

the Behavior Therapist

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PRESIDENT'S MESSAGE

A Few Things I Have Learned

Gail S. Steketee, Boston University



AS I APPROACH retirement on August 31 at the end of this summer, I find myself doing a lot of looking forward and looking back at my own career and its intersection with the careers of the many fine colleagues I have worked with over the years. What did we learn? Did it help our clients and colleagues? Did I spend my time wisely? What could I have done better? What will I miss most? What will I do next?

Careers in academia, clinical research, and clinical practice have their own life cycles, with an impressive range of experiences and emotions that affect us all in the course of our careers. I realize that my own career experiences may be peculiar only to me, but I have learned a few things about clinical research over the years that I'd like to share in case they are of use to anyone else. Here goes:

- In my experience, learning from books does not substitute for good mentoring and the knowledge that comes with lots of experience—listen and, if it makes sense, try it out, even when scary.
- Good colleagues make life so much more interesting: two heads are better than one, and three are better than two, and so on until you have too many cooks in the kitchen—then pare it down to a manageable few whom you really like working with.

[continued on p. 199]

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■ Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.

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■ Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.

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- You can have a really interesting career if you choose very fine people to work with and are willing to work very hard. When you don't do something well, find someone who does and work closely with them.
- Build a pyramid to manage your time and projects in academic research—undergrads work for master's students who work for doctoral students and postdocs who work for and with you.
- Listen to the entire team, no matter their status—some of the best ideas come from those in the trenches.
- Our clients/patients are great teachers—listen to them carefully.
- Pay close attention to your doubts, even the niggling little ones. If something seems amiss, it probably is. Better to find it than let it fester.
- Bias is everywhere and the truth is hard to find—keep looking.
- Keep it simple—go for the most parsimonious explanation.
- Keep the channel open, even for the most challenging of colleagues, collaborators, and clients—the noisy ones bear listening to for the kernels of truth that lies therein.
- “I wish I'd worked harder,” said no one on his/her deathbed—always prioritize family and friends. I hope your closest colleagues are among them.

I'm sure there is more to say, and that many of my colleagues will say it better, but that's it for the moment. I'm proud and grateful that as my professional home for 40 years now, ABCT has done so much to foster my career, especially as a social work clinical researcher who grew up among wonderful psychology and social work mentors and colleagues. I look forward to trying to be articulate in my Presidential Address in San Diego about some of these matters, and hope you will join me there for a great conference in the fall.

...

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RESEARCH-TO-PRACTICE LINKS

Advances in Cognitive Behavioral Treatment Design: Time for a Glossary

Maya M. Boustani, Resham Gellatly, Jonathan G. Westman, Bruce F. Chorpita, *UCLA*

AS THE FIELD OF DISSEMINATION and implementation has highlighted the importance of fit between treatments and the context of community-based settings, there has been an increasing focus on specifying aspects of treatment designs that could better address such challenges. These design innovations have in turn popularized an accompanying new vocabulary. For example, there has been increasingly formalized research on modular treatment approaches in the past 10 years, with a focus on cognitive behavioral treatments in particular (Chorpita, Daleiden, & Weisz, 2005b; Weisz et al., 2012), and there are currently at least two dozen child or adult treatments that could be considered modular, transdiagnostic, or both (e.g., Kolko et al., 2009; Wetherell, Sorrell, Thorp, & Patterson, 2005). The primary purpose of this article is to suggest clarifying terminology regarding emerging treatment design (modular, transdiagnostic, flexible). A glossary allows treatment developers and providers to understand the various qualities of these new treatment designs, along with their applicability in different contexts. In addition, we provide an overview of recent findings relevant to innovative treatment designs for youth. Finally, we discuss future directions of relevance to modular treatment approaches, including exciting research challenges ahead.

Terminology

The terms *common elements*, *modular*, *transdiagnostic*, and *flexible* often appear in the literature in reference to treatment design and are often used interchangeably. Although these terms are ostensibly used to describe treatment designs that may have one or more overlapping qualities, we contend they are conceptually different. We aim to clarify what each of these terms means and how they are related. In addition, we hope this article will facilitate the use of a consistent language in order to decrease the risk of confusion, while facilitating the dissemination of clinical and

research knowledge surrounding these treatment designs.

Common Elements

The Distillation and Matching Model (DMM), sometimes referred to as the “common elements approach” (e.g., Barth et al., 2012), was proposed by Chorpita, Daleiden, and Weisz (2005a) as a literature analysis procedure that (a) identifies specific practice techniques and strategies common across a defined set of selected treatments (e.g., evidence-based treatments) and (b) identifies contexts in the literature in which practices have characteristic profiles (e.g., a high prevalence of the use of exposure in the context of treating anxiety). This procedure presents a view of the literature that aggregates across all treatments relevant to a particular context (e.g., adolescents with depression), as opposed to limiting inferences to lines of research specific to a single protocol or laboratory. *Common elements* are not to be confused with *common factors*. Although these approaches share the aim of improving the understanding of treatment content and composition, particularly in the context of evidence-based practice delivery, each conceptualizes two important but different aspects of therapy. The common elements approach focuses on analysis of specific components of treatments, typically with the aim of estimating how often discrete procedures occur when aggregating across many effective treatments. This approach allows for a view of what procedures are common among effective treatments and thus allows analyses of practice to aggregate across many different treatment approaches that may emanate from different laboratories and even different schools of thought. In contrast, the *common factors* framework (e.g., Duncan, Miller, Wampold, & Hubble, 2010; Sparks & Muro, 2009) highlights the importance of nonspecific factors of therapy that characterize many psychosocial interventions. Common factors including therapeutic alliance, client goals and motivation, and

therapist characteristics have been identified as facilitators of therapy and therapeutic outcome, regardless of type of treatment protocol or element employed (Barth et al.). One principal difference between these two approaches is that the common elements model is explicitly silent on the effectiveness of elements, noting that common elements analysis only characterizes how common particular practices are among treatments that are effective in their complete forms (Chorpita, Becker, & Daleiden, 2007), whereas the common factors model attests that nonspecific effects are responsible for treatment outcomes, at least in part.

Like any literature analysis, DMM can be used to inform treatment design. Yet the DMM was not proposed as a model of treatment; it is merely an analytic framework for summarizing practice knowledge. Hence, according to the model, a “common elements treatment” is potentially a misnomer. Although the term could refer to a treatment whose constituent procedures were informed by a DMM analysis, in and of themselves, a collection of elements is *not* a treatment (Chorpita et al., 2007). For example, relaxation and exposure are practice elements common among evidence-based treatments for anxiety in youth. However, we contend that there is no “common elements model” that suggests relaxation and exposure are sufficient to yield a full treatment comparable to those from which its elements were derived. The addition of theory or a logic model for how these common elements are to be organized and delivered is essential to moving from a set of isolated elements to a treatment. Finally, “elements” as conceptualized in the DMM need not refer to component practices, but in fact could refer to any features of treatment, such as format (e.g., group, individual, self-directed), or logic (e.g., linear sequence, conditional sequence), or audience (e.g., child, family, parents). Thus, we see value in conceptualizing the “common elements” framework principally as a literature analysis tool, which can merely inform treatment development through a summary of common features of successful treatments specific to a given context (e.g., depression, or adolescents, or schools) or some combination of contexts (e.g., depression in schools).

Modularity

Chorpita et al. (2005b) outlined a model of treatment design that articulated four principles about modular treatments: (a) they are partially decomposable (i.e., a

modular treatment can be divided into independent units or subunits); (b) each module should have its own goal and purpose, independent of other modules; (c) modules have an interface that allows them to connect to other modules in a standardized way (i.e., they are immediately compatible when linked); and (d) a module should be self-contained, such that all the information needed to deliver that module should be contained internally and not dependent on another module. Chorpita et al. (2005b) argued that these principles should allow for increased efficiency and simplified scalability in overall treatment design, all things being equal.

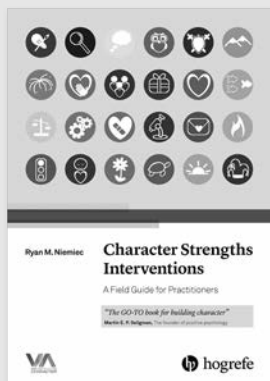
Although modules are commonly thought of as practices (e.g., a “session” or a “unit” that structures a specific therapeutic activity), modularity applies to any aspect of a protocol, such as a flow module that governs the practice order (e.g., a coordinating module could dictate that practice A must be followed by practice B; it could in turn be nested in a higher-order flow that states practices A, B, and C are to be used for youth, whereas D, E, and F are for adults). Note that one flow could be replaced without impacting the other, and any practice modules from A through F could be replaced without affecting the others and without affecting either flow module. In other words, a module is not defined by its content, but rather by its structure and design. Although modules are often made up of therapeutic strategies (e.g., “relaxation module”), they can just as well be therapeutic guides that inform the order of delivery of strategies, such as flow charts, or guides on how to address cultural barriers or engagement problems. Such modules provide information about how to deliver treatment (interface with other modules) but are also independent (do not rely on other modules for delivery). Interested readers may consult Chorpita et al. (2005b) for a detailed account of what constitutes modularity.

Transdiagnosticity

Transdiagnostic treatments such as the Unified Protocol (Barlow, Allen, & Choate, 2008) have the ability to address multiple diagnoses by using decision-rules to guide the use and dose of components based on symptom presentation and ongoing feedback (McHugh, Murray, & Barlow, 2009). The term “transdiagnostic,” first coined in 1977 by Steer, Shaw, Beck, and Fine, to describe overlap between depression and alcoholism, entered mainstream psychiatry after being introduced by Fairburn and col-

leagues in their work with eating disorders (Fairburn, Cooper, & Shafran, 2003). As highlighted by Sauer-Zavala and colleagues (2017), a treatment has to fall into one of three categories to be considered transdiagnostic: (a) *universally applied therapeutic principles* refers to treatments that use an identifiable school of thought to guide their therapeutic strategies, regardless of diagnosis or symptom presentation (e.g., humanistic, psychodynamic, cognitive-behavioral therapies); (b) *modular treatments* refers to treatments that are transdiagnostic by combining what we know works from multiple treatments into one treatment (it is important to note that not all modular treatments are necessarily transdiagnostic—a modular treatment can combine what we know from multiple treatment packages for one disorder into a modular approach); (c) *shared mechanisms treatment* refers to treatments that identify common processes that are believed to apply across disorders (e.g., negative emotions). The term “transdiagnostic” implies that a treatment must address multiple diagnoses. However, it is unclear if a treatment must address multiple diagnoses within one diagnostic category (e.g., generalized anxiety disorder and panic disorder within anxiety) or diagnoses in multiple domains (e.g., depression and anxiety) to be considered transdiagnostic. This matter is further complicated by changes in diagnostic criteria. For example, a treatment that previously focused on both generalized anxiety disorders and obsessive-compulsive disorders may not have been transdiagnostic under DSM-IV, but now is under DSM-5, as they are now classified in different chapters. Indeed, if we are to describe disorders on a dimensional construct, as encouraged by the National Institute of Mental Health’s Research Domain Criteria (RDOC; Insel et al., 2010), rather than disorder categories, then the term “transdiagnostic” may be misleading. For that reason, we prefer the term “multiproblem” to describe treatments with multiple foci and are reluctant to recommend how far a treatment has to branch out of a disorder category in order to be considered transdiagnostic. Nevertheless, transdiagnostic treatments have the advantage of allowing for heterogeneous symptom presentations and even the possibility to adapt the treatment for different individuals (McHugh et al., 2009).

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Flexibility

Flexibility refers to the ability of a treatment to be adapted and individualized during its delivery (Chorpita et al., 2005b). Although flexible treatments can have manuals that provide guidance about the treatment approach, including recommended treatment goals at various phases of treatment, they need not dictate strict session-by-session content, scripts, or a prescribed number of sessions. Examples of flexible treatments include Multisystemic Therapy (Henggeler & Borduin, 1990), Multidimensional Family Therapy (Liddle et al., 2001), and some approaches to marital therapy (Jacobson et al., 1989). The most flexible treatments generally provide a philosophy of treatment and guidance while relying relatively more on clinical judgment than on a defined treatment structure. Researchers have consistently found that providers prefer flexible

approaches to serve their clients (Nelson, Steele, & Mize, 2006), and some developers have provided guidelines on ways to flexibly implement evidence-based manualized treatments (Kendall & Beidas, 2007). At the same time, there is mixed evidence regarding whether flexibility is associated with greater treatment efficacy (e.g., Schulte, Kunzel, Pepping, & Schulte-Bahrenberg, 1992).

Our use of the term *flexibility* in this context should be distinguished from the kind of microsocial-level flexibility that is commonly a part of “bringing a treatment to life,” so to speak, even a highly structured one. In other words, with few exceptions (e.g., some technologically delivered treatments), there is always some degree of adjustment according to provider style and client preferences. This “flexibility within fidelity” has long been described as an important tenet of implementing manual-

based treatments (Kendall, Chu, Gifford, Hayes, & Nauta, 1998; Kendall, Gosch, Furr, & Sood, 2008). In this context, flexibility is encouraged in order to develop a stronger therapeutic relationship, which leads to better treatment outcomes (Creed & Kendall, 2005). Therapists are also encouraged to address client concerns rather than ignore them to deliver content from the manual (Kendall et al., 2008). That said, our use of the term “flexibility” refers more generally to a coarse-structure flexibility that would involve such parameters as highly variable length of treatment, the ability to add or omit particular practices altogether, the option to repeat some practices based on client response, etc. Of course, the term “flexible” (and for that matter, “modular” and “transdiagnostic” as well) is a binary simplification of a dimensional construct, simplified to promote communication about design; treatments can be more or less flexible, modular, or transdiagnostic.

Table 1. Treatment Design Definitions and Examples

	Transdiagnostic A transdiagnostic program targets multiple disorders	Modular A modular program is made up of modules, or partially decomposable, independent units, that interface to create a treatment.	Flexible A flexible program can be adapted and individualized during its delivery.
Attachment-based family therapy (Diamond et al., 2010)			✓
Acceptance and Commitment Therapy (Hayes et al., 1999)	✓		
Modular Approach to Therapy for Children (Chorpita & Weisz, 2009)	✓	✓	✓
Modular CBT for childhood anxiety (Chiu et al., 2013)		✓	✓
Multisystemic Therapy (Henggeler & Borduin, 1990)	✓		✓

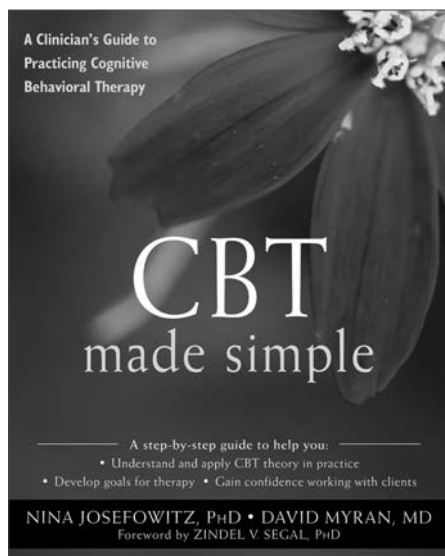
Examples of Modular, Transdiagnostic, and Flexible Evidence-Based Treatments

A brief review of the literature reveals a recent proliferation of treatments described as transdiagnostic, modular, or flexible. Some treatments fall under one of these categories, whereas others fall under more than one. Table 1 highlights how various treatments fall into one or more of the treatment design categories (modular, transdiagnostic, or flexible) and provides a definition for each treatment design. There are many treatments that address multiple problems and can be considered *transdiagnostic*. For example, traditional CBT, which has been proven to be effective for depression, anxiety, and multiple other disorders, is *transdiagnostic* but not necessarily *modular*, as content from later sessions often builds on knowledge gained in earlier sessions (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) is another example of a *transdiagnostic* treatment indicated for multiple problem areas that is not *modular*, although there have been recent calls for a modularization of ACT (Villatte et al., 2016).

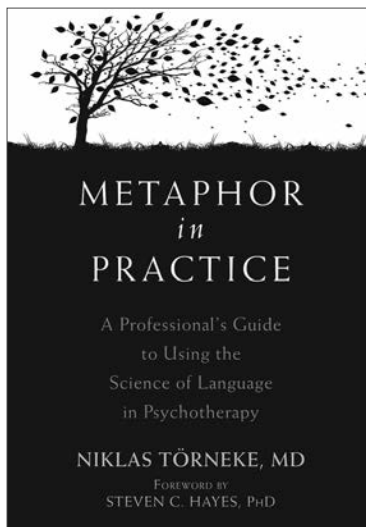
Building Confidence is a treatment approach that was adapted from a manualized CBT treatment for children with anxiety disorders (Chiu et al., 2013). Providers select and sequence modules based on their client's presenting concern and administer

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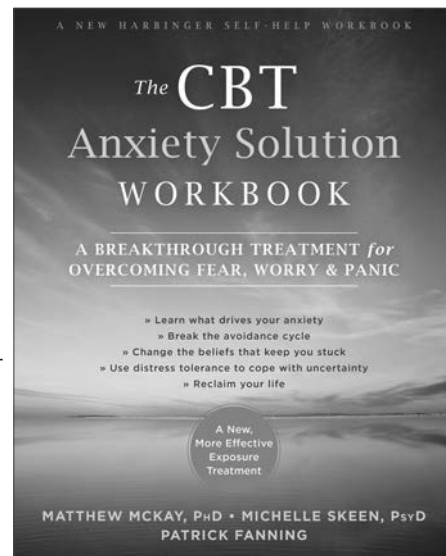


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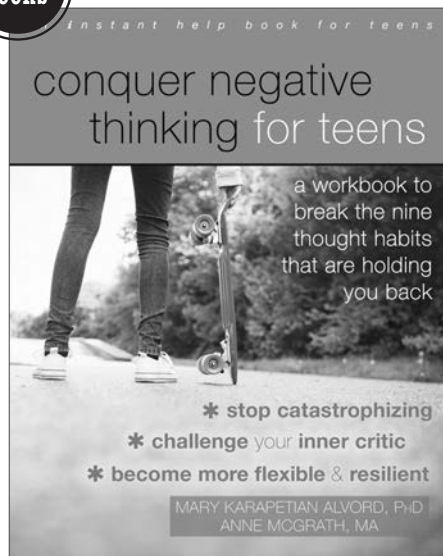


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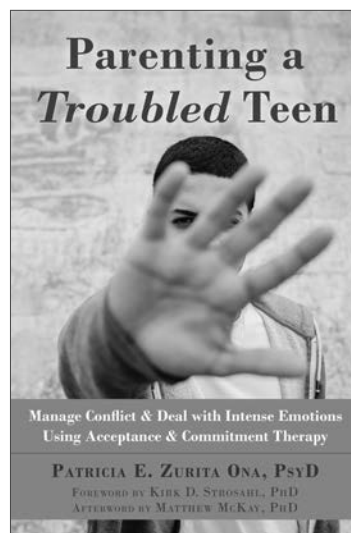


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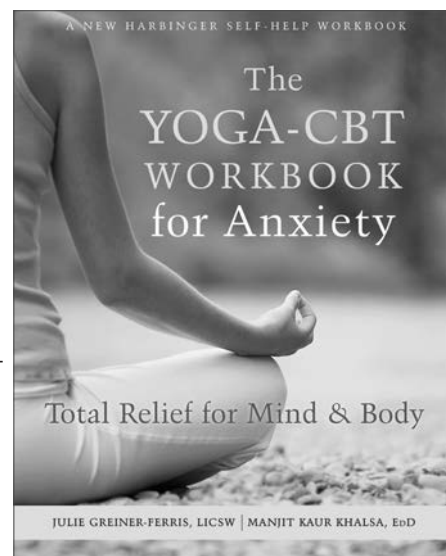


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treatment for 1 to 16 sessions, depending on the child's needs and ongoing symptomatology. Hence, this treatment is both *modular* and *flexible*, but probably not *transdiagnostic*, as it is meant to treat anxiety disorders only. However, one could argue that the treatment works across multiple anxiety diagnoses, and is thus transdiagnostic, but that is in part a reflection of the level of analysis of the chosen diagnostic nosology, as we have previously discussed. Building Confidence showed promise by outperforming a waitlist condition in elementary-aged children, such that children who received the intervention had less severe anxiety symptomatology (Chiu et al.).

In another study, Kolko et al. (2009) examined how a modular treatment approach for children with conduct disorder or oppositional-defiant disorder performed in a clinic versus a community-based setting. Seven treatment modules were derived from a variety of evidence-based treatments such as CBT, parent management training, family therapy, and case management. An algorithm was used to determine the nature of the modules to be delivered and their order. Children assigned to a community-based setting had higher attendance, and outcomes comparable to clinical settings, despite prior research indicating more difficulty engaging families in community settings (e.g., Southam-Gerow et al., 2010). This treatment is *modular* and could also be considered *transdiagnostic*, because it treats both conduct and oppositional-defiant disorders—even though they are both disruptive behavior disorders.

MATCH-ADTC (Modular Approach to Treatment for Children with Anxiety, Depression, Trauma and Conduct problems; Chorpita & Weisz, 2009), is an example of an evidence-based treatment that falls under all three of these treatment designs: it is *modular*, *transdiagnostic*, and *flexible*, and has demonstrated to be effective in two randomized effectiveness trials in community settings (Chorpita et al., 2013, 2017; Weisz et al., 2012). MATCH is modular because it is made up of various units that may be administered independently to respond to each individual client's needs. MATCH is a full manual and includes scripts, worksheets, and a sequence of modules, along with flowcharts to guide treatment decisions and treatment planning depending on symptoms and interferences. The treatment is flexible because the provider is free to pick which modules to deliver based on the

client's current needs and responses to prior modules, as indexed by progress monitoring and feedback. Finally, MATCH is transdiagnostic because it can be used to address any of several presenting problems commonly seen in children and adolescents (anxiety, depression, conduct problems, traumatic stress). The research on MATCH indicates that as a modular, transdiagnostic and flexible approach, it was more effective, more efficient, and more popular than treatment as usual, and in some cases more than standard (nonmodular, less flexible, and single diagnosis) evidence-based treatment designs (Chorpita et al., 2013, 2017; Weisz et al.).

Another example, MAP (Managing and Adapting Practice), is a system of resources that clinicians use to design, deliver, and evaluate treatment (Chorpita & Daleiden, 2014). MAP provides clinicians access to a database of research on evidence-based treatments to inform their treatment design. From this searchable database, practitioners can identify treatments that have been proven effective in clinical trials for certain populations with specific problems. Furthermore, practitioners can discover the most common elements found in those treatments, along with practice and process guides (modules) to facilitate implementation of individualized content. Finally, clinicians can develop a clinical dashboard for each of their cases to track progress and practices delivered into a visual summary (Chorpita et al., 2008). Because MAP is not a treatment, but more of a toolkit for clinicians to select an existing treatment or build a new one from a set of knowledge resources, it has only been tested in open trials in large mental health systems. However, those demonstrations have shown that it is highly scalable, well-liked by providers, and yields large effect sizes (Daleiden et al., 2006; Southam-Gerow et al., 2014). Once therapists have designed a treatment using MAP, it could be qualified as *modular*, *transdiagnostic*, and *flexible* (although it is theoretically possible to design a static sequence of practices with a single treatment focus only).

Why Is a Glossary Needed?

The examples of innovative treatments highlighted above suggest the value of attending to a consistent design vocabulary to describe them. That is, if we discover that new interventions (or new arrangements of the old interventions) offer advantages, there is some practical benefit

to having a shared terminology to understand what may have produced those advantages. Recent research suggests that these new treatment designs may indeed afford advantages, at least in situations that must contend with cost or training constraints, unpredictable aspects of treatment context, comorbidity, or background complexity and life stress. If these new treatment designs are to become mainstream in mental health, we need a common and consistent language to establish meaning and avoid confusion. We believe that there is already enough evidence that these designs have potential; hence, we seek to provide clarity to our members about these treatment designs. Using MATCH as an example of a treatment that is *modular*, *transdiagnostic*, and *flexible*, we highlight a few advantages of these novel treatment designs.

They Can Be Effective

In randomized effectiveness trials conducted in ethnically diverse community settings, participants receiving MATCH experienced more rapid improvement of internalizing and externalizing symptoms than individuals enrolled in comparison groups (usual care or standard evidence-based treatments; Chorpita et al., 2013, 2017; Weisz et al., 2012). MATCH also yielded steeper reductions in non-study service utilization and breadth of psychotropic medication use than comparison treatments, suggesting that MATCH is an effective stand-alone treatment for a wide range of presenting problems (Chorpita et al., 2017; Park et al., 2016). Finally, the effectiveness of MATCH in diverse community settings was better than standard evidence-based treatments, which often perform better in controlled laboratory studies (Southam-Gerow et al., 2010; Weisz, Jensen-Doss, & Hawley, 2006).

They Can Be Efficient

MATCH and other transdiagnostic treatments can target comorbidity without resorting to a second treatment. When comorbidity occurs, the sequence of treatment is adjusted by selecting modules that address the comorbidity (Weisz et al., 2012), allowing for a continuous treatment flow without referring to another treatment or continuing with interventions that are not addressing comorbid issues. In addition, the average duration of MATCH, which does not have a prescribed treatment length, was significantly shorter than that of usual care (Chorpita et al., 2017; Weisz et al.). The potential to address comorbid-

ity and provide a shorter duration of treatment suggests that MATCH may be more efficient than treatment as usual and traditional manualized evidence-based treatments.

