

the Behavior Therapist

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SCIENCE

Risk Factors for Early and Late Dropout From Dialectical Behavior Therapy for Suicidal Adolescents

Miguelina Germán, Montefiore Medical Center/Albert Einstein College of Medicine

Vincent P. Corcoran, Fordham University

Lorey Wheeler, University of Nebraska—Lincoln

Jeana L. DeMairo, The New School for Social Research

Olivia M. Peros, Hofstra University

Tanvi Bahuguna, Teachers College, Columbia University

Alec L. Miller, Cognitive & Behavioral Consultants of Westchester and Manhattan and Montefiore Medical Center/Albert Einstein College of Medicine

PREVIOUS STUDIES REVEAL that a number of variables contribute to treatment dropout among suicidal adolescents. Adolescents with a history of suicide attempts were more likely to drop out of treatment than their nonsuicidal counterparts (15% vs. 3%; Barbe, Bridge, Birmaher, Kolko, & Brent, 2004). Adolescents

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In an effort to embrace one aspect of ABCT's strategic initiative—commitment to globalization—the Board of Directors is recommending a change to our mission statement and purposes:

Article II

Mission Statement

The Association for Behavioral and Cognitive Therapies is a multidisciplinary organization committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through the global application of behavioral, cognitive, and biological evidence-based principles.

Purposes

The purposes of the Association are to globally:

1. Encourage innovations that advance scientific approaches to behavioral, cognitive, and biological evidence-based approaches to behavioral health;
2. Promote the utilization and dissemination of behavioral, cognitive, and biological evidence-based approaches to behavioral health;
3. Facilitate professional development, interaction, and networking among members;
4. Promote ethical delivery of science-based interventions;
5. Promote health and well-being through a commitment to diversity and inclusion at all levels.

We appreciate your feedback by March 1
(mjeimer@abct.org).



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.

who reported current suicidal ideation were also more likely to drop out of treatment than their nonsuicidal counterparts (28.6% vs. 4.3%; Barbe et al., 2004). Adolescents who reported both lifetime and current suicidality were associated with greater impairment at intake and also with dropout from treatment (Barbe et al.). Dropout rates were higher when suicidal adolescents were in nondirective supportive therapy than in cognitive behavioral therapy or in systemic behavioral family therapy (Barbe et al.). Studying dropout among this high-risk population is the first step toward developing targeted strategies for prevention. Studies on evidence-based interventions have shown 11 to 13 sessions are needed for a majority of patients to achieve clinically significant symptom remission (Hansen, Lambert, & Forman, 2002; Lambert, 2007).

Given the limited amount of research on suicidal adolescents who drop out from treatment, we draw upon the broader literature that has examined nonsuicidal adolescents and treatment dropout. These studies suggest that adolescents who are more likely to drop out of therapy tend to be older (de Haan, Boon, Vermeiren, Hoeve, & de Jong, 2015), experience lower symptom severity (Chasson, Vincent, & Harris, 2008; Kazdin & Mazurick, 1994) and are members of minority groups (McFarland & Klein, 2005), such as African-American (Nock & Kazdin, 2001; Wierzbicki & Pekarik, 1993). To our knowledge there are no published, empirical studies on treatment dropout from Dialectical Behavior Therapy (DBT), an evidence-based treatment for suicidal adolescents. This study drew upon an ecological framework to identify both intrapersonal and interpersonal variables that could potentially impact treatment participation for suicidal adolescents.

DBT is a treatment for suicidal adolescents who may also be exhibiting symptoms of borderline personality disorder (BPD). While suicidal adolescents are often also depressed and thus have symptom profiles consistent with internalizing disorders, adolescents who are both suicidal and have BPD symptoms also endorse problems with impulsivity, emotion dysregulation, interpersonal deficits, and confusion about self. While these patient characteristics are important to examine in a study about suicidal adolescents and treatment dropout from DBT, an ecological framework highlights multiple influences on a child's development, including influential adults. For example, adolescents are typi-

cally brought to therapy by parents or caregivers. Parental involvement and participation are viewed as an essential component for successful treatment of adolescent mental health problems in many treatment approaches (Erhardt & Baker, 1990; Mendlowitz et al., 1999). However, parental dropout has been shown to be as high as 60% (Armbruster & Fallon, 1994; Pekarik & Stephenson, 1988), and is associated with higher child dropout (Kazdin & Mazurick, 1994). DBT also strongly encourages parental participation in treatment. However, to our knowledge, there are no studies that have reported dropout rates from DBT in a community clinic outside of a randomized controlled trial.

Research has shown that another important relationship for the patient is the therapeutic relationship, in that the strength of the therapeutic alliance can affect treatment outcome (Martin, Garske, & Davis, 2000). Although therapist transfer (i.e., the transfer of a patient's care mid-treatment) has been shown to be a barrier to treatment, few studies have focused on its relation to patient dropout (Kazdin, Marciano, & Whitley, 2005). In a training clinic, patients often must be transferred between therapists mid-treatment due to trainees moving on to different electives. This is an important variable to study, particularly for a suicidal adolescent sample with BPD symptoms, one of which is a fear of abandonment. If a patient feels abandoned by their therapist, these feelings may precipitate dropping out of DBT prematurely. However, no study has explored this hypothesis in DBT or with adolescents.

Taken together, there appear to be a variety of relevant domains that contribute to treatment dropout for suicidal adolescents. For the purpose of this study, general demographic risk factors (e.g., age, gender, race), parental participation in treatment, occurrence of therapist transfer, severity of adolescent BPD symptomatology, self-harm history (e.g., suicide attempts, NSSI), and self-reported emotional and behavioral problems will be explored in the context of treatment dropout. Rather than hypothesize a single path to treatment dropout, we borrow from Kazdin, Mazurick, and Bass. (1993) the concept of risk proneness, and that dropout is likely a result of multiple risk factors operating in combination. Therefore, we hypothesize that identified individual risk factors and their accumulation will increase the likelihood of adolescent dropout from DBT treatment in an outpatient setting.

Method

Participants

The study consisted of patients admitted to a 20-week DBT outpatient therapy program ($N = 98$) from 2005–2014. The program was affiliated with a university hospital training clinic located within the New York metropolitan area. The sample was predominately female (84.5%) with an average age of 15.07 years ($SD = 1.50$). Additionally, the majority of the sample consisted of ethnic minority adolescents, with Hispanic (65.1%) and African-American adolescents (20.9%) representing the two largest groups.

The standard DBT protocol of the clinic entailed a pretreatment phase in which adolescents met with their individual therapist once per week, and an active comprehensive treatment phase that incorporated weekly group work. During active treatment, the adolescent attended 20 weeks of multifamily skills group, received phone coaching as needed, and continued meeting with their individual therapist. Parents were strongly encouraged to attend skills groups as well. Attendance rules were clearly stated to the adolescent and their participating family member(s) at the beginning of multifamily skills group. Specifically, if an adolescent or parent accumulated a total of 4 absences for any reason during the 20-week program, that individual was deemed ineligible to continue and designated a dropout from treatment.

An adolescent entered active treatment upon attending the initial multifamily skills group. For the purpose of this study, patient dropout was explored in two ways: early dropout from treatment and late dropout. An adolescent was an early dropout if he/she was assigned to DBT but never attended the first multifamily skills group (thus never entering active treatment). Late dropout consisted of adolescents who discontinued treatment at any point after attending their first multifamily skills group. Chart reviews were conducted to determine when a patient or parent(s) dropped out of DBT treatment. Inclusion criteria for the study were patients who completed the intake process and were assigned to DBT. During the intake, patients filled out a battery of self-report measures that were used in the analyses for the current study.

Measures

Treatment dropout variable. Charts were reviewed to determine the timing of

when a patient and parent had dropped out of treatment. Separate variables were created for adolescent dropout and parent dropout that were coded in the following way: 0 = *completed treatment*, 1 = *dropped out early*, and 2 = *dropped out late*. The adolescent dropout variables were used as the outcome variables of this study. In contrast, the parent variables were used as predictors.

Borderline personality disorder symptomatology. The Life Problems Inventory (LPI; Rathus, Wagner, & Miller, 2005) is a 60-item self-report measure designed to assess core borderline symptomatology within adolescents: impulsivity, emotion dysregulation, interpersonal problems, and confusion about self. Thus, the LPI consists of four corresponding subscales that address each of these core borderline features. The subscales contain 15 items that are each scored on a 5-point Likert-type scale with answers ranging from “Not at all like me” to “Extremely like me.” The total score, calculated by summing all 4 subscales, measures total borderline symptomatology. Items include “I often feel I will totally fall apart if someone important abandons or rejects me” and “When I don’t get my way, I quickly lose my temper.” All of the LPI subscales demonstrated strong internal reliability: confusion about self ($\alpha = .90$), impulsivity ($\alpha = .76$), emotional dysregulation ($\alpha = .92$), and interpersonal chaos ($\alpha = .87$).

Youth mental symptoms. The Youth Self-Report (YSR; Achenbach, T., 1991) is a 112-item self-report measure of emotion and behavioral problems in adolescents within the past 6 months. For the purpose of this study, the internalizing and externalizing behavior subscales were examined. The syndromes of problems identified in the internalizing subscale included withdrawn/depressed, anxious/depressed, and somatic complaints, while syndromes of problems identified in the externalizing subscale included aggressive behavior and rule-breaking behavior. Both subscales demonstrated excellent internal reliability: internalizing ($\alpha = .90$) and externalizing ($\alpha = .85$).

Suicide attempts and nonsuicidal self-injury (NSSI). The evaluating clinician obtained information regarding lifetime history of NSSI and suicide attempts during the intake process. One variable was created for NSSI and a separate variable was created for suicide attempts. These variables were coded as follows: 0 = *no*

attempt, 1 = *at least one attempt*, 2 = *more than one attempt*.

Therapist transfer variable. Whether or not the patient transferred therapists during their treatment was also explored by reviewing patient charts. Two separate dichotomous variables were created to signify whether a patient transferred therapists either during pretreatment or active treatment. Both variables were coded as follows: 0 = *no transfer*, and 1 = *transfer occurred*.

Demographic variables. Patients’ age, gender, and ethnic background were identified using chart review. Gender was dichotomously coded as 1 = *male*, and 0 = *female*. Ethnic background was dummy coded with codes for each group (Hispanic, African American, Asian, and mixed background (coded 1) as compared to Caucasian youth (coded 0).

Analytic Plan

To address the study goals, we implemented a two-part analytic plan. In Step 1, we used bivariate and multivariate techniques to determine risk factors for early and late dropout from DBT treatment. In Step 2, we used the statistically significant variables from Step 1 to create a cumulative risk model. While bivariate and multivariate techniques can identify individual risk factors and the magnitude of their association with treatment dropout, cumulative risk models can shed light on the additive effects of having multiple risk factors (Kazdin, Mazurick, & Bass, 1993).

Step 1. To determine which risk factors were related to adolescent dropout we used a series of analyses. First, we used chi-square tests for the categorical variables (i.e., NSSI, therapist transfer, parent dropout, youth gender and ethnic background) in SPSS 23 and MANOVA in Mplus 7.3 (Muthen, & Muthen, 1998-2014) for the continuous variables (i.e., BPD symptomatology, externalizing and internalizing problems, youth age) to determine differences in frequency or mean for the predictor variables, respectively, by adolescent dropout (0 = *completer*, 1 = *early dropout*, 2 = *late dropout*). The analysis in Mplus included comparing the fit of a model in which the continuous predictor was constrained to be equal across the dropout groups to a model in which they were free to vary across the dropout groups. Evidence of mean differences on the predictor variable was indicated when the constrained model resulted

in a significant change in chi-square statistics, and fit indices indicated that the unconstrained model fit better than the constrained model (Kline, 1998). Second, to determine which predictors uniquely predicted dropout, two logistic regression analyses were conducted (one for each outcome variable; i.e., dummy codes for early and late dropouts compared to completers) in Mplus. Mplus was utilized to take advantage of advanced missing data techniques given that missing data ranged from 3.07% to 26.54% in the study variables. Simulation studies have demonstrated that the use of multiple imputation results in more accurate parameter estimates (Enders, 2010; Little & Rubin, 2002; Schafer & Graham, 2002). We imputed 10 data sets and then analyzed in Mplus using the “type is imputation” command.

Step 2. To develop the cumulative risk indices (CRI) for predicting early and late dropout, we only included predictors that were significantly related ($p < .05$) from the Step 1 analyses. All of the predictors were dummy coded such that higher scores represented greatest risk. For the continuous variables, this was completed by examining the 25th, 50th, and 75th percentile values of each continuous variable using separate chi-square analyses in SPSS to determine which percentile value best differentiated among the dropout groups. Variables were recoded so that a score of 1 (*at greater risk*) was given for each individual risk factor. Risk was represented as a sum of the individual indicators.

Next, to determine if this cumulative risk model differentiated among the dropout groups, we estimated a series of ANOVA models in Mplus assessing mean differences using the dropout variables as the grouping variable in an unconstrained model (means on the risk variable were allowed to vary across the groups). Mean differences were tested by comparing the fit of the unconstrained model to a model in which the mean of the CRI was constrained to be equal across the groups. Evidence of mean differences was present when the constrained model resulted in a significant change in χ^2 , $p < .05$, indicating that the unconstrained model fit significantly better than the constrained model (Kline, 1998). Multiple imputation was used to address missing data (10 data sets were imputed).

Additional
Classroom
Resources



Olle Jane Z. Sahler /
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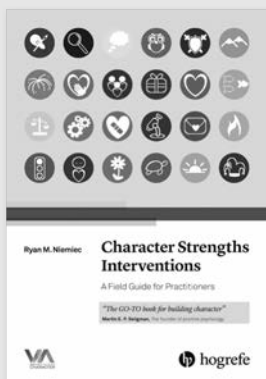


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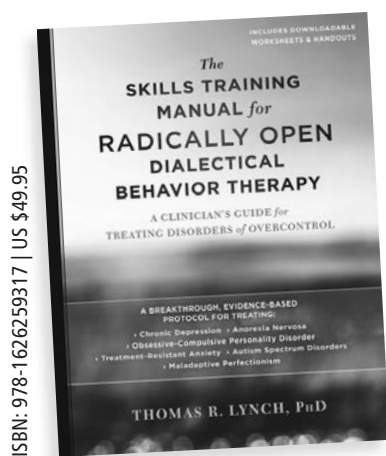
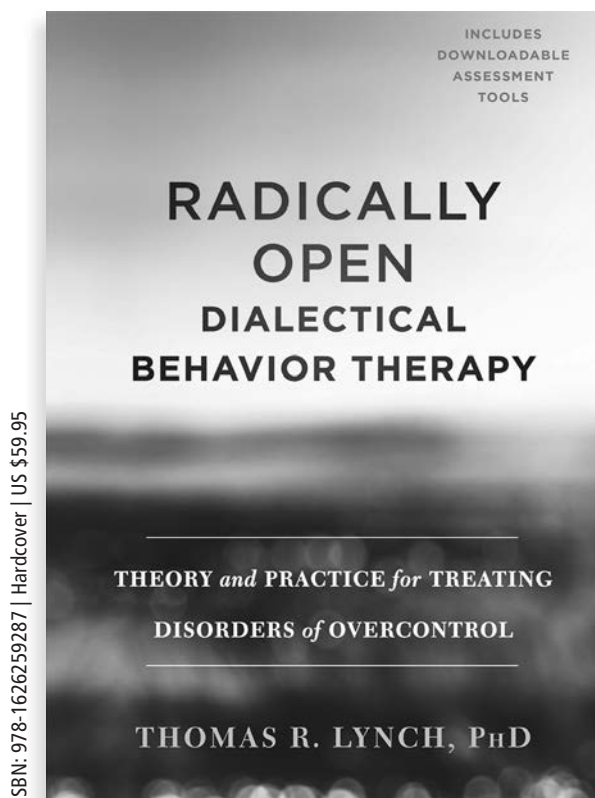
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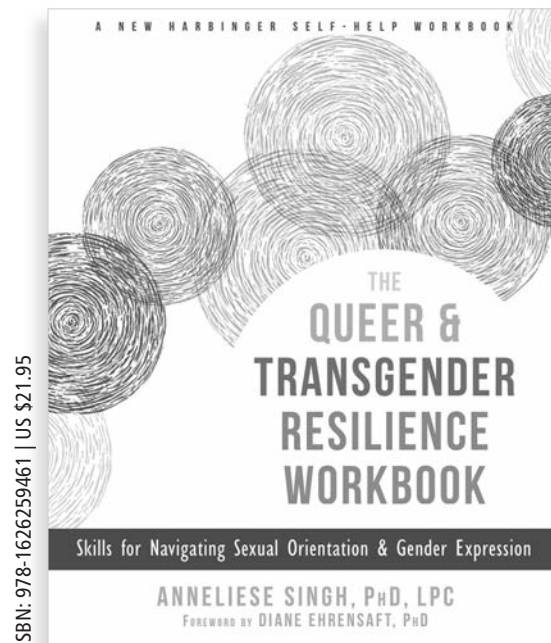
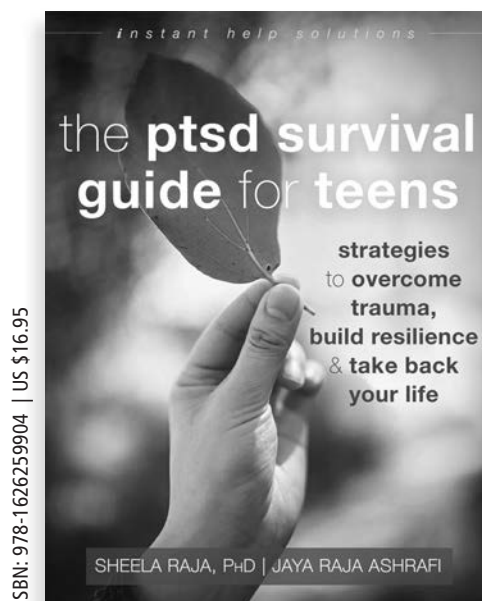
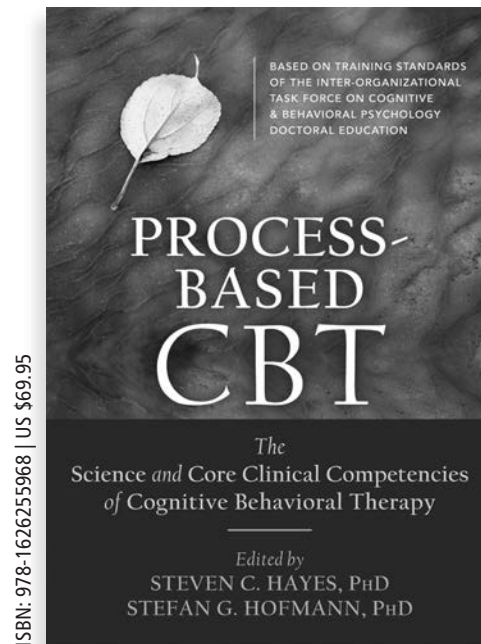
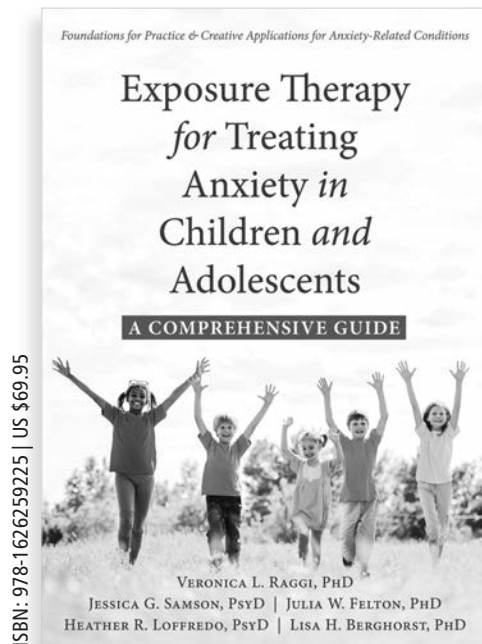
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Results

