

# the Behavior Therapist

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## PRESIDENT'S MESSAGE

### ABCT in Context

*Gail S. Steketee, Boston University*



IN THIS, MY FIRST presidential column for ABCT, I have a chance to touch base with our members about the current status of our organization, of CBT in general, of the mood of the country, and to look forward to our coming year. I'm aware of the many ongoing activities within our large 5,000-member professional organization that just completed an impressive 50th Annual Convention in New York City with near record attendance. Program Chair Katharina Kircanski provided us with an outstanding array of topics and venues, with many wonderful opportunities packed into each day. So many of us enjoyed learning from our senior scholars in the field on a wide variety of topics that ranged from CBT for people with psychotic disorders to 50 years of treatment for OCD to CBT in resource-limited international settings. Our nearly 40 Special Interest Groups mounted excellent presentations across the tremendous range of populations and problems that benefit from CBT interventions. President Michelle Craske provided us with impressive vision of the future of CBT and its potential impact on many current challenges in the world around us. We absorbed information, talked with our colleagues, partied often, and slept little. Overall, it was a fine celebration of 50 years of commitment to our CBT roots, our research-based clinical practices, and to ensuring that they are broadly available to those in need.

Not long after the conference came news of the U.S. presidential election results, which has

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*At our 50th Convention, many of our past presidents gathered to celebrate our accomplishments and plan for our future. We captured that moment and are pleased to be able to show off some of psychology's greatest contributors.*

## 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>): *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](mailto: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.

also reverberated among our North American neighbors and worldwide. Many are concerned about the health and safety of vulnerable groups. ABCT's mission to enhance health and well-being is inclusive and considers race, class, culture, social and economic status, gender identity, sexual orientation, ability, and age. We mental health professionals can work together to ensure that our measures and interventions are culturally relevant and competent. Our scientific knowledge is expanding and our perspectives are evolving. As the U.S. population continues to change, no single racial or ethnic majority will exist by 2055; thus, social and cultural aspects of CBT for a broad reach of settings and populations becomes even more critical to our research, practice, and training.

Toward that end, 2017 is around the corner, and soon we will be opening the portal for the San Diego conference. The 51st Annual Convention marks more than a half-century of serving the broad public

by providing up-to-date empirical information about mental health problems and their treatment. Our goal for the San Diego convention is to highlight the flexibility of CBT to meet the complex and diverse needs of our world and its people. This underscores ABCT's multidisciplinary commitment to science that improves human functioning through evidence-based assessment, prevention, and treatment. Program Chair Jordana Muroff and I share the experience of being educated in clinical social work research (we have M.S.W.s and Ph.D.s in social work and psychology) and being trained in CBT by masters in the field. Our conference theme is "Applying CBT in Diverse Contexts." Our goal is to draw researchers and clinicians from across the mental health disciplines together to improve our understanding of people and problems in context. ABCT in general and the San Diego conference in particular aim to advance clinical practice, training, and research in CBT and other

evidence-based practices that are so badly needed to improve lives across the socioeconomic spectrum. Jordana and I look forward to receiving submissions for symposia, panel discussions, clinical round tables, mini workshops and posters. ABCT's website ([www.abct.org](http://www.abct.org)) will have information about the conference, and the online submission portal will open on February 15 and remain open until March 15, 2017.

I look forward to hearing from many of you in the coming year about your exciting work, and about what ABCT can do best for its members and to alleviate human suffering,

...

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## Message From the Editor

Kate Wolitzky-Taylor, *UCLA*



MY NAME IS Kate Wolitzky-Taylor, and I am pleased to serve as the new editor of *the Behavior Therapist*. ABCT has been my primary academic and professional community since I began graduate school in 2003 at the University of Texas at Austin. ABCT is an organization that I have watched grow and develop over the relatively short period of time since I have been a member. ABCT continues to grow and evolve in large part because of the curiosity and scientific contributions of its members, and because of the increased attention to behavioral and cognitive therapies in clinical and training settings, much of which is driven by the efforts of our members. *the Behavior Therapist* continues to serve a unique role within the ABCT community, bringing together in one place the interests, advances, and topics that support the organization's mission. *the Behavior Therapist* provides a way to rapidly disseminate information, science, and new innovations and also provides a respectful platform for dialogue related to issues of

importance to ABCT members. It is particularly exciting to be taking over as editor as we are just wrapping up our 50th year as an organization. In honor of this important milestone, we include some highlights from the 50th anniversary conference in this issue.

I want to thank my friend and collaborator, Brett Deacon, for his tireless work as the editor of *the Behavior Therapist* over the past 3 years. Under Brett Deacon's editorial leadership, we all saw what great potential this journal has to keep us informed, keep us thinking, keep us discussing amongst ourselves, and keep us moving forward. I know I speak for many when I say that the special issues published under Brett's leadership were thought-provoking and stimulated interesting discussions. Following his example, I am already working with members of my fantastic editorial board to put together ideas for more special issues that cover timely topics of interest to the ABCT community.

Finally, we want to hear from you! As you know, *the Behavior Therapist* publishes many different types of articles, including empirical papers, opinion and commentary, descriptive and informational articles,

spotlights on fantastic programs and people, training models, clinical interventions, humor, and more. *the Behavior Therapist* serves as a place for ABCT news but is much more than a newsletter. Please contribute! Submission instructions can be found in each issue of *the Behavior Therapist*. You can always email submissions (or thoughts, questions, suggestions) directly to me at [kbtaylor@mednet.ucla.edu](mailto:kbtaylor@mednet.ucla.edu). I look forward to hearing from you all and am very excited for this role.

...

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[kbtaylor@mednet.ucla.edu](mailto:kbtaylor@mednet.ucla.edu)



# A Review and Critique of Continuing Education\*

Kalina N. Babeva, *UCLA*

Gerald C. Davison, *University of Southern California*

IN THE HEALTH PROFESSIONS in general, and in clinical psychology in particular, after one earns one's degree and license, continuing education (CE) is a form of professional development that is deemed necessary in light of the evolving nature of science and the health fields. Psychologists typically receive 5 to 7 years of doctoral training and an additional 1 to 2 years of postdoctoral supervised experience. These formal training years, which are structured and regulated in terms of specific experiences and competencies that must be obtained, are then followed by a licensing exam, ensuring that psychologists are prepared for professional practice. In the career years that follow, CE, which is much less structured and generally self-directed, aims to supplement and update knowledge acquired through graduate training; ensure that psychologists maintain necessary skills and acquire new ones; and help protect the public from poor-quality services. CE is also considered an ethical obligation and is required by most states for licensure renewal.

The American Psychological Association (APA, 2015) specifically defines CE as "an ongoing process consisting of formal learning activities that (1) are relevant to psychological practice, education, and science, (2) enable psychologists to keep pace with emerging issues and technologies, and (3) allow psychologists to maintain, develop, and increase competencies in order to improve services to the public and enhance contributions to the profession." This fairly broad definition allows CE activities to vary considerably in content and form of presentation (e.g., workshops, seminars, online courses).

## Brief Background

In 1957 Maryland was the first state to mandate CE, with most other jurisdictions also doing so in the 1960s and 1970s (Association of State and Provincial Psychology Boards, 2001). In 1998, the Association of State and Provincial Psychology Boards (ASPPB) recommended that psychologists complete a minimum of 20 CE hours per year, which was then implemented by the majority of states. The modal number of required CE hours is still 20 per year. Six states (Colorado, Connecticut, Hawaii, Michigan, New Jersey, and New York) do not currently require formal CE for licensure renewal. The other 44 states and District of Columbia require differing amounts of CE, ranging from "some" hours<sup>1</sup> (South Dakota) to 60 hours (Arizona, Vermont, Washington) per licensing period (which varies between 1 and 3 years). Thus, there is variability in mandated hours but, as we shall see, also in content as well as program approval and monitoring of compliance.

## CE Approval Mechanism

The majority of CE activities are courses approved by the APA's Continuing Education Committee (note: an individual, non-approved course may be reviewed by a state Psychology Board and CE credit may be granted for it; however, there is a limit on how much credit can be earned this way). There were previously two mechanisms through which APA's Office of CE Sponsor Approval (CESA) approved courses. The first one, which is no longer utilized, was a one-time approval of a specific course, usually reserved for entities only occasionally offering CE. The second, and currently only, mechanism is approval at the institutional level. Entities such as university psychology departments, medical centers,

VAs, clinics, or private companies are approved as CE sponsors and then are permitted to provide an unlimited number of CE programs. A list of APA-approved sponsors by state is publicly available online: <http://www.apa.org/education/ce/sponsors.aspx>. The evaluation of the quality of the specific CE programs offered is the responsibility of the approved sponsor. CESA reviews the programs annually and upon the sponsor's application for renewal of approval. Seven specific standards are used for sponsor approval (American Psychological Association, 2015):

### Standard A: Goals

Program goals must be in line with the fact that CE builds upon a graduate degree in psychology and programs offered must be appropriate for psychologists with a doctoral degree.

### Standard B: Program Management

Sponsors must utilize effective program management (e.g., plan programs with input from psychologists, ensure compliance with APA CE standards, address complaints swiftly and ethically, etc).

### Standard C: Educational Planning and Instructional Methods

CE programs must be carefully planned and have a priori, measurable learning objectives, appropriate education methods, and competent instructional personnel with established expertise.

### Standard D: Curriculum Content

Content offered must be in line with APA's definition of CE and must be evidence-based.

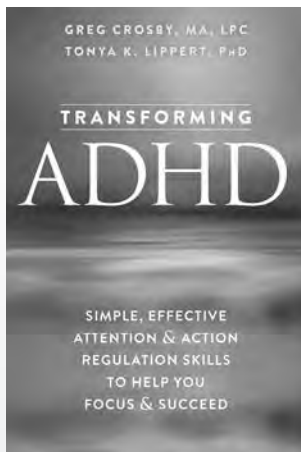
### Standard E: Program Evaluation

A mechanism for program evaluation is required. For in-person programs, this is satisfied by self-rated evaluation of acquired knowledge, satisfaction with the program, and perceived utility of the content/skills. It is suggested that post-tests that assess mastery of material can be administered, but they are not required for in-person programs; such mastery tests, though, are mandatory for online and other programs that do not require personal attendance, like reading books or articles.

\*This article is an update and extensive revision of a recent publication by us in: Cautin, R. L., & Lilienfeld, S. O. (Eds.). (2015). *The Encyclopedia of Clinical Psychology*. Hoboken, NJ: Wiley.

<sup>1</sup>South Dakota law does not specify a number of CE hours required for licensure renewal, but psychologists must complete "some continuing education."

# BOOKS TO HELP CLIENTS CULTIVATE CHANGE

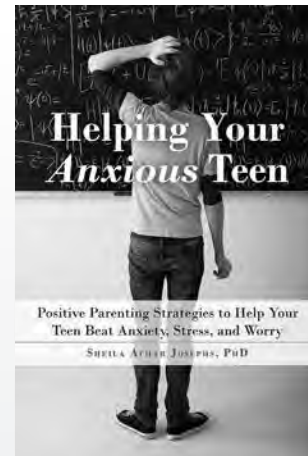


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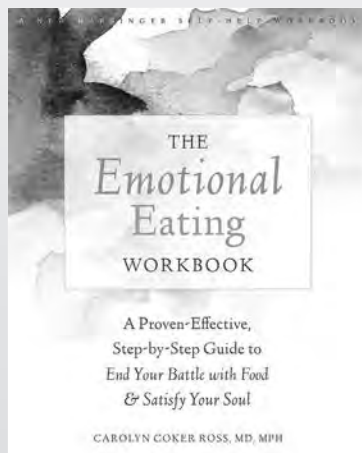
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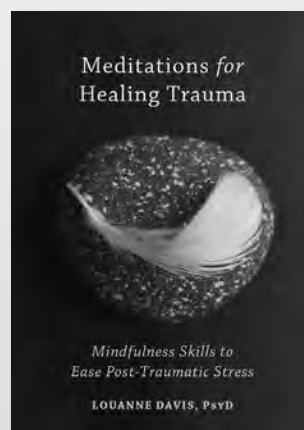
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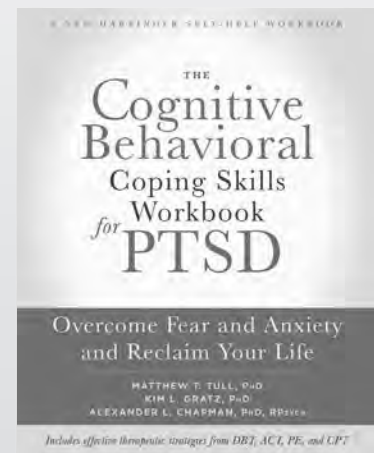
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### **Standard F: Standards for Awarding Credit**

Standardized procedures for awarding credit must be in place [e.g., attendance must be monitored and credit is to be assigned based on instructional time (1 hour = 1 credit)].

### **Standard G: Promotion and Advertising of Programs**

Full, accurate information about the CE course (e.g., learning objectives, cost, credentials of the instructor, commercial support/conflict of interest) must be made available to potential attendees in advance of registration.

These standards were most recently revised in January 2015 to reflect the push in recent years for CE to be exclusively evidence-based. In 2013, the APA issued a Quality Professional Development and Continuing Education Resolution outlining principles to guide evidence-based design and content of CE programs. The resolution states the following: "Quality continuing professional development activities and continuing education programs should be dedicated to an evidence-based approach with content substantiated by the empirical literature. Quality continuing professional development and continuing education activities should be founded on evidenced-based education methods" (APA, 2013).

As a result, the standard used to evaluate CE curriculum content (Standard D) was revised to exclude "credibility" (defined as "the involvement of the broader psychological practice, education, and science communities in studying or applying the findings, procedures, practices, or theoretical concepts") as an acceptable metric for CE (APA, 2015). In other words, program content that does not have empirical support can now not be taught on the basis of being accepted/commonly used/well-liked in psychological practice or research. The updated Standard D further states that the evidence base must come from "the contemporary peer reviewed scientific literature beyond those publications and other types of communications devoted primarily to the promotion of the approach" (APA, 2015). In other words, content pertaining to assessment and intervention has to be supported by independent sources/research groups, not solely by the creators or by those who stand to benefit from it financially. Program content related to areas other than evaluation and/or intervention (e.g., research methods, issues related to education and the

practice of psychology) must also be "supported by contemporary scholarship grounded in established research procedures." The APA (2015) further explicitly states that while new emerging techniques and technologies in the field are important, CE on them cannot be approved and offered to psychologists until there is enough scientific support for them to meet the Standard D.

This new resolution and this specific standard change are both commendable and significant. Given their recency, however, we have yet to see how these changes will be fully implemented. Of particular concern is how the CE committee will respond to complaints about sponsors who are financially and/or professionally invested in a given approach, an issue which the second author of this article witnessed first-hand when he served on this committee in the 1990s. For example, a legal concern for "restraint of trade" was an issue that the committee had to address routinely. More on this below.

### **CE Content**

CE programs cover a wide range of topics, reflecting the diversity of clinical psychology as a field. The three main content areas are: (a) psychological assessment and/or intervention for various disorders/conditions (e.g., diagnosis, assessment, and treatment of insomnia); (b) ethical, legal, and regulatory policies/practices/guidelines (e.g., threats to patient privacy in cloud data storage); (c) other topics related to the practice of psychology, teaching, or research (e.g., how to grow a private practice; crossover between ICD 10 and DSM-5; APA, 2016). The topics within these categories vary in their scope and specificity. A list of books, articles, and video CE courses available on demand by content areas is provided by the APA on its website: <http://www.apa.org/education/ce/topic/index.aspx>.

The obvious benefit of the availability of diverse topics is that licensed psychologists are able to choose programs that are most pertinent to their interests as well as their professional development needs and responsibilities. Studies document that content is one of the main factors psychologists consider when selecting CE programs (Neimeyer, Taylor, & Wear, 2010; Sharkin & Plageman, 2003). The majority of states, however, have at least one mandated CE topic. The most common ones include ethics/law, domestic/spousal violence, and cultural diversity. These requirements are in place to ensure at least mini-

mal knowledge in these domains, despite the fact that the number of required hours is generally minute (e.g., typically between 2 and 6 hours per licensure renewal period are required in ethics). Another problem is that licensees have to take CE offerings in most mandated topics infrequently or only once, which is inconsistent with the principle that psychologists need to be familiar with evolving knowledge and practices. For example, in Florida, 2 hours on domestic violence are required every third biennial licensure renewal period and in Oregon, 7 hours on pain management are required only once. Furthermore, none of the states has mandates regarding research methods and statistics, despite the fact that clinical psychology is a science and that there are new advanced techniques emerging in statistics. Finally, since many jurisdictions have limited requirements in terms of curriculum that must be covered for licensure renewal, a disadvantage of freedom of choice is that licensees may opt to complete only certain CE programs within a narrow scope and would therefore not update their knowledge in other important areas. (What is deemed important, of course, will vary across the many theoretical and meta-theoretical camps within clinical psychology.)