They Can Be More Likely to Be Adopted and Disseminated

The high cost of training providers in multiple diagnosis-specific manuals may be problematic for community agencies with limited resources that serve clients with heterogeneous symptom presentations (Barlow, Allen, & Choate, 2004; McEvoy, Nathan, & Norton, 2009). Modular and transdiagnostic treatments offer service organizations a potential solution that can address multiple problems, increasing their likelihood for adoption and dissemination, all other things being equal.

They Can Be Popular Among Providers

Despite research support for the efficacy of evidence-based treatments for children's mental health disorders (Weisz et al., 2006), manualized approaches remain underutilized (Riemer, Rosof-Williams, & Bickman, 2005). Some research shows that

providers' hesitancy to use evidence-based treatments may be more associated with concerns about their typically high degree of structure, rather than with the fact that they were developed through empirical testing (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009). Providers of MATCH, for example, reported increased engagement in treatment, in part because MATCH allowed them to flexibly adapt content to meet the individual needs of clients (Palinkas et al., 2013). However, in that same research trial, it did not appear that flexibility had a simple linear relationship with provider preference. For instance, in a study on therapist satisfaction, providers using MATCH gave higher satisfaction ratings than providers in the highly flexible usual-care condition (Chorpita et al., 2013), which suggests that there is an intermediate level of flexibility that is preferred. It is notable that such flexibility can easily be adjusted upward or downward from trial to trial with a modular treatment (i.e., simply by adding or removing constraints from the treatment flow). Thus, it may in fact be modularity that is primarily more important than flexibility

when attempting to address provider concerns about making treatment feel more individualized.

They Offer Individualized Content

By flexibly selecting modules that correspond to the client's needs, modular, flexible and/or transdiagnostic approaches provide an opportunity to individualize treatment for a particular client with unique symptom presentation, cultural background, learning style, and more.

Designs Are Options, Not Absolutes

Despite the successful performance of MATCH in clinical trials, we contend it is a misinterpretation to advocate for treatment arrays in service systems to be only modular in nature, or only transdiagnostic, or only flexible. Rather, such designs at best will provide options for particular audiences or contexts, such as settings with limited resources or heterogeneity in their diagnosis presentation. Even within those systems, there is room for providers and treatment consumers to have preferences for one kind of design over another, provided they are efficacious. Those prefer-



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ences could even be related to improved outcomes or sustained use in certain contexts. Thus, we argue that these innovations in treatment design should serve the aim of assembling arrays of services that offer best-fitting sets of options for the variety of providers and consumers that such systems will involve.

Conclusion

We have made great progress towards improving the mental health of youths through the development of evidence-based treatments, yet many challenges remain. As dissemination efforts succeed, many providers will encounter increased complexity, including issues such as the lack of available evidence-based treatments for a variety of common clinical presentations (Chorpita, Bernstein, & Daleiden, 2011), emergent life events that can shift or derail the focus of treatment (Chorpita, Knowles, Korathu-Larson, & Guan, 2014; Guan et al., 2017), cultural issues (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010), poor treatment engagement (Pellerin, Costa, Weems, & Dalton, 2010), or parent psychopathology (McLaughlin et al., 2012). In addition, we have a majority of children in low- and middle-income countries who do not have access to evidence-based treatments at all. An accompanying challenge for our field will be to extend the reach of our evidence-based treatments to countries that currently do not have the workforce or resources to implement and sustain such treatments (Saraceno et al., 2007).

Thus, as we gain better insights into strategies for dissemination and implementation, any resulting success will bring new problems. One part of addressing them will involve a continued focus on developing new treatments or making structural adaptations to existing treatments, so that we might boost their effectiveness and scope in these new contexts. These designs will likely involve a host of structural parameters that are worthy of experimental manipulation. Hence, we look forward to a time when we not only have a larger vocabulary for such designs, but also have a deeper understanding of which aspects of treatment design yield particular advantages in which contexts.

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CLINICAL DIALOGUES

On Becoming an Activist: Tips From Cognitive Behavior Therapy

Dara G. Friedman-Wheeler, *Goucher College*

Jamie S. Bodenlos, *Hobart and William Smith Colleges*

How wonderful it is that no one has to wait, but can start right now to gradually change the world! —Anne Frank (1944)

Working toward what one values not only brings a sense of satisfaction but changes what one becomes in the process.
—Al Bandura (2011, p. 11)

REGARDLESS OF YOUR PARTICULAR political views, you may be one of many Americans who has decided over the last few months to get more involved in social activism. Indeed, seeing the divides in political positions, opportunities, and lived experiences, many of us have recently declared that we cannot, in good conscience, passively wait for others to make the world a better place.

However, you may have found that, since these declarations, you haven't done a whole lot on this front. Or perhaps you've done some, but you're not sure which way to go to do more, to make more of a difference, without having to quit your job to become a full-time activist. Or maybe you're doing it, but some days it doesn't feel like you're making a difference.

Well, lucky for you, many of us have a variety of tools (along with those hefty student loans) from our years of graduate training that can help us become effective activists in whatever time we have to give. Activism is defined as “a doctrine or prac-

tice that emphasizes direct vigorous action especially in support of or opposition to one side of a controversial issue” (Merriam-Webster, n.d.). Activism can be focused on anything from the environment to civil liberties, and it can be explicitly political or can be aimed more broadly at making the world a better place.

Depending on your “cause,” activism may take a variety of forms. It could be anything from participating in a march or rally to writing letters to the newspapers to calling your senators and members of congress. You could clean up (or March for Science) on Earth Day. You could skip your morning latte and use that money as a monthly donation to an organization that is important to you. Haven't you been meaning to give up the extra sugar anyway? (Or just make sure you're buying that coffee from a company whose values don't directly contradict your own.) The reality is that there are many ways to make a difference — but sometimes we can get a little stuck.

Among the many challenges we face in making these changes to our behaviors: busyness, anxiety about particular forms of activism, and sometimes depressed mood or hopelessness about the situations you would like to address. Are you noticing what we noticed? We have lots of tools for

addressing these types of challenges, right in our CBT toolboxes.

Challenge #1: When on Earth Am I Supposed to Squeeze This in?!

This issue of busyness is very real (cf. Safi, 2014). Many of us wear a variety of “hats” in a day. From 6:00 a.m. to 8:00 a.m. you are sporting your parent hat, from 8:30 a.m. to 2:00 p.m. you are wearing a hybrid researcher/teacher hat, and maybe from 3:00 to 6:00 p.m. it's the clinician hat. Then, after you get in your car after seeing your last patient, you hurry up and shove the parent hat back on before you get home. It's not until around 8:00 or 9:00 p.m. that you get to take all of your hats off or at least put your pajamas on and do a little work before bed. Does this sound familiar? How would you be able to fit in one more thing into your already tiring and overscheduled day?

The best way to get started may be to monitor exactly how you spend your time (are you thinking “Oh yeah . . . !” You tell your clients this all the time, right?). As scientist-practitioners, we realize the importance of measurement, so let's take a look at how we are using each hour of the day. Spend a few weekdays and a weekend day measuring what you do with your time. After you have the data compiled, critically examine your data. Are you spending a few hours scanning Facebook at lunch and after the kids go to bed? Do you hang around the office a little later than needed to complain to colleagues about a student or even politics? While we wouldn't advocate giving up sleep or exercise, perhaps the hour or so that you spend on social media daily (perhaps reading news stories about issues that upset you) could be better used making a call or two to your senators or congress people or composing a letter or postcard. Or perhaps split that hour between the two.

Monitoring our time can remind us to consider another issue related to busyness: prioritization. While many of us are really and truly so busy we can't find a free moment, we may be busy doing things that are actually less important to us than some of the things we're not getting to (e.g., Facebook vs. phone calls). Or perhaps you go out for drinks with coworkers pretty often because you feel like you should, but in fact it's not really your thing, and you could use that time to go to meetings with like-minded folks who care deeply about what's most important to you. Even once you're doing this, however, it can seem like Really Urgent Action is needed on many fronts at once, all the time, in a way that is just not sustainable.

But wait, that feeling is familiar, too... Have you had clients with whom you've developed really great concrete, measurable goals — but you spend most of every session putting out the fires of the latest crises, and those goals just keep getting transferred from one agenda to the next? What do you do? Perhaps reserve some time to respond to crises (10 minutes to call your members of Congress about whatever the latest thing is), but then leave the rest of your activism hour for systematic pursuit of your broader goals.

That plan assumes you've identified some broader goals, which can also be tricky when so many things seem critical. In order to identify these goals, perhaps some ACT-based values clarification would be helpful (Hayes, Strosahl, & Wilson, 1999). Think about your values broadly, for a moment (or more). What kind of psychologist do you want to be? What kind of friend do you want to be? What kind of sibling/parent/child/partner do you want to be? What kind of world citizen do you want to be? Consider your responses to these questions with respect to what you have learned about how you spend your time, from monitoring (above). Are you living a life consistent with these values?

Suppose you learn, from the above exercise, that actually what is really important to you is being a good friend, but you haven't had much time to devote to your friendships recently. Perhaps, then, the kind of "active" you want to be now has more to do with your existing relationships than it does with making particular political changes. Learn that a friend is home sick? Bring them some soup. Know of an immigrant family in the neighborhood who may be feeling scared or unwelcome? Invite them over for dinner (it can be pizza;

you don't necessarily have to cook). These types of gestures, we know, can make a big difference in people's lives.

OK, perhaps you decide that "steward of the earth" is an important aspect of your identity. You already recycle and ride your bike to work, but you'd like to do more. By using implementation intentions (Snie-hotta, 2009) to achieve goal-directed behaviors, you can use "if-then" plans to achieve your goal of taking action for your cause. For example, you might decide that *if* your member of Congress holds a town hall meeting, *then* you will go. More recently, it has been proposed that "when-then" statements might be appropriate in some situations (Armitage, 2016), such as: "*When* I hear that work is beginning on midterm election campaigns, *then* I will get informed about the candidates and start working for the one who is most committed to protecting the earth." Remember, the more details you work out in advance, the easier it will be to carry out your plans when the time comes. Perhaps you typically don't see clients on Thursday mornings and could schedule in some "activism time" every Thursday morning at 10. Yes, seriously.

***OK, this feels doable ... No, wait ...
I'm feeling overwhelmed again***

There can be lots of ups and downs in this type of work. Remember that you don't have to (and can't) single-handedly save the world. You only have to do your part (whatever you decide that is). Chances are pretty good there are other people out there who share some of your goals. The social support and the reminder that the responsibility is shared can be really important. Start small. What would you like to do *this week* that will represent movement in your valued direction? How likely are you to do that? If you think the chances of your doing it are only 60%, pick something smaller (or

rehearse; Beck, 2011). Set yourself up for success. Oh, and then reward yourself for taking the steps you take! Maybe one of those recently-given-up lattes? Or watching a clip from your favorite show online? And also: It's OK to feel overwhelmed sometimes. We can tolerate that (cf. Linehan, 1993).

Challenge #2: Identity Crisis

Does this kind of work not feel like "you"? These kinds of feelings can take many forms. Perhaps you hate talking on the phone. Perhaps you don't like to ruffle feathers or be seen as radical. Perhaps you're afraid that getting involved will mean you have to talk to people whose values and beliefs are offensive to you, or who will be rude.

If it's phone calls that are the problem but perhaps also seem like the most obvious way to contribute, do some exposure. Start small, like calling a store to ask their hours, or offer to order the pizza (your partner/roommate will be thrilled!). Ditto for attending meetings, rallies, etc. Go the first time (perhaps with a friend) but plan to be passive, if you like (vs. speaking up). Practice at home with a partner or in front of the mirror. Write a script to help you formulate your thoughts. Interestingly, there have been some great compilations of tips on this subject recently, particularly with respect to social anxiety (e.g., McGee-Tubb, 2016).

By the way, you won't necessarily have to talk to people you disagree with ... probably if you go to meetings you'll find lots of people you do agree with. Though engaging in difficult conversations at times is probably a good goal for some of us, too.

Still feel funny? Maybe even guilty about bothering people or ruffling feathers? Try the downward arrow technique (Burns, 1980). What does it mean to work

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on these issues? What does it say about you? What does that mean?

No, but really—I am not an activist. I have no skills, experience, or training in this domain, and I don't know how to be effective.

Good news! Other people have this expertise and are eager to share it with you! Once you've identified some causes/organizations that feel important to you, see what they recommend, in terms of getting involved. Perhaps you can join a call they're having. If you can, listen and see if you feel like they know what is and is not effective (hint: you may [should?] recognize some social-psychology content in there), and if their suggestions feel like a good fit for you. You don't have to reinvent the wheel.

Challenge #3: Emotion Regulation

"The more I engage/stay informed, the more despair I feel. It feels hopeless." Yes, sometimes it can. First, we'd encourage you to see how you're defining "engaging." Reading upsetting news for several hours a day may not be the only or the best way to stay informed, and it may not really constitute engagement, either. But sometimes even our best-directed efforts can seem but a drop in the bucket. Here's where you whip out your favorite mood-management strategies:

Positive Reinforcement/ Pleasant Activity Scheduling

How are you spending your time? Are there enough energizing/reinforcing/joy-producing activities in your schedule? No? Consider adding some. Perhaps even as rewards for your activism efforts? Or not. Pick "activism" activities that are themselves positively reinforcing. Go into the community and work with children. Do something with friends, rather than alone (or go and make a new friend).

And yes, your acts of social engagement might themselves be emotionally regulating! Did you hear any participants in the Women's March (or perhaps you yourself) saying, "I feel hopeful for the first time in months"? Solidarity, validation, feeling like you're doing something ... these may be pretty powerful themselves! Of course, not all of these experiences will be positive, and there may be some ugly or disappointing moments (if people with different beliefs from yours become hostile, or if a congressperson's staffer doesn't let you in). So again, keep track of your resources, and do what you need to do to stay afloat.

Mood Monitoring

Be vigilant, and notice when you're starting to slide (snapping at kids/students? Finding it harder and harder to get out of bed?). You do need to stay afloat to do this work (and perform your other roles). Prioritize self-care. What works for you with respect to this kind of stress? Rediscover knitting, movies, music, candles, or soft blankets. These things don't have to be hugely time-consuming.

Mindfulness

One of the hardest things about passions is that they can take over your life. You may find yourself sitting at dinner with your family and thinking about the work you have to do to prepare for the meeting you have that night. Or maybe you are still reeling from the energy you have from a recent protest you participated in. It's a challenge to switch gears from these activating events, and several aspects of your life may suffer if you don't practice mindfulness. Finding 5 minutes a day to do a breath-based meditation to help refocus your attention can do wonders for your mood and your ability to be present for your loved ones. In the same vein, when you are home, truly be at home. Put your phone in a location that isn't easily accessible so that you can be present where you are. Social media, emails, and texts can wait.

Practice Gratitude

There may come a time during your work as an activist where you start feeling overwhelmed or lose your focus. It's easy to miss seeing the forest through the trees. In addition to clarifying your values, as discussed earlier, this may be a good time to start a journal. For example, perhaps you become dysphoric or begin seeing more of the negative in the world than the positive. Are you feeling like you are climbing a never-ending mountain without any signs of the top? A gratitude journal could be beneficial. In the grand scheme of things, you probably do have things that you are grateful for. Reflecting on these on a daily basis, perhaps for a few minutes before bedtime, can help you stay focused on what's important and may enhance your mood. (You could also use a journal to write about your activism experiences and how these tie into the things that you value and care deeply about—even just logging your efforts may be helpful.)

Stimulus Control

You control the dose. If you're doing too much, step back and practice saying no. Remember, hopelessness and despair probably won't help your cause. Control your exposure to news and other "hot button" stories (this might involve limiting time online). Have your favorite (soothing?) CD in the car to change to immediately when the news starts to stress you out. Maybe only listen to the news one way to work, not both. Or maybe don't listen at all. If you're on the email lists of organizations that share your values, you can be pretty confident they'll let you know when there's something you might want to respond to (and thus that you won't miss anything critical by turning off the radio or logging out of Facebook).

Social Support

You may find it helpful to find an activist buddy (maybe through meetup.com) or to join a Facebook group such as Psychologists Spark Social Action. Your activist buddy could be a colleague who is also engaging in social activism for the first time or someone more experienced. That person could provide emotional support and also help keep things in perspective and remind you of the importance of self-care. It's also important to consider whether time engaged in activism has to be time away from family and other friends. Finding a way to include your children, spouse, and friends in social activism can serve two purposes. First, it will allow you to spend time with the important people in your life while doing work that is important to you. Second, you will be teaching your children to be engaged citizens. Watching their parent or parents engage in activism will teach them how to use their voice, skills, and energy to facilitate change and help others. And, by the way, this might help with the "busyness" factor — if you're able to achieve two goals with one activity (e.g., spend time with kids and attend protest).

Sleep Hygiene

Just a friendly reminder! It can be tempting to think that being vigilant/engaged/informed is so important you need to stay up later than you'd planned in order to do it, but remember how lousy you feel (and how impairing it is) to get less sleep than you need. You know what you need to do (but <https://medlineplus.gov/ency/patientinstructions/000757.htm> also has some good reminders). Give yourself some screen-free time before sleep. Put

the phone and computer away a half-hour before bed. In addition to mitigating the effects that screens may have on your circadian rhythm (Cajochen et al., 2011), putting them away will also help you avoid news stories or social media posts that may serve as negative mood inductions prior to sleep.

Exercise

Ditto (friendly reminder). We all know the extensive literature that supports both the physical and mental health benefits of exercise (cf. Penedo & Dahn, 2005), but it might seem like you can't spend time on yourself when you should be out working for change. Again, the investment in your well-being will allow you to give more to whatever movements you're feeling passionate about right now. Many people also find they get ideas or clarity during exercise. Perhaps even integrating some mindfulness into the exercise can help you anchor yourself to the present moment while you are strengthening your cardiovascular system.

Cognitive Restructuring

Are you having automatic thoughts that are getting in the way? Perhaps something like, "my whole state feels the opposite of how I do, so what's the point?" Examine the evidence ... both for and against! You may be in the minority, but you're probably not totally alone in your views. And are you sure that your actions are useless? Might it be important to let your representatives know that their district is not entirely homogeneous, and that the status quo might not always lead to their reelection? And to let judges and lawyers know people feel strongly about these issues? Again, we defer here to the experts on this kind of social engagement, but you probably have all the data you need to evaluate these thoughts with respect to that other criterion: helpfulness. What are the consequences of these thoughts? Are they leaving you feeling hopeless, despondent, alone, and unmotivated? Any one of those outcomes is enough to warrant reevaluation, right?

Bottom line: Like so many things you might have become interested in and pursued, if you really want to become more engaged, you can. And as cognitive-behavioral therapists, we have more tools than most to help ourselves do it. Remember, activism doesn't have to focus just on ways to affect the government. Reach out to companies such as grocery store chains to decrease plastic bag use. Start composting. Bring your kids to clean up trash near a stream. Reconsider your program of research: Are there ways to apply your research to make (more) positive change in the world? And remember: you probably already are making the world a better place through the people you help in your practice, the students you train in evidence-based practices, and the research you are currently conducting. Becoming an activist can represent building on those contributions or applying what you know to another arena.

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Taking a Gap Year: A Guide for Prospective Clinical Psychology Ph.D. Students

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Faculty and graduate students are frequently approached by undergraduates seeking advice about whether to take a gap year before applying (or reapplying) to clinical psychology Ph.D. programs. This article, written by current clinical psychology graduate students, is intended to serve as a resource for two primary audiences: (a) undergraduates uncertain about their readiness to apply to clinical psychology doctoral programs, who want to learn about the advantages and disadvantages of taking a gap year, and (b) those seeking guidance about improving their application after applying but not being admitted to clinical psychology doctoral programs. Our hope is that faculty advisors and graduate student mentors will disseminate this resource to Ph.D. hopefuls grappling with these predicaments.

SO YOU'RE NEARING THE END of college and have decided to pursue a Ph.D. in clinical psychology ... but you've run into roadblocks. Maybe you feel unqualified due to concerns you have not accumulated enough research experience to make you a competitive applicant. Maybe you feel confident about your academic vita, but have personal hesitations about jumping into a doctoral program immediately following graduation. Alternatively, perhaps you have already applied to clinical psychology doctoral programs but feel lost after receiving rejection notices. In this article, we draw upon our own experiences, as well as the experiences of undergraduates we have supervised, to guide Ph.D. hopefuls in determining the best course of action to gain admittance to a clinical psychology program. First, we help readers examine whether they have accumulated sufficient experience to ensure their competitiveness for clinical psychology doctoral programs. We also believe consideration of personal factors is a neglected, yet crucial area of consideration. Thus, we help readers consider whether they are personally prepared to take on another 5 to 7 years of schooling,

Next, because students sometimes feel disappointed when faced with the possibility of delaying academic goals, we normalize the decision to take time off between undergraduate and doctoral education. We then describe and critically evaluate the two most common paths taken by students en route to their Ph.D.—completing a master's program, and obtaining employment as a research assistant (RA). Finally, we conclude with suggestions for making the most of a gap year by gaining additional clinical experience, improving GRE scores, attending conferences, and establishing and maintaining professional relationships.

Of note, while this topic has been discussed in other articles (Calhoun & Prinstein, 2017; Prinstein, 2017), our article is unique in that it is written by six clinical psychology Ph.D. students who pursued a range of different pathways toward their doctoral degree, including research-oriented master's programs—an option largely overlooked in prior guides. We also provide an up-to-date list of easily accessible online resources for students. Finally, although our personal experiences do not allow us to speak directly to related degrees and disciplines (e.g., experimental psychology, Psy.D. programs, school psychology, counseling psychology, social work), we believe many of the issues addressed below cut across these disciplines as well.

How Do I Know If I'm Ready?

When gauging readiness for entering a Ph.D. program in clinical psychology, there are two key domains to consider. The first domain—academic qualifications—refers to the skills and experiences that will determine how competitive you will be during the application process, and enable you to hit the ground running when you begin a doctoral program. The second domain—personal readiness—reflects your level of enthusiasm for further schooling and your preparedness for undergoing a major life transition. Together, academic qualifica-

tions and personal readiness contribute to your potential for gaining admission and succeeding in graduate school.

The academic qualifications needed for acceptance into graduate school encompass a range of skills and experiences. Though an in-depth discussion of readiness goes beyond the scope of this paper (for further guidance see: <http://mitch.web.unc.edu/files/2017/02/MitchGradSchoolAdvice.pdf> as well as "Additional Resources" at the end of this article), we provide an overview of considerations for determining the type of program best suited to your interests, and whether you will be perceived as an attractive candidate. First, reviewing program websites will help you confirm that you are pursuing the degree and discipline aligned with career goals. For example, students opposed to the extensive clinical training required in a clinical psychology Ph.D. program should consider pursuing a purely research-focused doctoral degree in a related discipline (e.g., neuroscience and behavior). Alternatively, students who are disinterested in research but passionate about working as a clinician may wish to pursue a degree entirely focused on preparation for clinical practice (e.g., master's in social work, Psy.D. programs). Next, the necessary qualifications for admittance will differ based on the types of programs to which you apply. Within clinical psychology, programs adopt different training models (i.e., clinical science, scientist-practitioner, practitioner-scholar), corresponding to different areas of emphasis (see Bell & Hausman, 2014, for a description of common training models). Generally, research-focused programs expect prospective students to have already demonstrated productivity in research, such as an honors thesis, poster presentations, and even peer-reviewed publications—which are increasingly represented in application packets of competitive doctoral applicants. In contrast, clinically oriented programs place a greater emphasis on prior exposure to clinical settings. It is important to review program websites to get a sense of what skills are most valued in incoming graduate students.

Next, all APA-accredited clinical programs are required to provide data on admitted students within a section of their website entitled "Student Admissions, Outcomes, and Other Data." Comparing your scores to program average GPAs and GRE scores should give you a rough indication of how competitive you might be academically. Of course, even if your scores are

consistently above the mean of previously accepted students, this is not a guarantee that your overall application will be evaluated favorably. Additional academic qualifications including research experiences (reflected in personal statements and curriculum vitae) and letters of recommendation are equally important components of your application. Similarly, if your GPA and GRE scores are consistently below the mean, this may not be a deal breaker in the evaluation process if your other qualifications are exceptional. Faculty may have different standards for your GPA depending on the relevance and rigor of your undergraduate coursework. Programs also differ in how much weight they place on applicants' GRE scores; many programs recognize that the results of standardized tests only weakly relate to graduate school success and may be biased against students coming from disadvantaged backgrounds (Miller & Stassun, 2014; also see <https://aas.org/posts/news/2015/12/presidents-column-rethinking-role-gre>).

Whether a given applicant is qualified for a Ph.D. is based on a unique amalgam of factors. You can learn a great deal about your own competitiveness from speaking to faculty or academic advisors who are familiar with the graduate admissions process. Ideally, you can identify a faculty member for whom you have served as an RA and set up a meeting, long before application deadlines, to discuss your career goals. During this meeting, the faculty member can help you recognize areas of strength and weakness. It is critical to come prepared with a copy of your curriculum vitae (CV) so the faculty member can get a comprehensive understanding of your qualifications to date (for tips on how to write a strong CV, see Bannon & Rowe-Johnson, 2013). Because research experiences are difficult to quantify, faculty can help you determine whether your experiences are substantial enough to make you competitive.