Sample Description

Of the sample, 18% of adolescents were considered early dropouts while 27% of the sample dropped out late. In all, 55% of adolescents ended up completing the 20-week DBT program. See Table 1 for descriptive statistics (mean, standard deviation, percentages) for the total sample and the subgroups.

Bivariate correlations revealed three predictor variables were significantly related to adolescent early dropout from treatment. These variables included age, r

$= .23, p < .05$, NSSI history, $r = -.23, p < .05$, and parent early dropout, $r = .70, p < .01$. In addition, two predictor variables were found to be significantly correlated with late adolescent dropout from treatment; these variables were parent late dropout, $r = .40, p < .01$, and ethnicity (African Americans more likely to drop out compared to Caucasians), $r = .21, p < .05$.

Step 1: Predictors That Distinguish Adolescent Dropouts and Completers

Chi-square tests revealed that adolescents who dropped out early were more likely to have a parent who dropped out

early as compared to adolescent late dropouts and completers, $\chi^2(2) = 49.69, p = .00$. MANOVA analyses for age, LPI total score, LPI confusion about self, and LPI interpersonal chaos showed that the unconstrained model fit better than the constrained model. Adolescents who dropped out early ($M = 15.72, SE = .37$), and adolescents who dropped out late ($M = 15.00, SE = .29$), were older than those who completed treatment ($M = 14.82, SE = .18$), $\Delta\chi^2(2) = 6.71, p = .03$. In addition, adolescents who dropped out early ($M = 22.94, SE = 3.84; M = 21.54, SE = 3.73$), and adolescents who dropped out late ($M = 22.08, SE$

Table 1. Characteristics of Adolescent Sample ($N = 98$)

Predictor Variables	Size (n)	Completers	Early Dropout	Late Dropout
		($n = 54$)	($n = 18$)	($n = 26$)
		M (SD)	M (SD)	M (SD)
Age	98	14.81 (1.32)	15.72 (1.60)	15.00 (1.50)
Gender (%)	98			
Female	-	87.0	77.8	92.3
Male	-	13.0	22.2	7.7
Race/Ethnicity (%)	98			
African American	-	16.7	22.2	38.5
Hispanic	-	68.5	66.7	53.8
Caucasian	-	3.7	-	-
Asian/Native American	-	1.9	5.6	7.7
Mixed Race	-	9.3	5.6	-
Suicide Attempts (%)	84			
No attempt	-	62.5	75.0	45.0
One attempt	-	20.8	18.8	15.0
More than one attempt	-	16.7	6.2	40.0
NSSI (%)	84			
No attempt	-	5.6	25.0	15.0
One attempt	-	11.1	18.8	10.0
More than one attempt	-	72.2	56.2	75.0
Parental Drop Out (%)	98			
Dropped out early	-	11.1	100	26.9
Dropped out late	-	29.6		65.4
Completed	-	59.3		7.7
Therapist Transfer (%)	95			
Transfer Early	-	67.9	75.0	65.38
Transfer Late	-	32.1	-	30.77
Life Problems Inventory	82			
Impulsivity	-	33.85 (10.27)	32.93 (8.28)	35.14 (10.02)
Confusions About self	-	43.91 (15.16)	37.80 (15.00)	36.19 (11.73)
Interpersonal Chaos	-	41.83 (14.24)	35.80 (15.50)	34.71 (9.41)
Emotional Dysregulation	-	43.87 (15.70)	38.00 (15.94)	39.38 (12.97)
Youth Self-Report	72			
Externalizing Problems	-	18.20 (10.18)	14.60 (8.91)	21.80 (11.38)
Internalizing Problems	-	24.58 (10.56)	14.70 (10.73)	23.10 (10.86)
Adolescent Drop Out (%)	98			
Dropped out early	-	-	-	-
Dropped out late	-	-	-	-
Completed	-	-	-	-

Emotional Disorders in Children and Adolescents

Jill Ehrenreich-May, Ph.D., University of Miami

- 11:00 A.M.–12:30 P.M. Eastern | 10:00 A.M.–11:00 A.M. Central | 9:00 a.m.–10:30 A.M. Mountain | 8:00 A.M. – 9:30 A.M. Pacific
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The Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C/UP-A) present the compelling idea that there may be a more efficient method of presenting effective strategies, such as those commonly included in CBT and third-wave behavior therapies, in order to simultaneously address an array of emotional disorder concerns in children and adolescents. The child and adolescent Unified Protocols frame treatment strategies in the general language of strong or intense emotions and promote change through a common lens. Specifically, the UP-C and UP-A help youth by allowing them to focus on a straightforward goal across emotional disorders. This webinar will provide a comprehensive introduction to the UP-A, a modular, individual therapy for adolescents; and, a more structured, group therapy for children (UP-C), the latter of which also includes a full parent-directed curriculum. Case illustrations and brief technique demonstrations throughout the webinar will help illustrate the flexible nature of the UP-C and UP-A materials and how they may be utilized in a clinician-directed manner to optimize and personalize treatment outcomes.

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The 2018 ABCT Class of Fellows will be acknowledged at the Friday, November 16 Awards Ceremony in Washington, DC.

= 2.88; $M = 20.97$, $SE = 2.64$), had lower levels of BPD symptomatology on the LPI subscales of confusion about self: $\Delta\chi^2(2) = 8.11$, $p = .02$; and LPI interpersonal chaos: $\Delta\chi^2(2) = 7.31$, $p = .03$, respectively.

Logistic regression models were conducted to assess which significant risk factors were the strongest predictors for each outcome variable (adolescent early and adolescent late dropout; Table 2). When controlling for other variables, age was found to be a predictive risk factor for adolescent early dropout from treatment. For late adolescent dropout, parent dropout from treatment (both early and late) was found to be a predictive risk factor.

Step 2: Cumulative Risk Model

The results of Step 1 revealed five significant risk factors that we used to create the cumulative risk index (i.e., age, confusion about self, interpersonal chaos, parent early and late dropout). These variables were dummy coded to represent greater risk. Results of chi-square analyses indicated age of 16 as greatest risk for dropout, $\chi^2(2) = 5.32$; $p = .07$. For confusion about self and

interpersonal chaos, less than the 50th percentile results in greatest risk of dropout, $\chi^2(2) = 9.10$; $p = .011$ and $\chi^2(2) = 10.82$; $p = .004$, respectively. Parent early and late dropout related to greatest risk of dropout, $\chi^2(2) = 49.69$; $p = .000$ and $\chi^2(2) = 21.24$; $p = .000$, respectively. See Figure 1 for frequency of cumulative risk by dropout group.

The sum of cumulative risk was then used in an ANOVA analysis in Mplus to determine if it differentiated among the dropout groups. Results indicated that dropout groups were significantly different on the mean number of risk factors, $\Delta\chi^2(2) = 13.73$; $p = .000$. Follow-up analyses indicated that adolescents that completed ($\Delta\chi^2(1) = 11.78$, $p = .000$; $M = 1.02$) or dropped out early ($\Delta\chi^2(1) = 8.45$, $p = .000$; $M = 1.13$) had fewer risk factors than those who dropped out late ($M = 2.06$). Adolescents who completed and dropped out early were not significantly different on mean number of risk factors, $\Delta\chi^2(1) = .156$; $p = .69$.

Discussion

The purpose of this study was to explore risk factors related to adolescent dropout from DBT, an evidence-based therapy to treat suicidal adolescents with borderline personality disorder symptomatology in a community outpatient setting. To the best of our knowledge, no studies have examined adolescent dropout rates from DBT in a community clinic outside of a randomized controlled trial. We defined early dropout as withdrawing from DBT treatment before attending the first multifamily skills group, and late dropout as withdrawing from treatment after the first skills group. Utilizing the concept of risk proneness (Kazdin, Mazurick, & Bass, 1993), we hypothesized that risk factors and their accumulation will increase the likelihood of adolescent dropout from DBT treatment in an outpatient setting.

In identifying factors associated with adolescent early dropout, we found adolescent age and parental dropout were related to adolescent early dropout. Adolescent late dropout was associated with identifying as African American (compared to

Table 2. Results from Logistic Regression Models Predicting Adolescent Dropout ($N = 98$)

Variables	Early Dropout			Late Dropout		
	<i>b</i>	<i>se</i>	<i>B</i>	<i>b</i>	<i>se</i>	<i>B</i>
Adolescent age	.26*	.15	.32	.15	.23	.10
Male adolescents	.28	.59	.08	-.40	.78	-.06
African American adolescents	.10	.68	.04	.67	.99	.13
Hispanic adolescents	-.01	.74	-.01	-.25	.95	-.06
NSSI	-.73	.57	-.20	-1.31	.96†	-.19
Therapist transfer (pretreatment)	.22	.51	.09	-.78	.89	-.16
Therapist transfer (during treatment)				-.11	.66	-.02
LPI confusion about self	.01	.03	.17	-.03	.04	-.19
LPI impulsivity	.01	.05	.07	.01	.07	.03
LPI emotional dysregulation	.00	.03	.02	.01	.05	.10
LPI interpersonal chaos	-.01	.02	-.13	-.06	.05	-.36
Externalizing problems	.00	.04	.02	.04	.04	.18
Internalizing problems	-.03	.03	-.27	.06	.05	.32
Parent early dropout				3.41*	1.32	.73
Parent late dropout				2.54*	1.17	.55
R^2	.27	.17		.78*	.14	

Note. Criterion variables were dummy codes as compared to completers. Gender coded as 1 = male, 0 = female. Ethnicity dummy codes as compared to Caucasian youth. NSSI dummy coded as compared to no NSSI. Therapist transfer dummy coded as compared to no transfer. Parent dropout dummy coded as compared to completers.

* $p < .05$.

Caucasian) and having a parent who dropped out at any time. These initial findings are in line with previous research findings indicating that older adolescents and those of ethnic minority groups are more likely to drop out of psychotherapy treatment (de Haan et al., 2015; Nock & Kazdin, 2001; Wierzbicki & Pekarik, 1993). The finding that parental dropout was related to adolescent dropout, although not surprising, reinforces the notion that engaging parents is critical in adolescent DBT treatment.

Further investigation into factors that differentiated those adolescents who dropped out early, dropped out late, or completed treatment uncovered several significant results. Supporting our initial findings, group comparisons indicated that adolescents who dropped out either early or late were older than their treatment completing counterparts. A possible explanation for this finding is that older adolescents demonstrate more autonomy, whether granted or taken, with parents having less control over whether their child is attending treatment. However, perhaps most interesting was that lower BPD symp-

tomatology (e.g., “LPI-confusions about self”; “LPI-interpersonal chaos”) served as a risk for dropout, with both early and late adolescent dropouts endorsing lower symptom severity compared to treatment completers. In contrast, the subscales of LPI-emotion dysregulation and LPI-impulsivity were not a risk for dropout. Previous research has indicated that individuals with higher levels of BPD symptomatology are more likely to seek mental health treatment in general, often citing high comorbidity and elevated degrees of functional impairment as contributing factors (Tomko, Trull, Wood, & Sher, 2014). However, our finding suggests that specific BPD symptom profiles may be worth exploring in understanding not only who seeks, but who completes, mental health treatment.

To examine which variables were most predictive of treatment dropout, we conducted logistic regressions for respective treatment phases. Analyses showed that age was most predictive of adolescents dropping out early, and parental dropout was the strongest predictor of adolescents' late dropout. Although Miller, Rathus, and

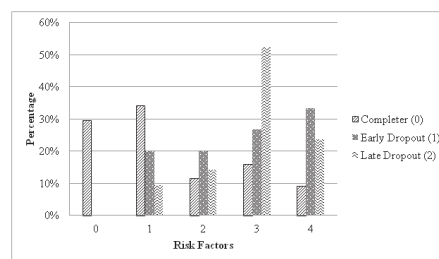


Figure 1. Risk factors for dropout (non-enrollment or non-completion DBT) vs. completion (completion DBT)

Linehan (2007) explicate strategies for obtaining commitment to therapy from suicidal adolescents, they do not put forth a framework by which to evaluate differential risk for treatment dropout in this population. Having knowledge of specific factors that contribute to dropout can aid clinicians in identifying very early in the intake process which patients are most at risk for dropout and, subsequently, dedicate more time to using the commitment strategies on those patients. The finding that age is most predictive of dropout in the



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early stages of DBT treatment suggests that clinicians should draw upon additional commitment resources to engage and retain older suicidal adolescents. Additionally, parental participation appears crucial in making sure adolescents complete DBT treatment. Child therapists often share anecdotes of parents who resist participating in therapy, in part, because the parents perceive the problem as residing in the adolescent and may have other barriers that are difficult to overcome (e.g., job schedule, transportation, etc.). Going forward, therapists can cite this study's results to parents to help motivate them to participate in treatment, especially if the parents want their adolescent to complete the recommended course of DBT treatment. To better understand this link between parental participation in treatment and adolescent dropout rates, we suggest future research explore mechanisms that might explain this link in more detail.

The concept of cumulative risk is not dissimilar to the idea of a tipping point or threshold effect. Many individuals may have 1 or more risk factors that slowly tip them towards a particular outcome, but it is not until these factors accumulate and reach a tipping point that this outcome becomes reality. This model also recognizes that there is often no one singular pathway to a particular outcome, like treatment dropout (Kazdin, Mazurick, & Bass, 1993). Our cumulative risk model included 5 significant risk factors identified through earlier statistical analyses. These risk factors were age, LPI-confusion about self, LPI-interpersonal chaos, early parent dropout, and late parent dropout. In our model if you were an adolescent who was 16 years or older, scored less than the 50th percentile for confusion about self and interpersonal chaos, and had a parent drop out, you were conceptualized as likely being the most at risk. The max number of risk factors assigned to an individual patient was 4 (because timing of parent dropout being mutually exclusive). It is worth noting that every single patient who dropped out had at least one of the indicated risk factors in the model. Although no significant differences were found in mean number of risk factors between those adolescents who dropped out early and those who completed treatment, there was a significant finding for those who dropped out late as compared to the other two groups. Nearly 75% of adolescents who dropped out late had ≥ 3 risk factors, suggesting that once a patient exceeds 2 risk factors their probability of completing

treatment is greatly affected. The cumulative risk model is yet another tool for DBT clinicians to utilize while working on commitment to therapy during the pretreatment phase. However, it should be noted that several patients who had 3 or more risk factors were able to complete treatment. What makes these individuals different? Future research may want to explore the role of, and identify, specific protective factors that foster patient resilience and mitigate treatment dropout.

