

the Behavior Therapist

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CLINICAL FORUM

Cognitive Behavioral Therapy Tools for Clients With Limited Functional Literacy

Freddie A. Pastrana, Ana J. Bridges, Bianca T. Villalobos, Aubrey R. Dueweke, Juventino Hernandez Rodriguez, University of Arkansas

COGNITIVE BEHAVIORAL THERAPIES (CBT) are a family of interventions that explain mental health problems in clients as stemming from the interactions between thoughts, feelings, and behaviors. These include treatments that focus primarily on thoughts (cognitive therapies) and actions (behavior therapies). Behavior therapy, in particular, focuses on how rewards influence the likelihood of behavior being repeated. CBT is perhaps the most well-researched intervention in mental health service delivery (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012), having amassed an impressive amount of evidence supporting its efficacy at treating a wide variety of disorders, beginning from its roots in the treatment of depression (Beck, 1970; Ellis, 1962) and extending to the treatment of substance use disorders (Dutra et al., 2008), psychotic disorders (Gould, Mueser, Bolton, Mays, & Goff, 2001), antisocial behavior (Gibbon et al., 2010), and internalizing symptoms (Ismail, Winkley, & Rabe-Hesketh, 2004).

CBTs are collaborative and empirically based, and make use of client data in order to assist people in making quick and clinically meaningful change. Homework assignments and symptom tracking play a crucial role in the beneficial outcomes of CBT for clients (Kazantzis, Deane, & Ronan, 2000; Proudfoot &

[continued on p. 139]

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Published by the Association for Behavioral and Cognitive Therapies

305 Seventh Avenue - 16th Floor
New York, NY 10001 | www.abct.org
(212) 647-1890 | Fax: (212) 647-1865

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Subscription information: *tBT* is published in 8 issues per year. It is provided free to ABCT members. Nonmember subscriptions are available at \$40.00 per year (+\$32.00 airmail postage outside North America). **Change of address:** 6 to 8 weeks are required for address changes. Send both old and new addresses to the ABCT office.

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Nicholas, 2010). Increasingly, clinicians are being urged to track client symptoms early and often so as to better ensure the quality of services (Lambert et al., 2003). Data obtained through various methods, including symptom tracking, mood ratings, logging responses to behavioral experiments, and so forth, lie at the heart of effective CBT interventions. However, the quality of the data collected may be compromised and the ability to obtain data for activities occurring outside of session can be difficult when working with clients with limited literacy. Alternatively, clinicians often must rely on client self-report during sessions, but this is also problematic because retrospective recall is notoriously inaccurate (Proudfoot & Nicholas, 2010). In response to these challenges, we describe literacy rates in the U.S., the impact that a client's literacy level might have on the provision of and adherence to CBT treatments, and briefly review the results of a survey of CBT practitioners regarding their own clinical work with limited literacy clients. We then describe the development of a set of psychoeducational and monitoring CBT tools for clinicians, modified for use with clients evincing limited literacy, which we have found to be helpful with this underserved population.

Functional Literacy: Prevalence and Mental Health Outcomes

Functional literacy comprises both skill (reading and writing) and application (understanding and applying what is read) components (UNESCO Education Sector, 2004). According to a 2002 report by the U.S. Department of Education (Kirsch, Jungeblut, Jenkins, & Kolstad, 2002), 21–23% of U.S. adults demonstrate English literacy skills in the “lowest level of prose, document, and quantitative proficiencies” (p. xvi). Recently, the National Center for Educational Statistics reported that 18% of adults in the U.S. who completed the Program for the International Assessment of Adult Competencies (PIACC) Household Studies experienced problems at the lowest level of literacy (Rampey et al., 2016). Older adults and immigrants make up a disproportionate number of this low-level English literacy group, and most of the individuals in this lowest performing group have less than a high school education. These and other studies suggest ethnic and racial minorities, including Hispanics, are more likely to be in this lowest literacy group compared to White adults.

Lower English literacy levels are associated with greater likelihood of having a physical, mental, or other health condition that keeps the person from being able to participate fully in work, and is associated with greater health care expenses (Kirsch et al., 2002; Lincoln, Arford, Doran, Guyer, & Hopper, 2015). Furthermore, lack of literacy is stigmatizing, impedes a client's ability to fully participate in treatment decision-making, and may limit access to needed evidence-based treatment (Lincoln et al., 2015). Limited literacy is associated with living in poverty and difficulties with finding adequate employment (Kirsch et al., 2002), all of which can contribute to or exacerbate mental health difficulties (Lincoln et al., 2006). Limited literacy also indeed appears to impact therapists' willingness to utilize CBT or its components with clients (Lincoln et al., 2015).

Cognitive behavior therapists are increasingly recognizing the role that limited literacy plays in treatment. For instance, Kuhajda, Thorn, Gaskins, Day, and Cabbil (2011) described the modification of a CBT protocol for treating chronic pain in a low-literacy rural population by simplifying language, reducing the number of concepts discussed in each therapy session, incorporating more visual aids, and increasing in-session interactive practices and activities. Also, Kneebone (2016) described modifying CBT to accommodate acquired communication deficits in victims of stroke, including using more behavioral versus cognitive strategies, recording exercises completed in session so that clients can refresh their memories of materials covered in session between sessions, and involving caregivers or significant others in treatment. Though some studies have begun focusing on literacy as a potential barrier to health care, clinicians are still lacking a general consensus of how to manage challenges associated with service provision for clients with limited literacy. Unfortunately, there is little empirical data regarding clinicians' experiences working with clients evincing literacy problems.

A Snapshot of the Problem

In our own clinical work, we have experienced the challenges of working with clients with limited functional literacy. The authors of this paper have provided or supervised clinical service provision at two integrated primary care clinics in north-west Arkansas. These clinics are part of a federally qualified health center (FQHC)

providing services to medically underserved community patients. A recent study by Bridges et al. (2015) reported that the demographic makeup for patients across these clinics was approximately 50% Hispanic, 60% female, 40% uninsured, and 50% children or adolescents. In these clinics, over 10% of our adult clients struggled with basic reading and were unable to complete symptom checklists or read psychoeducational handouts without assistance. Our clinical experiences have suggested that limited client literacy can be a barrier to successful implementation of and compliance with CBT.

To complement our own informal observations, we recruited CBT clinicians to complete a brief online survey, approved by our institutional IRB. The survey asked what clinicians are doing to assess client literacy, adapt CBT for limited literacy populations, and evaluate outcomes of CBT with clients evidencing limited functional literacy. Participating clinicians were recruited via an e-mail solicitation distributed through three professional organization listservs: Association for Behavioral and Cognitive Therapies (ABCT), American Psychological Association (APA) Division 38 (Society for Health Psychology), and APA Division 45 (Society for the Psychological Study of Culture, Ethnicity and Race). To be eligible to participate in the survey, clinicians had to currently (a) devote a minimum of 20 hours per week to clinical service provision; (b) ascribe primarily to a cognitive-behavioral treatment approach; and (c) provide therapeutic services to adult clients (i.e., at least half of the cases seen by the participant had to be adults).

Participating were 75 clinicians (Mage = 37.7 years; 72.9% female; 82.4% White), of which 78.4% had doctoral degrees and 21.6% had master's degrees. Of these clinicians, 67.6% were licensed as mental health professionals, with an estimated 30% working under a licensed mental health provider. Clinicians reported averaging 9.8 years (range = 1–37) as practitioners in mental health professions (83.8% in clinical psychology) across various settings (27% in medical centers; 20.3% in Veterans Affairs Medical Centers; 14.9% in private practice). One-third of respondents (31%) reported providing therapeutic services to a moderate to large percentage of clients with limited literacy (26–75%). Similarly, 36.3% of respondents indicated regularly assessing the literacy levels of their clients. More clinicians in Veterans Affairs Medical Centers (80%), psychiatric hospitals

(50%), and other medical centers (42%) reported having a sizeable portion of their clients struggle with literacy compared to clinicians who worked in other settings (e.g., university counseling, independent practice).

When asked about strategies used to assess literacy, 36.5% of clinicians surveyed noted they do not typically use formal assessment to evaluate clients' literacy level; instead, informal approaches (e.g., behavioral observations, asking clients to read out loud) are commonly used. The majority of respondents (80.6%) reported believing that limited literacy decreases the effectiveness of CBT, and 85.4% believed that limited literacy decreases clients' ability to complete CBT homework. Most were less likely to provide a psychoeducational handout or monitoring sheet to clients with limited literacy compared to clients with adequate literacy levels. Almost half of respondents (47.6%) indicated that they would provide these materials for clients with limited literacy if they were simple and easy-to-understand or included visuals. However, almost a quarter of clinicians (23.8%) reported a lower likelihood of providing a monitoring sheet, noting that they would not want to embarrass or shame

their clients who cannot read or write. One clinician noted, "there are not enough resources . . . for my patients with limited literacy. If I had the time to adapt and create simple photos with pictures to capture their self-ratings of feelings, thoughts, and situations, our sessions would have more of an impact." This informal survey of CBT clinicians highlights the extent to which limited literacy patients are underserved by traditional approaches to client data gathering. Therefore, the remainder of this article describes methods to adapt CBT tools for clients with limited functional literacy.

Guidelines for Creating CBT Tools for Clients With Limited Functional Literacy

The Centers for Disease Control and Prevention (CDC, 2009) drafted a guide for creating health information materials for people with limited reading ability. We used these guidelines to develop a set of templates for CBT tools. According to the CDC, health educational and information sheets should be developed with the following considerations in mind. First, clinicians should identify the audience and key health

problems or areas they want to target. For instance, in the primary care clinics where we practice, patients tend to be adults of Hispanic ethnicity, only half of whom use English as their primary language, and the most frequent reasons for behavioral health referrals are depression and anxiety (Bridges et al., 2015). Therefore, it was important to us to create materials in both Spanish and English that would target depression and anxiety disorders in adults.

Second, clinicians should determine the key messages they wish to convey to clients about these health problems or areas. These messages should be pilot-tested to ensure they are received appropriately, are culturally congruent, and are not offensive. Relatedly, knowing ahead of time what the best method is for delivering the health information (print materials, audio or video recordings) and how these materials will be distributed (via postal mail, in person, via brochures, or on the Internet, for instance) can help streamline the process of developing CBT materials for low-literacy clients. In our case, we felt that print materials that could be given to patients during their behavioral health visit by the therapist would be most effective, given many of our patients may not have Internet access in the home (Perrin & Duggan, 2015).

Third, the CDC (2009) recommends psychoeducational materials should convey messages that are clear, relevant, and appropriate to the client. In order to do so, they recommend the following: (a) give the most important information first; (b) limit the number of main ideas or points to just three or four per document, skipping details when possible; (c) tell the client what they need to do or what action steps should be taken (using active voice, and stating what should be done rather than what should not be done); (d) explain why this action is important; and (e) use short words or phrases, avoid acronyms and jargon, and write in a conversational tone that is respectful.

Fourth, the CDC (2009) recommends print material should be attractive and easy to understand. This is helped by selecting large font sizes (between 12 and 14 points), fonts with serifs (which give individual letters more distinctiveness), avoiding use of all capital letters, and being judicious in the use of bold, underline, and italic type. The materials should have plenty of white space, present an entire message or idea on a single page (rather than break up a message across multiple pages), and use bullet

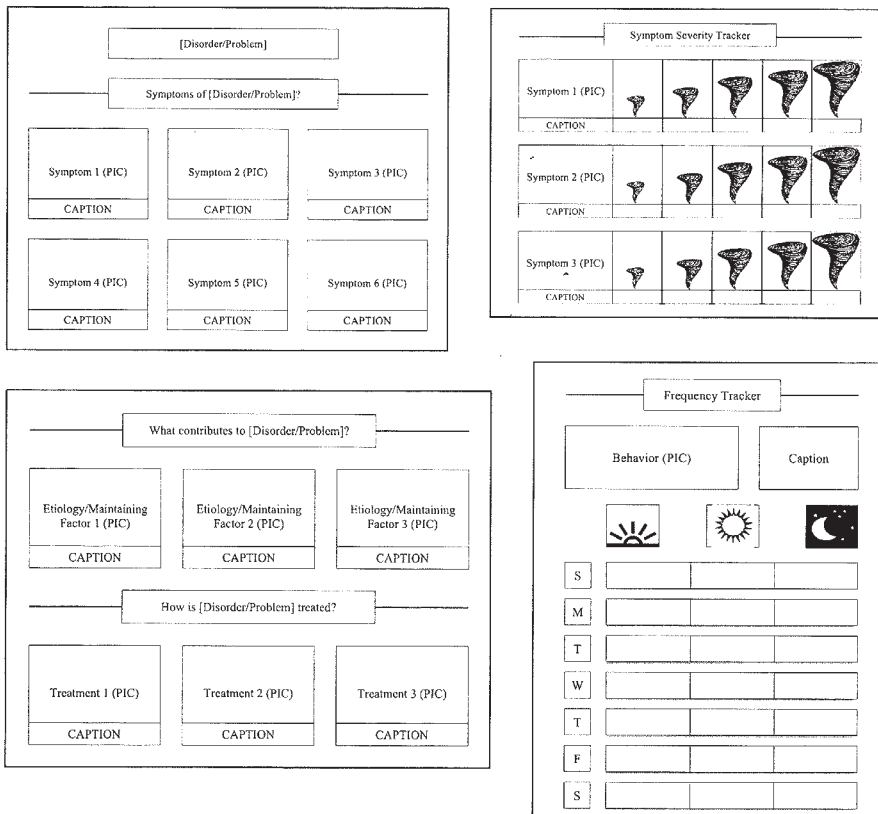


Figure 1. Psychoeducational handout and symptom monitoring sample templates for use with clients evincing limited functional literacy

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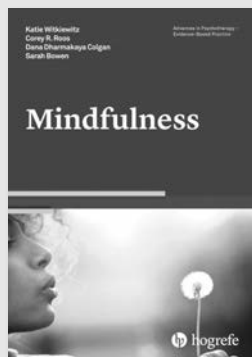
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points or text boxes for emphasis and ease of reading.

Fifth, health information materials for clients with limited literacy should employ the use of visual aids, including pictures or clip art. According to the CDC (2009), the choice of which types of visual aids to use depends on the purpose of the health information, with photographs best for showing “real life” events or “how-tos,” and cartoons or simple drawings best for highlighting key points that may be detailed in text. In all cases, visuals should have sharp resolution and be high in contrast. Visual aids such as clip art or photographs should include a brief caption and present only one idea or message. In the case of developing materials for clients with no literacy, visual aids can sometimes replace entire sections of text.

Sixth, once a first draft of the materials is completed, clinicians should test this draft for cultural sensitivity, appropriateness, and readability. This can be done informally, such as by asking a few clients to provide feedback on the materials, or more formally, such as through focus groups. The readability statistics of a document can be easily determined through

functions within word processing programs, special software, or even through free readability calculators housed on websites such as Online-Utility.org (Tests Document Readability, n.d.).

