the ABCT Annual Convention in Atlanta.