Research from 2010 documents that at the time, CE programs in the domains of ethics, anxiety disorders, and assessment were the most commonly completed (Neimeyer, Taylor, & Wear, 2010). An informal survey (by the authors of this article) of websites of companies providing online CE suggests that among the current most popular online courses are those in the topic areas of law and ethics, motivational interviewing, sleep, disorders pertaining to children and adolescents, gender dysphoria, and multicultural competencies (e.g., CE4less, 2016; [continuingeducation.com](http://continuingeducation.com), 2015).

Topic selection also varies based on professional responsibilities and depends on workplace setting. For example, in some states (e.g., Kentucky), licensed psychologists performing clinical supervision are required to complete CE in this topic. In their study of 6,095 licensed psychologists across North America, Neimeyer, Taylor, and Wear (2010) found that compared to those working in community clinics, private practice, and academia, psychologists in medical settings were more likely to complete CE programs on medically relevant topics such as chronic illness, pain management, neuropsychology, and health psychology. Thus, the limited content area

# New titles out January

in the Advances in Psychotherapy book series



Robert P. Reiser / Larry W. Thompson /  
Sheri L. Johnson / Trisha Suppes

## Bipolar Disorder

(Advances in Psychotherapy –  
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2nd ed. 2017, viii + 120 pp.  
US \$29.80  
ISBN 978-0-88937-410-2

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edition

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described, along with decision trees for evaluating the best treatment options. They then outline a systematic, integrated, and empirically supported treatment approach involving structured, directive therapy that is collaborative and client-centered. This edition includes completely updated medication management guidelines in the form of very concise and user friendly tables. Special considerations, including managing suicide risk, substance misuse, and medication non-adherence, are also addressed.



Katie Witkiewitz / Corey R. Roos /  
Dana Dharmakaya Colgan / Sarah Bowen

## Mindfulness

(Advances in Psychotherapy –  
Evidence-Based Practice – Volume 37)  
2017, viii + 80 pp.  
US \$29.80  
ISBN 978-0-88937-414-0

New  
strand

This clear and concise book provides practical, evidence-based guidance on the use of mindfulness in treatment: its mechanism of action, the disorders for which there is empirical evidence of efficacy, mindfulness practices and techniques, and how to integrate them into clinical practice. Leading experts describe the concepts and roots of mindfulness, as well as examining the science that has led to this extraordinarily rich and ancient practice becoming a foundation to many contemporary, evidenced-based approaches in psychotherapy. The

efficacy of mindfulness-based interventions in conditions as diverse as borderline personality disorder, post-traumatic stress disorder, depression, alcohol and substance use, emotional dysregulation, attention-deficit hyperactivity disorder, chronic stress, eating disorders, and other medical conditions including type 2 diabetes and rheumatoid arthritis is also described. The book is therefore invaluable reading for all those curious about the current science around mindfulness and about how and when to incorporate it effectively into clinical practice.

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mandates appear to allow licensed psychologists to self-select pertinent programs.

### Critiques

In addition to the problems noted above, there are other issues we believe are important. While recent changes to the empirical requirements for CE are a notable improvement, there is still more to be desired with respect to the implementation of CE. To begin with, for CE courses attended in person, there is no mechanism in place for ensuring mastery of new knowledge and skill. Psychologists typically rate how much they believe that the course has achieved its *a priori* goals. Attendees receive CE credit for simply being present during a course. One can literally take long naps during a workshop and still earn CE credits for attendance. When compared to the rigorous evaluation practices in doctoral programs, this is especially striking and unfortunate.

Furthermore, since psychology is one of the disciplines that studies learning and measurement, it is even more surprising that evidence-based learning and assessment principles are not implemented in our continuing education. If CE is the means through which psychologists maintain their knowledge and learned skills, remain up to date with advances in the field, and continue their professional development, it is disconcerting that level of competency is not evaluated. Furthermore, taking a CE course seldom ensures mastery of new skills. For example, although formal CE workshops on various therapy approaches exist, delivering a treatment with fidelity requires both intensive didactic training and carefully supervised practice for many more hours and under more controlled circumstances than is found in CE courses.

Another critique of CE is related to the number of mandated hours. As previously mentioned, this number is not uniform across the U.S. states, varying from 0 to 60 hours. Even at the higher end of this range, the amount of required CE is minuscule in comparison to the amount of education and training an individual receives in graduate school.

Recall that the principle purpose of CE is to protect the public. One manifestation of not meeting this critical mission would seem to be complaints and/or lawsuits for malpractice. Therefore, it would be instructive to compare the adjusted rates of such negative events in states that mandate CE with those that do not.

*Monitoring specific programs.* Of overriding importance is quality control. The most recent policy states that every program of every sponsor is provided annually to the CE committee for meeting the various requirements (APA, 2012):

Approved sponsors must submit yearly Annual Reports [...] [which] must include a list of all activities offered by the sponsor to psychologists for credit in the previous year, a promotional piece for each corresponding program, and a list of such programs planned for the upcoming year. Staff may make inquiry into programs or activities that appear to be in violation of the Standards and Criteria. Failure to submit a complete Annual Report in a timely manner and/or failure to comply with the Standards and Criteria will result in probation and, ultimately, in termination of approval. (APA, 2012)

Yet there are programs that some members of the clinical science community, especially those in the Society for a Science of Clinical Psychology (SSCP), continue to find problematic (on the SSCP listserv, more colorful adjectives than “problematic” are often used). In various email communications over the past few years with CE committee members, the argument has been made by APA that the task of annual/continuing reviews of specific programs was far larger than the resources available and that complaints can be lodged after the fact by people who question the legitimacy of specific programs.

Is close oversight being implemented? Note that the above-quoted policy requires that sponsors provide lists of their offerings. Are enough details being provided to allow the scientific integrity of each offering to be vetted? Remember that the APA CE committee emphasizes that it is *sponsors* who are evaluated and approved or disapproved, not specific offerings. Sponsors who are found to have given their blessings to offerings that are in violation of APA CE requirements are supposed to be held responsible and their renewal status not granted if enough (how many?) violations are found. In our opinion, the jury is out as to how well this increased oversight is working. And if resources are lacking and poor-quality offerings are out there (and we believe this to be the case), then perhaps APA should not be involved in monitoring CE *at all*. It may be preferable to not engage in an activity rather than do it in an incomplete and problematic fashion.

### Recommendations

Straightforward recommendations to address the above-mentioned concerns and further improve the CE enterprise can be and have been made. One such suggestion is to eliminate heterogeneity by implementing a single national CE mandate (Fagan et al., 2007; Neimeyer, Taylor, & Wear, 2009) and by clearly defining required competencies (Daniels & Walter, 2002). This would standardize CE experiences across states without limiting psychologists’ ability to choose preferred courses beyond the mandated ones.

To achieve this, however, it is first necessary for a more sound scientific approach to be implemented in the domain of CE. To begin with, existing research on effective learning and teaching principles needs to be applied to CE courses. For example, studies on medical education suggest that problem-based learning, an interactive approach requiring students to synthesize and critically apply knowledge in solving real-world clinical problems, predicts clinical competency and is also associated with high levels of self-reported satisfaction (Koh et al., 2008). Second, objective learning outcomes measures must be mandated, especially for in-person CE courses, in order to determine whether actual learning has occurred. Last, research designs and methods such as experiments, RCTs and meta-analysis, which are routinely used in intervention research and other areas of psychology, need to be similarly employed with the goal of developing effective evidence-based continuing education. These recommendations are all in line with the principles outlined in APA’s Quality Professional Development and Continuing Education Resolution and it is our hope they will be widely implemented soon.

It is important to be mindful of the reality that CE is in part a business endeavour, as psychologists pay to obtain credits. For this reason, customer satisfaction with courses matters. However, reported satisfaction with a program should not be confused with its effectiveness in maintaining and expanding clinical competency, which is the main goal of CE. Of note, more than 50% of licensees report being opposed to the use of objective assessment of learning (e.g., Neimeyer, Taylor, & Wear, 2009; Sharkin & Plageman, 2003). It is thus clear that there are barriers that must be addressed as the effort to develop high-quality, evidence-based CE continues.



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## Continuing Education in Psychology: The Ghost in the Machine

Steven D. Hollon, *Vanderbilt University*

THERE IS A HOVERING antipathy toward the American Psychological Association (APA) on the part of many clinical scientists that was exacerbated by the recent Hoffman Report (<https://www.apa.org/independent-review/APA-FINAL-Report-7.2.15.pdf>) but dates back over a quarter of a century to the “hostile takeover” of the organization by a group (the so-called “dirty dozen”) who preached professionalism over science (Wright & Cummings, 2001). The Society for a Science of Clinical Psychology (SSCP), which is technically Section 3 of Division 12 (Clinical Psychology) of APA, has been roiled in recent years by those who want to disaffiliate from the APA because of what they see as its disavowal of science and those who want to remain within the organization and change it from the inside. I fall into the latter camp.

Last summer an opinion piece appeared in the *Washington Post* by a board certified psychiatrist at New York Medical College, in which the author described his growing interest in and involvement with exorcisms as a means of ridding people of the “demons” that caused their mental disorders (Gallagher, 2016). That triggered a firestorm of controversy on the SSCP listserve and led members to look to see if the APA offered such a program for continuing education (CE) credit. Such a program was found to exist and this led to considerable consternation among the membership and renewed calls for SSCP to cut its ties with APA.

As it turned out, that program was not offered for CE credits to psychologists, but it did lead us to ask for a meeting with the staff at APA that oversaw the CE process. SSCP had been engaged for some time in working with APA staff to ensure that programs that get offered for CE credit are based on science (when not purely focused on ethics) and had played a role (along with many others) in the recent revision in the Standards and Criteria for Approval of Sponsors of Continuing Education for Psychologists (<http://www.apa.org/ed/sponsor/resources/approval-standards.pdf>). Although there is some difference of opinion among our members as to the value of

continuing education as it is currently implemented, there is no disagreement that any such offerings should be based on evidence and meet reasonable standards of scientific integrity.

As described in a recent article in the SSCP newsletter, past and future presidents Mitch Prinstein and Scott Lilienfeld and I met with Drs. Antoinette Minniti, who oversees the Office of CE Sponsor Approval (CESA), and Cynthia Belar, the current CEO, at the annual convention in Denver. What we found is that Drs. Minniti and Belar shared many of our concerns and were as committed as we were to maintaining the scientific integrity of the programs being offered to psychologists for CE credits. Nonetheless, there are systematic problems that plague the CE process that both they and we hope to see addressed. I lay those problems out below.

The major source of the problem is that APA does not review specific programs before they are offered but rather approves sponsors—some of whom propose multiple programs in any given year that are not all intended for psychologists. Some egregious courses could well slip through for which CE credits could be earned. How often that actually occurs is not entirely clear, but it does sometimes happen. It would be better to screen programs in advance, but it is not clear that the person-power exists under the current system to screen at the level of the specific program. Dr. Minniti has a staff of three working under her to screen applications from over 800 approved sponsors, some of whom provide over 1,000 programs a year. A 14-person Continuing Education Committee (CEC), comprised of APA members who volunteer their time, reviews the applications. The workload is immense and the resources available are limited at best. CESA could raise its fees but the sponsors likely would pass that on to the professionals seeking CE credits. The question is how many egregious programs get through the screen and whether there is some way to harness the resources in the field.

What we settled on was the following plan. Dr. Minniti pointed out that there is a

formal complaint process and asked the members of SSCP (and by extension ABCT) to help the process along by calling her attention to any particularly egregious examples of programs that should not receive CE credits from APA. As she describes in her companion piece in the SSCP newsletter, anyone who wishes to file a complaint about a sponsor or program can do so through the APA’s CESA complaint process (<http://www.apa.org/ed/sponsor/resources/complaint-process.aspx>). This allows the members of ABCT to act as the “eyes and ears” for CESA, and she made it clear that those complaints would be taken seriously. In effect, she was asking for our help in policing the scientific integrity of the CE programs.

She did ask that we first contact the particular sponsor in question to see if they would rectify the problem. That sometimes is enough. She also asked that we indicate the title of the program in question when we file a complaint so that CESA can figure out whether it was being offered to psychologists for credit (a given sponsor might provide continuing education to a variety of different professions so the program in question might not be one that psychologists can take for credit). That being said, one might become suspicious of the overall quality of what a sponsor offers if many of its programs are particularly egregious and CESA keeps track of those sponsors that are repeat offenders. She cautioned against filing multiple complaints about the same program since that will only clog the system (each complaint is fully investigated) but having multiple signees to a complaint is a perfectly reasonable way to express breadth of support.

Filing a complaint will not necessarily lead to a sponsor or even a program losing approval. There are guidelines that APA must follow or risk opening itself to legal repercussions. Conversion therapy for sexual orientation is the only type of therapy that the APA has formally ruled out and there are many other types of treatments with little evidence of efficacy or questionable scientific rationales. How the CEC will interpret those guidelines in any given instance is unclear in advance but best tested by filing a complaint. The guidelines can be found at: <https://www.apa.org/ed/sponsor/resources/policy-manual.pdf>. Dr. Minniti has provided an overview of the way in which this process is handled in her article in the SSCP newsletter.

It remains unclear to me just how large the problem is. In the aftermath of that

meeting at the APA convention I sent a message out on the SSCP listserv asking members to let me know if they knew of egregious CE offerings and encouraging them to file complaints if they did. I expected to be inundated and was surprised at how few responses I received. That may mean that the problem is not that big or just that most folks are away in August. The examples that were raised mostly involved interventions intended to deal with the aftermath of trauma, such as critical incident debriefing (which may do more harm than good) or energy field therapy (a cardinal example of pseudoscience at its worst). It will be interesting to see if the first of the APA's long-awaited clinical practice guidelines on PTSD and trauma has anything to say about such approaches and, if so, whether that will influence subsequent decisions regarding CE credits.

There may be offerings that err because they promise more than they can deliver. One recent advert described "a simple 5-step protocol that quickly reconsolidates traumatic memory" and implies that it is superior to "medication, CBT, exposure, and other traditional approaches" in treat-

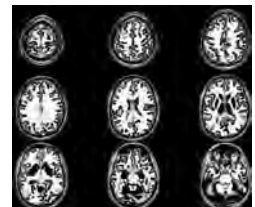
ing trauma (Armstrong, 2016). Would that it were true, but given what I have seen in the treatment literature my sense is that the advert more oversells its product than it is entirely off base, so long as it incorporates exposure. Complaints can be filed with respect to the basic offerings themselves or with respect to the claims that are made in the adverts. The first responsibility of a profession is to protect the public from bogus treatments and scurrilous claims of special efficacy. It will be interesting to see how the CEC responds to the complaints that it receives but it is a mechanism worth testing.

Filing complaints about existing programs may turn out to be at best a stopgap solution, but it can be put into immediate effect. Doing so will allow us to see just how large the problem is and whether it can be rectified using existing policies and procedures. However, there is more that could be done. Sponsors are required to submit an annual report that lists all programs offered in the preceding year, including the promotional pieces for those programs and a list of the programs planned for the upcoming year. That information could be

made available to all in an easily accessible electronic format, along with the articles cited as scientific justification for the program. Doing so would make it easier for interested parties outside of the CESA to monitor the scientific integrity of the programs offered for CE credit. It would be better still if that were done prospectively, but retrospective information is better than none at all. The CEC does retain an institutional memory for programs that are found to not be in compliance and it does maintain a "grievance grid" for problematic sponsors that include decisions/outcomes (e.g., which program[s] is [are] no longer permitted to be offered for CE). This provides some protection against the "whack-a-mole" concern that the same or different sponsors will simply resurrect disallowed programs in subsequent years.