Like academic readiness, personal readiness to undertake doctoral training is also multifaceted. First, it is helpful to gauge your own gut reaction, and consider hesitations you may have at the thought of applying to a doctoral program. Common reasons students delay applying to doctoral programs include being geographically limited, perhaps due to ties with significant others, family obligations, or financial considerations. Students may have a range of financial concerns, including a desire to earn an income to pay off debt from undergraduate education, hesitations about their

ability to manage the cost of applications, or uncertainty as to whether a given doctoral stipend will be sufficient to offset the cost of living in certain locales. Although many APA-accredited clinical psychology doctoral programs waive tuition and provide students with stipends, these programs are typically more competitive than tuition-charging programs, which commonly charge between \$10,000–\$40,000 per year (see <http://clinicalpsychgradschool.org/dprog.php> for information about incurred debt). A good understanding of the costs associated with graduate school is helpful for informing decision-making related to financial concerns.

If you do sense personal hesitations, we recommend you ask yourself two questions. First, "Despite these hesitations, am I still committed to pursuing a Ph.D. in clinical psychology?" If yes, then ask yourself, "Can I address any of these concerns during a gap period before graduate school?" For example, if you are unsure whether you truly enjoy the research process, spending time working in a research lab postbaccalaureate may help inform your decision. However, if you are opposed to the often necessary relocation required to attend graduate programs, you will need to honestly consider whether these hesitations could change over the course of a gap year. Although a certain level of anxiety accompanies any major life decision, it is up to you to determine whether the benefits of graduate school outweigh the costs.

Relatedly, we recommend examining whether there are factors propelling you toward doctoral study in clinical psychology. It is a good sign if you feel inspired and enthusiastic at the prospect of jumping back into another 5 or more years of school. A key factor that may inform your level of enthusiasm is whether you have identified a specific research area about which you feel passionate. During graduate school, you will develop expertise in a very specific area; students may find this prospect either thrilling or daunting, depending on their level of interest in the material. To this end, taking an extra year to identify your research passion may result in a more rewarding graduate (and future career) experience. Finally, it can be challenging to make an informed decision to apply to doctoral programs if you do not know what being a graduate student actually looks like day-to-day. For example, in undergraduate programs, students' primary goal is to obtain a high GPA; in contrast, doctoral programs deemphasize the

importance of obtaining perfect grades in favor of building a program of research and developing clinical competencies, with the ultimate goal of preparing students for careers as independent researchers and clinicians. Therefore, we recommend you speak to graduate students (more than one if possible, as opinions may vary!) to get a better sense of what graduate school entails.

Coming to Terms With a Gap Year

The process of reflection is vital to making informed decisions about whether you are ready to pursue a doctoral degree in clinical psychology, and, if you choose to take a gap year, will help you make the most of that time. For some, making the decision to take a gap year is relatively easy. For others, coming to terms with the decision to delay entry to graduate school in favor of a gap year is challenging. Students intent on pursuing a Ph.D. in clinical psychology tend to be highly ambitious and driven to succeed. Perhaps, at present, you feel you don't have enough research experience to make you sufficiently competitive, personal considerations are holding you back, or a combination of the two is making you hesitant to apply. Regardless of the reason(s), for some, the decision to take a gap year (or two) may, at first, trigger feelings of dejection. When imagining career trajectories, you may have assumed you would proceed seamlessly from your undergraduate education to your Ph.D. program if you worked hard enough. If so, coming to terms with the fact that you may be unable to achieve your goals in the time line you expected can be disheartening. Further, sharing your decision with important people in your life can be particularly challenging. You may worry that your family and friends will be disappointed in you, possibly perceiving that your decision to take time off is indicative of "giving up." Unfortunately, many are unaware of the competitiveness of clinical psychology Ph.D. programs! Addressing these misperceptions is important to helping your loved ones understand that you have made an informed decision that will best help you reach your goals, and does not reflect upon your commitment to your career. Supporting the notion that coming to terms with a gap year is challenging, an online search reveals a number of Internet forums (e.g., The GradCafe Forums, The Student Doctor Network) with countless threads offering advice to individuals seeking words of wisdom about graduate applica-

tion concerns. Among the most popular threads are those in which students ask others to evaluate “what are my chances” of acceptance into a clinical psychology program (i.e., WAMC threads; <https://forums.studentdoctor.net/threads/wamc-what-are-my-chances.686573>). Spend a few minutes reading through comments on these websites, and one quickly senses how the decision to delay application (or take a gap year following rejection) is sometimes beset by frustration and self-doubt.

We are here to reinforce the message that there is nothing wrong with deciding to take a gap year. In fact, although we are unaware of existing empirical data, the trend of taking gap year(s) between college and doctoral education may well have increased as clinical psychology Ph.D. programs have become more competitive over time (see <http://mitch.web.unc.edu/files/2013/10/AdmissionsRates.pdf> for admission rates by program between 2008–2013). Among the six student authors of this article, the majority (four of six) took between 1 to 3 gap years prior to acceptance into the Clinical Psychology Training Program (CPTP) at the University of Nebraska-Lincoln. All four of us benefitted immensely, both professionally and personally, from our decision to take time off. We all believe we gained entry into a competitive clinical psychology program fitting our career goals by making the deliberate decision to use our gap time to our advantage. To help you decide how best to use your gap year(s), the next section delineates the two options that we believe offer students the greatest opportunities to gain critical research and clinical experiences needed for acceptance to a strong clinical psychology program.

Master's Programs

Some students may want to pursue a master's degree in clinical psychology or a related field (e.g., experimental psychology, counseling psychology) as an intermediate step on the way to doctoral programs. As a master's student, you may have opportunities to boost the quality of your research and clinical experiences, expand expertise within a certain area of study, and obtain stronger, more tailored letters of recommendation—all ingredients of a strong graduate school application. Completing a master's program can also familiarize you with the rigors of graduate-level training, thus, potentially easing your transition into a doctoral program.

It is important to identify master's programs that will serve to assist you in reaching your end goal. We recommend pursuing programs that are known for preparing students for future doctoral study. These programs tend to emphasize training in research methods and statistics (as opposed to practice-oriented programs). Not only can these programs help you build research skills, but students who have not identified a clear research interest can gain concentrated experience within a particular content area, and have opportunities to disseminate their work in peer-reviewed outlets (e.g., conferences, journals). Relatedly, we recommend only pursuing master's programs with a thesis option. Completing an empirical thesis in your master's program will allow you to gain valuable experience conducting a study independently, which will provide you fodder for your personal statement and interviews, and enable you to develop foundational research skills pertinent to success in doctoral programs. It is possible (though certainly not guaranteed) that completing a thesis in your master's program will even allow you to waive your doctoral program's thesis requirement.

Though arguably less important for doctoral admission, some master's programs also provide clinical training. Because it can be difficult to find clinical opportunities prior to completing a bachelor's degree, many undergraduate students apply to graduate school with limited clinically relevant experience. Master's-level clinical practica will not only boost this section of your CV, but may also prepare you for doctoral-level clinical training. While your cohort members struggle with the anxieties of seeing their very first client, you might find solace in knowing that you indeed have some basic clinical skills. Furthermore, assessment, intervention, and supervision hours accrued during your master's program will ultimately be included on your application for internship (the final step in your doctoral training). Additionally, because the best master's programs tend to accept small cohorts of students, you are likely to have substantial interaction with faculty members across various aspects of training (e.g., courses, research, clinical work). This will allow you to establish close relationships with faculty who can attest to your ability to do graduate work, thus facilitating stronger letters of recommendation as well as mentorship and guidance in the application process. Finally, if you decide not to pursue your doctorate in clinical psychology after

obtaining your master's in clinical psychology, you may be able to work as a master's-level clinician under the supervision of a licensed practitioner, depending on your state of residence.

Despite the benefits of pursuing a master's degree, it is important to consider the potential drawbacks of this option. First, master's programs can be costly. Many do not offer assistantships or fellowships to offset tuition costs. Second, completing a master's degree will not necessarily shorten the length of your Ph.D. training. You may be able to transfer some course credits and even waive the thesis requirement. However, even then, you will likely have at least 4 years of doctoral training ahead of you. Third, although earning a master's degree can bolster certain aspects of your application to a doctoral program, it does not guarantee that you will be admitted into a Ph.D. program. Finally, though a master's program will provide you with a breadth of experience, clinical and course requirements may indeed detract from research productivity. Some argue that research experience is most pertinent to doctoral admission, and as such, gap year options focused solely on research might be more worthwhile.

If, after weighing the various factors discussed above, you decide to pursue a master's degree during your gap year(s), then it will be important to carefully choose a high-quality master's program. As noted, a “stepping stone program” that provides abundant research training and opportunities to present and publish will better fit your goals than would a clinically focused program aiming to train master's-level clinicians. If clinical training is offered, look for programs that emphasize cognitive behavioral therapy or other evidence-based approaches. You can also identify stepping-stone programs by talking with program directors about the number of students who go on to apply and gain admission to doctoral programs in clinical psychology. Some examples of these programs, which emphasize CBT training, can be found in a previous *tBT* article (Tafari, Jaffe, & DiLillo, 2015).

Research Assistant Positions

As an alternative to the master's degree route, some students may choose to acquire additional experience by working as an RA. These positions have various titles, such as research technician, study coordinator, and project manager. Regardless of title, taking on a full- or part-time

RA position will bolster your resume by providing you the opportunity to carry out diverse research activities, focus your research interests to a particular content area, and develop greater clarification of your own career goals. Typically, research assistantships last between 1 and 2 years, and are either funded or volunteer. Ideal research positions provide you the opportunity to be involved in multiple stages of the research process, including: (a) grant writing, which provides you experience assembling components of a new project; (b) study start-up, which may involve protocol design and preparation of documents for the Institutional Review Board (IRB); (c) recruitment and data collection, which often involves interaction with participants and learning unique procedures (e.g., structured interviews, physiological assessments, behavioral coding); (d) data entry and management, which allows you to gain familiarity with important software programs; and (e) data analysis/manuscript preparation, skills essential for conducting your own independent research. If tasks you desire are not written into your job description, simply asking to do more can go a long way! RAs who are motivated to take on additional responsibilities are greatly appreciated by their supervisors. However, if you are unable to obtain the experiences you desire in your current position, be sure to seek them out elsewhere through volunteering.

There are several key benefits to post-baccalaureate research assistantships. The best research positions immerse you in the detailed workings of a research lab, thus preparing you for what will be expected of you in a Ph.D. program. Many principal investigators (PIs) will allow RAs to conduct secondary data analyses of previously collected research, which may be presented at local, national, or international conferences (a clear resume builder). Ambitious RAs may even seek to publish a manuscript in a peer-reviewed journal; doing so helps you stand out among other applicants in the pool. Additionally, you will likely be provided the opportunity to run research participants, allowing you hands-on clinical interaction, which can significantly add to your breadth of experiences.

An added benefit of completing a research assistantship is the number of professional connections that you will build as a result of your time commitment. Based on your diligence in completing tasks to which you are assigned, your skills in working with research participants, your ability to work effectively as part of a team, and

your prowess for conducting work independently, your supervisor(s) may have much to say in a letter of recommendation about your strengths. Thus, when considering various research positions, it is important to assess the extent to which you will develop a professional relationship with your PI, and ensure this level of contact matches your desired level of supervision. Some supervisors may meet with their RAs on a weekly basis, offering close supervision, while other PIs may have you report directly to an intermediary point of contact such as a postdoc or graduate student. Finally, because RAs often work in a team setting, you will likely receive support and resources from both your peers and professionals as you prepare to take the next step.

Despite the benefits of research assistantships, there are some limitations of which you should be aware. First, some research positions may not give you the opportunities that ideally set you up for graduate school (e.g., a position that primarily involves one task, such as data entry). Asking questions at job interviews about your specific responsibilities is essential to ensuring your expectations match the reality of the position. Additionally, you may find it difficult to obtain a paid research assistantship. Paid positions are not plentiful, particularly in the current funding climate. Thus, you may find yourself competing with nearly as many applicants as you would find applying to doctoral programs! Individuals most competitive for paid RA positions tend to already have experience in research. If you are unable to obtain a paid RA position, it may be possible to pursue a quality volunteer position that provides you the opportunities you are seeking, while simultaneously working elsewhere part-time.

Perhaps after reading this, you decide you are interested in pursuing a research assistantship. Faculty and/or graduate students at your undergraduate program are among your greatest resources for getting connected with PIs at research-intensive universities or academically affiliated hospitals actively conducting research in an area of interest. We also recommend you search online for faculty working in a research area of interest (e.g., using PsycINFO) and email them inquiring whether they have research assistantships available. If you already applied to doctoral programs but were not admitted, it is perfectly acceptable to email faculty who were unable to admit you and inquire about potential positions. Successful doctoral applicants can and do move for gap year

experiences! There are additional resources available as well. You may wish to join free listservs advertising postbaccalaureate assistantships and other job opportunities (such as the ABCT members digest at <http://www.abct.org/Members/?m=mMembers&fa=ListServe>). You can search <https://projectreporter.nih.gov/reporter.cfm> to look for grants in your area of interest which have been recently funded, and email the study PI. Your local Psi Chi chapter may regularly receive emails about job opportunities for positions. Finally, we recommend visiting <http://clinicalpsychgradschool.org/pbacc.php> and searching online for "clinical psychology research assistantships," along with keywords related to your area of interest.

How Many Gap Years Should I Take?

As mentioned, four of us delayed application to doctoral programs to serve as RAs or enroll in a clinical master's program. Specifically, we took off 1 year ($n = 1$), 2 years ($n = 1$), and 3 years ($n = 2$). There are several factors to consider when deciding how long to delay applying to doctoral programs. First, if your goal in taking a gap year is to gain critical research, clinical, and academic experiences, you may choose how long to take off based on what you need to increase your competitiveness. For example, those with substantial research experience by the end of college may only need 6 months to a year to gain additional worthwhile experiences. Of course, there is no litmus test for determining when you have accrued the necessary experience, but our guide above, in addition to our reference list below, can help point you in the right direction. Next, the amount of time you take off may be dictated by logistical reasons. For example, your master's program or research position may require up front a commitment of 2 years. Taking 2 gap years can be advantageous in helping faculty and supervisors get to know you better before writing letters of recommendation (remember, individuals choosing to take 1 year off will need to solicit recommendations the fall after they graduate from college). Finally, you may choose to take several gap years because you are enjoying the time away from school, in addition to accruing valuable experiences. For example, the two authors who decided to take 3 years off were able to see large-scale research projects through to completion, publish findings, earn a salary, and enjoy extra leisure time before launching back into school.

Additional Resume Builders and Professional Networking

If you decide to take a gap year, there are a number of other activities that will help you to further strengthen your application, as well as more clearly identify your interests. Prospective students may wish to gain clinical experience, which can be obtained by volunteering on a crisis hotline, assisting at a domestic violence shelter or child advocacy center, working as a behavioral aid, or assisting with group therapy or skills training in a residential treatment setting. These opportunities can help you gain exposure to clinical populations of interest, and make an informed decision about whether you ultimately want to pursue a clinically oriented Ph.D. Speak to faculty and academic advisors at your undergraduate institution to get the best information about valuable clinical opportunities in your region. As a disclaimer, although clinical experience with a population of interest is looked upon favorably by Ph.D. admissions committees, faculty at more research-oriented doctoral programs generally do not consider this a vital part of an application (Prinstein, 2017). Thus, we recommend students seek clinical opportunities as an adjunct to continued research.

During your gap year(s), it may also be wise to retake the GRE depending on the score you received. Undergraduates often take the GRE for the first time in their final year of college; this is a busy time during which it can be challenging to adequately prepare. To make an informed decision, we recommend reviewing the websites of prospective doctoral programs, updated annually, to determine whether your GRE scores fall within the range of scores of recently accepted students. Furthermore, upon reviewing the required materials for prospective doctoral programs, some students may find that the GRE Psychology Subject Test is required, necessitating you to devote additional time to prepare for another exam. If you do decide to retake the GRE, you can visit https://www.ets.org/gre/revised_general/prepare to obtain resources such as flashcards, study guides, and sample tests.

Another valuable way to enhance your CV and develop connections with faculty mentors of interest is through presenting research at regional and national conferences. If you have a role in an ongoing project at your undergraduate institution, discuss opportunities with your research advisor for presenting findings. Conferences are a prime way to disseminate your

research, network with potential faculty advisors, and meet other students with similar interests. To determine appropriate outlets, speak to current graduate students and faculty at your undergraduate institution about conferences they frequent. We recommend attending the annual ABCT convention. In addition to being populated by a range of professionals with diverse interests, ABCT offers a "Getting Into Graduate School" panel each year, sure to be useful as you navigate through the process. Joining professional organizations as a student or postbaccalaureate member also offers numerous networking, mentoring, and presentation opportunities. For example, ABCT offers approximately 40 Special Interest Groups (SIGs), which unite members with similar research and/or clinical interests. Undergraduates may wish to submit posters through a SIG because they have later submission deadlines and a greater proportion of submissions are accepted. Even if you are unable to showcase your own research, it may still be beneficial to attend conferences to introduce yourself and share your research interests with potential faculty mentors and graduate students.

It is also useful to communicate your interest to faculty via email during the fall before applying to doctoral programs. First, check the faculty websites to obtain all available information. When emailing faculty, be sure to avoid questions already answered on their website (e.g., whether they plan on taking a graduate student the following year). We recommend you briefly introduce yourself (e.g., undergraduate institution, current research employment) and express your fit with the faculty mentor and your enthusiasm for the program as a whole. Finding a good match with a faculty mentor is invaluable in graduate school; thus, it is essential to be thoughtful in your search.

Finally, if you decide to take time off following your undergraduate education and you have already developed close professional relationships, we recommend you communicate your plans for your gap year(s) to faculty, and inquire whether they would be willing to write a letter of recommendation for you when the time comes to apply to graduate school. During your gap year(s), stay in touch with these faculty by sending email updates quarterly, and keeping them abreast of your new experiences, as well as your career goals. This will allow letter writers to say they have remained in contact with you and communicate the

experiences you have gained over the gap year(s) in their letters of recommendation.

Conclusion

There are many factors to consider when deciding whether to take a gap year before applying to Ph.D. programs in clinical psychology. Committing not only to a graduate program, but also to a career in clinical psychology is a major life decision that should be carefully considered. Reflect on your commitment to this broad career choice (becoming a psychologist), the specific field (clinical psychology), and your particular research and clinical interests. Consider your readiness for graduate training by reflecting on both academic preparedness and personal factors. Discuss any concerns with academic advisors, graduate students, mentors, and other supports in your life. If you identify areas needing improvement, consider whether these areas can be addressed over the course of one or more gap years. Be honest with yourself about what you would do during these gap years; taking time off only helps improve your chances of graduate admissions if you use this time to build your vita and improve your application. Remember that there are a variety of options to gain additional research and clinical experience, including master's programs, paid and volunteer research assistantships, and clinically relevant employment opportunities. Build upon the momentum you have now to seek out and take on new experiences.

We hope this article will serve as a helpful resource in directing your attention toward some important considerations when deciding whether to take a gap year. Ambiguity and uncertainty about these career decisions are common at this stage. A leap of faith is required in making any major life decision, including entering a graduate program, and you are not expected to have mapped out your exact career trajectory prior to entering graduate school. Be aware of any tendencies you may have to be too critical (or perhaps not critical enough) of your qualifications. If you otherwise feel ready to apply to graduate school, but are unsure whether your credentials would merit acceptance into a competitive program, you may consider applying with a backup plan in mind if you are not accepted. In sum, remember that there are no right or wrong choices, but giving careful consideration to the idea of a gap year may help you to improve your long-term success in the field of clinical psychology.

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SCIENCE FORUM

Irritability in Youth: Expert Perspectives on the State of the Science

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A Brief Background

By age 10, "James" had a long history of frequent, severe temper outbursts—at home, at school, and with peers. His parents described themselves "walking on eggshells" constantly, so as not to frustrate him with demands. He wasn't asked to do household chores. Getting James to complete his homework was a laborious task for everyone in the family. Family jaunts outside the home were infrequent. More often than not James woke up cranky and grumpy, and this irritable mood sometimes continued throughout the day as he was easily annoyed or provoked by others, especially at school. At age 4, he had been asked to leave preschool

because of his behavior. With his current classmates he was typically inflexible (e.g., arguing that other kids should do things his way). These struggles made it difficult for James to make and keep friends; rarely was he invited on playdates. He often felt guilty and remorseful about his behaviors, especially toward his parents, and he desperately wanted close friends. At the same time, he couldn't imagine being any other way.

Irritability is one of the most common presenting problems for which children and adolescents are referred to treatment (e.g., Collishaw et al., 2010; Peterson et al., 1996). Chronic, severe irritability in early life confers risk for other forms of psychopathol-

ogy (e.g., anxiety, unipolar depression), functional impairment, and suicidality in adulthood (e.g., Copeland et al., 2014; Nock et al., 2007; Pickles et al., 2010). In brief, irritability constitutes a prevalent, substantial public health burden.

However, irritability has come into the research spotlight relatively recently. In the 1990s, there was controversy surrounding the diagnosis of bipolar disorder in children and whether chronic, nonepisodic irritability may be a developmental presentation of bipolar disorder. Leibenluft and colleagues (Leibenluft et al., 2003; reviewed in Leibenluft, 2011) addressed this nosological debate by operationalizing symptom criteria for chronic, severe irritability and directly examining whether it is indeed a presentation of bipolar disorder in youth. This work demonstrated that youth with chronic, severe irritability differed from youth with classically defined bipolar disorder (i.e., clearly demarcated episodes of mania or hypomania) on longitudinal course, family psychiatric history, and key brain and behavioral measures. Collectively this work supported that irritability is not a developmental presentation of bipolar disorder, and facilitated the scientific study of irritability in its own right. In addition, this work informed the development of the DSM-5 diagnosis, disruptive mood dysregulation disorder (DMDD), intended to characterize children such as James for improved evaluation and treatment.

The past decade has witnessed an upsurge in research on irritability and, currently, the field is ripe for further clinical research developments (Avenevoli et al., 2015). In this context, we individually surveyed five of today's leading experts on irritability, with the aim of culling current knowledge and stimulating future work. Below, our expert contributors responded to a few targeted questions on irritability, which we present here.

How do you define irritability in youth?

Dr. Melissa Brotman: We define irritability as an elevated proneness to anger, relative to one's peers (Brotman et al., 2017). Proneness to anger is a dimensional trait; clinically, severely irritable children and adolescents have a lowered threshold for expressing anger, leading to more frequent temper outbursts. When such outbursts occur, they have greater behavioral intensity than that of their typically developing peers. Outbursts are characterized by increased motor activity, prominent displays of anger and other negatively valenced emotions, and verbal, as well as sometimes physical, displays of reactive aggression. Between temper outbursts, severely irritable children often have a persistent angry mood, involving sullen nonverbal behaviors and reports of being annoyed over many days.

Dr. Christen Deveney: I currently define irritability as a proneness to anger that exceeds what is typical in one's peers. However, the proneness to anger appears to reflect abnormalities in the constructs of emotional reactivity and emotion regulation, especially when children are responding to frustration and threatening stimuli.

Dr. Francheska Perepletchikova: Irritability is a core diagnostic criterion of DMDD that is critical to accurately assess, and it is usually done via parental and child reports. I have found that parents I see clinically frequently have difficulty grasping this construct as, for the most part, their children's baseline mood is irritable. This may distort parents' understanding of what normal or neutral mood may look like, resulting in underreporting of irritable mood. Thus, it is imperative to help parents understand the definition of irritability when doing an assessment. Before asking parents to describe their child's mood, I first give them an image of irritability as an underground river that

once in a while, when pressure rises, bursts into geysers of temper outbursts. Irritability may take different forms, such as frequently waking up grumpy in the morning, cursing, mumbling under one's breath, giving snappy or "smart aleck" comments, brushing against people when walking by, stomping away, angry posturing (e.g., with arms crossed), rolling or squinting eyes, sucking teeth, tightening lips, sighing impatiently, moaning, groaning, or frequently complaining.

Dr. Amy Roy: Irritability can be defined in various ways that typically reflect chronicity and related mood states. Some children exhibit a chronic "irritable mood." Parents of these children report that their child is angry or irritable from the time he or she wakes up in the morning and remains in this mood for most of the day. This would be the type of irritability characteristic of DMDD. For these children, emotional reactivity in the form of temper outbursts is superimposed on an underlying angry or irritable mood. However, some children are euthymic or even in a happy mood most of the time, but have a short fuse. In these cases, the irritability is evident in how quickly they are "set off" when they are frustrated. Emotional reactivity is a key issue for these children as they switch from one mood state to another very quickly.

Dr. Denis Sukhodolsky: We view irritability as a tendency to experience and express anger in developmentally inappropriate ways, such as temper outbursts or screaming matches. We also find it helpful to define anger as an emotion which can lead to aggression, an overt behavior that can result in harm to self or others.

What are some key concepts or findings from your own work on irritability?

Dr. Perepletchikova: My research and clinical practice for many years has focused on children with DMDD. I have found that irritability is highly associated with emotional sensitivity, which has four main characteristics. First, emotional reactions have a low threshold for occurrence. For these children, emotional triggers may involve just a thought or a memory, or an actual event. Sensitive children have an uncanny ability to observe and attend to events in the environment that others totally miss. Second,

emotional reactions are very intense. Using a scale of 1–100, when other children go to a level 50 on anger, emotionally sensitive children will usually go straight to a 100. Third, emotional reactions happen very fast. Parents and children alike describe these reactions as going from 0 to 100 in a millisecond. Fourth, emotional reactions take a long time to subside. Once emotionally sensitive children get upset, it sometimes may take an hour or even more for them to fully calm down, as compared to just a couple of minutes for other children.

