

# *the* Behavior Therapist

## *Contents*

### **President's Message**

*Michelle G. Craske • 101*

### **Institutional Settings**

*Michael T. Finn, Gyrid Lyon, Michael R. Nash*

Predicting and Understanding Mental Health Clinic  
Operations Over Time • 106

### **Research-Practice Links**

*Amanda K. Stary, Stephen D. A. Hupp, Jeremy D. Jewell,  
Gregory E. Everett*

Parent Acceptability of Time-Out, Spanking, Response Cost,  
and Positive Reinforcement • 112

*R. Trent Codd, III*

How to Develop a Robust Practice-Based Research  
Repertoire • 118

### **News & Notes**

*Helen Z. MacDonald*

Spotlight on a Mentor: Dr. Lizabeth Roemer • 121

### **Clinical Forum**

*Holly Bedotto*

How Horse Training Made Me a Better DBT Therapist • 123

### **At ABCT**

Welcome, New Members • 125

Call for Editors • 131

50th Anniversary

Gratitude Ads • 117

Call for Golden Moments • 131

*tBT* Survey • *back page*

### PRESIDENT'S MESSAGE

**Michelle G. Craske, UCLA**



IN THIS COLUMN, I provide an update on our advances in the implementation of our ABCT strategic plan and the 50th Anniversary Convention (October 27–30, New York, NY).

As a reminder, the strategic plan includes five primary strategic initiatives (see dashboard of 2015–2017 strategic plan, p. 104). These are (1) member community and value, with the goal of enhancing membership and membership satisfaction; (2) dissemination, through means such as clinical guidelines, resources that translate research into practice, and engaging health care practitioners and directing them to evidence-based practices; (3) outreach, which includes building media relations and public education; (4) funding, or working to increase funding opportunities for CBT research; and (5) technology upgrades for membership and the ABCT infrastructure. The Board and Central Office are working hard to move forward on all fronts related to these strategic initiatives.

Within the member community and value initiative, there has been much discussion of ways of sustaining and augmenting membership to keep our organization vital and growing. In this regard, we have been working on expanding our horizons to clinicians and researchers from allied fields such as behavioral medicine, addictions, primary care, public health, psychiatry, and social work. Due to these and other efforts, our membership was at the highest level ever in 2015 with 5,225. We are also aiming to create personalized experiences for our members through bringing social media options as up-to-date as possible, identifying and providing up-to-date and relevant CE

[continued on p. 103]

## the Behavior Therapist

*Published by the Association for  
Behavioral and Cognitive Therapies*

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

EDITOR . . . . . *Brett Deacon*  
Editorial Assistant . . . . . *Melissa Them*  
Access and Equity . . . . . *Monnica Williams*  
Behavior Assessment . . . . . *Matthew Tull*  
Book Reviews . . . . . *C. Alix Timko*  
Clinical Forum . . . . . *Kim Gratz*  
Clinical Dialogues . . . . . *Brian P. Marx*  
Clinical Training Update . . *R. Trent Codd III*  
Institutional Settings. . . . . *Dennis Combs*  
Lighter Side. . . . . *Elizabeth Moore*  
Medical and Health Care  
Settings . . . . . *Laura E. Dreer*  
News and Notes. . . . . *Nicholas Forand*  
  *Nathaniel Herr*  
  *James W. Sturges*  
  *Shannon Wiltsey-Stirman*  
Professional  
and Legislative Issues . . . . . *Susan Wenzel*  
Public Health Issues. . . . . *Giao Tran*  
Research-Practice  
Links . . . . . *David J. Hansen*  
Research-Training  
Links. . . . . *Stephen Hupp*  
Science Forum . . . . . *Jeffrey M. Lohr*  
  *Michael Anestis*

Special Interest  
Groups . . . . . *Aleta Angelosante*  
Student Forum . . . . . *David DiLillo*  
  *Shannon Blakey*  
Technology Update . . . . . *Steve Whiteside*

ABCT President . . . . . *Michelle G. Craske*  
Executive Director. . . . . *Mary Jane Eimer*  
Director of Education &  
Meeting Services . . . . . *Linda M. Still*  
Director of Communications *David Teisler*  
Director of Outreach  
& Partnerships . . . . . *Tammy Schuler*  
Managing Editor . . . . . *Stephanie Schwartz*

Copyright © 2016 by the Association for Behavioral and Cognitive Therapies. All rights reserved. No part of this publication may be reproduced or transmitted in any form, or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without permission in writing from the copyright owner.

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

ABCT is committed to a policy of equal opportunity in all of its activities, including employment. ABCT does not discriminate on the basis of race, color, creed, religion, national or ethnic origin, sex, sexual orientation, gender identity or expression, age, disability, or veteran status.

All items published in *the Behavior Therapist*, including advertisements, are for the information of our readers, and publication does not imply endorsement by the Association.

April is  
ABCT  
election  
month!

OTING  
*electronic*  
 ABCT

***Full Members, New Member Professionals, and  
Fellows: Remember to cast your electronic vote.***

If we do not have your email in our system, then we mailed you a paper ballot. If you did not receive voting materials, please contact us: [lyarde@abct.org](mailto:lyarde@abct.org)

## INSTRUCTIONS *for* AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100- word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

**Submissions must be accompanied by a Copyright Transfer Form** (a form is printed on p. 35 of the February 2011 issue of *tBT*, or download a form from our website): *submissions will not be reviewed without a copyright transfer form.* Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Brett Deacon, Ph.D., at [bdeacon@uow.edu.au](mailto:bdeacon@uow.edu.au). Please include the phrase ***tBT submission*** and the author's last name (e.g., ***tBT Submission-Smith et al.***) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.





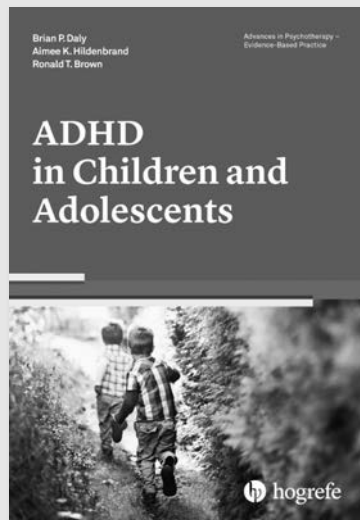
## ABCT 2015-2017 Strategic Plan Dashboard

MISSION				
ABCT is a multidisciplinary organization committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention and treatment of human problems through behavioral, cognitive, and other evidence-based principles.				
CORE VALUES				
SCIENCE	QUALITY	DIVERSITY	MENTORSHIP	ACCOUNTABILITY
STRENGTHENING THE FOUNDATION of ABCT's operations, programs, and services through strategic, targeted investments that fuel growth and increase member satisfaction				
<ul style="list-style-type: none"><li>Assist members during their professional transition</li><li>Strengthen membership recruitment and retention</li><li>Broaden the scope of ABCT content and program offerings to adequately reflect the breadth of CBT research and practice</li></ul>		<ul style="list-style-type: none"><li>Optimize ABCT's technology infrastructure to improve the user experience and increase member engagement with the association</li><li>Expand avenue for member participation particularly for early career professionals and underrepresented populations</li><li>Model effective practices in association governance, volunteer management, and planning</li></ul>		
STRATEGIC INITIATIVES				
Member Community and Value: create perks for members, expand SIG benefits, welcome practitioners to working groups, "expand the tent" for all who value scientifically informed CBT, and evaluate ACA opportunities, etc.				
Dissemination: Review & impact "illness-based" clinical guidelines (and partner with like-minded organizations to achieve this), develop resources that translate research to practice, engage healthcare practitioners and direct them to current evidence.				
Outreach: build media relations, engage healthcare professionals, disseminate "alternative to medication" approach, leverage key members, develop speakers bureau, develop Public Education				
Funding: secure CBT research dollars, place more CBT reviewers with NIMH, expand database of alternative funding sources				
Technology: ensure the effectiveness of the new AMS, enhancing the website, develop new video and rich media content, implement SEO, develop interactive presentation and engagement platforms at convention (e.g. app), create responsive design, secure office infrastructure, explore auto membership renewal, etc.				
GOALS AND OBJECTIVES				
FOSTER AWARENESS of cognitive and behavioral therapies to increase their acceptance and impact	EDUCATE for research funding and healthcare policies that will facilitate widespread adoption of CBT		EXPAND ACCESS to qualified cognitive and behavioral therapist to drive better health outcomes.	
<ul style="list-style-type: none"><li>Expand the translation of research findings into practical applications and vice versa</li><li>Broadly communicate the distinct advantages of CBT approaches on health and economic outcomes</li><li>Expand opportunities for members to engage in media relations</li></ul>	<ul style="list-style-type: none"><li>Forge collaborations with like-minded organizations to drive favorable policy outcomes</li><li>Attract funds for CBT research priorities</li><li>Identify and align clinical CBT approaches with policy provisions provided by the Affordable Care Act</li></ul>		<ul style="list-style-type: none"><li>Enhance training and mentoring to improve competency of more professionals</li><li>Develop and disseminate professional development offerings that increase practitioners' competence in CBT</li><li>Develop evidence-based treatment guidelines to inform and educate professionals of CBT's benefits</li></ul>	
OUTCOMES				
<ul style="list-style-type: none"><li>Increased funding for CBT research</li><li>Higher awareness of CBT among healthcare providers</li><li>Increased website traffic in key areas</li></ul>		<ul style="list-style-type: none"><li>Increased number of ABCT members on funding agency study sections</li><li>Improved acquisition and retention in key membership segments</li><li>Increased CBT research published in select medical journals for key audiences</li></ul>		

# Advances in Psychotherapy

## Evidence-Based Practice

New  
Titles



Brian P. Daly / Aimee K. Hildenbrand / Ronald T. Brown

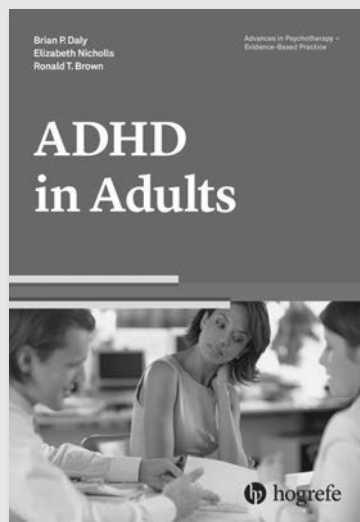
### ADHD in Children and Adolescents

Advances in Psychotherapy—  
Evidence-Based Practice, Vol. 33  
2016, viii + 90 pp.  
US \$29.80  
ISBN 978-0-88937-412-6  
Also available as eBook

Attention-Deficit/Hyperactivity Disorder (ADHD) is a common childhood disorder that can have serious consequences for academic, emotional, social, and occupational functioning.

This volume is both a compact “how to” reference, for use by professional clinicians in their daily work, and an ideal educational

reference for practice-oriented students. The most important feature of this volume is that it is practical and “reader friendly”. It is a compact and easy to follow guide covering all aspects of practice that are relevant in real life in the assessment and management of ADHD across the life span.



Brian P. Daly / Elisabeth Nicholls / Ronald T. Brown

### ADHD in Adults

Advances in Psychotherapy—  
Evidence-Based Practice, Vol. 35  
2016, viii + 96 pp.  
US \$29.80  
ISBN 978-0-88937-413-3  
Also available as eBook

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder that emerges during childhood. However, it is now well recognized that ADHD frequently persists over the lifespan and well into adulthood. Although ADHD is typically first identified during the childhood years, the presentation of symptoms may differ considerably

between adults and children. Without appropriate symptom management, ADHD can significantly interfere with academic, emotional, social, and work functioning. As the companion volume *ADHD in Children and Adolescents* it is “reader friendly” and practice-oriented.

Hogrefe Publishing  
30 Amberwood Parkway  
Ashland, OH 44805  
Tel. 800 228-3749 (toll-free in North-America)  
Fax 419 281-6883  
customerservice@hogrefe.com  
www.hogrefe.com

 **hogrefe**

## Predicting and Understanding Mental Health Clinic Operations Over Time

Michael T. Finn, Gyrid Lyon, Michael R. Nash, *University of Tennessee*

ACCURATE FORECASTS CAN GIVE WAY to fundamental shifts in clinical management. Planning is more effective when one possesses accurate data: one can realistically plan clinic hours, staffing, and service priorities with the security afforded by empirical forecasting. In business, it has been established that firms that use time series forecasting are incrementally more financially successful (Danese, Kalchschmidt, & Leading Edge of Inventory Research, 2011). In the context of clinics, this would likely translate into both increased financial stability and increased reach of services. Kazdin (2008) has pointed out that one of the biggest challenges facing implementation of empirically supported treatments is population reach. Time series forecasting provides a tangible tool to managers of clinics for prioritizing resources and, thus, discovering ways to realistically alter or expand clinical services.

Community mental health centers, Veterans Affairs clinics, and substance abuse clinics may particularly benefit from understanding their seasonal changes and trends in clinical phenomena because of their large numbers of patients and traditionally less predictable patient behavior. That said, smaller clinics facing the pressure of limited resources could also benefit from reliable predictions. Tracking phenomena like kept appointments, number of intakes, referral follow-through, and appointment no-shows can reveal and predict information that we authors fear is merely speculated about by many who have limited knowledge of time series analysis. Even informed, careful human judgments are highly outperformed by empirical methods across fields (Sanders & Manrodt, 2003). Such methods are foundational for business analytics in both large and small firms and likely have much promise for improving the efficiency and reach of mental health clinics.

Improving efficiency in mental health care is a crucial aspect of ameliorating current barriers to optimal care and intervening without excessive delay (Moran & Jacobs, 2013; Wynne, 1979). Initiatives like

the integration of mental health care with primary care in community settings not only drastically improve efficiency, but demonstrate the ability of administrative action to enhance efficiency (Pomerantz, Cole, Watts, & Weeks, 2008). In the institutional health-care literature, time series methods have been particularly applied to model and predict important variables such as medical emergency room visits (Jones, Joy, & Pearson, 2002). Similarly, time series analysis presents as a ready instrument for application to mental health care administration, giving clinic administrators reliable tools for planning and resource allocation to enhance efficiency and, in turn, patient care.

In the following study, we apply time series data analysis to the specific needs of mental health clinics. While time series methodology is often used for single-case analysis (Borckardt et al., 2008), to our knowledge, this methodology has not been applied to the operations of mental health clinics or systems in the literature. We aim to demonstrate the effectiveness of such an analysis in the accurate prediction of clinic operations.

### Method

#### Data

Data for this study were the number of therapy hours per month at the University of Tennessee, Knoxville's in-house psychotherapy clinic over an 8-year span. The originally known data began with July 2005 and ended with November 2012 (7 years, 5 months). The model reported here was created at the beginning of December 2012, predicting into the genuinely unknown future to October 2013 (an additional 11 months). Thus, the authors were blind to the true data and were able to directly compare the results of the model after these 11 months had passed.

Reviewing Current Procedural Terminology (CPT) codes from July 2005 to November 2012, we summed the totals of the following codes for each month: 90806 (outpatient psychotherapy, 45–50 min-

utes), 90846/7 (family psychotherapy with/without the patient present). Changes in CPT codes in 2013 were easily adapted to the data without any apparent impact. These data were collected in the course of clinic operations and were easily transferred from clinic records for use in statistical analysis.

#### Setting

The University of Tennessee Psychological Clinic is the training clinic of the Clinical Psychology doctoral program. As such, it provides a wide variety of psychotherapy and assessment services that include adult individual psychotherapy, child and family therapy, couples therapy, full psychological evaluations, psychoeducational evaluations, and forensic assessments. About 78% of the patients are adults, 51% are female, and 19% of the total cases are assessment. For some context as to the size of the practice, the 2010–2012 fiscal years had an average of 289 new patients per year and 3,893 intervention hours per year. Most of the patients in the clinic are not associated with the university. In fact, over 80% of the patients fall into this category. The clinic is primarily staffed by students of the clinical psychology doctoral program who are supervised by licensed clinical psychologists, though some students from related programs also train there.