Limitations

This study has several limitations. It is likely that other variables account for adolescent dropout from DBT treatment that were not measured, such as stigma against mental health treatment. The community clinic from which the sample is drawn is located in an urban, predominantly low-income, majority Hispanic and African-American sample that may have limited generalizability to other groups. Last, although this study identified two time points for dropout (early versus late) due to relatively low dropouts and the limited sample size, it would be helpful if future studies could examine a midpoint for dropout (i.e., after 10 group sessions). This type of analysis could yield more practical clinical implications. Despite these limitations, the study was longitudinal and examined dropout at two different time points, an important methodological distinction since the risk factors differed depending on timing of adolescent dropout. Future research should incorporate attitudinal measures toward therapy as a predictor and other family process variables that may shed light on the specific mechanisms that contribute to treatment dropout among adolescents.

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Correspondence to Miguelina Germán, Ph.D., Department of Pediatrics Behavioral Health Integration Program, Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, NY, 10467
mgerman@montefiore.org

CLINICAL FORUM

A Conversation With Steve Hayes and Stefan Hofmann About Process-Based CBT

Joanna J. Arch, *University of Colorado, Boulder*

THE SAN DIEGO SUN is shining as I sit together with Drs. Steve Hayes and Stefan Hofmann in a quiet corner of the ABCT hotel lobby to discuss their new edited book *Process-Based CBT: The Science and Core Clinical Competencies of Cognitive Behavioral Therapy* (2018).

What inspired this collaborative project for the two of you, an unlikely couple?

STEFAN: We really wanted to move the field forward. We see empirically supported treatment at a breaking point. We can only advance behavior therapy by advancing the processes. Most people would agree that we've reached a saturation of protocol treatments—treatment X for disorder Y. Process-based therapy is an attempt to free ourselves from the dictatorship of the DSM and to find mechanisms that cut across disorders that ultimately allow us to group people in a more meaningful way. One way to move that forward is to identify the processes or mechanisms linked to a specific testable theory that can be empirically tested. ACT and CBT have much more in common but we don't yet fully understand the process by which these treatments work. We need to identify and understand change processes and advance coherent models that guide their use.

STEVE: We became friends and also colleagues around our common interest in processes of change and moving the field forward. The story of this book links to our relationship in an interesting way because we've had many discussions and disagreements around what it means for acceptance, mindfulness, and values to come into CBT and evidence-based care. When we discovered that we both have an interest in processes of change and in the deeper issues involved, it became much easier for our discussions to be progressive because once you're down to the level of process, it's a lot easier to see connections.

Steve describes how the inter-organizational task force report on CBT training (Klepac et al., 2012) provided a foundation:

STEVE: The ABCT-sponsored interorganizational task force on training in CBTs brought in many different people and organizations—and the resulting report said that we need to focus more on core competencies, basic principles, processes of change, and clarity about our philosophical assumptions. We both agree with that idea and as far as we know this is the first book that's consciously organized around that ABCT report.

Tell me more about your process-based approach and why you are excited about it.

STEVE: I hope that a process-based approach will help eliminate needless walls between the evidence-based psychotherapies. But that is not all. I think it will help open up behavior science to go whenever it needs to go in the larger culture. It marries us up with some of the important changes that are happening socially and economically, and orients us to the different avenues we're going to need to reach people.

The era of a 50-minute psychotherapy hour is fading. We can't afford it and it's not how many people can or will receive care in the future. We've built these gold-plated Cadillacs—these monster technological protocols with 16 sessions and so on—and now find we can't drive them down narrow country roads. A 15-minute primary care consultation with a behavior health specialist could be more powerful in turning around a problematic life trajectory. You can't teach elaborate protocols for each disorder, and then deliver them with adherence. It's not scalable. But if you can get intervention down to a limited and coherent set of broadly applicable change processes connected to trainable procedures, then you can nibble away at dissem-

ination and training, and find simpler ways to move these processes.

STEFAN: We don't think the change processes we know about now will be the final number or content—there are probably hierarchies of processes. These all need to be worked out. This is a work in progress. An evolution.

STEVE: What I hope people will do if they're used to their particular model or set of technologies is ask: What would it look like if you took a process-based approach? What are the key processes? What procedures move these processes?

STEFAN: A process-based approach also invites laboratory-based research because it allows for a finer grade test of certain assumptions of the processes—we all go back and do the hard work in the lab. This is how science should be done.

STEVE: Early on behavior therapy had a more process focus but we were unable to fully develop them, in part because we relied too much on the animal lab as the source of principles and processes, and as a field we became a bit too relaxed or even lazy about where new “high precision / high scope” principles would come from. Then the process focus got washed away with federal money that required linking syndromes to particular treatment packages, defined technologically. RCTs are fine as far as they go, but unless you look at mediators and moderators we're left with very crude conclusions: use this protocol. All of it, always? For everyone with that set of symptoms? What do you do about comorbidity? How do you deal with difficulties in implementing these manuals in particular systems of care? What about the fact that most people only come for 2 or 3 sessions? How can you make clinicians follow a manual, and is it even wise to seek that? The whole model was off.

STEFAN: We don't think these change processes are isolated and independent—they're probably all linked. We'll identify that in the future. For now, let's identify some of the main processes and move people toward valued living.

STEVE: I am really comfortable with the approach and I do have to say that the ACT and ACBS [the Association for Contextual Behavioral Science, the group primarily guiding the development of ACT] community has had a process-focus for a long while. Stefan and I got interested in how an

approach like this applies broadly, across the various models and problem areas. What we're hoping to do eventually is distill down to successful mediators across all psychotherapies.

Do you think people are ready for a process- or dimension-based approach, when our minds tend to work categorically?

STEVE: Dimensional thinking is a challenge—we do need categories—but there are ways of getting to categories by means of dimensional thinking. Sets of processes that are self-amplifying can be delineated as a category; dynamic patterns of change processes that predict outcomes can be a category.

STEFAN: It's like turning ice into water. Ice is a qualitatively different state yet you turn it [into water] by increasing temperature, which is dimensional. The state changes.

What was most challenging about doing this project together?

STEFAN: I think you have to have slightly different views on a matter in order to make it an enriching experience. If you speak the same language all the time you can't learn anything new. We fought our battles and then we moved beyond the struggle and tried to figure out: What do we both want? What do we have in common? How do we work together? It's not that we agree on every aspect on the philosophical level but I've learned a lot and we have become very good friends.

STEVE: When you understand that there are differences in philosophical assumptions, it's not something you need to argue about. It's more like: let's just understand them and then use these different points of perspective to move these issues forward. I reached a key point in our relationship of seeing how flexible and serious Stefan was as a colleague. Now when we have disagreements, we can go down to the level of assumptions and try to take the perspective of the other person. That can help us to come back out with data—not testing our assumptions (those are pre-analytic) but moving the practical issue forward. As an applied science, we have the great advantage of a common goal—to help people—and we can look at the data from that angle regardless of differences in assumptions.

When did your collaboration begin?

STEVE: We'd been making intellectual progress for some time but a key moment was when I was in Germany giving a talk five years ago to the German cognitive behavior therapy association and I fainted onstage shortly after the talk. I was standing one moment, and the next I was on my back looking up at the ceiling. That night I was having all of these cardiac symptoms and the organizers took me to the hospital. It turns out I had undiagnosed atrial fibrillation.

STEFAN: It was the emergency room and we thought he wouldn't make it.

STEVE: Well, who's sitting next to me by the bed but my mean opponent, my “enemy” Stefan! He sat next to me and talked with care and kindness until 3 A.M. It showed what kind of person he is, and when you experience something like that, you can't quite go back. We still argued, but there was a bond there. It's much easier to argue usefully with your friends, because you know not to take disagreements personally. You keep looking for common ground. Who knows how many of our “opponents” and “enemies” are actually our friends, just a fraction of an inch away. It's probably true even when we get outside of CBT—the psychodynamic and humanistic people and so on are just friends we haven't made yet!

STEFAN: This was a critical turning point for me as well. Another was when I went to an ACT conference. Initially I thought they were just nutcases, but by the end I really did appreciate they speak a different language and have different assumptions.

STEVE: I remember being surprised by that a bit later. At ABCT someone was arguing with me quite forcefully about an issue between ACT and mainstream CBT and Stefan steps in and says to the other person, “You don't understand. These people have very different philosophical assumptions,” and he proceeds to explain contextualism to the guy. My jaw dropped slightly—Stefan had taken the issue seriously, and he'd read and thought about it. That moment showed me how flexible and serious he was and substantively, if we understand each other's assumptions, it's a lot easier to work together and respect each other even when we disagree. That's one reason the task force called on the field to teach students more about their philosophical assumptions.

Who is the book's intended audience?

STEFAN: We've aimed at a very large audience. We want students to learn it, practitioners to learn it. We're targeting clinical programs with the hope that they will incorporate a process-based focus into their training. We're building it up—we're producing a library of web-based video clips that illustrate certain techniques and ideas in the book.

STEVE: First and foremost, we hope that the book will be used in classes on CBT, but the book itself is evolutionary, not revolutionary. The goal is to help move the field, but the field itself will decide how fast and how far. I think as we move down this process-based route, we'll be able to modularize the field so that it simplifies our training and dissemination tasks. As we learn what amounts to new ways of doing functional analysis, it will make it easier to fit evidence-based care to the individual people we're trying to help.

Last Word

STEVE: The fact that we've become friends and colleagues tells in microcosm a story that might be able to be expanded out to all forms of evidence-based care. Based on mutual respect and concern for evidence, we can use a focus on processes of change

to help us work together to improve the lives of those we serve. There is no reason to worry about who is wrong: We're all wrong. Let's just find out where we're wrong more quickly and move the field forward.

STEFAN: It's not to say I've become an ACT guy—Steve has not become a mainstream CBT guy either. We're just two human beings connecting on a different level and with a little effort we'll both move closer to the truth.

As the conversation wraps up and we look forward to a busy day at the conference, I cannot help but recall a decade earlier when the rooms of ABCT were filled with passionate debate between the two men sitting before me and numerous others. For those of us who shared or witnessed those debates, the significance of their friendship and collaboration marks what I hope is becoming a more unified push forward for the sake of those who need us to reach them with our collective work.

The edited volume that forms the basis of our conversation, *Process-Based CBT: The Science and Core Clinical Competencies of Cognitive Behavioral Therapy* (2018), is published by New Harbinger. Divided into

3 sections, the book chapters range from establishing a scientific and practical foundation for process-based CBT (Part 1) to describing core CBT processes that cut across protocols (Part 2) to articulating and illustrating numerous specific therapeutic procedures and processes (Part 3).

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Correspondence to Joanna J. Arch, Ph.D., University of Colorado, Boulder, 345 UCB Muenzinger, Office 313B, Boulder, CO 80309-0345; Joanna.Arch@colorado.edu

RESEARCH-PRACTICE

Publishing a Single-Case Study

Jacqueline B. Persons, *Cognitive Behavior Therapy and Science Center, Oakland, CA, and University of California at Berkeley*

Alexandra S. Jensen, *Cognitive Behavior Therapy and Science Center, Oakland, CA*

WHY WRITE UP AND PUBLISH a report of a single case? Data from a single case can contribute to the literature in situations in which a randomized controlled trial or other group study is infeasible. An example is the study of a rare condition or of an innovative and promising intervention that has not yet been studied systematically in a group study. In addition, single-case data, when collected systematically in a controlled and carefully designed single-case experimental design (see Barlow, Nock, & Hersen, 2009; Kazdin, 2011), can provide strong tests of causal hypotheses. For

example, an ABAB design can show quite convincingly that a particular intervention (B) causes behavior change that is not present in the A (baseline condition or condition in which B is withdrawn). (Of course, an ABAB design is not always practical, as in cases when the intervention [B] involves teaching skills that are not unlearned when the intervention is withdrawn. In this case, the investigator might instead choose a multiple baseline or other design; see Barlow et al., 2009; Kazdin, 2011.)

The single-case study can also play an important role in the scientific task of

hypothesis-generation; for example, it can provide a bit of evidence to support a hypothesis about a change mechanism in treatment or a novel intervention that can prompt replication studies and group studies. Finally, the publication of a single-case study serves a professional development function, in that it offers a route for clinicians, who often do creative and innovative work, to disseminate their findings to fellow clinicians and to the scientific community. In so doing, clinicians can help not just the patients they treat, but many others. As readers of *the Behavior Therapist* likely know, the study of a single case has a long and important tradition in behavior therapy (see chapter 9 of Hayes, Barlow, & Nelson-Gray, 1999, for an inspiring discussion of this topic).

Our goal in this article is to help students, clinicians, and researchers write up a case report for publication. We briefly discuss three topics: selecting a case, addressing ethical issues, and finding a publication outlet.

Table 1. Peer-Reviewed Journals that Publish Single Case Designs

Journal	Impact Factor ^a	Relevant Submission Information Provided by the Editor	Recent Publications
<i>Depression and Anxiety</i> ^b	4.971	“The journal publishes only two types of articles: original Research Papers and Reviews. A priority is placed on treatment and review papers, and on papers with information and findings that will enhance the clinical evaluation and care of individuals struggling with the effects of these disorders.”	Jiménez Chafey, M. I., Bernal, G., & Rosselló, J. (2009). Clinical case study: CBT for depression in a Puerto Rican adolescent: challenges and variability in treatment response. <i>Depression and Anxiety</i> , 26(1), 98-103.
<i>Journal of Consulting and Clinical Psychology</i> ^{b, c}	4.593	“JCCP also considers methodologically sound single-case designs (e.g., that conform to the recommendations outlined in the “What Works Clearinghouse (WWC) Single-Case Design” paper).” <i>Reference:</i> Kratochwill, T. R., Hitchcock, J., Horner, R. H., Levin, J. R., Odom, S. L., Rindskopf, D. M. & Shadish, W. R. (2010). Single-case designs technical documentation. Retrieved from What Works Clearinghouse website: http://ies.ed.gov/ncee/wwc/pdf/wwc_scd.pdf	Boswell, J. F., Anderson, L. M., & Barlow, D. H. (2014). An idiographic analysis of change processes in the unified transdiagnostic treatment of depression. <i>Journal of Consulting and Clinical Psychology</i> , 82(6), 1060-1071.
<i>Journal of Abnormal Psychology</i> ^c	4.133	“Case Studies from either a clinical setting or a laboratory will be considered if they raise or illustrate important questions that go beyond the single case and have heuristic value. Empirically-based papers are strongly preferred.”	Bryant, R. A., & Das, P. (2012). The neural circuitry of conversion disorder and its recovery. <i>Journal of Abnormal Psychology</i> , 121(1), 289.
<i>Behaviour Research and Therapy</i> ^c	4.064	“The following types of submissions are encouraged: theoretical reviews of mechanisms that contribute to psychopathology and that offer new treatment targets; tests of novel, mechanistically focused psychological interventions, especially ones that include theory-driven or experimentally-derived predictors, moderators and mediators; and innovations in dissemination and implementation of evidence-based practices into clinical practice in psychology and associated fields, especially those that target underlying mechanisms or focus on novel approaches to treatment delivery.”	Challacombe, F. L., & Salkovskis, P. M. (2011). Intensive cognitive-behavioural treatment for women with postnatal obsessive-compulsive disorder: A consecutive case series. <i>Behaviour Research and Therapy</i> , 49(6), 422-426.

Note. ^aJournals are presented in decreasing order of impact factor as reported on journal website. ^bThis journal publishes case series more frequently than single case studies. ^cThis journal rarely publishes single case designs.