Further, emotional sensitivity tends to come in a package. For example: (1) Emotionally sensitive children frequently look for ways to avoid effort. These children are constantly overwhelmed by their own emotional experiences and may be less inclined to face challenges. This is an important consideration for parents, who might think that their emotionally sensitive children are lazy. (2) These children are also usually hyperreactive, and may exhibit behaviors such as anxiety attacks, physical aggression, verbal outbursts, temper tantrums, suicidality, cutting, burning, and engaging in other forms of nonsuicidal self-injury (NSSI). (3) These children dislike change. They respond well to structure, sameness and security. Anything new is met with reluctance and having to transition from one activity to the next is problematic for them. (4) They display impulsive behaviors. Sensitive children may often do things without thinking. The intensity of their emotional reactions is so high that they may not be able to fully process their urges before they act on them. This may also be related to their difficulty with delayed gratification and with feeling pained because they are being blocked from immediately achieving a goal. (5) Emotional sensitivity is highly associated with sensory sensitivity, or a low tolerance to sensory stimulation. Some or all senses may be affected including touch, smell, taste, sound, and vision. Trying a new flavor, going to a crowded mall, or even putting on a new sweater or a pair of socks may cause a high level of discomfort and even a sensory overload. (6) These children frequently have severe interpersonal difficulties with siblings and parents and may have problems with peers and friends. Their reactivity often greatly interferes with developing and maintaining stable relationships. (7) They have extreme thinking style, such as black-and-white thinking and catastrophizing. They also

tend to perseverate and ruminate. That is quite understandable, given that under high arousal, attention narrows down and thoughts become more rigid.

Dr. Roy: In our own work with 5- to 9-year-old children who are referred for severe temper outbursts, we find that very few exhibit chronic irritability characteristic of DMDD (Roy et al., 2013; Roy et al., in press). However, they are still highly impaired, and thus remain an important group to study. In our most recent paper, we demonstrated that children with these outbursts exhibit altered intrinsic functional connectivity of the anterior mid-cingulate cortex, a region involved in negative affect and cognitive control, two components essential to regulation of frustration and anger responses. We are continuing to examine these networks in larger samples to determine if connectivity of these networks can be used to define subgroups within the highly heterogeneous group of children with severe temper outbursts.

Dr. Brotman: We recently developed a translational model of irritability that specifies brain circuitry-based targets for novel interventions (Brotman et al., 2017). In this model, we attribute pathological irritability to aberrant responses to frustrative nonreward (e.g., nonhuman primate and rodent models; Amsel, 1958) and threat. This model emerged directly from our functional neuroimaging studies, which found that irritable youth have dysfunction in the brain circuitry underlying frustration and threat responses, including in the prefrontal cortex, striatum, and amygdala. We developed and are now testing two novel treatments that target both aberrant threat and reward processing.

For example, using a computer-based treatment, interpretation bias training (IBT), we are working to target the rapid, automatic processing of social threats in irritable youth. Because irritable youth are more likely than typically developing children to attend to facial threats and label ambiguous facial stimuli as threatening (Brotman et al., 2009; Stoddard et al., 2016), during IBT, children are taught implicitly to make more benign interpretations of ambiguous face stimuli. Preliminary, open data suggest that such training may decrease irritability (Stoddard et al.) and we are currently conducting a randomized controlled trial of IBT for DMDD (NIH Protocol 15-M-0182;

<https://www.clinicaltrials.gov/ct/show/NCT02531893>).

We have also just completed piloting an exposure-based CBT for irritability. Irritability shares many features with anxiety, another condition where specific cues in the environment trigger phasic, high-arousal states, and disorders of behavioral dysregulation. Based on this, we developed a manualized CBT that builds on the successes of CBT for anxiety and of parent training for disruptive behavior. In session, we develop an anger hierarchy and hypothesize that extinction learning will occur as graded exposure to frustrating situations leads to increased frustration tolerance. We bring anger-inducing stimuli into session in order to conduct exposure in vivo. We also adopt instrumental learning techniques from parent training for disruptive behavior disorders. Because our early open pilot trial shows promise, we are in the process of beginning a more rigorous study (i.e., within-subjects multiple baseline design).

Dr. Sukhodolsky: Our research on pediatric irritability has been guided by a cognitive-behavioral approach in which children learn emotion-regulation skills for managing frustration and parents learn to foster their child's competence in navigating frustrating situations (Sukhodolsky et al., 2016). The goal of the treatment is to reduce the frequency and intensity of anger outbursts and aggressive behavior. This approach to CBT for anger and aggression has emerged over the course of three randomized trials in children with disruptive behavior as well as pilot work in children with irritability in the context of neurodevelopmental disorders, including autism and Tourette syndrome. A large randomized controlled trial of CBT for aggression in children across diagnostic categories is under way (Sukhodolsky et al.).

The treatment starts with a detailed assessment of the frequency (i.e., number of episodes per week), duration (i.e., time), and intensity (i.e., risk of injury, property damage, and impact on family) of anger outbursts. Aggressive behaviors are operationalized as instances of verbal threats, physical fighting, or property damage. Two or three of the most pressing problems (e.g., temper outbursts) are identified as target symptoms and used to tailor therapeutic techniques that are detailed in the treatment manual (Sukhodolsky & Scahill, 2012). During the child-focused portions of the treat-

ment, children discuss situations that trigger their anger or their conflicts with parents, teachers, or peers with the therapist and then problem-solve to identify prevention strategies to avoid these triggers. The core portion of CBT is dedicated to learning and practicing emotion-regulation skills such as cognitive reappraisal of triggers and consideration of consequences of aggressive responses to cope with frustrating events that cannot be changed or avoided. Each of the 12 CBT sessions consists of a menu of therapeutic techniques and activities that can be used in a flexible yet reliable manner towards the goal of reducing anger outbursts and aggressive behavior. Parents also learn how to reward their child's calm responses to potentially frustrating events with praise, attention, and privileges in dedicated parenting sessions.

Although our current study is designed for children across diagnostic categories with clinically significant levels of aggression defined by a score on the CBCL aggression subscale, case reports suggest that CBT may be helpful for reducing anger and aggression for children who meet criteria for DMDD (Tudor et al., 2016).

What are some important, open questions on irritability? Are there research challenges to address?

Dr. Deveney: The existing empirical research focuses on initial emotional reactivity. Comparatively, little research has examined emotion regulation processes once an affective state exists—that is, whether individuals with irritability tend to use maladaptive strategies or whether they fail to use emotion strategies flexibly in response to different contexts is unknown. Such knowledge would inform psychosocial interventions with patients and their families. A second important area of inquiry concerns the developmental trajectory of irritability and is associated mechanisms from childhood into adulthood. Whether deficits detected in childhood persist into adulthood is unknown. Such information would help identify candidate biomarkers of irritability versus deficits likely to resolve during the course of development.

Relatedly, a challenge for pathophysiological and neuroimaging research on irritability is the relative absence of information regarding how typically developing children respond to frustration-based experimental manipulations. Such infor-

mation is essential for identifying what processes are intact among children with irritability and where they exhibit deficits. In order to minimize statistical comparisons and protect against Type I error, many neuroimaging studies focus on regions where clinical and nonclinical groups differ. However, such comparisons fail to identify neural circuitry that is appropriately engaged by both groups.

Dr. Roy: The greatest challenges for research on irritability involve assessment, particularly of young children. In our own work, we rely heavily on parent report of tantrum frequency and duration, and behaviors that characterize the outbursts. However, parent reports are likely influenced by their own emotions regarding these outbursts, as well as their ability to tolerate their child's distress. Thus, these reports may not be accurate descriptions of the child's behavior. Objective, ecologically valid measures that include behavioral and psychophysiological components are needed to improve understanding of factors impacting emotional reactivity and regulation in irritable youth.

Dr. Brotman: There are numerous research opportunities in the field of irritability research. First, despite the fact that irritability is so common clinically, few effective, empirically supported treatments are available. Second, computational approaches that model behavior using mathematical terms are beginning to be used to study irritability (e.g., Kircanski et al., 2017) and to determine unique and overlapping behavioral and neural deficits with other symptom dimensions, such as anxiety. Such methods could be applied to the behavioral deficits (e.g., reward and threat processing) associated with irritability. Finally, a current challenge for research on irritability is the use of established, well-validated measures to study the phenotype. There are few measures, and different research groups often use different measures. To address this pressing need, our group has been developing a clinician-administered irritability assessment that we hope to validate and disseminate to the wider clinical and research community. In addition, we are incorporating real-time, digitally based event sampling using ecological momentary assessment (EMA), a method to acquire clinical data in real time using smartphone technology.

An Ongoing Dialogue

These expert perspectives highlight irritability as a distinct, multifaceted clinical construct that is relatively early in its scientific evolution—and our understanding continues to evolve with each new study. While clinical research on irritability has progressed immensely in the past decade, some core research challenges (e.g., measurement) remain to be addressed. These challenges are tractable, with the potential for current work to greatly impact future understanding and treatment. Indeed, the field of irritability is ripe for developments in both basic research (e.g., affective science, neuroscience) and clinical translation (e.g., cognitive-behavioral therapies for DMDD). Irritability is also reflected in the National Institute of Mental Health (NIMH) Research Domain Criteria (RDoC) initiative (<https://www.nimh.nih.gov/research-priorities/rdoc/constructs/rdoc-matrix.shtml>) through the construct of frustrative nonreward, thereby facilitating future studies. Further scientific and clinical dialogue on irritability will help to address this pressing public health need.

Continue the dialogue at the ABCT 2017 Convention!

- Drs. Ellen Leibenluft and Melissa Brotman of the NIMH will lead a Clinical Grand Rounds entitled “Mechanism-Based Treatments of Irritability: Exposure-Based CBT and Interpretation Bias Modification.”
- Trainees of Drs. Amy Roy and Denis Sukhodolsky will present posters on irritability and related constructs.
- Spencer Evans of the University of Kansas will chair a Symposium entitled “Irritability in Children and Adolescents: Treatment Needs and Mechanisms for Change.”

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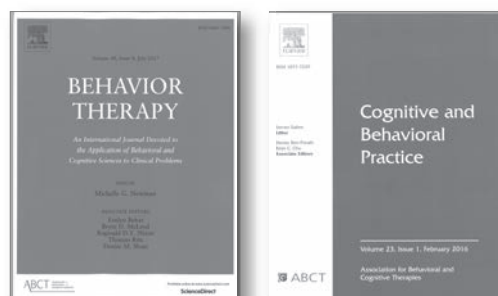
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K. Ong, Ph.D.

The 8th Wonder of the CBT World

• PART ONE •

Jonathan Hoffman, *Neurobehavioral Institute*

Dean McKay, *Fordham University*

Present Time

The gargantuan simian gazed down at the mirror-surfaced lake far below and took a last bite of his pterodactyl sandwich. He examined his beard in the water's reflection, grateful that it remained well above the knot in his rep tie—his latest profession's unwritten rule. He then reinserted his monocle, a symbol of authenticity that he favored over the bowties, red capes, Sherlockian pipes, and Blakiston's Fish Owls¹ often sported by the dignitaries in his guild. Ong placed a great deal of importance on "looking the part."

He knuckle-walked to his office, mindful of his decision not to trample any more trees. He sat on a large log in his cavern and started his new consult. "Hi, this is Dr. Ong, how may I be of service?" He couldn't wait to try out his new therapy protocol.²

1933³

Pretending to be machine-gunned off the spire of the Empire State building by a squadron of biplanes had proved unexpectedly disconcerting to Ong, who was indestructible and immortal. At first, he couldn't quite put his enormous finger on why. Usually he enjoyed any opportunity to be a drama queen.

After he'd smashed into the sidewalk, he played possum for an enormous crowd of rubberneckers. Soon afterwards, the authorities, falling for his act, had lowered

him by crane into an immense pit that had been excavated in a landfill on Staten Island. Ong waited for the activity around his make-shift grave to cease long enough for him to be certain he was alone. After digging his way out, he backfilled the now empty crater to hide his resurrection, trying his best to be inconspicuous. A short time later, Ong waded into New York Harbor for the long swim back to his Island.

Ong pondered as he stroked through the waves: About once a year, for ages, he'd been rescuing women who had been, inexplicably, tied up by each arm to posts on a wooden platform outside the largest human village on his Island. Ong was a very selective Good Samaritan; other than this thankless work, he pretty much did as he pleased without any regard for its impact on others. (Truth be told, it also gave him something to do—a downside of immortality is that it's tedious.) After freeing them, he carried these understandably upset women—they virtually never stopped screaming—to sanctuary on a nearby cay.

The lady whose rescue had precipitated his first trip to the Big Apple was a tourist named Ann.⁴ Like her predecessors, she'd been left beyond the village entrance to rot or be eaten by one of the Island's fearsome denizens for reasons unknown. ("This can't be good for the Island's hospitality business," he'd thought at the time.) Ann

had calmed down more quickly than any of the other victims, so Ong couldn't help but be impressed and without further ado pledged allegiance to her in the style of a courtly admirer, as any other sort of relationship was, of course, patently absurd. To his amazement, a well-armed band of fellow tourists had followed his tracks into the jungle to get Ann back. This, under typical circumstances, would have led to their certain demise. But, in exact counterpoint to his protective urge toward Ann, he had impulsively acted as if he was rendered helpless by a gas bomb he was immune to and allowed them to recapture her. "Weird," he thought. Soon afterwards, he and Ann were transported via ship to Manhattan, although their accommodations were not equitable: she had a cabin; he was lashed onto a raft that was roped to the vessel's stern. In Gotham, he had further allowed himself to be caged, chained, and exploited as a theatrical exhibit. (It was a sell-out, and he regretted not having prenegotiated a percentage of the gate.) He did not, however, ever lose sight of his mission to help Ann.

After breaking out of "captivity" and finding her again (no small trick in The City That Never Sleeps), he scaled the aforementioned tallest building in the area just to gain his bearings, holding her gingerly in one of his humongous hands. But then, out of nowhere, he instinctively knew that Ann would be fine without him and decided to forego a potentially awkward conversation with her by base-jumping off the parapet and enacting a Tony Award-worthy "death scene." While he was in corpse pose, he inhibited the urge to get up and bow to the bystanders, as if they were an audience at a Broadway show. He had overheard one of the lookie loos, who sounded like the showman who had wanted to display him like he was a mindless animal, say to another one, "Oh no, it wasn't the airplanes. It was beauty killed the beast." Ong, realizing he wasn't the "beauty" being referred to, barely restrained himself from retaliating for the "diss," another first.

Then right in the middle of his Australian crawl Ong made a momentous decision: He didn't want to play the monster anymore, even as the "King." He needed a new career. But which one?

1949⁵

After his travails in '33 Ong was a changed anthropoidal colossus. Not only had he rediscovered his travel bug, but

¹ Though it was the largest owl, with a two-meter wingspan, perched on Ong's mountainous shoulder it would have looked like a flea.

² As will be explained in Part 2.

³ This was the year the *highly* fictionalized movie *King Kong* was released. The similarity between the names of this film's ill-fated "monster" and the real K. Ong was coincidental.

⁴ The "heroine" of the film referenced in the prior footnote.

⁵ This was the year when, at the Boulder Conference, the American Psychological Association (APA) recognized the scientist-practitioner training model put forth by David Shakow as henceforth the standard for the training programs it accredited.

seeking a new direction in his life, he had become an applied psychology autodidact. These two interests converged on a bouldering trip on Pike's Peak in Colorado when he overheard the conversation that inspired his new métier.

Since he wanted to rebrand himself, Ong couldn't appear randomly in a major population center and cause a ruckus like he used to do. He had discovered that hiking trails were a good place for both introspection and for satisfying his innate curiosity by listening in on other hikers. He could do this because he was so massive and expectancy-discrepant that if he stood very still he blended into the landscape.

So, when he saw a small group of hikers approaching he went into a by now well-practiced tree-pose to listen. He leaned in closer when he realized the topic at hand. They were recounting why they had traveled to a conference center in Boulder;⁶ incredibly, it was to ratify a "scientist-practitioner model" for the nascent profession of clinical psychology. What a lucky break!

Like other neophytes in the field, Ong's self-guided initial forays into the world of psychology included a heavy, temporarily intoxicating dose of Freud. Thus, for a time he believed that unconscious guilt explained his odd and contradictory behaviors regarding Ann (whom he often Freudian-slipped into calling "Anna"). On the other hand, Ong thought, "Whaat?" since even during the height of his infatuation with psychoanalysis, he recognized its preposterous and highly subjective nature. Soon enough, however, like most sentient beings, Ong discovered scientifically based psychology, beginning with Wundt's creation of the first experimental psychology lab, running through Thorndike and Watson, and up to and beyond Skinner's *Behavior of Organisms*. On his own, he deduced that for psychology to be taken seriously it needed to be solidly research-based and eschew Freudian-style unprovable hypotheses and subjectivity. Consequently, he was thrilled to learn from his fellow hikers that his thinking on this subject was congruent with that of the thought

leaders of scientific psychology who had gathered in Colorado.

Ong attended the rest of the conference surreptitiously, taking full advantage of his ability to hide in plain sight. He told himself he would send the admission fee in once he got home, anonymously, but immediately realized he was rationalizing—he hated spending coin on anything but himself. ("Darn it, they might not be scientific but some of those analytic terms were hard to suppress, or is that repress, Ha-ha," he thought). But Ong did leave The Centennial State knowing what he wanted to do with his life at this juncture: no matter what it took, he was going to become a scientist-practitioner as per the revolutionary Boulder Model of clinical psychology!

1966

Dr. Ong was delighted to be accepted as a member of a brand new behavioral therapies advocacy group.⁷ He couldn't wait to display its certificate. He had become an early devotee of Cognitive Behavioral Therapy (CBT), attracted to both its philosophical and scientific aspects. He, more than most, had personally experienced the problems associated with irrational belief systems.

Though by now he had become licensed to practice psychology on his Island, this grand achievement had been possible because he was not only the self-appointed head of its Department of Psychology, but its only Board member, and as such in charge of its licensing decisions. He'd obtained his doctorate and fulfilled internship and postdoctoral training requirements via a mail-in distance education program that the Board (he) had approved, but on a single case basis. He condoned his obvious conflicts of interest due to the "special circumstances" inherent in his being not only his Island's first and sole psychological practitioner, but the first great ape to be licensed for the independent practice of clinical psychology, so far as he knew.

Yet, despite these accomplishments, to say his practice had difficulty getting off the ground would be an understatement. Neither the indigenous human population nor the prehistoric reptiles in his catchment area had responded to his attempts at marketing nor offers to conduct free workshops. He ran ads in the local newspaper, and held community talks highlighting the medical cost offset and potential economic rewards of a psychologically healthy Island populace, but nothing worked.

For instance, Dr. Ong had been sure that his seminar on self-regulation would be of interest to the conspicuously unreflective and impulsive dinosaurs, but it turned out to be a total flop. Only villagers who were deemed mentally unstable by dint of challenging the Island's powers that be were mandated to him for treatment, and then only because these referrers were counting on Ong having new patients for a snack; when this didn't turn out as expected even this trickle of intakes ceased (he had written, "Psychologists will not eat patients, even those with personality disorders or who fall behind in payment" in his Island's Ethics Code); and besides, he was seriously trying to take better care of his cardiovascular system and avoid animal protein. As for the animal, reptile, and mammoth insect population that questioned his sincerity as a clinician, well, Ong understood he had had only himself to blame for his many years of insensitivity toward their feelings—in addition to lying waste to their habitats and eradicating many of their kin.

2007⁸

As a nontraditional practitioner, Ong's entry into clinical work necessitated some creative problem solving. The answer to his local "reputational problem" was an emerging clinical modality—phone sessions. Since patients couldn't see him, to them he was simply an understanding and helpful CBT expert. The telephone also provided him with access to patients not only in the numerous nearby isles, but worldwide. At first he had trouble modulating his speaking volume, which naturally was a deafening roar, especially when he was being empathetic. But after irrevocably damaging a few patients' eardrums, he shaped a rather sonorous "inside voice." He also self-treated with Habit Reversal to control his urge to violently thump his chest when he got excited about a therapeutic intervention proving efficacious.

⁶ Boulder was a 2.5-hour bus ride from Pike's peak for the psychologists, but just a hop, skip, and a jump away for Ong, literally.

⁷ Ong has never been clear about what organization he joined. But it was in 1966, which was the inaugural year of AABT, later called the Association for Behavioral and Cognitive Therapies (ABCT). Only way to be sure is to check the certificate in his lair. Lotsa luck with that!

⁸ While the first true smartphone, IBM's Simon Personal Communicator, was introduced in 1992, it was not until around 2007 that cell phones were ubiquitous.

However, despite this burgeoning success, it uncharacteristically nagged at him that he was not only being deceptive but ashamed about who he was. Characteristically, he justified it because: (a) he was providing care to historically underserved patients; (b) he was practicing primarily in regions where, other than on his own atoll, the title and practice of psychology was not protected by statute; and most importantly (c) he didn't accept insurance.

By word of mouth alone, Dr. Ong's telephonic practice grew rapidly; the busier he was, the happier he was too. But within a few years, another technology advancement, video sessions, placed him in a quandary. His patients wanted more than to hear his voice, they wanted to see him. As a proponent of increasing access to behavioral healthcare, Ong had to be in favor of teleconferencing. But he feared that if his patients found out his identity they would feel afraid, betrayed, or, worse, terminate needed, fee-for-service treatments. To his patients Dr. Ong was a staunch proponent of inclusiveness, social tolerance, and self-advocacy. And his own experiences with body image problems (more about this in Part 2) shaped his attitudes about self-acceptance. Yet, Ong couldn't apply these overarching values to himself.

As an unforeseen consequence of becoming more self-aware and his training as a psychologist, Dr. Ong, who had nothing to fear from any creature that had ever walked the Earth, was not quite as impervious to anxiety and social rejection as usual. "Boy, being civilized sure has its downsides," Ong thought. He also wondered if being a psychologist was good for his mental health, or for his wallet.

The upcoming annual conference on CBT was a golden opportunity to find some answers. He made up his mind to attend.

Find out what happened next in Part 2, "CBT and its Discontents."

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The authors have no conflicts of interest or funding to disclose.

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OBITUARY

Blair Morris

Alec Miller, Simon Rego, and Sandy Pimentel,
Montefiore Medical Center

BLAIR MORRIS, as a psychology extern and intern at Montefiore, was the "dream psychology student." She was eager to learn, bold and ready to dive into working with new and high-risk clinical populations, never shy to ask questions, and always at the ready to lend a helping hand to a peer, supervisor, or client. It was not surprising to get a call or a text from her in the evening after she had stayed at the office later than she needed to in order to make sure that a client and their family were okay, even though she had her own family waiting at home. Blair was a powerfully emotional person, balancing an emotional sensitivity with a great sarcastic wit. She conducted her dissertation empirically evaluating Dr. Marsha Linehan's Biosocial Theory with adolescents being treated in the Adolescent Depression and Suicide Program in the Child Outpatient Psychiatry Department at Montefiore. She completed her doctorate at Fordham University, under the capable tutelage of Dr. Peggy Andover, and delivered her second child (her son, Graham) just four days before our graduation ceremony for the Psychology Internship Training Program at Montefiore. No one could believe Blair entering the Botanical Gardens ceremony with a broad smile on her face.

Blair was then hired as part of the Pediatric Behavioral Health Integration Program (BHIP) at Montefiore. She was a passionate and dedicated clinician who arrived at her site with a remarkable commitment, not only to helping her patients find hope in the midst of their suffering, but also to her colleagues, and the entire staff. With her excellent DBT training and fierce advocacy skills, she reached children who were in dire need but had never before received mental health services. She was bright and quick-witted, bringing laughter and cheer with her wherever she went. She was never afraid to ask tough questions or stand up for what she believed in, and often sought out support and advice on the things she didn't know in an effort to understand more. With her kind soul, she also counseled colleagues facing their own struggles. She was regularly one of the most productive team members, and also one of

the first to lend a colleague an ear, encouragement, or celebrate an accomplishment. She embraced her identity as a competent early-career psychologist, delivering trainings to family medicine residents and BHIP colleagues while treating patients, and being a member of the editorial board of *the Behavior Therapist*.

Perhaps most important, Blair put the same energy into parenting Whitney and Graham, her two beautiful children, with her husband, Michael. There was rarely a day when she wouldn't share Whitney's achievements in school or Graham's milestones with awe and pride. She was determined to provide her children with anything she could—playdates, ballet, sports, vacations, elite schools—but, above all, she wanted them to feel safe and loved. She was always curious about their behaviors, feelings, and ideas—driven to listen and be there for them, no matter what. Blair's drive to protect the vulnerable extended into her political views. She ardently supported LGBTQ and women's rights and was outspoken against bigoted or intolerant viewpoints. One of her goals was to ensure that her children appreciated the diversity and complexity of the world around them, which reached its pinnacle when she took them to vote with her in the recent presidential election.

Blair was a rare gem, in both complexity and splendor. She was a beloved student, peer, colleague, and supervisor in the Montefiore family and she will be deeply missed. She left this world far too soon, but the memory of her lives on in all of those that were lucky enough to know her.