#### Data Analysis Strategy

Time series decomposition. A particularly useful form of time series model for our purposes is called time series decomposition analysis (DeLurgio, 1998). An advantage to decomposition modeling is that, in the process of building a predictive model, one creates directly interpretable descriptive factors that describe general trends and aid in visualization of meaningful components. A decomposition model considers the following four calculable components: trend, seasonal, cyclical, and error. "Trend" refers to the linear change over time, "seasonal" refers to the variation directly attributable to the month of a given value, and "cyclical" stands for other predictable fluctuations (a common example would be economic recession).

After decomposing the data stream to these theoretical components using NCSS 9 software, we recalculated for our modeled values and forecasted values with the following formula:

$$\text{Predicted value} = (\text{Mean}) \times (\text{Trend}) \\ \times (\text{Seasonality}) \times (\text{Cycle}) \times (\text{Error})$$



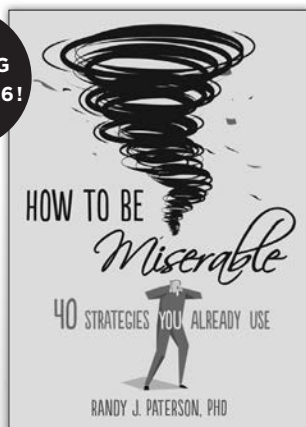
# ESSENTIAL NEW BOOKS FOR YOUR PRACTICE

A WITTY, IRREVERENT GUIDE WILL  
SHOW YOUR CLIENT WHAT NOT TO DO

COMING  
MAY 2016!

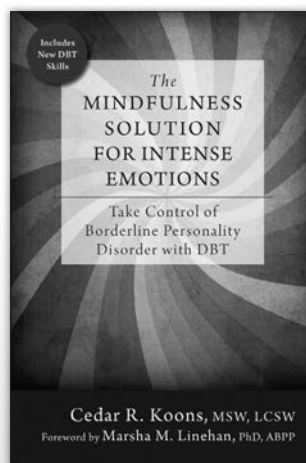
"...A gem of a parody on how to cope with the inevitable difficulties we all must face in order to live a happy and fulfilling life."

—Simon A. Rego, PsyD, ABPP,  
associate professor, Albert Einstein  
College of Medicine



ISBN: 978-1626254060 / US \$15.95

THIS PRACTICAL GUIDE OFFERS NEW MINDFULNESS SKILLS  
DRAWN FROM DIALECTICAL BEHAVIOR THERAPY



ISBN: 978-1626253001 / US \$16.95

"I would highly recommend this book for anyone struggling with intense, hard-to-tolerate emotions."

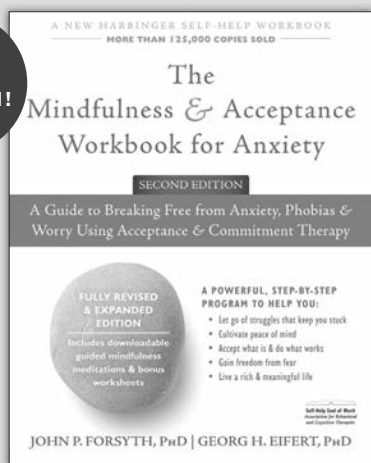
—Alexander L. Chapman,  
PhD, RPsych, president of the  
DBT Centre of Vancouver

A POWERFUL, STEP-BY-STEP PROGRAM TO  
HELP BREAK FREE FROM ANXIETY

NEW  
EDITION!

"Highly recommended for all those struggling with worry, anxiety, and fear."

—David H. Barlow, PhD,  
author of *Anxiety and Its Disorders*



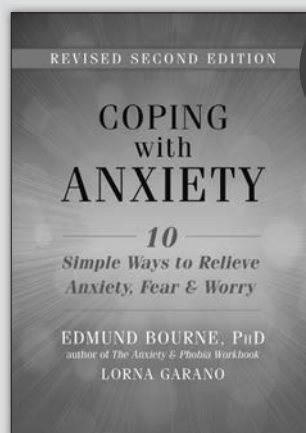
ISBN: 978-1626253346 / US \$24.95

EFFECTIVE WAYS TO HELP YOUR CLIENT OVERCOME ANXIETY

NEW  
EDITION!

"This book is a broad and accessible resource for anyone struggling to manage anxiety."

—Jeffrey Brantley, MD,  
founding director of the  
Mindfulness-Based Stress  
Reduction Program  
at Duke Integrative Medicine

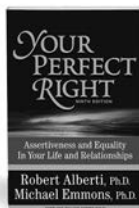


ISBN: 978-1626253858 / US \$15.95

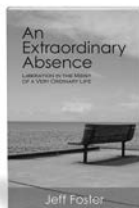
Announcing our acquisition of  
**IMPACT PUBLISHERS & NON-DUALITY PRESS**



Impact Publishers



NON-DUALITY PRESS



**TRANSFORM  
YOUR PRACTICE.**  
Learn more about  
evidence-based continued  
education and training  
with Praxis.

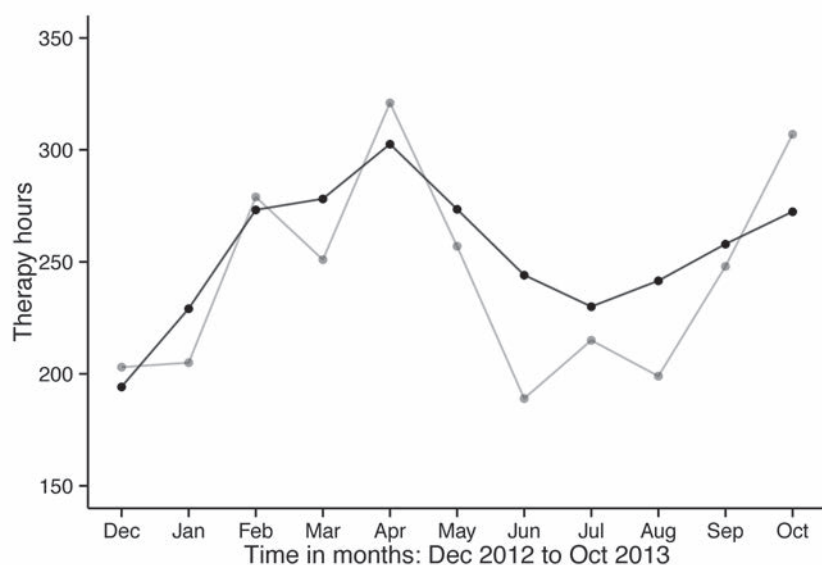
PRAXIS

Visit [praxiscet.com](http://praxiscet.com)  
for upcoming events.



newharbingerpublications

800-748-6273 / [newharbinger.com](http://newharbinger.com)



**Figure 1.** Decomposition model predictions of genuine future compared with data collected after the prediction duration passed. *Note.* Predicted values are represented by the black line and true values are represented by the grey line.

These components do not only forecast future data, but can also use them to better understand underlying processes in the time course of the single variable. By isolating the values of the seasonal factor, for example, one can observe the average monthly fluctuations expected over any given year. These values can, in turn, be used to “deseasonalize” the known stream of real data. Removing this variability in the hours that is attributable to the regular monthly changes, one can more easily visualize trends over time in intervention hours without the stagger of months. In effect, we are able to more clearly observe the long-term trends in the data with greatly diminished noise.

**Forming a model with known data.** In time series forecasting, past data are modeled in order to forecast future data. In addition, by examining past data, one can gain insight into the underlying nature of a variable’s time course and determine how to best predict future months with a statistical model. One first determines an artificial duration at the end of the data stream, called the holdout sample, for pretesting a model’s accuracy. The rest of

the data are called the training sample. For the current study, we used available months of the calendar year at the time of the data analysis as the holdout sample (January 2012 to November 2012). High accuracy of the training model in predicting the holdout sample provides confidence in refitting the model with all known data for forecasting future months—the primary goal of time series forecasting.

**Accuracy of forecasted values.** The approach to developing a time series model is as follows: if the training model proves to accurately predict the holdout sample, then one proceeds to refit the same model over the entire available data stream, forecasting into the genuinely unknown future.<sup>1</sup> Thus, we used all the data (July 2005 to November 2012) in order to predict months beyond all known values, into the genuine future. Having allowed the prediction window time to pass, we were able to compare the actual values with the decomposition model’s predicted values one year later. We consider this statistical comparison the test of whether this type of analysis can be successfully applied to a mental health clinic.

## Results

### Accuracy of the Model

**Training model.** The training decomposition accurately predicted therapy hours in the holdout sample,  $R^2 = .77$  (59.29% of the variance), and was refitted across the entire sample in order to predict future values.

**Forecasted values.** After allowing the year-long forecast interval to pass, we could directly evaluate the accuracy of our predicted therapy hours against the actual hours. The decomposition model proved accurate, producing a good fit of the true data,  $R^2 = 0.51$  (explaining 25.7% of the variance). The average error across the months during this year was 23.45 ( $SD = 14.54$ ) hours/month. By comparison, if we were to have used the previous month’s therapy hours for prediction, updating the model each month, we would have had a much less successful model,  $R^2 = 0.05$  (.25% of the variance). Most months were highly accurate and the model’s less accurate months were fairly balanced in terms of overestimating (e.g., June and August 2013) and underestimating (e.g., October 2013) the number of therapy hours. See Figure 1 for a line graph comparing the predicted and the true therapy hours. Figure 2 shows the model over the entire time period.

### Interpreting the Model

Having verified the accuracy of the model of therapy hours, we can then turn to interpreting its indices for the purpose of the understanding the nature of our 7 years of past data.

**Expected monthly variation in therapy hours.** We found that therapy hours at the psychological clinic fluctuate in predictable ways over the course of an average year. There was a statistically significant difference across months per Kruskal-Wallis test, a non-parametric version of the ANOVA test, for therapy hours,  $X^2 = 22$ ,  $p < .05$ . Use of the Kruskal-Wallis test is advised when examining group differences time series data as it does not require the parametric assumption of independence. That is, as is common in time series data, the number of therapy hours in a month of a given year is not best considered as an individual observation, rather its value depends on the value of a previous year. Figure 3 shows boxplots of the monthly variation with the calculated seasonal indices. To note, the seasonal index produced by decomposition analysis can be

<sup>1</sup>The cyclical component needs to be modeled independently and this can be done with any number of other time series analysis methods. We used an optimal ARIMA model to give values for this factor over the forecast interval.



directly interpreted as a percentage modifier (e.g., 1.11 = 111% of annual average).

The results of analysis can be directly interpreted as demonstrating the monthly variation in hours. For example, "lore" in our clinic may suggest that treatment hours drop off significantly when the school year ends in May. However, an examination of the seasonal variation data reveal in our clinic that treatment hours tend to remain relatively high in May before dropping off significantly in June.

*Removing seasonality in order to observe past trends.* An effective way for us to examine trends in the data over years is by deseasonalizing the data, that is, controlling for the known effects of seasonality. Since we confirmed the presence of seasonality, we can proceed to remove its effects to gain a more accurate picture of growth trends over the course of the clinic. We used the calculated seasonal indices from our decomposition modeling to remove this variation in the actual data. Figure 4 shows the graphical result of deseasonalizing past data when compared with the true data. With the effects of seasonality removed, this graph becomes a document-

tation of the long-term changes in the clinic over the previous 7 years. It can promote shared understanding of changes throughout the history of the clinic and inform further decision-making. With this figure, one can see how monthly therapy hours have been steadily growing after a dip from mid-2007 to mid-2009. Forecasts for therapy hours seem to show that this upward trend will continue.

### Discussion

Time series decomposition modeling was used to evaluate usage of the UT Psychological Clinic in therapy hours. The model adequately fit data from July 2005 to November 2012 and, in turn, could forecast values with considerable accuracy into the next calendar year. In addition, this model could show properties of the nature of past therapy hours, predict monthly variation of therapy hours, and model trends in therapy hours with the known influence of months removed. In sum, we have shown time series decomposition analysis can be applied to the treatment hours of mental health clinics. Without much effort, any clinic can transform

aspects of its recorded monthly operations into data for the analysis of past trends and the creation of predictions for the future. In most clinics, these data are already within arm's reach.

As psychotherapy hours are a key component to the training of clinical psychology Ph.D. students, we determined that these metrics could inform planning for space allocation, expectable psychotherapist case loads, and supervisory needs. Time series analysis is an incredibly flexible tool, but it is incumbent upon the administrative team to determine which variables are pragmatically relevant to their needs.

### Context of Time Series Decomposition Analysis

It is important to emphasize that time series decomposition analysis is inherently descriptive and predictive. Being an analysis of a single variable over time, it is unable to directly ask the kind of explanatory or mechanistic questions typical of analyses more traditional to empirical psychology. However, the advantage of this method lies in its flexibility toward reliably describing trends and making pragmatic predictions

## Finally, the App that delivers **YOUR** homework.

### Introducing **iPromptU** for iOS & Android

**The first fully customizable mobile app for CBT homework.**

**Program it to ask only the questions YOU want.**

**Program it to run whenever your patient presses a button. Or program it to do random time sampling. Patients can simply dictate their responses.**

**Answers are date/time stamped, saved in a log, and can be emailed to you.**

**Free, and ad-free.**



**Available free in both the App Store and Google Play**



App Store



Google play

Displays any question, or series of questions, and prompts the user for written or dictated answers.

Saves responses with date and time stamps so user can email them to therapist or researcher.

User can initiate prompting immediately, as they would with a coping card or worksheet. Researchers and therapists can set prompting to occur at random time intervals, for truly random time sampling.

All prompts are 100% customizable, and can be presented singly or in sequential or random order.

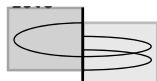
Researcher or therapist can install a security password to prevent alteration by the user.

Capable of virtually any non-branching Ecological Momentary Assessment research.

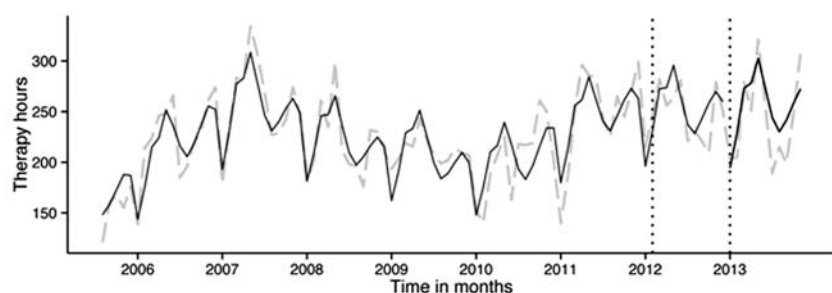
Capable of recording any CBT Activity Schedule, Thought Record, or Worksheet in the real world.

Clean, no-nonsense user interface.