(Table 1, continued)

Journal	Impact Factor ^a	Relevant Submission Information Provided by the Editor	Recent Publications
<i>Behavior Therapy</i> ^c	3.434	“Although the major emphasis is placed upon empirical research, methodological and theoretical papers as well as evaluative reviews of the literature will also be published. Controlled single-case designs and clinical replication series are welcome.”	Willson, R., Veale, D., & Freeston, M. (2016). Imagery rescripting for body dysmorphic disorder: A multiple-baseline single-case experimental design. <i>Behavior Therapy</i> , 47(2), 248-261.
<i>Psychotherapy</i>	2.573	“Directly related to the main aims of this Journal we also encourage submission of ... Evidence-Based Case Studies that integrate verbatim clinical case material with standardized measures of process and outcome evaluated at different times across treatment. In particular, http://www.apa.org/pubs/journals/pst/evidence-based-case-study.aspx calls for evidence-based case studies as part of the journal’s special series. The specific guidelines listed are found at http://www.apa.org/pubs/journals/pst/evidence-based-case-study.aspx .”	Arco, L. (2015). A case study in treating chronic comorbid obsessive-compulsive disorder and depression with behavioral activation and pharmacotherapy. <i>Psychotherapy</i> , 52(2), 278-286.
<i>Psychotherapy Research</i>	2.570	“The journal is committed to promoting international communication by addressing an international, interdisciplinary audience, and welcomes submissions dealing with: -diverse theoretical orientations (e.g., psychodynamic, cognitive, behavioral, humanistic, experiential, systems approaches) -treatment modalities (e.g., individual, group, couples, family) -research paradigms (e.g., quantitative, qualitative, clinical trials, process studies, outcome prediction, systematic case studies, measure development, meta-analyses)”	Dillon, A., Timulak, L., & Greenberg, L. S. (2016). Transforming core emotional pain in a course of emotion-focused therapy for depression: A case study. <i>Psychotherapy Research</i> , 1-17.
<i>Cognitive and Behavioral Practice</i>	2.537	“ <i>Cognitive and Behavioral Practice</i> publishes clinically rich accounts of innovative assessment and therapeutic procedures that are clearly grounded in evidence-based practice. The primary focus is on application and implementation of procedures. Accordingly, topics are selected to address current challenges facing practitioners, both in terms of technique, process, and the content of treatment. To meet this goal, articles may include rich descriptions of clinical interventions, examples of client-therapist dialog, embedded video clips readers can view online, and/or significant case descriptions.”	Paulus, D. J., & Norton, P. J. (2016). Purging anxiety: A case study of transdiagnostic CBT for a complex fear of vomiting (emetophobia). <i>Cognitive and Behavioral Practice</i> , 23(2), 230-238.

Note. ^aJournals are presented in decreasing order of impact factor as reported on journal website. ^bThis journal publishes case series more frequently than single case studies. ^cThis journal rarely publishes single case designs.

(Table 1, continued)

Journal	Impact Factor ^a	Relevant Submission Information Provided by the Editor	Recent Publications
<i>Clinical Psychology: Science and Practice</i>	2.38	“ <i>Clinical Psychology: Science and Practice</i> presents cutting-edge developments in the science and practice of clinical psychology by publishing scholarly topical reviews of research, theory, and application to diverse areas of the field, including assessment, intervention, service delivery, and professional issues.”	Wendland, J., Brisson, J., Medeiros, M., Camon-Sénéchal, L., Aidane, E., David, M., ... & Rabain, D. (2014). Mothers with borderline personality disorder: Transition to parenthood, parent–infant interaction, and preventive/therapeutic approach. <i>Clinical Psychology: Science and Practice</i> , 21(2), 139-153. ^d
<i>Frontiers in Psychology (Clinical Settings)</i>	2.323	“Case Reports are reports on human or animal patients having particular clinical course, diagnostic work-up, unexpected diagnosis, or treatment outcomes that are of relevance for clinical practice and medical teaching. Case Reports must include a brief introduction that provides appropriate context for the case, and a case presentation that includes: age, sex and occupation of the patient, presenting symptoms, the patient’s history and any relevant family or social history, and relevant clinical findings. This should be followed by a description of laboratory investigations and diagnostic tests. Authors should provide explanations for any differential diagnosis, final diagnoses, treatment, and also comment on the progress of disease and/or treatment. The report should conclude with a short discussion of the underlying pathophysiology and the novelty or significance of the case.”	Johnson, S. U., & Hoffart, A. (2016). Metacognitive therapy for comorbid anxiety disorders: A Case Study. <i>Frontiers in Psychology</i> , 7(1515).
<i>Journal of Clinical Psychology</i>	2.123	“The Journal includes research studies; articles on contemporary professional issues, single case research; brief reports (including dissertations in brief); notes from the field; and news and notes.”	Wu, M. S., & Storch, E. A. (2016). A case report of harm-related obsessions in pediatric obsessive-compulsive disorder. <i>Journal of Clinical Psychology</i> , 72(11), 1120-1128.
<i>Clinical Psychology and Psychotherapy</i>	1.933	“ <i>Clinical Psychology & Psychotherapy</i> aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. <i>Clinical Psychology & Psychotherapy</i> will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research.”	Ferreira, J. F., Vasco, A. B., Basseches, M., Santos, A., & Ferreira, J. M. (2016). Exploring phase progression throughout the therapeutic process: The case of Eva. <i>Clinical Psychology & Psychotherapy</i> , 23, 407-426.

Note. ^aJournals are presented in decreasing order of impact factor as reported on journal website. ^bThis journal publishes case series more frequently than single case studies. ^cThis journal rarely publishes single case designs.

(Table 1, continued)

Journal	Impact Factor ^a	Relevant Submission Information Provided by the Editor	Recent Publications
<i>Journal of Applied Behavior Analysis</i>	0.914	“Innovative pilot work, replications, and controlled case studies will be considered for publication as Reports. Reports will be judged according to the following criteria: (a) The subject matter has applied significance, (b) the information necessary to replicate the procedures is contained in the report, and (c) the data collection and analysis permit reasonable conclusions about the phenomenon.”	DeRosa, N. M., Roane, H. S., Bishop, J. R., & Silkowski, E. L. (2016). The combined effects of noncontingent reinforcement and punishment on the reduction of rumination. <i>Journal of Applied Behavior Analysis</i> , 49(3), 680-685.
<i>Clinical Case Studies</i>	0.523	The journal is devoted solely to case studies and “seeks manuscripts that articulate various theoretical frameworks (behavioral, cognitive-behavioral, gestalt, humanistic, psychodynamic, rational-emotive therapy, and others). All manuscripts will require an abstract and must adhere to the following format: (1) Theoretical and Research Basis, (2) Case Introduction, (3) Presenting Complaints, (4) History, (5) Assessment, (6) Case Conceptualization (this is where the clinician’s thinking and treatment selection come to the forefront), (7) Course of Treatment and Assessment of Progress, (8) Complicating Factors (including medical management), (9) Access and Barriers to Care, (10) Follow-up (how and how long), (11) Treatment Implications of the Case, (12) Recommendations to Clinicians and Students, and References.”	Babinski, D. E., & Nene, N. V. (2016). Persistent family stress in the course of cognitive-behavioral therapy for a 7-year-old girl with social anxiety disorder. <i>Clinical Case Studies</i> , 15(4), 263-279.
<i>Pragmatic Case Studies in Psychotherapy</i>	unrated	“We seek manuscripts in the areas of individual case studies; multiple case studies; analytical or critical comparative reviews of previously published case studies, particularly those that have been published in PCSP; and case study method. A manuscript can cover either one case or a series of cases of a particular type. All cases have to be described in systematic, qualitative detail. Client scores on standardized, quantitative measures at the beginning, during, end, and follow-up of therapy are highly desirable where feasible and consistent with the theoretical approach employed. Such scores normatively contextualize a case.”	Cohen, R. (2016). Getting into the ACT with psychoanalytic therapy: The case of “Daniel.” <i>Pragmatic Case Studies in Psychotherapy</i> , 12(5), 1-30.

Note. ^aJournals are presented in decreasing order of impact factor as reported on journal website. ^bThis journal publishes case series more frequently than single case studies. ^cThis journal rarely publishes single case designs.

Selecting a Case

To identify a case that you can write up and submit for publication, we offer a list of questions that might yield an idea about a case to study: Have I successfully treated a patient who had problems for which no empirically supported treatment is available? Have I devised an innovative treatment that has been helpful to one or more patients? Have I applied a well-known treatment to a new problem or disorder with good results? Have I successfully used an empirically supported treatment with a patient who had characteristics (e.g., non-White race or ethnicity, transsexual, blind, deaf) not represented in the randomized controlled trials of that treatment? Have I treated a patient and simultaneously monitored symptoms and the psychological mechanisms I viewed as causing the symptoms, so that I learned something about relationships between interventions, changes in psychological mechanisms, and changes in symptoms over time? (e.g., Boswell, Anderson, & Barlow, 2014; Brown, Bosley, & Persons, 2017). Do I have long-term follow-up data from any of my patients? In all of these types of situations—and others not listed here—a write-up of the case can make a contribution to the field. It's useful to select a patient who had a good response to treatment. In general, I assume that if the patient had a poor outcome, there must be something I don't understand about the case. However, even failure can be informative (see Dimidijan & Hollon, 2011). A particularly informative case is the patient whose initial outcome was poor but ultimate outcome was good (e.g., Persons, Beckner, & Tompkins, 2013).

To publish a case report, the clinician must have some data. The quality of the data and the design of a case report can vary widely, from an informal report with little or poor quality data, to a carefully controlled study that meets high standards for a single-case design, as described in Kratochwill et al. (2010) and Smith (2012). One of us published (Persons & Mikami, 2002) a case of hypochondriasis where the main data were simply a verbal report from the patient at every session about how many flare-ups of hypochondriasis symptoms he had had during the previous week! If you find that when you go into your records, you do not have the data you need to write a publishable report, you can begin collecting more systematic progress monitoring data in your practice with a view to the future publication of a case.

Ethical and Privacy Issues

Unless the data were collected via federal funding or you are a faculty person or student at a university, a review of your report by a formally constituted institutional review board is likely not needed. However, you may want to conduct an informal review, inviting a colleague or two to review your treatment and writeup, and documenting the results of this process. It is a good idea to consult the ethical principles of your professional association and use them to guide your treatment, data collection, and writeup, in order to protect your patient's interests and privacy, and to protect yourself from ethical errors. It can also be helpful to consult with your malpractice insurance company, which will be happy to offer guidance that can protect you, your patient, and your practice from harm.

To protect your patient's privacy, you will want to disguise details of your patient's identity, doing this in a way that preserves the integrity of the scientific or clinical contribution of the material. Don't forget to disguise the clinical material so that even the patient described cannot recognize it. It is also ideal to obtain your patient's written permission to publish the material and to give the manuscript to the patient to review before you submit it.

Sometimes the demands of science and good care conflict. For example, the clinician wanting to use an ABAB design must withdraw an intervention that has been helpful to the patient. Transparency is a key piece of the solution to this dilemma. I have often found that if I want to do something in treatment, such as withdraw an intervention in order to learn something that can contribute to science, that my patient, if fully informed, is quite willing to do it, especially if we can find a way to do it that is not unduly burdensome to him or her. Patients are often quite generous and eager to contribute to science and to the reduction of others' suffering. (And a treatment withdrawal, while uncomfortable, can yield useful information that can provide some long-term benefit for the patient.) A consultation with a colleague to be sure you are carefully considering all of the ethical issues is especially important in this type of situation.

Finding a Publication Outlet

Group designs are the current dominant research method in clinical psychology. Finding a publication that will publish a single-case study can seem daunting, but

it is possible. To guide your search to publish, we provide in Table 1 a list of peer-reviewed empirical clinical psychology research journals that have recently published single-case studies, including uncontrolled case reports and tightly controlled single-case experimental designs. The table provides, for each journal, the impact factor, pertinent submission information from the journal's editors, and the citation for a recently published example. Smith (2012) also provides information about journals that publish single-case experimental designs.

The table lists peer-reviewed journals. However, the practitioner can also consider submitting his or her case to a professional association newsletter like *the Behavior Therapist* (e.g., Persons, 1990). For ABCT members, publishing in *tBT* is a gratifying way of contributing to our own professional community. It's also a great way for students and clinicians to take a first step toward sharing with a larger professional community what they are learning from their work with their patients.

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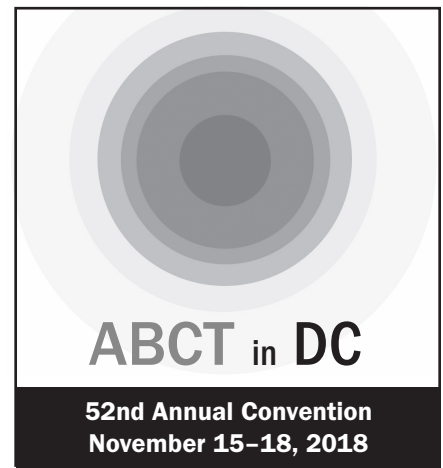
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Correspondence to Jacqueline B. Persons, Ph.D., Cognitive Behavior Therapy and Science Center, 5625 College Ave Ste 215, Oakland, CA 94618-1590; persons@cbtscience.com



TECHNOLOGY

emotions101: Development of an Online Prevention Course for College Students Based on the Unified Protocol

Julianne Wilner, Keara Russell, and Shannon Sauer-Zavala,
*Center for Anxiety and Related Disorders at Boston University,
Boston University*

SINCE THE MID-1990S, in a trend dubbed “the crisis on campus,” rates of mental disorders among young adults in university settings have continued to escalate (Center for Collegiate Mental Health, 2016; Eiser, 2011). Indeed, in a recent cross-national study, the World Health Organization found that over one in five college students met criteria for a *Diagnostic and Statistical Manual of Mental Disorders/Composite International Diagnostic Interview* disorder within the past year (Auerbach et al., 2016), with anxiety and mood disorders as most common. Unfortunately, despite high prevalence rates and known stressors, only a small proportion of students experiencing mental health difficulties receive treatment (Auerbach et al.).

From 2010 to 2015 alone, a recent study found a 6% increase in the percentage of college students seeking treatment for anxiety-related concerns, and a 3% increase in treatment-seeking for depression (Barr, Rando, Krylowicz, & Reetz, 2010; Reetz, Krylowicz, Bershada, Lawrence, & Mistler, 2015). In an extreme example of this trend, one college counseling center reported a 30% increase in treatment-seeking students during a 6-year period, growing at a

rate over five times faster than that the university’s total student enrollment and posing significant problems for accommodating students in need of services (Center for Collegiate Mental Health, 2016). This lack of care, due to a combination of delayed help-seeking (Wang, 2007) and limited on-campus resources (Mowbray et al., 2006), is problematic as untreated anxiety and depressive disorders are associated with high rates of comorbidity (e.g., Brown, Campbell, Lehman, Grisham, & Mancill, 2001), mortality (e.g., Walker, McGee, & Druss, 2015), and economic burden (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012; Konnopka, Leichenring, Leibing, & König, 2009). Furthermore, among college students, anxiety and depression are associated with risky behaviors like substance use (Potter, Galbraith, Jensen, Morrison, & Heimberg, 2016), eating disorders (e.g., Eisenberg, Nicklett, Roeder, & Kirz, 2011), diminished academic achievement, and lower graduation rates (American College Health Association, 2011).

Given these concerns, interventions that may prevent mental disorders before they fully emerge have received increased

attention (National Research Council and Institute of Medicine, 2009). In fact, the development of effective preventive interventions for common mental disorders was recently declared one of four main priority areas by the National Institute of Mental Health Strategic Plan for Research (National Institute of Mental Health, 2015). Studies in line with this priority have begun to bear fruit, suggesting that prevention programs are efficacious for reducing subclinical symptoms or vulnerability factors in younger populations (e.g., Christensen, Pallister, Smale, Hickie, & Callear, 2010; Fisak, Richard, & Mann, 2011; Stice, Shaw, Bohon, Marti, & Rohde, 2009; Stockings et al., 2016) within school, community, and clinical settings (e.g., Bennett et al., 2015).

While such interventions are promising, there remain several limitations. First, the majority of studies have been limited to child and adolescent populations (Danitz & Orsillo, 2014; Seligman, Schulman, & Tryon, 2007), resulting in a need for programs that buffer against mental disorders in young adults. Because of the unique developmental and social stressors associated with transitioning roles, responsibilities, and life situations (e.g., Arnett, 2000; Schulenberg, Bryant, & O’Malley, 2004; Schulenberg, Sameroff, & Cicchetti, 2004), this population (e.g., college-aged students) is at elevated risk for developing anxiety and depressive disorders (e.g., Kessler et al., 2005, 2007). Students with a mental disorder diagnosis prior to matriculating are less likely enter college following acceptance and more likely to drop out (Auerbach et al., 2016). Thus, incorporating interventions within university settings may be ideal for reaching a large number of at-risk individuals (Danitz & Orsillo, 2014). Second, existing preventive inter-

ventions are typically adapted from traditional cognitive-behavioral frameworks for clinical disorders that, despite being effective, are time-intensive and resource-heavy. The populations that preventive programs are intended for may not require a full dose of such interventions (e.g., 8–12 sessions; Fisak et al., 2011), and meta-analytic research suggests that briefer interventions may have the same or, in some cases, greater effects than longer ones (Christensen et al., 2010; Fisak et al.; Stice et al., 2009; Stockings et al., 2016). Third, a major obstacle to dissemination of existing prevention programs is that most tend to target specific disorder areas (e.g., anxiety, depression, substance use, eating disorders; Black Becker, Smith, & Cio, 2006; Denering & Spear, 2012); this specificity means that a multitude of individual programs must be provided to address these related and co-occurring disorder areas, which is prohibitive and costly. An alternative, and perhaps more efficient, approach is to target underlying vulnerabilities that put an individual at risk to develop a range of psychological difficulties.