Education Fund

The family has set up an education fund for Blair's two young children, Whitney and Graham. Donations may be sent through www.paypal.me/KilmartinEducation or by checks in equal amounts to Whitney and Graham Kilmartin at 215 East 95th Street 30K, NY NY 10128. For questions, please contact: KilmartinEducationFund@gmail.com

ABCT

Applying CBT in Diverse Contexts

51ST ANNUAL CONVENTION

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Welcome to San Diego! As the 2017 Program Chair, I am thrilled to welcome you to the Association for Behavioral and Cognitive Therapies (ABCT) 51st Annual Convention! San Diego is an outdoor-extravaganza with its magnificent climate, pristine beaches and diverse terrain, numerous dynamic neighborhoods, enchanting attractions (e.g., “the largest urban cultural park,” world-class zoo, major port), “rich military history,” and proximity to Mexico. Local Arrangements Committee chairs Aaron Blashill and Tiffany Brown will introduce you to the many outstanding sites and events, including the ABCT Saturday-Night Dance Party!

The theme of the convention this year is “Applying CBT in Diverse Contexts.” Presentations will address the social and cultural aspects of CBT, including contextual cues that inform our hypothesis development and treatment strategies with clients. Our program will showcase research, clinical practice, and training that increases our understanding of mental health problems and mechanisms, improves the efficacy and effectiveness of CBT for diverse groups, and enables us to disseminate these evidence-based treatments across professions.

I am incredibly honored and excited to have five luminary invited speakers discuss their groundbreaking work that highlights our theme. Stanley Sue from Palo Alto University and UC Davis (Emeritus) will speak on “Cultural Competency: Political Correctness or Necessity?”, raising and reflecting on controversies and dilemmas associated with research on cultural competency and consider the effects on practice and psychological science. Steven Safren from University of Miami will focus on the need for integrated interventions that address both health behavior change and comorbid mental health challenges in his talk on “Applying Evidence-Based CBT Principles to Disease Prevention and Self-Care in Diverse, Sexual Minority and Global Populations: Lessons Learned From HIV/AIDS.” Next, Jeanne Miranda from UCLA will present her work on improving disparities in health care, reviewing outcomes and gaps in her address on “Cognitive Behavioral Therapy with Low-income and Minority Communities.” Marsha M. Linehan from the University of Washington will present her Lifetime Achievement Award Address, “DBT: Where We Are, Where We Were and Where We Are Going.” She will discuss DBT as “a trans-diagnostic modular behavioral intervention,” and consider mechanisms of action and the guidelines for the use of treat-

ment components. Finally, in her presidential address, “Team Science Across Disciplines: Advancing CBT Research and Practice for Hoarding,” Gail Steketee will highlight the challenges and essential roles played by academic colleagues, trainees, and community partners in opening the door to understanding and treating a complex mental health problem from multiple perspectives.

It has been an honor to serve as Program Chair. I am grateful to President Gail Steketee and the ABCT Board for inviting me and supporting me through this process. Working with President Steketee is a privilege and genuine pleasure. I would like to thank the record 360 members of the 2017 Program Committee for their expertise, careful reviews, and flexibility during the peer review process resulting in a well-rounded exceptional program (and an extra thanks to the “Super Reviewers”). Additionally, I thank the chairs of the Convention and Education Issues Committees for their dedication and exceptional job developing this year’s exciting program: Barbara Kamholz (CIT), Aidan Wright (AMASS), Lauren Weinstock (Workshops), Sarah Kertz (Master Clinician Seminars), Risa Weisberg (Research & Professional Development), Christina L. Boisseau (Institutes), Kiara Timpano (2018 Program Chair), and Aaron Blashill and Tiffany Brown (Local Arrangements). I sincerely appreciate the valuable insights and support of Mary Jane Eimer, Executive Director, Barbara Kamholz, Coordinator of Convention and Education Issues, and Sandra Pimentel, Representative-at-Large and Board liaison to Convention and Education Issues. A hearty thanks to Tammy Schuler, Barbara Mazzella, and all of the ABCT Central Office Staff for their extraordinary devotion to the Convention planning and ABCT. I am especially grateful to past Program Chair Katharina Kircanski and past Coordinator of Convention and Education Issues Jeffrey Goodie for their invaluable guidance. A special thank you to Linda Still, Director of Education and Meeting Services, and Annie Dantowitz, Assistant Program Chair, for their industriousness and support that has been crucial to this process and the success of this Program. Linda’s wisdom and instrumental support facilitated this entire process. I am also incredibly thankful for Annie’s diligence, unwavering commitment, and humor throughout the planning process. Thanks to the many others (too many to name individually) for the countless efforts and gestures that contributed to this program. Finally, a heartfelt thanks to my spouse and children for their patience, cheer, and teamwork!

Wishing you all a fun and stimulating convention!

Convention Itinerary Planner

The pages that follow provide an overview of the ticketed sessions and general sessions that will be part of the 2017 convention in San Diego. In order to learn more details about the sessions, including full descriptions and times, skill levels, and learning goals, please utilize the Itinerary Planner. Feel free to access the Itinerary Planner at ABCT’s website at www.abct.org/conv2017. To view the entire convention program—including SIG meetings, poster sessions, invited addresses—you can **search** by session type, date, time, presenter, title, category, or keyword, or you can view the entire schedule at a glance. (Keep in mind, the physical program book will only be available onsite in San Diego.) After reviewing this special Convention 2017 insert, we hope you will turn to the online Itinerary Planner and begin to build your ultimate ABCT convention experience!



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Note

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

Wednesday, 8:30 a.m.-5:00 p.m., Day 1

Thursday, 8:30 a.m.-5:00 p.m., Day 2

CIT 1 | **The Mindful Way Through Anxiety in Practice: Developing Case Conceptualization and Treatment Delivery Skills to Help Your Clients Worry Less and Live More**

Susan M. Orsillo, Ph.D., *Suffolk University*

Lizabeth Roemer, Ph.D., *University of Massachusetts at Boston*

Acceptance-based behavioral therapies (ABBT) effectively reduce symptoms and promote quality of life among clients struggling with anxiety and comorbid disorders. This training is aimed at helping clinicians to understand the model underlying ABBT for GAD and related disorders, apply this general model to specific clients to inform case conceptualization and treatment planning, learn the core clinical strategies of ABBT, and identify and successfully address stuck-points that can be encountered in clinical practice. The training will demonstrate the ways specific mindfulness practices can be used to help clients increase their understanding of their internal experiences, broaden their awareness, and promote engagement in valued life activities. In addition, participants will learn strategies to help clients distinguish between clear and muddy emotions, change their response to their emotions, and articulate and take actions consistent with what they value. Drawing from both their clinical experience and their program of research developing and testing the efficacy of an ABBT for GAD, the presenters will describe case examples, lead participants through experiential practices, demonstrate the use of specific handouts and exercises, and provide coached opportunities for participants to practice applying strategies that they can use in their own clinical practice.

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

CIT 2 | **Parent-Child Interaction Therapy**

Cheryl B. McNeil, Ph.D., *West Virginia University*

This training describes Parent Child Interaction Therapy (PCIT), an evidence-based behavioral treatment for families of young children with disruptive behavior disorders. PCIT is based on Baumrind's developmental theory, which holds that authoritative parenting—a combination of nurturance, good communication, and firm limits—produces optimal child mental health outcomes. In PCIT, parents learn authoritative parenting skills through direct therapist coaching of parent-child interactions, guided by observational data collected in each session. Parents receive immediate guidance and feedback on their use of techniques such as differential social attention and consistency as they practice new relationship enhancement and behavioral management skills. Videotape review, slides, handouts, and experiential exercises will be used to teach participants the basic interaction skills and therapist coding and coaching skills used during treatment sessions. Applications of PCIT within physically abusive families and other special populations will be discussed.

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

CIT 3 | **Building a Better CBT: An Introduction to the TEAM-CBT Model**

David D. Burns, M.D., *Stanford University School of Medicine*

Jill T. Levitt, Ph.D., *Feeling Good Institute*

Clinical practice and research suggest that many different aspects of psychotherapy can enhance positive outcomes, including the quantitative assessment of therapist effectiveness—or lack of effectiveness—at every session (i.e., Routine Outcome Monitoring), a strong therapeutic alliance, and homework compliance, as well as the use of powerful CBT techniques that target each patient's specific negative thoughts and feelings. Dr. Burns has integrated these elements in an evidence-informed, transdiagnostic treatment called TEAM-CBT. The components of TEAM-CBT include:

T = Testing. Measurement of symptoms as well as the quality of the therapeutic alliance at the start and end of every session.

E = Empathy. A sophisticated set of skills to help therapists connect with challenging patients and repair alliance ruptures.

A = (Paradoxical) Agenda Setting. 15+ innovative techniques to identify and reduce therapeutic resistance and boost motivation.

M = Methods. 50+ cognitive, behavioral and interpersonal techniques, such as the Externalization of Voices Technique, The Acceptance Paradox, The Paradoxical Double Standard Technique, and more.

This training will review each component of the TEAM-CBT model and participants will leave with new tools to enhance therapeutic connection, boost motivation, and reduce symptoms of anxiety and depression in their patients. Teaching methods will include lecture, role-play demonstrations, and small group practice, as well as opportunities for audience members to work on their own feelings of insecurity and self-doubt and experience personal healing. The session will be lively and interactive, with plenty of time for practice.

Designed for clinical practitioners, discussions and display of specific intervention techniques.

THURSDAY

Institute 1 | 8:30 a.m. - 5:00 p.m.

Making Space for Life: Cognitive-Behavioural Strategies for Hoarding Behaviour

Sheila Woody, Ph.D., *University of British Columbia*
Christiana Bratiotis, Ph.D., LCSW, *Portland State University*

Institute 2 | 8:30 a.m. - 5:00 p.m.

How to Integrate CBT for Insomnia Into CBT for Depression, Chronic Pain and Anxiety Disorder Protocols

Colleen Carney, Ph.D., *Ryerson University*

Institute 3 | 1:00 p.m. - 6:00 p.m.

Emphasizing the FUN in the Fundamentals of CBT With Youth

Robert Friedberg, ABPP, Ph.D., *CSTAY at Palo Alto University*

Institute 4 | 1:00 p.m. - 6:00 p.m.

Common Elements Treatment Approach: An Evidence Based CBT Transdiagnostic Approach for Low-resource Settings

Kristie Metz, Ph.D., *Harvard University*
Stephanie van Wyk, M.P.H., LCSW, *Johns Hopkins University School of Public Health*
Laura Murray, Ph.D., *Department of Mental Health*
Shannon Dorsey, Ph.D., *University of Washington*

Institute 5 | 1:00 p.m. - 6:00 p.m.

Evidence-Based Assessment and Treatment of Bipolar Disorder and Mood Dysregulation in Youth and Early Adulthood

Mary Fristad, Ph.D., *Ohio State University*
Eric Youngstrom, Ph.D., *University of North Carolina*

Institute 6 | 1:00 p.m. - 6:00 p.m.

Emotion Regulation Therapy

Douglas Mennin, Ph.D., *Hunter College*
David Fresco, Ph.D., *Kent State University*

Institute 7 | 1:00 p.m. - 6:00 p.m.

Conceptualizing Patient Beliefs in Cognitive Processing Therapy for PTSD

Patricia Resick, ABPP, Ph.D., *Duke University School of Medicine*
Stefanie LoSavio, Ph.D., *Duke University Medical Center*

Institute 8 | 1:00 p.m. - 6:00 p.m.

Crisis Response Planning for Suicidal Patients

Craig Bryan, ABPP, Psy.D., *University of Utah*

Institute 9 | 1:00 p.m. - 6:00 p.m.

The Problem of Obsessions: How to Boost CBT Effectiveness With Self-Regulatory Strategies

David A. Clark, Ph.D., *University of New Brunswick*
Adam Radomsky, Ph.D., *Concordia University*

Advanced Methodology and Statistics Seminars

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

THURSDAY

AMASS 1 | 8:30 a.m.-12:30 p.m.

An Introduction to R for Clinical Scientists

Aaron J. Fisher, Ph.D., *University of California, Berkeley*

AMASS 2 | 1:00 p.m.-5:00 p.m.

Applied Missing Data Analysis

Craig Enders, Ph.D., *UCLA*

Master Clinician Seminars

TICKETED SESSIONS

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

FRIDAY

MCS 1 | 8:30 a.m. - 10:30 a.m.

Harnessing the Power of Brief Behavioral Interventions: Seven Principles for Success

Kirk Strosahl, Ph.D., *Mountainview Consulting Group*
Patricia Robinson, Ph.D., *Mountainview Consulting Group*

MCS 2 | 8:30 a.m. - 10:30 a.m.

CBT for Difficult-to-Treat Depressed Patients

Judith Beck, Ph.D., *Beck Institute*

MCS 3 | 11:45 a.m. - 1:45 p.m.

Acceptance and Change in Couple Therapy: Integrative Behavioral Couple Therapy

Andrew Christensen, Ph.D., *UCLA*

MCS 4 | 1:45 p.m. - 3:45 p.m.

Alliance-Focused Training for CBT: Strategies for Identifying, Addressing, and Repairing Ruptures in the Therapeutic Alliance in CBT

Jeremy Safran, Ph.D., *New School for Social Research*
J. Christopher Muran, Ph.D., *Adelphi University*
Catherine Eubanks, Ph.D., *Ferkauf Graduate School of Psychology*

MCS 5 | 4:00 p.m. - 6:00 p.m.

Collecting Progress Monitoring Data to Guide Treatment and Contribute to Research

Jacqueline Persons, Ph.D., *Cognitive Behavior Therapy and Science Center and UC-Berkeley*

SATURDAY

MCS 6 | 8:00 a.m. - 10:00 a.m.

Assertive Defense of the Self: CBT for Social Anxiety

Christine Padesky, Ph.D., *Center for Cognitive Therapy*

MCS 7 | 10:15 a.m. - 12:15 p.m.

An Interactive Demonstration of the Unified Protocol for the Treatment of Emotional Disorders in Children (UP-C)

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

MCS 8 | 11:45 a.m. - 1:45 p.m.

Cognitive Therapy for Decision Making: Overcoming Problems in How People Make Faulty Decisions

Robert Leahy, Ph.D., *American Institute for Cognitive Therapy*

Workshops

TICKETED SESSIONS

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

FRIDAY

Workshop 1 | 8:30 a.m. - 11:30 a.m.

Contextual Behavioral Therapies for Gender and Sexual Minorities

Matthew Skinta, ABPP, Ph.D., *Palo Alto University*
Danny Ryu, M.S., PGSP, *Stanford Psy.D. Consortium*

Workshop 2 | 8:30 a.m. - 11:30 a.m.

The Nuts and Bolts: Practical Strategies and Tools for Effective Implementation of CBT for Child and Adolescent Anxiety Disorders in Diverse Contexts

Muniya Khanna, Ph.D., *Children's Hospital of Philadelphia/Children and Adult's Center for OCD & Anxiety*
Deborah Ledley, Ph.D., *Children's and Adult Center for OCD and Anxiety*

Workshop 3 | 11:45 a.m. - 2:45 p.m.

Adolescent Behavioral Activation Program

Elizabeth McCauley, ABPP, Ph.D., *University of Washington*
Kelly Schloredt, Ph.D., *Seattle Children's Hospital*
Gretchen Gudmundsen, Ph.D., *University of Washington*
Christopher Martell, Ph.D., *University of Massachusetts Amherst*

Workshop 4 | 3:00 p.m. - 6:00 p.m.

Case Formulation and Treatment Planning in Dialectical Behavior Therapy

Shireen Rizvi, ABPP, Ph.D., *Rutgers University*
Jennifer Sayrs, ABPP, Ph.D., *Evidence Based Treatment Centers of Seattle*

Workshop 5 | 3:00 p.m. - 6:00 p.m.

Practical Skills for Practicing in Integrated Primary Care Settings

Ryan Landoll, ABPP, Ph.D., *Uniformed Services University*
Jeffrey Goodie, ABPP, Ph.D., *Uniformed Services University*
Kathryn Kanzler, Psy.D., *UT Health San Antonio*
Lisa Kearney, ABPP, Ph.D., *VA Center for Integrated Healthcare*

Workshop 6 | 3:00 p.m. - 6:00 p.m.

When Helping Doesn't Help: Overcoming Therapeutic Resistance With TEAM-CBT

David Burns, M.D., *Stanford University School of Medicine*
Jill Levitt, Ph.D., *Feeling Good Institute*

SATURDAY

Workshop 7 | 8:00 a.m. - 11:00 a.m.

Individual and Group Cognitive-Behavioral Therapy for Diverse Addictive Behaviors

Bruce Liese, Ph.D., *University of Kansas*

Workshop 8 | 8:00 a.m. - 11:00 a.m.

Applying CBT in the Digital Age: E-Mental Health Resources and Skills for Practitioners

Michael Kyrios, Ph.D., *Research School of Psychology, Australian National University*

Workshop 9 | 8:00 a.m. - 11:00 a.m.

Thinking Skills for Work: Cognitive Remediation to Improve Work in People With Serious Mental Illness

Susan McGurk, Ph.D., *Boston University*
Kim Mueser, Ph.D., *Center for Psychiatric Rehabilitation, Boston University*

Workshop 10 | 11:15 a.m. - 2:15 p.m.

Trauma Informed Guilt Reduction: A Transdiagnostic Cognitive Behavioral Therapy for Posttraumatic Distress

Carolyn Allard, Ph.D., *VA San Diego Healthcare System/UC San Diego*
Sonya Norman, Ph.D., *National Center for PTSD; Center of Excellence for Stress and Mental Health and VA San Diego Healthcare*
Brittany Davis, Ph.D., *James A. Haley Veteran's Hospital*
Christy Capone, Ph.D., *Alpert Medical School, Brown University / Providence VA Medical Center*
Kendall Browne, Ph.D., *Center of Excellence in Substance Abuse Treatment and Education*

Workshop 11 | 11:15 a.m. - 2:15 p.m.

Developing and Deepening Your Experiential Practice in Acceptance and Commitment Therapy

Jill Stoddard, Ph.D., *Alliant International University*
Kelsey Schraufnagel, Psy.D., *Gateway Psychiatric Institute*

Workshop 12 | 2:30 p.m. - 5:30 p.m.

Tricking Coyote: Cutting-Edge Strategies for Harnessing Motivation

Eugenia Gorlin, Ph.D., *Boston University*
Michael Otto, Ph.D., *Boston University*

Workshop 13 | 2:30 p.m. - 5:30 p.m.

Culturally Adapting Psychotherapy for Diverse Populations: An Evidence-Based Approach

Wei-Chin Hwang, Ph.D., *Claremont McKenna College and Private Practice*

Workshop 14 | 2:30 p.m. - 5:30 p.m.

Beyond Panic: Applying Interoceptive Exposure Across the Anxiety-Related Conditions and Life Span

Shannon Blakey, M.S., *University of North Carolina at Chapel Hill*
Jonathan Abramowitz, Ph.D., *University of North Carolina at Chapel Hill*

Workshop 15 | 2:30 p.m. - 5:30 p.m.

Conducting Psychological Assessments for U.S. Immigration Cases

Robert Meyers, Psy.D., JD, *New York Psychological Wellness, PC/St. Johns University*

General Sessions

NO TICKET REQUIRED

Clinical Roundtables, Mini Workshops, Panel Discussions, and Symposia are part of the general program: no tickets are required.

■ CLINICAL ROUNDTABLES

Applications of the Unified Protocol: Implementing Transdiagnostic Strategies for Complex and Highly Comorbid Clinical Cases

Moderator: Heather Latin, Ph.D.
Panelists: Todd Farchione, Ph.D., Shannon Sauer-Zavala, Ph.D., Laren Conklin, Ph.D., Kristen Ellard, Ph.D.

Applying Dialectical Behavior Therapy to the Treatment of Emotion Dysregulation in Gender-Diverse People

Moderator: Colleen Sloan, Ph.D.
Panelists: Jillian Shipherd, Ph.D., Danielle Berke, Ph.D., Adam Carmel, Ph.D., Colleen Sloan, Ph.D.

Couple Therapy and Research, Plus or Minus Forty: A Brief Look Back, a Major Look Forward

Moderator: Howard Markman, Ph.D.
Panelists: Donald Baucom, Ph.D., Andrew Christensen, Ph.D., Kurt Halweg, W. Kim Halford, Ph.D.

Demonstration of Two Psychotherapy Approaches With One Client

Moderator: Raymond DiGiuseppe, ABPP, Ph.D.
Panelists: Kristene Doyle, Ph.D., Robert Leahy, Ph.D., Jessica Randel, B.A.

Demystifying Cognitive-Behavioral Interventions in Pediatric Medical Populations

Moderator: Becky Lois, Ph.D.
Panelists: Corinne Catarozoli, Ph.D., Christina Salley, Ph.D., Lara Brodzinsky, Psy.D., Samantha Miller, Ph.D., Johanna Carpenter, Ph.D.

Do All Roads Lead to Rome? Examining the Treatment of OCD From Different Theoretical Perspectives

Moderator: Lata McGinn, Ph.D.
Panelists: Jonathan Abramowitz, Ph.D., Adam Radomsky, Ph.D., Michael Twohig, Ph.D.

Enhancing Recovery From PTSD With Co-Occurring Psychosis in Veterans

Moderator: Carolyn Allard, Ph.D.
Panelists: Dimitri Perivoliotis, Ph.D., Yuliana Gallegos Rodriguez, Ph.D., Eric Eichler, LCSW, Fernando Alessandri, Ph.D.

Exploring the Fullness of Time: Delivering Effective Mindfulness- and Acceptance-Based Interventions and Programs for Older Adults

Moderator: Donald Marks, Psy.D.
Panelists: Jennifer Block-Lerner, Ph.D., Patricia Marino, Ph.D., Jeffrey Greeson, Ph.D., Steven Hickman, Psy.D., Jed Seltzer, M.A.

Reducing Cognitive Load of CBT: Process of Adapting and Implementing CBT in a Low-Literacy Chronic Pain Population

Moderator: John Burns, Ph.D.,
Panelists: Beverly Thorn, ABPP, Ph.D., Benjamin Van Dyke, M.A., Calia Torres, M.A., Andrea Newman, B.A.

Strategies for Successful Implementation of Measurement-Based Care Implementation Across Diverse Contexts

Moderators: Corey Fagan, Ph.D., Richard N. Leightweis, Ph.D.
Panelists: Whitney Black, M.D., Christianne Esposito-Smythers, Ph.D., Alyssa Gatto, B.A., Freda Liu, Ph.D., Robyn Mehlenbeck, ABPP, Ph.D.

Targeting Barriers to Evidence-Based Practice in Diverse Populations

Moderator: Christine Laurine, B.A., Sannisha Dale, Ph.D.
Panelists: Janie Hong, Ph.D., Lloyd Chapman, Ph.D., John Kloczek, Ph.D., Michael Newcomb, Ph.D., Antonio Polo, Ph.D.

The Traumatized, Suicidal Adolescent: Treatment Considerations in the Application of DBT-A and PE-A

Moderator: Amanda Edwards, LCSW
Panelists: Colleen Lang, Ph.D., Elissa Brown, Ph.D., Melanie Harned, Ph.D.

Treating Anxiety Disorders From Early Childhood to Late Adulthood: Developmental Adaptations and Clinical Wisdom

Moderator: Anne Marie Albano, ABPP, Ph.D.
Panelists: Shannon Bennett, Ph.D., R. Meredith Elkins, Ph.D., Patricia Marino, Ph.D., Donna Pincus, Ph.D.

Using Evidence-Based Practices With Specific Religious and Nonreligious Populations

Moderator: Caleb Lack, Ph.D.
Panelists: Harold Robb, Ph.D., David Rosmarin, ABPP, Ph.D., Michelle Pearce, Ph.D., Shadi Beshai, Ph.D.