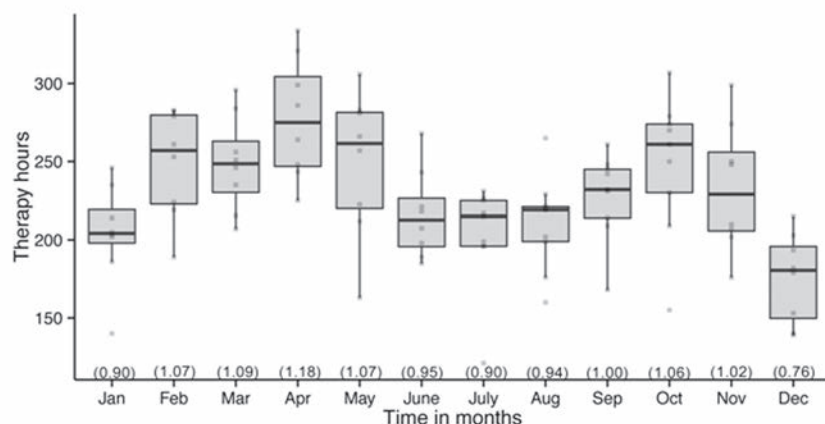
Produced as a gift to the CBT community by:



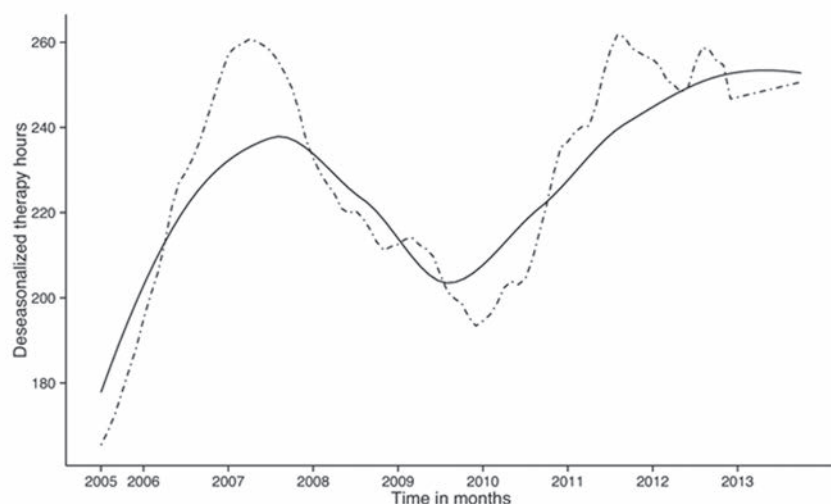
**Cognitive Behavioral Institute of Albuquerque, LLC**  
Bradford C. Richards, Ph.D., ABPP  
Director and Supervising Psychologist



**Figure 2.** Therapy hours compared with the decomposition model predicted values across the entire window of data. *Note.* Predicted values are represented by the black line and true values are represented by the dashed grey line.



**Figure 3.** A boxplot of the therapy hours by month showing the effects of seasonality. *Note.* Grey dots indicate the individual data points for all of the months used in the full time series decomposition model.



**Figure 4.** Therapy hours across the entire window of data with the effects of seasonality removed. *Note.* The dotted line shows the raw deseasonalized time series values; the solid line shows a LOESS smoothing of the values, giving further clarity of general trends.

about any regularly collected, quantified count data—in our case, monthly intervention hours.

Assuming the basic understanding of time series analysis outlined in this paper, implementation is rather straightforward. Many statistical packages provide user interfaces for the easy application of many time series methods, though it is recommended that those who are new to this area begin with decomposition analysis. SPSS, SAS, and NCSS all have dialogues for assisting in time series analysis. *R* is a favorite among statisticians and is free to use. While we used 7 years of data for this analysis, decomposition analysis can perform with much less data (e.g., around 2 years), granted the time series model is successful on a holdout sample.

### Implications

Given an empirical forecast of how treatment hours might fluctuate over the course of time, more informed decisions can be made about securing resources, purchasing supplies, and making personnel decisions. For example, if a model is calling for a substantial increase in treatment hours during an upcoming season, the director of the clinic may prepare by converting storage space into a spillover therapy room, purchasing extra appointment cards, and hiring a part-time employee to assist at the front desk.

Use of time series statistical methods for forecasting gives an advantage in situations such as these. Introduction of time series methodology into various fields of business have proven significantly helpful for improving efficiency (Danese et al., 2011). In our data, time series decomposition drastically improved upon using the previous month's value for prediction, giving a whole year's worth of accurate values for planning. Further, statistical methods of time series prediction are more reliable than nonstatistical intuitive methods, such as visual analysis, as has been demonstrated in the context of empirical single-case studies (Robey, Schultz, Crawford, & Sinner, 1999). The practical utility of time series analysis likely increases with the size of the clinic, as allocation of resources and planning of future years pose more difficult problems for administration.

One can create different forecasts of the rates at which the types of services offered at a clinic might be rendered and the staff can prepare accordingly. For example, if a psychological clinic offers both psychotherapy and psychological assessment

to their clients, and a forecasting model predicts that disability assessments will decrease over the long term as psychotherapy hours increase, the clinic might decide to attract more assessment patients in order to meet student training goals and financial benchmarks. Time series models provide the opportunity for more accurate reflection on past trends, and they may also illuminate possible explanations for those trends. Empirical models of long-term trends and monthly fluctuations of treatment hours can aid in obtaining a more accurate picture of the past than subjective speculation may afford.

## References

- Borckardt, J.J., Nash, M.R., Murphy, M. D., Moore, M., Shaw, D., & O-Neil, P. (2008). Clinical practice as natural laboratory for psychotherapy research. *American Psychologist*, 63, 77-95.
- Danese, P., Kalchschmidt, M., & Leading Edge of Inventory Research. (2011). The impact of forecasting on companies' performance: Analysis in a multivariate setting. *International Journal of Production Economics*, 133, 1, 458-469.
- DeLurgio, S.A. (1998). *Forecasting principles and applications*. New York: Irwin/McGraw-Hill.
- Jones, S.A., Joy, M.P., & Pearson, J. (2002). Forecasting demand of emergency care. *Health Care Management Science*, 5, 4, 297-305.
- Kazdin, A. E. (2008). Evidence-based treatments and delivery of psychological services: Shifting our emphases to increase impact. *Psychological Services*, 5(3), 201-215. <http://doi.org/10.1037/a0012573>
- Moran, V., & Jacobs, R. (2013). An international comparison of efficiency of inpatient mental health care systems. *Health Policy*, 112(1-2), 88-99.
- Pomerantz, A., Cole, B. H., Watts, B. V., & Weeks, W. B. (2008). Improving efficiency and access to mental health care: Combining integrated care and advanced access. *General Hospital Psychiatry*, 30(6), 546-551.
- Robey, R. R., Schultz, M. C., Crawford, A. B., & Sinner, C. A. (1999). Single-subject clinical-outcome research: Designs, data, effect sizes, and analyses. *Aphasiology*, 13(6), 445-473.
- Sanders, N. R., & Manrodt, K. B. (2003). The efficacy of using judgmental versus quantitative forecasting methods in practice. *Omega*, 31(6), 511-522. doi: 10.1016/j.omega.2003.08.007
- Wei, W. S. (2005). *Time Series Analysis: Univariate and Multivariate Methods* (2 edition). Boston: Pearson.
- Wynne, L. (1979). Cost-efficiency and staffing in mental health services. *Administration in Mental Health*, 7(1), 58-68.

...

We acknowledge Christy Lynch and Lina Colvin for their assistance with the data collection and management.

**Correspondence to** Michael T. Finn, 305 Austin Peay Building, University of Tennessee, Knoxville, TN 37996-4503; [mfinn1@vols.utk.edu](mailto:mfinn1@vols.utk.edu).



## Become an ABPP Board Certified Specialist in Behavioral and Cognitive Psychology

**Why?** The practice of psychology has become increasingly complex and competitive. Certification by ABPP demonstrates that psychologists have met the standards and possess the competencies required in their specialty.

### Board Certification Is Valuable and is Increasingly Becoming an Expectation in our Profession:

- ABPP listing enhances practitioner credibility for clients and patients
- Distinguishes you from other psychologists in the job market
- Potential salary benefits by the VA, hospitals, and other health care facilities
- Enhances qualifications as an expert witness
- Facilitates inter-jurisdictional licensing and practice mobility
- Streamlines the credentialing process for licensing boards, insurance companies, and medical staff

**Three Steps:** (1) Review of education and training; (2) Submission of a practice sample; and (3) Collegial, in-vivo examination. **Please note that a consulting service to support the application process is an available option and is free of charge for all candidates.**

**Specific requirements and online application:** <http://www.abpp.org/i4a/pages/index.cfm?pageID=3299>

**Early Entry Application: Start Early!** Application fee is discounted from \$125 to \$25 for graduate students, interns, and residents: <http://www.abpp.org/i4a/pages/index.cfm?pageID=3299>

**Senior Option:** With 15 years of postdoctoral experience in cognitive and behavioral psychology there is flexibility in the requirement for a practice sample: <http://www.abpp.org/i4a/pages/index.cfm?pageID=3299>

**When are Exams Conducted?** Exams are conducted in different places, but are typically done at the APA (Denver 1st week in August 2016) and ABCT (New York last week in October 2016) annual conferences. This year exams can also be conducted at the ABPP conference in Chicago in early May 2016. Other exams can be arranged in other locations on a case-by-case basis.



## Parent Acceptability of Time-Out, Spanking, Response Cost, and Positive Reinforcement

Amanda K. Stary, Stephen D. A. Hupp, Jeremy D. Jewell,  
Gregory E. Everett, *Southern Illinois University Edwardsville*

DISCIPLINE TECHNIQUES ARE COMMONLY discussed in the media. Recently, for example, *Time* magazine included an article entitled, “‘Time-Outs’ Are Hurting Your Child” (Siegel & Bryson, 2014). Soon thereafter, the Society of Clinical Child and Adolescent Psychology (Division 53 of the American Psychological Association) responded to the *Time* article with a press release entitled, “Outrageous Claims Regarding the Appropriateness of Time Out Have No Basis in Science” (Atkins et al., 2014). This public debate, alone, illustrates that child discipline is a hot topic; and other debates also frequently occur regarding topics such as spanking and positive reinforcement.

Child discipline is an important topic for all parents, as well as for the professionals who work with them. Externalizing behaviors (i.e., noncompliance, aggression, inattention, hyperactivity, and impulsivity) are some of the most common reasons children are referred to mental health professionals (McMahon, Wells, & Kotler, 2006). There are multiple techniques for managing externalizing behaviors, many of which are included in behavioral parent training programs. Behavioral parent training and many of its individual components have research support for treating externalizing child behaviors that are core to such disorders as oppositional-defiant disorder (ODD), conduct disorder, and attention-deficit/hyperactivity disorder (ADHD) (Eyberg, Nelson, & Boggs, 2008; Pelham & Fabiano, 2008). While spanking is not currently part of evidence-based behavioral parent training programs, it is still a very common tool that many parents use (Benjet & Kazdin, 2003; Kazdin & Benjet, 2003; Strauss & Stewart, 1999).

Although there is evidence for these behavioral management techniques in decreasing externalizing behaviors, parents of children with certain characteristics, such as developmental disabilities, may be less willing to use them. Woolfson (2014) proposed a psychosocial model of disabili-

ty-related behavior problems, suggesting that societal beliefs about disability (i.e., that it is a medical problem, a tragedy, and/or disabled people are dependent/need protection) may contribute to parent beliefs that then lead to parents' tolerance of problematic behaviors or overprotection of their children. Such attitudes and behaviors of parents are likely to influence their acceptance of certain behavior management techniques, possibly finding them less acceptable for children with developmental disabilities than for typically developing children. These attitudes may be particularly important to examine in relation to children with autism spectrum disorder, given the recent rise in prevalence rates of this disorder (Baio, 2014).

Acceptability of behavior management techniques is important to evaluate because the more acceptable clients find different aspects of the treatment protocol, the more likely they are to comply with the requirements of treatment (Boothe & Borrego, 2004). Additionally, treatment acceptability has been found to relate to positive outcomes in treatment independent of that contributed by treatment compliance (Addis & Jacobson, 2000). Many studies have evaluated parents' ratings of acceptability of the different interventions from behavioral parent training, including time-out, response cost, and positive reinforcement (e.g., Boothe & Borrego; Frentz & Kelley, 1986; Jones et al., 1998; Kazdin, 1984). The majority of this research has shown that parents rate response cost as the most acceptable technique for externalizing behaviors (e.g., Boothe & Borrego; Frentz & Kelley, 1986). Positive reinforcement is often rated by parents as similarly acceptable to response cost and as significantly more acceptable than other behavior management techniques (e.g., Jones et al., 1998; Reimers, Wacker, & Cooper, 1991). Although rated below positive reinforcement and response cost, time-out has been rated as more acceptable than other strategies, including differential attention,

spanking, time-out with spanking (Frentz & Kelley, 1986), medication (e.g., Heffer & Kelley, 1987; Miltenberger et al., 1989), and spanking alone (Miltenberger et al.).

Researchers have also examined parent ratings of the acceptability of spanking, and despite its frequent use, it is often rated by parents as the least acceptable method of dealing with problem behaviors (e.g., Jones et al., 1998). This significantly lower rating of spanking has occurred when it is compared to techniques such as differential attention, overcorrection, positive reinforcement, response cost, time-out, and time-out with spanking (e.g., Jones et al.).

Labeling bias, or expectations that people might have for someone given a particular diagnostic label (Stinnett, Crawford, Gillespie, Cruce, & Langford, 2001), may be expected to influence ratings of acceptability of certain behavior management techniques. Stinnett and colleagues (2001) found that teachers did not rate the acceptability of medication and special education placement as interventions differently for a child with ADHD versus a child with no label. However, differences have been found in ratings of acceptability of certain interventions by parents of medically healthy children compared to parents of children with cancer (Miller, Manne, & Palevsky, 1998). Specifically, response cost and time-out were rated as significantly less acceptable, and positive reinforcement as significantly more acceptable, by parents of children with cancer as compared to ratings of parents with medically healthy children. Additionally, Boothe and Borrego (2004) found that parents of children with communication disorders found response cost as more acceptable than positive reinforcement, whereas other studies have found positive reinforcement as comparable to response cost. Given that some previous research has found a difference in ratings of behavior management techniques dependent on diagnostic label, ratings of treatment acceptability cannot be assumed to be the same across other diagnostic labels, as well.

Although some previous studies have examined differences in rating of acceptability of school personnel's ratings of behavior management techniques dependent on the child's diagnosis of ADHD versus no diagnosis, no known studies have examined parents' perceptions of behavior management techniques across diagnoses. Examination of whether parents' perception of the acceptability of behavior management techniques for children with ASD may also be important given societal beliefs

about disability and the recent rise in prevalence rates of ASD. Therefore, the purpose of this study is to evaluate whether current parents' acceptability ratings of time-out, response cost, positive reinforcement, and spanking differ depending on whether a child displaying externalizing behaviors is said to have ADHD, autism, or no diagnosis at all. Based on previous research it was predicted that (a) response cost would be rated by parents as significantly more acceptable than time-out, positive reinforcement, and spanking; (b) positive reinforcement would be rated as significantly more acceptable than time-out and spanking; and (c) time-out would be rated as significantly more acceptable than spanking. We also explored how ratings of behavior management techniques might vary based on diagnostic status but did not propose any hypotheses for this variable.

## Method

### Participants

Three hundred thirty-three participants were recruited. Participants were excluded from the study if they did not meet the

inclusion criteria, if they took the survey more than once, or if they completed a survey other than the one to which they were assigned. The final sample consisted of 200 parents. Participants that were excluded did not significantly differ from those participants in the included sample in education level,  $\chi^2(8, 310) = 7.12, p = .52$ , or income level,  $\chi^2(10, 313) = 11.19, p = .34$ . The majority of the parents were female (71%) and had a mean age of 40.90 years ( $SD = 11.01$ ). Eighty-five percent of the sample identified themselves as Caucasian/White, 5.0% identified as Black/African American, 3.5% as Asian, 2.5% as American Indian/Alaskan Native, 2.0% as other ethnicity, and 2.0% as two or more ethnicities. Additionally, individuals that identified themselves as Hispanic composed 3.6% of the sample.

Participants reported incomes as follows: under \$10,000 (5.5%), \$10,000–\$29,999 (18.5%), \$30,000–\$49,999 (25.0%), \$50,000–\$69,999 (20.0%), \$70,000–\$109,999 (25%), and over \$110,000 (6%). The majority of participants had a bachelor's degree (34.3%), followed by some college (24.2%), a high school diploma or GED equivalent (15.2%), a master's degree

(11.6%), a doctoral or professional degree (4%), and 8th grade or less (.5%). The mean age of the participants' youngest child was 11.49 years ( $SD = 9.33$ ), and the mean age of their oldest child was 15.45 years ( $SD = 9.86$ ).