The Unified Protocol (UP) for Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2011) is a cognitive-behavioral intervention that was developed to directly address core vulnerabilities in individuals diagnosed with anxiety, depressive, and related disorders. The UP has demonstrated efficacy in treating anxiety across a number of trials to date (e.g., Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010; Farchione et al., 2012), including a large randomized controlled equivalence trial, in which the transdiagnostic UP approach was observed to be just as effective as more targeted approaches for single anxiety disorders (Barlow et al., 2017). There is also initial evidence to support the efficacy of the UP in treating depression (e.g., Boswell, Anderson, & Barlow, 2014) and other related conditions such as PTSD (Gallagher, 2017), alcohol use (Ciraulo et al., 2013), borderline personality disorder (BPD; Sauer-Zavala, Bentley, & Wilner, 2016), and nonsuicidal self-injury (Bentley, Sauer-Zavala, et al., 2017).

Given the UP's focus on vulnerability factors that lead to depressive and anxiety symptoms, as well as its emphasis on adaptive emotion management (a universally applicable topic), this intervention is well-suited for adaptation in a prevention context. As such, our research team developed a single-session, 2-hour workshop that was based on the UP and pilot tested it with 45

Boston University (BU) undergraduates, compared to an assessment-only condition (Unified Protocol for Prevention [UP-P]; (Bentley, Boettcher, et al., 2017). The goal of the UP-P, which was presented as an "emotion management workshop," was to provide students with skills to respond adaptively to their emotional experiences in order to reduce their vulnerability for developing anxiety or depressive disorders. The workshop, which was delivered via PowerPoint slides, didactic verbal material, and interactive discussion, consisted of four treatment modules distilled from the full UP intervention. Each module consisted of an experiential practice exercise (e.g., breaking down an emotion into thoughts, physical feelings and behaviors, engaging in a brief mindfulness exercise) and utilized examples of particular relevance to undergraduate students (e.g., academic pressure, comparisons to others on social media).

Complete results from the workshop have been described in detail elsewhere (see Bentley, Boettcher, et al., 2017). In general, feedback on the workshops ($n = 45$) was very favorable overall, and participants rated the workshops as highly acceptable on average, with 82% of participants rating the workshop content as "very acceptable" or "extremely acceptable." Participants reported high satisfaction with workshop content; specifically, 69% indicated that they were "very satisfied" or "extremely satisfied." Approximately 40% of workshop participants accessed electronic copies of workshop materials via the online Blackboard course after the workshop. In addition, 50% of participants elected to receive reminders via email to continue practice of skills. At both 1- and 3-month follow-up assessments, participants indicated that, on average, they used workshop skills to manage emotional experiences between "some of the time" and "most of the time." Statistically significant, small effects on the tendency to experience negative emotions, quality of life, and avoidance of emotions (all in the expected direction) were observed in the workshop condition from baseline to 1-month follow-up (Bentley et al., 2017).

Given the strong theoretical rationale for an emotion-focused (rather than symptom-focused) preventive intervention for mental illness in college students, along with promising pilot data for our live, UP-based "emotion management" workshop, we sought to adapt this program for online delivery. A self-paced, stand-alone, online course has a number of advantages over a

leader-facilitated, in-person workshop; most notably, online delivery has the potential to reach a greater number of individuals than traditional, live courses that are limited by the number of trained providers and capacity constraints (e.g., provider/patient ratios, facility size). This aided our decision to move forward with an online format as a next step, as the pilot study evidenced difficulties with attendance and attrition, and a greater number of participants would allow for meaningful comparisons across groups.

At the time of writing, this course is being offered to incoming BU freshman as part of a research opportunity. Our team spent the past year gaining institutional support from the university to create the course, working with various departments to develop it, and designing research methods to best assess course feasibility and accessibility. The goals of the present article are to offer commentary on the above-mentioned processes, as they have been valuable learning experiences for our group. We hope that others may benefit from learning from our experience—challenges that we have faced at various stages, and efforts to address such limitations to help make a difference for students making the often difficult transition to college.

Gaining Institutional Support

Obtaining Administrative and Financial Support

The first step in translating our brief, preventive version of the UP to an online format was to secure the financial resources necessary to build the course. Given that our pilot project focused on college student mental health, we elected to explore funding options within our own institution, BU. First, we approached BU's Digital Learning Initiative (DLI), an on-campus department committed to using technology to enhance learning experiences for BU students. In initial communication, we described the rationale for a transdiagnostic prevention program, the results of our pilot project, and our desire to increase the program's reach via moving to an online platform. Unfortunately, the DLI's director indicated that our goals were not a good fit for their department, but suggested that we contact BU's Office of Distance Education (DE).

The mission of DE is to create flexible, engaging online courses and certificate programs for BU's academic departments. We scheduled a meeting in which we described our goals and presented materi-

als from our live workshop. DE staff showed us examples of courses they had previously built and it quickly became clear that they would be able to execute an online adaptation of our program. Understandably, their services came at a cost and, without a funding source, we would not be able to engage them. The director of DE suggested that we seek broad institutional support via reaching out to BU's Dean of Students and/or the Vice President of Enrollment and Student Administration.

We followed up on these recommendations by reaching out to both administrative offices via email. Several weeks later, we heard back from BU's VP of Enrollment and Student Affairs and scheduled a meeting. Given the emphasis of this office in supporting students, we prepared for our meeting by collecting information to suggest that BU students may not be satisfied with the university's handling of mental health concerns; for example, the *Huffington Post* had recently published two Op-Eds from BU students maligning the long waits for on-campus counseling. Of course, the VP of Enrollment and Student Administration was aware of this perception and highlighted her commitment to building resilience on campus. She helped us identify other outcomes representing student adjustment (e.g., GPA, leave-of-absence status, ratio of courses attempted to courses completed) that her office would be willing to provide in order to evaluate the effect of the course on functioning. The VP also noted that her office may be able to provide some financial support to build our online course but suggested that we contact BU's VP of Research and the DLI, where we started, for additional resources. A brief email correspondence with the VP of Research revealed that this office does not fund faculty research projects, but we were again encouraged to reach out to the DLI.

Given that we had received multiple recommendations to seek support from

BU's DLI, we elected to follow up with the director of this office, despite prior feedback that our project was not a good match with their goals. In this correspondence, we noted that BU's administration was in support of our project and that our work actually fit well within one of their strategic goals: to enhance BU students' overall experience while on campus. We were pleased when the DLI's director responded, inviting us to submit a formal proposal and to schedule a meeting to present the project to DLI staff. At the close of this meeting, we were informed that the DLI would support our proposal to translate our live, UP-based prevention program to an online, self-paced course. In addition, they would also provide funds to pay students to complete follow-up questionnaires throughout the year following their completion of the course as a means to assess its impact.

In sum, we felt confident in the merits of building an emotion-focused, transdiagnostic program to prevent mental illness on college campuses. This confidence brought us from meeting to meeting across our campus extolling the benefits of our intervention. In the end, our persistence "won the day" and, after approximately 5 months of sending emails and attending various meetings, we obtained support. We encourage our colleagues to look within their own institutions to find sources of support for valuable projects that may not be a strong match for traditional funding opportunities.

Developing the Course

Seeking funding from internal BU sources and collaborating with DE to build the course meant that our course would need to be explicitly tailored to the experiences of BU students. Blackboard is the platform used by DE to build online courses; given that each university has its own contract with Blackboard, the course we would develop would only be accessible

to BU students and thus very difficult to transfer to other settings. The lack of ability to disseminate our program is an obvious disadvantage to institutional funding and in-house course development. However, we reasoned that we would be able to collect strong pilot data to support a future funding proposal (e.g., small business innovation research application). Additionally, the opportunity to work with DE allowed us to capitalize on their experienced team of instructional designers with expertise in making live courses engaging in an online format. The DE team also has considerable experience with methods to make online courses accessible to students with disabilities.

The narrow focus on BU students afforded us the ability to channel the BU experience, developing content that would resonate specifically with its students. As such, we heavily relied on BU undergraduate research assistants to provide relevant and appropriate examples of emotion-provoking situations that commonly occur for them and their peers (e.g., failing to receive a response to a text message), careful not to come across as forced. We also sought to include pop-culture references to make the course fun and engaging, and worked with students to identify television shows, movies, and memes that would appeal to BU undergraduates. As pop-culture references can become dated quickly, care was taken in the type and amount of references used to avoid the need for excessive revisions. Any future iterations of the course will be checked for relevancy and updated as needed; DE staff is easily able to make changes to the content in the Blackboard course.

Adapting the UP

In creating the online course content, we simplified the full UP to four key modules, as we had in the live workshop version. Upon entering the course, participants are directed to a landing page with

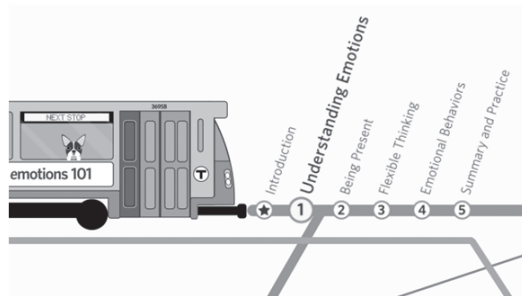


Figure 1. Screenshot of course platform with course goals.

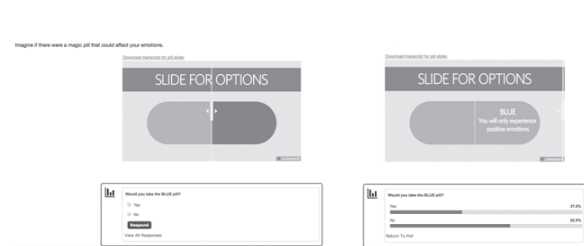


Figure 2. Screenshots of the interactive pill graphic and poll in the Understanding Your Emotions module.

animation that resembles a metro car from Boston's public transportation system (i.e., the "T") that runs through the BU campus. In the car sits a cartoon version of Rhett the terrier, BU's mascot. With Rhett as their guide, participants take a T-ride through an emotion-focused journey, where each T stop represents a healthy coping skill (Figure 1). Each of the modules included various forms of media and examples to increase engagement.

Module 1, "Understanding Your Emotions," provides psychoeducation to teach students about the functional nature of their emotions, discourage judgment of those emotions, and identify the parts of an emotional experience (i.e., thoughts, physical sensations, and behaviors). We included short videos of college-relevant scenarios where anxiety, sadness, and anger may be helpful, such as preparing for a difficult exam or standing up to a roommate. Polling questions were also utilized throughout the course; for example, we asked participants whether they would consider taking a magic pill to get rid of negative emotions. We used an interactive graphic of a pill (Figure 2), in which participants could slide their cursor to reveal options of (a) only experiencing positive emotions or (b) possibly experiencing negative emotions. Upon answering, they were shown the responses of others who had taken the course, gaining the perspective of their peers. The video examples, coupled with relevant guiding questions, helped translate the module into relatable material for college students.

Module 2, "Being Present," focused on introducing mindful emotion awareness and equipped participants with techniques for staying present in daily life. Here, we discussed the consequences of a wandering

mind with a short, animated video (<https://vimeo.com/131682712>), and used an interactive category game to practice identifying thoughts as either past, present, or future-oriented (Figure 3). We then guided participants through a brief meditation exercise to practice nonjudgmentally noticing thoughts, physical sensations, and behavioral urges in the present moment. Supplemental mindfulness resources were also included.

Next, in Module 3, entitled "Flexible Thinking," we considered the relationship between thoughts and emotions and encouraged participants to challenge their automatic negative appraisals of ambiguous situations. Videos emphasized the reciprocal relationship between thoughts and emotions, and an ambiguous picture exercise, taken directly from the UP client workbook (Barlow et al., 2010), was used to highlight the automaticity of thinking. Young adult-relevant scenarios were included to illustrate how, in emotional situations, trusting one's first impression may not always be helpful (e.g., Have you ever had a friend not text you back right away and assumed that they were ignoring you?). Students were prompted to practice identifying their first impressions and to come up with other possible explanations for the scenario.

In Module 4, "Emotional Behaviors," we focused on the way that behaviors in response to strong emotions can influence their trajectory. We again developed several videos to demonstrate the short- and long-term consequences of engaging in different kinds of emotional behaviors (e.g., taking a nap when feeling sad after a breakup, despite having a lot of work to do), and then asked participants to question whether their actions in response to emotions are helpful or harmful in the long term. Additionally, we had participants identify opposite actions for emotional behaviors common in college students (e.g., being invited to a party where you will not know many people, feeling insecure in a relationship). We concluded with a summary of skills, along with exercises for additional practice and a list of nearby mental health resources.

Implementation and Assessment Strategy

In addition to course development and distribution, as a team of researchers, we were interested in collecting data from students in a manner that would allow us to make informed decisions about how to

improve upon the course in the future. Specifically, we hoped to assess the feasibility, acceptability, and efficacy of the online program. Based on promising results from our in-person pilot study, we hypothesized that the online course would (a) be feasible to implement, (b) be satisfactory to undergraduates, and (c) result in lower ratings of anxiety and depressive symptoms at long-term follow-up assessment points. While conducting treatment outcome studies was not new to our research team, this study's methodology differed significantly from our previous experience and necessitated the development of several creative solutions during the formation our approach.

First, we needed to consider steps for participant recruitment and consent obtainment. In order to reach the entire incoming freshman class at BU, roughly 3,400 students, we elected to send a mass email the week before the start of the fall semester to all members of the incoming freshman class inviting them to participate in our research study. Interested students were instructed to click a link embedded in the email directing them to an online consent form (via Qualtrics). Eligible students were asked to provide information necessary for compensation and participant tracking including their email, university student identification number (UID), and full name. Participants then indicated separately whether they consented for research staff to use their UIDs to collect additional data (e.g., leave-of-absence status) from BU's Office of Student Affairs.

After the consent process, participants were prompted to complete several questionnaires that assess anxious, depressive, and related symptomology. Specifically, we selected the Depression, Anxiety, and Stress Scales (DASS; Lovibond & Lovibond, 1995), the Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988), the Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ; Endicott, Nee, & Blumenthal, 1993), the Brief Experiential Avoidance Questionnaire (BEAQ; Gámez et al., 2014), and the Emotion Regulation Questionnaire (ERQ; Gross & John, 2003). While it was important for us to include measures that assessed a range of emotional factors, we were careful to select those that were also brief so as to increase the likelihood that students would realistically complete the questionnaires and, most important, make it to the course itself.

Following completion of the questionnaires, participants were randomly assigned to the emotions101 condition or

Download Past, Present, Future Thoughts transcript.
Drag the thoughts to Past, Present, or Future.



Figure 3. Screenshot of interactive game from Being Present module, in which participants drag and drop thoughts into their respective category.

the no-intervention condition on a 1:1 schedule. The randomization logic was created in Qualtrics, and the program automatically conducts the randomization in real-time when the last questionnaire is completed. Following randomization, those assigned to the course are directed to the link to the Blackboard platform to begin the course, and those in the control group are led to a page thanking them for their participation in the surveys.

After the course, those in the emotions101 condition were directed back to Qualtrics to complete a satisfaction questionnaire to assess the acceptability of the course (adapted from Borkovec and Nau's [1972] commonly used treatment credibility measure). We also assessed feasibility with a brief, multiple-choice declarative knowledge quiz to assess uptake of course information. For longitudinal results, all participants were prompted with additional email reminders to complete the baseline assessment battery study at 1-month, 6-month, and 12-month follow-up points.

One of our final challenges related to the research strategy involved determining the best way to compensate students. Given that one of our primary aims was to assess the acceptability of the course, we were hesitant to incentivize participants by offering compensation for completing the course, as doing so would likely skew the number of students who opted to enroll in and complete the course. Thus, we decided to compromise and offer compensation for the completion of follow-up questionnaires. We opted to pay students \$5 in "convenience points," that they can use at various locations on campus, and did so via an online portal and use of their UIDs. This solution served as a simple and effective way of paying a large sample of college students. The BU Institutional Review Board approved all study procedures.

Summary and Future Directions

In sum, there is a clear need to address the increasing rates of anxiety and depressive disorders among college students, and preventive interventions that address underlying vulnerabilities for developing a range of emotional disorders show promise (e.g., Bentley et al., 2017; Center for Collegiate Mental Health, 2016). The present article describes the process of gaining support for creating a brief, stand-alone, online preventive course for incoming BU freshman, development of the course itself, and research methods for assessing accept-

ability and feasibility. We look forward to receiving feedback from participants about their impressions of the course and hope that findings support the case for implementation of the course as a mandatory part of university orientation and matriculation requirements. BU has already integrated a required online prevention course for risky alcohol use (AlcoholEdu) into their health requirements for first-year students, which has garnered empirical support at other higher education institutions (Paschall, Antin, Ringwalt, & Saltz, 2011; Wall, 2007; Wyatt, DeJong, & Dixon, 2013). University administration expressed high interest in and support of the emotions101 course becoming mandated for all students, pending favorable results. If so, little to no cost for continuation would be needed, as it is stand-alone in nature, lending itself to sustainable implementation. A required course for healthy emotional coping may lead to a reduction in rates of anxiety and depressive symptoms, and, with its inclusion within university, communicate to students that mental health is a priority of the university. A brief intervention could have significant implications for the university as well, including higher rates of student retention, higher GPAs, fewer classes dropped, and less medical leave. Furthermore, while the course is currently BU-specific (examples, pictures, etc.), the key messages are universal and we hope that this intervention serves as a time-efficient and cost-effective model for others looking for means to easily aid in the prevention of mental disorders on campuses.