As I indicated at the beginning of this piece, I have been struck by the antipathy toward APA among many of the members of SSCP. I suspect that ambivalence is shared by many of the members of ABCT as well. The impulse to disaffiliate from APA is a recurring theme at SSCP and we are midway through a 3-year process of

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deciding whether or not to do so. While I am no fan of torture and have no doubt the Hoffman Report had much to do with this latest surge of disaffection, I think that this is just the latest skirmish in a larger struggle over the push toward the “professionalization” of psychology noted in the beginning of this article. While I am sympathetic to the need to defend the economic and professional interests of clinical psychologists, those interests are best defended when clinical psychology has something to offer the public and what sets us apart from other disciplines is that what we do is grounded in science. As Dr. Richard McNally points out in his review of the “dirty dozen” text, society grants privileges to a profession based on the claim that its practitioners possess special expertise that it uses for the public good. If psychology severs its connection with science it will cease to command the allegiance of the public. If you have not read the McNally review (<http://www.srmhp.org/0201/review-02.html>), I strongly recommend it. Keeping the science in psychology is the best way to keep the profession strong in the perception of the public, and helping to police the CE offerings via the complaint mechanism is one way to keep the science strong in psychology.

I have been guardedly optimistic in my dealings with the APA over the last few years. I think the decision to generate clinical

practice guidelines was long overdue but very sound and I applaud them for it. For example, the first of the guidelines on the treatment of PTSD is set to go to Council in February and it will be followed by guidelines on depression and childhood obesity within the year. The APA fought a rear-guard action for years to oppose any effort to use science to inform treatment (another legacy of the “professionalization” of psychology), first in the guise of protecting the public from bad guidelines (APA, 2002) and later in an unsuccessful attempt to undercut the effort to identify the empirically supported treatments (APA, 2006). It now appears to have come around to the notion that it must rely on experimental evidence based on systematic reviews as filtered through multidisciplinary panels to justify what it offers to the public if it wants to survive as a profession (Hollon et al., 2014). This is exactly the right thing to do and keeping a vigilant watch on programs offered for CE credits can only facilitate the process.

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# Keeping It Real: Enhancing the Ecological Validity of Problem-Solving Assessment Through Self-Monitoring

Shannon L. Brothers, Hannah A. Ford, and Douglas W. Nangle,  
*University of Maine*

PROBLEM SOLVING INVOLVES the generation, selection, and implementation of solutions to everyday problems (D’Zurilla & Nezu, 2007). Research suggests that individuals with a rational and systematic approach, who are confident in their abilities to solve problems, tend to be more effective problem solvers (D’Zurilla & Nezu). On the other hand, those with less adaptive problem-solving abilities, who generate less effective solutions, have higher levels of anxiety (Belzer, D’Zurilla, & Maydeu-Olivares, 2002), negative affect (Dixon, 2000), and negative self-statements (Larson, Potenza, Wennstedt, & Sailors, 1995). Additionally, these individuals experience lower self-efficacy and confidence (Heppner, Reeder, & Larson, 1983; Heppner, Witty, & Dixon, 2004).

Problem solving is one of the more researched and robust constructs in clinical psychology. Related deficits have been linked to a wide range of clinical disorders and health concerns (e.g., Anderson, Goddard, & Powell, 2009, 2011; D’Zurilla & Nezu, 2010; Elliott, Grant, & Miller, 2004; Nezu, Nezu, & D’Zurilla, 2013). For example, ineffective problem solving has been shown to be a risk factor for depression (Dixon, 2000) and is thought to play a prominent role in its etiology and maintenance (Nezu, 1985). Also contributing to intervention, Problem-Solving Therapy (PST; D’Zurilla & Goldfried, 1971; D’Zurilla & Nezu, 2007) is effective in treating a range of mental and physical health problems, including depression, generalized anxiety, schizophrenia, suicidal ideation, obesity, and diabetes (D’Zurilla & Nezu, 2010; Malouff, Thorsteinsson, & Schutte, 2007).

Even with all we have learned about problem solving and psychopathology, there remain some lingering concerns about the validity of the most widely used measures (Anderson et al., 2009; D’Zurilla & Maydeu-Olivares, 1995). There are two major concerns. One is that the measures

tend to assess process (i.e., general problem-solving attitudes and abilities) and ignore outcome (i.e., performance and solution quality; D’Zurilla, Nezu, & Maydeu-Olivares, 2004). The second, and focus of this paper, is that these measures have limited ecological validity (Mook, 1983). That is, because of their focus on process, reliance on global self-reports, and use of hypothetical scenarios, the degree to which these measures actually assess real-life problem-solving skills has been questioned (Anderson et al., 2009; D’Zurilla & Maydeu-Olivares, 1995). Said another way, at this point we can better assess what people think about solving problems more generally than what they actually do when faced with a particular problem.

In this paper, we first review the most frequently used problem-solving measures with these concerns in mind, and explore the potential of self-monitoring as one possible way to boost ecological validity. Our review is, by necessity, brief and to-the-point. Readers wanting more comprehensive coverage of problem-solving assessment and related issues are encouraged to consult an excellent review by D’Zurilla and Maydeu-Olivares (1995). Per the suggestion of D’Zurilla and Maydeu-Olivares, we follow the review with a consideration of the merits of self-monitoring in enhancing ecological validity.

## Brief Review of Problem-Solving Measures and Ecological Validity Concerns

The two most widely used problem-solving measures are the Problem Solving Inventory (PSI; Heppner & Peterson, 1982) and the Social Problem-Solving Inventory-Revised (SPSI-R; D’Zurilla, Nezu, & Maydeu-Olivares, 2002), which are based on the often-cited social problem-solving (SPS) model first proposed by D’Zurilla and Goldfried (1971). The SPS model describes a cognitive-behavioral process

(e.g., orientation/attitudes toward problem solving, problem recognition and definition, generation of alternative responses, and implementation and evaluation of the enacted response) in which individuals discover effective coping strategies to manage real-life problems. Although frequently used, these self-report inventories assess more global attitudes and beliefs about problem solving (i.e., process) rather than performance and solution quality (i.e., outcome), limiting their assessment of problem-solving abilities.

## PSI

The PSI is a self-report measure that assesses problem-solving appraisal and perceptions of problem-solving abilities (Heppner et al., 2004). The PSI examines three dimensions of problem solving, with lower scores indicating more adaptive problem-solving capacity, including global perceptions of the degree of control over emotions and behaviors while problem solving (e.g., “There are times when I become so emotionally charged that I can no longer see the alternatives for solving a particular problem”), confidence in the ability to solve problems (e.g., “When faced with a novel situation, I have confidence that I can handle problems that may arise”), and behaviors associated with the choice to solve a problem (e.g., “I am usually able to think of creative and effective alternatives to my problems”; Heppner & Peterson, 1982). Although purported to be, and usually described as, an indicator of problem-solving abilities, the PSI actually measures subjective cognitive processes related to general problem solving, not real-life problem-solving performance (Heppner et al., 2004). In fact, although the PSI has been associated with negative attributions and negative self-statements in several studies (e.g., Heppner et al., 1983; Heppner et al., 2004; Larson et al., 1995), there is little evidence of its link to problem-solving performance.

## SPSI-R

The SPSI-R is a multidimensional measure that taps into an individual’s general perceptions, appraisal of, and attitudes toward problem solving. Specifically, the SPSI-R examines global attitudes and beliefs about everyday problems (e.g., “When my first efforts to solve a problem fail, I know if I persist and do not give up too easily, I will be able to eventually find a good solution”; D’Zurilla et al., 2002). It also assesses problem-solving style or an understanding of the problem and how to

cope with or find solutions to the problem (e.g., “After carrying out a solution to a problem, I do not take the time to evaluate all of the results carefully”; D’Zurilla et al.). Though these style dimensions (i.e., rational, impulsive/careless, and avoidant) are sometimes construed as outcome measures because of the references to solutions and implementation, they do not meet the criteria for true outcome measures because they do not assess specific solutions to specific problems (D’Zurilla & Maydeu-Olivares, 1995). Instead, they assess more generalized tendencies to approach problems in certain ways.

Ecological validity questions notwithstanding, there is little doubt about the importance of the types of global attitudes and beliefs assessed by the PSI and the SPSI-R. For example, D’Zurilla and Goldfried (1971) proposed a foundational role for “general orientation” or attitudes toward a problem in their SPS model and empirical work based on this model has consistently demonstrated a strong relationship between negative problem orientation (i.e., seeing problems as unsolvable, threatening, and overwhelming) and depression in particular (e.g., Chang & D’Zurilla, 1996; Haugh, 2006; Siu & Shek, 2010; Wilson, Bushnell, Rickwood, Caputi, & Thomas, 2011).

Turning to ecological validity, it is also important to acknowledge the limitations of the global self-report measures. As trait-like measures, they rely on individual estimates of generalized responding to more abstract, hypothetical problems and ignore possible situational variation (e.g., problem type, context). Further, they do not assess the actual problem and instead ask respondents to consider imagined scenarios known only to them. Though these measures may, and probably do, predict real-world performance, there is surprisingly little evidence that they actually relate to everyday problem solving. This lack of evidence does not stem from mixed or contradictory findings, but rather from an absence of validation attempts (or unsuccessful attempts not published) demonstrating associations with more direct assessments of real-world problem-solving efforts. In fact, given the predominance of global self-report measures and lack of established alternatives, there is relatively little cross-method validation of any problem-solving measures in the literature (see Anderson et al., 2009, and Anderson et al., 2011, as notable exceptions).

### *Means-Ends Problem-Solving Procedure (MEPS)*

One alternative method is the Means-Ends Problem-Solving Procedure (MEPS; Platt & Spivack, 1975). The MEPS measures attitudes toward interpersonal problem solving, as well as the solution to the problem (D’Zurilla et al., 1995). In particular, the MEPS assesses the ability to think through steps that are important in reaching a particular problem-solving goal, consider barriers that may interfere with goal attainment, and recognize that adaptive problem solving can be time intensive. Respondents listen to a series of hypothetical problem scenarios and imagine themselves as the protagonist in the situation. Each scenario includes information on how the problematic situation started and how it was resolved (Anderson et al., 2009; Platt & Spivack, 1975). Respondents are asked to fill in the middle portion of the story. For example, “H. loved his girlfriend very much, but they had many arguments. One day she left him. H. wanted things to be better. The story ends with everything being fine between H. and his girlfriend. You begin the story with his girlfriend leaving him after the argument” (House & Scott, 1996, p. 244).

The MEPS offers a number of advantages over the global self-report measures. It uses a standard set of problem scenarios and is capable of assessing important SPS process (e.g., anticipation of barriers, time/commitment to problem solving) and outcome (e.g., generating steps towards a solution) variables. The MEPS, however, has limits as an outcome measure. It cannot assess whether the respondents can actually carry out selected solutions or whether the problems are resolved in a satisfactory manner. Furthermore, despite its use of standard problem scenarios, the MEPS is a hypothetical test of problem solving. In fact, the measure instructions refer to it as a “test of imagination,” asking respondents to fill in what they would “ideally” do in a problem situation (D’Zurilla & Nezu, 2004; Marx, Williams, & Claridge, 1992). The format of MEPS also varies considerably across studies (e.g., instructions, whether scenario is in 2nd or 3rd person, scoring procedures), which makes it challenging to interpret findings and impacts reliability (House & Scott, 1996). When asked, for example, how they would ideally respond to a situation, respondents may report on how they think the problem could be solved under the best of circumstances, but these solutions may not be

reflective of what they would actually do when faced with a problem. The hypothetical vignettes may also lack personal relevance for the respondents. D’Zurilla and Goldfried (1971) suggest that the ability to problem solve in hypothetical situations is distinct from the ability to generate and implement problem-solving strategies in real-life situations. Unfortunately, as with the global self-report measures, there is little research examining whether performance on the MEPS translates to real-world problem solving.

### *Self-Monitoring as a Possible Solution*

Given the limitations of the most frequently used assessment methods, D’Zurilla and colleagues have suggested that self-monitoring be considered as a way to more directly examine problem-solving skills in real time (D’Zurilla & Maydeu-Olivares, 1995). Self-monitoring (i.e., self-observation) is defined as the repeated recording of specific behaviors directly after their occurrence over a specified period of time. For a number of reasons, it has become one of the most commonly used methods of assessment in clinical research and practice (Foster, Lavery-Finch, Gizzo, & Osantowski, 1999; Sigmon & LaMattina, 2006). Self-monitoring can be used to assess the frequency of a behavior, identify antecedents and consequences, to monitor ongoing effects of treatment, and is an effective intervention in its own right, with research showing that simply observing behaviors often leads to behavioral change (Sigmon & LaMattina). In addition, it is an efficient and cost-effective way to directly observe thoughts and behaviors across a range of settings (Anderson et al., 2009; Baird & Nelson-Gray, 2000). As such, it has become a staple in many cognitive-behavioral therapies, including PST (D’Zurilla & Nezu, 2007).

By providing a more direct assessment, self-monitoring has the potential to enhance the ecological validity of problem-solving assessment and may prove to be a viable alternative or adjunct to more traditional measures. Capitalizing on this potential, D’Zurilla and colleagues developed the Problem-Solving Self-Monitoring (PSSM; D’Zurilla & Nezu, 1999) form as a clinical tool to monitor improvement in individuals engaged in PST (e.g., D’Zurilla et al., 2004). It is a diary-based measure combining self-report and self-observation methods to assess attitudes, skills, and actual abilities in solving problems (Anderson et al., 2009; D’Zurilla & Maydeu-Olivares, 1995). The PSSM and SPSI-R have a



similar conceptual basis and can be used together in assessing client progress in PST (Nezu et al., 2013). In completing the PSSM, respondents are asked to identify a significant problem and describe it in detail (e.g., “Where and when did the problem occur,” “What happened”). With this problem in mind, they respond to a series of multiple-choice questions assessing attitudes toward solving the problem (e.g., “To what extent did you view this problem as a threat—potential for harm or loss?”), emotional reactions (“Describe and rate the intensity of your emotions”), and feelings after carrying out their chosen solution (e.g., “What is your perceived satisfaction with the outcome?”). Although these items assess attitudes and beliefs towards problem solving, the responses are tied to specific and actually experienced problems. Respondents also record their problem solutions and the quality of each solution can be rated by a clinician or researcher (D’Zurilla & Nezu, 1999; D’Zurilla et al., 2004).

The assessment of solution quality and effectiveness is a unique feature of the PSSM. Solutions are judged based on the degree to which they change the situation for the better or reduce emotional distress, while minimizing negative and maximizing positive consequences (D’Zurilla & Nezu, 1999). This can be done less formally in clinical settings or more formally for research purposes (e.g., expert judges rate effectiveness on a 1 = *low* to 7 = *highly effective* scale). An average effectiveness score can also be generated as a global index of problem-solving ability (D’Zurilla et al., 2004). More precise assessment of the problem and solution also allows for the coding of problem type (e.g., work-related, interpersonal) and solution function (e.g., avoidance/distraction; D’Zurilla & Nezu, 1999).

Despite its potential, the PSSM has rarely been used for research purposes and the measure has not undergone any formal psychometric evaluation. The work of Anderson and her colleagues is the exception. Pointing to similar concerns as those described in the current review, these investigators critiqued existing studies for their failure to directly assess real-life problem solving and continued reliance on self-appraisal or responses to hypothetical problems. In two studies examining problem solving, anxiety, and depression in college student samples, they added some PSSM-derived variables to their assessment battery (Anderson et al., 2009; 2011).

In the 2009 study, Anderson and colleagues compared the social problem-solving abilities of those with comorbid anxiety and depression, anxiety only, and controls with no significant depression or anxiety symptoms. Participants completed several problem-solving measures, including the SPSI-R, the MEPS, and a modified version of the PSSM. On the PSSM, each respondent completed at least four entries based on interpersonal problems they encountered over a 2- to 4-week period. For each entry, they were asked to describe the problematic situation and how they actually solved it, as well as an added item asking what strategy, in retrospect, they believed would have been ideal. Entries were rated for solution effectiveness by expert judges. In addition, participants completed the traditional version of the MEPS, as well as a modified version, the Personal MEPS (P-MEPS). In the P-MEPS, respondents were presented with four MEPS scenarios and asked to write down similar problems that had occurred in their lives, how they actually solved them, and what their ideal problem-solving strategies would have been in hindsight. Interestingly, although both the comorbid and anxiety groups exhibited deficits in problem-solving orientation as measured by the SPSI-R, they were equally effective in producing ideal strategies on the PSSM and P-MEPS as the controls. When it came to actual strategies, however, only participants in the comorbid group showed deficits in relation to the controls. Thus, the measures targeting actual problems and solutions were more sensitive in detecting impairments in real-world problem solving than those relying on global self-appraisals or hypothetical situations (Anderson et al., 2009).