■ MINI WORKSHOPS

Mini Workshop 1

Using Telemental Health in Diverse Contexts to Overcome Barriers of Access to Care

Daniel Hoffman, ABPP, Ph.D., Northwell Health Zucker Hillside Hospital
Mary Karapetian Alvord, Ph.D., Alvord, Baker & Associates, LLC
Jonathan Comer, Ph.D., Florida International University

Mini Workshop 2

Taking ERP From Treatment Manual to Your Patients: A (Fun) Guide to Application

Patrick McGrath, Ph.D., AMITA Health

Mini Workshop 3

Spirituality and Cognitive Behavioral Therapy

David Rosmarin, ABPP, Ph.D., McLean Hospital/Harvard Medical School, Center for Anxiety

Mini Workshop 4

A Winter-Break Model of Treating College-Age Young Adults With OCD: The Fast Track to Improvement

Avital Falk, Ph.D., Weill Cornell Medical College
Shannon Bennett, Ph.D., Weill Cornell Medical College

Mini Workshop 5

Everything You Need to Know About Your Patients' Sex Life, but Are Afraid to Ask

Risa Weisberg, Ph.D., VA Boston Healthcare System / Boston University School of Medicine

Mini Workshop 6

"What Do You Mean, 'Think About My Thinking?'" Making Abstract Concepts Come to Life in CBT for Kids

Sarah Kate Bearman, Ph.D., University of Texas at Austin
Joanna Robin, Ph.D., Westchester Anxiety Treatment Psychological Services, PC

Mini Workshop 7

Therapist Drift in CBT: Why Well-Meaning Clinicians Do Dumb Things (and How to Do Fewer of Them)

Glenn Waller, DPhil, The University of Sheffield

Mini Workshop 8

Integrating Mind Over Mood (2nd Ed.) With Evidence-Based Practice

Christine Padesky, Ph.D., Center for Cognitive Therapy

Mini Workshop 9

End the Insomnia Struggle: Enhancing Cognitive Behavioral Therapy for Insomnia Using Acceptance and Commitment Therapy

Alisha Brosse, Ph.D., Private Practice and University of Colorado Boulder
Colleen Ehrnstrom, Ph.D., Eastern Colorado Healthcare System

Mini Workshop 10

Targeting Military Trauma With Adaptive Disclosure

Brett Litz, Ph.D., VA Boston Healthcare System
Julie Yeterian, Ph.D., VA Boston Healthcare System
Matt Gray, Ph.D., University of Wyoming
Danielle Berke, Ph.D., Boston VA Medical Center

Mini Workshop 11

Cultural Competence Matters: Clinical Adaptations to Effectively Address Race-Based Stress in Black Clients

Monica Johnson, Psy.D., Cherokee Health Systems
Michelle Melton, Psy.D., US Department of Veteran Affairs, Phoenix

Mini Workshop 12

Cognitive Behavior Therapy for Personality Disorders

Judith Beck, Ph.D., Beck Institute

Mini Workshop 13

Delivering Culturally Competent Behavioral Couple Therapy When Working With Same-Sex Couples

Brian Buzzella, Ph.D., VA San Diego Healthcare System
Sarah Whitton, Ph.D., University of Cincinnati
Shelby Scott, Ph.D., Denver VA Medical Center

Mini Workshop 14

Teaching and Disseminating Behavioral Medicine Principles to Primary Care Physicians and Allied Health Professionals

Pooja Dave, Ph.D., Nancy Beckman, Ph.D., Andrea Busby, Ph.D., University of Chicago Medicine

Mini Workshop 15

Behavioral Couples Therapy for Substance Use Disorders

Keith Klostermann, NCC, Medaille College

Mini Workshop 16

Psychological Services in Forensic and Correctional Settings: Treatment, Safety, and Ethical Issues

Michael Wydo, ABPP, Psy.D., US Dept. of Justice / Federal Bureau of Prisons

Mini Workshop 17

Implementation of Cognitive Behavioral Therapy With Children and Adolescents in School Settings

Torrey Creed, Ph.D., University of Pennsylvania School of Medicine

Mini Workshop 18

Exposure-Based Treatment for Eating Disorders: Addressing Anxiety on Both Sides of the Table

Carolyn Becker, Ph.D., Trinity University
Glenn Waller, DPhil, The University of Sheffield

Mini Workshop 19

Recovery-Oriented Cognitive Therapy for Schizophrenia: An Evidence-Based Program for Individuals With Schizophrenia, in and out of the Hospital

Paul Grant, Ph.D., Aaron Brinen, Psy.D., Ellen Inverso, Psy.D., Aaron Beck, M.D., University of Pennsylvania

■ PANEL DISCUSSIONS

Panel Discussion 1

Social Work Training in CBT: The Columbia DBT Training Program

Moderator: Andre Ivanoff, Ph.D.
Panelists: Jennifer Stefanik, MSW, Jacquelyn Smith, MSSW, LCSW-R, Lauren Bochicchio, MSW, Nancy Ring, MSW, LCSW-R, Hilary Ferris White, MSW

Panel Discussion 2

New Grounds to Promote CBT in Diverse Contexts: Clinical Practice Guidelines for Clinical Training, Practice, Research, and Policy

Moderator: Bethany Teachman, Ph.D.
Panelists: Timothy Cavell, Ph.D., Gregory Aarons, Ph.D., Jason Satterfield, Ph.D., Kimberly Hepner, Ph.D., Steven Hollon, Ph.D., Lynn Bufka, Ph.D.

Panel Discussion 3

Translational Collaborations to Further Integration and Exploration of Neural Mechanisms Across Diverse Treatment Contexts

Moderator: Kate Nooner, Ph.D.
Panelists: Greg Siegle, Ph.D., John McQuaid, Ph.D., Rudi De Raedt, Ph.D., Vanessa Brown, M.S., Kean Hsu, Ph.D.

Panel Discussion 4

Neural Network Models: Relevance for the Present and Future of CBT

Moderator: Jonathan Hoffman, ABPP, Ph.D.
Panelists: Dean McKay, ABPP, Ph.D., Greg Siegle, Ph.D., Kristen Ellard, Ph.D.

Panel Discussion 5

Charting Clinical Psychology Careers in Behavioral Medicine Settings

Moderators: Nicholas Perry, M.S., Aaron Blashill, Ph.D.
Panelists: Cara Fuchs, Ph.D., Trevor Hart, Ph.D., Jason Satterfield, Ph.D., Christina Luberto, Ph.D.

Panel Discussion 6

If I Knew Then What I Know Now: Best Practices in Ambulatory Assessment of High-Risk Populations

Moderators: Kate Bentley, M.A., Sarah Victor, M.A.
Panelists: Matthew Nock, Ph.D., Mitch Prinstein, ABPP, Ph.D., M. Zachary Rosenthal, Ph.D., Jason Lavender, Ph.D., Brian Baucom, Ph.D.

Panel Discussion 7

Treating Military Service Members, Veterans, and Their Families in the Private Sector: A Consortium of New York Hospitals

Moderator: Todd Adamson, Psy.D.

Panelists: Ari Lowell, Ph.D., Michael Valdivinos, ABPP, Psy.D., Amanda Spray, Ph.D.

Panel Discussion 8

Incorporating Contextual, Sociopolitical, and Culture-Based Cues in Mindfulness and Acceptance-Based Therapies

Moderator: Jason Lillis, Ph.D.

Panelists: Shelly Harrell, Ph.D., Akihiko Masuda, Ph.D., Elizabeth Roemer, Ph.D., Lindsey West, Ph.D.

Panel Discussion 9

You Will Get Better and You Won't: Using Brain Imaging and Biomarkers to Predict Treatment Response

Moderator: Simon Rego, ABPP, Psy.D.

Panelists: Ed Craighead, Ph.D., Stefan Hofmann, Ph.D., Barbara Rothbaum, Ph.D., David Tolin, ABPP, Ph.D.

Panel Discussion 10

Effective Interventions in Mental Health: Netherlands Institute for Advanced Studies 2017 Depression Theme Group

Moderators: Greg Siegle, Ph.D., Claudi Bockting, Ph.D.

Panelists: Steven Hollon, Ph.D., Michael Thase, M.D.

Panel Discussion 11

Breaking Through the Ivory Ceiling: Strategies and Successes for Women in Psychology and the Clinical Sciences

Moderators: Alex Keller, M.A., Lydia Chevalier, M.A.

Panelists: Gail Steketee, Ph.D., MSW, Sabine Wilhelm, Ph.D., Shannon Bennett, Ph.D., Emily Ricketts, Ph.D.

Panel Discussion 12

Primary Care Behavioral Health: Practical Concerns and Pragmatic Advice in Applying CBT in Primary Care Settings

Moderator: Risa Weisberg, Ph.D.

Panelists: Jeffrey Goodie, ABPP, Ph.D., Patricia Robinson, Ph.D., Abbie Beacham, Ph.D., Cara Fuchs, Ph.D., Kristin Gregor, Ph.D.

Panel Discussion 13

Shortening the Science-to-Service Pipeline: Forming a Tighter Link Between Neuroscience and Implementation Science

Moderator: Cassidy Gutner, Ph.D.

Panelists: Shannon Stirman, Ph.D., Debra Kaysen, Ph.D., Greg Siegle, Ph.D., Philippe Goldin, Ph.D.

Panel Discussion 14

The Current State of PTSD Diagnosis: Controversies and Future Directions

Moderators: Molly Franz, M.A., Christina Hein, M.A.

Panelists: Edna Foa, Ph.D., Dean Kilpatrick, Ph.D., Brian Marx, Ph.D., Richard McNally, Ph.D., Patricia Resick, ABPP, Ph.D.

Panel Discussion 15

Multicultural Research Meets Evidence-Based Practice: Achievement in College Students From Underrepresented Ethnic Groups

Moderator: Maren Westphal, Ph.D.

Panelists: Maren Westphal, Ph.D., Stefan Hofmann, Ph.D., Anne Marie Albano, ABPP, Ph.D., Swati Desai, Ph.D., LCSW, Laura Knouse, Ph.D.

Panel Discussion 16

DBT in College Counseling Centers

Moderator: Jim Mazza, Ph.D.

Panelists: Amanda Uliaszek, Ph.D., Carla Chugani, Ph.D., Jacqueline Pistorello, Ph.D., Tina Goldstein, Ph.D., Monicah Muhomba, Ph.D.

Panel Discussion 17

Evidence-Based Treatments for Youth With Autism Spectrum Disorder and Other Neurodevelopmental Disabilities

Moderator: Audrey Blakeley-Smith, Ph.D.

Panelists: Susan Hepburn, Ph.D., Judy Reaven, Ph.D., Cara Pugliese, Ph.D., Emily Kuschner, Ph.D.

Panel Discussion 18

Intensive Group Behavioral Treatments for Children and Early Adolescents With Selective Mutism

Moderators: Jami Furr, Ph.D., Cristina del Busto, Ph.D.

Panelists: Steve Kurtz, ABPP, Ph.D., Rachel Merson, Psy.D., Shelley Avny, Ph.D., Erin O'Connor, M.A.

Panel Discussion 19

Developing and Deploying Effective Mobile and Connected Mental Health Intervention Efforts for Youth and Families

Moderator: Denise Pintello, Ph.D., MSW

Panelists: Ryan Stoll, M.A., Armando Pina, Ph.D., Kevin Gary, Ph.D., Donna Pincus, Ph.D., Mina Johnson-Glenberg, Ph.D., Deborah Beidel, ABPP, Ph.D.

Panel Discussion 20

Treating Obsessive-Compulsive Spectrum Disorders in Diverse Contexts and Populations

Moderator: David Houghton, M.S.

Panelists: Shannon Bennett, Ph.D., Matthew Capriotti, M.S., Flint Espil, Ph.D., Christopher Flessner, Ph.D., Martin Franklin, Ph.D., Douglas Woods, Ph.D.

Panel Discussion 21

Innovation and Implementation: Technology as a Tool to Reduce Mental Health Disparities

Moderators: Allura Ralston, B.A., Arthur Andrews, III, Ph.D.

Panelists: Debra Hope, Ph.D., Denise Chavira, Ph.D., Matthew Price, Ph.D., Adrian Aguilera, Ph.D.

Panel Discussion 22

Exploring the Intersection of Policy, Practice, and Research: Adapting an Evidence-Based Ecological Intervention

Moderator: Suzanne Kern, Ph.D.

Panelists: Kitty Dahl, Ph.D., Kristin Presteng, B.S., Oda Skagseth, M.S., Sarah Cusworth Walker, Ph.D., Eric Trupin, Ph.D., Pal Christian Bergstrom, M.S.

Panel Discussion 23

Process-Based CBT

Moderator: Steven Hayes, Ph.D.

Panelists: Stefan Hofmann, Ph.D., Steven Hayes, Ph.D., Michelle Craske, Ph.D.

Panel Discussion 24

Pediatric Primary Care Opportunities for Implementing Behavioral and Cognitive Therapy Interventions and Consultations

Moderator: David Curtis, Ph.D.

Panelists: Stephanie Chapman, Ph.D., Arlene Gordon-Hollingsworth, Ph.D., Christie Gardner, Ph.D., Jennifer Kazmerski, Ph.D.

Panel Discussion 25

Prevent or Permit? The Issue of Safety Behavior Use During Exposure Therapy for Anxiety

Moderator: Shannon Blakey, M.S.

Panelists: Jonathan Abramowitz, Ph.D., Brett Deacon, Ph.D., David Tolin, ABPP, Ph.D., Adam Radomsky, Ph.D., Roz Shafran, Ph.D.

Panel Discussion 26

Considering the "Modern Family": Multicultural Identities in Family-Based CBT

Moderator: Lillian Reuman, M.A.

Panelists: Christopher Martell, Ph.D., Monnica Williams, Ph.D., Deborah Jones, Ph.D., Denise Chavira, Ph.D.

Panel Discussion 27

Supporting Implementation of Evidence-Based Practices in School and Community Settings

Moderator: Marc Atkins, Ph.D.

Panelists: Elizabeth Schaughency, Ph.D., Aaron Lyon, Ph.D., Eric Bruns, Ph.D., Michael Pullman, Ph.D., Stacy Frazier, Ph.D.

Panel Discussion 28

How Do We Improve Engagement in Evidence-Based Therapies for Individuals From Diverse Backgrounds? Suggested Strategies

Moderators: Hyun Kim, M.A., Broderick Sawyer, M.A.

Panelists: Anu Asnaani, Ph.D., Janie Hong, Ph.D., Aya Williams, M.A., Sannisha Dale, Ph.D., Nadine Chang, Ph.D.

■ **SYMPOSIA**

A New Way Forward? Novel Applications of Exposure-Based Therapy in the Context of Eating Disorders

Eric Storch, Ph.D., Chair

Nicholas Farrell, Ph.D., Chair

Carolyn Becker, Ph.D., Discussant

A Noninferiority Randomized Controlled Trial of Written Exposure Therapy for PTSD: Outcomes, Moderators, and Mediators

Denise Sloan, Ph.D., Chair

Barbara Rothbaum, Ph.D., Discussant

A Tailored Implementation of CBT in a Youth Residential Setting

Cara Lewis, Ph.D., Chair

Judith Beck, Ph.D., Discussant

Stephen Hinshaw, Ph.D., Discussant

Late Onset ADHD: What It Is, What It Is Not, and Why It Matters

Laura Knouse, Ph.D., Chair

Brian Wymbs, Ph.D., Chair

Acceptance-Based Treatments in the Context of Established Evidence-Based Interventions: Differential Effects

Joanna Kaye, M.S., Chair

Michael Twohig, Ph.D., Discussant

Adaptations of CBT for Diverse Groups Living With or At Risk for HIV

Sannisha Dale, Ph.D., Chair

Jessica Magidson, Ph.D., Discussant

Adapting Exposure Therapy to Address Disordered Eating and Body Dissatisfaction in Diverse Populations and Treatment Settings

Jamal Essayli, Ph.D., Chair

Drew Anderson, Ph.D., Discussant

Addressing Mental Health Disparities via Integrated Pediatric Primary Care

Heather Jones, Ph.D., Chair

David Kolko, ABPP, Ph.D., Discussant

Adolescents and Young Adults With ADHD: Challenges and Transitions

Kari Benson, B.A., Chair

Steven Evans, Ph.D., Discussant

Advancing the Pragmatic Measures Construct and Three New Measures of Implementation Outcomes

Cara Lewis, Ph.D., Chair

Gregory Aarons, Ph.D., Discussant

Aftercare Engagement Across Diverse Contexts: Identifying Vulnerable Consumers and Effective Intervention

Kristen Keefe, M.A., Chair

Ivan Miller, Ph.D., Discussant

Alternative Classification Systems Within Eating Disorders: Insights From Innovative Methodological Investigations

Michelle Jones, Ph.D., Chair

Erin Reilly, M.A., Chair

Jason Lavender, Ph.D., Discussant

Am I at Risk? Factors Predicting the Development and Maintenance of Obsessive-Compulsive-Related Disorders

Hilary Weingarden, Ph.D., Chair

Gail Steketee, Ph.D., MSW, Discussant

An Invisible and Underrepresented Health Disparity Population: Stigma and Mental Health Among Bisexual Individuals

Brian Feinstein, Ph.D., Chair

Wendy Bostwick, Ph.D., Discussant

An Update on Research Investigating the Phenomenology of Hoarding Disorder: Consideration of Core Features and Associated Factors

Kiara Timpano, Ph.D., Chair

Randy Frost, Ph.D., Discussant

Applying Advanced Structural Equation Modeling to Understand and Disseminate Substance Use Data in Diverse Contexts

Mark A. Prince, Ph.D., Chair

Stephen Maisto, Ph.D., Discussant

Applying CBT in Diverse Contexts: LGBTQ+ Treatment Outcomes

Courtney Beard, Ph.D., Chair

Debra Hope, Ph.D., Discussant

Applying Cognitive Behavioral Therapy in Low and Middle Income countries: Trials, Advances, and Implementation Strategies

Laura Murray, Ph.D., Chair

Beverly Pringle, Ph.D., Discussant

Approaches to Increase Access to Parent Mediated Interventions for Families of Children With Autism Spectrum Disorder

Karen Bearss, Ph.D., Chair & Discussant

Approaches to Treatment Personalization for Serious Mental Illness Across the Biopsychosocial Spectrum

Emily Treichler, Ph.D., Chair

Will Spaulding, Ph.D., Discussant

Assessing and Modeling Stress Processes in Suicide and Depression

Richard Liu, Ph.D., Chair

Josephine Shih, Ph.D., Chair

Kate Harkness, Ph.D., Discussant

Behavioral Interventions for Pediatric Health Conditions: Results From Prospective Studies

Christine Sieberg, M.A., Ph.D., Chair
Elizabeth McQuaid, ABPP, Ph.D., Discussant

Bench to Bedside: Understanding Suicide Prevention From Biomarkers to Implementation Science

Rinad Beidas, Ph.D., Chair
Courtney Benjamin Wolk, Ph.D., Chair
Joan Asarnow, Ph.D., Discussant

Beyond Diagnosis: Mediators Underlying the Link Between PTSD and Adverse Outcomes

Shannon Blakey, M.S., Chair
Peter Tuerk, Ph.D., Discussant

Beyond PTSD: Far-Reaching Effects of Exposure-Based PTSD Treatment on Common Clinical Complexities

Alicia Jerud, Ph.D., Chair
Edna Foa, Ph.D., Discussant

Biomarkers and Mechanisms of Anxiety in Autism: Implications for Assessment and Behavioral Interventions

Denis Sukhodolsky, Ph.D., Chair
Megan Tudor, Ph.D., Discussant

Boosting CBT Efficacy With Pre-Session Memory Enhancers: The Current State of the Art

Michael Otto, Ph.D., Chair
Barbara Rothbaum, Ph.D., Discussant

Brief Behavioral Therapy for Anxiety and Depression in Pediatric Primary Care: Associated Outcomes

V. Robin Weersing, Ph.D., Chair
Joan Asarnow, Ph.D., Discussant

Can We Assess Suicide Without Asking About It? Implicit Markers of Suicidal Ideation, Behavior, and Risk

Tony Wells, Ph.D., Chair
Matthew Nock, Ph.D., Discussant

CBT in Older Adults: Treatment Targets and Modified Strategies

Kimberly Van Orden, Ph.D., Chair
Jarred Gallegos, M.A., Chair
Julie Wetherell, Ph.D., Discussant

CBT to Diverse Contexts: Patterns, Implementation, and Scalable Training for Graduate and Post-graduate Therapists

Adam Reid, M.S., Chair
Jonathan Comer, Ph.D., Discussant

Cognitive Control, IQ, and Inattention in OCD

Lauren Hallion, Ph.D., Chair
Amitai Abramovitch, Ph.D., Chair
Dean McKay, ABPP, Ph.D., Discussant

Common and Specific Predictors of Depression and Anxiety Across Diverse Settings

Gabriela Khazanov, M.A., Chair
David Watson, Ph.D., Discussant

Cultural Considerations in Context: Working With Latino Youth With Internalizing Disorders

Cristina del Busto, Ph.D., Chair
Jami Furr, Ph.D., Chair
Denise Chavira, Ph.D., Discussant

Culture and Parenting Practices in Latina Mothers of Young Children: Implications for Parent Training Programs

Esther Calzada, Ph.D., Chair
Ruben Parra Cardona, Ph.D., Discussant

Cutting-Edge Longitudinal Models for CBT Research

Alessandro De Nadai, M.A., Ph.D., Chair
Eric Storch, Ph.D., Discussant

Data Mining in Clinical Research: Demonstrating Applications in Self-Injurious Thoughts and Behaviors

Taylor Burke, M.A., Chair
Brooke Ammerman, M.A., Chair
Matthew Nock, Ph.D., Discussant

Data-Driven Approaches to Exploring Heterogeneity in Response to Treatments for Mood and Anxiety Disorders

Nicholas Allan, Ph.D., Chair
Michael Zvolensky, Ph.D., Discussant

Dealing With the Effects of Childhood Adversity Among Adult Primary Care Patients: A Novel Approach to Risk Reduction

Keith Dobson, Ph.D., Chair
Dennis Pusch, Ph.D., Discussant

Demonstrating the Effectiveness of Group CBT and Pain Education for Multiply Disadvantaged Patients

Beverly Thorn, ABPP, Ph.D., Chair
John Burns, Ph.D., Discussant

Depression and Self-Injurious Thoughts and Behaviors in Young People With ADHD: Identifying Risk Processes and Informing Prevention Efforts

Carlos Yeguez, B.S., Chair
Jeremy Pettit, Ph.D., Chair
Eric Youngstrom, Ph.D., Discussant

Designing and Disseminating Large-Scale Interventions for Anxiety in Youth

V. Robin Weersing, Ph.D., Chair
Joel Sherrill, Ph.D., Discussant

Developing, Refining, and Implementing Text-Message Interventions for At-Risk Populations

Dana Litt, Ph.D., Chair
Jennifer Cadigan, Ph.D., Chair
Matthew Martens, Ph.D., Discussant

Disseminating Motivational Interviewing in Diverse Settings: Lessons Learned From Research and Practice

Melissa Faith, ABPP, Ph.D., Chair
Ana El-Behadli, M.A., Discussant

Diversity of Response to Trauma and to Trauma-Focused Treatment

Keith D. Renshaw, Ph.D., Chair
Lauren Paige, M.S.Ed., Chair
Marylene Cloitre, Ph.D., Discussant

Electrophysiological Correlates of Treatment Outcomes for Youth Populations

Erin Kang, M.A., Chair
Matthew Lerner, Ph.D., Chair
Greg Hajcak, Ph.D., Discussant

Emotion Regulation in Child Development: Clinically Relevant Outcomes From Infancy Through Adolescence

Kim Gratz, Ph.D., Chair
Alice Carter, Ph.D., Discussant

Emotional Reactivity and Regulation in BPD: Illuminating Patterns Across Diverse Contexts and Samples

Katherine Dixon-Gordon, Ph.D., Chair
Kim Gratz, Ph.D., Discussant

Empirically Supported Mental Health Care With Transgender and Gender-Nonconforming Individuals: Beyond Clinical Expertise

Debra Hope, Ph.D., Chair
Jillian Shipherd, Ph.D., Discussant

Engagement in CBT Among Hard-to-Reach Populations Using Culturally Informed Approaches

Sylvanna Vargas, M.A., Chair
Stan Huey, Ph.D., Discussant

Evaluating Individual Emotional Skillfulness in Relationship Health

Emily Maher, M.A., Chair
Taylor Dovala, B.A., Chair
James Cordova, Ph.D., Discussant

Evaluating Prominent Theories Concerning the Role of Stress in Anxiety and Depression Trajectories

Rebecca Schneider, M.A., Chair
Richard LeBeau, Ph.D., Chair
Richard Zinbarg, Ph.D., Discussant

Evidence-Based Assessment and Treatment of Anger: Forensic, Veteran, and Couples-Based Applications

Erica Birkley, Ph.D., Chair
Raymond Novaco, Ph.D., Discussant

Evidence-Based Mental Health Service Delivery: Implementation Strategies for School Professionals

Elizabeth Koschmann, Ph.D., Chair
Rinad Beidas, Ph.D., Discussant

Exercise in Individuals With Disordered Eating: How and for Whom Might It Be Beneficial?

Leigh Brosof, B.A., Chair
Margarita Sala, M.A., Chair
Cheri Levinson, Ph.D., Discussant

Expanding the Reach of Relationship Health Care: Disseminating and Implementing the Marriage Checkup Across Diverse Settings

Tatiana Gray, M.A., Chair
Andrew Christensen, Ph.D., Discussant

Factors Influencing Engagement With Evidence-Based Psychotherapies for PTSD in Diverse Patient Populations

Jennifer Wachen, , Ph.D., Chair
Barbara Niles, Ph.D., Chair
Patricia Resick, ABPP, Ph.D., Discussant

Family Interactions and Expressed Emotion Across the Life Span and Across a Spectrum of Psychopathology

Marc Weintraub, M.S., Chair
David Miklowitz, Ph.D., Discussant

Fighting Mental Illness Stigma: Recent Conceptual and Intervention-Related Advances

Jennifer Na, M.A., Chair
Stephen Hinshaw, Ph.D., Chair
Amori Mikami, Ph.D., Discussant

Forensic Assessment: Applying Evidence-Based Principles to Diverse Settings and Populations

Raymond Chip Tafrate, Ph.D., Chair
Raymond DiGiuseppe, ABPP, Ph.D., Discussant

From Efficacious to Effective: Interventions for Disadvantaged Couples

Kayla Knopp, M.A., Chair
Katherine Baucom, Ph.D., Discussant

From Engagement to Treatment: The Role of Culture and Race in the Treatment of Psychosis

Piper Meyer-Kalos, Ph.D., Chair
Amy Weisman de Mamani, Ph.D., Discussant

From Global to Local: Assessment and Treatment of Culturally Diverse Trauma-Exposed Groups in Low-Resource Settings

Merdijana Kovacevic, M.A., Chair
Patricia Resick, ABPP, Ph.D., Discussant

Healing From Trauma Through CBT: How and Why Change Occurs in Evidence-Based Treatment for PTSD

Carly Yasinski, Ph.D., Chair
Andrew Sherrill, Ph.D., Chair
Sheila Rauch, ABPP, Ph.D., Discussant

Heteronormative Monogamy: Examining Diversity in Romantic Relationships and Commitment Structures

Ronald Rogge, Ph.D., Chair
Kristina Coop Gordon, Ph.D., Discussant

How Can Ecological Momentary Assessment Help Us Understand Mood and Anxiety Pathology Better?