With these guidelines in mind, we developed a set of templates for three types of CBT tools: psychoeducational information sheets, behavior tracking sheets, and symptom rating sheets. The generic templates we used for these types of CBT tools are in Figure 1. Our template for psychoeducational handouts included two pages of pictures with captions. All pictures we used are publicly available, royalty-free clip art. The sheet page provides information about the symptoms associated with a particular mental disorder (such as major depressive disorder) or problem in living (such as managing stress). The second sheet includes information about causes of the disorder or problem and evidence-based treatment approaches to managing that problem or disorder. For instance, Figure 2 depicts the psychoeducational materials we created to address substance use disorders. The pictures represent a few of the most common symptoms of a substance use disorder, including tolerance, withdrawal,

cravings, use in risky situations, time spent obtaining, using, or recovering from the effects of substance use, and social or psychological problems as a result of use. The causes of drug use are depicted by pictures and captions, which illustrate the role of genetics, life stress, and peer pressure or social norms. The treatment approach includes information about psychotherapy, medications, and support groups. Importantly, these psychoeducational sheets are meant to be used by the clinician in session first, with the clinician providing verbal details about the disorder, its symptoms, and the evidence-based treatment options that can be discussed with the client, allowing the client to ask questions, provide input, and otherwise respond to the material. The sheet can then be given to the client to take home, where it can serve as a cue or reminder of the detailed conversation that took place in session.

Tracking behaviors that are targets of change in CBT is critical to evaluating whether treatment is working. As such, we have included a template for tracking behaviors of interest that can be easily used by clients with limited literacy. Sometimes, we want clients to track the behavior that is the target of change (such as the number of alcoholic drinks they had in a day). Figure 1 depicts a sample template for tracking the severity or amount of problems and symptoms that are the target of change. At other times, we would like the client to track engagement in intervention behaviors, such as finding time to engage in behavioral activation for depression or taking medications as prescribed. The last sheet depicts a sample template that includes the target behavior, an estimated time of day in which the behavior is either scheduled for or occurring, and the day of the week. The specifics will vary by client; thus, the templates we have created are only suggested guidelines but can be fully customized by clinicians after crafting individualized treatment plans with clients. An example template for tracking generalized anxiety disorder is shown in Figure 2. In this particular case, the client’s treatment plan included (a) engaging in regular physical activity; (b) making time for daily relaxation (something the patient and therapist had practiced in session); and (c) setting aside time to worry.

We have placed our templates on a website (comp.uark.edu/~abridges/resources.html) so that others can freely utilize them. The templates we created are only suggested starting points for how to customize CBT tools for clients with limited literacy.

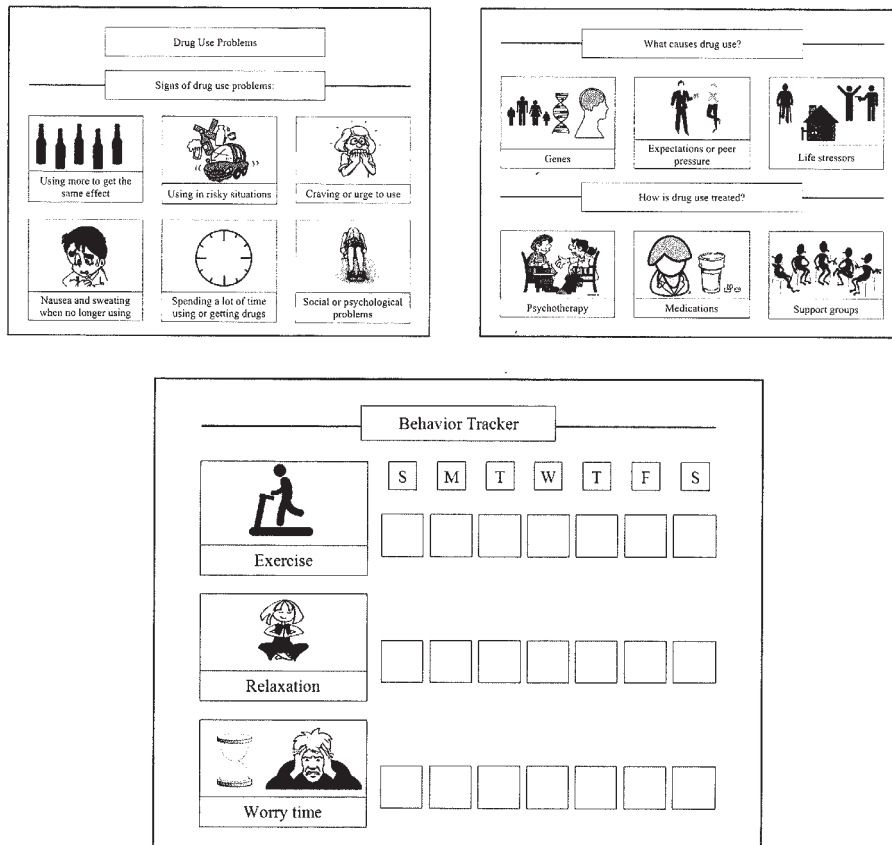
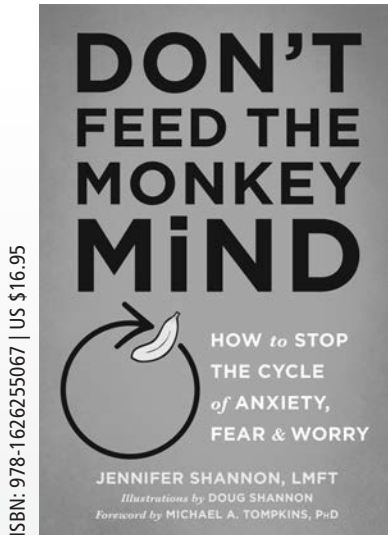
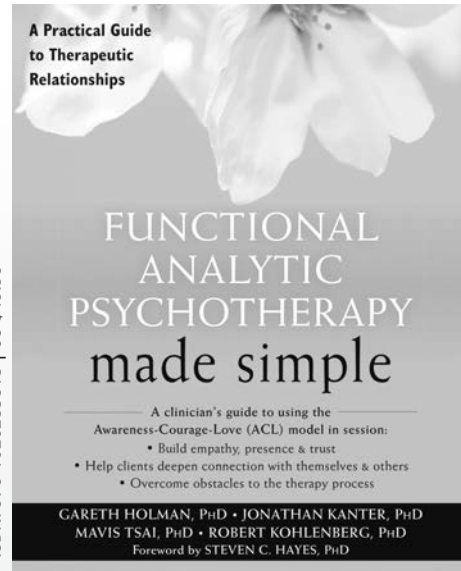


Figure 2. Sample templates for adapted handouts on substance use disorder and behavior tracker for generalized anxiety disorder

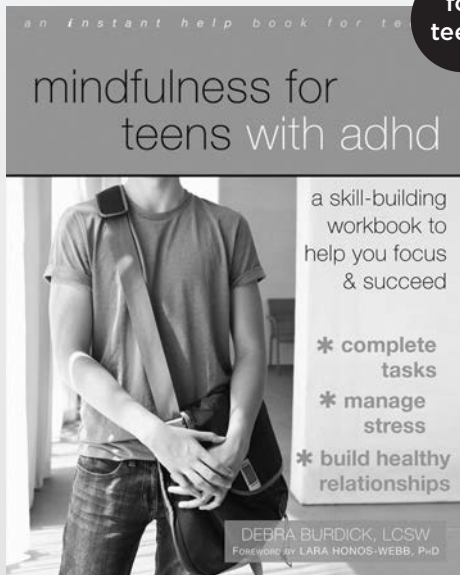
EVIDENCE-BASED RESOURCES TO HELP CLIENTS THRIVE



**HELP CLIENTS BREAK FREE
FROM THE CYCLE OF ANXIETY**

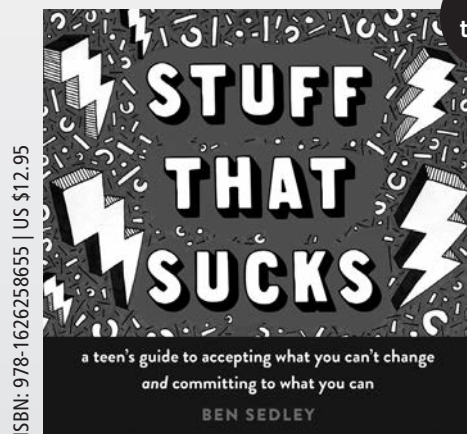


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The pictures, captions, and behaviors can all be fully customized. They are equally useful for working with adults and younger children, as well as potentially useful for working with people of diverse cultures who speak different languages. In our own practice, we have found that going over the materials with our patients during session and providing these sorts of materials, largely pictorial and lacking much text, resulted in increased patient self-efficacy and compliance to complete needed homework assignments and tracking sheets.

Discussion

Despite the strong evidence that cognitive behavioral interventions are highly efficacious in treating a variety of mental and behavioral health concerns (Hofmann et al., 2012), they frequently rely on written materials and between-session assignments that can serve as impediments for clients with limited literacy (Lincoln et al., 2015). In our clinical practice, we have increasingly worked to adapt CBT materials for this underserved population. Our survey of CBT clinicians also found approximately one-third of respondents have a significant caseload of adult clients with limited literacy. Clinicians working in medical centers, psychiatric hospitals, and Veterans Affairs Medical Centers were more likely to report having clients who struggle with literacy compared to those working in other settings, such as private practice or community health centers. This is consistent with data showing associations between limited literacy, poverty, and ill health (Kirsch et al., 2002) and suggests clinicians in these settings should be particularly attentive to literacy issues with their patients.

The bulk of clinicians in our survey reported believing limited literacy decreases the effectiveness of CBT for adult clients, and reported they would be less likely to provide psychoeducational handouts or tracking sheets and worksheets to clients who struggle with literacy. This is consistent with Lincoln and colleagues' (2015) assertion that limited literacy can reduce treatment effectiveness in this already underserved population.

So how do clinicians manage treatment with limited literacy patients? First, it is clear from our survey that clinicians are attuned to these issues and make efforts to modify CBT to accommodate their clients. Clinicians whose caseloads included a sizeable portion of clients with limited literacy noted they adapt CBT "much of the time."

Qualitative data indicated clinicians mostly adapt CBT by changing the language they use and ensuring language is simpler and culturally appropriate. Clinicians also commonly incorporated visual aids into treatment, including using videos, pictures, and drawings to illustrate concepts. In our own clinical practice, we found the use of images for psychoeducational handouts and tracking sheets to be especially helpful. However, because of the limited text in our adapted materials, we recognize their use requires extended time in session to explain what each picture means to the client. The adapted materials serve more as visual reminders or cues to memory, rather than as sole teaching devices. Use of comprehensive instructional video or audio recordings could help reduce time burden on clinicians, but requires clients to have access to electronic devices outside of session.

Scholarly interest in the intersection of functional literacy and cognitive-behavior therapy is increasing, and ripe for future research and for clinical toolkits. For instance, we do not know how clients with limited literacy perceive CBT in its traditional or adapted forms. It would be helpful in future studies to collect data from clients regarding literacy and what materials or adaptations they would find most helpful. The materials we developed only address a limited number of concerns that we see frequently in our own practice setting, and may not fit well with other types of cognitive behavioral therapies. Further, patients' functional literacy appears to have significant implications for broader health outcomes and medical treatment adherence (Miller, 2016). As such, it might be beneficial for clinicians to collaborate with other health care professionals to continue discussing and exploring strategies to improve treatment provision and adherence for patients evincing limited functional literacy. It would be helpful to build an expanded library of resources for clinicians, perhaps encouraging others to share materials they have found or developed would be useful, especially if these resources were in one central location. Finally, the lack of a rapid and reliable measure of clinical literacy is a barrier to treatment adaptation and suggests that efforts to develop such a measure for mental health, much like the Short Assessment of Health Literacy (SAHL; Lee, Stucky, Lee, Rozier, & Bender, 2010), would encourage clinicians to adopt a standardized practice of assessing literacy in clients.

Conclusion

CBT clinicians are likely to have a sizeable portion of clients who struggle with literacy. The effectiveness of CBT may be reduced because of limited literacy. Our own clinical work suggests more attention should be paid to this underserved population and to creating CBT materials that can be readily utilized with clients who struggle with literacy. We hope others will join us in sharing resources and adaptations that have been effective with other clinicians so access to this family of evidence-based treatments is not limited to just those who can read and comprehend well.

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- DISCLOSURE STATEMENT: The authors have considered all relationships that may present conflicts of interest with the Behavior Therapist. The authors declare that they have no conflict of interest pertaining to this submission.
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SCIENCE FORUM

Acceptance and Commitment Therapy for PTSD and Trauma: An Empirical Review

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THE ESTIMATED LIFETIME prevalence of posttraumatic stress disorder (PTSD) is 8.3% (Kilpatrick et al., 2013). Effect sizes for PTSD treatments are large for cognitive processing therapy, exposure therapy, and eye movement desensitization and reprocessing ($g = 1.63, 1.08, \text{ and } 1.01$, respectively; Watts et al., 2013). Cognitive behavioral therapy (CBT) approaches outperformed pharmacotherapies and are

among the most effective treatments for PTSD (Watts et al.). In addition, Watts et al. reported no differences among cognitive-behavioral approaches that emphasized cognitive restructuring, exposure, or a combination of the two, suggesting that individuals have multiple options when seeking treatment for trauma symptoms. However, CBT for PTSD is not a cure-all, with a recent meta-analysis showing pre-

treatment to posttreatment response rates of 59% (63% to follow-up) and high dropout rates (up to 54%; Loerinc et al., 2015). Therefore, there is a need for additional treatment options.

A potential alternative for trauma and PTSD is Acceptance and Commitment Therapy (ACT), which has been increasingly studied due to demonstrated efficacy for a number of treatment concerns (Hayes, Pistorello, & Levin, 2012). The goal of ACT is to increase psychological flexibility, the ability to flexibly engage in valued behaviors in the presence of difficult internal experiences. As such, ACT promotes a stance of acceptance—the willingness to experience thoughts, feelings, and sensations as they are, without efforts to change or control them—as opposed to experiential avoidance, which encompasses attempts to alter and/or escape unpleasant internal experiences, which result in lower functioning. Acceptance is an active choice

* These authors contributed equally on this manuscript.