In the 2011 study, these authors used a longitudinal design to examine the link between social problem-solving skills (again using the MEPS, SPSI-R, and the PSSM) and depression (Anderson et al., 2011). Only the original MEPS, not the modified P-MEPS version, was used in this study. In an adaptation for this particular investigation, problem-solving styles were also coded by examining the general content of each diary statement (i.e., functional, avoidant, or impulsive/careless) using D’Zurilla and Nezu’s (1999) criteria. Findings indicated that MEPS and PSSM solution effectiveness scores predicted later depressive symptoms, but SPSI-R scores did not. Overall, the PSSM scores were able to predict change above and beyond the traditional and hypothetical (i.e., SPSI-R and MEPS) problem-solving measures,

suggesting the added value of its more direct, real-world assessment. Another advantage of the PSSM in both of these studies was that it allowed these researchers to focus on interpersonal problems, in particular, which have been found to play a unique role in depression (Gotlib & Asarnow, 1979).

The findings of Anderson and colleagues point to the promise of the PSSM, but the studies did not use the full measure and instead focused on just two scores, solution effectiveness and style ratings, which were an adaptation for the 2011 study and not part of the PSSM proper. To get a better sense of the properties of the full measure and its potential as a research tool, our research team has begun a preliminary investigation of the psychometric properties of the PSSM using a large undergraduate sample (Andrews et al., 2016; Brothers et al., 2016). Using an online platform, participants completed up to seven PSSM entries over a 2-week period. For each entry, they identified a significant problem, responded to questions assessing attitudes, emotions, and responses to outcome, and recorded their solution. The solutions were rated by trained graduate student raters using the D’Zurilla and Nezu (1999) criteria ( $ICC = .93$ ; Brothers et al., 2016). We then submitted all of the PSSM items to a factor analysis that yielded a three-factor structure that comported with the SPS model (Brothers et al.). The first factor, Outcome Evaluation, reflected components of the SPS model relating to “problem-solving proper” or self-monitoring of the consequences and self-evaluation of the outcome. The next two factors, Negative Problem Appraisal and Problem-Solving Agency, assessed dimensions of “problem orientation,” a critical component in the SPS model. Specifically, Negative Problem Appraisal coincided with problem orientation dimensions that examined the importance of problems to well-being, time/effort spent on problems, and problem appraisal. The third factor, Problem-Solving Agency, reflected problem orientation components assessing the belief that problems are solvable and the confidence to solve them. Perhaps most interesting was the emergence of an outcome factor, a dimension not assessed in the global self-report measures. Finally, examining convergent and discriminant validity, PSSM scores were significantly related to PSI and SPSI-R scores, as well as measures of anxiety and depression, but not related to WAIS-IV Comprehension or Symbol

Search subscale scores (Andrews et al., 2016).

Our preliminary work, together with the findings of Anderson and colleagues, suggests that the PSSM can be an important addition to traditional problem-solving assessments. PSSM items yield interpretable factors that comport with the SPS model and include an outcome factor, problem solutions can be reliably coded, and some of the derived scores contribute added sensitivity and predictive value. More work evaluating the full PSSM measure is needed. One question we are investigating, for example, is whether the derived factors offer any incremental validity over and above the more traditional global self-reports in predicting anxiety and depression. Clinical utility is another question in need of further attention. Reducing the costs associated with use of the PSSM, particularly the time investment required to reliably code solution effectiveness, would go a long way in that regard. Another exciting avenue is exploring ways to adapt the PSSM to fit advanced technologies, such as smartphones (e.g., Luxton, McCann, Bush, Mishkind, & Reger, 2011).

## Conclusion

It has been over 20 years since D'Zurilla and Maydeu-Olivares (1995) called for more real-life assessments of problem-solving ability. Up to this point, this call has gone largely unanswered. The literature continues to be dominated by global self-reports that are limited by their focus on hypothetical problems, exclusive targeting of process variables, and assessment of generalized response tendencies that ignore possible situational variation (e.g., problem type, context). Echoing that 1995 call (D'Zurilla & Nezu, 1999), we recommend that self-monitoring be included in the battery of commonly used problem-solving measures.

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## CLINICAL TRAINING

# Integrating Routine Outcome Monitoring Into Graduate Training Clinics to Advance Evidence-Based Practice

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ROUTINE ASSESSMENT of client progress and outcomes is a core principle, and we would argue value, of scientifically guided health service/evidence-based practice (EBP). The practice of routine clinical assessment during the course of treatment has been referred to by several terms, most commonly Routine Outcome Monitoring (ROM), and more specifically as the practice of Measurement Based Care (MBC), which refers to not just collecting outcome data, but also to using those data to make informed treatment decisions (Scott & Lewis, 2015). Over the past 10 to 20 years, ROM has achieved the status of being an evidence-based practice recommended by the APA Presidential Task Force on Evidence-Based Practice (2006), APA Interdivisional Task Force on Evidence-Based Therapy Relationships (Norcross & Wampold, 2011), and Inter-Organizational Task Force on Cognitive and Behavioral Psychology Doctoral Education (Klepac et al., 2012). This EBP status is the result of increasingly rigorous research showing that ROM can help to identify clients at risk of treatment failure and improve treatment outcomes (Gondek, Edbrooke-Childs, Fink, Deighton, & Wolpert, 2016; Shimokawa, Lambert, & Smart, 2010). As we describe below, the practice of frequent and routine assessment is a longstanding tradition in cognitive and behaviorally oriented treatments, with roots in applied behavior analysis (ABA). Although ROM aligns closely with the principles and values of cognitive-behavioral therapies, there is clear data showing that ROM is not as widespread in practice as would be expected given the

strong evidence for its clinical utility. We argue that to increase the dissemination and implementation of ROM as an EBP, a strong push from university-affiliated community training clinics is required to establish the early practice and value associated with ROM.

## ROM and CBT

Though ROM gained official recognition as an EBP in 2006, its foundational principles have been integrated into cognitive-behavioral therapies (CBTs) since their inception. In fact, ROM is firmly rooted in the scientific discipline of ABA, and has been considered an EBP in behavior analysis for several decades. Further, it is a required practice set forth by the Behavior Analyst Certification Board (2016). CBTs are designed around functional analyses, which require repeatedly measuring treatment targets thought to maintain the client's problems (e.g., day-to-day thought processes), as well as directly assessing the client's problems (e.g., problematic behaviors). In a discussion of behavioral assessment, Hayes and Nelson (1986) listed administering the same measures repeatedly as 1 of 10 guidelines for assessing the effects of therapeutic interventions. Others also expressed the need for routine monitoring of client functioning, especially with measures providing information about clinical significance, to best assess client progress (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Kazdin, 1996; Lambert & Brown, 1996). Research and promotion of ROM continued in the 2000s (Eifert & Feldner, 2004;



Haynes & O'Brien, 2000; Persons & Davidson, 2010), highlighting that simple assessment of client progress during treatment is not enough. Rather, providing feedback to the clinician about client progress, stagnation, or deterioration is of key importance to improving treatment outcomes (Lambert, Hansen, & Finch, 2001). This aligns with the concept of MBC, which refers not just to collecting outcome data or receiving feedback, but also the practice of using those data to make informed treatment decisions (Scott & Lewis, 2015).

Based on the current state of the literature, integration of ROM into practice appears generally indicated for psychotherapy. In addition, there are at least three reasons ROM fits particularly well with cognitive-behavioral orientations. First, CBT is an approach that aims to integrate evidence into each key component of the therapy, including assessment approaches, case conceptualization, and treatment planning. In light of research reviewed above suggesting ROM is an evidence-based approach to treatment, adopting ROM aligns well with CBT. Second, both behavior and its relation with the environment (i.e., functional relations) are dynamic (Haynes, 1992; Skinner, 1953). Therefore, to adequately measure important aspects of a treatment target, such as rate, duration, or functional relations between the environment and a behavior, the behavior must be measured repeatedly across time (Haynes & O'Brien, 2000). Third, CBT can be conceptualized, in part, as a method of developing evidence-based hypotheses in the form of a case conceptualization, which are then tested via clinical intervention (Ledley, Marx, & Heimberg, 2010). From this perspective, ROM offers important information about the effects of the intervention that informs evaluation of the hypothesized mechanisms maintaining a client's problem(s). For these reasons, the collection and utilization of ROM-based measurement feedback for clinicians clearly aligns with cognitive-behavioral approaches to psychotherapy and is supported as an evidence-based practice.

Despite wide empirical support for ROM, research with practitioners has revealed a more complicated picture. Contemporary cognitive-behavioral therapists often endorse valuing ROM as a clinical tool; however, a much lower percentage of cognitive-behavioral therapists report administering progress measures on a monthly or session-by-session basis (i.e., 13.9%; Jensen-Doss et al., 2016), rates at which ROM has been shown to improve

client outcomes. This is situated in the broader practice landscape in which the vast majority of clinicians utilize unstandardized assessment measures (Cook et al., 2015). This research-practice gap may originate in the lack of graduate training in ROM, or the notable discrepancy during training that emphasizes the intake assessment process relative to progress assessment (Hunsley, 2007). This juxtaposition of the long-standing scholarly recommendations to conduct ROM, along with typically positive attitudes regarding ROM, against the low implementation rates in practice both raises concerns about measuring the success of CBT and offers an exciting opportunity for cognitive-behavioral therapists to enhance treatment outcomes and demonstrate the success of evidence-based practice. Those involved in the dissemination of CBT, including faculty members of graduate training programs, are increasingly addressing the challenges in expanding efficacious clinical practices to typical care settings. Similarly, evidence-based assessment proponents must also address the challenge of increasing therapist adherence to ROM as an evidence-based practice.

### Establishing ROM Early in Graduate Training

We echo the sentiment from others (Callahan et al., 2014; Hershenberg, Drabick, & Vivian, 2012) that psychology training clinics offer an excellent environment for key stakeholders in the CBT arena to disseminate ROM practices to the next generation of clinicians and scholars. Although training clinics necessarily prioritize protecting the well-being of clients and providing optimal client care, they are also settings where novel approaches to training in evidence-based service provision can be examined and refined to support long-term use of EBPs. In particular, graduate training clinics provide a clear opportunity to expand ROM in practice by providing instruction to the next generation of evidence-based practitioners on how and why ROM should be integrated into practice.

Emphasizing ROM in graduate students' initial phase of training could be beneficial for multiple reasons. First, it may decrease barriers to ROM implementation and maintenance by making it standard practice. Students who have used ROM are far more likely to anticipate using the practice in their future clinical work compared to students who have not. They also see the

demands of ROM as less burdensome than non-ROM users (Overington, Fitzpatrick, Hunsley, & Drapeau, 2015). Second, training in standardized assessment practices, a professional competency acquired early in graduate training (APA Standards of Accreditation for Health Service Psychology, 2016), is a strong predictor of their use (Cook et al., 2015). Although the mechanics of using and discussing ROM data with clients can be intimidating and nuanced, the frequent supervision in graduate programs is an ideal setting to address concerns and help students learn to use ROM effectively. Its use requires students to practice integrating objective and subjective measures of client change. ROM may aid the development of students' clinical skills by providing data to guide treatment plan modifications and refinement (Tsai et al., 2016). Furthermore, ROM provides a way to identify which clients a student should prioritize for supervision discussions (Swift et al., 2015).

Of interest to supervisors and clinic directors, the practice of ROM also provides data on progress and performance for individual trainees and at the aggregate level. Given the variable client outcomes observed in training clinics (Callahan et al., 2014), ROM provides a platform for clinic directors to integrate much-needed quality assurance into their programs. In this sense ROM data can directly inform clinical supervisors in what areas students are excelling and where they could possibly use more training or support. ROM measures related to client symptoms and functioning can provide key data about client progress on outcome indices; however, perhaps most relevant early in training is evaluating students' ability to develop a strong therapeutic alliance with their clients. Although trainees with less exposure to ROM may have concerns about the use of ROM as an evaluative metric of their clinical services (Overington et al. 2015), objective and concrete data may be easier for a student to accept compared to more subjective assessments, thereby facilitating data-informed conversations about trainee performance (Swift et al., 2015).

Early ROM training can also foster the integration of science and practice, particularly by instilling a positive regard for evaluating one's own clinical services. This value is most closely aligned with the concept and application of Practice-Oriented Research (POR). Considered complementary to more classic psychotherapy studies, POR is characterized by the integration of data collection into routine clinical care

(Castonguay, Youn, Xiao, Muran, & Barber, 2015). Trainees exposed to POR in the context of ROM will be more likely to retain this practice in their careers and remain active contributors to our knowledge base, regardless of whether they have a clinical or research focus. This training aim ultimately should increase the accuracy with which clinicians are implementing evidence-based cognitive-behavioral interventions. If scientific and clinical rigor is an insufficient motivator for increasing the practice of ROM, perhaps training programs will be further convinced by the increasing practice reality in which some insurance companies and managed care have begun to mandate some form of ROM (Boswell, Kraus, Miller, & Lambert, 2015). To adequately prepare trainees for the postdoctoral practice landscape, it is incumbent on training programs to institute ROM practices.

### **ROM Implementation Barriers**

While ROM is associated with favorable clinical outcomes, few clinicians utilize ROM procedures in clinical care (Hatfield & Ogles, 2004). For example, Ionita and Fitzpatrick (2014) found that less than 15% of clinicians engaged in ROM. Similarly, CBT therapists reported a comparable low rate, 13.9% (Jensen-Doss et al., 2016). Primary reasons for low utilization tend to be philosophical (i.e., beliefs about evidence-based assessment) and practical (i.e., time burdens for clinician and clients) barriers. Alternatively, ROM implementation rates in training clinics appear more favorable. Overington et al. (2015) found that 70% of training clinicians were aware of ROM measures and over 80% had utilized them with at least one client. This suggests that training clinicians may have more access to ROM and fewer barriers to implementation.

Although training clinicians may be more likely to use ROM, there are important barriers to reaching an MBC level of implementation. While several studies have classified barriers as either practical or philosophical (Boswell et al., 2015; Hatfield & Ogles, 2004), we categorize barriers as philosophical (e.g., clinical judgment), practical (e.g., time burdens), and organizational (e.g., cost). To better understand the perspective of ROM implementation in a training clinic, we discuss these barriers, their effects, and suggestions to help out.

### **Philosophical Barriers**

Philosophical barriers are mainly the result of clinicians' beliefs concerning the utility of ROM measures and their effect on the treatment process. For example, Hatfield and Ogles (2004) found that the fourth most common reason why clinicians did not use outcome measures was because they "feel it is not helpful" (more common reasons were categorized as "practical" factors). Some clinicians report they rely on clinical judgment, though studies consistently find that clinicians overestimate client positive outcomes, and are unable to identify clients deteriorating in treatment (Walfish, McAlister, O'Donnell, & Lambert, 2012). Other philosophical concerns include that ROM measures are not specific enough for highly complex clients, and that ROM may affect alliance, and depersonalize the overall therapeutic experience (Hatfield & Ogles, 2004, 2007; Norman, Dean, Hansford, & Ford, 2014; Youn et al., 2015).

Some of these aforementioned barriers are likely less prevalent in training clinics. Graduate trainees using ROM report that it is useful for tracking client change and facilitating discussions with clients (Overington et al., 2015). However, trainees do have some philosophical barriers, including concerns that ROM could be used against them to evaluate their clinical skills (Overington et al.). Additionally, the culture of ROM in a training clinic can affect trainee utilization. While the majority of trainee clinicians using ROM report that their colleagues also use ROM measures, less than 35% of nonuser trainees reported that their colleagues utilized outcome assessments (Overington et al.).

There are many solutions for targeting these philosophical barriers. To ensure trainees and clinical supervisors understand the purpose of ROM, and its superiority to clinical judgment, a clinic director can orchestrate psychoeducation training on ROM. To help ensure that ROM does not negatively impact alliance, regular discussion for ROM measures can be encouraged, so that clinicians and clients view these measures as helpful and integral to routine clinical care. To soothe concerns over ROM use in trainee evaluations, supervisors should utilize ROM measures in supervision, but focus the evaluative portion on ROM process and utilization, rather than clinically significant client change.