Participants were randomly assigned to surveys containing one of three scenarios: the version of the vignette where the child was said to have either an ADHD diagnosis ( $n = 68$ ), an autistic disorder diagnosis ( $n = 57$ ), or no diagnosis ( $n = 75$ ). There were no significant differences among the three groups in gender,  $\chi^2(2, N = 200) = 2.18, p = .34$ , ethnicity,  $\chi^2(10, N = 199) = 4.84, p = .90$ , education level,  $\chi^2(14, N = 198) = 13.10, p = .52$ , income,  $\chi^2(20, N = 200) = 29.44, p = .08$ , age of oldest child,  $\chi^2(74, N = 200) = 67.05, p = .70$ , or age of youngest child,  $\chi^2(74, N = 200) = 83.69, p = .21$ .

### Materials

*Online survey.* Amazon's Mechanical Turk was used to link participants to a survey site. The survey in this study contained the consent form, followed by one of three vignettes, four discipline technique descriptions (i.e., time-out, response cost, positive reinforcement, and spanking), the



# INSTITUTE *for* BEHAVIOR THERAPY

New York City

## *Celebrating Its 44th Anniversary*

**Steven T. Fishman, Ph.D., ABPP | Barry S. Lubetkin, Ph.D., ABPP**  
***Directors and Founders***

Since 1971, our professional staff has treated over 30,000 patients with compassionate, empirically-based CBT. Our specialty programs include: OCD, Social Anxiety Disorder, Panic Disorder, Depression, Phobias, Personality Disorders, and ADHD-Linked Disorders, and Child/Adolescent/Parenting Problems. Our externs, interns, post-doctoral fellows and staff are from many of the area's most prestigious universities specializing in CBT, including: Columbia, Fordham, Hofstra, Rutgers, Stony Brook, St. John's, and Yeshiva Universities.

Conveniently located in the heart of Manhattan just one block from Rockefeller Center. Fees are affordable, and a range of fees are offered.

***For referrals and/or information, please call: (212) 692-9288***

20 East 49th St., Second Floor, New York, NY 10017

e-mail: [info@ifbt.com](mailto:info@ifbt.com) | web: [www.ifbt.com](http://www.ifbt.com)

treatment acceptability questionnaire (completed once for each technique), and a demographic questionnaire.

**Demographic questionnaire.** Questions regarding the participants' age, gender, ethnicity, number of children, ages of children, education level, and range of income were contained at the end of the survey. There was also a question regarding what country the participants live in to verify that respondents met the qualifications listed.

**Vignettes and technique descriptions.** Each of the three vignettes had the same description of a fictional child with various challenging behaviors, such as temper tantrums and defiance. A boy was used in the vignette since the majority of the diagnoses were more common in boys than in girls at the time data were collected (i.e., ADHD, U.S. Department of Health and Human Services, 2008; and autistic disorder, Boyle et al., 2011). The following vignette was presented to all parents:

James is a 5-year-old who recently started kindergarten. His parents report that his most challenging behaviors are frequent temper tantrums and refusal to follow directions. James is frequently very irritable, as well. James' temper tantrums include yelling, throwing his toys, and sometimes even hurting himself and/or others. He prefers a certain way of doing things, and if anybody disrupts his routine he often has a temper tantrum. James also has temper tantrums when told to do something he does not want to do. James is easily distracted, and often makes silly mistakes on tasks as a result. James has . . . [been diagnosed with ADHD; been diagnosed with autistic disorder; not been diagnosed with any psychological disorder].

The only difference among the three vignettes was the last sentence describing James as having ADHD, autistic disorder, or no diagnosis, diagnoses that are consistent with the diagnostic manual in use at the time that data were collected (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision; DSM-IV-TR). Four different discipline technique descriptions were then provided for time-out, response cost, positive reinforcement, and spanking, in that order. The discipline technique descriptions were slightly modified from the Jones et al. (1998) study and are included in the Appendix.

**Treatment Evaluation Inventory–Short Form–Selected Items (TEI-SF-SI).** Selected items from the Treatment Evaluation Inventory–Short Form (TEI-SF; Kelley, Heffer, Gresham, & Elliott, 1989) were used to measure ratings of acceptability for the four discipline technique options. The TEI-SF consists of 9 items that include statements that individuals rate on a 5-point Likert scale. Ratings range from “strongly disagree” to “strongly agree.” Total scores on the measure can range from 9 to 45. The TEI-SF has been used in previous studies as a measure of treatment acceptability (Boothe & Borrego, 2004; Njardvik & Kelley, 2008). Previous studies have found satisfactory reliability data for the measure, with a coefficient alpha of .85 (Kelley et al., 1989). Only some selected items from the TEI-SF were used in this study to decrease the amount of work for participants since each participant had to complete the questionnaire four times. The selected items from the TEI-SF were: “I find this technique to be an acceptable way of dealing with the child's problem behavior”; “I believe this technique is likely to be effective in scenarios such as this”; “I believe this technique is likely to result in permanent improvement”; and “Overall, I have a positive reaction to this technique in this scenario.” Total scores were used in the analyses for this study, and possible range of scores is 4 to 20. In this study, the selected items of the TEI-SF had a coefficient alpha of .92 for time-out, .93 for response cost, .94 for positive reinforcement, and .96 for spanking. Thus, this modified version of the TEI-SF had strong internal consistency with this sample.

### Procedure

Participants were recruited through Amazon's Mechanical Turk, a tool available on the Internet that allows organizations or individual researchers (i.e., “requesters”) to recruit participants (i.e., “workers”) to complete “Human Intelligence Tasks” (HITs), many of which are in the form of questionnaires. Individuals can become workers by creating an account on the Mechanical Turk website. Workers are able to view all of the HITs available, including descriptions of the tasks, criteria for participating, the compensation amount, and the date the HIT expires. From there workers are able to select which HIT they want to complete.

To participate in the study, workers had to be a U.S. resident and a parent of a child that was at least 5 years old. Furthermore, qualifications were set that the participants

must have had 90% of their previous HITs approved by previous requesters, meaning that 90% of the tasks that the worker had completed were approved by the requester for that particular task. This specification helps to exclude those individuals who are participating in tasks for which they do not qualify. Preliminary research has shown that Mechanical Turk obtains samples that are slightly more representative of the United States than other Internet samples and are more diverse than college student samples (Buhrmester, Kwang, & Gosling, 2011).

Participants were randomly assigned to a survey containing either the version of the vignette with an ADHD diagnosis, an autistic disorder diagnosis, or no diagnosis. After being routed to the survey, the participants were presented with the informed consent page and indicated whether they consented to being in the study. Participants who consented were presented with their assigned vignette. The vignette was followed by a description of each of the discipline techniques in the following order: time-out, response cost, positive reinforcement, and spanking. After each discipline technique they were asked to rate how acceptable they found the techniques for the child in the scenario using the selected items from the TEI-SF. The survey ended with the demographic questionnaire. After participants finished the survey, they were provided with a redemption code which they then could enter into the Mechanical Turk website to obtain 25 cents worth of compensation.

### Results

To investigate how ratings of acceptability of the treatment techniques varied across the different vignettes, a mixed model analysis of variance (ANOVA) was conducted. Table 1 includes the means and standard deviations. A statistically significant main effect was found for the within-group factor of treatment technique,  $F(3, 591) = 104.20, p < .001$ , partial  $\eta^2 = .35$ , indicating that ratings on the selected items of the TEI-SF differed based on the treatment technique being evaluated. The results showed that the between groups factor of diagnostic status was not significant,  $F(2, 197) = .27, p = .76$ , nor was there a significant diagnosis-by-treatment interaction,  $F(6, 591) = .64, p = .70$ . Repeated measures  $t$  tests were conducted on all pairwise comparisons to test for the nature of the effect of treatment technique.

The first hypothesis, that response cost will be rated as significantly more accept-



able than time-out, positive reinforcement, and spanking, was partially supported. Response cost was rated as significantly more acceptable than spanking,  $t(199) = 14.03, p < .001, d = 1.39, 95\% \text{ CI } [1.16, 1.60]$  and time-out,  $t(199) = 4.37, p < .001, d = 0.33, 95\% \text{ CI } [0.13, 0.53]$ . However, response cost was not rated as significantly more acceptable than positive reinforcement. As hypothesized, positive reinforcement was rated by parents as significantly more acceptable than both time-out,  $t(199) = 5.44, p < .001, d = 0.48, 95\% \text{ CI } [0.28, 0.68]$ , and spanking,  $t(199) = 12.98, p < .001, d = 1.04, 95\% \text{ CI } [1.28, 1.72]$ , and time-out was rated as significantly more acceptable than spanking,  $t(199) = 9.90, p < .001, d = 1.04, 95\% \text{ CI } [0.83, 1.25]$ . See Table 1 for means and standard deviations for the treatment techniques.

For illustrative purposes, Table 1 also shows the percentage of parents that had a "positive reaction" to each discipline technique. Participants were considered to have a positive reaction if they "agreed" or "strongly agreed" with this statement: "Overall, I have a positive reaction to this technique in this scenario." The other items on the TEI-SF are not phrased in terms of overall "positive reaction" and so were not used in this analysis. Percentages for the behavioral parent training strategies of positive reinforcement (73.0%), response cost (71.0%), and time-out (60.0%) were fairly high. On the other hand, the percentage for spanking (18.5%) was fairly low.

## Discussion

Positive reinforcement and response cost were rated by parents as the most acceptable techniques to use, regardless of diagnostic status. Positive reinforcement and response cost were both rated as significantly more acceptable than time-out and spanking, but they were not rated significantly different from each other. Also, time-out was rated as significantly more acceptable than spanking. These results suggest that parents find response cost and positive reinforcement as the most acceptable behavior management techniques, regardless of a child's diagnosis.

The results of the analysis are consistent with previous research that has shown positive reinforcement and response cost to be rated as highly acceptable and similar in ratings to each other (e.g., Jones et al., 1998; Miller & Kelley, 1992). However, some previous research has also shown response cost as rated significantly higher than posi-

tive reinforcement by parents, which is not consistent with these results (Boothe & Borrego, 2004; Borrego, Ibanez, Spendlove, & Pemberton, 2007). Similar to the results of the current study, previous research has found positive reinforcement as more acceptable than time-out (e.g., Jones et al., 1998; Reimers et al., 1991), and spanking (e.g., Jones et al., 1998; Miller & Kelley, 1992).

In prior studies, parents have rated response cost as significantly more acceptable than both time-out (e.g., Boothe & Borrego, 2004; Jones et al., 1998) and spanking (e.g., Boothe & Borrego, 2004; Borrego et al., 2007; Jones et al., 1998), which is consistent with our results. The finding that time-out is rated by parents as more acceptable than spanking is also consistent with previous research (e.g., Borrego et al., 2007; Jones et al., 1998).

Although the results of the present study expand on the previous treatment acceptability literature, there are limitations that must be noted. One limitation is that the method of sampling limits generalizability of the results. In order to partici-

pate in the study, individuals had to have access to the Internet. Examples of some differences are that Internet users tend to be younger and wealthier than nonusers and also tend to be more trusting and have more expansive social networks (Skitka & Sargis, 2006). Some of these characteristics appear to be consistent with those of our sample, which was underrepresentative of individuals with extremes of income and of those with lower education levels. Another limitation of the present study is that ratings of acceptability were not examined separately for mothers and fathers, who might be expected to evaluate the behavior management techniques differently. Thus, future studies might evaluate whether there are indeed differences in acceptability ratings between mothers and fathers.

Another limitation of this study is that counterbalancing was not able to be used because of cost limitations, as the version of Survey Monkey with counterbalancing costs additional money. As a result, the treatments were presented in the same order to every participant. It is also important to note that the target child in the

**Table 1.** Descriptive Statistics for Acceptability Ratings of Techniques and Diagnostic Status

Technique/Diagnosis	Mean	SD	% with positive reaction
<b>Time-Out</b>			
ADHD	13.26	4.43	60.2%
Autistic Disorder	13.54	3.33	61.4%
No diagnosis	13.75	3.97	58.7%
All groups	13.53	3.96	60.0%
<b>Response cost</b>			
ADHD	14.87	4.03	73.6%
Autistic Disorder	14.42	3.18	68.4%
No diagnosis	15.01	3.60	70.6%
All groups	14.80	3.63	71.0%
<b>Positive reinforcement</b>			
ADHD	15.82	3.45	70.6%
Autistic Disorder	15.37	4.02	73.7%
No diagnosis	14.99	3.91	74.6%
All groups	15.38	3.79	73.0%
<b>Spanking</b>			
ADHD	8.78	4.60	19.1%
Autistic Disorder	8.86	4.66	19.3%
No diagnosis	9.53	4.46	17.4%
All groups	9.09	4.55	18.5%

*Note.* Range of scores on the selected items of the TEI-SF is from 4 to 20 with higher scores in representing higher acceptability. The "% with positive reaction" was calculated by combining the percent of parents that 'agreed' or 'strongly agreed' with the this statement "Overall, I have a positive reaction to this technique in this scenario."

vignette was a boy and, thus, the ratings of acceptability of the different behavioral management techniques may not generalize to ratings of acceptability for use with girls.

The theoretical rationale behind exploring whether there were differences in ratings of treatments for a child depending on diagnosis is that parents may be susceptible to societal beliefs about disability that may contribute to tolerance of problematic behaviors (Woolfson, 2014), which may in turn influence the acceptability of various behavior management techniques. Therefore, one direction for future research could be to investigate whether parents' beliefs regarding a child's disability mediates the relation between their child's diagnosis and their ratings of acceptability of different behavior management techniques.

Despite being an effective strategy for decreasing externalizing behaviors, time-out continues to be related significantly lower than other effective strategies. Thus, a future direction for research could be to assess the effect of a brief intervention on parents' ratings of acceptability of a technique such as time-out. It is possible if a session focuses on explaining the rationale for time-out and has parents practice using time-out, that this may have an effect on

parents' opinions of the technique. It would also be helpful to explore the possible reasons why parents find some of the discipline techniques more acceptable than others. These reasons would help practitioners determine whether they should teach parents other techniques, or simply address misconceptions that may exist about certain techniques, such as time-out.

This is one of the first studies to evaluate acceptability of behavior management techniques for externalizing behaviors in children with different diagnoses, including ASD. It is also one of the first studies in the area of treatment acceptability to use online methods for data collection and found similar results to previous studies regarding acceptability of behavioral management techniques. This study also provides updated information regarding what percent of parents have a positive reaction to different discipline techniques. Therapists using behavioral parent training may be encouraged by the positive reactions to their techniques, regardless of diagnosis, including that of a developmental disability. They also may be encouraged about the low support for spanking.

## References

Addis, M. E. & Jacobson, N. S. (2000). A closer look at the treatment rationale and

homework compliance in cognitive-behavioral therapy for depression. *Cognitive Therapy and Research*, 24, 313-326. doi: 10.1023/A:1005563304265

Atkins, M., Albano, A. M., Frisstad, M., Pelham, B., Piancentini, J., Abidin, D., . . . Youngstrom, E., (2014). *Outrageous claims regarding the appropriateness of Time Out have no basis in science*. Society of Clinical Child and Adolescent Psychology press release retrieved from <http://effectivechildtherapy.com/>

Baio, J. (2014). *Prevalence of Autism Spectrum Disorder among Children aged 8 years – Autism and Developmental Disabilities Network, 11 Sites, United States, 2010*. Report retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6302a1.htm>.

Benjet, C., & Kazdin, A. E. (2003). Spanking children: The controversies, findings, and new directions. *Clinical Psychology Review*, 23, 197-224.

Boothe, J. L., & Borrego, J. (2004). Parents' acceptance of behavioral interventions for children with behavior and communication problems. *Child & Family Behavior Therapy*, 26(2), 1-15. doi: 10.1300/J019v26n02\_01

Borrego, J., Ibanez, E. S., Spendlove, S. J., & Pemberton, J. R. (2007). Treatment acceptability among Mexican American parents. *Behavior Therapy*, 38, 218-227.