Table 1. Outline of Data Collected for All Reviewed Studies

Author	Population	<i>n</i>	Outcome Measures	Intake/ Pretreatment	Termination
Batten (2005)	Adult Female, Age 19	1	SCL-90-R	.88	.16
			BDI	16	4
			AAQ	36	27
			ATQ-F	48	42
			ATQ-B	48	35
Twohig (2009)	Adult Female, Age 43	1	AAQ	33	8
			PCL-C	67	28
			BDI-II	34	4
			BAI	38	7
Burrows (2013)	Adult Female, Age 18	1	AAQ-II	36	26
			WBSI	73	57
			TSC-40	70	45
			VLQ (Composite)	38	42
			VLQ (Importance)	63	66
			VLQ (Consistency)	53	56
Lang et al. (2016)	Veterans (M age = 34.2)	160	BSI-18 GSI ACT (Avg.)	73.3	65
			BSI-18 GSI PCT (Avg.)	74	66.8
			SDS - ACT (Avg.)	6.7	4.9
			SDS - PCT (Avg.)	6.5	5.3
			AUDIT - ACT (Avg.)	5.3	4.1
			AUDIT - PCT (Avg.)	5.7	4.4
Jansen & Morris (2016)	Adults, Aged 21-27 (M age = 23.7)	3	AAQ-II (Avg.)	44	22
			BAI (Avg.)	28	8
			BDI-II (Avg.)	29	9
			IES-R (Avg.)	58	10
			PCL-C (Avg.)	51	25
Woidneck, Morrison, & Twohig (2014)	Adolescents, Aged 12-17 (M age = 14.6)	7	Self-Monitoring	27	6
			CAPS-CA (Avg.)	60	23
			CPSS (Avg.)	23	8
			ComQol-O (Avg.)	54	64
			ComQol-S (Avg.)	66	N/A
			TEI-SF (Avg.)	71	67
Boals & Murrell (2016)	Adults, Aged 22-52 (M age = 35.7)	63	CES ACT+TAU (Avg.)	28	23.3
			TAU Only (Avg.)	26.3	26.5
			PCL-S ACT+TAU (Avg.)	60	43.3
			TAU Only (Avg.)	55.9	47.1
			BDI ACT+TAU (Avg.)	30.7	19.6
			TAU Only (Avg.)	25.4	22.6

Note. SCL-90-R= Symptom Checklist-90-R; BDI=Beck Depression Inventory; AAQ=Acceptance and Action Questionnaire; ATQ-F=Automatic Thoughts Questionnaire-Frequency; ATQ-B=Automatic Thoughts Questionnaire-Believability; PCL-C= Posttraumatic Checklist-Civilian Version; BDI-II=Beck Depression Inventory-II; BAI=Beck Anxiety Inventory; AAQ-II=Acceptance and Action Questionnaire-II; WBSI=White Bear Suppression Inventory; TSC-40=Trauma Symptom Checklist-40; VLQ= Valued Living Questionnaire; BSI-18 GSI= Brief Symptoms Inventory-18 Global Severity Index; SDS= Sheehan Disability Scale; Audit= Alcohol Use Disorders Identification Test; IES-R= Impact of Event Scale-Revised; CAPS-CA= Clinician Administered PTSD Scale for Children and Adolescents; CPSS=Children's PTSD Symptom Scale; ComQol-O=Comprehensive Quality of Life Scale-Objective; ComQol-S=Comprehensive Quality of Life Scale - Subjective; TEI-SF= Treatment Evaluation Inventory-Short Form; AFQ-Y= Avoidance and Fusion Questionnaire for Youth; CES=Centrality of Events Scale; PCL-S=PTSD Symptom Checklist

undertaken by an individual to embrace inner experiences while they are occurring.

Experiential avoidance has been suggested as a key factor in the development and maintenance of PTSD, as well as a potential barrier to improved psychological functioning (Bluett et al., 2014; Hayes et al., 2013). This is because experiential avoidance reduces behavioral flexibility in the face of distressing stimuli. For example, an individual with military trauma and high levels of experiential avoidance may choose to keep away from situations that contain trauma cues, such as celebratory events where loud noises are present, even when being at those situations may be important or meaningful to them.

Other ACT processes are pertinent to PTSD as well. Cognitive defusion aims to alter the way individuals interact with thoughts or the function of thoughts. Specifically, defusion weakens the literality of thoughts and instead encourages seeing thoughts for what they are, in lieu of what they say they are. For instance, a trauma survivor may be plagued by the thought, “Everything was my fault.” Taken literally, the thought can occasion self-blame, additional self-critical thoughts, and self-pun-

ishing actions. However, if taken to be a thought that shows up in one’s mind, the individual may instead be able to make valued choices in the presence of a once-powerful thought. Distressing thoughts about the future or the past (e.g., flashbacks) can result in loss of contact with the present moment, such that the individual fails to live life as it is occurring. Yet, by experiencing the world as events occur, the individual’s behavior can become more flexible, sensitive to direct contingencies, and consistent with values (Hayes et al., 2011).

Self-as-context is another ACT process that entails viewing oneself as a context for internal experiences; as such, it involves perspective taking. Rather than holding on to a self-narrative tightly (e.g., “I am a bad person”), the self-as-context perspective encourages contact with an “observer self” who notices these self-stories and can flexibly respond to them. Clarifying values—things that are important to the individual—can help the individual maintain focus in the face of life challenges. In other words, values are what make difficult experiences worth having. Values are also used to evaluate the effectiveness of behavior;

behaviors that bring one closer to values are effective, whereas those that bring one further away from values are ineffective. Committed action is the behavioral instantiation of one’s values. These processes do not function independently, but rather collectively to describe the overarching goal of psychological flexibility that defines the ACT model.

The Acceptance and Action Questionnaire (AAQ; Hayes, Luoma, Bond, Masuda, & Lillis, 2006) is a measure of psychological inflexibility and experiential avoidance. Currently, the second version of the AAQ, the AAQ-II is more commonly used, and scores between 24 and 28 on the AAQ-II have been associated with clinically significant distress (Bond et al., 2011). Higher scores on the AAQ have been associated with reexperiencing, avoidance/numbing, and hyperarousal, the three PTSD symptom clusters (Meyer, Morissette, Kimbrel, Kruse, & Gulliver, 2013). Higher scores on the AAQ-II were also associated with more severe PTSD symptomatology, controlling for avoidance symptoms and negative emotionality (Meyer et al., 2013). While there is some support for this model of PTSD, the effects



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of ACT on PTSD have not been recently reviewed.

The objective of this review was to summarize data on the effectiveness of ACT interventions on PTSD and trauma symptoms. Specifically, this paper reviews treatment studies using ACT in cases of PTSD and trauma, discusses clinical implications of these data, and highlights future research directions.

Method

A literature search on PsycINFO and MEDLINE/PubMed using three combinations of search terms was conducted: (1) "ACT" AND "trauma," (2) "AAQ" AND "PTSD," and (3) "ACT" AND "PTSD." To be included, articles had to be published in English between 1990 and 2016. Prior to 1990, research on ACT was limited to the treatment of depression and Follette first used ACT in the treatment of trauma in 1990 (McLean & Follette, 2016). Articles were reviewed for relevance and those that did not report on the treatment of trauma using ACT were excluded. Studies reporting on individuals with a diagnosis of PTSD or with clinically significant trauma symptoms were included. In total, three case studies, one case series, one single-subject design, and two randomized trials were included in this review.

Empirical Support

Case Studies

Three case studies applying ACT to trauma have been published. ACT was used with a 19-year-old female diagnosed with substance abuse and PTSD resulting from a history of sexual abuse (Batten & Hayes, 2005). ACT was chosen because a transdiagnostic treatment specifically focused on the reduction of experiential avoidance might be expected to simultaneously affect PTSD and substance abuse, which are disorders commonly associated with significant levels of experiential avoidance that can be comorbid. In other words, ACT targeted the function of the client's behavior—avoidance of unpleasant internal experiences—through increasing psychological flexibility rather than the disparate behaviors themselves. The client's AAQ score fell from 36 at intake to 27 at termination. Additionally, her scores on measures of general psychopathology and believability of thoughts decreased at termination (see Table 1). Batten and Hayes reported that the client's self-report scores on the measures were below cutoffs for

clinically significant distress after 12 months of therapy, and that these gains were maintained until treatment termination. In addition, the client reported abstinence of substances from the 7th month until the end of therapy (see Table 1).

A second case study involved a 43-year-old female who was diagnosed with PTSD after experiencing verbal and physical abuse (Twohig, 2009). The client reported experiencing flashbacks, intrusive recollections, and dreams of the abuse. She did not respond to previous CBT interventions that focused on cognitive challenging and exposure scripts. Prior to beginning the 21-week trial of ACT, she scored 33 on the AAQ and 67 on the Posttraumatic Checklist – Civilian Version (PCL-C; Ruggiero, Ben, Scotti, & Rabalais, 2003). By the end of the trial, her score was 8 on the AAQ and 28 on the PCL-C. The mean upper quartile scores of experiential avoidance on the AAQ was 42 for clinical samples and 38 for nonclinical samples (Hayes et al., 2004). Clinical range for the PCL-C is indicated by scores of 44 and above, which suggests that the client's trauma severity was no longer in the clinical range. The client's depression and anxiety scores also declined (see Table 1).

In the third case study, Burrows (2013) conducted a case study with an 18-year-old female who experienced sexual assault. She developed self-deprecating thoughts and a high level of anxiety at the prospect of going out in public, due to avoidance of flashback-inducing stimuli. The therapist conceptualized the client's struggles as stemming from maladaptive ways of avoiding uncomfortable inner experiences (e.g., thought suppression, withdrawing from social relationships). Thus, ACT was the indicated treatment. By the end of the 18-session ACT trial, the client's AAQ-II score had fallen from 36 to 26. AAQ-II scores in the range of 24 to 28 are considered clinical (Bond et al. 2011). Measures of thought suppression and trauma symptoms also declined, while her scores on the Valued Living Questionnaire rose (see Table 1).

Case Series

Jansen and Morris (2016) conducted a 12-week ACT study with three participants who met criteria for schizophrenia and PTSD. Mean AAQ-II score dropped by an average of 23 by the end of the therapy. Improvements were also reported at post-treatment in other self-report measures of PTSD, anxiety, and depression symptoms (see Table 1). This study provides additional evidence that in-vivo ACT treatment

programs can result in improvements across a variety of measures and can be effective for those with comorbid conditions.

Single-Subject Designs

Seven adolescents with a variety of trauma experiences participated in a 10-week course of ACT tested in two multiple baseline designs (Woidneck, Morrison, & Twohig, 2014). There was a decrease in self-reported and observer-rated PTSD symptomatology, as well as psychological inflexibility. Additionally, objective and subjective quality-of-life scores increased (see Table 1). In this study, the three participants that were considered treatment dropouts experienced considerable sexual abuse histories and exhibited complex symptomatology, suggesting a possible need to modify or augment the treatment protocol to target interfering behaviors. One set of participants also lived in residential care and were concurrently receiving individual, family, and group therapy while participating in this study, though trauma was not targeted in the other types of therapy.

Randomized Controlled Trials

A treatment comparison study examined 160 individuals with current diagnoses of PTSD, anxiety, depression, and postconcussive symptoms (Lang et al., 2016). These individuals were randomly assigned to either the ACT or present-centered therapy (PCT) condition. Twelve 1-hour sessions of individual therapy were conducted for each participant in each group. Scores on measures of well-being, functioning, and alcohol use all decreased (see Table 1). Improvements were observed for both groups and the only significant difference between groups was that ACT was associated with more improvement in insomnia at posttreatment. This study, like others working with veterans, experienced a high rate of attrition. Another consideration with regard to this study was that 82% of the sample was diagnosed with PTSD, thus results may not generalize to individuals with only traumatic experiences.

Boals and Murrell (2016) conducted a clinical trial that included 63 participants with elevated PTSD symptoms. Their active intervention consisted of four 1-hour ACT sessions that emphasized self-as-context to target event centrality, or the degree to which the traumatic event is incorporated into the individual's identity, in addition to treatment as usual at a com-

munity outreach center. The control group only received treatment as usual. Results indicated a significant effect of treatment condition from pre- to posttreatment on event centrality, PTSD symptoms, and depression. In addition, Boals and Murrell found that event centrality significantly mediated the link between study condition and PTSD symptoms, suggesting that the ACT intervention worked in a theoretically consistent way (see Table 1). It is important to note that control participants who wanted to switch to the treatment condition were allowed to do so at the pretreatment assessment; thus, this was a semirandomized trial.

Discussion

The objective of the present review was to summarize existing data on the application of ACT to trauma and PTSD. This area of research is in its nascence and preliminary evidence suggests that ACT is potentially an effective intervention, though the

dearth of large-scale trials with well-defined PTSD symptoms tempers recommending dissemination of ACT for PTSD. More information on moderating factors of treatment response or mediational pathways through which psychological flexibility and quality of life improved would enable more informed clinical decision making and individualization of treatment approaches.

Because ACT adopts a transdiagnostic stance on psychopathology and has demonstrated its efficacy across a range of conditions (A-Tjak et al., 2015), one might assume that ACT will be effective for treating PTSD. However, clinical trials demonstrating the effectiveness of ACT across varying trauma presentations and client variables are still needed to better understand the best ways to apply ACT in the context of PTSD. Examining the acceptability and feasibility of ACT in nonresearch settings may reveal practical advan-

tages to presenting ACT as a treatment option for PTSD.

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Mixed Methods Research Offers a More Powerful Gold Standard for Evaluating Psychological Treatments

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THE RANDOMIZED CONTROLLED TRIAL (RCT) has been regularly referred to as the gold-standard methodology in research evaluating the efficacy of psychotherapies and providing evidence for what works in real-world clinical settings (Baker, McFall, & Shoham, 2009). This is an ambiguous metaphor. After all, the gold standard failed as a basis for the world economy and was eventually abandoned in 1971. Several commentators, in pointing out the limitations of the conclusions that can be derived from RCTs, have used the counter metaphor of “fool’s gold” (e.g., Edwards, 2007). In our recently published book (Fishman, Messer, Edwards, & Dattilio, 2017), we contend that if we are to retain the “gold standard” metaphor, it needs to be expanded. We argue that important limitations of and problems caused by relying on RCTs as the main source of evidence can be addressed by using a mixed methods approach. More specifically, we advocate incorporating qualitative methods into outcome studies that include a close examination of single cases that were part of the clinical trial.

RCTs employ elaborate logical designs to achieve experimental controls. They focus on specific variables and discreet, quantitative measures of them; require fidelity to therapy manuals; and rely on extensive statistical analysis of the results. All of these factors contribute to building confidence in general laws about what treatments work and for which problems. On this basis, some have argued that clinicians should only deliver treatments that follow manuals used in research trials where efficacy has been demonstrated through one or more RCTs (e.g., Baker et al., 2009). However, this attitude has main-

tained a divide between researchers and practitioners in clinical psychology (Barlow, 1981; Dattilio, 2002; Jones, 1993; Silverman, 2001).

Moreover, the serious limitations of this approach, offered in the name of science, and its damaging impact on clinical practice have attracted considerable commentary from psychotherapy researchers over the past two decades (Barber, 2009; Dattilio, Piercy & Davis, 2014; Hollon, 2006; Messer, 2004; Wampold, Imel, & Miller, 2009; Westen, Novotny & Thompson-Brenner, 2004). A large number of limiting factors of RCTs have been identified, including those that can be addressed specifically through a mixed methods approach.

For example, because of the difference in the controlled, experimental setting of RCTs and the naturalistic setting of practice, RCT studies have not been viewed by practitioners as attuned to their thinking and clinical experience (Barlow, 1981; Dattilio, 2002; Jones, 1993; Silverman, 2001). Specifically, treatment protocols in research trials may be artificially constrained to accommodate the requirements of research designs, such as artificially shortening the treatment time (Dattilio, Edwards, & Fishman, 2010) or limiting the responsiveness of clinicians that is a normal part of their clinical behavior and indeed essential for ethical practice (Stiles, 2009). Moreover, practitioners in naturalistic practice may have more complex cases and fewer resources available, such as ongoing supervision, than in research trials (Schoenwald & Hoagwood, 2001). Consequently, treatments delivered in RCTs may differ from those offered in routine clinical practice. In response to this apparent “lack

of fit” between RCTs and naturalistic practice, systematic case studies of clients within RCTs capture the important clinical contexts of the RCT treatment, not apparent from the RCT research design per se, so that the full contexts of RCT cases can be compared with those of practice in naturalistic settings. Such a comparison of these contexts can help to answer the question of whether the case studies associated with RCT manuals are effectively transportable to naturalistic contexts of practice. Such a comparison is enhanced by also conducting systematic case studies of routine practice and comparing and contrasting them with the case studies drawn from an RCT.