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Correspondence to Julianne Wilner, Center for Anxiety and Related Disorders, 648 Beacon St, 6th Floor, Boston, MA 02215; jwilner@bu.edu

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CLINICAL DIALOGUES

He/She/I Said What?! Reflections on Addressing Microaggressions in Supervision

Melissa L. Miller and Gabriela A. Nagy, *Duke University Medical Center*

“RACIAL MICROAGGRESSIONS are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color” (Sue et al., 2007, p. 271). The concept and term was first used by psychiatrist Dr. Chester Pierce (1970, 1974) to describe the experiences of African Americans. Despite microaggressions often being discussed in the context of race and ethnicity, they can occur in relation to various identities (e.g., ethnicity, gender, sexual orientation). Importantly, there is compelling evidence indicating the experience of microaggressions is suggested to adversely impact mental health (e.g., Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Nadal, Wong, Sriken, Griffin, & Fujii-Doe, 2015). It has been suggested that microaggressions are commonplace and occur in everyday experiences (Kanter, Williams, Kuczynski, Manbeck, Debreux, & Rosen, 2017). Despite their prevalence, there is a paucity of available resources related to handling

microaggressions in the context of clinical supervision. We conducted a PsycINFO literature search with keywords “supervision” and “microaggressions,” which yielded only eight results in the past decade (comprising four journal articles, three dissertations, and one book). Without proper resources or training, it can difficult to navigate discussions about microaggressions in supervision (Constantine, 2003).

On our last day of clinical supervision together, we (a supervisor and a trainee) reflected on the various behaviors that led to an effective year of clinical, professional, and personal growth. One active component that we identified was the straightforward and honest manner in which we acknowledged, discussed, and responded to microaggressions, or subtle and indirect expressions of prejudice or bias (Sue, 2010). We were confronted with several examples of microaggressions throughout the year, including those occurring from trainee to trainee, supervisor to trainee, and client to trainee. Although these experiences can be confusing, hurtful, and diffi-

cult to discuss, we did our best to address them directly in supervision. In this article, we document our personal experiences as candidly as possible. We briefly describe the circumstances in which microaggressions occurred, and we reflect (via re-created conversation transcript) on the manner in which we addressed each situation in supervision. We then discuss practical steps for addressing microaggressions in supervision, and include sample language and additional considerations. Further, we provide specific recommendation for supervisors and trainees in Figure 1. We hope that sharing our experience will empower supervisors and trainees to directly approach and have productive conversations about microaggressions.

Microaggressions From Trainee to Trainee

Supervision Situation

A trainee experiences a microaggression from a peer. The peer responds defensively to feedback about the microaggression. The trainee must decide whether to discuss the interactions with the supervisor and how to respond to the peer.

Reflections

GABY (*trainee*): When my peer made a comment about my accent, I felt confused and hurt because it reminded me of being teased for my accent as a kid. It happened in front of a supervisor and other peers, and it was challenging to know whether or not I was appropriately feeling hurt, if and how to address it with my peer, and whether to bring it up in supervision. Iulti-

mately decided to bring it up in supervision because I trusted Melissa and thought she would be able to think through it with me, in a nonjudgmental manner.

MELISSA (*supervisor*): I was glad that Gaby decided to discuss this in supervision, and I thought that how I responded would communicate a lot of information—about me, our supervisory relationship, as well as a broader intuitional message. It certainly helped for me to have a working knowledge of microaggressions so that I could label the overall experience and actually name the specific type of microaggression (characteristics of speech; please see Rivera, Forquer, & Rangel, 2010, for additional reading). As a supervisor, I wanted to communicate that her experience was legitimate, help her to evaluate the options, and try to ensure that she felt empowered to respond to her peer in whatever manner that she chose.

GABY: That dialogue in supervision left me feeling validated, and it helped me identify and cope with my emotions (particularly the guilt and shame secondary to feeling hurt). Once my emotions were manageable, I could more effectively decide how I wanted to respond to my peer. I felt empowered to be able to navigate the situation in a way that was consistent with my values and also appropriate in our professional setting. Ultimately, I decided to follow up with my peer. In that interaction, I provided context for why it was particularly hurtful, he understood and apologized, and we were able to repair the rupture.

MELISSA: Following our conversation, Gaby gave me feedback about how I responded to her concerns. It was helpful to directly hear the ways in which our conversation impacted her, and I am grateful that she chose to do that. I imagine that was difficult because we were just beginning to develop a supervisory relationship, but it definitely reinforced my behavior.

Microaggressions From Supervisor to Trainee

Supervision Situation

A supervisor makes a microaggression against a trainee and realizes it. The supervisor must decide whether to discuss the microaggression with the trainee in supervision and repair the transgression.

Reflections

MELISSA: There was another time, early in our relationship, when I could either confront my own microaggression or just assume that Gaby understood what I meant. We were about to lead a therapy group together, and we were talking about upcoming conferences. I said, “Oh, you’ll get to be with your people!” in reference to the National Latina/o Psychological Association conference (it makes me cringe to think about how carelessly I said that). My intention was to refer to beloved colleagues with similar professional interests, akin to how I would say “my DBT people.” Despite my intention, I realized that I had totally microaggressed against her and that there was far more behind that comment than I intended (color-blindness; please see the American Psychological Association, 2003, and Sue, 2007, for additional readings).

GABY: Being familiar with the concept of microaggressions myself, I realize that microaggressions can often happen without the individual intending to be hurtful. I knew this could have been interpreted as a microaggression, but I also assumed Melissa was not trying to be insensitive. I didn’t feel particularly hurt; I felt curious. Of course, we could not discuss it right then because group was starting.

MELISSA: I decided to address it the next day in supervision. Even though I knew that I meant it in a friendly way, I felt some guilt and shame and I did have urges to avoid the conversation. Having a solid understanding of behaviorism definitely helped me in this situation, because I know the long-term consequences of avoiding something because it is emotionally difficult to approach (i.e., it becomes more challenging to approach in the future). Additionally, I thought that acknowledging my own microaggression would strengthen our relationship and, again, communicate an important message to her (specifically, that I cared about her and wanted to be sensitive to her personal experience). Essentially I said, “I realize that I microaggressed against you yesterday in group, I’m really sorry about that, and I’m hoping that we can talk about it” (please refer to Figure 1 for sample language to use). Gaby expressed interest, and then we had a candid conversation about what I said, how she felt, and microaggressions in general.

GABY: I was pleasantly surprised to know Melissa had thought about our interaction

after it happened. This demonstrated that she was trying to understand my experience as a woman of color, and that I might have experienced that interaction as hurtful and potentially damaging to our supervisory relationship. I appreciated that she decided to bring it up with me and modeled vulnerability as supervisor. That created more trust in the relationship, which then led to further vulnerability in our supervision.

Microaggressions From Client to Trainee

Supervision Situation

A trainee repeatedly experiences potential microaggressions from a client. The trainee must decide whether or not to discuss with the supervisor and then how to respond to the client.

Reflections

GABY: I was seeing a client who repeatedly alluded to me not being competent, especially when she was feeling dysregulated. It was unclear if this was because of my training level (predoctoral intern), age, gender, ethnicity, or some other reason. Her comments were incredibly painful, and working with her was very challenging.

MELISSA: This was especially insidious, as is often the case with microaggressions, because it was never directly clear that the client’s statements were related to any of Gaby’s identities (ascription of intelligence; please see Hernandez, Carranza, & Almeida, 2010, for additional reading). The client often engaged in hostile and aggressive verbal and nonverbal behaviors when emotionally dysregulated, and she regularly expressed remorse once she was calm again. The situation was complex, and we were constantly prioritizing high-acuity treatment targets (including serious suicidal behavior and extreme emotion-regulation skill deficits), which did not include clarifying whether or not the comments were microaggressions.

GABY: We discussed this repeatedly in supervision, and we talked about the impact on me both professionally and personally. The client really needed help with emotion regulation and interpersonal effectiveness, but it was so hard to receive her comments. We ultimately decided to set firm contingencies to reduce and eliminate the client’s hostile and aggressive behavior, but we never actually addressed the microaggressions directly.

MELISSA: I felt quite protective of Gaby, and I wanted to ensure that she was not enduring unnecessary harm. I wanted her to feel validated and supported in supervision, and I also wanted her to feel empowered to decide to continue working with this client or to refer her to a different provider.

Practical Recommendations

It can be particularly challenging to navigate microaggressions in the context of clinical supervision. Trainees and supervisors alike may feel aversive emotions (e.g., embarrassment, anxiety, or frustration), fear negative evaluation, or lack a framework for discussing these experiences. Given that microaggressions often represent implicit social biases that are deeply imbedded in us all (Payne & Gawronski, 2010), it is functionally impossible to avoid them entirely. During our year of effective supervision, we focused on ameliorating the aftermath of microaggressions by addressing them directly. We discuss them here, and also direct you to Figure 1 for a flow diagram of our recommendations.

The first three practical steps for supervisors to address microaggressions are: identify and label the microaggression, assess the impact, and validate (and don't invalidate!) the effect. It's important to assess the impact, because the personal reactions that trainees experience in response to microaggressions may differ greatly (Dover, 2016; Tran, Miyake, Martinez-Morales, & Cszimadia, 2016), and supervisors will benefit from neither magnifying nor minimizing trainees' responses (Constantine, 2003). When comments are made by peers or clients, supervisors can help trainees by brainstorming and evaluating various options for responding (Hernandez et al., 2010; Schoulte, Schultz, & Altmaier, 2011). If supervisors are the ones who have microaggressed, we recommend communicating a plan to repair any harm caused by the comment, as doing so may increase vulnerability and strengthen the supervisory relationship. This does not mean assuming responsibility for intention to harm, but rather, simply acknowledging the impact (nondefensively), despite the intention. Supervisors also ought to refrain from overapologizing, as this could, paradoxically, function to inhibit future disclosures (e.g., for fear of hurting the supervisor's feelings or concern that the discussions will be excessively time consuming). In all situations, it's helpful for supervisors to invite and incorporate feedback, and this can provide valuable infor-

mation to help guide future interactions and discussions.

A challenge of the recommendations outlined above is that these types of conversations may be uncomfortable for both the trainee and supervisor, and thus avoidance may seem like an attractive option. Importantly, we believe this type of dialogue is best in the context of a supervisory relationship where trust, honesty, and vulnerability exist. This may be particularly challenging to attain toward the beginning of a supervisory relationship or in cases wherein a rupture may have occurred.

Alternatively, it is our experience that increased trust, honesty, and vulnerability may be a by-product of engaging in this type of dialogue. Thus, we believe that the potential benefits outweigh the costs (even if the conversations are, admittedly, difficult to approach).

The practical steps outlined here focus on supervisors empowering trainees to respond to microaggressions, with supervisors providing support "behind the scenes" in supervision. However, in cases where the environment is too powerful or the costs are too high, it may be more effective for

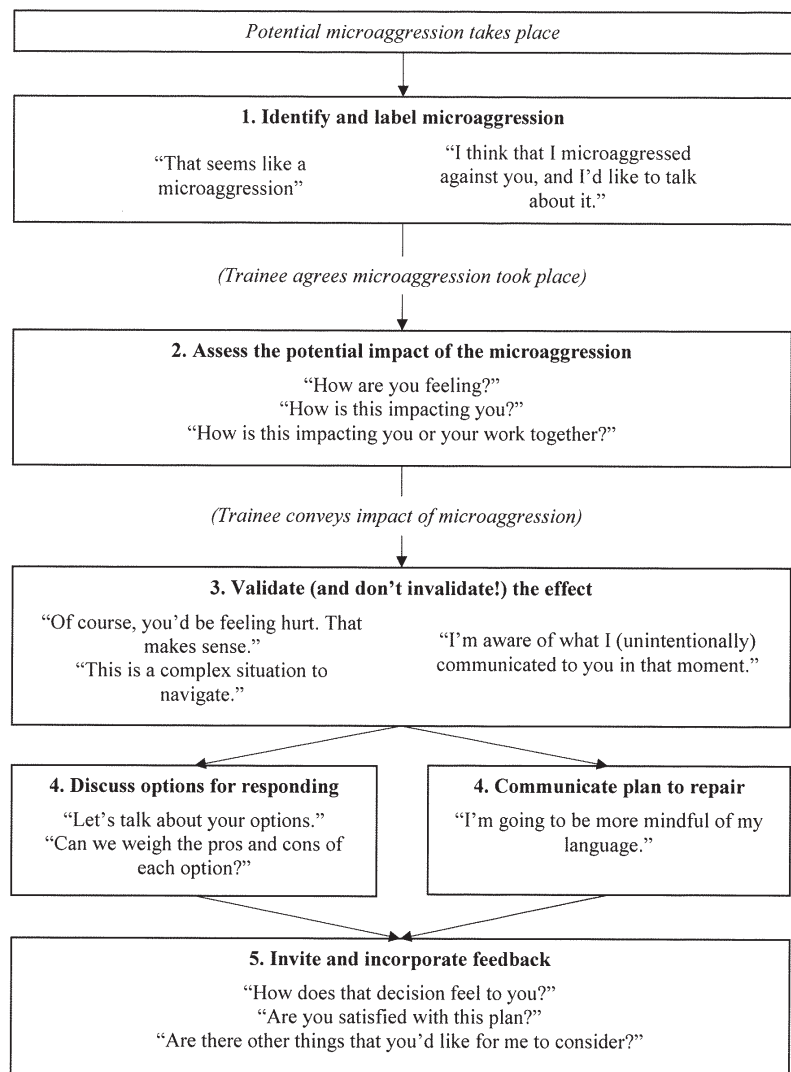


Figure 1. Practical steps and sample language to address microaggressions in supervision. Text on the left in steps 1, 3, and 4 represents situations wherein other trainees, colleagues, or clients have microaggressed toward trainee, and text on the right reflects instances in which supervisors have done so. Text in steps 1 and 5 includes sample language that could be utilized regardless of who microaggressed toward the trainee.

Find a CBT Therapist



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

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

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

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

supervisors to intervene directly and advocate on behalf of trainees. Additionally, for the purposes of this article, we chose to focus on exemplary situations in which supervisors help trainees with their experience of microaggressions. Certainly, supervisors may also be the recipients of microaggressions, and we encourage them to seek similar forms of support from their colleagues and superiors. As effective behavior therapists, we know that approaching these difficult conversations gets easier with practice, experience, and exposure.

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Correspondence to Melissa L. Miller, Ph.D., Cognitive Behavioral Research and Treatment Program, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center (DUMC 3026), 2213 Elba Street, Office 235, Durham, NC 27710; melissa.l.miller@duke.edu

2017 ABCT Featured Student Award Recipients

Katherine Baucom, *Chair, Awards & Recognition Committee*

ON BEHALF of the Awards & Recognition Committee I want to thank the many members who were able to join us for the Awards Ceremony in San Diego, where we honored a number of our members! Over the course of the coming year *the Behavior Therapist* will feature many of the 2017 recipients, starting with students.

STUDENT TRAVEL AWARD

Recipient: **Dev Crasta, M.A.** (University of Rochester)

Presentation: **Going Beyond Accessibility: Evaluating the Efficacy of a Minimal Self-Help Couples Treatment in Economically Disadvantaged Neighborhoods**

Advisor: Ron Rogge, Ph.D.

Dev's research aims to improve accessibility of psychological tools to underserved families. His translational approach uses basic research techniques from sociology and psychology to understand how community context impacts relationships and highlight key processes working across contexts. These findings then inform applied research developing online tools such as the Promoting Awareness & Improving Relationships program (PAIR). Dev's presentation at the convention integrated these two threads by investigating PAIR in a geographically diverse sample of parents. Dev's work is supported by grants from the American Psychological Foundation, the Family Process Institute, as well as a National Science Foundation Graduate Research Fellowship.

GRADUATE STUDENT RESEARCH GRANT

Recipient: **Hannah Lawrence, M.A.** (University of Maine)

Project: **Physiological and Affective Correlates of Visual and Verbal Rumination in Adolescence**

Advisor: Rebecca Schwartz-Mette, Ph.D.

Hannah's research is focused on rumination in the form of mental imagery versus verbal thought and the impact of visual and verbal rumination on the experience of depression. In particular, her work examines the affective, cognitive, and physiological correlates of visual and verbal induced rumination in adolescent samples. She co-authored a published book on evidence-based assessment and treatment of child and adolescent depression as well as numerous publications on rumination, depression, and mental imagery. She is the recipient of multiple research awards including the Janet Waldron Doctoral Research Fellowship at the University of Maine, a Beck Institute Student Scholarship, and the Society for Psychophysiological Research Training Fellowship to support training in physiological assessment with Dr. Greg Siegle at the University of Pittsburgh School of Medicine.