Michelle Newman, Ph.D., Chair
Ki Eun Shin, M.S., Chair
Rudi De Raedt, Ph.D., Discussant

Impact of Borderline Personality Symptoms on Interpersonal Functioning and Maladaptive Emotion Regulation

Nathaniel Herr, Ph.D., Chair
M. Zachary Rosenthal, Ph.D., Discussant

Implementation of Evidence-Based Practices for Serious Mental Illness on Assertive Community Treatment Teams

Eric Granholm, Ph.D., Chair
Gary Morse, Ph.D., Discussant

Improving the Dissemination of Evidence-Based Early Interventions Through Technology

Amanda Costello, Ph.D., Chair
Kathleen Baggett, Ph.D., Discussant

Improving Treatment for Under-served Racial/Ethnic Minority Young Adults With Anxiety Disorders

Anne Marie Albano, ABPP, Ph.D., Chair
Maria Carolina Zerrate, M.D., Chair
Jeanne Miranda, Ph.D., Discussant

Indications for Adaptations to Evidence-Based Practices in Community Mental Health

Miya Barnett, Ph.D., Chair
Anna Lau, Ph.D., Discussant

Innovations in CBT for Active Duty Military Personnel

Feea Leifker, M.P.H., Ph.D., Chair
David Riggs, Ph.D., Discussant

Innovations in the Treatment of Obsessive-Compulsive and Related Disorders

Kiara Timpano, Ph.D., Chair
Jonathan Abramowitz, Ph.D., Discussant

Innovative Interventions to Reduce Alcohol-Related Risk Among Diverse Populations: Patients, Veterans, and Young Adults

Anne Fairlie, Ph.D., Chair
Melissa Lewis, Ph.D., Chair
Clayton Neighbors, Ph.D., Discussant

Innovative Ways to Involve Families in PTSD Treatment

Leslie Morland, Psy.D., Chair
Brian Buzzella, Ph.D., Discussant

Intimate Partner Violence Across Diverse Contexts: Basic and Translational Research

Arthur Cantos, Ph.D., Chair
K. Daniel O'Leary, Ph.D., Discussant

Intraindividual Network Analysis: Implications for Clinical Assessment and Individualized Treatment Planning

Sarah Jo David, M.A., Chair
Gregory Mumma, Ph.D., Chair
Richard McNally, Ph.D., Discussant

Introducing Computational Clinical Science: Techniques to Improve Methods, Theory, Diagnosis, and Prediction

Peter Hitchcock, M.S., Chair
Richard McNally, Ph.D., Discussant

Irritability in Children and Adolescents: Treatment Needs and Mechanisms for Change

Spencer Evans, M.A., Chair
Jeffrey Burke, Ph.D., Discussant

Issues Involving Special Populations in Hoarding Disorder

Sheila Woody, Ph.D., Chair
Jordana Muroff, Ph.D., LICSW, Discussant

Lessons on Behavioral Intervention Technologies for Depression and Anxiety in Children, Adolescents, and Adults

Eduardo Bunge, Ph.D., Chair
Stephen Schueller, Ph.D., Discussant

Machine Learning Techniques Accurately Predict Suicide Ideation, Attempts, Death: Implications for Theory and Practice

Joseph Franklin, Ph.D., Chair
& Discussant

Managing Minority Stress: Cognitive, Affective, and Behavioral Responses to Discrimination Among Sexual Minorities

Ilana Seager, M.A., Chair
Debra Hope, Ph.D., Discussant

Maximizing Telephone- and Web-Based Interventions for Couples and Families

Steven Sayers, Ph.D., Chair
Scott Stanley, Ph.D., Discussant

Measurement-Based Care: Barriers and Facilitators to Implementing Measurement-Based Care in Diverse Settings

Amanda Jensen-Doss, Ph.D., Chair
Susan Douglas, Ph.D., Discussant

Mechanism-Based Approach to Targeted Provider Training for Improving Quality and Outcomes of Exposure Therapy

Joel Sherrill, Ph.D., Chair
Kristen Benito, Ph.D., Chair
Bruce Chorpita, Ph.D., Discussant

Mechanisms and Treatment of Aggression: Novel Findings and Implications for CBT Practice

Laura Watkins, Ph.D., Chair
Lauren Sippel, Ph.D., Chair
Leslie Morland, Psy.D., Discussant

Mechanisms of Change in Mindfulness-Based Interventions

Michael Moore, Ph.D., Chair
Greg Feldman, Ph.D., Discussant

Mechanisms of Risk for Intergenerational Transmission of Anxiety and Depression: Multimodal Methodologies

Jillian Lee Wiggins, Ph.D., Chair
Jennie Kuckertz, M.S., Chair
V. Robin Weersing, Ph.D., Discussant

Meeting People Where They Are: Innovative Strategies for Expanding Access to CBT

Kenneth Weingardt, Ph.D., Chair
Amanda Stewart, Ph.D., Discussant

Mental Health and Substance Use Disorders Among Clients With Criminal Justice System Involvement

Kelly Moore, Ph.D., Chair
Mandy Owens, Ph.D., Chair
Raymond Chip Tafrate, Ph.D., Discussant

Moving Beyond Mental Health Clinics and Delivering Services to Children in Their Natural Environments

Amanda Sanchez, M.S., Chair
Marc Atkins, Ph.D., Discussant

Moving Science From Clinic to Community: Designing and Testing CBT Interventions in Community Agencies

Joseph Himle, Ph.D., Chair
Michelle Craske, Ph.D., Discussant

Neurocognitive Interventions: Gaze-Contingent Training Techniques to Target Attention Biases in Psychological Disorders

Rudi De Raedt, Ph.D., Chair
Alvaro Sanchez, Ph.D., Chair
Ernst Koster, Ph.D., Discussant

Neurocognitive Mechanisms of Worry and Rumination

Lauren Hallion, Ph.D., Chair
Ernst Koster, Ph.D., Discussant

New Advances in Group CBT: Expanding the Reach and Context of Interventions

J. Gayle Beck, Ph.D., Chair
Denise Sloan, Ph.D., Chair
Richard Heimberg, Ph.D., Discussant

New Advances in the Treatment of Hoarding Disorder

David Tolin, ABPP, Ph.D., Chair
Randy Frost, Ph.D., Discussant

New Developments in Understanding Cognitive Processing in Anxiety

Lucas LaFreniere, M.S., Chair
Sadia Najmi, Ph.D., Discussant

New Frontiers in Cognitive Training and Cognitive Bias Modification

Andrew Peckham, M.A., Chair
Nader Amir, Ph.D., Discussant

Novel Applications and Mechanistic Investigations of Exercise for Mood and Anxiety

M. Alexandra Kredlow, M.A., Chair
Kristin Szuhany, M.A., Chair
Michael Otto, Ph.D., Discussant

Novel Extensions for Interventions Targeting Transdiagnostic Risk Factors for Anxiety and Related Psychopathology

Ashley Knapp, Ph.D., Chair
Sherry Stewart, Ph.D., Discussant

Novel Interventions for Smoking Cessation

Adrienne Johnson, M.A., Chair
Alison McLeish, Ph.D., Chair
Adam Gonzalez, Ph.D., Discussant

Novel Strategies for Preventing Relapse for Anxiety-Related Disorders: Advances From Translational Research

Elizabeth Marks, M.A., Chair
M. Alexandra Kredlow, M.A., Chair
Michael Otto, Ph.D., Discussant

Novel Targets and Change Mechanisms in Prevention

Lata McGinn, Ph.D., Chair
Colleen Conley, Ph.D., Discussant

OCD in Diverse Contexts: Culture, Race, and Religion

Jonathan Abramowitz, Ph.D., Chair
Martin Franklin, Ph.D., Discussant

Overcoming Barriers to Disseminating EBP's Through Service Delivery in Urban Schools and Primary Care

Thomas Power, ABPP, Ph.D., Chair
Jenelle Nissley-Tsiopinis, Ph.D., Chair
Marc Atkins, Ph.D., Discussant

Personalized Treatment Selection for Depression: For Whom Do Antidepressants and Psychodynamic Therapy Work?

Robert DeRubeis, Ph.D., Chair
Stefan Hofmann, Ph.D., Discussant

Prevention of Depressive Disorders Among "At-Risk" Adolescents

Ed Craighead, Ph.D., Chair
Judy Garber, Ph.D., Chair
V. Robin Weersing, Ph.D., Discussant

Promotion of Evidence-Based Treatments for Youth Through State and Local Policy Initiatives: Implementation Science

Alex Dopp, Ph.D., Chair
Shannon Stirman, Ph.D., Discussant

Putting the Positive Into SAD: Understanding of SAD to Optimize Treatment Efficacy and Effectiveness

Charles Taylor, Ph.D., Chair
Lynn Alden, Ph.D., Discussant

Race-Related Stress and Mental Health Outcomes Among Black/African Americans: Clinical Considerations

Jennifer Martinez, M.A., Chair
Shelly Harrell, Ph.D., Discussant

Reaching At-Risk Populations: Implications for Interventions Aimed at Reducing Sexual Violence, PTSD, and Alcohol Use

Christina Balderrama-Durbin, Ph.D., Chair
Nadine Mastroleo, Ph.D., Chair
Jennifer Read, Ph.D., Discussant

Recent Advances in the Study of Anxiety Sensitivity Among Individuals With Medical Conditions

Laura Dixon, Ph.D., Chair
Matthew Tull, Ph.D., Discussant

Recent Innovations in Mobile Health Interventions for Depression: From Internet-Delivered Behavior Activation to Serious Games

Ernst Koster, Ph.D., Chair
Kristof Hoorelbeke, M.S., Chair
Heleen Riper, Ph.D., Discussant

Refining Our Understanding of Cognitive Biases in Social Anxiety: New Insights Based on Diverse Methodologies

David Moscovitch, Ph.D., Chair
Bethany Teachman, Ph.D., Discussant

Resilience to Risk to Prevention: Immigrant Status and Duration of Untreated Psychosis in U.S. Latinos With First-Episode Psychosis

Steven Lopez, Ph.D., Chair
David Penn, Ph.D., Discussant

Role of Coercive Control in Diverse Intimate Relationships

Patti Timmons Fritz, Ph.D., Chair
K. Daniel O'Leary, Ph.D., Discussant

Romantic Relationship Functioning Among Sexual-Minority Youth, Adults, and Couples: Methodological and Scientific Advances

Brian Feinstein, Ph.D., Chair
Joanne Davila, Ph.D., Discussant

Self-Harm Behavior Does Not Discriminate: Nonsuicidal Self-Injury and Suicide Across Diverse Populations

Amy Brausch, Ph.D., Chair
Jennifer Muehlenkamp, Ph.D., Chair
Brianna Turner, Ph.D., Discussant

Self-Stigma Among People With Serious Mental Illness: Health, Sense of Belonging, and Proactive Coping

Emily Treichler, Ph.D., Chair
Alicia Lucksted, Ph.D., Discussant

Sensory Features of Obsessive-Compulsive-Related Disorders: From Community to Clinical Populations

David Houghton, M.S., Chair
Douglas Woods, Ph.D., Discussant

Spotlight on the Glass Ceiling: A Presentation of Gender Disparities With Implications for the Future of Our Field

Sasha Gorrell, M.A., Chair
Carolyn Becker, Ph.D., Discussant

Supporting CBT Implementation: Typical and Optimal Approaches to Training and Supervision

Sarah Kate Bearman, Ph.D., Chair
Ann Garland, Ph.D., Discussant

Supporting Clinicians to Deliver CBT Across Routine Clinical Settings: Insights From Implementation Science

Emily Becker-Haimes, Ph.D., Chair
Rinad Beidas, Ph.D., Discussant

Taking Treatment With You: Enhancing CBT Using Technology

Marie Forgeard, Ph.D., Chair
Dror Ben-Zeev, Ph.D., Discussant

The Dissemination of Personalized Evidenced-Based Psychotherapy Treatments for High-Risk Older Adults

Patricia Marino, Ph.D., Chair
Patrick Raue, Ph.D., Discussant

The Forgotten Psychologies: Understanding and Treating Perfectionism, Procrastination, and Self-Criticism

Maureen Whittal, ABPP, Ph.D., Chair
Adam Radomsky, Ph.D., Discussant

The Neurobiology of Reward and Punishment: No Free Lunch in Life

Thilo Deckersbach, Ph.D., Chair
Michael Otto, Ph.D., Discussant

The Role of Trauma-Related Cognitions in PTSD

Stefanie LoSavio, Ph.D., Chair
Patricia Resick, ABPP, Ph.D., Discussant

The Utility of Network Analysis for CBT: Clinical Integration

Nader Amir, Ph.D., Chair & Discussant

Therapist Effects: Current Knowledge, Empirical Advances, and Implications

James Boswell, Ph.D., Chair
David Atkins, Ph.D., Discussant

Toward the Clinical Application of Cognitive Bias Modification: Addressing the Psychometric Properties of Measure
Nader Amir, Ph.D., Chair

Transdiagnostic Examination of the Impact of DBT Skills and Strategies on Emotion Regulation
Lillian Krantz, M.A., Chair
M. Zachary Rosenthal, Ph.D., Discussant

Translational Research on Emerging Risk and Maintenance Factors for PTSD
Nicole Short, M.S., Chair
Joseph Boffa, M.S., Chair
Sheila Rauch, ABPP, Ph.D., Discussant

Trauma and Posttraumatic Cognitions: Differences Across Diverse Populations
Minden Sexton, Ph.D., Chair
Margaret Davis, Ph.D., Chair
Sheila Rauch, ABPP, Ph.D., Discussant

Treating Dysregulated Anger in Traumatized Populations: Outreach Along the Continuum of Care
Margaret-Anne Mackintosh, Ph.D., Chair
Tara Galovski, Ph.D., Discussant

Treatment of Families of Children With ADHD Across Diverse Contexts
Rosanna Breau, M.S., Ph.D., Chair
Dara Babinski, Ph.D., Chair
Charlotte Johnston, Ph.D., Discussant

Underlying Risk Factors of Addictions and Their Implication for Treatment
Jeremiah Weinstock, Ph.D., Chair
Sherry Stewart, Ph.D., Discussant

Understanding the Role of Diversity in Treatment Response to Rehabilitative Approaches in Schizophrenia
Felice Reddy, Ph.D., Chair
Will Spaulding, Ph.D., Discussant

Understanding the Underlying Mechanisms of Bipolar Disorder: Preliminary Data on Inflammation
Louisa Sylvia, Ph.D., Chair
Eric Youngstrom, Ph.D., Discussant

Using Computers, Internet, and Mobile Applications to Treat Anxiety: A Mechanisms Approach
Andrea Niles, Ph.D., Chair
Richard McNally, Ph.D., Discussant

Utilizing Technology-Based Interventions to Increase Access to Evidence-Based Treatments for Internalizing Disorders
Jennifer Dahne, Ph.D., Chair
Stephen Schueller, Ph.D., Discussant

What Influences Therapist Delivery of Child Evidence-Based Interventions in Community Mental Health Settings?
Nicole Stadnick, M.P.H., Ph.D., Chair
Kelsey Dickson, Ph.D., Chair
Miya Barnett, Ph.D., Discussant

Where Do We Start? Early Intervention and Treatment for Young Children With ADHD Across Diverse Contexts
Bridget Poznanski, B.S., Chair
Katie Hart, Ph.D., Chair
Gregory Fabiano, Ph.D., Discussant

Invited Addresses & Lifetime Achievement Address

Invited Address 1
Friday, 12:30 p.m.–1:30 p.m.
"Cultural Competency: Political Correctness or Necessity?"
Stanley Sue, Ph.D., *Emeritus Distinguished Professor of Clinical Psychology at Palo Alto University and Emeritus Distinguished Professor of Psychology at UC Davis*

Invited Address 2
Saturday, 12:00 p.m.–1:00 p.m.
Applying Evidence-Based CBT Principles to Disease Prevention and Self-Care in Diverse, Sexual Minority and Global Populations: Lessons Learned From HIV/AIDS
Steven A. Safren, Ph.D., ABPP, *University of Miami*

Invited Address 3
Saturday, 1:45 p.m.–2:45 p.m.
Cognitive Behavioral Therapy with Low-income and Minority Communities
Jeanne Miranda, Ph.D., *UCLA*

Lifetime Achievement Address
Friday, 11:00 a.m.–12:00 p.m.
DBT: Where We Are, Where We Were and Where We Are Going
Marsha M. Linehan, Ph.D., ABPP, *University of Washington*

PRESIDENTIAL ADDRESS

Saturday, 5:30 – 6:30 PM | Sapphire Ballroom, Level 4, Sapphire Level

Gail S. Steketee, Ph.D., M.S.W., *Boston University School of Social Work*

**Team Science Across Disciplines:
Advancing CBT Research and Practice for Hoarding**

Special Interest Group Meetings

Attendance at an ABCT SIG meeting is a wonderful networking opportunity. The SIGs focus on a diverse range of topics, including treatment approaches, specific disorders, or unique populations.

Addictive Behaviors • Saturday, 1:45 p.m. – 3:15 p.m.,
Sapphire 411, Level 4, Sapphire Level

African Americans in Behavior Therapy • Friday, 10:30
a.m. – 12:00 p.m., Sapphire 411, Level 4, Sapphire Level

Aging Behavior & Cognitive Therapy • Friday, 12:00 p.m. –
1:00 p.m., Aqua 309, Level 3, Aqua Level

Anxiety Disorders • Friday, 12:00 p.m. – 1:30 p.m., Indigo
206, Level 2, Indigo Level

**Asian American Issues in Behavior Therapy
& Research** • Saturday, 12:00 p.m. – 1:30 p.m., Aqua 310,
Level 3, Aqua Level

Attention-Deficit/Hyperactivity Disorder (ADHD) •
Saturday, 10:15 a.m. – 11:45 a.m., Aqua 310, Level 3, Aqua Level

Autism Spectrum and Developmental Disorder •
Friday, 10:15 a.m. – 11:45 a.m., Indigo 206, Level 2,
Indigo Level

Behavior Analysis • Saturday, 10:15 a.m. – 11:45 a.m.,
Sapphire 411, Level 4, Sapphire Level

Behavioral Medicine and Integrated Primary Care •
Saturday, 3:30 p.m. – 5:00 p.m., Sapphire 411, Level 4,
Sapphire Level

Behavioral Sleep Medicine • Saturday, 10:15 a.m. – 11:45
a.m., Indigo 206, Level 2, Indigo Level

Bipolar Disorder • Saturday, 10:15 a.m. – 11:45 a.m., Aqua
309, Level 3, Aqua Level

Child and Adolescent Anxiety • Friday, 1:45 p.m. – 3:15
p.m., Indigo 206, Level 2, Indigo Level

Child and Adolescent Depression • Saturday, 12:00 p.m. –
1:00 p.m., Aqua 309, Level 3, Aqua Level

Child and School-Related Issues • Saturday, 2:30 p.m. –
3:30 p.m., Aqua 309, Level 3, Aqua Level

Child Maltreatment and Interpersonal Violence •
Friday, 1:30 p.m. – 3:00 p.m., Aqua 309, Level 3, Aqua Level

Clinical Psychology at Liberal Arts Colleges • Saturday,
8:30 a.m. – 10:00 a.m., Indigo 206, Level 2, Indigo Level

Clinical Research Methods and Statistics • Friday,
3:15 p.m. – 4:15 p.m., Sapphire 411, Level 4, Sapphire Level

Cognitive Therapy • Friday, 4:45 p.m. – 5:45 p.m., Indigo
206, Level 2, Indigo Level

Couples Research and Treatment • Friday, 9:15 a.m. –
10:15 a.m., Sapphire 411, Level 4, Sapphire Level

Dissemination and Implementation Science •
Saturday, 8:30 a.m. – 10:00 a.m., Juilliard & Imperial Rooms,
5th Floor

Forensic Issues and Externalizing Behaviors •
Saturday, 12:00 p.m. – 1:30 p.m., Sapphire 411, Level 4,
Sapphire Level

Functional Analytic Psychotherapy • Saturday, 1:15 p.m. –
2:15 p.m., Aqua 309, Level 3, Aqua Level

Hispanic Issues in Behavior Therapy • Friday, 4:30 p.m.
– 6:00 p.m., Aqua 309, Level 3, Aqua Level

Men's Mental and Physical Health • Sunday, 10:15 a.m. –
11:45 a.m., Aqua 310, Level 3, Aqua Level

Military Psychology • Saturday, 12:00 p.m. – 1:30 p.m.,
Indigo 206, Level 2, Indigo Level

Mindfulness and Acceptance • Saturday, 3:45 p.m. – 5:15
p.m., Aqua 309, Level 3, Aqua Level

**Native American Issues in Behavior Therapy and
Research** • Friday, 3:15 p.m. – 4:15 p.m., Aqua 309, Level 3,
Aqua Level

Neurocognitive Therapies/Translational Research •
Saturday, 4:00 p.m. – 5:30 p.m., Indigo 206, Level 2, Indigo
Level

Obesity and Eating Disorders • Friday, 4:30 p.m. – 6:00
p.m., Sapphire 411, Level 4, Sapphire Level

Oppression and Resilience: Minority Mental Health •
Sunday, 8:30a.m. – 10:00a.m., Aqua 309, Level 3, Aqua Level

Parenting and Families • Saturday, 8:30 a.m. – 10:00 a.m.,
Sapphire 411, Level 4, Sapphire Level

Schizophrenia and Other Serious Mental Disorders •
Friday, 1:30 p.m. – 3:00 p.m., Sapphire 411, Level 4, Sapphire
Level

Spiritual and Religious Issues • Friday, 3:30 p.m. – 4:30
p.m., Indigo 206, Level 2, Indigo Level

Student • Sat., 1:45 – 3:15 p.m., Aqua 310, Level 3, Aqua Level

Study of Gay, Lesbian, Bisexual, and Transgender •
Saturday, 1:45 p.m. – 3:15 p.m., Indigo 206, Level 2, Indigo
Level

Suicide and Self-Injury • Saturday, 8:30 a.m. – 10:00 a.m.,
Aqua 309, Level 3, Aqua Level

Technology and Behavior Change • Friday, 8:30 a.m. –
10:00 a.m., Aqua 309, Level 3, Aqua Level

TIC and Impulse Control Disorders • Friday, 12:15 p.m. –
1:15 p.m., Sapphire 411, Level 4, Sapphire Level

Trauma and PTSD • Friday, 10:15 a.m. – 11:45 a.m., Aqua
309, Level 3, Aqua Level

Women's Issues in Behavior Therapy • Friday, 8:30 a.m. –
10:00 a.m., Indigo 206, Level 2, Indigo Level

Registration

Preregister on-line at www.abct.org. To pay by check, complete the registration form available in PDF format on the ABCT website. Participants are strongly urged to register by the preregistration deadline of October 16. Beginning October 17 all registrations will be processed at the on-site rates. Please note: Convention Program Books will be distributed on-site.

To receive member registration fees, members must renew for 2018 before completing their registration process or to join as a New Member of ABCT: (<https://www.abctcentral.org/eStore/index.cfm>)

Preconvention Ticketed Sessions & Registration Preconvention Sessions will be held on Wednesday, November 15, and Thursday, November 16 at the Hilton San Diego Bayfront Hotel. All preconvention sessions are designed to be intensive learning experiences. Preregister to ensure participation.

Registration for the Clinical Intervention Training Session 1 (scheduled for Wednesday and Thursday) that has open spots will be on sale on Wednesday from 7:30 a.m. – 9:00 a.m. in front of Aqua 310 on the 3rd Floor, Aqua Level.

Registration for all other PRE-Convention Sessions (AMASS, Clinical Intervention Seminars, Institutes) will take place in the Hilton San Diego Bayfront Hotel at the ABCT Onsite Registration area on the 4th Floor, Sapphire Level.

- Thursday, November 16: 7:30 a.m. – 6:00 p.m.
- Friday, November 17: 7:30 a.m. – 6:00 p.m.
- Saturday, November 18: 7:30 a.m. – 6:00 p.m.
- Sunday, November 19: 7:30 a.m. – 1:00 p.m.

General Registration

Upon arrival at the Hilton San Diego Bayfront Hotel, you can pick up the program book, addendum, additional convention information, and ribbons at the Pre-Registration Desk on the 4th floor, Sapphire Level.

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

Onsite Registration AND Preregistration pickup will be open:

- Thursday, November 16: 7:30 a.m. – 6:30 p.m.
- Friday, November 17: 7:30 a.m. – 6:30 p.m.
- Saturday, November 18: 7:30 a.m. – 6:30 p.m.
- Sunday, November 19: 7:30 a.m. – 1:00 p.m.

The general registration fee entitles the registrant to attend all events on November 16 – November 19 except for ticketed sessions. Your canceled check is your receipt. Email confirmation notices will be generated automatically for on-line registrations and will be sent via email the same day you register. Email confirmations will be sent within 1 week for faxed and mailed registrations. If you do not receive an email confirmation in the time specified, please call the ABCT central office, (212) 647-1890, or email Tonya Childers-Collens at tchilders@abct.org. You must wear your badge at all times to be admitted to all official ABCT sessions, events, and the exhibits. If you lose your badge there will be a \$15 charge for the replacement.

All presenters (except for the first two presenters of ticketed CE sessions) must pay the general registration fee. Leaders of ticketed session will receive information regarding their registration procedure from the ABCT Central Office.