In addition, the requirement of quantification leads to a reliance on established metrics that don’t fully and accurately capture the experiences of participants available in case studies and can result in bias with respect to the conclusions that are drawn (Blanton & Jaccard, 2006; Kazdin, 2003; Levitt, Pomerville, & Surace, 2016). Because the focus of RCTs is on the efficacy of treatments, they typically provide limited information about the mechanisms through which treatments work, the type of information which case studies can substantially augment. Findings are largely limited to the conclusion that a treatment works the same as or better than placebo or than another treatment. While such conclusions are, of course, important, they are very broad and sweeping and do not do justice to the complexities involved in individual participants’ responses to treatment. There are wide individual differences with respect to how clients respond to different treatments or even aspects of a single treatment. Factors such as client characteristic features, the therapeutic alliance, the credibility of the therapy in the eyes of the client, the client’s motivation and expectations, the client’s life context with respect to social support and competing demands, the therapist’s theoretical allegiance, and the therapist’s skill can all affect the nature of participants’ engagement with the therapy process (Barber, 2009; Fishman et al., 2017; Wampold et al., 2009). In short, the internal validity of the findings is compromised by the fact that there is little or no evaluation of the role of a large number of factors— independent of the techniques outlined in the therapy manual employed—that impact the course of treatment and whether it will be effective in particular cases, and all this is the very type of information that systematic case studies can provide.

Practitioners are responsible for keeping informed about research findings so that they can deliver interventions considered to be best practice in light of current knowledge. At the same time, they are strongly influenced by their clinical experience of how different clients respond. Indeed, studies suggest that most clinicians tend to rely largely on clinical experience and give limited attention to the research literature (Mussell et al., 2000; Stewart & Chambless, 2007). In this context, it is important to note that in a recent issue of *the Behavior Therapist*, Babeva and Davison (2017) discuss the nature of effectiveness in continuing education in the health professions and conclude from the empirical research on medical education 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” (p. 8). Systematic case studies provide a crucial vehicle for such problem-based learning.

Research on the accuracy of clinical decisions (mostly about diagnosis and prognosis) guided by statistical information and normative data, as compared with pure clinical judgment, has shown that, although the former have a somewhat higher level of accuracy, in some studies clinical judgment is superior (Ægisdóttir et al., 2006). It is unfortunate that these two sources of knowledge have often been seen as pitted against each other, rather than complementary (Messer, 2016).

Fortunately, the American Psychological Association’s Task Force on Evidence-Based Practice in Psychology (EBPP) concluded that clinicians need to base decisions about treatment on a synthesis of their clinical experience and clinical judgment together with evidence from research that would include but not be limited to RCTs (Goodheart, 2005). Thus, qualitative studies, including narrative case studies, are considered appropriate sources of evidence that can contribute to making clinical decisions.

This was not a radical position but was in line with the view of evidence-based practice in medicine (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996) and psychology. Over three decades ago, Kiesler (1981) argued that the development of interventions in psychotherapy calls for a multidimensional research enterprise requiring various talents and approaches. Different research methods (e.g., multivariate and experimental studies, group

comparisons, outcome designs, therapy process models, case-based studies, and qualitative research methods) each offer a unique type of evidence that can be drawn on to contribute to the scientific development and evaluation of useful treatments. The availability of a wider set of information and the synthesis of perspectives and conclusions from qualitative and quantitative methods offer a more balanced view of what has been discovered in a project.

Twenty years after Kiesler’s statement, in the United Kingdom, Salkovskis (2002) articulated this approach more sharply with the concept of “empirically grounded clinical interventions,” which, he argues, are established when the evidence from different types of studies is carefully evaluated and integrated. This integrative research perspective is more widely recognized in the U.K. with the result that clinical psychologists there have a greater respect for the research literature than those in the U.S. (Cooper & Graham, 2009).

A mixed methods research strategy goes beyond the view that data from multiple studies employing different sources and methods need to be drawn on in clinical decision-making. It advocates the use of a range of research methods within a single study (Hanson, Creswell, Clark, Petska, & Creswell, 2005). This would mean, for example, conducting an RCT with all that this involves in terms of controlling for extraneous variables, quantification, and statistical analysis, together with studying the same clients within the same study. Reporting a series of largely qualitative case studies would bring into focus the wider range of factors that impacted the treatment than can be measured in the formal quantitative study. The results would not be presented in independent reports, with one describing the RCT and another describing the case studies and/or other qualitative analyses. Both would be incorporated into a single research report, which would draw conclusions on the basis of both kinds of findings. In this spirit, Dattilio et al. (2010, p. 433) proposed that “reporting a small set of representative SCSs [systematic case studies] should become a mandatory part of the scientific reporting of studies evaluating psychological treatments through RCTs.”

The comprehensive information on individual cases that is often gathered in well-conducted RCTs constitutes a rich source of untapped scientific data. On occasion, these are employed in the writing of case studies for publication. Several of the case studies published in the journal

Clinical Case Studies, for example, have been taken from clinical trials. Such studies may provide valuable instantiations of the kinds of processes that unfold when a treatment works (Messer, 2011), or of the kinds of obstacles encountered that impact negatively on outcome (Rizvi, 2011). However, the publication of case studies from clinical trials so far has been a largely haphazard process. Barlow and Knock (2009) have argued that “the time is now right to put more emphasis on idiographic strategies that can be integrated in a healthy way into existing nomothetic research approaches” (p. 20). Requiring that systematic case studies from therapy trials be integrated into reporting and the drawing of conclusions would be a way of making this a reality.

A more refined strategy, proposed by Fishman (2011), is to select two cases from a trial, one where treatment was effective and one where it was not, and publish these together (for examples, see Burckell & McMains, 2011). In all these publications, however, the case reports are independent of the report of the RCT. For the first time, as far as we know, combined reports of an RCT and those of case studies are examined together in single book chapters (Fishman et al., 2017), although the RCTs themselves were also published previously and independently. These, therefore, are unique examples of mixed methods reporting.

Case Studies Within a Mixed Methods Approach

Creswell, Fetters, and Ivankova (2004) pointed out that case studies are particularly appropriate for inclusion as the qualitative perspective in mixed methods research evaluating health service interventions like psychotherapy. Bromley (1986) aptly argued that case study research constitutes the “bedrock of scientific investigation,” and the details of clinical practice are invariably derived from a synthesis of clinical principles derived, at least informally, from case observations, rather than from the findings of multivariate research (Edwards, 1996). This is because case studies in which the individual is “the unit of the interest and the unit of analysis” (Eells, 2007, p. 35) allow for an examination of multiple complex processes as they interact across time within the same individual. When evaluating the treatment of different individuals within the same RCT condition, comparative case studies, as in the example of the Fishman (2011) strategy

described earlier, are particularly valuable in that they permit the formal examination of individual differences in response to the same treatment approach. They also provide information of relevance to therapists with respect to their need to be responsive to client differences, such as a client's stage of readiness for a particular treatment intervention.

In the final phase of the research process, case studies have another important value to science, which is the communication of findings. Well-written case studies offer a unique means of communicating clinical knowledge because reading them can directly engage the interest of busy clinicians and inform practice in a way that is not achieved by other methods of research publication (Stewart & Chambless, 2007).

Methodological Standards for Systematic Case Studies

Case studies were discredited during the latter half of the 20th century on the ground that there was inadequate quality control in so far as authors could easily select and distort the narratives to suit their own theoretical or ideological agendas. This outlook underestimated the value of case studies to clinical practice and overestimated their limitations. In the context of the growing appreciation of the value of qualitative research, and with the articulation of principles and methods to ensure the greater trustworthiness of conclusions drawn, case studies are once again taking their rightful place as a foundational form of clinical research (Fishman et al., 2017).

Case studies in which a qualitative narrative account of the assessment and therapy process is a central feature are termed "pragmatic case studies" (Fishman, 2005), or "systematic case studies" (SCSs; McLeod, 2010). Criteria for quality assurance in such studies have been extensively described (Dattilio, 2006a, 2006b; Edwards, Dattilio, & Bromley, 2004; Fishman, 2005; Kazdin, 2003).

Drawing on Peterson's (1991) disciplined inquiry model, Fishman (2005) argued for a five-stage process of assessment, case formulation, treatment, ongoing monitoring leading to possible revision of the treatment, and concluding evaluation. In the assessment phase, information is systematically gathered about the case using clinical interviews, self-report measures and, where available, collateral information from significant others. This provides the basis for a case formulation

within whatever treatment model the clinician is using and for which there is an existing body of basic and applied research. The formulation incorporates several clinical hypotheses that are used as a basis for a treatment plan. Once the treatment is initiated it becomes a test of the formulation and of the clinical hypotheses it incorporates. A limited response to treatment captured by monitoring can lead to a revision of the formulation and a change of treatment approach, a course correction that can be documented in the case narrative. Finally, a systematic evaluation of the process and outcome of the case is conducted to understand both the case itself and its relevance for generalizations about other, similar cases.

Fishman recommends that self-report scales be used to monitor specific symptoms that are related to the presenting problem, and that these are administered not only during assessment but on a regular basis until the end of treatment and at follow-up. The quantitative results of these can be presented in graphical form as part of the case study and linked to the processes described in the narrative. Systematic case studies are, therefore, mixed methods studies in that conclusions are based on a synthesis of both qualitative and quantitative data. When possible, all sessions should be recorded and the transcripts used as the basis for constructing the case narrative. This will necessarily be selective and the material included will be relevant to the central themes that emerge from the clinician's qualitative understanding of the salient factors in the case either as the case proceeds or in retrospect. The session transcripts provide a basis for quality assurance that the selection and thematic interpretation of the therapy process has not been biased.

Recommendations: Towards a Credible Gold Standard for Psychotherapy Outcome Research Using a Mixed Methods Paradigm

A number of the criticisms of RCTs can be addressed by including in an RCT project systematic case studies drawn from the experimental condition of the RCT, by providing insight into dimensions of the response to treatments that are missing in a typical RCT report. The number of real-world factors that impact on participants' response is so large that even where researchers include measures of critical variables (such as the therapeutic alliance, or the credibility of the treatment), infor-

mation about other important factors will simply not be available. The same is true for factors that impact on the enormous variability across participants in response to treatment. Qualitative studies, and case studies in particular, can bring these factors sharply into focus and provide a basis for guidelines for clinicians in how to deal with them in practice.

We therefore recommend that reporting a small set of representative systematic case studies becomes a mandatory part of the scientific reporting of studies evaluating psychological treatments through RCTs. This would balance the reporting of group comparisons and effect sizes, and would allow a focus on the process of treatment and the factors that affect its delivery in specific cases and context. Given that electronic publication need not have the same space limitations as print publication, the full case studies might be included in a separate online Appendix to the journal in which RCTs are reported. However, the conclusions of the article should be based on combining the perspectives and insights gained from both methods, and selected material from the systematic case studies should be incorporated into the main article.

In the context of the above, we propose that in addition to the RCT and case studies, a comprehensive mixed methods strategy should also include a third evaluative component in which questions are asked about the process and implementation of the research plan (Teddlie & Tashakorrie, 2009). For example, in multisite studies, conflicts between the researchers and the managers of the research site (hospital or clinic) may lead to steps that compromise the research protocol. There may be similar conflicts between researchers and clinicians who feel that an inappropriately rigid protocol has been imposed on a clinical situation. At some sites, there may be practical problems such as limited availability of therapy rooms or an environment that is noisy. These types of factors are likely to affect the data collected, but remain hidden in the report of quantitative results where the impact on scores is simply ignored, or statistical procedures are employed for dealing with "missing data."

Finally, we believe that for practitioners who are asked to follow treatment protocols in ways that are at odds with their need for situational, clinical responsiveness and even with their professional judgment, the kind of mixed-method study described here can be a most important useful resource and reference point.

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Spotlight on a Mentor • Dr. Scott Coffey

The ABCT *Spotlight on a Mentor* program aims to recognize excellence in mentorship by profiling a selection of exceptional mentors within the membership of ABCT. We are pleased to present an interview with our most recent spotlighted mentor, Dr. Scott Coffey.

Scott F. Coffey, Ph.D., received his Bachelor of Science degree from Arizona State University and his Ph.D. in Clinical Psychology from the University of Mississippi. He completed his internship at the Medical University of South Carolina (MUSC) followed by a Postdoctoral Research Fellowship, sponsored by the National Institute on Drug Abuse, focused on the co-occurrence of addiction and posttraumatic stress disorder (PTSD). He is Professor and Director of the Division of Psychology in the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center and is the Vice Chair for Research. His research interests, funded by the National Institutes of Health and the Substance Abuse and Mental Health Services Administration, include mechanisms that initiate or maintain substance use disorders, PTSD, the co-occurrence of PTSD and substance abuse, psychotherapy treatment development, and impulsivity.

Within the Mississippi Psychology Training Consortium, Dr. Coffey has formally mentored 6 postdoctoral research fellows and 11 psychology residents (the term for "psychology interns" at this site) and has informally mentored numerous psychology residents and psychology graduate students. Dr. Coffey, along with Dr. Julie Schumacher, leads a 12-session grant-writing seminar directed at psychology residents within the Mississippi Consortium. Through this activity, Dr. Coffey has an opportunity to provide focused, limited mentoring on the process of successful grant writing. For his research mentoring efforts, he was awarded the Faculty Research Mentor Award from the Mississippi Consortium in 2011-2012, 2013-2014, and 2015-2016. He was also honored with the 2009-2010 Faculty Clinical Mentor Award from the Mississippi Consortium and was named Teacher of the Year in the Residency Training Program in Psychiatry at the University at Buffalo.

Dr. Coffey received nominations from seven former trainees for the Spotlight on a

Mentor award. The nomination letters praised Dr. Coffey for his exemplary clinical and research mentorship. Specifically, Dr. Elizabeth Nosen wrote: "Dr. Coffey is an amazingly dedicated, considerate and caring mentor. He clearly prides himself on meeting students where they are and providing very honest and constructive feedback to help students take whatever next step they desire. He also has a keen sense of what kind of guidance would be useful to students, whether that be clinical advice related to handling difficult cases and collegial relationships or provision of in-depth coaching and walk-throughs related to filling gaps in one's CV and navigating job markets, post-doc interviews, salary negotiations and NIH grantsmanship. Dr. Coffey wants everyone he mentors to succeed and he is willing to go above and beyond to make this happen."

Another former trainee, Dr. Rita E. Dykstra, spoke about Dr. Coffey's clinical mentorship: "I was fortunate to have him as my clinical mentor on internship, and I can honestly say that I left a better clinician because of his feedback and teaching. He helped me learn to be kind and compassionate during treatment while still encouraging clients to do the 'hard work' necessary for a successful treatment outcome. It's rare to find someone who is equally committed to their research and to serving clients, and Scott was a fantastic mentor in this regard. Scott is truly the embodiment of what it means to be a scientist-practitioner."