### **Practical Barriers**

The primary reasons most practicing clinicians do not utilize ROM is that it "adds too much paperwork" or "takes too much time" (Hatfield & Ogles, 2004, p. 487). These barriers are echoed by graduate trainees (Overington et al., 2015). Specifically, weekly paper-pencil assessment measures for multiple clients can add several hours to a trainee's workload, including time spent scoring and interpreting measures. Similarly, the use of ROM measures also affects time spent in therapy, if a clinician has to set aside part of the therapy session for administration of measures. Suggestions for addressing practical barriers include the use of a ROM system that is web-based (allowing clients to access it before sessions to reduce the effect on therapy time and alliance), has brief measures (reducing time burden for clinicians and clients), and is auto-scored and auto-graphed (reducing clinician scoring and interpretation burden). Additionally, clinic directors and supervisors can develop templates for chart documentation and case presentations that can help reduce trainee workload. Lyon and colleagues (2016) conducted a comprehensive review of ROM systems used in behavioral health-care settings and reported the capabilities and functional characteristics of each available system, providing a useful resource to clinicians, researchers, and training programs.

### **Organizational Barriers**

Organizational barriers to ROM implementation, often directly addressed by the training clinic director, include buy-in, costs, training, and conducting research in a service setting. Training clinics housed within a science-based training program focused on EBP and CBT will likely find strong philosophical support for ROM by the vast majority of stakeholders. Two critical stakeholders are supervisors and student clinicians; each has a direct influence on the range and level of EBPs employed and prioritized. As noted above, we recommend a web-based ROM system that includes brief measures, auto-scoring, and auto-graphing to help ensure acceptability and feasibility of ROM implementation. Yet, such a system can be costly, including initial cost and annual fees, plus the ancillary and sustainability costs of computers, Internet bandwidth, personnel, etc. Additionally, successful broad implementation of ROM cannot be achieved without a hands-on didactic training for student clinicians and supervisors. Simply expecting everyone to "know" how ROM works will

lead to disappointing rates of utilization. These issues often contribute to concerns about sustainability of ROM within the training clinic setting. Finally, research involving ROM within a training clinic is not without its own hurdles, most commonly the intersection of research and service practice in the Institutional Review Board (IRB) approval process.

Suggestions for organizational barriers include incorporating student and supervisor perspectives on anticipated barriers; developing a set of trainings on ROM utilization for both clinicians and supervisors; conducting a systematic review of all available ROM systems on an electronic platform; emphasizing the need for financial support from administrators with a dedicated budget for ROM training and utilization in order to maximize sustainability; and consulting with your IRB or contacting a training clinic practice-research network if interested in research applications.

As Wampold (2015) aptly noted, “Anyone who has been involved with the implementation of ROM in practice settings, either in the context of a randomized clinical trial or as part of standard practice, knows that implementation is difficult” (p. 459). To best assess these barriers and target them head-on, the following are recommended: (a) utilize periodic surveys to assess clinician, client, and supervisor barriers; (b) complete implementation in a staged process to address barriers as they are encountered; and (c) examine individual clinician utilization to address implementation feasibility. Most important, implementation champions are needed, especially “local champions” (Aarons, 2005) who drive the implementation process and troubleshoot difficulties as they arise. In a training clinic context, one to three designated students can work as these champions. While implementation can be complex and difficult, individuals involved should not lose sight that each challenge also provides exciting research opportunities to scientifically inform implementation as well as the quality of EBP and CBT delivered to clients.

### **Leveraging Training Clinics to Expand ROM**

Training clinics provide an excellent environment in which to conduct research on substantive questions about ROM implementation. Indeed, Clinic Directors/Directors of Clinical Training are broadly interested in new ways to improve training (and in some instances to promote

clinical research). Training clinics are uniquely positioned to address questions on how to effectively support implementation, because although they often have budget constraints, they also tend to be small and fairly agile in their ability to implement new technology, while also having local knowledge and often expertise in cognitive behavioral assessment. Many training clinics have evaluated the utility of emerging ROM technologies in their settings, whereas others have valiantly attempted to construct their own systematic process for administering paper-and-pencil outcome assessment and establishing associated databases. However, little research currently exists that details the implementation process and evaluation in the training clinic setting.

We see enormous potential for leveraging training clinics as a laboratory for testing questions about ROM in the context of traditional clinical research, but also within the vein of practice-oriented research. One of the key contributions that training clinics can provide is to contribute data to establish average and local norms for client trajectories through treatment, which can help to develop predictive models about client progress (Cannon, Warren, Nelson, & Burlingame, 2010). Graduate-level training clinics, in particular, can offer opportunities to study the mechanisms that hinder and maintain the practice of ROM, such as student and supervisor attitudes towards evidence-based assessment, and towards ROM specifically, technological hindrances and supports, and client perceptions of the utility of ROM. It is also worthwhile to consider the behavioral contingencies that reinforce and maintain clinician use of ROM. For example, recent technological advancements (e.g., web-based platforms) enhance the capability of ROM to provide immediate feedback to clinicians regarding client improvement and worsening. It is therefore possible, if not likely, that the consequences of ROM exert control over the behaviors involved in implementing ROM. Training clinics can also contribute to breaking down some of the organizational barriers to ROM, such as lack of funding, by providing additional empirical evidence for improved client outcomes in the context of ROM. Furthermore, training clinics can also work individually and collaboratively to encourage the integration of science and practice by providing graduate students with opportunities to conduct research on facets of practice (ROM frequency, therapeutic alliance, treatment fidelity) in relation to client out-

comes, or finding new ways to enhance the effects of ROM in practice through group or single-case design research (Hershenberg et al., 2012). Indeed, Penn State University has been capitalizing on such an opportunity (Castonguay, Pincus, & McAleavey, 2015), providing an exciting example of the potential to build trainee investment in ROM as an EBP. The authors have expanded this idea in the context of a training clinic Practice Research Network (PRN), with current members including Utah State University, Virginia Tech, Toledo, Arkansas, Boston University and George Washington University, which is working to develop best practices for ROM implementation, training, and research in the training clinic setting. Taken together, we believe that it is possible to leverage the strengths of the training clinic setting to understand the mechanisms influencing ROM implementation, and also to encourage student investment in practice-oriented research, which ultimately can substantially improve our ability to increase clinicians’ use of repeated assessment to inform their clinical practice.

### **Summary**

In this paper we identify and describe ROM as an evidence-based practice, assert ROM as a core value of the competent cognitive-behavior therapist, and discuss several key issues and potentials surrounding integration of ROM into graduate training clinics. Despite mounting empirical support, ROM is not meeting its full potential (Miller, Hubble, Chow, & Seidel, 2015; Wampold, 2015); thus, we summarize major barriers, present a variety of specific suggestions to increase utilization of ROM and overcome barriers to implementation, and argue for the establishment of ROM early in graduate training. Our collective wisdom is comprised of training clinic directors, researchers, and doctoral students; from this perspective we assert the argument that university-affiliated psychology training clinics provide the ideal environment for ROM to be disseminated to the next generation of clinicians and scholars. Training clinics are uniquely positioned to overcome many implementation barriers, and have great potential to function as research-based training laboratories where implementation research is conducted and integration of science and practice is crystalized. Finally, it is our hope that this article encourages training programs and front-line clinicians to maximize their level of scientific rigor through



full establishment of ROM in clinical practice.

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## NEWS

# ABCT's 50th Anniversary Invited Panel on Cognitive Science and Transdiagnostic Principles

Tony T. Wells, Morganne A. Kraines, Lucas J. A. Kelberer, Meghan E. Delano, and Cassandra P. Krug, *Oklahoma State University*

THE THEME OF THE ABCT convention this year was “Honoring the Past, Envisioning the Future.” Each of the panelists echoed this theme in her or his own talk with a focus on how cognitive science can improve the treatment of psychiatric disorders. Drs. Jutta Joormann (Yale University), Emily Holmes (Cambridge), Bethany Teachman (University of Virginia), and Matthew Nock (Harvard University) each presented their research for 20 to 25 minutes, followed by a question-and-answer session and some discussion among the panelists, which was moderated by Dr. Steven Hollon (Vanderbilt University).

## Dr. Jutta Joormann

Dr. Joormann highlighted her work investigating the importance of positive affect in regulating negative emotion and the cognitive factors that influence the ability to engage in positive affect-driven emotion regulation. She noted that depressed individuals have an inability to repair a negative mood state when recalling positive autobiographical memories, something that nondepressed individuals do well (e.g., Joormann, Siemer, & Gotlib, 2007). In what was a common thread among the panelists, Dr. Joormann discussed the potential of the modification of cognitive processes (e.g., attention,

memory) as a transdiagnostic intervention, and specifically referred to her recent work in positive memory specificity training for depression. From this work, she found preliminary evidence implicating the role of positive memory recall in reducing negative affect.

## Dr. Bethany Teachman

Dr. Teachman also focused on the potential of cognitive bias modification (CBM) as an intervention and spoke specifically about her research examining CBM for anxiety and obsessive-compulsive disorder. In particular, she discussed the value of CBM as an intervention that can be delivered to individuals who otherwise would not receive treatment. Moreover, Dr. Teachman highlighted that changing how individuals interpret information may be the mechanism by which CBM reduces anxiety-related distress. Dr. Teachman noted the strengths of CBM, including its flexibility and evidence of equivalence with gold-standard treatments such as exposure therapy for fear of heights (see Steinman & Teachman, 2014). However, she also highlighted the need for additional evidence for the efficacy of CBM approaches and methods for making CBM more reliable and

robust. Further, Dr. Teachman emphasized CBM as a means to train flexibility in thinking, rather than to simply train individuals to attend to positive information. Dr. Teachman also highlighted the importance of collaboration with scientists from other fields (e.g., engineering) in order to improve the effectiveness and attrition in CBM protocols. Finally, Dr. Teachman discussed future directions for CBM, including disseminating computer-based therapeutic techniques through free-access websites.

#### Dr. Emily Holmes

Dr. Holmes presented on the transdiagnostic importance and implications of mental imagery. She noted that mental imagery is commonly acknowledged as an important symptom and facet of posttraumatic stress disorder (PTSD; e.g., flashbacks), but is also important in other disorders and processes such as bipolar disorder (e.g., these individuals may have overactive imagery systems), major depressive disorder (e.g., these individuals may lack positive imagery about the future or have increased intrusive negative memories), and suicidal ideation (e.g., these individuals have vivid imagery of suicide attempts in the future). Dr. Holmes suggested that it may be possible to regulate mood by regulating mental imagery. Dr. Holmes emphasized the importance of collaborating with, and “borrowing” from, other sciences and highlighted the promise of this approach by presenting data from her own work demonstrating that combining visuospatial tasks with recall of the trauma can interfere with traumatic mental imagery and reduce PTSD flashbacks and related symptoms (Holmes, James, Coode-Bate, & Deeprose, 2009).

#### Dr. Matthew Nock

Dr. Nock discussed suicidal behavior as a transdiagnostic factor and how underlying transdiagnostic processes (e.g., stress reactivity, propensity for self-criticism, cognitive flexibility) may contribute to suicidal behavior and other psychiatric diagnoses and problems. He initially outlined how our ability to predict suicidal behavior has shown only limited improvement over the last four or five decades, perhaps due to a focus on the same five general factors to predict suicidal risk. He emphasized the potential of advances in science and technology to improve our detection and treatment of suicidal behaviors and other psychological problems. In particular, Dr. Nock noted the utility of the quantity and

quality of data generated by fitness trackers, smartphones, and other personal devices to illuminate the dynamics and detection of psychological processes like suicidal behavior. He also highlighted the promise of using mobile phone applications to deliver novel interventions informed by cognitive science (e.g., therapeutic evaluative conditioning; see Franklin et al., 2016) as well as to leverage technology to improve the efficacy or availability of traditional interventions by, for example, using crowdsourcing to challenge negative thinking (e.g., the Koko mobile app; see Morris, Schueller, & Picard, 2015).

### Discussion

During the talks and subsequent question-and-answer session and discussion, it was apparent that two key themes emerged. First, each of the panelists acknowledged the benefits of using advances in technology to further clinical psychology while acknowledging the limitations of technology and technology-based approaches. For example, CBM and app-based interventions provide tremendous potential for offering interventions to individuals who would otherwise be unable or unwilling to seek traditional psychotherapy, but lack the therapeutic interpersonal relationship that accompanies traditional psychotherapy. This raises a number of important questions that our field will need to answer going forward; in particular, if CBM and other technology-based approaches are indeed equivalent in efficacy to traditional cognitive behavioral interventions (e.g., Steinman & Teachman, 2014), what are the practical and ethical implications for the practice and delivery of these interventions and for traditional psychotherapy?

Second, the panel emphasized the need for clinical psychology to collaborate with other fields such as cognitive science and computer science to advance our own field. While we have certainly made gains within our field in the last half-century in the development and dissemination of evidence-based treatments, collaboration with other disciplines may help us to refine and improve the treatments as well as make them more widely available and improve the targeting of these treatments to those who need them most. Clearly the panelists and others are making gains in these endeavors (e.g., Franklin et al., 2016; Holmes et al., 2009; Morris et al., 2015), but barriers still remain. In particular, it will be critical for these advances to be disseminated

to both practitioners and the general public. In addition, there are likely to be debates regarding the practical and ethical issues surrounding the commercialization of these interventions.

In summary, the panelists presented a range of transdiagnostic approaches and interventions that have the potential to further our field. At the same time, important practical and ethical questions remain regarding these approaches and their applicability as interventions. Clearly, ABCT members have an opportunity to help answer these questions and continue to provide the theory and data that will further our field over the next 50 years.

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## Integrating Technology and Evidence-Based Treatment: Insights From Leaders in the Field on the 50th Anniversary of ABCT

Michael Treanor, *UCLA*

BEHAVIORAL AND COGNITIVE-BEHAVIORAL treatments (CBT) are considered front-line interventions for various psychiatric difficulties. However, barriers to care, including the limited number of clinicians trained in evidence-based approaches, the high number of individuals requiring treatment, and the cost of providing one-on-one care present challenges for the large-scale dissemination of CBT (Shafran et al., 2009). Overcoming these challenges requires creative solutions to complex problems, and leveraging mobile and online technology may offer one solution to expand the reach of evidence-based assessment and treatment. ABCT brought together an esteemed panel of researchers, including Dr. Christopher Fairburn (chair), Dr. Ricardo Muñoz, Dr. Kathleen Carroll, Dr. Ellen Frank, and Dr. David Mohr, to discuss the promises and pitfalls in using mobile and online technology in the assessment and treatment of psychiatric disorders. The present article will summarize the content of the panel discussion, with a particular focus on the opportunities and challenges facing the increased integration of technology with assessment and treatment.

### *Dr. Ricardo Muñoz*

In addition to the obstacles mentioned above, underserved populations often face additional barriers to receiving evidence-based treatment, including transportation issues and cost of services. However, Dr. Muñoz discussed how technology, such as online or computer-assisted treatment programs, can be leveraged to expand access to care for underserved communities both in the United States and abroad. For example, online treatment programs have the benefit of being accessible from home, reducing the potential burden related to transportation or taking leave from work for appointments. Should individuals be unable to access programs from their home, community health clinics can provide access to the technology and programs, allowing clinic staff to magnify their

impact on mental health for a greater number of individuals.

Muñoz also noted that traditional evidence-based treatments are “consumable” in that once the patient has left the session, or taken the pharmacological agent, another individual cannot benefit from that same exact resource. Online interventions allow one resource to be used repeatedly by a number of different individuals and therefore represent a “non-consumable” intervention (Muñoz, 2010). Dr. Muñoz asked us to imagine the cost in developing a pharmacological agent, or paying staff salaries to provide psychotherapy, relative to the minimal cost in developing and maintaining an online behavior change program that can be repeatedly accessed.

Delivering treatments via the Internet not only reduces costs, but may also greatly expand the number of individuals who can access evidence-based care. For example, in numerous international studies of an online smoking-cessation program by Muñoz and colleagues, several hundred thousand individuals accessed the material. This is obviously well beyond the reach of traditional behavior change interventions, and, despite the large dropout rate inherent in massive online intervention studies, still results in a large number of individuals receiving treatment (Muñoz et al., 2015).

### *Dr. Kathleen Carroll*

As discussed previously, the limited number of counselors trained in evidence-based approaches is a significant barrier to large-scale dissemination. In addition, even when evidence-based treatments are available in the community, it is unclear if they are always delivered with sufficient fidelity. Carroll noted that both the availability and adherence to evidence-based treatments for addiction could be improved with the use of technology. Indeed, in several studies examining the use of a computer-assisted CBT treatment (CBT4CBT), Carroll and colleagues have demonstrated beneficial results in the treatment of indi-

viduals with polysubstance dependence (Carroll et al., 2008; 2014).