Call *for Award Nominations . . .*
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- ◆ Career/Lifetime Achievement
- ◆ Outstanding Mentor
- ◆ Distinguished Friend to Behavior Therapy
- ◆ Mid-Career Innovator
- ◆ Anne Marie Albano Early Career Award
- ◆ Outstanding Service to ABCT

STUDENT AWARDS:

- ◆ President's New Researcher (*deadline:* Aug. 1)
- ◆ Virginia A. Roswell Student Dissertation
- ◆ Leonard Krasner Student Dissertation
- ◆ John R. Z. Abela Student Dissertation
- ◆ Elsie Ramos Memorial Student Poster Awards
- ◆ Student Travel Award

Deadline: March 1, 2018

Minutes of the Annual Meeting of Members

Friday, November 17, 2017, Hilton San Diego, Bayfront, San Diego

Call to Order

President Steketee called the meeting to order at 12: 32 p.m. PST and welcomed members to the 51st Annual Meeting of Members. Notice of the meeting had been sent to all members in September.

Minutes

Secretary-Treasurer Larimer asked for any comments or corrections on the minutes from last year's meeting.

M/S/U: The October 29, 2016, minutes were unanimously accepted as distributed.

Expressions of Gratitude

President Steketee thanked the members of the organization for their hard work this year. She thanked Michelle Craske, rotating off as Immediate Past President; Keith Dobson, Representative-at-Large and liaison to Membership Issues, 2014-2017; Shireen Rizvi, 2014 - 2017 Academic & Professional Issues Coordinator; Katherine J. W. Baucom, 2014 - 2017 Awards and Recognition Committee Chair; Sarah Kate Bearman, 2015 - 2017 Academic Training and Education Standards Committee Chair; and Michael S. McCloskey, 2014 - 2017 Dissemination of CBT and Evidence Based Treatments Committee Chair. She thanked the Chairs rotating off Convention and Education Issues: Jordana Muroff, 2017 Program Chair; Jonathan S. Comer, 2013 - 2017 Continuing Education Committee Chair; Sarah J. Kertz, 2014 - 2017 Master Clinician Seminar Series Chair; and Risa B. Weisberg, 2015 - 2017 Research and Professional Development Committee Chair. She thanked the Chairs rotating off Membership Issues: Alyssa M. Ward, 2014 - 2017 Special Interest Groups Committee Chair; Bradley C. Riemann, 2014 - 2017 Membership Committee Chair; and Patrick L. Kerr, 2014 - 2017 List Serve Committee Chair. The President thanked Michelle Newman, *Behavior Therapy* Editor, Volumes 45-48, and Kristene A. Doyle, 2014-2017 Web Editor.

President Steketee remarked, "We all know that to put together a program of this size takes a lot of time and dedication. This

year we had an astonishing 360 members help review program submissions—the largest number of reviewers in our history! We also want to acknowledge our 76 Super Reviews who helped us out this year. A heartfelt thank you to the 2017 program committee members."

President Steketee thanked Amitai Abramovitch, Lauren Alloy, Drew Anderson, Mike Anestis, Joye Anestis, Laura Anthony, Michael Armev, Anu Asnaani, Marc Atkins, Shelley Avny, Alisa Bahl, Amanda Baker, Anne Bartolucci, Kimberly Becker, Stephen Becker, Sara Becker, Rinad Beidas, Kathryn Bell, Kristen Benito, Erin Berenz, Noah Berman, Erica Birkley, Abby Blankenship, Jennifer Block-Lerner, Heidemarie Blumenthal, Jamie Bodenlos, Fabian Boie, Christina Boisseau, Maya Boustani, Scott Braithwaite, Christiana Bratiotis, Lindsay Brauer, Allison Bray, Ana Bridges, Lauren Brookman-Fraze, Timothy Brown, Lily Brown, Shandra Brown Levey, Steven Bruce, Alexandra Burgess, Andrea Busby, Will Canu, Nicole Caporino, Matthew Capriotti, Daniel Capron, Cheryl Carmin, Alice Carter, Corinne Catarozoli, Mark Celio, Dianne Chambless, Alexander Chapman, Ruby Charak, Gregory Chasson, Joshua Clapp, David Clark, Elise Clerkin, Rebecca Cobb, Meghan Cody, Meredith Coles, Laren Conklin, Bradley Conner, Elizabeth Connors, James Cordova, Travis Cos, Shannon Couture, Suzannah Creech, Torrey Creed, Jessica Cronce, Kristy Dalrymple, Pooja Dave, Charlie Davidson, Thompson Davis, Brett Deacon, Thilo Deckersbach, Tamara Del Vecchio, Patricia DiBartolo, Angelo DiBello, Gretchen Diefenbach, Ray DiGiuseppe, David DiLillo, Linda Dimeff, Katie Dixon-Gordon, Deidre Donaldson, Alex Dopp, Brian Doss, Sheila Dowd, Amy Drahota, Chris Eckhardt, Barry Edelstein, Jill Ehrenreich-May, Polina Eidelman, Thane Erickson, Melissa Faith, Angela Fang, Brian Feinstein, Thomas Fergus, Brooke Fina, Aaron Fisher, Nicholas Forand, Elisabeth Frazier, Steffany Fredman, Andrew Freeman, David Fresco, Robert Friedberg, Steven Friedman, Randy Frost, Kristin Gainey, Richard Gallagher, Matthew Gallagher, Frank Gardner, Sarah

Garnaat, Brandon Gaudiano, Andrea Gold, Philippe Goldin, Jeffrey Goodie, Cameron Gordon, DeMond Grant, Kim Gratz, Kelly Green, Jonathan Green, Amie Grills, John Guerry, Cassidy Gutner, Emily Haigh, Kevin Hallgren, Lauren Hallion, Lindsay Ham, David Hansen, Shelby Harris, Ashley Harrison, Tae Hart, Trevor Hart, Tamara Hartl, Cynthia Hartung, Sarah Hayes-Skelton, Alexandre Heeren, Craig Henderson, Aude Henin, Debra Herman, Nathaniel Herr, Kathleen Herzig, Melanie Hetzel-Riggin, Crystal Hill-Chapman, Joseph Himle, Michiyo Hirai, Daniel Hoffman, Stefan Hofmann, Janie Hong, Cole Hooley, Debra Hope, Lindsey Hopkins, William Horan, Joseph Hovey, Kean Hsu, Megan Hughes-Feltenberger, Andre Ivanoff, Nuwan Jayawickreme, Amanda Jensen-Doss, Robert Johnson, Kathryn Kanzler, Heather Kapson, Maria Karekla, Howard Kassinove, Amy Keefer, Megan Kelly, Robert Kern, Connor Kerns, Sarah Kertz, Elizabeth Kiel, Lisa Kilpela, Katharina Kircanski, Nancy Kocovski, Amelia Kotte, Kevin Krull, Magdalena Kulesza, Steven Kurtz, Michael Kyrios, Caleb Lack, Sara Landes, Ryan Landoll, David Langer, Jennifer Langhinrichsen-Rohling, Sean Lauderdale, Matthew Lehman, Penny Leising, Michelle Leonard, Marie LePage, Matthew Lerner, Adam Lewin, Crystal Lim, Kristen Lindgren, Danielle Lindner, Jessica Lipschitz, Richard Liu, Sandra Llera, Patricia Long, Christopher Lootens, Tamara Loverich, Aaron Lyon, Sally MacKain, Brittain Mahaffey, Maria Mancebo, Sarah Markowitz, Donald Marks, Ali Mattu, Michael McCloskey, Joseph McGuire, Kate McHugh, Dean McKay, Carmen McLean, Alison McLeish, Daniel McNeil, Julia McQuade, Elizabeth Meadows, Douglas Mennin, Jennifer Merrill, Thomas Daniel Meyer, Robert Meyers, Jamie Micco, Mary Beth Miller, Damon Mitchell, John Mitchell, Zella Moore, Michael Moore, John Moring, Lauren Moskowitz, Kim Mueser, James Murphy, Laura Murray, Taryn Myers, Brad Nakamura, Douglas Nangle, Lisa Napolitano, Michael Newcomb, Amie Newins, Michelle Newman, Kate Noonan, Sébastien Normand, Roisin O'Connor, Lisa O'Donnell, Bunmi Olatunji, Trina Orimoto, Sarah O'Rourke, Camilo Ortiz, Julie Owens, David Pantalone, Rebecca Pasillas, Laura Payne, Fred Penzel, Jacqueline Persons, Sandra Pimentel, Antonio Polo, Kristina Post, Mark Powers, Loren Prado, Rebecca Price, Amy Przeworski, Cara Pugliese, Adam Radomsky, Holly Ramsawh, Lance Rappaport, Carla Rash, Sheila

Rauch, Judy Reaven, Neil Rector, Felice Reddy, Madhavi Reddy, Hannah Reese, Simon Rego, Jessica Richards, John Richey, John Riskind, Kelly Rohan, George Ronan, Anthony Rosellini, Barbara Rothbaum, Rebecca Sachs, Dustin Sarver, Nina Sarver, Shannon Sauer-Zavala, Steven Sayers, Tracy Sbrocco, Heather Schatten, Katherine Schaumberg, Brad Schmidt, Casey Schofield, Jill Scott, Laura Seligman, Kathy Sexton-Radek, Benjamin Shapero, Tomer Shechner, Frederick Shic, Ryan Shorey, Nicholas Sibrava, Greg Siegle, Jedidiah Siev, Monica Skewes, Stephanie Smith, April Smith, Moria Smoski, Jennifer Snyder, Laura Sockol, Kristen Sorocco, Claire Spears, Amanda Spray, Susan Sprich, Shari Steinman, Jill Stoddard, Eric Storch, Lauren Stutts, Denis Sukhodolsky, Maureen Sullivan, Louisa Sylvia, Robyn Sysko, Raymond Tafra, Jennifer Taitz, Jeff Temple, Alix Timko, Patti Timmons Fritz, Kiara Timpano, Theodore Tomeny, Michael Tompkins, Casey Trainor, Kimberli Treadwell, Matthew Tull, Cynthia Turk, Brianna Turner, David Valentiner, Kathryn Van Eck, Shona Vas, Clorinda Velez, Andres Viana, Jason Vogler, Suzanne Vrshek-Schallhorn, Anka Vujanovic, Melanie Wadkins, Alyssa Ward, Allison Waters, Laura Watkins, Elliot Weiner, Hilary Weingarden, Jeremiah Weinstock, Lauren Weinstock, Risa Weisberg, Tony Wells, Susan Wenzel, Chad Wetterneck, Michael Wheaton, Bradley White, Kamila White, Stephen Whiteside, Shannon Wiltsey Stirman, Sheila Woody, Edward Wright, Michael Wydo, Matthew Young, Alexandra Zagoloff, Alyson Zalta, Laurie Zandberg, and Eric Zhou.

We also want to thank the Local Arrangements Committee and Co-chairs Aaron J. Blashill and Tiffany Brown for a terrific job making us all feel very welcome in San Diego.

Appointments

President Stekete listed the new appointments: Katherine J. W. Baucom, 2017-2020 Academic and Professional Issues Coordinator; Cassidy Gutner, 2017-2020 Awards and Recognition Committee Chair; Anu Asnaani, 2017-2020 Continuing Education Committee Chair; Kiara R. Timpano, 2018 Program Chair; Alyssa Ward, 2018 Associate Program Chair; Courtney Benjamin Wolk, 2017 – 2020 Master Clinician Seminar Series Chair; Cole Hooley, 2017-2020 Research and Professional Development Committee Chair; Kathleen Gunthert, 2017-2020 Member-

ship Committee Chair; Lance Rappaport, 2017-2020 Special Interest Groups Committee Chair; Gabrielle Liverant, 2017-2020 List Serve Committee Chair; Regine Galanti, 2017-2020 Web Editor, and Denise Sloan, Editor, *Behavior Therapy*, for volumes 49-52.

Finance Committee Report

The Secretary Treasurer reminded the membership that the Finance Committee oversees the financial health of ABCT, monitors the fiscal forecasts, oversees that funds are set aside for specific projects, ensures money is invested prudently, and evaluates financial considerations related to ownership of the central office.

Our fiscal year is from November 1 – October 31. 2016 fiscal year (FY) ended with a positive balance of \$245,012, with income (\$2,353,977) greater than expenses (\$2,108,965). This is considerably better than the operating deficit of \$74,622 that was originally projected. The 2017 fiscal-year-approved budget was projected to show income over expense of \$215,650 and we expect to exceed that.

ABCT uses a financial advisor at Boening and Scattergood to guide us in our investment decisions. The funds have “conservative growth with income” as its investment goal, with a 6.86% annual yield. ABCT endowment funds are invested in a “moderately conservative” fashion. The total endowment portfolio value as of July 3, 2017 was \$1,202,670.23 with a 7.74% 1-year yield. Rules regarding the investment and dispersal of money associated with named awards are established when the funds are bequeathed. We have six named award funds at B & S and a general fund-the-future endowment. ABCT continues to enjoy good financial health, including robust reserve funds.

Coordinators Reports

Academic and Professional Issues

Shireen Rizvi, Coordinator of Academic and Professional Issues, reported that the Self-Help Book Recommendations Committee recommended additional books that are evidence-based for our website. The Board approved five, which can be found at <http://www.abct.org/SHBooks/>. The Awards and Recommendations Committee, chaired by Katherine Baucom, thanked the Board of Directors for approving the recommendations of the committee that Dev Crasta, University of Rochester, receive the Student Travel Award along

with the Elsie Ramos Poster awards to: Chloe Hudson, Queen’s University; Christian Goans, University of North Texas; and Kate Kysow, University of British Columbia. Members were encouraged to attend the Awards Ceremony that evening. The International Associates Committee, spearheaded by Lata McGinn, continues to focus on expanding the World Congress Committee to the World Confederation of Behavioral and Cognitive Therapies that will look at global issues in addition to our tri-annual world congresses. Call for submissions for the 2019 World Congress in Berlin will begin June 2018. The Academic Training and Education Standards Committee has incorporated the work of the former Committee on Dissemination of CBT & Evidence-Based Treatment. The committee has several subcommittees that focus on training resources for our website, maintaining the online Mentor Directory where students can see the research of the professors where they are applying for admission and the Spotlight on a Mentor program. This year the Board approved the recommendations that Stacey Frazier, Florida International University; Robert Friedberg, Palo Alto University, and Shireen Rizvi, Rutgers University receive the Spotlight awards and they will be acknowledged at the Friday night Awards Ceremony. The Research Facilitation Committee, with Board approval, awarded the Student Research Grant to Hannah Lawrence, University of Maine and the Graduate Student Research Grant Honorable Mention to Amanda L. Sanchez, Florida International University. Chair Nate Herr’s informative summary of the 2017 NIMH Professional Coalition for Research Progress Meeting will be published in the December issue *the Behavior Therapist*. Dr. Herr will represent us again in 2018.

Convention and Continuing Education

Barbara W. Kamholz, Coordinator of Convention and Education Issues, reported that there were 2,094 submissions across 56 primary categories, and 41 secondary categories. Of these, 1,632 submissions were accepted across 53 primary categories and 36 secondary categories. There were also a record number of reviewers on the program committee (N = 360). An estimated 3,200+ professionals attended the San Diego convention. The group is researching program book options for 2018, and evaluating the current mix of paper, online, and smartphone app vs. online and smartphone app only.

Coordinator Kamholz reported that the Continuing Education Committee organized a total of 9 webinars (7 already completed, 2 more scheduled). The 2018 goal is 10–11 webinars. The APA accreditation issue, a major deterrent to a full webinar series in 2016, was resolved for live webinars. APA accreditation was also received for home-study and archived webinars, but will require the CE committee to generate missing CE post-test questions for all previous webinars before 2017 in order for members to receive credit for these webinars. She also reported that Anu Asnaani has begun successful transition to Chair role (2018-2020) and Carmen McLean has successfully assumed formal role as Marketing and Outreach Facilitator (2018-2020).

Coordinator Kamholz reported that the 2018 Program theme is “Cognitive Behavioral Science, Treatment, and Technology.” Invited speakers include Christian Rueck (Treatment: iCBT); Rosalind Piccard (Assessment: Sensors); James Fowler (Human Networks) and Dianne Chambless (2017 Lifetime Achievement Award Winner). She noted that we are looking at Invited Conversation with Dr. Josh Gordon and an Invited Panel on Funding & CBT (PCORI, NIDA, National Institute of Child Health and Human Development, Administration for Children and Families). She encouraged members to submit for the ticketed sessions and general sessions. Information can be found in the program book and on the ABCT website. The November 15–18 convention will be held in Washington, DC.

The Coordinator thanked Jordana Muroff, our 2017 Program Chair; Jon Comer, 2013-2017 Continuing Education Committee Chair; Anu Asnaani, 2017-2020 Continuing Education Committee Chair; Sandy Pimentel, Representative-at-Large and Liaison to Convention and Education Issues; Mary Jane Eimer, Executive Director; Linda Still, Director of Education and Meeting Services, and the entire ABCT Central Office Staff for their contributions to the Convention Planning and CE Committees.