Dr. Dykstra went on to state, "When Scott gives you advice, it's not based on his personal beliefs, it's based on what he thinks is best for the person in that particular situation and on years as a successful clinical psychologist and researcher. In the years since I completed internship, Scott is still one of my go-to people when I need professional advice. I place a high value on his opinions and professional judgments and have the utmost trust in the advice he gives."

Dr. Erin Berenz described her mentorship relationship with Dr. Coffey this way: "Dr. Coffey is committed both to high-quality research and clinical training, which is a rare combination. I feel so privileged to have had the opportunity to train with him on internship, and to be able to continue working with him today. Given the strength of our relationship, which is largely based in Dr. Coffey's generosity in

mentoring me and fostering my professional development, Dr. Coffey and I have continued to collaborate on manuscripts, conference presentations, and NIH grant applications. I would not be the professional I am today without having him as a role model.”

Finally, several of Dr. Coffey’s former trainees credited Dr. Coffey with future professional achievements. For example, Dr. Kathryn A. Roecklein wrote, “I attribute to him much of my ability to obtain a tenure track [faculty position] at the prestigious University of Pittsburgh in the Clinical Psychology program, and independent NIMH funding for my work. He was immensely helpful when it came time to negotiate when I had an offer in hand.”

Similarly, Dr. Andrew K. Littlefield described the role that Dr. Coffey’s mentorship played in his professional trajectory: “There are multiple times each week that I ask myself, ‘What would Scott Coffey do?’ I ask this not only in terms of how he might reach critical clinical and/or research decisions, but also how he would tactfully approach and manage interpersonal exchanges with his mentees. Scott certainly highlighted that mentorship IS a process and a continual one at that. I think overall Scott ‘taught’ mentorship by example. For instance, he provided mentorship on all stages of a novel prospective data collection that I was able to complete during my internship year. This project was invaluable to my research career, and I have little doubt that having this research experience directly contributed to me getting an offer to be an assistant professor following my internship year. This exemplification of generosity has impacted my own behavior.”

Dr. Coffey responded to questions from ABCT’s Academic Training and Education Standards Committee about his experience and goals as a mentor, as well as his mentorship philosophy and mentorship practices.

For how long have you engaged in the type of mentoring that you engage in now?

Since coming to the University of Mississippi Medical Center and joining the Mississippi Consortium in 2004, I have sought to have a close relationship with one to two psychology residents each year and my postdoctoral fellow. Although I am available and frequently meet privately with all 11 residents, particularly when the residents are negotiating faculty position offers or have grant-related ques-

tions, I tend to focus my time and efforts on the psychology resident assigned to me as a research preceptee, my postdoctoral fellow, and, on occasion, one additional resident.

What type of mentor do you aspire to be? Do you have a mentorship philosophy?

Relatively early in my career, I realized that 10 to 20 years after I publish my last article, I will no longer be cited in peer-reviewed papers unless I happen to publish a seminal work. Given the definition of the term “seminal work” and the specificity of my research area, I recognized it was unlikely that I was going to publish a seminal work. I continued to believe that my research was, and is, important, but I now recognize that it is a building block that is part of a much larger project. It is my hope that my research will play a part in helping alleviate human suffering and it might affect the trajectory of the field, but it is far from lasting. However, effectively mentoring junior colleagues and trainees has the potential to have a much more enduring impact on the field and the lives of the mentees. So, the type of mentor I aspire to be is one that will have a lasting impact on behavioral psychology through the impact the mentor has had on his mentees.

What are your strengths as a mentor?

I believe my most important strength is a willingness to spend time and to listen to the needs of a person seeking my help. It is my goal that the individual in front of me will receive my undivided attention, and, I believe, this is an important first step in mentoring. I enjoy meeting with young academics, and I have experience in two important and related issues they will face: how to negotiate an academic position, how to develop a fundable program of research, and how these issues are interwoven. For example, it is important that trainees don’t apply for faculty positions at locations that are unable to support their program of research and I find this important point is sometimes overlooked in the anxiety-driven search for a first academic job.

As a clinical mentor, it is my hope that one of my strengths is that my mentee recognizes how important I think effective cognitive behavioral therapy is in alleviating human suffering and why I think it is important to help alleviate human suffering. Perhaps another strength I have as a mentor is simply the fact that while I

greatly enjoy research and providing clinical care to patients, the most enjoyable aspect of my job is mentoring young academics. It is my hope that this love for mentoring comes across in my interactions with my mentees.

Whom do you perceive to be your most influential mentors? Describe the main lessons that you have learned from your mentors.

I have had numerous wonderful mentors throughout my career and if I did not have their wise counsel, I would not have the satisfying career that I have enjoyed to date. However, two mentors stand out because they helped me a great deal during a period of career transition: Bonnie Dansky, Ph.D., and Kathleen Brady, M.D., Ph.D. Although I was interested in research coming into graduate school, I did not pursue a research track when I first entered graduate school. However, over time, I became more and more interested in research and was fortunate enough to match at an internship with ample research opportunities: the Charleston Consortium. The research preceptor assigned to me was Bonnie Dansky and I was her first preceptee. She was a young Assistant Professor, only a couple of years older than I was. Although I learned many things from Bonnie, such as how to be a generous mentor, how to assess the strengths and weaknesses of a preceptee, how to focus on the needs of the preceptee, how to help a trainee network professionally, etc., the most important lesson I learned was how to have an appropriate relationship with a mentee. Bonnie and I were approximately the same age and had many overlapping interests outside of work and it would have been very easy for us to become friends. It was very clear to me from the beginning of our relationship that this was not going to happen during internship. Bonnie established excellent boundaries that allowed us to be friendly with one another without becoming friends. Since we were not friends, it was very easy for her to give me the feedback I needed when I needed it and for the relationship to focus on my professional needs; the relationship did not need to be balanced. I believe this aspect is central to a healthy mentoring relationship and I had this style modeled very well for me early in my career. As my role changed at MUSC and other mentors replaced her, she and I became close friends and remain friends to this day.

My other mentor during this transition phase was Kathleen Brady. Kathleen was one of my mentors while I completed my National Institute on Drug Abuse-funded postdoctoral research fellowship at MUSC. From Kathleen, I learned how to be an unselfish mentor. For example, during the 1990s, impulsivity was all the rage in the addictions literature. While I was familiar with the literature, I was focused on my primary research interest investigating the relationship between PTSD and substance use craving. During a meeting with Kathleen in which we were discussing impulsivity, she offered to send me to the laboratory of the late Charles Schuster, Ph.D., former director of the National Institute on Drug Abuse. His group was very involved in studying impulsivity in addicted individuals, so I quickly took her up on her generous offer. This opportunity led to my first grant, an institutional grant from MUSC, and a publication that has turned out to be my most frequently cited peer-reviewed publication. It also served as pilot data for a

NIMH-funded R21 focused on impulsivity and emotion dysregulation in borderline personality disorder with and without substance use disorders. These experiences have enabled me to mentor students, such as Andrew Littlefield, Ph.D., on impulsivity-focused projects that, I believe, have furthered their careers. This whole line of research and mentoring in the area of impulsivity is the ever-growing, outward-moving impact of a single generous act, much like a small pebble dropped in a body of water. It is my hope that over the course of my career I will continue to drop small pebbles in water.

What advice would you give to other professionals in your field who are starting out as mentors?

If a faculty member is just beginning to mentor others, such as students and fellows, it may be that this individual is relatively junior. For these individuals, the best advice I can provide is to maintain clear boundaries in the mentor-mentee

relationship. Maintaining clear boundaries in mentor-mentee relationships can be challenging early in an academic's career because the mentor might have more in common with the mentee than he or she has with other faculty members. However, it can be difficult to simultaneously manage the dual relationship of mentor and friend, so my advice is to avoid the dual relationship. ■

Spotlight on a Mentor interviews are presented by ABCT's Academic Training and Education Standards Committee with editing by Helen Z. MacDonald. If you are interested in learning more about Dr. Coffey's work as a mentor, to learn about other exceptional ABCT mentors, or to add your mentorship profile to the ABCT Mentorship Directory, please visit www.abct.org/mentorship/.

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NEWS

Featured Award Recipient: Outstanding Contribution by an Individual for Education/Training

Katherine J. W. Baucom, *Chair, Awards & Recognition Committee*



This month we are pleased to feature Christine Maguth Nezu, Ph.D., ABPP, recipient of the 2016 Outstanding Contribution by an Individual for Education/Training

Award. This award recognizes ABCT members who have provided significant contributions to the education and training of behavior therapists.

Dr. Maguth Nezu is a Professor of Psychology and Professor of Medicine at Drexel University. She has maintained a licensed practice for nearly 30 years (Nezu Psychological Associates, of which she is Clinical Director of Training) and is board certified in Clinical as well as Behavioral and Cognitive Psychology. Over the course of nearly 30 years, she has provided training in behav-

ior therapy to hundreds of doctoral students, practicum externs, psychology interns, and postdoctoral supervisees. As co-developer and master trainer of Contemporary Problem-Solving Therapy (PST), Dr. Maguth Nezu has provided 24 training workshops at ABCT and the WCBCT, as well as scores of other national and international workshops on PST. She has trained nearly 1,000 VA and DoD professionals in the nationwide roll-out of Moving Forward, a PST-based intervention she co-developed to enhance resilience and reduce emotional distress.

In addition to this long list of contributions, Dr. Maguth Nezu has made substantial contributions through her participation on and leadership of the American Board of Professional Psychology (ABPP). She was pivotal in the designation of Behavioral and

Cognitive Psychology as a specialty, and represented the specialty as a member of the Board of Trustees of the ABPP for 10 years. She is a past president of ABPP and the recipient of the 2014 Russell Bent Award for Distinguished Contributions to ABPP.

Although this award recognizes professional accomplishments, at the Awards Ceremony in New York we learned that Dr. Maguth Nezu's training in the principles of behavior therapy permeates all aspects of her life. Her children and grandchildren sent the following note that was read at the ceremony: "Your 3 children and 4 grandkids want to send their love and admiration on this special occasion. We can't imagine a more appropriate honor for our mom given how you were able to teach and train us to solve problems, live passionately, and try our best. Although we cannot be physically present in NYC today, we are there in spirit and incredibly proud of you for getting this award. We know dad (Dr. Art Nezu) feels the same way! Much congrats, mommers!—From Frank, Ali, & Linda and the 4 grandkids."

Given the extent of her direct or indirect impact on the training of countless ABCT members in cognitive and behavioral therapy, the Awards Committee agreed with her nominators that "it [was] time for ABCT to recognize her with this distinguished award." ■

Addictive Behaviors Special Interest Group Early Career Achievement Award: Jennifer Merrill

Eleanor L. Leavens, *Oklahoma State University*



The Association for Behavioral and Cognitive Therapies Addictive Behaviors Special Interest Group recognizes members who have made a substantial impact in the field of addictive behaviors. At the 2016 ABCT Convention, we honored Dr. Jennifer Merrill, who was nominated and selected for the Early Career Achievement Award. This award is presented biannually to a member who has made substantial early career contributions to the field of addictive behaviors. Jennifer Merrill received her Ph.D. from the University at Buffalo in 2012. She is currently an Assistant Professor (Research) at the Center for Alcohol and Addiction Studies in the Department of Behavioral and Social Sciences at Brown University. In their enthusiastic recommendations, Jennifer Merrill's mentors describe her as "highly productive" and note "the depth of her work in multiple areas defines an impressive trajectory as an early career scientist." Only 4.5 years post-Ph.D., she has over 40 peer-reviewed publications with numerous others under review.

Dr. Merrill has primarily focused on investigating the etiology and consequences of alcohol misuse among young adults, with a particular interest in the subjective evaluation of alcohol-related consequences. During her graduate training, she earned an NIH F31 from NIAAA. In her dissertation, she showed that when upperclassmen perceive their recent consequences as particularly negative, they engage in downward shifts in drinking in the short term (Merrill et al., 2013). She later replicated and extended this study in a larger sample of underclassmen, followed over 2 years (Barnett, Merrill et al., 2015). She has documented that subjective evaluations mediate the relationship between two other antecedent variables (perceived consequence norms and prior experience with consequences) and alcohol use (Mer-

rill et al., 2013). Recently, she documented both between- and within-person predictors of consequence evaluations (Merrill et al., 2016). Passionate about this line of research, Dr. Merrill has secured a K01 award from NIAAA to support implementation of an ecological momentary assessment study to examine whether evaluations of consequences in real-time are associated with later drinking. Her work in this area highlights the etiological importance of how students personally experience alcohol consequences and is likely to inform interventions for young adult drinkers.

Dr. Merrill has also been adding to a growing body of literature on pregameing among college students. Specifically, she examined risk factors and reasons for pregameing (Read, Merrill, & Bytschkow, 2010), and helped to develop a measure on motivations to pregame (Bachrach, Merrill, Bytschkow & Read, 2012). She later adapted the Timeline Follow-back interview to assess links between pregameing behaviors and associated alcohol-related consequences in a fine-grained manner. She used multilevel modeling to demonstrate that pregameing put students at greater risk for consequences at the event-level (Merrill et al., 2013). Most recently, she examined descriptive pregameing norms as a predictor of pregameing, and theory-based moderators of this association (Merrill et al., 2016).

In addition, she has a growing interest in mobile-health interventions for alcohol misuse, and recently completed a pilot study to deliver accurate descriptive and injunctive norms information to college student drinkers, via text messaging, in hopes of impacting their drinking attitudes and behaviors. She has current interests in qualitative methods, ecological momentary assessment, advanced data analysis, and intervention development.

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The Cruel Postdoctoral Tutelage of Dr. Mei

Jonathan Hoffman, *Neurobehavioral Institute*

Dean McKay, *Fordham University*

“OCD treatment is a dish best served
a la carte”

—Old CBT Proverb

My advisor, Dr. Bill, had scheduled a sendoff meeting with me after graduation. I’d finally earned the “comma Ph.D.” after my name. Like dragon images branded on the forearms of Shaolin temple grads, this sacred lettering would forever be in my signature.¹

I swaggered into Bill’s office like an ABPP in Behavioral and Cognitive Psychology. After all, I was about to begin two years of postdoctoral residency specializing in obsessive-compulsive disorder (OCD) with the fabled Dr. Mei. Dr. Mei was Bill’s mentor, and had been a highly sought after supervisor for ages. I had obtained this coveted but enigmatic posting—no applicant had been accepted in recent memory—only thanks to the philosophical backing of Dr. Bill in her recommendation letter.

To prepare for this “beyond the match” APPIC-approved training program, I had immersed myself in the latest manualized interventions for OCD. Endless hours of role-playing as both therapist and patient while leaping back and forth between chairs in my living room had helped me learn each exact step in my manuals by heart. My “manuals’ kata” was flawless.

I told Dr. Bill all about my prowess. Then she said, “Kiddo, I can see you’re feeling pretty good. I don’t want to be a Dr. Debbie Downer, but there’s a historical case example that I need to tell you.” She stopped to play her dizi, a long bamboo flute. “Ah, tenure,” I thought.

The parable commenced, “Once upon a time at the very first ABCT annual conference, in around the year one-double-knot-

three . . .”² (Of course it wasn’t known as ABCT back then.)

And continued, “. . . coming from opposite directions toward a salon to hear a panel called ‘The Great Wall of China as a Metaphor for Denial,’ a talented young postdoc and an infinitely powerful Fellow named Dr. Mei crossed paths. Dr. Mei, in an almost unfathomable display of generosity, gave the postdoc the slightest of nods. The nod was not returned.”