Buhrmester, M. D., Kwang, T., & Gosling, S. D. (2011). Amazon's Mechanical Turk: A new source of inexpensive, yet high-quality, data? *Perspectives on Psychological Science*, 6, 3-5. doi: 10.1177/174569161039398

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 215-237.

Frentz, C., & Kelley, M. L. (1986). Parents' acceptance of reductive treatment methods: The influence of problem severity and perception of child behavior. *Behavior Therapy*, 17, 75-81.

Heffer, R. W., & Kelley, M. L. (1987). Mothers' acceptance of behavioral interventions for children: The influence of parent race and income. *Behavior Therapy*, 2, 153-163.

Jones, M. L., Eyberg, S. M., Adams, C. D., & Boggs, S. R. (1998). Treatment acceptability of behavioral interventions for children: An assessment by mothers of children with disruptive behavior disorders. *Child & Family Behavior Therapy*, 20(4), 15-26.

Kazdin, A. E. (1984). Acceptability of aversive procedures and medication as treatment alternatives for deviant child

## Appendix

### Discipline Technique Descriptions

- **Time-out:** To address James's refusal to follow directions, his parents have him sit in a chair in the corner. His parents have him sit on the chair for 3 minutes. After 3 minutes, James's parents will give him permission to get off the chair if he is quiet. If James gets off the chair before his parents give permission, James must stay on the chair another 3 minutes.
- **Response cost:** To address James's refusal to follow directions, his parents take away a privilege that James normally has. James's parents tell James why he is losing the privilege for that day. The privileges that James might lose are things that he really likes, like a favorite TV show, dessert after dinner, a bedtime story, or playing with a favorite toy.
- **Positive reinforcement:** To address James's refusal to follow directions, every time that James does follow directions, his parents put a sticker on James's sticker chart. When James earns four stickers, his parents give him extra special things that he likes. The special things may be extra TV time, a special snack, a trip to the park to swing, or a small toy.
- **Spanking:** To address James's refusal to follow directions, his parents spank him. When James refuses to follow a direction, one of his parents walks James over to a chair and tells him that because of his refusal he is going to get a spanking. One of his parents then puts James over his/her lap and gives him two spanks on the bottom with an open palm.

- behavior. *Journal of Abnormal Child Psychology*, 12(2), 289-302.
- Kazdin, A. E., & Benjet, C. (2003). Spanking children: Evidence and issues. *Current Directions in Psychological Science*, 12(3), 99-103.
- Kelley, M. L., Heffer, R. W., Gresham, F. M., & Elliott, S. N. (1989). Development of a modified treatment evaluation inventory. *Journal of Psychopathology and Behavioral Assessment*, 11(3), 235-247.
- McMahon, R. J., Wells, K. C., & Kotler, J. S. (2006). Conduct problems. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 3-62). New York: Guilford.
- Miller, D. L., & Kelley, M. L. (1992). Treatment acceptability: The effects of parent gender, marital adjustment, and child behavior. *Child & Family Behavior Therapy*, 14(1), 11-23.
- Miltenberger, R. G., Parrish, J. M., Rickert, V., Kohr, M. (1989). Assessing treatment acceptability with consumers of outpatient child behavior management services. *Child & Behavior Family Therapy*, 11(1), 35-44.
- Njardvik, U., & Kelley, M. L. (2008). Cultural effects on treatment acceptability: A comparison of the acceptability of behavioral interventions between Icelandic and American parents. *Nordic Psychology*, 60(4), 283-294. doi: 10.1027/1901-2276.60.4.283
- Pelham, W. E., & Fabiano, G. A. (2008). Evidence-based psychosocial treatments for attention-deficit/hyperactivity disorder. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 184-214.
- Reimers, T. M., Wacker, D. P., & Cooper, L. J. (1991). Evaluation of the acceptability of treatments for children's behavioral difficulties: Ratings by parents receiving services in an outpatient clinic. *Child and Family Behavior Therapy*, 13(2), 53-71.
- Siegel, D. J., & Bryson, T. P. (2014). 'Time-outs' are hurting your child. *Time Magazine*. Retrieved from <http://time.com/3404701/discipline-time-out-is-not-good/>
- Skitka, L. J., & Sargis, E. G. (2006). The internet as psychological laboratory. *Annual Review of Psychology*, 57, 529-555. doi: 10.1146/annurev.psych.57.102904.190048
- Stinnett, T. A., Crawford, S. A., Gillespie, M. D., Cruce, M. K., & Langford, C. A. (2001). Factors affecting treatment acceptability for psychostimulant medication versus psychoeducational intervention. *Psychology in the Schools*, 38(6), 585-591.
- Straus, M. A., & Stewart, J. H. (1999). Corporal punishment by American parents: National data on prevalence, chronicity, severity, and duration, in relation to child and family characteristics. *Clinical Child and Family Psychology Review*, 2(2), 55-70.
- U.S. Department of Health and Human Services. (2008). Diagnosed Attention Deficit Hyperactivity Disorder and Learning Disability: United States, 2004-2006. *Vital and Health Statistics*, 10(237).
- Woolfson, L. (2004). Family well-being and disabled children: A psychosocial model of disability-related child behavior problems. *British Journal of Health Psychology*, 9, 1-13.
- ...

Amanda K. Stary is now at Department of Psychology, The University of Southern Mississippi.

This manuscript is based on data that was used for the first author's master's thesis and was supported in part by a Research Grant for Graduate Students from Southern Illinois University Edwardsville.

**Correspondence to** Amanda K. Stary, University of Southern Mississippi, Department of Psychology, 118 College Dr., #5025, Hattiesburg, MS 39406; [akstary@gmail.com](mailto:akstary@gmail.com)



## Join us in celebrating our 50 years!

ABCT: Get ready for, and be a part of, the October *tBT*, a commemorative issue marking ABCT's 50 trailblazing years.

This is your chance to publicly thank someone (or thing) in your cognitive, behavioral, research, academic, professional life.

**Place a Gratitude Ad.\***



## \*Gratitude Ad

OCT. ISSUE ONLY!

Thank a mentor, training program, publisher, faculty, book, concept, friend

Send text/art to [sschwartz@abct.org](mailto:sschwartz@abct.org)

Payment: credit card or check to ABCT:

305 Seventh Ave., 16th floor, New York, NY 10001

**RESERVE by AUGUST 15**  
Camera-ready deadline: August 25

DIMENSIONS: 2 3/16 x 1" (or approximately 145 characters)  
PRICE: \$50



## How to Develop a Robust Practice-Based Research Repertoire

R. Trent Codd, III, *Cognitive-Behavioral Therapy Center of WNC, P.A.*

IN 1992, MY UNDERGRADUATE astronomy professor declared to the class that most discoveries in the field of astronomy were made by amateurs. Before the turn of the 21st century, amateurs discovered most comets, many supernovae, novae, nebulae, and more.

Astronomy has changed some since then. There's been a proliferation of orbiting spacecraft and earth-based robotic telescopes with linked survey programs that have decreased the relative percentage of amateur scientific discoveries. Nevertheless, amateurs still play a significant role in scientific discovery; they help to examine the thousands of astronomical images taken daily for the purpose of distant galaxy classification. Most discoveries of comets, supernovae, and novae are now found on these images. Amateurs continue to play a large role because there's a lot of sky to look at out there!

What if the cognitive-behavioral clinician could play an analogous role in the clinical scientific discovery process? They are "amateurs" in the sense that they are not full-time researchers in a university setting, but they are in settings where they can ask and answer important research questions and can contribute to the growth rate of the scientific database. There's a lot of clinical behavior to look at out there!

The call for increased research activity in clinical practice settings is not new and has been made by many others (e.g., DeFife et al., 2015). Despite the number of such calls, research output in clinical practice settings remains negligible among mental health professionals, including counselors (Lundervold & Belwodd, 2000), social workers (Davis et al., 2013) and clinical psychologists (Eke, Holtum & Hayward, 2012). Publication rate data for counselors and social workers are unavailable. However, researchers have determined the modal publication rate among clinical psychologists to be zero (Eke et al., 2012). Clinical psychologists' low productivity level with respect to research activity is particularly concerning because they emphasize

the value of research to a greater degree than other mental health professionals and, generally speaking, espouse a scientist-practitioner model (Shapiro, 2002). The dearth of research produced from the various mental health disciplines is disappointing.

Representatives of various mental health professions have requested that barriers to increased clinical research activity be identified and remediated (e.g., Davis et al., 2013; Lundervold & Belwodd, 2000). For example, most clinicians chose clinical practice over full-time research because that is where their interests and competencies lie. Indeed, research suggests that one barrier to research activity is that many clinicians are not adequately trained in research methods (Baker, McFall & Shoham, 2009; Davis et al.; Lundervold & Belwodd). Also, for those clinicians who maintain an interest in research, it may have been a great deal of time since their research training. Finally, because the clinical practice context generally does not support such activity, any research repertoire previously developed is likely extinguished.

Many other barriers to conducting practice-based research exist (e.g., difficulty accessing an Institutional Review Board [IRB], time, financial constraints, etc.) and their proposed solutions have been the subject of other papers (see LeJeune & Luoma, 2015) as well as forthcoming works (see Codd, in preparation).

One solution to the problem of an inept research repertoire is to invoke a behavioral approach to its development. Such an approach has not been adequately discussed in the literature. In the pages following, a brief yet dense roadmap is provided for the practicing clinician who wishes to construct a behavioral repertoire that is up to the task of clinical scientific discovery. This repertoire consists of at least two distinct component repertoires: one pertaining to the development of competence with research methods and the other pertaining to fluency with the scholarly literature.

Strategies for the development of both component repertoires are addressed below.

### Constructing a Practice-Based Research Repertoire

#### *Research Design Repertoire*

*Shaping your repertoire.* Research activity in a practice setting involves the behavior of the clinical scientist. Therefore, this behavioral repertoire should be acquired, like any other behavior, by successive approximation through replication and extension (Iwata, 2006). This requires the clinician to engage in repeated successful behavioral practice (i.e., behavior that contacts reinforcement) and gradually increase the requirements for reinforcement. Most clinicians fail to build a successful repertoire because they do not arrange conditions that afford repeated reinforced practice. Some examples of common mistakes include: initiating projects where the response effort is too great, where the behavioral chain is too long and complex, or where reinforcement is too delayed. These ineffective approaches are not surprising, as they are likely the result of having been trained under the thesis/dissertation model which, in essence, only provides two learning trials, both of which require a large response effort and involve significantly delayed access to reinforcement (Iwata, 2006). The clinician trained under this model was taught an ineffective method of achieving behavioral acquisition, and it is likely that any existing research repertoire was extinguished or never fully reached acquisition in the first place.

A more effective approach exists. The clinician can use principles from the science of behavior to arrange their environment in such a way that it develops and supports a complex research repertoire (Iwata, 2006). For example, they should begin with a series of low-risk projects that afford a high probability of accessing reinforcement. Such projects may involve the investigation of easy-to-solve problems and questions where the answer is already known. They may also involve simple design and measurement procedures and/or the use of robust independent variables that produce large effects (Iwata, 2006). As their repertoire grows, they can begin balancing low- and high-risk projects. It is important that they not embark on high-risk efforts while still in the acquisition phase.

*Maintain the saliency of reinforcing consequences.* Clinicians engaging in research behavior can contact many reinforcing consequences that are generally not obvious to an observer and, unfortunately, clinical scientists often fail to transmit the availability of these reinforcers to aspiring researchers. Recognizing this difficulty, Sidman (2007) wrote a paper addressing these issues in which he conveyed many of the available reinforcers: "When we publish behavioral research, we are not allowed to communicate the thrill, the poetry, or the exhilaration that are outcomes of the discovery process. Yet, these are among our most potent reinforcers" (p. 309). The aspiring practice-based researcher is encouraged to read Sidman's paper and to incorporate his communication methods.

To facilitate contact with reinforcement, it is also important to do research that matters. Before embarking on a research project, clinicians would be wise to ask themselves the following questions: How will the findings from this project make a contribution to my field? When I'm on my deathbed will I be satisfied that I

explored these questions? Pursuing research that matters increases its reinforcing value. There is one note of caution, however. If a clinician is in the acquisition phase, the answers to these questions can easily pull for going through with research regardless of how improbable or delayed reinforcement contact is. As discussed previously, this will interfere with development of the desired repertoire. The solution is to view the smaller projects as steppingstones to these larger efforts and to see that meaningful projects can still be selected on smaller scales.

### ***Develop Fluency With the Research Literature***

*Acquisition stage.* Fluency with the research literature is an important component of a composite practice-based research repertoire. One method for acquiring fluency is to define a target pattern to work toward based on a model (i.e., a senior clinician-researcher) that already possesses the fluent pattern.

*Target exemplar.* A prototype is developed by interviewing an adept clinician-

researcher about the behavior that makes up their repertoire. Specifically, they are interviewed about their process of reaching fluency as well as their current maintenance pattern. One such model is described below (another is described in Carr & Briggs, 2010).

Dedicate one day a week (or at least a portion of one day per week) to reading the literature. Schedule and protect this time from any distractions. Identify the important journals in your area of interest and systematically read the last 10 years of articles published in each of these journals. During this process, record on a notepad anything that you do not understand or are unfamiliar with. Investigate these concepts. Behavioral practice with this material is an important final step (see Sudak et al., 2015, for a method of achieving behavioral fluency). Once you've read the last 10 years of material and have developed fluency with it, you are on your way to achieving command of the literature. It can also be useful, time permitting, to get involved with a reading group with colleagues who have similar areas of interest.



## **Director of Inpatient Psychology**

HARVARD MEDICAL SCHOOL  
BRIGHAM AND WOMEN'S HOSPITAL  
DEPARTMENT OF PSYCHIATRY



The Department of Psychiatry at Brigham and Women's/Faulkner Hospital, an academic teaching affiliate of Harvard Medical School, is seeking a Director of Inpatient Psychology to join our faculty. The 24 bed inpatient psychiatry unit provides care to a diverse population with high medical co-morbidity and is a major teaching site for the Harvard Psychiatry Residency Training Program, Harvard medical students, as well as a clinical externship site for psychology graduate students. We are seeking candidates with clinical and management experience in an inpatient setting and expertise in models of behavioral health care within inpatient settings. Preference is given to candidates with a strong background in cognitive behavioral theory and treatment or behavioral analysis. Responsibilities include direct clinical service, administration and program development, and multidisciplinary training/supervision, with opportunities for research. Applicants should be licensed in Massachusetts or license eligible with a graduate degree from an APA-accredited doctoral program in clinical psychology and must have completed an APA-accredited internship. Academic rank at Harvard Medical School will be commensurate with experience, training and achievements. Review of applications will begin immediately and continue until the position is filled.

**If interested, please send CV, in confidence, to:** Megan Oser, Ph.D., Director, CBT and Behavioral Medicine Program, Associate Chief of Psychology, Department of Psychiatry, Brigham and Women's Hospital, Harvard Medical School; [moser@bwh.harvard.edu](mailto:moser@bwh.harvard.edu)

*Harvard Medical School and Brigham and Women's Hospital are Affirmative Action/Equal Opportunity Employers.  
We strongly encourage applications from women and minorities.*

*The maintenance stage.* Once one has reached criterion, it is important to stay abreast of the literature. In order to maintain this behavior, one must arrange the contingencies appropriately. This may be accomplished through individual self-management procedures or through a reading group (Carr & Briggs, 2010).

At least one reading group model has been evaluated empirically (Parsons & Reid, 2011), and is associated with high acceptability among its participants as well as increases in knowledge. It also offers a minimal financial and time burden. The Parsons and Reid procedure involved reading one chapter or article per month, and a monthly hour-long meeting. The items chosen for reading were selected based on their relevance to their participants' practice as well as their expressed preferences. Only manuscripts that would take less than 1 hour to read were chosen. Several study questions were developed by the group facilitator to guide participant reading.