Membership Issues

Hilary Vidair, Membership Issues Coordinator, reported that ABCT ended the 2017 membership year with 5,372 members, an increase of 279 from the prior year! For the upcoming membership year, we have 2,521 members compared to 1,784 last year at comparable timing, an increase of 318 full members and 227 Student mem-

bers. She highlighted the three New Professional categories with 98, 77, and 67 members, respectively, for a total of 242 New Professional members, compared to a total of 108 last year. This great news suggests our innovative 3-Year Stepped New Professional categories are capturing members who may have registered as Student members in the past. These categories balance the goal of keeping costs for recent graduates reasonable while recognizing their new professional status and increasing ABCT’s membership revenue. The overall increase in membership in a year when our convention is on the West Coast is very promising, as historically our numbers have been higher when the convention is on the East Coast.

Coordinator Vidair reported that we continued to expand outreach to PsyD Psychologists, Social Workers, Master’s-level Licensed Marriage and Family Therapists, Licensed Mental Health Counselors/Therapists, Licensed Professional Clinical Counselors, and Nurses. Changes in our database process require members to indicate their field of study and year in which their terminal degree was earned when they join or renew. This will allow us to keep track of the number of members we have in each field (e.g., PsyDs, social workers) over time, market to specific subgroups, and determine if changes in membership correlate with our recruitment efforts. We plan to continue executing ideas from last year’s PsyD Think Tank. For example, one next step is to develop podcasts for PsyDs to help them think of ABCT as their professional home, including what they can expect to gain from the organization and the convention.

The Coordinator reminded the membership of the work of the Student Committee. They have launched a Featured Lab project for the web, updated the “slang dictionary” so new members can get up to speed on ABCT culture faster and process all the acronyms we use.

The Coordinator also noted that the Clinical Directory and Referral Issues Committee reinstated the Featured Clinician on our website in addition to developing a Pioneer Series and promoting information on CBT that addresses different disorders by month. The List Serve continues to be a valuable resource to the membership. The Social Networking Media Committee is expanding our reach through the ABCT Facebook and Twitter accounts. Our Special Interest Groups remain robust and we now have 39 groups with one more in-formation. She reminded

the full members to be on the lookout for the 2018 application period to become a Fellow and it is time for the membership to nominate colleagues or themselves for office. The Call for Nominations is your program addendum, appears in the October and December issues of *tBT*, and on the web.

Coordinator Vidair has 8 committee chairs along with the Ambassador Chair reporting to her. She thanked Alyssa Ward, Special Interest Groups Committee Chair; Bradley Riemann, Membership Committee Chair; Joy Pemberton, Student Committee Chair; David Pantalone, Leadership and Elections Committee Chair; Laura Payne, Clinical Directory and Referral Issues Committee Chair; Patrick Kerr, List Serve Committee Chair; Emily Bilek, Social Networking and Media Committee Chair; and David DiLillo, Fellows Committee Chair, along with their committee members for the amazing work they do throughout the year and to make ABCT a vibrant organization where members want to renew.

Publications Committee

Steve Safren, Publications Coordinator, reported that both journals continue to boast higher impact factors, with *BT* at 3.434/4.765 (13th of 121 journals) and *C&BP* at 2.537/2.635 (36th of 121 journals); improved manuscript disposition, with *BT* at mean of 32.6 days and *C&BP* at 64 days; and increased manuscript flow, with *BT* projecting 270 manuscripts and *C&BP* 106. The Coordinator thanked the editors who handle a heavy work load to great effect. Both editors singled out Stephanie Schwartz, our managing editor, in the Central Office. Michelle Newman is completing her term as editor and Denise Sloan is already handling all new submissions as editor-elect.

In *tBT*, Kate Wolitzky-Taylor is producing both quality and quantity, including several special series, one mirroring this convention’s theme. She restructured the editorial board, making most into at-large editors to give them greater freedom to accomplish tasks. After reviewing alternate delivery approaches for *tBT*, we recommend that the newsletter be kept as a print journal, available in PDF on the web site (issues back to 2002 can be found at <http://www.abct.org/Journals/?m=mJournal&fa=TBT>).

We said goodbye to Kristene Doyle after 3 fun years at the web’s helm. She introduced new video components, including Spotlight on the 50th (an anniversary

issue with thoughtful commentary at http://www.abct.org/Members/?m=mMembers&fa=Spotlight_50) and the Presidents' Muse (<http://www.abct.org/Members/?m=mMembers&fa=PresidentsMuse>). Several other videos currently grace the home page and enlighten the lay public on various disorders (see pieces on ADHD, bullying, and OCD at <http://www.abct.org/Home/>) as well as adding to the section on CBT in the News (http://www.abct.org/Information/?m=mInformation&fa=CBT_News). Regine Galanti assumes the mantle as Web Editor at an exciting time as we ponder new ways to approach the web.

The Speakers Bureau is up and running at <http://www.abct.org/xMedia/>. Bob Schachter and his crew will also be developing a host of videos and documents to help our members be polished ambassadors of CBT and to allow the media to more adeptly and accurately discuss CBT's effects on various disorders.

Susan Sprich continues to work independently and with several other committees to generate and polish Fact Sheets, adding three new ones in 2017. Six Fact Sheets have been translated into Spanish.

Susan White heads ABCT's partnership with Oxford University Press in the "Series on Implementation of Clinical Approaches." Five books are under way, with one already delivered to OUP's editors. Susan is working with four AEs: Lara Farrell, Matthew Jarrett, Jordana Muroff, and Marisol Perez. The first book, *Application of the Unified Protocol for Transdiagnostic Treatment for Emotional Disorders*, edited by Todd Farchione and David Barlow, is already printed.

Executive Director's Report

Mary Jane Eimer, the Executive Director, reported that our March strategic planning retreat resulted in 7 strategic initiatives: Member Community and Value; Dissemination and Implementation; Innovation and Advancement of Science; Outreach; Partnerships and Coalitions; Globalization; and Technology. She noted that we ended the 2017 membership year with 5,372 members, and, most importantly, are maintaining our full members.

Ms. Eimer noted that we created the Audit Committee this year which reviewed the 2016 year-end financials, and ABCT will most likely have an income over expense of \$320,000 on the operating budget, which is \$96,000 more than projected. Our accounting firm continues to

give us high marks during our annual audit for being fiscally sound and compliant with all state and federal regulations. They point out that ABCT is well managed.

The Executive Director reported much more activity with social media, with measurable efforts. Growth has continued from 3,000 'likes' at the 2014 convention, to 4,300 at the 2015 convention, to 6,785 at the 2016 convention, to 8,167 as of this report. ABCT has had a high level of involvement in the Coalition for the Advancement and Application of Psychological Sciences (CAAPS). We continue to be an active presence in COSSA and the Mental Health Liaison Group.

The Executive Director thanked her staff for the incredible work they do and encouraged members to introduce themselves to:

- **David Teisler**, Director of Communications and Deputy Director
- **Linda Still**, Director of Education and Meeting Services
- **Tammy Schuler**, Director of Outreach and Partnerships
- **Barbara Mazzella**, Administrative Secretary, who handles all fulfillments, and staffs our Membership Booth at the annual conventions
- **Tonya Childers Collens**, Administrative Assistant, Exhibits Manager, and Convention Registrar
- **Dakota McPherson**, Membership Services Associate

Stephanie Schwartz, our Managing Editor, and Kelli Long-Jatta, our bookkeeper, keep the home fires burning while the rest of the staff attended the San Diego convention. These are your dedicated professionals who want to see the association and its members succeed in all endeavors.

President's Report

President Steketee reported that leadership had a very productive year, noting the March, 2017 Strategic Planning Retreat. As Ms. Eimer mentioned, we reviewed and agreed upon 7 strategic initiatives for the coming three years. Leadership and staff are very much aware that clear communication, stated goals, and timelines are required for good governance and progress. Yesterday our first Think Tank was launched, "Digital CBT Technologies to Provide Care to Difficult to Reach and Underserved Populations" with Bethany

Teachman as facilitator. She proposed 5 possible outcomes:

1. An article in *tBT*
2. For Providers: a webinar or MOOC or workshop to share information on using technology in practice in a non-therapy way
3. For Researchers: a web-based clearing-house of resources; recommendations; consensus statements, and tools
4. For Consumers a "dream idea": Digital Apothecary
5. Provide information to people on evaluation of digital approaches-ABCT partners with Cyber Guide to identify CBT support apps on our web page

The Board is very much aware that many ABCT members are thought leaders, and we need to engage them in moving the field and in specific specialty areas forward. The President noted she was very pleased with the theme and offerings of this year's convention and thanked her Program Chair, Jordana Muroff, for putting it all together. She noted it was an honor and pleasure to serve as ABCT President.

Transition of Officers

President Steketee introduced the new officers for the coming year: Risa Weisberg, Representative-at-Large and liaison to Membership Issues, Bruce Chorpita, 2017-2018 President-Elect, and Sabine Wilhelm, President to whom she handed over the gavel and the meeting.

Comments from the Membership

President Wilhelm asked those in attendance if they had any questions or comments. There being none, she adjourned the meeting at 1:34 p.m. PST.

—Adjournment—

ABCT's 52nd Annual Convention

November 15–18, 2018 • Washington, DC

Preparing to Submit an Abstract

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

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

- **Presentation type:** Please see the two right-hand columns on this page for descriptions of the various presentation types.
 - **Number of presenters/papers:** For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The chair may present a paper, but the discussant may not. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.
 - **Title:** Be succinct.
 - **Authors/Presenters:** Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their degree, ABCT category (if they are ABCT members), and their email address. (Possibilities for “ABCT category” are *current member; lapsed member or nonmember; postbaccalaureate; student member; student nonmember; new professional; emeritus.*)
 - **Institutions:** The system requires that you enter institutions before entering authors. This allows you to enter an affiliation one time for multiple authors. DO NOT LIST DEPARTMENTS. In the following step you will be asked to attach affiliations with appropriate authors.
 - **Key Words:** Please read carefully through the pull-down menu of already defined keywords and use one of the already existing keywords, if appropriate. For example, the keyword “military” is already on the list and should be used rather than adding the word “Army.” Do not list behavior therapy, cognitive therapy, or cognitive behavior therapy.
 - **Objectives:** For Symposia, Panel Discussions, and Clinical Round Tables, write three statements of no more than 125 characters each, describing the objectives of the event. Sample statements are: “Described a variety of dissemination strategies pertaining to the treatment of insomnia”; “Presented data on novel direction in the dissemination of mindfulness-based clinical interventions.”
- Overall:** Ask a colleague to proof your abstract for inconsistencies or typos.

Thinking about submitting an abstract for the ABCT 52nd Annual Convention in DC? The submission portal will be opened from February 14–March 14. Look for more information in the coming weeks to assist you with submitting abstracts for the ABCT 51st Annual Convention. The deadline for submissions will be 11:59 P.M. (EST), Wednesday, March 14, 2018. We look forward to seeing you in Washington, DC!

52nd Annual Convention

November 15–18, 2018 • Washington, DC

Call *for* Papers

Program Chair: Kiara R. Timpano, Ph.D.

ABCT has always celebrated advances in clinical science. We now find ourselves at the cusp of a new era, marked by technological advances in a range of different disciplines that have the potential to dramatically affect the clinical science we conduct and the treatments we deliver. These innovations are already influencing our investigations of etiological hypotheses, and are similarly opening new frontiers in the ways that assessments and treatments are developed, patients access help, clinicians monitor response, and the broader field disseminates evidence-based practices. Building on the strong, theoretical and practical foundations of CBT, we have the exciting opportunity to use our multidisciplinary values to identify new and emerging technologies that could catapult our research on mental health problems and well-being to the next level.

The theme of ABCT's 52nd Annual Convention, "Cognitive Behavioral Science, Treatment, and Technology," is intended to showcase research, clinical practice, and training that:

- Uses cutting-edge technology and new tools to increase our understanding of mental health problems and underlying mechanisms;
- Investigates how a wide range of technologies can help us improve evidence-based practices in assessment and the provision of more powerful interventions; and
- Considers the role technology can have in training a new generation of evidence-based treatment providers at home and across the globe.

The convention will highlight how advances in clinical science can be strengthened and propelled forward through the integration of multidisciplinary technologies.

Submissions may be in the form of symposia, clinical round tables, panel discussions, and posters. Information about the Convention and how to submit abstracts will be on ABCT's website, www.abct.org, after January 1, 2018.

**general
sessions**

Theme:

COGNITIVE
BEHAVIORAL
SCIENCE,
TREATMENT,
and
TECHNOLOGY

Portal opens

February 14, 2018

*Deadline
for submissions:*

March 14, 2018

Submission deadline: March 14, 2018



Understanding the ABCT Convention

General Sessions

There are between 150 and 200 general sessions each year competing for your attention. An individual must LIMIT TO 6 the number of general session submissions in which he or she is a SPEAKER (including symposia, panel discussions, clinical roundtables, and research spotlights). The term SPEAKER includes roles of chair, moderator, presenter, panelist, and discussant. Acceptances for any given speaker will be limited to 4. All general sessions are included with the registration fee. These events are all submitted through the ABCT submission system. The deadline for these submissions is 11:59 PM, Wednesday, March 15, 2017. General session types include:

Symposia

In response to convention feedback requesting that symposia include more presentations by established researchers/faculty along with their graduate students, preference will be given to symposia submissions that include non-student researchers and faculty members as first-author presenters.

Symposia are presentations of data, usually investigating the efficacy or effectiveness of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. No more than 6 presenters are allowed.

Panel Discussions and Clinical Round Tables

Discussions (or debates) by informed individuals on a current important topic. These are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. No more than 6 presenters are allowed.

Spotlight Research Presentations

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

Poster Sessions

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

Targeted and Special Programing

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

Invited Addresses/Panels

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

Mini Workshops

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

Clinical Grand Rounds

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

Research and Professional Development

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

Membership Panel Discussion

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

Special Sessions

These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years, the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate

school, career development, information on grant applications, and a meeting of the Directors of Clinical Training.

Special Interest Group (SIG) Meetings

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

Ticketed Events

Ticketed events offer educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment.

Clinical Intervention Training

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

Institutes

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

Workshops

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

Master Clinician Seminars

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

Advanced Methodology and Statistics Seminars

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

Continuing Education

See <http://www.abct.org/Conventions/?m=mConvention&fa=ceOpportunities>

● *complex cases* } **Clinical**
 ● *master clinicians* } **Grand**
 ● *live sessions* } **Rounds**

- Steven C. Hayes, Acceptance and Commitment Therapy
- Ray DiGiuseppe, Redirecting Anger Toward Self-Change
- Art Freeman, Personality Disorder
- Howard Kassinove & Raymond Tafrate, Preparation, Change, and Forgiveness Strategies for Treating Angry Clients
- Jonathan Grayson, Using Scripts to Enhance Exposure in OCD
- Mark G. Williams, Mindfulness-Based Cognitive Therapy and the Prevention of Depression
- Donald Baucom, Cognitive Behavioral Couples Therapy and the Role of the Individual
- Patricia Resick, Cognitive Processing Therapy for PTSD and Associated Depression
- Edna B. Foa, Imaginal Exposure
- Frank Dattilio, Cognitive Behavior Therapy With a Couple
- Christopher Fairburn, Cognitive Behavior Therapy for Eating Disorders
- Lars-Goran Öst, One-Session Treatment of a Patient With Specific Phobias
- E. Thomas Dowd, Cognitive Hypnotherapy in Anxiety Management
- Judith Beck, Cognitive Therapy for Depression and Suicidal Ideation

3-SESSION SERIES

- DOING PSYCHOTHERAPY: Different Approaches to Comorbid Systems of Anxiety and Depression

(Available as individual DVDs or the complete set)

- Session 1 Using Cognitive Behavioral Case Formulation in Treating a Client With Anxiety and Depression (**Jacqueline B. Persons**)
- Session 2 Using an Integrated Psychotherapy Approach When Treating a Client With Anxiety and Depression (**Marvin Goldfried**)
- Session 3 Comparing Treatment Approaches (moderated by Joanne Davila and panelists Bonnie Conklin, Marvin Goldfried, Robert Kohlenberg, and Jacqueline Persons)

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4 or more videos: \$20.00

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call for submissions

Graduate Student Research Grant

The ABCT Research Facilitation Committee is sponsoring a grant of up to \$1000 to support graduate student research. Eligible candidates are graduate student members of ABCT seeking funding for currently unfunded thesis or dissertation research. Grant will be awarded based on a combination of merit and need.

For full information on what to submit, please go to:
<http://www.abct.org/Resources/?m=mResources&fa=GraduateStudentGrant>

To submit: please e-mail all required documents to Dr. Nathaniel Herr at **nherr@american.edu**.

The grant will be awarded in November 2018, with the award recipient announced and presented with the funds during the Friday evening Awards Ceremony at the November 15-18 Annual Convention in Washington, DC.

For more information on the grant and application procedures and requirements, please visit the ABCT website at www.abct.org/Awards/

► **Applications are due April 23, 2018**