Bill mused, “Now was it the intention of the resident to insult Dr. Mei? Or did he just fail to see the generous social gesture? That remains unknown. What is known were the consequences.” The resident had soon realized his grievous affront and tried to console Dr. Mei, only to find him “in . . . consolable.” < Pause for effect > “So began the massacre of the postdoc’s record of supervised hours toward licensure.” < Flute solo > “And so the legend of Dr. Mei’s Five-PowerPoint-Exploding-Reputation technique began.”³

Bill had wrapped up our meeting saying, “one of the things I’ve always liked about you, Kiddo, is < flute interlude >, you appear wise beyond your years. So, allow me to impart a word to the wise: Whatever—WHAT-EVER—Dr. Mei says, reinforce it. If you flash, even for an instant, any prepackaged therapeutic verbiage, or if you throw him any Third Wave CBT sass, he will snap your treatment plans like they were twigs, and that will be the narrative of you. Now remember, no post-truth explanations, or referencing your adulting workshops, at least for the first year or so . . . Adios.”

Ah, so the point of the parable had emerged: Dr. Bill was concerned that my infatuation with manualized OCD treatment might be my undoing with Dr. Mei. Of course, I respected Dr. Bill but frankly . . . she

was old school. She always wanted me to think of metaphors for action in response to patients’ interests and readiness for change in any given moment. Honestly, who had time for that with so much research to consume? Anyway, I had no doubt that manualized OCD interventions were the future.

Not long afterwards, I tackled the 100 steep and overgrown rock-hewn steps to the OCD treatment center. Dr. Bill had warned me, saying, “Ugh, just recalling those stairs makes my back ache, and not only that, so many new patients struggle to get up them due to the asymmetry and the need to count.” When I reached the top, Dr. Mei was waiting in an executive-style office chair blocking the entrance, compulsively flicking at his long white beard (“There’s probably an excellent manualized app for that,” I thought). I walked toward my new master clinician and put the backpack carrying my arsenal of manuals down. Then I greeted him saying, “I am unworthy to be your student.” After observing me closely, Mei sighed deeply and said, “Bill is your advisor, is she not? “Yes,” I answered. “She’s informed me you’re not entirely unschooled in OCD treatments. What clinical training do you possess?”

“I am proficient in the exquisite art of manualized exposure-based interventions for OCD,” I answered proudly, with just a soupçon of arrogance. In response, Mei unleashed a torrent of invectives about my shortcomings as a clinician. Giving him the benefit of the doubt, I wondered if this was coprolalia or if it was a guilt-induced symptom from his “massacre” of the ill-fated postdoc, a.k.a. Dr. Jackson. (Of course, thanks to Dr. Bill, I knew it was best not to share my opinions with my new supervisor.)

Once he was finished swearing at me, Mei calmly asked, “Do you consider yourself my equal as a practitioner-scientist?” I indicated I did not (and said, again just to myself, “It’s scientist-practitioner, you dolt”), to which he replied, “Let’s see how good you really are.” Whirling his fighting staff around at incredible speed, he attacked me with a series of rapid-fire challenges to my clinical acumen that were so intellectually rigorous that the “manualized CBT styles” I had practiced were useless. I was “as helpless as a worm fighting an eagle,” Dr. Mei observed.

But as soon as I had totally capitulated to his overwhelming therapizing dominance, Dr. Mei’s stern countenance softened. He gently inquired, “Is it your wish to understand the mysteries of evidence-supported OCD interventions for diverse clinical presentations?” “Yes,” I whimpered, not so

¹If you’re not well versed in Q & U, please view *Kill Bill* Vols. 1 and 2.

²Apologies to Q, a.k.a. Quentin Tarantino, for mangling his classic dialogue in this piece of work.

³The postdoc, who revealed himself years later as Dr. S. L. Jackson, who published extensively in *Organizational Behavior* after his debacle with Dr. Mei, particularly on the famous “Marsellus Method.” Prior to “the massacre” his speech was filled with profanities. Afterwards, whatever he said was quickly followed by, “while I have been most cautious in my phrasing, I hope I have not inadvertently offended anyone.”

much out of meekness but because he had me in an excruciatingly painful Chicken Wing Wrist Lock.

So began my postdoctoral training under the cruel tutelage of Dr. Mei.

Day 1

I was told to design three recommendations for each OCD case discussed in the morning staffing, but to refrain from mentioning them. Although I didn't get the point, I dutifully obeyed.

Day 5

What a week! I'd done nothing but stay quiet, and do the required readings—which were manga written entirely in Japanese. And I don't speak Japanese! I had also been told I would be examined on their plot elements but never was. I was beyond confused; and jealous. I saw on Snapchat that my peers at the other OCD training programs were already filling in the blanks on hierarchy worksheets.

Day 8

When would my real training in how to treat OCD begin? Where were the manuals? I hoped that the first week of my program would turn out to be some traditional hazing we'd all get a big laugh from later. Still, recalling the importance of being sensitive to different CBT cultures, I persevered. I was told to binge watch the entire "Drunken Master" martial arts film series. What this had to do with treating OCD I couldn't imagine. I thought nothing could've been more frustrating than having been a teaching assistant for Stat. 101, but this was.

Day 22

It had been one bizarre task after another since my first day as a postdoc, and still, no sign of an OCD manual. And yet . . . the patients in the clinic seemed to be progressing. My assignment on this shift was to conduct a literature review of Marvel's Avengers, highlighting the various metahumans' personality deficits and illustrating them with quotes from "Ant-Man while acting like I was the Professor from the X-Men." What a juggling act! I was also assigned to read an unintelligible tBT "Lighter Side" series called "CBTers Assemble."

Day 47

This was a new low. Dr. Mei said, "Kiddo, no matter what a patient verbalizes, respond with a joke." An adolescent in our

program said, "I had the thought that unless I knocked on wood in three series of eight perfectly timed taps someone in my family would get sick." I responded, "How 'thoughtful' of you." As the day progressed, my jokes improved, albeit slightly. An older gentleman whose OCD interfered with his marriage complained that his wife would not go to the gym with him, to which I quickly replied, "Well you know, some relationships just don't work out." Nonetheless, I was determined to see my training program through, if only to prove to Drs. Bill and Mei that I was worthy indeed.

Day 60

Each day I thought, "It can't get any worse." But Dr. Mei gave me his most bizarre instruction yet: to wax and then unwax his car, a gleaming Datsun 240Z. I could not experientially tolerate him one second longer. Yet, staying professional, I clenched my teeth and said, "Dr. Mei . . . I came here for training in OCD treatment, but I haven't learned . . . a . . . single . . . thing . . . in . . . two . . . months!"

His immediate reaction was to assault me with vignettes of highly complex and refractory OCD cases. But this time, my responses were instinctive and uncannily on-point—I was using OCD treatment-relevant concepts and strategies at a level of clinical acumen that I had never experienced. Thought-action fusion. Boom! Inflated sense of responsibility. Boom! Overvalued ideation; Intolerance of uncertainty; The "just right" error. Boom! Boom! Boom! But I didn't plan any of these concepts, they were just there. I also somehow knew how to contextualize my clinical protocols in the proper theory. At will, I was utilizing Inhibitory Learning Theory, even Neural Network Models, as conceptual frameworks for exposure-based therapy.

But how had I learned all of this? Even stranger: I wasn't relying on what I had memorized in the OCD treatment manuals, not at all! I was flexibly and dynamically utilizing principles and neuroscience-based mechanisms of action, adapting to what each patient was doing in the moment rather than imposing any a priori structure. As our sparring ended, Dr. Mei simply bowed and stated, "You have been set free from the manual, grasshopper." I was taken aback by the insect reference, but it was still a high compliment, and as I had not

received any the past two months, I was grateful.

Then I had an epiphany: OCD treatment could not live by manual alone. As Bruce Lee, the founder of Jeet Kune Do, the art of fighting without a fixed methodology, said:

"Don't get set into one form, adapt it and build your own, and let it grow, be like water. Empty your mind, be formless, shapeless—like water. Now you put water in a cup, it becomes the cup; you put water into a bottle it becomes the bottle; you put it in a teapot it becomes the teapot. Now water can flow or it can crash. Be water, my friend."

To me, in the blink of an eye, Dr. Mei had metamorphosed from being a detested tormentor to an honored mentor. I realized what he and his unorthodox "teaching way" had accomplished; he'd transformed me from a clinical mechanic into a clinical-scientist-warrior. I finally understood that Dr. Bill had been trying to save me from myself. Manuals Schmanuals! What a lucky postdoc resident I was! I, Dr. Beatrix Kiddo, told Dr. Mei I was ready to be like water in conducting OCD treatment.

Beaming with satisfaction, he said, "Call me Pai." Then he put a pebble in his hand and asked me to try and snatch it before he could close his fingers. I failed. He said my training would be concluded when I could do this, inherently linking it to mastery of skills not a set time. Then he said, "okay, if you can't grab the pebble, see what happens when you pull my finger."

That infantile comment from Dr. Mei summed up the essence of OCD treatment. It is "never a straight line. It's a forest. And like a forest it's easy to lose your way."⁴ I now understood that weird "Old CBT proverb." This treatment, at its highest level, must be constantly renewed and reimagined in the instant of its application, "a la carte." Its complexities cannot be learned from the pages of a manual any more than the nuances of Kung Fu. "Beyond the manual" OCD treatment can be deadly serious, opaque, frustrating, take the therapist and patient down many blind alleys, and even be quite silly, especially the exposure exercises—but for all you Kiddos out there like me, that's the process you'll need to master to truly learn the art of practicing this clinical science.

. . .

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⁴This is how the character Hattori Hanzo, an incomparable swordsmith, described "revenge" in *Kill Bill*. FYI, in history there was a famous ninja with this name.

ABCT | *Welcome, New Members!*

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Alison Harvey
Christina Hatgis
Marit Hauschildt
Catherine Hearne
Karen Hebert
Craig Henderson
Susan Hepburn
Jacqueline Hersh
Emma Leah Hettrich
Denise Hien
Daniel Hilliker
Alicia Hirsch
Hung-Yi Cindy Ho
Kathryn Hoffses
William Horan
Kristin Huang
Jennifer Hughes
John Hunsley
Roxann Intriligator
Marni Jacob
Marcia Jensen
Beth Jerskey
Melissa Johnson
Monique Johnson
Monica Johnson
Janice Jones
Dan Josua
Laura Juliano
Roselinde Kaiser
Fergus Kane
Michelle Kaplan
Danielle Kaplan
Ayse Kart
Mu Kyung Kim
Jiyon Kim
Norman Kim

Kerri Kim
Shawn King
Birgit Kleim
Sarah Kleiman
L Suzanne Klenck
Sarah Kopelovich
Katherine Krawiec
Pieter Kruger
Emily Krusheski
Elyse Kupperman-
Chaifetz
Emily Kuschner
Christina Laitner
Yulia Landa
Frederic Langlois
Denise Lash
Maria Laszcz
Amy Lawrence
Evin Lawson
Erin Lawton
Alison Leary
Michelle LeRoy
Jill Levitt
Beth Lewis
Maya Libben
Keri Linas
Elizabeth Lloyd-
Richardson
Michelle Lohnes
Susan Longley
Eliot Lopez
Ricardo Lucena
Victoria Lusk
Joseph Madonia
Carla Marin
Ane Martinez-Lora
Craig Marker
Alvina Marris
Kimberly Mathewson
Kristopher Mathis
Ali Mattu
Tori Mauseth
Keith McBurnett
Diane McGuffin
Heather McIssac
Jennifer McKelvey
Andrea McLaughlin
Lachlan McWilliams
Roslyn Mendelson
Sally Merry
Rachel Merson
Sarah Mintz
Roberto Montes
Tina Montreuil

Luis Morales Knight
Jennifer Muehlenkamp
Chad Muffley
Kristen Mulcahy
Elise Munoz
Karen Munoz
Amy Murrell
Enrique Neblett
Sandra Neer
Charles Neuhoff
Thanh-Lan Ngo
Maressa Nordstrom
Sebastien Normand
Seth Norrholm
Gareth Nortje
Lies Notebaert
Mary O'Brien
April O'Grady
Megan Olden
Julianne Oliver
Kaori Osawa
Jorge Osma
Howard Osofsky
Joy Osofsky
Claire Oxtoby
Anthony Papa
Holly Parker
Jeffrey Parsons
Laura Pass
Mia Paustian
Beth Pearson
Deborah Pease
Katie Peinovich
Michelle Pemble
Alissa Pencer
Melissa Peskin
Naomi Peyerl
Philip Pierce
Harry Pitsikalis
Helene Poitras
Jerlym Porter
Mandy Porter
Thomas Power
Sally Powers
Laura Pratchett
Jennifer Primack
Christine Rabinak
Michelle Ramos
Tali Raviv
Felice Reddy
Cassie Reeve
H. Jonathon Rendina
John Paul Reyes
Barry Ries