Reading group meetings followed a specific structure and were led by a facilitator. Each meeting contained the following elements: (a) describing the relevance of the selected reading to group members, (b) prompting each participant to convey their impressions of the article, (c) prompting participants to answer one of the study questions and then asking the other participants their perception of the given answer (going through each study question ensured that all major points of the reading were covered), (d) asking each participant to relate a key concept from the reading to their clinical duties, (e) a group leader summation of the main points discussed, and (f) thanking members for their participation.

The Parsons and Reid (2011) procedure can be replicated in a group practice setting. A solo practitioner could also implement such a program by connecting with other solo practitioners for this purpose. For example, they could arrange to meet in a physical location with other local practitioners, or they could implement this virtually.<sup>1</sup> In either case it would be important to optimize the verbal community by striving to include at least one participant who is already fluent with the literature of interest.

Other barriers to staying current with the scholarly literature, and their solutions,

have been identified in the literature. For example, Carr and Briggs (2010) addressed barriers involving large financial costs and high degrees of response effort. They noted the expense involved with subscribing to searchable databases such as PsycINFO and many individual journals. They suggested a number of solutions including the use of Google Scholar, RSS feeds, e-mail alerting services, low-cost journal subscriptions, and contacting authors directly for copies of manuscripts. They also suggested adjuncting at a local college in order to access that college's databases and holdings, or pursuing library privileges through their alumni association. They further reminded readers that in the U.S. these expenses are tax deductible. Some journal subscriptions are cost prohibitive for the practitioner, but others are free or available at reasonable rates. Another way of reducing response effort is to automate the literature search process (see Debuque, 2011, for a step-by-step procedure for automating this process).

## Conclusion

Clinical practitioners have an important role to play in the scientific discovery process. They can make significant contributions to the literature if they can overcome the many barriers embedded in their settings. This paper focused on one such barrier— an inept research repertoire— and described a behavioral approach to surmounting it.

## References

- Baker, T.B., McFall, R.M., & Shoham, V. (2009). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral health care. *Psychological Science in the Public Interest*, 9, 67-103.
- Carr, J. E., & Briggs, A. M. (2010). Strategies for making regular contact with the scholarly literature. *Behavior Analysis in Practice*, 3(2), 13.
- Codd, III, R.T. (Ed.). (in preparation). *Practice-based research: How to conduct meaningful research in your practice setting*.
- Davis, S., Gervin, D., White, G., Williams, A., Taylor, A., & McGriff, E. (2013). Bridging the gap between research, evaluation and evidence-based practice. *Journal of Social Work Education*, 49, 16-29.
- DeFife, J., Drill, R., Beinashowitz, J., Bal-lantyne, L., Plant, D., Smith-Hansen, L., . . . Nakash, O. (2015). Practice-based psychotherapy research in a public health setting: Obstacles and opportunities. *Journal of Psychotherapy Integration*, 1-14.
- Dubuque, E. M. (2011). Automating Academic Literature Searches With RSS Feeds and Google Reader™. *Behavior Analysis in Practice*, 4(1), 63.
- Eke, G., Holttun, S. & Hayward, M. (2012). Testing a model of research intention among U.K. clinical psychologists: A logistic regression analysis. *Journal of Clinical Psychology*, 68(3), 263-278.
- Iwata, B. A. (2006, May). The peer-review process and its implications for research training. Presentation delivered at Association for Behavior Analysis International Annual Convention, Chicago, IL.
- LeJeune, J. T., & Luoma, J. B. (2015). The integrated scientist-practitioner: A new model for combining research and clinical practice in fee-for-service settings. *Professional Psychology: Research and Practice*, 46(6), 421.
- Lundervold, D.A. & Belwood, M.F. (2000). The best kept secret in counseling: Single-case (N = 1) experimental designs. *Journal of Counseling & Development*, 78, 92-102.
- Parsons, M. B., & Reid, D. H. (2011). Reading groups: A practical means of enhancing professional knowledge among human service practitioners. *Behavior Analysis in Practice*, 4(2), 53.
- Shapiro, D. (2002). Renewing the scientist-practitioner model. *The Psychologist*, 15(5), 232-234.
- Sidman, M. (2007) The analysis of behavior: What's in it for us? *Journal of the Experimental Analysis of Behavior*, 87(2), 309-316.
- Sudak, D. M., Codd III, R. T., Ludgate, J. W., Sokol, L., Fox, M. G., Reiser, R. P., & Milne, D. L. (2015). *Teaching and supervising cognitive behavioral therapy*. New York: John Wiley & Sons.

...

**Correspondence to** R. Trent Codd, III, Ed.S., BCBA, Cognitive-Behavioral Therapy Center of WNC, P.A., 1085 Tunnel Road, Unit 7A, Asheville, NC 28805; [rtcodd@behaviortherapist.com](mailto:rtcodd@behaviortherapist.com)

<sup>1</sup>Many services for this purpose are low cost or free. Here's one example: <https://www.freeconferencecall.com/>



## Spotlight on a Mentor: Dr. Lizabeth Roemer

Helen Z. MacDonald, *Emmanuel College*

THE ABCT SPOTLIGHT ON A MENTOR program recognizes some of our organization's most talented and well-regarded research mentors. Our goal is to highlight excellent mentors across all levels of academic rank, area of specialization, and type of institution. We are pleased to present an interview with our current spotlighted mentor, Dr. Lizabeth Roemer.

Dr. Lizabeth Roemer is Professor of Psychology at the University of Massachusetts Boston, where she has been a faculty member since 1996. She received her Ph.D. from The Pennsylvania State University in 1995, under the supervision of Dr. T. D. Borkovec, and completed an internship and postdoctoral fellowship at the National Center for PTSD – Behavioral Sciences Division at the Boston VA. At UMass Boston, Dr. Roemer mentors clinical psychology doctoral students, provides clinical supervision to doctoral students in their first clinical practicum, and teaches.

Dr. Roemer has an active, productive research career, including publishing over 100 journal articles and book chapters and co-editing two books on the role of emotion regulation, mindfulness, and experiential avoidance in anxiety and other disorders, and the use of acceptance-based behavioral therapies. In collaboration with Dr. Susan Orsillo, Dr. Roemer has developed an acceptance-based behavioral therapy for generalized anxiety and comorbid disorders and, in collaboration with Dr. Sarah Hayes-Skelton, has examined its efficacy and mediators and moderators of change in a series of studies funded by the National Institute of Mental Health. Drs. Roemer and Orsillo are co-authors of *Mindfulness- and Acceptance-Based Behavioral Therapies in Practice* and *The Mindful Way Through Anxiety*, both published by Guilford Press, as well as a new forthcoming self-help book tentatively titled *Worry Less, Live More: The Mindful Way Through Anxiety Workbook*.

Ms. Natalie Arbid, one of Dr. Roemer's current clinical psychology doctoral students, nominated Dr. Roemer for the Spotlight on a Mentor award. Ms. Arbid described Dr. Roemer's mentorship style in this way:

From the first [individual mentorship] meeting, Liz is clear that she wants to help us clarify our own research interests and to support us in the process. She wants us to develop our own personal values and discover how those values fit into our professional and research goals as clinical psychologists. She takes an acceptance-based behavioral therapy approach to mentoring that involves being mindful during interactions with students and highlights her own commitment and values related to mentoring. This transparent process is central in her ability to help us explore and navigate our own professional and personal values.

Ms. Arbid also discussed the way in which Dr. Roemer's commitment to social justice informs her work as a mentor:

Liz helps us explore students' experiences with oppression and privilege, and how to negotiate various aspects of our identities as they interface with coursework, program material, research questions, and clinical experiences. Liz's commitment to social justice in her mentoring helps us explore various ways to respond to systemic inequities in our society. She does so by engaging in research exploring racism and discrimination across various identities, organizing community activism, and working to acknowledge areas of privilege and oppression, which all lead to policy changes at various levels within communities and organizations. Liz also openly discusses her process of working towards social justice, and does so in a way that normalizes and demonstrates compassion around the challenges that are inherent in this process. Liz has taught me that mentoring can be one of the most rewarding parts of a career. She has also modeled the ways in which compassion, commitment, and high expectations provide a context for students to thrive and develop personally and professionally.

Dr. Roemer responded to questions from ABCT's Academic Training and Education Standards Committee about her experience and goals as a mentor, as well as

her mentorship philosophy and mentorship practices.

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

My mentoring is always evolving, but I have been mentoring doctoral students and undergraduate students, and teaching, since 1996.

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

I aspire to provide students with the support, resources, guidance, and education they need to be successful in whatever way they want to be successful. This includes helping them to achieve competence across all the roles of clinical psychologists, while delving more deeply into the areas that are most important to them. I encourage my students to try on all possible roles because often a student who thinks she doesn't want to teach, for instance, finds she loves it. Once they've tried things, I'm respectful of what they value most, as long as they develop broad competencies. I also see my role as helping them to develop personally and professionally, including clarifying what is important to them and finding ways to engage in their work that are meaningful and rewarding, while also attending to other areas of their lives. I mentor the whole person and help each student find themselves in their work so that they are developing a lifelong relationship with their work that involves learning, growing, and stretching themselves.

My philosophy of mentoring is that my role is to facilitate growth through my presence, my genuine sharing of my own experiences, knowledge, and feedback, and by creating a context in which students feel comfortable trying new things, making mistakes, and then coming back and doing better. I encourage a collaborative environment in which students generally enjoy each other's successes, allowing them to each help the other reach higher and do more, rather than feeling competitive or lessened by others' successes.

*What practices do you engage in that foster your mentorship style?*

I communicate to mentees that their work and learning is important to me by meet-

ing with them regularly, being present and attentive in meetings, and responding as quickly as possible to their questions and their work between meetings.

I consult with colleagues regularly to make sure that I am being attentive to specific needs of my mentees and doing everything I can to facilitate their growth and development. I also connect my students with secondary mentors who can provide role models and guidance in areas that I can't (e.g., who have expertise I don't, or share aspects of identity with my mentees that I don't).

I provide regular opportunities for leadership and scholarship to each of my students so they can practice taking on these roles and find their strengths and abilities in the context of my lab.

I practice mindfulness to help me be emotionally present and open so that I can have genuine, engaged relationships with mentees and be intentional in my interactions with them.

I am authentic and genuine so that I can provide an honest model of being a human being and a professional at the same time.

#### ***What are your strengths as a mentor?***

My compassion and acceptance of my students, coupled with belief in their ability to excel and a willingness to challenge them to do so.

My ability to tolerate mentees' anxiety and distress and help them turn toward their experiences instead of avoiding, so that they can do what matters to them.

My genuine enthusiasm for clinical psychological research, including both the methods we use and the aims and implications of our studies. My genuine belief in the scientist-practitioner model and my ability to model this synthesis.

My commitment to social justice and to recognizing areas of marginalization and privilege and helping students to see these systemic factors in their own and others' lives.

My love of mentoring.

My ability to create an encouraging, supportive lab in which students genuinely care for one another and wish each other well, allowing everyone to be successful. In clinical supervision, my ability to create a context in which trainees feel comfortable being vulnerable and sharing their fears and reactions so that we can work together to address them to meet the needs of their clients and provide effective, ethical care.

My appreciation for the varied contributions that each student can make—letting them be the best clinical psychologist they can be, rather than fitting them into some set mold in which everyone needs to be the same.

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

Tom Borkovec was my doctoral mentor and he is the person who taught me to love science, clinical psychology, and mentoring. He taught me to be passionate about the pursuit of truth, while maintaining humility about our ability to truly do so. He also modeled that one could be successful and productive while also truly caring about other people and having meaningful relationships. When I graduated, he told me that I had learned skills that would be valuable no matter what I did, including owning a bird store (he loved birds). The freedom to choose my career path and to know he would be proud of me no matter what is what allowed me to clearly choose the academic path and know that I was doing it because I loved it, not because I was expected to. I try to convey the same message to my own students and I do truly enjoy and feel proud of every path they choose.

Sue Mineka was my undergraduate mentor and my first role model. She taught me the beauty and elegance of experimental psychopathology and I share that with my students all the time. She was also the first person to treat me like an independent researcher and to support me developing my own ideas, which had a powerful effect that I try to pass along to my students.

Brett Litz was my post-doc mentor. He helped me recognize what mattered to me as a professional, including my love of teaching and mentoring, which gave me the courage to leave the comfort of the VA and pursue an academic job.

Sue Orsillo was a post-doc when I was an intern and has been a peer mentor to me throughout my career. There isn't room to say what I've learned from her, but it's in pretty much everything I've written and everything I do. Mostly she taught me how to connect to what's important to me and to choose my actions, so that mentoring is a chosen, valued action, rather than a responsibility or a burden. The time I spend on mentor-

ing is extremely rewarding and nourishing to me and is closely tied to me being the person I want to be.

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

My advice is to be intentional about the kind of mentor you want to be. Reflect on your own experiences and the experiences of people you know and also on what you find rewarding about mentoring. Find ways to bring your full self to your mentoring relationships and be transparent and authentic with mentees. Be clear and transparent about expectations with your mentees and learn how to provide honest feedback—it can feel challenging or unkind, but it is the way that we are able to best help our students learn and grow.

. . .

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

## How Horse Training Made Me a Better DBT Therapist

Holly Bedotto, *DBT by Design, Miami, FL*

I AM A DBT CLINICIAN AND A NASCENT equestrian. I rode as a child and this is important, because as a child I rode with a pathological amount of confidence.

Months ago I was on a young horse that I had ridden before. Horses, like many of our patients, can be very different across encounters. So, on a brisk morning, this familiar horse was out of control at the walk. Fear grew inside me and the worse I got, the worse she got. She refused to go forward, resisted my attempts for upward transitions, swished her tail, threw her head, pinned her ears, and engaged her hind end (these are all behaviors that communicate “no”). I knew something was wrong but I didn’t have the skill or the confidence to fix these problems while on her back. I was reminded of my patients who often have this experience. I also was brought back to the years when I was a psychologist in training; I knew enough to be dangerous but not enough to be effective. A year before, I had attempted to fix just one of these problems on a different mare and she kicked out so many times, I threw my back out and couldn’t ride for months. I made things worse, again like my patients. I did not want to experience that again. I made it through the ride without her throwing me off her back, then immediately called my riding coach and got on another horse the next day in order to calm my fears and move forward.

Something was missing. I knew I needed more knowledge, more skill, more something. I went to my online riding site, but nothing helped. So, of course, I went to YouTube. I found this Australian horse trainer, Warwick Schiller. This guy is a DBT specialist for horses! I couldn’t believe what I was seeing . . . he retrains horses that are overly fearful (spook easily), have behavioral problems (can’t be clipped, rear up), have been abused or neglected, or just plain old rude behavior (barging into people). Sound familiar?

For any of you who are true behaviorists, you know how animal training works. Dogs respond to positive reinforcement. Horses, being prey animals, respond to

release of pressure (negative reinforcement). I started showing my colleagues at work some of these videos and one in particular stood out: worming a horse that had refused oral wormer for years. In less than 15 minutes, Schiller successfully worms a horse through negative reinforcement. This horse apparently used to duck her head or flip over backward for years in order to avoid the oral wormer. We were so enchanted with the ease of seeing the best of behaviorism. We now use this video in our basic DBT skills groups to begin teaching our patients behaviorism.