Thus, taken together, Dr. Muñoz and Dr. Carroll suggest that online and computer-assisted treatment programs can expand access to care, while simultaneously ensuring that the care that is delivered is consistent with evidence-based principles.

### *Dr. Ellen Frank*

Although the previous presenters primarily focused on the use of technology to enhance treatment, Dr. Frank noted that these are still “reactive” approaches, and that technology can also be leveraged for “proactive” or early intervention. Current smartphone technology allows passive monitoring of a variety of features relevant to psychopathology, including physical activity level, sleep, and social interaction. For example, disruption in a patient’s social rhythms is often a precursor to a manic or depressive episode, and unobtrusive monitoring of relevant factors via smartphone technology may facilitate rapid detection and early intervention. Clients can receive a message with suggestions when deviations in their typical levels of sleep or social rhythms are detected. Frank noted that machine learning algorithms can also be employed to further individualize a given patient’s profile to their own unique pattern of sleep, physical, and social activity levels (Matthews et al., 2016).

Mobile devices can even record aspects of your conversation, and, without recording the content of the discussion, can note the duration of the conversation, speaking rate, volume, and pitch (Matthews et al., 2016). Although potentially useful in detecting early signs of a manic or depressive episode, each of the panelists was quick to point out that this degree of passive monitoring does raise certain ethical questions.

### *Dr. David Mohr*

The standard model for delivering evidence-based treatments online is to modify traditional therapy elements for a computer-assisted format. However, Dr. Mohr noted that many elements of traditional therapy, including the duration of a given session (e.g., 50 minutes), do not necessarily map onto how individuals currently engage with technology. For example, Mohr noted most individuals spend less than a minute on any given mobile app. This may present difficulties when adapting traditional treatment models to an online or app format.

Thus, Mohr stressed that regardless of the efficacy of a given technological intervention, it won't be effective if individuals are unwilling to use it. He described recent research using "Intellicare," a suite of apps that target various behavior change strategies, with new apps continually added. Intellicare attempts to package behavioral interventions into a format that individuals are accustomed to using (e.g., apps that can be used briefly) in order to increase adherence.

## Discussion

The panelists primarily focused on the opportunities that technology provides for enhancing assessment and the dissemination of evidence-based treatments. Indeed, it is hard to ignore the potential benefits. However, during the question-and-answer session Dr. Fairburn and each of the panelists were quick to note the challenges as well. For example, despite the efficacy of online or computer-assisted approaches to treatment (cf. Roy-Byrne et al., 2010), their effectiveness is greatly reduced when there is no guidance or support (e.g., from therapist or trained paraprofessional; Anderson & Cuijpers, 2009; Richards & Richardson, 2012; Spek et al., 2007). Dr. Fairburn noted that this was an important issue in the presumed "scalability" of technology-guided treatments, and something the field needs to continue to explore. In addition, although it is often presumed that technology may improve the dissemination of evidence-based treatments to underserved communities, Dr. Fairburn questioned whether level of education or familiarity with technology may moderate outcomes. Indeed, Dr. Muñoz noted that the smoking-cessation program appeared to work better in high gross domestic product (GDP) countries. Finally, the panel discussed how the proliferation of apps and online programs purporting to target mental and behavioral health might paradoxically impede access to evidence-based approaches. That is, how can a consumer determine the difference between a good app or online program (supported by

research) and a bad one? How can the field assist consumers in accessing quality, evidence-based programs?

It is clear that mobile and online programs offer unique opportunities to expand the impact of evidence-based assessment and programs. Given the increased number of individuals who require mental health care, and the limited number of adequately trained clinicians, computer-based approaches will likely be indispensable in the delivery of treatment. For example, they may form an integral component of stepped-care approaches to treatment, providing treatment to a large number of individuals as a first-line intervention, and freeing trained clinicians to deliver treatment to the most seriously distressed individuals. In addition, online and mobile programs may facilitate the dissemination of evidence-based treatment principles to underserved communities with reduced access to mental health treatment. Despite the promises in these approaches, we must also be mindful of the myriad of challenges, and continue with rigorous experimental research (Kiluk et al., 2011).

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## The Role of Neuroscience in Psychological Interventions: Take-Aways From the 50th Annual Convention of ABCT

Kean Hsu, *UCLA*

APROPOS TO ABCT's 50th Annual Convention, this year's convention theme emphasized "Honoring the Past, Envisioning the Future." As the organization was founded on the basis of applying theoretical models and empirical findings from experimental psychology and the study of learning, one might see the similar translation of theoretical models and empirical findings from neuroscience as a potentially promising direction for the future of clinical science, as well as honoring the principles that led to ABCT's founding. A cursory glance at this year's convention itinerary shows a significant number of events, including panels and symposia, emphasizing this domain of research. Headlining this area, ABCT's conference committee organized an invited panel consisting of Drs. Daniel Pine, Elizabeth Phelps, Mary Phillips, and Eric Nestler on the topic of "Neuroscience and Psychological Treatment," moderated by ABCT's 2015–16 president, Dr. Michelle Craske. The frameworks outlined, findings discussed, and challenges highlighted in this program of events provide a glimpse at how neuroscience can play an increasingly meaningful role in the assessment and treatment of psychopathology. This article aims to provide an overview of the potential collaboration between, and integration of, neuroscience and psychological treatment based on this year's convention, specifically emphasizing the insights gleaned from the invited panel.

### Dr. Daniel Pine

Dr. Daniel Pine, Section Chief on Development and Affective Neuroscience in the National Institute of Mental Health, started the invited panel by outlining different ways he foresaw neuroscience changing psychotherapeutics. He first noted that current clinical features (e.g., the *Diagnostic and Statistical Manual of Mental Disorders*) do not map well onto brain function; rather, he believed that researchers ought to capture core psychological processes or intermediate phenotypes that bridge the gap between basic

neuroscientific findings and clinical symptomatology. Consequently, Dr. Pine suggested that translational neuroscience ought to select processes that are relatively well understood on a circuitry level yet also clinically relevant, such as memory and attention. He commented that while interventions targeting these domains, such as attention bias modification treatment, might not be quite ready for widespread clinical use (cf. Beard, Sawyer, & Hofmann, 2012; Hakamata et al., 2010; Mogoșe, David, & Koster, 2014), they may be meaningful ways of changing the therapeutic process and target dysfunction that is not addressed through psychotherapy (e.g., circuitry that is more rapid/automatic versus more slow/deliberate). In addition, Dr. Pine also noted that we can think of these processes or biomarkers as potential moderators or mediators of treatment outcome. For example, within the domain of learning and memory, individual differences in fear extinction may moderate response to cognitive behavioral therapy (CBT) in anxious children (Waters & Pine, 2016). Dr. Pine found it worth noting that the regions or processes that are associated with treatment response might not overlap with the regions or processes that differ at baseline between clinical and healthy groups. Furthermore, Dr. Pine put forth that, for now, one of the optimal ways to utilize neuroscience to move psychological treatments forward is to characterize patients who have relatively good or relatively poor responses to existing empirically supported treatments. Such characterization will suggest ways that we may be able to enhance existing interventions and also define a niche for novel interventions. Dr. Pine concluded his remarks by pointing to methodological issues in clinical research that need to be addressed to help move this field forward, including lack of study findings replicating due to Type I error and the need for improved reliability for study measures. Dr. Pine's talk provided an excellent general framework for thinking

about how to more effectively integrate neuroscience and psychological interventions from both a clinical and research perspective, including some of the next steps necessary for this developing field.

### Dr. Elizabeth Phelps

Dr. Elizabeth Phelps, Julius Silver Professor of Psychology and Neural Science at New York University, focused her talk around novel methods to prevent the return of threat responses. Dr. Phelps began by highlighting the two predominant forms of interventions used to prevent return of threat responses: exposure therapy and cognitive forms of emotion regulation. She noted that, unfortunately, minor factors such as timing, context, and even mild stress could reduce the efficacy of such interventions. Consequently, her work considered how such interventions might be strengthened based upon work done in the fields of neuroscience and cognitive science. For example, by harnessing the reconsolidation of memories that takes place during memory retrieval, Dr. Phelps and colleagues were able to demonstrate that safety training administered after a reminder of the memory (i.e., when memory is reconsolidating) was more effective than safety training done in a standard fashion, sans reminder (Schiller et al., 2010). In addition, by augmenting an extinction protocol with a novel neutral stimulus (versus no stimulus in a standard extinction protocol), Dr. Phelps' group was able to significantly reduce the spontaneous recovery of a subject's fear response posttraining (Dunsmoor et al., 2015). Dr. Phelps' talk provided outstanding exemplars of incorporating neuroscience research into the augmentation of existing treatments.

### Dr. Mary Phillips

Dr. Mary Phillips, Pittsburgh Foundation-Emmerling Chair in Psychotic Disorders and Professor in Psychiatry and Clinical and Translational Science at the University of Pittsburgh School of Medicine, highlighted the utility of studying impulsivity and sensation seeking in the context of risky decision-making in young adults. Dr. Phillips noted that these two constructs were associated with bipolar disorder and substance use disorders, suggesting that a better understanding of the circuitry underlying impulsivity and sensation seeking would allow researchers to better identify individuals at risk for these disorders and provide neural targets for intervention. Her group's work found that the



ventrolateral prefrontal cortex (vlPFC) and ventral striatum appeared more closely tied to impulsivity, while sensation seeking seem more closely tied to attention processing regions. Moreover, patients with bipolar disorder showed greater activation in the vlPFC during reward expectancy relative to healthy controls. Perhaps most important, risky decision making in young adults required both high impulsivity and high sensation seeking. Based on these findings, Dr. Phillips' team has begun exploring the utility of transcranial direct current stimulation in reducing risky decision-making via inhibitory neuromodulation of the left vlPFC and related reward circuitry. Through her talk, Dr. Phillips was able to model a clear and cohesive approach to integrating neuroscience into the study of abnormal behavior in clinical populations, as well as translating her findings into a targeted intervention on the neural circuitry underlying those behaviors.

#### *Dr. Eric Nestler*

Finally, Dr. Eric Nestler, Nash Family Professor of Neuroscience, Chair of the Department of Neuroscience, and Director of the Friedman Brain Institute at the Icahn School of Medicine at Mount Sinai, presented a medical model of addiction. Dr. Nestler began by defining addiction as a physical process, involving by necessity the ability of a certain type of chemical substance (i.e., drugs of abuse) to change the physical substrate, the vulnerable brain. Strikingly, out of the range of chemicals that exist, only a very small number of chemicals can cause addictions and they appear to share no common physical or chemical structure. Unfortunately, like all other psychiatric disorders at present, Dr. Nestler noted that substance use disorders can only be diagnosed on the basis of behavioral and symptom descriptions, not biological indices. Given this information, clarifying the neurobiology underlying drug addiction helps to fill critical gaps in our understanding of these disorders. The work that Dr. Nestler and others have done has revealed that all drugs converge on the ventral tegmental area (VTA)-nucleus accumbens (NA) reward circuit, particularly on VTA dopamine neurons. These addictive chemicals impact the VTA dopamine system to a degree not seen in the natural world, leading to persistent change in how individuals evaluate their decision making in response to reward and particularly to naturally rewarding activities relative to drugs of abuse. These changes in decision making due to drug use may be related to

changes in cell size and dendritic arborization for VTA neurons, mediated by deficits in BDNF signaling and availability. Consequently, Dr. Nestler suggested that neurosurgical interventions restoring BDNF signaling and availability may be one direction for future intervention in individuals with substance use disorders. Relatedly, given the increasing precision with which scientists are mapping out the molecular biology underlying brain dysfunction in addiction, Dr. Nestler noted the great potential for development of additional pharmacological interventions based on this area of research to supplement existing psychosocial interventions that, while effective, have high rates of recidivism. Dr. Nestler was able to effectively delineate how a better understanding of the neuroscience and neurobiology underlying drug addiction could clarify the clinical presentation and treatment of addiction.

#### **Discussion**

After the panelists painted a diverse and well-grounded picture of how neuroscience and psychological intervention research might effectively interact, Dr. Craske had an opportunity to pose two questions to the panelists to stimulate discussion. The first question asked panelists to muse on how the field of neuroscience emerging over the next decade might facilitate behavioral and cognitive treatments. Two themes emerged from the panelists' responses: (a) how early in the process of study researchers were, in terms of trying to get on the same page and developing better techniques for studying the human brain; and (b) how we should maximize the amount of information gained from our studies, through an emphasis on at-risk groups and better translational research from animal models to human experience. The second question had panelists address concerns raised by some ABCT members about the overemphasis on a biological reductionist perspective. All panelists acknowledged the power of existing psychological interventions but pointed to the possibilities offered through collaborating between and integrating neuroscience and therapeutics, both to refine existing treatments and to develop new interventions that address maintaining processes more directly and effectively. Collectively, the presentations and panelist discussion underscored the promise of employing neuroscience and clinical intervention science to inform one another in a synergistic process.

While the invited panel served to highlight the potential for neuroscience to inform psychological interventions, a host of other events throughout the convention further explored this potential. A glance at ABCT's itinerary found that a sizeable proportion of the symposia offered during this 50th Anniversary Convention fell under the auspices of neuroscience research, whether in terms of neural markers of risk characteristics or the impact of interventions on various biomarkers distributed across level of analysis. In addition, Dr. Kristen Ellard, Clinical Fellow in Psychology in the Department of Psychiatry at Massachusetts General Hospital/Harvard Medical School, moderated a panel discussion on CBT in the era of the Brain Initiative, drawing upon a diverse set of researchers with backgrounds in neuroscience or CBT to consider where psychological and cognitive-behavioral science may or may not align with neuroscience and biologically based methods, particularly in the context of a shifting funding climate at NIMH. The panel discussion helped to reveal that there was a lot more common ground than differences between these two empirical perspectives, including the critical importance of rigor and skepticism in conducting research, as well as the shared challenges of navigating the current funding environment of NIH. Importantly, even in the face of disagreement, the panel discussion remained positive, constructive, and respectful, and engendered further hope for the ability to effectively collaborate on translational research bridging the two domains. Finally, the Neurocognitive Therapies/Translational Research (NTTR) Special Interest Group (SIG) held a full-day preconference institute on neuroscience-informed behavioral interventions, organized by Dr. Rebecca Price, Assistant Professor of Psychiatry at the University of Pittsburgh School of Medicine. Drawing upon leading researchers integrating neuroscience and psychological interventions from around the world, participants of the institute were treated to a series of talks covering a diverse range of interventions and patient populations, from depression and anxiety to autism. The preconference institute ended with a demonstration fair of some of the developed interventions, allowing participants to obtain hands-on experience with these novel, empirically derived treatments.

The wide range of conference events incorporating neuroscience into the study of clinical disorder and psychological treatment suggest that neuroscience can play a

meaningful role in clinical psychological science and at ABCT. Moreover, the rise in applications of neuroscientific theory and research towards psychological interventions harkens back to ABCT's own roots in applying theory and research from experimental psychology and learning. While there are a number of challenges to be overcome in this burgeoning field, the frameworks and interdisciplinary collaborations that have been developed thus far and showcased at the 50th Annual Convention of ABCT hint at the exciting possibilities ahead.

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## NEWS

# What Happened at the 50th Anniversary Invited Panel on Dissemination and Implementation?

Kristene A. Doyle, *The Albert Ellis Institute*

DR. DAVID BARLOW INTRODUCED this panel by expressing his excitement about the topic and the distinguished panelists. Dr. Barlow provided the audience with a brief history of dissemination of evidence-based treatments, specifically the beginning of development of treatment manuals in the late 1980s to early 1990s, as clinical trials started to be conducted. As Dr. Barlow pointed out, in order to do these trials properly and for clinicians to find them useful, the interventions needed to be systematized, standardized, and operationalized. When Dr. Barlow was President of the Society of Clinical Psychology from 1992–1993, he was afforded the opportunity to pick an initiative. As Dr. Barlow pointed out in his introduction, although treatment manuals existed for panic disorder, obsessive-compulsive disorder, and depression, no one knew about them. In response, he chose his initiative to be “Promotion and Dissemination of Psychological Treatments,” with Dr. Dianne Chambless to chair this task force. One of the main tasks was to determine which treatments had empirical support to be subject to dissemination. Dr. Chambless and her committee developed standards and criteria for what was an empirically supported treatment. As Dr. Barlow stated, “The rest is history because now this has become very standardized.”