Erin Rivelis	Heddie Tinker	Molly Cox	Doni Silverstein	Valerie Everett
Courtney Rodrigue	Timothy To	Sarah Craig	Elizabeth Smyth	Margaret Farney
Deborah Rosenberg	Meghan Tomb	Julia Craner	Lauren Steffel	Julia Felicione
Kate Rosenblatt	Tea Trillingsgaard	Erin Eadie	Suzanne Straebler	Michelle Ferris
David Rosenstein	Beth Troutman	Tara Emrani	Erin Taylor	Natalie Finn
Jeffery Roskelley	Julia Turovsky	Sherry Fawcett	Kristel Thomassin	Courtney Forbes
Luba Roytburd	Alanna Updegraff	Hope Forbes	Mary Toolan	Anna Foulser
Amy Rubin	Nehal Vadhan	Nicole Fowler	Jay Trambadia	Aubrey Francavilla
Lesia Ruglass	Nady Van Broeck	Pablo Gagliesi	Letitia Travaglini	Aaron Frazier
Meredith Rumble	Saskia Van der Oord	Yuliana Gallegos	Aaron Trinh	Madelyn Frumkin
Paul Salkovskis	Carmelo Vazquez	Rodriguez	Julia Vahlsing	Alisa Garner
Matthew Sanders	James Vermilyea	Kristine Gerwell	Jorge Valderrama	Anna Gilmour
Douglas Scambler	Peter Vik	Karen Ghelani Ghelani	Jared Van	Karen Ginsburg
Amanda Scanlon	Denise Walker	Loren Gianini	Johanna Vigfusdottir	Juan Gonzalez
Jack Schapiro	Kathryn Walker	Deborah Golden	Duyen Vo	Nazc-a-ru Gonzalez
Charles Schrier	Megan Wallace	Arlene Gordon-	D. Catherine Walker	Jonathan Goode
Brandon Scott	Marion Wallace	Hollingsworth	Terrance Walker	Courtney Gregor
Kay Segal	Kate Walsh	Andrea Gottlieb	Emma Warnock-Parkes	Julianne Griffith
Rhonda Seiman	Kristen Walter	Kelly Graling	Kerry Wells	Iлана Haliwa
Shannon Self-Brown	Carl Weems	Brittany Hall	Miriam Wollesen	Maria Hanelin
James Seltzer	Jessica Weiss	Anna Harrison	Caroline Wright	Shannon Harper
Mavis Seow	Christopher Wenner	Jennifer Herring	Ali Yurasek	Kathryn Harris
Kelly Serafini	Patricia Wightman	Catherine Herrington	Imad Zaheer	Kirstie Herb
Lacey Seymour	Daniel Williams	Regina Hiraoka	Deborah Zlotnik	Emily Hockenberry
Daniel Shapiro	Jayne Williams	Olta Hoxha		Mira Hoffman
Jack Sherratt	Kenneth Wilson	Margaret Hunt	<i>Postbaccalaureate</i>	Jordan Hoffmeister
Benedikt Sigurdsson	Cami Winkelspecht	Brian Kaufman	Kala Allen	Kalyan Holmes
Stacy Simon	Til Wykes	Stephanie Keller	Murat Artiran	Birgitte Hovland
Erica Simon	Paula Yanas-Lukin	Bin-Na Kim	Isabel Augur	Jessica Hruschak
Jo Ann Sirey	Fatih Yavuz	Megan Kloep	Samantha Auty	MacKenzie Hughes
Nicole Sirrine Marshall	Elizabeth Yeater	Abigail Lambert	Margaret Baer	Franklin Huntington
Amer Smajkic	Michael Zarabi	Jan Leonardi	Kirsten Baker	Emily Ivey
Deborah Smyth	Sigal Zilcha-Mano	Svetlana Levak	Maha Balouch	Laura Jamison
Mary Solanto	Heidi Zinzow	Cheri Levinson	Katherine Benjamin	Jeremy Karp
T. (Soma)		Ari Lowell	Emilie Bertschinger	Michelle Keck
Somasundaram	<i>New Professional</i>	Alexandria Luxon	Kavita Bhandari	Jasmine Kim
Sue Sonshine	Leah Adams	Ana Carolina Macchione	Katherine Bogen	Yehsong Kim
Erin Sparapani	Rizwan Ahmad	Alyssa Mandel	Simone Budzyn	Savannah King
Anthony Speier	Dana Anderson	Doron Marbe	Maira Butler	Kiarra King
Elizabeth Spencer	Robin Aupperle	Joseph Meyer	Camila Caballero	Alexander Kinzler
Elana Spira	Kimberly Avallone	Meredith Meyer	Emilia Cardenas	Alexandra Klein
Clint Stankiewicz	Shelley Avny	Nida Mirza	Sofia Cardenas	Madison Knox
Georgia Stathopoulou	Margaret Bockrath	Tina Montreuil	Cintly Celis-de Hoyos	Maya Krek
Sheldon Stern	Michael Boroughs	Stuart Murray	Kathryn Coniglio	Elizabeth Lagbas
Regan Stewart	Yevgeny Botanov	Andrada Neacsu	Kristina Conroy	Lauren Laifer
Randi Streisand	Laura Boucher	Hong Nguyen	Abigail Cooper	Robbert Langwerden
Stefanie Sugar	Abby Braden	Anthony Onyemenem	Samantha Cootner	Adina Lieberman
Aimee Sullivan	Kelsey Bradshaw	Michele Parkhill	Katherine Corteselli	Frances Loeb
Beth Surbeck	Christine Brady	Sheena Potretzke	Rebecca Crochiere	James Madole
Nicole Swain	Amber Brandes	Kristina Reigstad	Spencer Cruz-Katz	Gerald Martin
Vandana Syali	Douglas Brodman	Meg Reuland	Constance Dekis	Colleen Maxwell
Deborah Szanto	A. Meltem Budak	Jennifer Rodgers	Barbara Depreeuw	Ciara McAfee
Christina Theodore-	Teresa Burrell	Vivian Rodriguez	Danielle Deros	Allyson McHugh
Oklot	Matthew Capriotti	Archilla	Katherine DiVasto	Katherine Melz
Kerrie Thompson	Leonardo Caraballo	Johana Rosas	Samira Dodson	Hannah Milhorn
Margret Thorarinsdottir	Ruby Charak	Lilly Rousseva-Stoyanova	Jessica Dowell	Hannah Miller
Katherine Thorpe	Taylor Chesney	Sarah Savoy	Jacqueline Economy	Rose Miller
Hrund Thrandardottir	Carla Chugani	Julia Schirm	Katherine Escobar	Mirinda Morency

Sara Naselsky	Victoria Votaw	Jessica Baltman	Alexandra Bruce	Elise Cohen
Yasunori Nishikawa	Angela Wang	Michelle Bancroft	Dana Bruck-Segal	Abigail Collins
Danielle Novick	Rebecca Weber	Laura Banu	Amanda Bruening	Anthony Colantonio
Lana Nye	John West	Nicole Barle	Lauren Brumley	Giselle Colorado
Emily O`Day	Carol Willner	Jennifer Barney	Jessica Bryant	Sidonia Compton
Daniel Oesterle	Eleanor Wu	Chelsey Barrios	Jennifer Buchholz	Lindsey Conkey
Richard Oring	Anna Yeo	Corinne Bart	Samantha Buchman	Katherine Conover
Shelby Ortiz	Stephanie Yu	Drew Bassett	Leslie Buchter	Catherine Coogan
Nanday-Robin Oti	Kelly Zentgraf	Catherine Baule	Matthew Buczek	Diana Cook
Christopher Owen	Leanne Zinn	Kyly Baxter	Abby Bugbee	Liana Cools
Jacqueline Pabis		Yvette Bean	Thomas Buqo	Maria Cornejo Guevara
Ryan Parigoris	Student	Lisa Beauvois	Kate Burger	Michael Costa
Elizabeth Parisi	Ahmed Abdelkarim	Lee Bedford	Anthony Burns	Allison Cotter
Olivia Peros	Samuel Acuff	Katie Behrhorst	Jamel Burroughs	Kristen Courtney
Lauren Persad	Maris Adams	Ted Bender	Seigie Butler	Alexandra Cowden
Katherine Phillips	Arela Agako	Natasha Benfer	Alexandra Byrne	Hindash
Catherine Pierre-Louis	Nishita Agarwal	Kathy Benhamou	Sofia Cabrera	Cassandra Crangle
Stefania Pinto	Fabian Agiurgioaei	Ashley Bennett	Chelsea Cadle	Jennifer Crawford
Solomon Plonka	Stephanie Ahtarap	Sophie Bennett	Katia Caetano	David Cregg
Noor Qasmieh	Laika Aguinaldo	Gregory Berlin	Sam Cain	Ryan Cummins
Arielle Rabinowitz	Erica Ahlich	Heather Berlin	Casey Calhoun	Fiona Cunningham
Elizabeth Raines	Laura Alba	Angela Berlinger	Christine Call	Julie Cunningham
Katrina Ramsey	Kenneth Allen	Arielle Bernstein	Kathleen Camacho	Angela Dahiya
Yasmin Rey	Desirae Allen	Laura Berssenbrugge	Abigail Camden	Jennifer Daks
Charla Rhodes	Deon Allen	Caroline Betancourt	Kimberly Cameron	Fran Dalis
Samantha Richards	Evan Alvarez	Katherine Bieger	Molly Campbell	Jessica Dalrymple
Ian Richardson	Michael Ambrose	Lindsey Bigham	Tim Campellone	Tiffany Daniel
Laura River	Dorin Amit	Benjamin Billingsley	Megan Carl	Annie Dantowitz
Nazli Rodriguez	Caitlin Anderson	Zachary Blackhurst	Nicolette Carnahan	BreAnne Danzi
Julia Rodriguez	Kirsten Anderson	David Blanchard	Daniel Caroll	Sarah Danzo
Emma Rogers	Kaitlin Andrewjeski	Lauren Blau	Meagan Carr	Matthew Darcy
Rachel Rosen	Laura Andrews	Angela Blizzard	Emily Carrino	Akanksha Das
Allison Rumelt	Carla Antenucci	Chelsea Boccagno	Mikaela Carter	Jordan Davis
Julia Sager	Ligia Antezana	Elizabeth Bodalski	Marquita Carter	Michelle Davis
Christina Sandman	Amber Anthenien	Lindsay Bodell	Laurel Casillas	Jared Davis
Marissa Sbrilli	Moses Appel	Brock Bodenbender	Eleanor Castine	Taylor Day
Samuel Seidman	Brenda Arellano	Jessica Bodie	Jennifer Cataldi	Edward De La Loza
Danusha Selva Kumar	Katherine Arenella	Khalima Bolden	Cynthia Cervoni	Hasse De Meyer
Edmine Serulien	Brian Arizmendi	Olivia Bolts	Wei Ting Chang	Carla De Simone Irace
Allie Silverman	Laura Aronow	Brittany Bonasera	Wendy Chang	Samantha Deana
Alexandra Silverman	Lianna Artessa	Shilpa Boppana	David Charny	Michelle Debski
Grace Simmons	Vinushini Arunagiri	Alice Borodiansky	Shayna Cheek	Levi DeFilipp
Vishnupriya Srivastava	Elizabeth Aslinger	Angeline Bottera	Yun Chen	Christopher DeJesus
Jill Stadterman	Kristina Aspvall	Anne Sophie Boulanger	Stephanie Chen	Cristina del Busto
Migle Staniskyte	Sara Atlas	Couture	Shannon Cheng	Lauren Delaparte
Hillary Stern	Lauren Atlas	Maya Boustani	Emily Cherenack	Ryan DeLapp
Tawni Stoop	Jorge Atuesta	Eugene Boyle	Vien Cheung	Claudia Delbasso
Joy Tajes	Tara Augenstein	Sarah Bragg	Hyein Cho	Alyssa DePasquale
Elizabeth Tampke	Bradley Avery	Ilana Brodzki	Philip Chow	Olivia Derella
Stephanie Thomas	Shaili Babbar	T. Jack Brooks	Michelle Chu	Kimberley Desir
Matthew Thompson	Emily Badin	Julia Brooks	Adam Chuong	Hillary Devlin
Asta Thrastardottir	Rohini Bagrodia	Marlies Brouwer	Christina Chwyl	Andrew Dials
Eric Tiffit	Nancy Bahl	Amanda Brown	Alyssa Ciampaglia	Kelsey Dickson
Krista Tocco	Allison Baier	Ieshia Brown	Sarah Cines	Cara DiClemente
Maria Vardanian	Lorien Baker	Casey Brown	Lindsay Clark	Alexandria DiGuisepppe
Sonya Varma	Myfanwy Bakker	Caitlin Brown	Caitlin Clark	Justina Dillon
Andrew Villier	Jessica Balderas	Tasha Brown	Eleanor Cobb	Samantha DiMeglio
Rachel Vitale	Caroline Balling	Tiffany Brown	Channing Cochran	Andrew Dimond

Allyson Dir	Heather Fleuriet	Gabriella Grimaldo	Sara Honickman	McFarlane
Christina DiSanza	Johanna Folk	Kailee Groshans	Caitlyn Hood	Jennifer Kelly
Laura Distel	Cameron Ford	Gabrielle Groth	Christian Hoover	Chris Kelly
Louise Dixon	Brittany Foreman	Jessica Gruber	Melissa Hord	Gail Kemp
Sara Dobosh	Zeleyka Fowler	Denise Guarino	Arielle Horenstein	Jamie Kennedy
Michael Dolsen	Kathryn Fox	Natasha Gulati	Shabnam Hossein	Traci Kennedy
Jim Doorley	Melanie Fox	Hannah Guz	Kristen Howard	Sarah Kennedy
Morgan Dorr	Brandon Frank	Eleonora Guzman	Dennis Hoyer	Shane Kentopp
Halina Dour	John Freeman	Edna Gyamfi	Jianan Hu	Shira Kern
Taylor Dovala	Eiko Fried	Anna Hall	Xieyining Huang	Anna Kessler
Sarah Dreyer-Oren	Laura Fritzsche	Elizabeth Hallock	Stephanie Hudiburgh	Lauren Khazem
Avery Ducey	Stefany Fuentes	Julia Halloran	Brynn Huguenel	Mariami Khourochvili
Gabriella Duke	Jennifer Funaro	Miklos Halmos	Alexis Humenik	Ammaar Kidwai
Deborah Duke	Allison Funk	Allison Hancock	Justin Hummer	Tess Kilwein
Angelo Dula	Rachel Gabelman	Emily Hanna	Kathryn Humphreys	Hyunsik Kim
Jessica Dupasquier	Jean-Philippe Gagne	Lyndsey Hansen	Carolyn Huntley	Jean Kim
Katherine Durham	Celina Gaines	Marie Hansen	Lauren Hurd	Anna Kim
John Durland	Marina Galante	Christine Hansen	Elisabeth Husabo	Thomas Kim
Courtney Dutton	Courtney Gallik	Kelsie Harding	Chelsea Hustus	Sung Kyu Kim
Michael Eaddy	Natalia Garcia	Crystal Hare	Shaina Hutchinson	Hyun Kim
Theresa Ebo	Jessica Garcia	Lauren Harnedy	Karim Ibrahim	Kristen Kipperman
Aileen Echiverri-Cohen	Anna Garner	Valisa Harris	Sarah Immerman	Norik Kirakosian
Charles Eckhart	Vanessa Gaudet	Jessica Hartman	Zachary Infantolino	Katelyn Kirk
Laura Eddy	Elena Gavrilova	Victoria Hartman	Lauren Irwin	Kimberly Klages
Kelsey Edwards	Jamilah George	Caroline Harvey	Ashley Isaia	Anne Kleinsasser
Anandi Ehman	Emily Georgia	Aaron Harwell	Stefanie Iwanciw	Megan Klement
Lauren Ehrlich	Alan Gerber	Gabe Hatch	Kyle Jackson	Christian Klepper
Ethan Eisdorfer	Derek Giannone	Danielle Hatchimonji	Erin Jackson	Christopher Kleva
Sharon Eldar	Brittany Gibby	Aleena Hay	Michael Jacobs	Elizabeth Kneeland
Jocelyn Elderton	Victoria Gibson	Marie Hayes	Jolene Jacquart	Jun Min Koay
Sophia Eldred	Grace Giedgowd	Eleftherios Hazapis	Anna Jadanova	Chaya Kobernick
Anjeli Elkins	Alexandra Gil	Casey Hearing	Kiera James	Holly Kobezak
Rosalind Elliott	Anna Gilbert	Carol Hecht	Cortney Janicki	Brandon Koscinski
Jordan Ellis	Lindsey Giller	Meagan Heilman	Iman Jarad	Dmitry Kovalev
Sarah Emert	Tracy Glazier	Natalie Hellman	Megan Jeffreys	Briana Koza
Naomi Ennis	Brianne Glazier	Sarah Helton	Martha Jenkins	Jacob Kraft
Chelsea Ennis	Hillary Gleason	Stephanie Henninger	August Jenkins	Oxana Kramarevsky
Dawn Epstein	Lisa Godfrey	Clarie-Ann Henriques	Dana Jerusalemi	Melanie Kramer
Lee Eshelman	Teresa Goff	Jordan Henslee	Michelle Joaquin	Nicole Kramer
Russell Esmail	Pauline Goger	Shaina Herman	Naydine Johney	Catherine Kraper
Chelsea Esmeier	Alexandra Gold	Evelyn Hernandez	Clara Johnson	Grete Kraus
Emma Faith	Pamela Goldsteen	Manuel Herrera Legon	Melissa Johnson	Juliet Kroll
Kristine Falkowski	Manuel Gonzales	Danielle Herring	Oliver Johnston	Kristen Krueger
Boyang Fan	Kaitlyn Gorman	Eleftherios Hetelekides	Anne Josephson	Olga Kucherina
Mahdiya Fazal	Brett Goshe	April Highlander	Eileen Joy	Anastacia Kudinova
Caley Featherstone	Hilary Gould	Sarah Hill	Devika Jutagir	Stephanie Kuhlman
Judith Feezer	Qalvy Grainzvolt	Peter Hilpert	Michal Kahn	Andrea Kulish
Kevin Feiszli	Colette Gramszlo	Elizabeth Hirschhorn	Jaclyn Kamradt	Amy Kupper
Jenna Feldman	Paola Granados-Radlick	Emily Hirschhorn	Leanne Kane	Bryan Kutner
Marley Felthousen	Hanna Grandgenett	Stella Hitzemann	Talia Kaplan	Leigh Kwasny
Jessica Ferreira	Marrissa Grant	Jesse Hochheiser	Francesca Kassing	Rebecca La Prade
Casara Ferretti	Tamara Greak	Brittney Holcomb	Billie Katz	Jamie Lacey
Laura Fewell	Ashley Dawn Greathouse	Camille Holiner	Brooke Kauffman	Ryan Lackner
Allison Fialkowski	Ashley Greene	Ryan Holliday	Lauren Keeley	Brittany Lance
Yudelki Firpo-Perretti	Mariam Gregorian	David Hollingsworth	Ivy-Lee Kehayes	Natalie Lankford
Robert Fite	Allison Griesmer	Tishanna Hollins	Caitlin Kehoe	Leann Lapp
Daniel Flack	Shayl Griffith	Kendra Homan	Cara Keifer	Caitlin Larsen
Alison Flett	Stephanie Grimaldi	Danyele Homer	Kirstie Kellman-	Madeline Larson