It is so easy to see success in animals. This was the first moment in time where I paused. The second time occurred when I was talking with the mother of one of our teens and she was telling me about the subtle changes she saw in her son after only two groups. My response to her was, “Well now you see why that commitment period took so long before he entered group; he needed time to hook on to the therapist and the therapy.” I walked out of my waiting room and realized I had used Schiller’s term, “hooking on,” to describe commitment. Hooking On in horse training vernacular is

. . . where a horse learns how to learn and [the process] has an amazing number of benefits including improving forward motion, bettering a horse’s focus and instilling an inclination to stand still quietly which makes them easy to catch. The hooking on process will teach your horse things that will carry over to every other aspect of your relationship which ultimately makes being around your horse a much more enjoyable and safe experience. (Schiller, 2014)

This is DBT and CBT at its best—teaching our patients how to use the therapy and take what they’ve learned into their world. Renowned horse trainer Ray Hunt says, “. . . you ask [your horse]; you offer it to him in a good way. You fix it up and let him find it. You do not make anything happen,

no more than you can make a friendship happen” (Hunt, 1991, p. 1).

And then we enter the paradox: If a young untrained horse wants to be near you, move away. If it wants to run from you, move toward it. The dance of trainer and horse is similar to that of therapist and patient. One strives to create a sense of safety and control within the organism while building trust and rapport. The result is a horse who is in control of itself, allows the human to catch it in the paddock, and can stand within a safe and healthy boundary from its handler. Again, so familiar.

After the YouTube adventure, I, of course, join his video training site (Warwickschiller.com) and am amazed at his ability to teach these concepts. He videotapes his sessions and explains his theory. There are skills to learn once hooking on takes hold. There is lateral flexion and bending to a stop, disengaging the hind end, riding on a loose rein in walk, trot and canter, and riding with contact. All of these horse training skills are consistent with DBT skills: mindfulness, distress tolerance, emotional regulation, and interpersonal skills. They all must be mastered for a rider and horse to communicate and for the horse to function in the equestrian world. And they must be done in a language a horse understands. The language of the herd. Same for DBT, we establish a language our patients need in order to get what they want in healthy ways. Ray Hunt discusses the importance of observation, honesty, and effectiveness. Observation about what the horse can teach you about where it is psychologically, honesty about your shortcomings, and effectiveness in carrying out training with each horse.

Schiller addresses the relationship with horse and rider. In training a horse, he is often heard saying, “It’s not my problem. . . I leave emotion out of it . . . they have to figure it out.” I often find myself saying these things in my head when confronted with difficult patient experiences. These words help me create a healthy space to allow for mistakes so we can correct them. Schiller is excited when a horse makes a mistake. So many equestrians think they can control their 1,200-pound steed and prevent mistakes. I learned that, for a horse, like with humans, mistakes are an important part of learning and only in that space can learning and change occur. So, when a patient arrives to my office, head held low and says, “You’re going to be mad . . .,” my response is “Great! Now we have an opportunity to learn.”



# now

ABCT

## online

### 50th Anniversary Podcast

Tune in as Ray DiGiuseppe invites you to the 50th celebration in NYC, describes his experience as a long-time member of ABCT, and reveals: "I've only missed two conventions—I've always felt very guilty about those . . ."

## in-press

### "Why" or "How": The Effect of Concrete Versus Abstract Processing on Intrusive Memories Following Analogue Trauma

"Accumulating evidence suggests that training individuals to process events (either during or afterwards) in a concrete relative to an abstract way increases resilience to these events."

White & Wild  
*Behavior Therapy*  
 doi: 10.1016/j.beth.2016.02.004

## archive

"...in so far as attention is a state favoring discrimination of stimuli, it is involved in that part of an animal's behavior which is derived from individual experience, since pure instinct discriminates but roughly ..."

—Margaret F. Washburn (1936)  
*The Animal Mind*  
 New York, Macmillan

As I watch more video, I wonder, Does this guy have some training in human therapy? Is his wife a clinician? He often refers to horse training theory books but sometimes he refers to concepts such as love language and mindfulness. Okay, I'm hooked! One of the reasons I ride horses is to engage in a truly mindful activity. Riding and training as I am now seeing takes all of one's cognitive and physical engagement. It is a true "participate" exercise. Like learning how to ride a bike or play an instrument, one has to learn a new language. How to engage one's body on horseback or on the ground in order to have effective communication. Horses have incredible memories and attend to the subtlest behaviors. We may be reinforcing the wrong behaviors without even knowing it and they will remember. Often, as a DBT therapist, I have had to disengage and review to see my part in an unhealthy behavior. And then comes the metaphor for wise mind . . .

My goal with a horse is for us to someday be in perfect harmony. It's like a candle light at the end of a long tunnel. It gets brighter and clearer all the time. Even though I realize I will never hold it in my hand, working for this goal is very real and rewarding. Each step along the way is its own reward (Hunt, 1991).

Schiller is also known for his saying, "Make the wrong thing hard and the right thing easy" (Schiller, 2014). "As a rider, you must slowly and methodically show your horse what is appropriate. You also have to discourage what's inappropriate, not by making the inappropriate impossible, but by making it difficult so that the horse himself chooses appropriate behavior. You can't choose it for him; you can only make it difficult for him to make the wrong choices. If, however, you make it impossible for him to make the wrong choices, you're making war" (Brannaman, 2001, p. 201). For example, if a horse gets locked up or is attracted to the gate (which means, home, food, and friends), the trainer will annoy his steed with tapping or kicks in the area close to the gate. When they move in the other direction, he leaves the horse alone. This is similar to the process of chain analysis. My patients hate them. They make the mistake, we chain it (annoying) and when they stop engaging in the wrong behavior, I leave them alone.

Balancing exercises are akin to dialectics and distress tolerance. A trainer will sensitize a horse (wave a flag, swing a lead rope to get the animal moving). Then he will desensitize (throw the rope over the horse's back or rub on the neck) in order to

repair any damage from sensitizing exercises (Acceptance and Change). These exercises help a horse to act in the world without being overly sensitive or overly numb. Schiller calls this "mental collection" (Schiller, 2015).

Recently, in a horse-assisted therapy training, the equine specialist said to an arena of 50 mental health professionals and horse trainers mixed in with three loose horses, "the horses know how to take care of themselves in a herd, it is your job to figure out how to keep yourselves safe" (Lytle, M., personal communication, September 16, 2015). Trust, respect, and faith. I trust my training, respect my patient's level of commitment and have faith, even during the most difficult parts of the therapy, that my patients will create a life worth living.

"In life, we don't know why things happen. I believe God is not responsible for the bad things that happen to you. Sometimes I think He's responsible for the good things, but sometimes it's something you shape up for yourself" (Brannaman, 2001, p. 260).

Happy trails.

## References

- Brannaman, B. (2001). *The faraway horses: The adventures and wisdom of one of America's most renowned horsemen*. Guilford, CT: Lyons Press.
- Hunt, R. (1991). *Think harmony with horses*. Fresno, CA: Pioneer.
- Schiller, W. (2012, January 17). *Worming the hard to worm horse* [Video file]. Retrieved from <https://youtu.be/qCZLjBp9dQ>
- Schiller, W. (2014). *Hooking on with a 3 year old Morgan mare, part one*. [Video file]. Retrieved from <http://warwickschiller.com>
- Schiller, W. (2015, November). *Five Minute Fix-disengaging, should you have them go, or desensitize them?* [Video file] Retrieved from <http://warwickschiller.com>.

...

**Correspondence to** Holly Bedotto, Psy.D.,  
 35 NE 40th Street, Suite 202, Miami, FL  
 33137; [drhbedotto@aol.com](mailto:drhbedotto@aol.com)

---

# ABCT | Welcome, Newest Members!

---

## ■ ASSOCIATES

Stephanie Kelleher  
Sadaf Khawar  
Jennifer O'Brien

## ■ FULL MEMBERS

Mike Abrams  
Breese Anderson  
Kristen Benito  
Doug Benson  
Rodney J. Benson  
Mitchell Berman  
Ryan Beveridge  
Jo-Ann Birt  
Abby Blankenship  
Rachel Whipple Blogg  
Lisa Bolden  
Joseph Alfred Bousquet  
Alisa Christine Bridger  
Alisha Brosse  
Joel K. Brotman  
Michelle Nicole Burns  
Colleen Byrne  
Nicole Caporina  
Andrew James Carini  
Annalise Lawler Caron  
Paul Cecchetti  
Anthony Chambers  
Chandler Sims Chang  
Brian Andrew Chapman  
Cory K Chen  
Jennifer Y Chen  
Kerry A Collins  
Susan Keortge Cook  
Aimee Coonerty-Femiano  
Stéphanie Cormier  
Meaghan Ashley Creedon  
Kerry Curran  
Jeffrey Danforth  
Reuven Dar  
Natalie Dattilo  
Julie Ann Deisinger  
Sonya Dinizulu  
Sapna Doshi  
Chad Drake  
Claudia Drossel  
Jamie Dunn  
Karyn Erkfritz-Gay  
Shawn Christopher Ewbank  
Chris Fairholme  
Natalia Ferrero  
Michael Frese  
Daniel Joseph Fridberg

Tara Ellen Galovski  
Jessica Garcia-Burgos  
Dalia Gefen  
Dodie A Gillett  
Andrea Gold  
Kimberley Golletz  
Kathryn Gordon  
Jean-Philippe Gouin  
Dorothy Grice  
Ryma Talaat Hady  
Jameson M Halberg  
James Paul Hambrick  
Elizabeth Harvey  
Nicole Elyse Heitler  
David Ryan Hooper  
Nicole Issa  
Dana J. Jackson  
Linda Jansen  
Pamela Kaczmarek  
Douglas Katz  
Sarah Keedy  
Peter James Kelly  
Kerri Kim  
Neil Kirkpatrick  
Jesse Klein  
Sihu Klest  
Nicole T. Kletzka  
Ernst Koster  
Ellen Koucky  
Mandy Kumpula  
Gerd Kvale  
Nathan Lambright  
Kristin Landsinger  
Steven Lawyer  
Noah Lazar  
Eli R Lebowitz  
John-Paul Legerski  
Lisa Nicole Legrand  
Scott C. Leon  
Michele D Levine  
Barbara Lilliston  
Elizabeth N Lima  
Brjánn Ljótsson  
Patricia Logan  
Jessica Lohnberg  
Sylvie A. Lombardo  
Beverly Jean Long  
Kristin A. Long  
Alison Looby  
Vasco M. Lopes  
Cristiana Macedo  
Richard Edward Madden  
Diane Magee

Leon Mandler  
Jeffrey C Mann  
Amy D. Marshall  
Kristin Kicki Martinsen  
Heather Mason  
Cindy McGeary  
Elizabeth McMahon  
Patrick David McMahon  
Kurt Michael  
Lauren Mills  
Noha Minshawi-Patterson  
Jeremy E. Mirsky  
Angela Elizabeth Mitchell  
Tricia Jordan Mlnarik  
John D Moore  
Sandra B. Morissette  
Chad Morris  
William Andrew Mullane  
Aimee Murray  
Velizar T Nikiforov  
Jeanette L. Nogales  
Ola Olen  
Kadir Ozdel  
Katie Parker  
Joshua Patras  
Mary Perrien  
R. Curt Peterson  
Mark Pfeffer  
Laura D. Pittman  
Claudia M. Prince  
Kathryn Reid Quinones  
Allecia Reid  
Sarah Victoria Revels  
Samara Rice  
Laura M Richardson  
Adeya Richmond  
Gwilym N. H. Roddick  
Mary Rooney  
David H Rosmarin  
Lori E. Ross  
Susan Ryerson  
Alison Salloum  
Jessica Samson  
Josefin Särnholm  
Karen Saules  
Alexandria Saulsberry  
Katherine Schaefer Berg  
Rachel Schmitt  
Jay Schulz-Heik  
Yvette Segura  
Minden Sexton  
Shilpee Sindwani  
Judith A Skala

Melissa Skrzypchak  
Marilyn G. Slutzky  
Erin Regina Smith  
Alexander Solodyna  
C. Richard Spates  
Rabeca Stahl  
Stephanie Steinman  
Kyle R Stephenson  
Cynthia Porter Stevens  
Lindsay Stewart  
Laszlo James Stojalowsky  
Andi Shell Stone  
Emel Stroup  
Lauren Stutts  
Stephanie N Sweatt-Sweatt  
Sandor Szollos  
Christina J Taylor  
Theodore Stephen Tomeny  
Kathleen Brigid Trainor  
Jan Tyson Roberts  
Lisa Unti  
Alyssa Denise Verbalis  
Miguel Villodas  
Patrick Anthony Vogel  
Lyndsay Kate Volpe Bertram  
Anka Vujanovic  
Allison M Waters  
Johanna Wekar  
Dahra Williams  
Wenhui Yang  
Athena Yoneda  
Alexander Stewart Young  
Shannon Zaitsoff  
Kristyn Zajac  
Christine Zalecki  
Natalie Zervas

## ■ NEW PROFESSIONALS

Christopher Arger  
Carolina Avila  
Katrina Marie Bell  
Stacey R Belmont  
Emily Berner  
Rebecca Rialon Berry  
Rebecca Blais  
Yevgeny Botanov  
Whitney Caitlin Brown  
Joanna Buscemi  
Ruby Charak  
Joseph Rich Cohen  
Erin B Cooper  
Mariana Craciun  
Sonja DeCou

Joanne Diacogiannis  
Lilian Dindo  
Danielle Doucette  
Lisa Dreger  
Tory Eisenlohr-Moul  
Macarena Espinoza Venegas  
Marie Forgeard  
Brooke Guttenberg  
Andrea Hiura  
Mariana Hoar  
Neil Llewelyn Howell  
Denada Hoxha  
Grace Hubel  
Leah Israeli  
Heather M. Jones  
Shaina Katz  
Nicole Kirkwood  
Corina Evelyn Klein  
Erkan Kuru  
Lauren Lawler  
Ashton Lofgreen  
Mark Lynn  
Catherine Maliszewski  
Sarah Mandel  
Brianna Dora Mann  
Lashley Feaster Marks  
Melissa Mattson  
Sonia Matwin  
Anna Matyja  
George Morelli  
Tara Myers  
Beth Myler  
Sarah Okey  
John Parkhurst  
Alexander Queen  
Kathryn Riehman  
Rebecca A Schwartz-Mette  
Matthew Todd Sewell  
Rebecca L. Silten  
Megan L. Smith  
Kristen Springer  
Sara Stasik-O'Brien  
Craig William Strohmeier  
Megha Tailor  
Lisa Nicole Vroman  
Amy M Williams  
Ping Zheng  
Jennifer Felder  
Kezia Shirkey  
Natalie Todd  
Katherine Young

#### ■ POST-BACCALAUREATES

Talia Aizenman  
Leigh Alexander Andrews  
Eliana Bauman  
Amber Lynn Billingsley  
Jennifer Blake  
Dylan Alexander Braun

Lucía Calderón  
Nicolás Capote  
Emily Carlson  
Sean Carp  
Michael Caruso  
Shayna Cheek  
Erin Curley  
Meredith Davis  
Jolie De Feis  
Maria DiFonte  
Peter Peek Ehlinger  
Eliot Elizabeth King Fearey  
Leah Kate Feinberg  
Claudia Gillam Feldhaus  
Nicole Ferretti  
Jennifer Foltz  
Kelly Fuller  
Carter John Funkhouser  
Shani Asha Gardner  
Lauryn Garner  
Andrew Gepty  
Alexandra Michelle Golik  
Rob Gross  
Karolina Grotkowski  
Roland Hart  
Casey Hearing  
Danelle Emily Hee  
Lauren Hoffman  
Byron Holzberger  
Gabriella Imbriano  
Kiera James  
Lisa Johnson  
Stephanie Johnson  
Katherine Ann Kennedy  
Yuri Kim Kim  
Chelsea Bethany Kozikowski  
Megan Leanne Krantz  
Tess Jennifer Lauricella  
Daniel Lee  
Alison Legrand  
Catherine Lyn MacCaskill-Whitethorne  
Kirby Magid  
Jillian L. Martucci  
Dassiell Medina  
Rebekah Mennies  
Fanny Mlawer  
Rebecca Montana  
Miguel Montero  
Damian Morden-Snipper  
Matthew Daniel Multach  
Jillian Doris Nelson  
Bridget Nestor  
Riley Palmer  
Jeffrey A Parlin  
Chloe Paterson  
Jessica Perez  
Amani Dawn Piers  
Laura Ann Purcell