Admission to all ticketed sessions is by ticket only. Preregistration is strongly advised as ticketed sessions are sold on a first-come, first-served basis.

Please note: NO PURCHASE ORDERS WILL BE ACCEPTED.

To register, please choose one format:

Registering On-Line The quickest method is to register on-line (go to abct.org and click on the convention banner on the home page, or go to www.abct.org/conv2017). Use this method for immediate feedback on which ticketed sessions you will be attending. To receive members' discounted rates, your ABCT dues must be up to date. If your membership has lapsed, use this opportunity to renew (<https://www.abctcentral.org/eStore/index.cfm>).

To get member rates at this conference, your ABCT dues must be paid through October 31, 2018. The ABCT membership year is November 1, 2017 – October 31, 2018. To renew, go to abct.org or the on-site membership booth.

Registering by Fax You may fax your completed registration form, along with credit card information and your signature, to (212) 647-1865. If you choose this method please DO NOT send a follow-up hard copy. This will cause double payment. For preregistration rates, please register BEFORE the deadline date of October 16.

Registering by Mail All preregistrations that are paid by check must be mailed to ABCT, 305 Seventh Avenue, 16th Floor, New York, NY, 10001. For preregistration rates, forms must be postmarked by the deadline date of Monday, October 16.

Forms postmarked beginning Tuesday, October 17 will be processed at on-site rates. Forms postmarked October 23, or later will be processed on-site. There will be no exceptions. Refund Policy Cancellation refund requests must be in writing. Refunds will be made until the October 16 deadline, and a \$40 handling fee will be deducted. Because of the many costs involved in organizing and producing the Convention, no refunds will be given after October 16.

Payment Policy

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

Exhibits, ABCT Information Booth Hours

- Friday & Saturday: 8:00 a.m. – 5:30 p.m.
- Sunday, 8:00 a.m. – 1:00 p.m.

Hotel

Hilton San Diego Bayfront Hotel
1 Park Boulevard
San Diego, CA 92101 US

To make a reservation online, go to:
<https://aws.passkey.com/go/ABCT2017>

To make a reservation by phone, call +1 800-445-8667 and use the group code ABCT for the ABCT Convention group rate.

Through this website, you can book, modify or cancel your hotel reservations at any time. When making your reservation you will be asked for a one night deposit, which is refundable up to 72 hours prior to date of arrival.

We look forward to seeing you!

The special ABCT Convention rate is \$229 single, \$249 queen/queen bedded room, per night plus 12.64% tax. These rates will be offered, based on mutual agreement with the Hotel, 3 days before and 3 days after the official Convention dates of November 16 – 19, 2017. For information on a discounted rate for student hotel rooms, contact ABCT Staff at convention@abct.org or call the ABCT Central Office at (212) 647-1890. The block is limited and available on a first-come basis until the block is depleted. If you are interested in upgrading your hotel accommodations, there are limited options available, at an increased rate. See the information when you click the reservation link.

All ABCT Convention scientific sessions will take place at the Hilton San Diego Bayfront Hotel. General registration includes panel discussions, clinical round tables, symposia, mini-workshops, and hundreds of poster sessions. SIG meetings and social events will enable non-stop networking. And don't forget to check out the limited-attendance CE events – both on Thursday and throughout the Convention on Friday through Sunday.

Stay at the Headquarters Hotel to meet your friends and colleagues on the elevator, in the coffee shop, as well as in the meeting rooms. Your support of the headquarter hotel also helps to keep the overall convention expenses to a minimum.

Rooms are available at the ABCT Convention rate until Monday, October 16, 2017. After this date, rooms and rates are subject to rate and room availability. Please be sure to book your reservation early!

Research and Professional Development

Research and Professional Development 1: **Experimental Therapeutics: Diverse Methods for Engaging Mechanisms from Treatment Development to Effectiveness Testing**

Moderators: Shannon Sauer-Zavala, Ph.D., Joel Sherrill, Ph.D.
Panelists: Moria J. Smoski, Ph.D., Adrienne Juarascio, Ph.D., Eric Granholm, Ph.D., Jill Ehrenreich-May, Ph.D.

Research and Professional Development 2: **Evaluation and Delivery of Competency-Based Supervision**

Moderators: Pooja N. Dave, Ph.D., Andrea E. Kass, Ph.D.
Panelists: Carol Falender, Ph.D., Kristin Rodzinka, ABPP, Ph.D., Jason Washburn, Ph.D., Amanda Wickett-Curtis, Psy.D., Shona N. Vas, Ph.D.

Research and Professional Development 3: **Strategies for Providing Effective Training in CBT With Diverse Populations**

Moderator: Sarah E. Kleiman, Ph.D.
Panelists: Monnica T. Williams, Ph.D., Jillian C. Shipherd, Ph.D., Anu Asnaani, Ph.D., Shadi Beshai, Ph.D., Lloyd K. Chapman, Ph.D., Jordana Muroff, Ph.D., LICSW

Research and Professional Development 4: **The Personal Is Political: Mentoring Women Through Career Phases**

Moderator: Barbara W. Kamholz, ABPP, Ph.D.
Panelists: Denise A. Chavira, Ph.D., Muniya Khanna, Ph.D., Elizabeth A. Meadows, Ph.D., Shireen L. Rizvi, ABPP, Ph.D., Risa B. Weisberg, Ph.D., Monnica T. Williams, Ph.D.

Research and Professional Development 5: **What Is Implementation Science and Why Is It Relevant to You?**

Panelists: Byron J. Powell, Ph.D., LCSW, Rinad Beidas, Ph.D., Cara C. Lewis, Ph.D., Aaron R. Lyon, Ph.D.

Research and Professional Development 6: **Using Data to Plug the "Leaky Pipeline": Empirically Supported Approaches for Promoting Gender Equity in the Academy**

Moderators: Julia M. Hormes, Ph.D., Laura E. Sockol, Ph.D.
Panelists: Julia M. Hormes, Ph.D., Laura E. Sockol, Ph.D., C. Alix. Timko, Ph.D., Susan J. Wenzel, Ph.D.

Research and Professional Development 7: **Careers in Clinical Psychology: Which Path Makes Sense For Me?**

Panelists: Sabine Wilhelm, Ph.D., Matthew K. Nock, ABPP, Ph.D., Jonathan B. Grayson, Ph.D., Barbara W. Kamholz, ABPP, Ph.D., Jed Siev, Ph.D.

Research and Professional Development 8: **Training the Next Generation in Measurement-Based Care: Implementation & Training of Routine Outcome Monitoring in Training Clinics**

Moderator: Lee D. Cooper, Ph.D.
Panelists: Haley G. Murphy, M.S., Rick A. Cruz, Ph.D., Lauren E. Hurd, M.A., Jason C. Levine, Ph.D., A. Paige. Peterson, M.S., Haley G. Murphy, M.S.

Research and Professional Development 9: **Models for Training Clinical Scientists**

Moderator: Jacqueline B. Persons, Ph.D.
Panelists: Matthew D. Lerner, Ph.D., Nancy Liu, Ph.D., David Sbarra, Ph.D., Robert Levenson, Ph.D., Casey L. Brown, M.A., Ryan M. Beveridge, Ph.D.

CLASSIFIEDS

► FELLOWSHIPS IN ADVANCED COGNITIVE THERAPY FOR SCHIZOPHRENIA WITH AARON T. BECK

University of Pennsylvania

We offer an exciting opportunity for post-doctoral applicants in the Aaron T. Beck Psychopathology Research Center at the University of Pennsylvania. Specifically, our mission is to develop professionals who will become leaders in the field of psychosocial approaches that promote recovery for individuals with schizophrenia. Under the direction of Aaron T. Beck, M.D., our program includes clinical trials of innovative treatments for the disorder, dissemination and implementation of these treatment protocols into community mental health centers and psychiatric hospitals, as well as basic research. We have been recognized for our cutting edge work in this field. For more information, see <http://aaronbeckcenter.org>.

Applicants who have earned an Ph.D., Psy.D., or equivalent in psychology, social work, medicine or other related field and have had previous training in cognitive therapy, severe mental illness, or recovery-oriented services are encouraged to apply. Bilingual candidates are especially encouraged to apply.

Please send a curriculum vita with a cover letter and two letters of recommendation via email to Aaron T. Beck, M.D., at abeck@mail.med.upenn.edu.

The University of Pennsylvania is an Equal Opportunity/Affirmative Action Employer. Seeking applicants for current and future positions. NOTES: 2 openings.

University of Pennsylvania, 3451 Walnut Street, Philadelphia, PA 19104. The University of Pennsylvania is an Equal Opportunity/Affirmative Action Employer.

► FULL TIME THERAPIST POSITION AVAILABLE.

Due to our growth, Mountain Valley Treatment Center seeks an additional licensed clinician to join our exceptional clinical team as a primary therapist at its beautiful campus in Pike, NH. Mountain Valley, a short term residential treatment program, serves male and female adolescents and emerging adults, 13 – 20 years old, from across the globe with debilitating anxiety and OCD. Located on the edge of the White Mountains and Connecticut River Valley, 30 minutes north of the Hanover, NH and Dartmouth College area,

Mountain Valley adds clinically intensive CBT and ERP within an experiential education program and mindfulness-based milieu.

Primary Therapists manage a caseload of 3-5 private pay residents over their 90 day treatment stay providing individual, group, and family therapy. Designing and implementing exposures with their clients on its iconic New England, 1800 acre conservation land location and within local communities provides a unique professional experience unmatched at any other residential treatment setting.

The ideal candidate will have at a minimum a master's degree, be currently licensed or license-eligible in New Hampshire clinician with an understanding of CBT based modalities such as DBT, ACT and ERP. Prior experience serving clients with OCD and anxiety disorders preferred.

Above average salary, full benefits package, relocation and temporary housing assistance, and annual professional development opportunities such as attending ABCT, ADAA and IOCDF conferences. Casual work and team focused environment. Mountain Valley supports the professional growth of all its staff.

Please contact Don Vardell, Executive Director at dvardell@mountainvalleytreatment.org for more information or to apply.

► BEHAVIORAL PRACTICE FOR SALE IN NORTH CAROLINA.

Well-established private practice is now for sale.

Prospective purchaser should have a cognitive and/or behavioral therapy background and be an experienced practice manager capable of directing the activities of up to ten professionals and support staff.

Over the past three years, average revenues have grown steadily from \$685K to over \$765K. Cash flow is \$100K+ (after paying owner's salaries of \$115K). The practice is priced at \$410,000; office building lease may be extended to the new owner.

The practice enjoys an outstanding reputation in the area with extensive referral networks in place. Clinicians are paid competitively.

For more information, a confidentiality (non-disclosure) agreement and buyer registration document will be required. Reply to Southeastern Regional Business Brokers at 828-687-7163 or email gsolms@sebrokers.com.

Find a CBT Therapist



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

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

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

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

ABCT 2017: Getting to Know San Diego, “America’s Finest City”

Aaron Blashill and Tiffany Brown, *Local Arrangements Co-Chairs*

ABCT’s 2017 Local Arrangements Committee is very excited to welcome you to San Diego, “America’s Finest City” (and we agree!) for the 51st Annual Convention in November. San Diego’s enchanting natural beauty, almost year-round 70-degree climate and relaxed, laid-back ambiance make it an ideal setting for ABCT convention-goers. From downtown San Diego and the historic Gaslamp District, to Coronado Island, North Park, Hillcrest, and Little Italy, and beach communities (Mission Beach, Pacific Beach, La Jolla, Del Mar), San Diego has something to offer everyone.

We expect that you will be busy with the convention, but be sure to make some time to enjoy our city and venture away from the hotel to become immersed in the full San Diego experience! Below, we have provided information on several activities, including sightseeing, shopping, cuisine, and more. However, there are so many incredible things that San Diego has to offer, that we also recommend reviewing <https://www.sandiegoreader.com> and <https://www.timeout.com/san-diego> close to the convention for up-to-date activity ideas, restaurants, breweries, music, and more.

We will also be updating you all on some exciting activities to enjoy at the convention, including yoga on the beach, the annual fun run, with more details coming soon. We also hope that you will join us for the Saturday-night dance party, which will feature a photo booth, DJ, and, of course, plenty of dancing!

Local Arrangements Table

If you need any kind of assistance during the convention, please stop by the Local Arrangements table. We will be able to provide helpful tips on getting around the city, things to do, places to eat, and more. We will also have maps, sign-up sheets for opportunities to “Dine with a San Diegan,” and information about additional activities throughout the convention.

Hotel and Immediate Surroundings

The convention is being held at the San Diego Hilton Bayfront Hotel, directly on the beautiful San Diego Bay and close to downtown. The hotel is most easily accessible by car, taxi, or ridesharing service (Uber, Lyft).

The Hilton features a fitness center, Wi-Fi in rooms and public spaces in the hotel, ATM, business center, The UPS Store, and more. The hotel’s website provides more information on amenities, as well as local attractions and sightseeing ideas.

There are several dining options within close proximity to the hotel, in addition to a Starbucks, a yogurt shop, and a few American cuisine restaurants within the hotel. However, if it works with your schedule, we recommend leaving the hotel for food, as there are many great options nearby. For local coffee, try The Copa Vida, Elixir Café, Café Virtuoso, or Bean Bar. If you are interested in breakfast or brunch, try The Mission, The Broken Yolk, or Café 222.

The hotel is also a short walk to nearby Seaport Village, where you can enjoy Bayfront dining and shopping. You can also hop on the ferry (in front of the convention center) for a short ride across the bay to Coronado Island, where you can visit the famous Hotel Del Coronado, take in the sunset on the gorgeous beaches, and enjoy a meal at one of the many restaurants along the charming Orange Avenue (try Leroy’s Kitchen, The Tavern, Chez Loma). The hotel is also situated a short walk from the downtown area, and the Gaslamp district, where you can enjoy an abundance of restaurants and nightlife (<http://www.gaslamp.org/>).

Getting to the Hilton San Diego Bayfront From the Airport

San Diego International Airport (SAN)
3225 N Harbor Dr, San Diego, CA 92101
(619) 400-2404

The San Diego International airport is approximately 3 to 4 miles, or 10 minutes by car, from the downtown area and convention hotel. Given the short distance, the

most convenient way to get from the airport to the hotel or downtown area is by taxi or rideshare service.

- **TAXI:** Taxis are available outside baggage claim in the taxi line. Taxis cost approximately \$15-20 from the airport to the hotel.

- **RIDESHARE SERVICE:** It is also possible to request a ridesharing service (Uber, Lyft, etc.) at the airport: Follow the signs from baggage claim across the skybridge to the pickup locations.

- **SHUTTLE:** The Hilton San Diego Bayfront does not offer complimentary shuttle service, but the Super Shuttle/Cloud 9 Shuttle is approximately \$10 to the hotel.

Getting Around San Diego

Downtown San Diego is very walkable; however, San Diego city neighborhoods outside of downtown are a bit more spread out and the primary method of transportation is by car (taxi, Uber, and Lyft). Taxis accept cash, debit, and credit cards and San Diego has several cab companies, including American Cab (619.234.1111), Orange Cab (619.291.3333), Silver Cab (619.280.5555), and Yellow Cab (619.444.4444).

If you are interested in taking a ride up the coast to visit some of the beach towns, the Coaster Commuter Train is also an option to see some breathtaking views of coastal scenery (<http://www.gonctd.com/coaster/>).

You can also ride the San Diego Trolley, which is a great way to get to Little Italy and Old Town. The closest stop to the hotel is on 5th and Harbor Dr., a 5-minute walk (<https://www.sdmts.com/>).

Things to Do in San Diego

Cuisine San Diego has a wide variety of cuisines available, with far too many incredible restaurants to list. Since some restaurants can book up quickly, reservations are frequently recommended. San Diego is known for its Cali Baja cuisine and famous fish tacos (try Oscar’s Mexican Seafood, Coasterra, El Zarape, Puesto, Blue Water Seafood Market & Grill), Mexican food (Try Lolita’s Taco Shop, La Puerta, Old Town Mexican Café, Casa Guadalajara), and seafood (try The Fish Market, Oceanaire Seafood Room, George’s La Jolla). However, San Diego also has a variety of cuisines peppered throughout the many unique local neighborhoods. For example, try Little Italy and nearby for Italian (try Davanti Enoteca, Buon Appetito, Cucina Urbana). For dessert try Extraordi-

nary Desserts, Donut Bar, Pappalecco, and Chocolat Cremerie. Fairly reliable restaurant reviews and recommendations by San Diego neighborhood can be found on Yelp and OpenTable.com. OpenTable.com is also very helpful for making restaurant reservations. We will also be posting a list of nearby restaurants by San Diego neighborhood on the ABCT website, and feel free to stop by the Local Arrangements table if you would like a copy.

Sightseeing Activities San Diego also has several unique cultural landmarks and sightseeing opportunities that are worth a visit. Balboa Park (2.5 miles from the hotel) is one of the oldest urban cultural parks in the U.S., and contains over 17 museums, natural vegetation zones, gardens (the rose and cactus gardens are a standout), several theaters (including The Old Globe), and the world-famous San Diego Zoo. Cabrillo National Monument (15 miles away) in Point Loma offers beautiful views of the downtown city area across the bay. Tour the U.S.S. *Midway* (1.5 miles away) and explore more than 60 exhibits with a collection of 27 restored air crafts or take a San Diego Bay Cruise (1.5 miles away) for a 1- or 2-hour narrated trip along the coast (<http://www.flagshipsd.com/cruises/san-diego-harbor-tour>).

Beaches Although November may not be prime beach weather (the water can reach 60 degrees Fahrenheit in November), San

Diego has incredible beaches that are worth a trip, even just to take a relaxing walk on the sand or enjoy a beautiful sunset. A few of the standout beach communities nearby, all of which have their own unique flavor, include: Coronado (3 miles from the hotel), Mission Beach (10 miles away), Pacific Beach (11 miles away), La Jolla Shores & Cove (16 miles away), Del Mar (25 miles away).

Shopping Nearby the hotel, Seaport Village has several charming and unique boutiques and souvenir shops. For more traditional shops, visit Westfield Horton Plaza in the heart of downtown San Diego. If you are in Old Town stopping by for some Mexican food, check out Bazaar Del Mundo, which includes a variety of lovely and colorful shops from Latin America and around the world.

Music San Diego has hundreds of music venues across the city, from intimate settings to large arenas. A few of the standouts include the Belly Up Tavern, House of Blues, The Observatory in North Park, The Casbah for Rock/Alternative, and Seven Grand for Jazz. Check out Ticketmaster.com for information about local concerts.

Bars and Breweries San Diego is a major attraction for craft beer enthusiasts and boasts over 120 breweries around the city! There are several popular breweries within walking distance of the hotel or a short

drive away, including: Mission Brewery, Stone Brewery, Resident Brewing, Modern Times Beer, Ballast Point, Monkey Paw Brewery, Half Door Brewing Company, and Karl Strauss. Not a beer drinker? Standout bars downtown include: Noble Experiment, Prohibition, Vin de Syrah (wine), and Altitude Sky Lounge (an open-air bar with views of the downtown skyline).

Weather

San Diego is famous for temperate weather nearly all year round! In November, the average high is around 70 degrees Fahrenheit during the day and the low drops to mid-50 degrees Fahrenheit. Make sure to layer and bring a light jacket and walking shoes.

We Look Forward to Seeing You

If you have any questions about San Diego, please feel free to email us and we will be glad to assist you (Aaron Blashill: ajblashill@mail.sdsu.edu or Tiffany Brown: tiffanybrown@ucsd.edu). Keep checking the ABCT website and listserv for information on Dine with a San Diegan (dinners have been arranged for Friday and Saturday nights), the fun run, yoga, and other news about the convention. We will have a Local Arrangements table at the convention near the ABCT registration counters, so stop by and let us assist you with where to go and what to do. ■

AWARDS & RECOGNITION

ABCT 2016 Awards & Recognition Highlighting Student Dissertation Awards

Anne M. Donnelly, *Awards & Recognition Committee*

Virginia Roswell Dissertation Award Winner: Emily J. Georgia

TITLE OF DISSERTATION: *Effectiveness of OurRelationship.com for Underserved Couples*

ADVISOR: Brian D. Doss, Ph.D., University of Miami

Emily's research sought to assess the efficacy and cost-effectiveness of OurRelationship.com (OR) for underserved couples (low income, those with limited access to services due to logistics, cultural and ethnic minorities). OR is an online self-help inter-

vention developed utilizing the tenets of Integrative Behavioral Couple Therapy. Results indicated that the intervention was beneficial for the underserved couples who completed the program, but noted a tendency toward attrition in this cohort. Regarding cost-effectiveness, data indicated that OR provided important cost savings over in-person couples therapy. Emily states, "I hope to continue my work in disseminating flexible interventions aimed at reducing relationship distress. I am particularly interested in investigating whether

the OurRelationship program can be tailored and disseminated to effectively improve military veterans' romantic relationships." Emily wishes to acknowledge her mentor, Dr. Brian D. Doss: "His guidance, expertise, encouragement, support (the list goes on) was instrumental in any success I've achieved."

At the ABCT 50th Convention in New York City, Emily's work contributed to the symposium "Minimizing Barriers and Maximizing Reach: The Dissemination of Online Relationship Interventions," with her presentation of "Cost-Effectiveness Comparison of Traditional vs. Online Relationship-Focused Interventions." Emily's research was represented in "Violent Couples Seeking Relationship Help: Who Are They and Can Online Interventions Help, Dissemination of a Free Web-based Couple Intervention to Minority and Low-income Couples."

In addition to the Virginia A. Roswell Student Dissertation Award, Emily also

received the following: Administration for Children and Families Dissertation Research Award (funding this research); Robert Weiss Student Research Award, 2nd Place from ABCT Couples SIG; Dean's Summer Research Fellowship, University of Miami; Graduate Activity Fee Allocation Committee Award, University of Miami; Max & Peggy Kriloff Student Travel Scholarship, University of Miami; Student Travel Award, University of Miami, Department of Psychology; Iowa Center for Research by Undergraduates Research Scholar, University of Iowa; Iowa Research Experience for Undergraduates Grant Recipient, University of Iowa; Outstanding Poster Award, Spring Undergraduate Research Forum, University of Iowa; Social & Behavioral Science Research Conference, Grand Prize, University of Northern Iowa.

John R. Z. Abela Student Dissertation

AWARD WINNER: Faith Orchard

TITLE OF DISSERTATION: *The Clinical Characteristics and Cognitive Biases Associated With Adolescent Depression*

ADVISOR: Shirley Reynolds, Ph.D., University of Reading

Faith's research was broken down into five separate papers, aiming to further elucidate and expound on relevant but not fully understood characteristics of depression in adolescents. In particular, she focused on interpretation and memory biases within both clinical and community samples of adolescents. The results of Faith's research provided validation for the utility of CBT in the treatment of adolescent depression in that "interpretation biases and a lack of positive memories were characteristic of adolescent depression." These data are now part of a larger dataset seeking to explore cognitive biases within the adolescent population on a national scale. Faith continues to research cognitive biases and their role in adolescent depression. She has started an additional project investigating sleep disturbances in both anxiety and depression within a population of young people. Faith gratefully acknowledges the many contributions of her advisor, Dr. Shirley Reynolds.

At the ABCT 50th Convention in New York City Faith presented a poster entitled "Defining Self-Evaluations in Adolescent Depression."

In addition to the John R. Z. Abela Student Dissertation Award, Faith also received the following: University of Reading Ph.D. Researcher of the Year; British Psychological Society Postdoctoral Confer-

ence Bursary, to attend and present at BABCP conference in Manchester; University of Reading Travel Grant, to attend and present at ABCT conference in New York; University of Reading Travel Grant, to attend and present at ADAA conference in Miami; ESRC Youth Mental Health Seminar Series, Poster Presentation Award and Travel Bursary.

Leonard Krasner Student Dissertation Award Winner: Tomislav D. Zbozinek

TITLE OF DISSERTATION: *The Effect of Positive Affect on Extinction Learning, Return of Fear, and Exposure Therapy*

ADVISOR: Michelle G. Craske, Ph.D., UCLA

Tomislav's research explored the impact of positive affect (PA) on various important indicators involved in the outcome of exposure therapy when used as a treatment for anxiety. His research results suggest that "increasing positive mood during exposure can reduce long-term fear and reduce two modes of return of fear: spontaneous recovery and rapid reacquisition." Thus, PA may be a variable that can improve the efficacy of exposure therapy for the treatment of anxiety. Tomislav's plans for ongoing and future research involve conducting both a replication and extension of his dissertation, exploring mechanisms that might "enhance generalization of extinction learning to stimuli that were not present during exposure." In addition, along with Michelle Craske, he awaits the publication of a paper "Investigating the Effects of Positive Mood on the Various Stages of Learning and Memory." Tomislav would like to thank his advisor, Dr. Michelle Craske, "who has been an amazing, caring mentor who emphasizes rigor in theory, methodology, and interpretation."

At the ABCT 50th Convention in New York City Tomislav chaired the symposium "Positive Affect, Anxiety, and Depression," with symposia presentations "Positive Affect as a Moderator of the Effects of Stressful Life Events on Anxiety" and "The Effect of Positive Mood Induction Before Extinction on Rapid Reacquisition."

In addition to the Leonard Krasner Student Dissertation Award, Tomislav also received the UCLA Dissertation Year Fellowship Award (funding final year of dissertation); Graduate Division Summer Mentorship Award, UCLA; Charles Y. Nakamura Research Award, UCLA; Award for Best Master's Thesis in Clinical Psychology, UCLA. ■

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