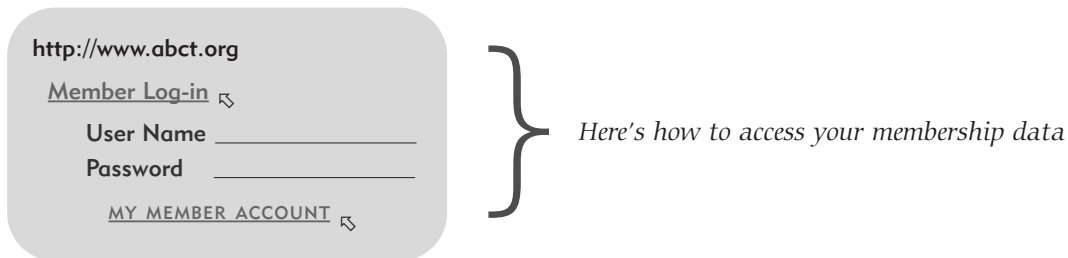
Denise Lau	Joclyn Malys	Cameron Mosley	Brandon Patallo	Natalie Richton
MarLa Lauber	Adam Mandel	Sara Moss	Anushka Patel	Nicole Ricketts
Rebecca Lauzier	Faigy Mandelbaum	Michael Mullarkey	Jennifer Patten	Lara Rifkin
Elaine Lavin	Atina Manvelian	Rachel Mumm	Kaitlyn Patterson	Laura Rindlaub
Jeffrey Lawrence	Igor Marchetti	Kristina Murani	Briana Paulo	Marina Ritchie
Nicholas Lazzareschi	Russell Marks	Lexa Murphy	Rena Pazienna	Clair Robbins
Thien-An Le	Elizabeth Marks	Meghan Murray	Bethany Pecora-Sanefski	Ciara Roberts
Trang Le	Lauren Martel	Saara Muscat	MacKenzie Peltier	Lauren Rodriguez
Yana Lechtman	Kimberly Martin	Zoe Mushkat	Ellie Peskosky	Craig Rodriguez-Seijas
Annie Ledoux	Nicole Massa Calderon	Michelle Myers	Madeline Peters	Mary Rogers
Jasper Lee	Babetta Mathai	Laura Nagy	Deena Peyser	Andrew Rogers
Angela Lee	Brandon Matsumiya	Khadeja Najjar	Randi Phelps	Brooke Rogers
Erica Lee	Caitlyn Maye	Claire Nakajima	David Phillips	Anna Rogic
Daniel Lee	Christina Mayfield	Monica Nanda	Steven Pilato	Rosalyn Rohling
Jin Lee	Caroline Mazzer	Jessica Nardi	Daniel Pineau	LG Rollins
Alena Lee	Laura McArdell	Samuel Nayman	Jennifer Piscitello	Brenton Roman
Alison Legrand	Shannon McCarrick	Ronni Nazarian	Maribel Plasencia	Julie Rones
Jennifer Lehmann	Julie McCarthy	Alyson Negreira	Kasia Plessy	Benjamin Rooney
Austin Lemke	Michael McClay	Erin Neill	Lillian Polanco	Andres Roque
Ariella Lenton-Brym	Katherine McCurry	Nicole Nelson	Ilana Pomerantz	Anna Ros
Karena Leo	Kellie McFarlane	Brady Nelson	Gabriella Ponzini	Chelsey Rosen
Erin Leonard	Shaan McGhie	Klavdia Neophytou	Gina Poole LaPosta	Tamara Rosen
Ruschelle Leone	Anastasia McGlade	Andrea Newman	Colleen Popores	Naomi Rosenbach
Francesca Lewis-Hatheway	Andrew McGrath	Leorra Newman	Will Porta	Zach Rosenberg
Qian Li	Kate McGrath	Lauren Ng	Andrew Porter	Eve Rosenfeld
Corey Lieneman	Caitlin McIlwee	Bao-Tran Nguyen	Amberly Portero	Allen Roshal
Stacy Lin	Allison McKinnon	Victoria Nicosia	Sriramya Potluri	Karlie Roshong
Tanya Line	Tierney McMahan	Marie-Christine Nizzi	Allison Powell	Cari Rosoff
Lance Linke	Jennifer McMahan	Lucy Nonas-Barnes	Andrea Pratt	Jaclyn Ross
Arielle Linsky	Elizabeth McRae	Sarah Nowalis	Jennifer Prentice	Karen Rothman
Alexandra Lipinski	Elleni Mehari	Stephen Nutt	Nikki Press	Melanie Roys
Levi Lipovenko	Kritzia Merced	Karey O'Hara	Jun Qi	Lauren Rozmus
Rachel Lippin-Foster	Kristina Metz	John O'Hara	Serene Qiu	Boaz Saffer
Leah Litwin	Allison Meyer	Robert Ogle	Dakari Quimby	Alison Sagon
Nicholas Livingston	Kelly Meyering	Sunyoung Oh	Victoria Quinones	Devora Samet
Louiza Livschitz	Whitney Mhoon-Mock	Kimberly OLeary	Alyssa Raggio	Courtney Santucci
Maxine London	Brett Millar	Olenka Olesnycky	Kanthi Raja	Naama Sarig
Alexandra Long	Elizabeth Miller	Lisa Olinger	Pamela Rakhshan	Melissa Saucedo
Devon LoParo	Natalie Miller	Kathryn Oost	Allura Ralston	Danielle Sauro
Patricio López Salazar	Llewellyn Mills	Sikandar Ortega	Amrita Ramakrishnan	Pamela Scalise
Jennifer Lorenzo	Summer Millwood	Brenda Osorio	Kaitlyn Ramian	Gabriella Scalzo
Noah Lorincz-Comi	Marissa Miroglotta	Hannah Ottmar	Jennifer Ramirez	Kayla Scamaldo
Rachel Luba	Erin Mistretta	Melina Ovanessian	Sofia Ramirez	Lauren Schaefer
Lauren Lucente	Neha Mistry	Victoria Owen	Devin Rand-Giovannetti	Jamie Schaffer
Rachel Luckman	Jenny Mitchell	Sarah Owens	Alora Rando	Christina Scharmer
Kelsey Ludwig	Lauren Mize	Nicole Pagano	Osiris Rankin	Jennifer Schild
Kelsey Luks	Anthony Molloy	Jessica Palmer-Bacon	James Rankin	David Schillinger
Ryan Lundell-Creagh	Hylton Molzof	Santiago Papini	Natalia Rappa	Andi Schmidt
James Lyng	Allison Momany	Anna Papova	Zach Rawlings	Taylor Schnaper
Maddison Lynn	Lyndsey Moran	Alexandra Pappas	Lauren Reeves	Mallory Schneider
Laura Machlin	Aisa Moreno Megui	Michaela Paraskeva	Kimberly Reinstein	Nicole Schultz
Natalia Macrynika	Alyssa Morgan	Siamata	Frances Rekrut	Amihai Schwab
Kelsey Magee	Daniel Moriarity	Meera Parbhakar	Alejandra Reyna	Kay Schwader
Ioan Mahu	Elizabeth Moroney	Juhyun Park	Brooke Reynolds	Rosanna Scott
Alyssa Mall	Sarah Morris	Suzanne Parker	Catherine Rice	Matthew Scult
Molly Maloney	Jessica Morse	Delana Parker	Malaya Richard	Kimberly Selgrad
Kathleen Maloney	Hannah Morton	Sarah Parrish	Jenae Richardson	Antonia Seligowski
	Danielle Moskow	Carly Parsons	Julia Richmond	Katelyn Selver

Kelsey Serier	Yosef Sokol	Alexandra Tanner	Marisol Velez	Danielle Willis
Nicole Seymour	Ingrid Solano	Laura Taouk	Rachel Venezia	Henry Willis
Lauren Shaffer	Amy Solen	Joseph Tarantino	Jennifer Vetter	Kelly Wilson
Mona Shah	Samantha Sommer	Emily Taverna	Angelica Vina-	Bram Wilusz
Jessica Shankman	Peter Soyster	Eugene Tay	Albarracin	Jessenia Winstanley
Kaitlin Sheerin	Cristina Sperrazza	Brigitte Taylor	Amanda Vitale	Jennifer Wiseman
Maxwell Sheintoeh	Ryan Stadnik	Sarah Terry	Allison Wagner	Andrea Wister
Alexandra Shiflett	Timothy Stahl	Katherine Tezanos	Samantha Wagner	Sara Witcraft
Tatiana Short	Lolly Starr-Glass	Christie Thiessen	Amanda Wagstaff	Lori Woehler
Craig Sidol	David Statman	Heather Thompke	Elinor Waite	Kristin Wolfe
Iris Sijercic	Jillian Stauffer	Nicole Thomson	Danielle Walerius	Rebecca Wolfe
Jesse Silberstein	Molly StDenis	Jamie Tingey	Rosemary Walker	Arielle Wolinsky
Alexandra Silvestre	Melanie Stearns	Margaret Tobias	Karen Wang	Carson Wong
Sharon Simon	Emily Steinberg	Lauren Todd	Karin Wang	Ashley Wood
Keneisha Sinclair-	Lauren Stentz	Tihomira Todorova	Binghuang Wang	Sherry Woods
McBride	Lauren Sternberg	Niza Tonarely	Christine Wang	Casey Wright
David Singer	Nicole Stettler	Audrey Torricelli	Jessica Ward	Joe Xiang
Rebecca Skadberg	Elizabeth Stevenson	Olivia Tousignant	Leah Ward	Colin Xu
Aliza Sklar	Shelby Stewart	Ivy Tran	Lauren Webb	Lillian Yamamoto
Rachel Slater	Jessica Stinnette	Han Tran	Melissa Wei	Jillian Yeargin
Melissa Slavin	Amanda Stone	Michael Treanor	Alainna Wen	Ira Yenko
Joanna Sletten	Jeremy Stout	Erika Trent	Hildy Wen	Jennifer Yip
Gabrielle Sloss	Daniel Stout	Zoe Trout	Elizabeth Wertz	Joanna Yost
Joseph Smetter	Brian Stran	Eleni Tsalikis	Shannon Westhead	Nick Zabara
Allison Smith	Katherine Stratton	Cheung Tsang	Michael Whitbord	Richard Zeifman
Joey Smith	Olivia Subramani	Aki Tsuchiyagaito	Jacob White	James Zemer
Diana Smith	Matthew Sullivan	Megan Tudor	Julia White	Lisa Zhang
Zoe Smith	Berta Summers	Natalie Tunnell	Thomas Whitfield	Ruya Zhang
Rachael Smith	Michael Sustaíta	Emilee Turner	Celina Whitmore	Xin Zhao
Lia Smith	Michaela Swee	Michael Unger	Molly Wickenhauser	Jiaqi Zhou
Brandi Smith	Julie Szarowski-Cox	David Varas Alonso	Madeline Wielgus	Rachel Zhuk
Jessica Smith	Kyle Szarzynski	Sylvanna Vargas	Caroline Wilkes	Courtney A. Zulauf
Keagan Smith	Natalie Szykowny	John Vasko	Ellen Wilkinson	Lucas Zullo
Caitlin Smith	Janice Ta	Areti Vassilopoulos	Alexander Williams	Kelly Zuromski

➡ **When was the last time** you took a look at your membership data?

April is election month. By now you should have received your username and password.

This is an excellent time to look at your membership directory information. Do we have all of your data correct? Is critical information missing? Did you know that ABCT's leadership looks to see how our members spend their time doing research, practice, and teaching and makes some decisions based on these data?



Do we have your licensure information and board updates? If not, send copies of this documentation to Sue Bezares, Membership Services Association, sbezares@abct.org

Find a CBT Therapist



findCBT.org

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.

the next ABCT **Webinar**

April 13, 2017

Implementing LGB-affirmative CBT: A Transdiagnostic Minority Stress Treatment Approach

John Pachankis, Ph.D., *Associate Professor at the Yale School of Public Health and Director of the ESTEEM Research Group in New York City*

- 11:00 A.M.–12:30 P.M. Eastern | 10:00 A.M.–11:00 A.M. Central | 9:00 a.m.–10:30 A.M. Mountain | 8:00 A.M. – 9:30 A.M. Pacific
- \$30 for members | \$45 for nonmembers

Sexual orientation disparities in mental health and related psychosocial outcomes are one of the most robust population disparities in psychiatric epidemiology, likely driven by LGB people's disproportionate exposure to stigma-related stress. This presentation will review the first evidence-based treatment package to reduce depression, anxiety, and related health conditions by reducing the processes through which stigma-related stress impairs the mental health of this population. Attendees will learn to utilize LGB-affirmative therapeutic principles and techniques to adapt standard cognitive-behavioral approaches to specifically address the stigma-related stress faced by LGB people across development. Preliminary efficacy data from a recent RCT will be presented suggesting that this LGB-affirmative treatment package, called ESTEEM, can reduce sexual minority men's depression, alcohol abuse, sexual compulsivity, and HIV risk behavior.

Register at www.abct.org

the Behavior Therapist

Association for Behavioral
and Cognitive Therapies

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ABCT 50th Anniversary Album P L A Y I T F O R W A R D

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Adam LaMotte, M.A. • Jaimie Lunsford, B.S. • Steve Mazza, M.A. •
Tony Puliafico, Ph.D. • Jose Soler-Baillo, M.A. • Dennis Tirch, Ph.D.
• Tim Verduin, Ph.D. • Jerome Yoman, Ph.D., ABPP

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