But along the way what happened to promotion and dissemination? Drs. David Barlow, David Clarke, and Edna Foa conducted workshops utilizing their manuals. They realized early on that conducting workshops wasn't sufficient to produce an impact on day-to-day practice. It was then that they began to examine how to disseminate their work. The question that was being asked was, How do ideas and new paradigms diffuse? Dr. Barlow informed the audience that in the mid- to late-1990s it became clear to some that developing effective evidence-based treatments was one thing, and one thing they knew how to do, but disseminating them was the more challenging task. Dr. Barlow concluded his introduction with the following statement:

“While we are nowhere near the pinnacle of knowledge of how best to do this, we've made enormous strides in the past 15 years.”

## Dr. David Clark

The first panelist was Professor David Clark, the recipient of the ABCT 2015 Lifetime Achievement Award. Dr. Clark reviewed the Improving Access to Psychological Treatments program (IAPT), which aims to increase the validity of evidence-based psychological treatments for anxiety and depression. The essence of the program is to train a new cohort of therapists (9,000) and position them in specialized services for anxiety and depression throughout the country. Dr. Clark indicated that there are currently 209 of those services covering England. A chief component of the program is complete public transparency of the clinical outcomes of all patients treated in the program. This goal is being achieved through publication of clinical outcomes not just in academic journals but also on the web so anyone can access the data. Dr. Clark believes this approach has started to transform the treatment of anxiety and depression in England. Currently, about 16% of the community prevalence of anxiety and depression are being treated (roughly 900,000 people per year), a big advancement from when they started with less than 5% of people were receiving evidence-based psychological treatments. When Dr. Barlow introduced Professor Clark, he highlighted that IAPT is “collecting data on an impressive 97% of their patients.” Dr. Clark got the audience laughing when he corrected Dr. Barlow by saying, “As David said, we do seem to be very good at recording our clinical outcomes. We're slightly better than what David said— it's 98% of that 540,000 people we have a measure for anxiety and depression at the beginning and end of treatment.” IAPT has demonstrated some impressive results: 66% of people show clear benefit from the program. How did this all come about? The key was using national clinical guidelines put forth by NICE (National Institute of

Clinical Excellence). Starting in 2004, NICE began issuing guidelines on mental health. The guidelines were very clear: the recommended first line of treatments for depression and all the anxiety disorders were evidence-based psychological therapies. The complication in 2004 was that almost no one was getting these treatments, despite the efforts of making treatment more available. A fortuitous meeting between Dr. Clark and Professor Richard Layard, a prominent economist, changed the course. Professor Layard asked why they hadn't been very successful (what Dr. Clark referred to as "a charming question"). Professor Layard asked if they had posed the economic argument, which had not been done. The bottom line is that treating anxiety and depression saves society much more money than the treatments cost. The government asked Dr. Clark to do a pilot project to see if the outcomes that you read in the research literature can be seen on a large scale in an implementation. Outcomes were roughly in line with what one would expect from NICE guidelines—52% of the people recovered and the gains were maintained 9 months later.

Some of the challenges that Dr. Clark highlighted included the question, What treatment should we be using? Dr. Clark's answer? Implementation of whatever treatment NICE recommends. Another challenge is how to get outcome data not just in the pilot project but in the whole national program. Finally, the biggest challenge noted was professional skepticism. Many clinicians felt it would be a burden for patients to fill in the questionnaires; many clinicians said it was unnecessary because when you have missing data you can safely assume that those patients improved as much as the patients for whom you do have data. This is not the case. Dr. Clark stated, "You're deluding yourself about how good your services are unless you get data." So what's the incentive for collecting outcome data? The assumption that if you haven't collected data on someone, they didn't recover. Dr. Clark concluded that the way to address these challenges is through public transparency about the data.

#### **Dr. Edna Foa**

The next panelist was Dr. Edna Foa, who spoke about her experience with the VA and the Army using prolonged exposure (PE) for PTSD. In 2007, the National Center for PTSD suggested that Dr. Foa disseminate PE throughout the VA with the goal that after 2 years Dr. Foa would provide the VA with a system that would

be able to train new therapists to be a consultant or supervisor to therapists and also to train new therapists. Dr. Foa and her team started with training 340 providers. There were different "systems": 4-day workshops plus one-to-one consultation on two cases of PE; a 5-day supervision workshop for clinicians who completed the 4-day workshop and also treated at least two patients with PE and that were recommended by their consultant to become a supervisor or consultant. Some consultants were then selected people to become trainers. Dr. Foa pointed out that in the beginning of the training, providers did the workshop but not the consultation because they couldn't find patients. Dr. Foa stated, "In the VA they couldn't find patients with PTSD," causing the audience to laugh. As a result, there was a change in the requirements—if you are participating in the 4-day workshop you have to have identified ahead of time two patients for which you will get consultation. This change helped, with 88% of those who completed the workshop also completed the consultation.

Dr. Foa then posed a question: Is consultation really important? Workshops are a relatively small investment. Given the larger financial cost of consultation, is it really important? Dr. Foa highlighted that after consultation the self-efficacy in conducting PE is quite high. Furthermore, therapists with high self-efficacy conduct more PE than those with low self-efficacy.

Dr. Foa moved on to a discussion of dissemination of PE within the Army. Although PE is also disseminated in the Army, compared to the VA, it is not widely used despite considerable resources invested in training. The VA trainings were composed of workshop plus supervision. The Army trainings contained just the workshop with no supervision. Dr. Foa wondered if the difference in the uptake of PE between the two systems is a result of the different trainings. To see if this is the case, she embarked on a study where providers were divided into those who received extended training (i.e., workshop plus consultation) and those who only received workshops. The goals: to see if those who received consultation have greater self-efficacy in doing PE; to see if those who received consultation do more PE; and are the outcomes of the patients better for those who received consultation. As this is an ongoing study, we'll have to wait for the results. Dr. Foa highlighted some of the challenges in the Army, which include a lack of a centralized plan for implementing PE, a lack of clear goals (e.g.,

there were no incentives to do anything after a workshop was conducted), and the rigid scheduling template in the military.

So what were Dr. Foa's words of wisdom? Consultation enhances PE in the VA and perhaps in the Army. Other conditions necessary for successful utilization include a top-down system to support effective implementation as can be seen in Britain; support from local leadership to allocate time for PE; resolve the demands that are in conflict with PE delivery; and incentivize delivery of PE. Dr. Foa pointed to "system barriers" that are not going to change quickly, and indicated that it's up to the trainers to find ways to improve dissemination.

#### **Dr. Vikram Patel**

Next up was Dr. Vikram Patel, who represents the field of global mental health, primarily concerned with reducing mental health disparities both between and within populations. A particular focus of his work is on improving access to care for people with mental health problems to evidence-based mental health interventions, in particular for people living in "low resource settings" (i.e., having a lack of general health, mental health, and social welfare resources). Important barriers to consider include supply side barrier (there aren't enough mental health care providers such as clinical psychologists, psychiatrists, or individuals with some kind of advanced training in the clinical mental health disciplines), as well as the often unrecognized demand side barrier (a barrier that is posed when the understandings that people have about their mental health difficulties are different from the models used in the biomedical field). Dr. Patel discussed Premium, a program for severe depression and harmful drinking, that he launched in India with the goal of designing psychological treatments that could address these barriers. An important premise of the program is that the treatments be scalable. In this program, one of the challenges is that the delivery agent is a lay person with no mental health or general health training. A second barrier in this program is that practically all patients were both treatment and diagnosis naïve.

Over the course of two and a half years, Dr. Patel and his team developed two adapted forms of treatments for depression and alcohol problems that met their requirement of scalability. They ran randomized control trials on nearly 500 people with severe depression and almost 400 men with harmful drinking. Patel emphasized



he and his team made a risky decision of having the same lay person deliver the two theoretically different treatments for two different conditions in an extremely challenging setting. The challenge for Dr. Patel: Even if the treatments were shown to be effective, would they be scalable? As he pointed out, “in the real world, are you ever actually going to have an alcohol counselor and a depression counselor in these sorts of settings?”

The key conclusions of these two trials were that brief psychological treatments (an average of 2–3 sessions for alcohol problems and an average of 6 sessions for depression) were acceptable; they were feasible for delivery in this very challenging primary care setting and cost effective; and, perhaps the most important point, they were delivered by the same individual in each of these health care centers in this extremely naïve population in terms of psychological treatments.

Premium is part of a flourishing evidence base. Twenty-seven randomized control trials have been identified with the unique feature that they were all delivered by lay people from 22 different countries. These trials have helped redefine psychological treatments in four ways: What comprises a psychological treatment? Where is the intervention delivered? Who provides the intervention? How is it delivered?

So what are the implications for global mental health? It’s important to acknowledge that the reported treatment gaps in low- and middle-income countries are very large, but they are also quite large in high-income countries. Dr. Patel pointed out that some of the reasons for this lack of access are that interventions are heavily medicalized; the interventions don’t engage sufficiently with the personal and community resources that most people have; they often are delivered in expensive, specialized settings by people who don’t feel comfortable working in rural areas; and often a language is used that is alienating and full of jargon.

#### **Dr. Bruce Chorpita**

The last panelist, Dr. Bruce Chorpita, thanked the audience for not leaving. Reflecting on ABCT’s 50th anniversary, Dr. Chorpita asked what the “big charge” is that members face. To date, he stated, we’ve reviewed over 900 randomized trials for treatments for youth mental health, which has produced 654 evidence-based treatments, most of which are CBT and BT variants. Dr. Chorpita pointed out that despite these good numbers, the majority

of youth do not receive the care that they need, or any care for that matter. Those who do receive care usually don’t get the treatments that work. Although we’ve discovered a lot of the answers, our delivery of those answers in terms of care still needs some attention.

Dr. Chorpita described an “uncomfortable relationship” with the idea of dissemination. By many definitions dissemination has to do with “an emphasis on persuasion to adopt a specific innovation.” If we think of dissemination and our next 50 years at ABCT as persuasion and the innovations as the specific products that we’ve established to date (e.g., manualized evidence based treatments), Dr. Chorpita stated we run the risk of limiting the impact that we make. Because he believes our goal is “still to help people have better lives,” he questioned whether dissemination should be our purpose.

Dr. Chorpita emphasized design side solutions to the problem of dissemination—build things well so you don’t have to work so hard on persuasion. The problem isn’t persuading people to use EBTs, the problem is how to get that to work on the ground. To do so, Dr. Chorpita said we need “flexible interfaces,” different ways for people to interact with that knowledge base from the 900 randomized trials for children to enable them to utilize those findings. We also need a “Plan B,” designing our treatments, systems, and training in a way that can accommodate when things go wrong. A better Plan B for Dr. Chorpita means we give providers alternatives when they don’t have an EBT that matches their needs, particularly in low resource areas.

Dr. Chorpita discussed Managing and Adapting Practice (MAP), a kit to build an EBT from the literature when you don’t have one. It has a tool to do a literature search, how to plan the treatment out in a sequence, how to monitor outcomes, specific guides on how to do specific procedures, and how to plan sessions. The only new aspect of this modular approach is the way it is organized. Dr. Chorpita pointed out that how we architect the treatments that we already have can be a design side solution.

In terms of training design, Dr. Chorpita has developed an umbrella system of competency spanning all EBTs in the form of a report card, which allows for providers to be credited for past learning. He emphasized the importance of having multiple pathways to get trained to a level of competency (e.g., university, online, through supervisors, workshops).

Dr. Chorpita concluded with a list of Do’s and Don’ts for the next 50 years of ABCT, including thinking about how treatments are going to work in a collection; build from the workforce we have, not the “imaginary workforce” we’d like to have; make usual care unusually good; and having flexible curriculum. According to Dr. Chorpita, ABCT is a place where the challenges are in front of us and not behind us, and the next 50 years can be revolutionary.

## **Discussion**

Dr. Barlow summarized some of the different perspectives from the panelists, from reengineering the traditional one-on-one or small group therapy to training people without any mental health background to some level of competence, thereby moving us towards the public health model, to moving away from our packaged treatments and providing elements from which clinicians can pick and choose. Dr. Barlow asked the panel if they thought we are moving away from one-on-one therapy and packaged treatments. Dr. Clark responded that he believes we should get away from one-on-one therapy, pointing out that as psychotherapy is about learning new skills, how you learn new skills sitting in an armchair and chatting? He doesn’t see one-on-one therapy as efficient, but sees a lot of opportunity is Internet-based treatment, which reduces the therapist time and is more convenient for patients.

Dr. Patel commented that he hopes ABCT can take this incredible knowledge out of the mental health professional world into the general health and public health world where it could have profound value. Dr. Chorpita commented that the amount of accumulated knowledge of how to help people vastly exceeds the ability to act on that knowledge. He doesn’t see one-on-one therapy or manualized treatments going away but does believe they need to be “more,” in terms of the interface issue. Finally, Dr. Foa responded by saying that we probably need a stepwise approach, tailoring the treatment to meet the needs of the patient.

And there you have it. With dissemination being an important component of ABCT’s 2015–2017 Strategic Plan, this invited panel gave the audience a lot to think about. Each panelist had some aspects of their talk that were unique; however, they all recognized that despite the successes evidenced thus

far, there is still much more to do. What all the panelists did agree on is that it is up to ABCT's members to take on that challenge.

...

**Correspondence to** Kristene A. Doyle, Ph.D., Albert Ellis Institute, 145 E. 32nd St., 9th floor, New York, NY 10016; krisdoyle@albertellis.org

## Call for Awards 2017

————— see pp. 34-35 —————

### NEWS

## Featured Student Award Recipients

Katherine J. W. 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 New York City! As you can see we honored a number of our members as well as The Honorable Patrick J. Kennedy. Over the course of the coming year *the Behavior Therapist* will feature many of the 2016 recipients. Given the tremendous success of #ABCTGoldChallenge2016 we first feature the students who benefitted from the funds raised.



### Student Travel Award

*Recipient:*  
Skye Fitzpatrick, M.A.

**PRESENTATION:** The Impact of Sleep Disruption on Emotional Reactivity and Regulation in Borderline Personality Disorder: An Experimental Study

LAB: Borderline Personality Disorder and Emotion Processing Lab, Ryerson University (Advisor: Janice Kuo, Ph.D.)

Skye's research is focused on identifying ways to optimize and expedite treatments for borderline personality disorder. In the context of two symposia she chaired at the 50th convention in New York, she presented data collected as part of her dissertation, "Optimizing Emotion Regulation in Borderline Personality Disorder: Why and When Strategies Do and Do Not Work." Skye received funding to support her dissertation work (e.g., the American Psychological Association Research Award, the Harry Rosen Institute for Stress and Wellbeing Grant, and the Canadian Institutes for Health Research Doctoral award), designed the study and oversaw a team of research assistants in data collect and cleaning, and conducted the data analysis. The Awards Committee selected Skye as the recipient of this year's Student Travel Award, which provided her with \$500 to use for travel to the convention in New York.



### Graduate Student Research Grant

*Recipient:*  
Lauren Forrest, M.A.

**PROJECT:** Examining Objective Interoception as a Novel Prospective Predictor of Self-Injurious Behaviors

LAB: Research on Eating Disorders and Suicidality Lab, Miami University, Ohio (Advisor: April Smith, Ph.D.)

Lauren's research is focused on risk factors for eating disorders and suicidality. The project funded by this grant focuses on interoception, an individual's ability to detect and become cognitively aware of the body's visceral cues. Using both self-report and physiological measures of interoception for cardiac, pain, and affective sensations, Lauren will examine differences in objective interoception between adults with a history of SIBs and healthy controls. Further, she will determine whether low objective interoception predicts future SIBs. Following a baseline lab assessment, Lauren will collect data from participants every week for 6 months. The Graduate Student Research Grant, awarded to Lauren by the ABCT Committee on Research Facilitation, provides \$1,000 that she will use for participant payments.

# ABCT AWARDS & RECOGNITION 2016

50th Annual Convention | October 28 | New York

(left) Patrick L. Kerr,  
Outstanding Service to ABCT



(right) Marsha Linehan's  
daughter, Geraldine Rodriguez,  
and granddaughter, Catalina  
Merseth Rodriguez, accepting  
the **Lifetime Achievement  
Award** for Marsha M. Linehan



(left) President Michelle G. Craske  
with **President's New Researcher**  
Cara C. Lewis



(right) Awards Chair Katherine  
Baucom with **Distinguished  
Friend to Behavior Therapy**,  
Patrick J. Kennedy



(below) Todd Moore presenting  
Emily Georgia with the **Virginia  
Roswell Student Dissertation**



**Leonard Krasner Student  
Dissertation:** Tomislav  
Damir Zbozinek



**John R. Z. Abela Student  
Dissertation:**  
Faith Orchard



**Anne Marie Albano  
Early Career Award:**  
Nicole Caporino



# ABCT AWARDS & RECOGNITION 2016



**Outstanding Mentor:** *Evan M. Forman*



**Outstanding Training/Education:**  
*Christine Maguth Nezu*

**Graduate Student Research Grant** (*left*) Rebecca Cox (honorable mention) and (*right*) Lauren Forrest



**Elsie Ramos Student Research Award Winners** (*left to right*) Morten Hvenegaard, Katerina Rnic, Ashley Isaia



**Student Travel Award Winner** (*left*) Skye S. Fitzpatrick with President Michelle G. Craske



**2017 ABCT Fellows** (*pictured with President Michelle G. Craske and Awards Chair Katherine Baucom*)



# Call for Award Nominations

*to be presented at the 51st Annual Convention in San Diego*

The ABCT Awards and Recognition Committee, chaired by Katherine J. W. Baucom, Ph.D., of the University of Utah, is pleased to announce the 2016 awards program. Nominations are requested in all categories listed below. **Given the number of submissions received for these awards, the committee is unable to consider additional letters of support or supplemental materials beyond those specified in the instructions below.** Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

## Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Recent recipients of this award include Thomas H. Ollendick, Lauren B. Alloy, Lyn Abramson, David M. Clark, and Marsha Linehan. Applications should include a nomination form (available at [www.abct.org/awards](http://www.abct.org/awards)), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include "Career/Lifetime Achievement" in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2017

## Outstanding Contribution by an Individual for Research Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions to the literature advancing our knowledge of behavior therapy. Recent recipients of this award include Alan E. Kazdin, David H. Barlow, Terence M. Keane, Thomas Borkovec, Steven D. Hollon, and Michelle Craske. Please complete the on-line nomination form at [www.abct.org](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include "Outstanding Research" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Education/Training, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2017

## Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Recent recipients of this award include the Doctoral Program in Clinical Psychology at SUNY Albany, Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology, the University of Nebraska-Lincoln Clinical Psychology Training Program, and the Charleston Consortium Psychology Internship Training Program. Please complete the on-line nomination form at [www.abct.org/awards](http://www.abct.org/awards). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include "Outstanding Training Program" in your subject heading. Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Ave., New York, NY 10001.

**Nomination deadline:** March 1, 2017

## Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Recent recipients of this award include Mark S. Bauer, Vikram Patel, Benedict Carey, and Patrick J. Kennedy. Applications should include a nomination form (available at [www.abct.org/awards](http://www.abct.org/awards)), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include "Distinguished Friend to BT" in the subject line. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001.

**Nomination deadline:** March 1, 2017

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

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT's mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano's core commitments. This award includes a cash prize to support travel to the ABCT Annual Meeting and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: 1) Candidates must be active members of ABCT, 2) New/Early Career Professionals within the first 5 years of receiving his or her doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care.

Applicants should submit: Nominating Cover Letter, CV, Personal Statement up to three pages (statements exceeding 3 pages will not be reviewed), and 2 to 3 supporting letters. Application materials should be emailed as one pdf document to [Awards.ABCT@gmail.com](mailto:Awards.ABCT@gmail.com). Include candidate's last name and "Albano Award" in the subject line. Also, mail a hard copy of your submission to ABCT, Anne Marie Albano Early Career Award, 305 Seventh Ave., New York, NY 10001.

This award is made possible by a generous donation to ABCT. A family who benefitted from CBT and knows of Dr. Albano's work expressed wanting to see others benefit from CBT and CBT-trained therapists

**Nomination Deadline:** March 1, 2017

## Student Dissertation Awards

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

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2016. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents (i.e., under age 18). Self-nominations are accepted or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at [www.abct.org/awards/](http://www.abct.org/awards/). Then e-mail the nomination materials (including letter of recommendation) as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include candidate's last name and "Student Dissertation Award" in the subject line. Also, mail a hard copy of your submission to ABCT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2017

## President's New Researcher Award

ABCT's 2016–2017 President, Gail Steketee, Ph.D., invites submissions for the 39th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of \$500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent work published in high-impact journals; and promise of developing theoretical or practical applications that represent clear advances to the field. While nominations consistent with the conference theme are particularly encouraged, submissions will be accepted on any topic relevant to cognitive behavior therapy, including but not limited to topics such as the development and testing of models, innovative practices, technical solutions, novel venues for service delivery, and new applications of well-established psychological principles. **For complete instructions, visit <http://www.abct.org/Awards/>**

**Submission deadline:** August 1, 2017

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

## Outstanding Service to ABCT

Please complete the nomination form found online at [www.abct.org/awards/](http://www.abct.org/awards/). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto:awards.abct@gmail.com). Include "Outstanding Service" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001.

**Nomination deadline:** March 1, 2016



# ABCT's 51st Annual Convention

November 16–19, 2017 • San Diego, CA

## 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 ABCT category. Possibilities 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 51st Annual Convention in San Diego?*

The submission portal will be opened from February 15–March 15. 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), Tuesday, March 15, 2017. We look forward to seeing you in San Diego!

# 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

New!

**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 pp. 40-41 for a complete description.

# call

for

## Continuing Education Sessions

ticketed  
sessions

*Submission deadline:  
February 1, 2017*

**51st Annual Convention**  
November 16–19, 2017  
San Diego

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

*Submit a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please visit [www.abct.org](http://www.abct.org) and click on "Convention and Continuing Education."*

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

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

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

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

**Master Clinician Seminars** | Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40–45 attendees, and are scheduled Friday through Sunday. Please limit to no more than 2 presenters.

For more information or to answer any questions before you submit your abstract, contact **Sarah Kertz, Master Clinician Seminar Committee Chair**  
[masterclinicianseminars@abct.org](mailto:masterclinicianseminars@abct.org)



51st Annual Convention  
November 16–19, 2017 • San Diego, CA

general  
sessions

# Call *for* Papers

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APPLYING CBT IN DIVERSE CONTEXTS

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**Program Chair: Jordana Muroff, Ph.D.**

As ABCT moves into its 51st year, the frontier of behavioral and cognitive therapies is the broad context surrounding the delivery of these therapies. Woven into the fabric of CBT is close attention to contextual cues when developing hypotheses and treatment strategies for clients. The theories and models of CBT practice are well-defined and many interventions have proven efficacious for subsets of the population. However, we must represent diverse settings and populations (e.g., ethno-racial minorities, LGBTQ, children, older adults) as we examine the social and cultural aspects of CBT research and practice, expand external validity, and maximize CBT benefits. Our scientific knowledge and our perspectives continue to develop and evolve. How do we incorporate new research evidence, models, and methods into effective practice with a very broad reach?

The theme of ABCT's 51st Annual Convention, "Applying CBT in Diverse Contexts" is intended to showcase research, clinical practice, and training to:

- increase our understanding of mental health problems and mechanisms across contexts
- establish or broaden the efficacy and effectiveness of interventions across diverse populations and settings
- disseminate effective cognitive, behavioral, and related treatments across professions

The convention will highlight how our scientific advances inform the who, what, and how of reaching diverse communities with effective treatments.

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](http://www.abct.org), after January 1, 2017. The online submission portal will open on Wednesday, February 15, 2017.

*Deadline for submissions:* 11:59 P.M. ET on Wednesday, **March 15, 2017**

***Portal opens***  
**February 15, 2017**

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***Deadline***  
***for submissions:***  
**March 15, 2017**

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*See p. 36*  
*for information*  
*about preparing*  
*your abstract*

# ABCT and Continuing Education

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

## **Ticketed Events Eligible for CE**

All Ticketed Events offer CE in addition to educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment beyond the general registration fee. For ticketed events attendees must sign in and sign out and complete and return an individual evaluation form. It remains the responsibility of the attendee to sign in at the beginning of the session and out at the end of the session.

### ***Clinical Intervention Trainings***

One- and two-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction. Participants attending a full day session can earn 7 continuing education credits, and 14 continuing education credits for the two-day session.

### ***Institutes***

Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday, and are generally limited to 40 attendees. Participants in the full-day Institute can earn 7 continuing education credits, and in the half-day Institutes can earn 5 continuing education credits.

### ***Workshops***

Covering concerns of the practitioner/educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees. Participants in these Workshops can earn 3 continuing education credits per workshop.

### ***Master Clinician Seminars (MCS)***

The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees. Participants in these seminars can earn 2 continuing education credits per seminar.

### ***Advanced Methodology and Statistics Seminars (AMASS)***

Designed to enhance researchers' abilities, there are generally two seminars offered on Thursday or during the course of the Convention. They are 4 hours long and limited to 40 attendees. Participants in these courses can earn 4 continuing education credits per seminar.

## **General Sessions Eligible for CE**

There are 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. Most of the sessions are eligible for CE, with the exception of the poster sessions, Membership Panel Discussions, the Special Interest Group Meetings (SIG), and a few other sessions. You are eligible to earn 1 CE credit per hour of attendance.

General sessions attendees must sign in and sign out and answer particular questions in the CE booklet regarding each session attended. The booklets must be handed in to ABCT at the end of the Convention.

General session types that are eligible for CE include:

### ***Clinical Grand Rounds***

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

### ***Invited Panels and Addresses***

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

### ***Mini-Workshops***

These 90-minute sessions directly address evidence-based clinical skills and applications. They are offered at an introductory level and clinical care or training issues.

### ***Panel Discussions and Clinical Round Tables***

Discussions (or debates) by informed individuals on a current important topic. These are organized by one moderator and include between three and five panelists with a range of experience and attitudes. The total number of speakers may not exceed 6.

### ***Spotlight Research Presentations***

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

### ***Symposia***

Presentations of data, usually investigating the efficacy 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. The total number of speakers may not exceed 6.

## General Sessions NOT Eligible for CE

### **Membership Panel Discussion**

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

### **Poster Sessions**

One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,400 and 1,600 posters are presented each year.

### **Special Interest Group (SIG) Meetings**

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

### **Special Sessions**

These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training. These sessions are not eligible for CE credit.

### **Other Sessions**

Other sessions not eligible for CE are noted as such on the itinerary planner and in the program book.

## How Do I Get CE at the ABCT Convention?

The CE fee must be paid (see registration form) for a personalized CE credit letter to be distributed. Those who have included CE in their preregistration will be given a booklet when they pick up their badge and registration materials at the ABCT Registration Desk. Others can still purchase a booklet at the registration area during the convention. The current fee is \$99.00.

## Which Organizations Have Approved ABCT as a CE Sponsor?

### **Psychology**

ABCT is approved by the American Psychological Association to sponsor continuing education for psychologists. ABCT maintains responsibility for this program and its content. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit.

For ticketed events attendees must sign in and sign out and complete and return an individual evaluation form. For general sessions attendees must sign in and sign out and answer particular questions in the CE booklet regarding each session attended. The booklets must be handed in to ABCT at the end of the Convention. It remains the responsibility of the attendee to sign in at the beginning of the session and out at the end of the session.

### **Social Work**

ABCT program is approved by the National Association of Social Workers (Approval # 886427222) for 25 continuing education contact hours. For those who want CE for Social Work, New York State has opted out of sponsorship with NASW. Therefore ABCT cannot offer CE for any Licensed or Clinical Licensed Clinical Social Workers in the State of New York.

### **Counseling**

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

## Continuing Education (CE) Grievance Procedure

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

Although ABCT goes to great lengths to assure fair treatment for all participants and attempts to anticipate problems, there will be occasional issues which come to the attention of the convention staff which require intervention and/or action on the part of the convention staff or an officer of ABCT. This procedural description serves as a guideline for handling such grievances.

All grievances must be filed in writing to ensure a clear explanation of the problem. If the grievance concerns satisfaction with a CE session the Director of Education and Meeting Services shall determine whether a full or partial refund (either in money or credit for a future CE event) is warranted. If the complainant is not satisfied, their materials will be forwarded to the Coordinator of Convention and Continuing Education Issues for a final decision.

If the grievance concerns a speaker and particular materials presented, the Director of Education and Meeting Services shall bring the issue to the Coordinator of Convention and Continuing Education Issues who may consult with the members of the continuing education issues committees. The Coordinator will formulate a response to the complaint and recommend action if necessary, which will be conveyed directly to the complainant. For example, a grievance concerning a speaker may be conveyed to that speaker and also to those planning future educational programs.

Records of all grievances, the process of resolving the grievance and the outcome will be kept in the files of the Director of Education and Meeting Services. A copy of this Grievance Procedure will be available upon request.

If you have a complaint, please contact Linda M. Still, CMP, Director of Education and Meeting Services at [lmstill@abct.org](mailto:lmstill@abct.org) or (212) 646-1890 for assistance.



## 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 on the **Renew/Join ABCT** icon on the right-hand side of the home page; then click on the PDF "2017 Membership Application." You will find the *Expanded Find a CBT Therapist* form on p. 6.

## CBT Medical Educator Directory

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

### Inclusion Criteria

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

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

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

### To Submit Your Name for Inclusion in the Medical Educator Directory

If you meet the above inclusion criteria and wish to be included on this list, please send the contact information that you would like included, along with a few sentences describing your experience with training physicians and/or allied health providers in CBT to Barbara Kamholz at [barbara.kamholz2@va.gov](mailto:barbara.kamholz2@va.gov) and include "Medical Educator Directory" in the subject line.

### Disclaimer

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

ABCT's  
Medical  
Educator  
Directory

<http://www.abct.org>

[Resources for Professionals](#)

[Teaching Resources](#)

[CBT Medical Educator Directory](#)

# Nominate the Next Candidates for ABCT Office

*I nominate* the following individuals:

**PRESIDENT-ELECT (2017–2018)**

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**REPRESENTATIVE-AT-LARGE (2017–2020)**

*Liaison to Membership Issues Coordinator*

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**NAME (printed)**

**SIGNATURE (required)**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Candidates for the position of President-Elect shall ensure that during his/her term as President-Elect and President of the ABCT, the officer shall not serve as President of a competing or complementary professional organization during these terms of office; and the candidate can ensure that their work on other professional boards will not interfere with their responsibilities to ABCT during the presidential cycle.

**Electioneering is prohibited on the ABCT List Serve and Facebook page.**

Please complete, sign, and send form to: **David Pantalone, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001** (fax: 212-647-1865); or email the signed form to [membership@abct.org](mailto:membership@abct.org). Subject line: NOMINATIONS (Note: only full members, fellows, and new member professionals may nominate.)

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

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

This coming year we need nominations for two elected positions: President-Elect and Representative-at-Large. Each representative serves as a liaison to one of the branches of the association. The representative position up for 2017 election will serve as the liaison to Membership Issues Coordinator.

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

## Three Ways to Nominate

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

The nomination form  
with your original  
signature is  
required,  
regardless  
of how  
you get  
it to  
us.



*the Behavior Therapist*

Association for Behavioral  
and Cognitive Therapies

305 Seventh Avenue, 16th floor  
New York, NY 10001-6008  
212-647-1890 | [www.abct.org](http://www.abct.org)

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## ABCT 50th Anniversary Album

P L A Y I T F O R W A R D

Jon Abramowitz, Ph.D. • Jon Comer, Ph.D. • Aaron Fisher, Ph.D. •  
Elizabeth Hall, Ed.D., Ph.D. • Steve Hayes, Ph.D. • Jon Hershfield,  
MFT • David Juncos, Psy.D. • Reed Kendall • Sam Kramer, MA •  
Adam LaMotte, M.A. • Jaimie Lunsford, B.S. • Steve Mazza, M.A. •  
Tony Puliafico, Ph.D. • Jose Soler-Baillo, M.A. • Dennis Tirsch, Ph.D.  
• Tim Verduin, Ph.D. • Jerome Yoman, Ph.D., ABPP



To celebrate the 50th anniversary of ABCT, **Play It Forward** has released a compilation album featuring 14 songs written and performed by ABCT members. Proceeds go to the ABCT student research grant and travel award funds.

Those who donate at least \$10 will receive a CD in the mail in addition to the digital download

*Now available for download*

***All donations go to ABCT***

MINIMUM DONATION: \$5.00

ABCT 50

donate  
here!

<https://www.playitforward.com/projects/14>