Andrew Harrison Rogers  
Peter Rosencrans  
Christina Scharmer  
Alexandra Ruth Schwartz  
Carly M. Schwartzman  
Natasha Sierra Seiter  
Annika Shearer  
Amanda Brooke Snyder  
Shelby Stanley Stanley  
Cassandra Lynn Summers  
Sebastian Szollos  
Elysia Tan  
Allison Vreeland  
Katherine A Walukevich  
Sarah Elizabeth Wilson  
Sara Witcraft  
Brittany Woods  
Blanche Wright  
Emily Wyckoff Wyckoff  
Carlos Yeguez  
Diheng Zhang  
Xin Zhao  
Garret Glenn Zieve

#### ■ STUDENTS

Rebecca Abbott-Sinclair  
George Abitante  
Margaret Achee  
Frode Adolfsen  
Paula Aduen  
Monica Elizabeth Aguilar  
Abdul Shakoor Ahmed  
Christen Aiguier  
Juliana Alba-Suarez  
Adelaide Alderks  
Bradley Aleshire  
Christy Allen  
Desirae Louise Allen  
Suzanne Chinyere Amadi  
Lindsay M Anderson  
Justin Jack Anker  
Laura Michelle April  
Brenda Arellano  
Simone Arent  
Victoria Argento  
Brian Ashenfelter  
Abigail Asper  
Mira Atia  
Tyler Auclair  
Andrea Avila  
Hallie Avizad  
Nicole Azores-Gococo  
Danielle Elyse Baker  
Sara Balestrieri  
Sarah Bannon  
Jennifer Barenz  
Andrea Barrera  
Marie Christine Barrett  
Laura Bartos

Gregory Bartoszek  
Emma-Lorraine Bart-Plange  
Heather Ruth Angela Batchelder  
Anna Batista  
Marin Caroline Beagley  
Taylor Brooks Beaudoin  
Colleen Bechtel  
Alexa Beck  
Kristin Becker  
Maria Beckman  
Ashley Belcher  
Miranda Leigh Beltzer  
Amina Benkhokha  
Riley Benko  
Kari Benson  
Daniel Bentley  
Maxwell Berlyant  
Rachelle Bernadel  
Michael W Best  
Alex Bettis  
Danielle Beyer  
Arjun Bhalla  
Jabeene Bhimji  
Grace Binion  
Johan Bjureberg Bjureberg  
Sarah R. Black  
Meredith Ann Blackwell  
Rachel Blain  
Lynn Blanchette  
Leah Bogusch  
Marianne Bonnert  
Carly Bosacker  
Colin Maxwell Bosma  
Summer Bottini  
Elizaveta Bourchtein  
Stephen Boyd  
Derrecka Boykin Boykin  
Laurel Brabson  
Lauren Bradstreet  
Anna Brandt  
Ashley Braun-Gabelman  
Kara Braunstein  
Morgan Brazille  
Jesse Briggs  
Carly Christine Brooks  
Milan Ailene Brooks  
Amanda Brown  
Cynthia Brown  
Robert Tyler Brown  
Shaquanna Brown  
Michael R Bruner  
Laura Jane Bry  
Victor Buitron  
Sarah Bujarski  
Brian Andrew Bulla  
Evan T. Burdette  
Amanda Burnside  
Erin Burr



Roslyn D Burton-Robertson	Laura Cusumano	Christina M Ferguson	Laura Katherine Hansen
Brianna Byllesby	Laura Cuttini	Mark Ferreira	Lyndsey Nicole Hansen
Emily Elizabeth Cameron	Ewa Czyz	Grace Feyjijjinmi	Jacqueline Hapenny
Claudine Campbell	Alexandra D'Agostino	Jennifer Fillo	Kaitlin Happer Happer
Moselle Campbell	Victoria Dahl	Tonya Filz	Gregory Harms
Ransom Campbell	Katelyn Kiera Daniels	Anna Fineberg	Andrea Harris
Rebecca Campbell	Allison Pennock Danzig	Sarah Fischer	Anna Harrison
Margaret Fesmire Canter	Samantha Daruwala Daruwala	Hayley Fitzgerald	Lynn Harrison
Annette Cantu	Issar Daryanani	Nicole Jamilen Fleischer	Kimberly Neva Hayes
Jennifer Castellow	Lauren David	Katherine Fogarty	Ellen Elizabeth Haynes
Ashley Castro	Alan K Davis	Kathryn Fokas	Ariana Hays
Olivia Castro	Fernanda Pinheiro De	Haley Ford	Sydney Katherine Heiss
Bridget Cauley Cauley	Oliveira	K. Jean Forrest	Emilie Held
Sarah Theresa Caverly	Kimberlye Dean	Lauren Forrest	Lauren Ashley Heller
Ayanda Chakawa	Draycen DeCator	Peter Franz	Nicola Hermanto
Kaitlyn Diane Chamberlain	Alex DeFelice	Maria Pia Freile	Juan Carlos Hernandez
Elizabeth Chan	Alison DeLizza	Aliza Friedman	Alyssa Hertz
Jesus Chavarria	Tyler Donald Demers	Maxwell Drew Froman	Meghan Elizabeth Hills
Dina Chavira	Nicholas J. Denney	Kristen Frosio	Sara Himmerich Himmerich
Randi Jeanne Cheatham-	Michael Dennin	Klint Fung	Chloe Hogue
Johnson	Meredith Leigh Dennis	William Stewart Futch	Jeff Holguin
Jasmine Chee	Andrea Despotos Despotos	Darren Jason Garcia	Sean Hollis
Ivy Y Chen	Rachel Detrie	Bri'Ana Danielle Gardiner	Natalie Rose Holt
Jessica Chen	Kathryn DeWitt	Edwards Garet	Jennifer Holzman
Miaoyun Chen	Justine Diener	Monika Gaspar	Melanie A Hom
Stephanie Jian Chen	Sandra DiVitalo	Alyssa Gatto	Daniel Horning
Xiaodi Chen	Cody G Dodd	Yulia Gavrilova	Adam Gabriel Horwitz
Yen-Ling Chen	Joseph Michael Donahue	Nioud Mulugeta Gebru	Shabnam Hossein
Liqiaonan Chen	Matthew Donati	Haley Gedek Gedek	Claire Houtsma
Joey Chun-Yi Cheung	Lu Dong	Amy Gencarelli	Hillary Howrey
Kar Wai Cheung	Krista K Dowdle	Ansley Geno Geno	Nichelle Huber
Terence H. W. Ching	Sarah Dreyer-Oren	Danielle Giovenco	Kelsey Hudson Hudson
Annie Chinneck	Steven Christopher Dufour	Catherine Glass	Hannah Hueneker
Dana Sheryl Chirumbole	Arielle Duinkerken	Tiffany Rose Glynn	Rachael Huff
Caitlin Chiupka	Jenna Nicole Duncalf	Christian Robert Rufus Goans	Nicole Humphrey
Bruno Chiurliza	Kelly Dunn	Miriam Goldstein	Julia Huston
Evelyn Cho	Tory Durham	Sara Gonzalez-Rivas	Morten Hvenegaard
Sophia Choukas Bradley	Emily R Dworkin	Samantha Goodin	Nataly Ibarra
Emily Alicia Christie	Matthew John Dwyer	Erica Goodman Goodman	Samantha Ingram
Christina Chwyl	Hana-May Eadeh	Amber Gorzynski Gorzynski	Alexandra Irwin
Shannon Clark	Rachel Elizabeth Eby	Kelly Goss	Melissa Ivins-Lukse
Jaime Ashley Coffino	Cierra Brooks Edwards	Marie-Helene Gosselin	Susan Iyican
Sally Cohen	Charley Edwards	Anna Beatrix Gould	Jennifer Dianne Jackson
Kimone Coley	Ilana Eisenberg	Jennifer Rebecca Gowins	Stina Jacobs
Nicole Colon-Quintana	Ana El-Behadli	Ana Belen Goya Arce	Samantha Jay Jay
Claire Conley	Brandi Michelle Ellis	Jessica Graham	Juliet Jenkelowitz
Alexis K. Conroy	Jessica Ellis	Kirsten L. Graham	Jessica Jenness
Emily Copps-Smith	Connor Gene Emmert	Christopher Grandits	Zunaira Jilani
Elisabeth Cordell	Alexander Epperly Epperly	Simona Graur	Ekaterina Katia Jitlina
Angelia Marie Corley	Meredith Erwin	Robert Graziano	Carly Johnco
Adina Coroiu	Kamran Eshtehardi	Christopher Gresham	Megan Johnson
Samantha Marie Corralejo	Russell Esmail	Fiona Grubin	Erica Catherine Johnstone
Morgan Brittany Costanza	Ashley Christine Estoup	Emily Guertin	Winter D Johnston
Amanda H. Costello	Spencer Evans	Shaina Gulin	Duncan Gage Jordan
ashley danielle cox	Wyatt Evans	Kayla Gurak Gurak	Margo Kahn
Hayley Crain	Kelsey Jean Evey	Erika Luz Gustafson	Faria Kamal
Julia Craner	Martha Fahlgren	Madison Marie Guter	Andrea Kaniuka
Raquel Craney	Emily Fanguy	Heidi Haenisch	Hannah Dolores Kassab
Alexi Cranford	Courtney Farmer	Kristy Ann Hamilton	Benjamin William Katz

Gregory Katzen	Erica Liebman	Rose Miller	Ellen Marie Parsons
Alicia Kauffman	Anne Limowski	Alexander Millner	Luciana Guardiano Payne
Caroline Cecil Kaufman	Jessica Nicole Linder	Courtney Mills	Jennifer Pearlstein
Michelle Kaufman	Keith Lit	Jennifer Minarcik	Maggie Peebles-Dorin
Nathan T Kearns	Huiting Liu	Caroline Minott	Tyler Pendleton
Kristen Keefe	Nicholas A. Livingston	Lucas Mirabito	Leticia Maria Perez Miranda
Andrew Keenan	Abby Lonnemann	Jonathan Miskevics	Victoria Perko
Elliot Nicholas Keenan	Travis Loughran	Samantha Haley Mohun	Lina Perl
Christine R Keeperts	Claudia Lugo-Candelas	John Monopoli	Amy Perschbacher
Lucas Kelberer	Julia Lynford Lynford	Raymond Lee Moody	Devin Petersen
Shira Kelin	Alexandra Haley Lyon	Kelly Elizabeth Moore	Tony Petruzzella
Shelby L Kelso	Allison MacDonald	Lindsay Moore	Peter Lee Phalen
Kristen Kemp	Anna MacKinnon	Joseph Morger	Ashley Lynn Pigore
Hannah Marie Kersting	Jessica F Magidson	Ashley Nicole Morris	Cynthia Pierre
Meera Khan	Emily Lucia Maher	Joshua Morris	Caitlin Mary McNamara
Pardis Khosravi	Ashley-Hart Maiorana	Sara Morrow	Pinciotti
John Francis Kilpatrick	Tobey Eve Mandel	Ryan Motykowski	Martha Piñones
Dovid Kirzner	Shannon Marie Manley	Szimonetta Mulati	Saxony Pique
Sarah Knapp	Sarah Mann Mann	Kyler Mulhauser	Caroline Pittard
Lauren Knauf	Erin Maresh	Daniel Mungal Christopher	Michelle Pitts
Ryan L Knigge	Ashley Marmouget	Mungal	Maribel Plasencia
Candace Armstrong Koman	Marmouget	Yolanda Evelyn Murphy	Gabriella Podolski
Olivia Kostecke	Brett Marroquin	Imman Musa	Michael Poggioli
Jennifer Krafft	Jaime Marrus	Ursula Susan Myers	Ani Rebecca Poladian
Kirstyn L. Krause	Julio Martin	Samantha Myhre	Kelly L Polnaszek
Kate Happel Krautbauer	Ana Martinez de Andino	Elena Navarro Navarro	Hayley Elise Pomerantz
Audra Kriauciunas	Caitlin Martin-Wagar	Kara Lynn Nayfa	Sarah Ann Potts
Cassandra Krug	Jamie Alexa Mash	Stephanie Nelson	Natalee N Price
Jacqueline Krychiw	Irina A Mason	Jacqueline Nessi	Valerie Price
Lindsay Kurahara	Brittany Matheson	Christine M Newman	Amanda Proctor
Mun Yee Kwan	Abel Mathew	Danielle N Newman	Kristen Protasiewicz
Julian Christopher Lagoy	Elizabeth McLean Mathias	Stacey Ng	Clare Purvis
Shari Lagrange-Aulich	Alexandra Mattern	Binh-an Nguyen	Shuyu Qiu
Maria Lalouni	Casey May	Du Thuy Nguyen	Jean Marie Quintero
Nicole Gabrielle Lancaster	Ashley Mayworm	Simona Noaghiul-Yland	Anna Rabasco
Isabelle Lanser	Paige McAllister	Samantha Kay Noose	Sahar Rabizadeh
Stephanie Anne Larew	Nicole McBride	Lynn Norwood	Jonathan Rabner
Destiny Renae LaRue	Meaghan Elizabeth	Megan Leah Novak	Francesca Ramirez
Alisson Lass	McCallum	Sarah Nowalis	Gabriela Ramirez
Jamie M Lawler	Glynnis A McDonnell	Caitlin O'Donnell	Elizabeth Ramjas
Priscilla Grace Layman	Adam McGuire	Maeve Bronwyn O'Donnell	Lene-Mari Rasmussen
Kirsten Leaberry	Laura McKenzie	Kimberly O'Leary	Rasmussen
Matthew Lebowitz	Savannah McSheffrey	Madison Shea O'Meara	Victoria Raupp
Aaron A. Lee	Evelyn Pearl Meier	Marykate T Oakley	ShawnMarie Rehfeld
Amy Lee	Tamara Lynn Meixner	Sharon Jennifer Odriozola	Adam Michael Reid
Jessica Lee	Brian Menard	Sarah K Odum	Shannon I Reid
Lauren Marie Lee-Rowland	Jennifer June Mendoza	Clarissa Ong	Danielle Restrepo
Elizabeth Lehinger	MC Mercer	Emma Oremus	Amanda Claire Rhodes
Michelle Lemay	Kristen G. Merkitich	Joseph Orsini	Dylan Richards
Hugh Leonard	Brooke Lauren Mellow	Elizabeth Ortiz	Brian Richter
Hannah Kathryn Lessing	Kaune Metterg	Krysten Osinski	Adam James Ripley
Holly Frances Levin-	Kayne Mettert	Lauren Ostarello	Mary Veronica Rivers
Aspenon	Isha Walwina Metzger	Jennifer Oswald	Katerina Rnic
Cara Levitch	Alexandria Meyer	Michael Jesse Ovalle	Sarah Roane
Melanie Levitt	Neil Meyer	Lauren Paige	Caroline Mason Roberts
Clare Lewandowski	Judy Mier-Chairez	Janelle Painter	Casey Maria Roca
Allen Liao	Annette Miller Miller	Cara Alexis Palmer	Amelie Rochefort
Stephanie Cornell Lichiello	Jackie Miller	Maura Lee Pantone	Megan Ann Roe
Lynne Nicole Lieberman	Michelle L Miller	Jamie Parnes Parnes	Courtney Bramblett Rogers

Samantha Rogowicz	Amanda Shaw	Deanna Mina Louise Swain	Danielle Weber
Laina Rosebrock	Zoey Shaw	Corinne R Sweeney	Emily Weber
Diane Rosenbaum	Karen Shebuski	Pamela Swift	Crystalia S. Weidner
Leah Rothschild	Micah Shields	Jessica Swinea	Orly Weltfreid
Ivy Catherine Rouder	Madelyn Silber	Jenna Leigh Taffuri	Keiana R West
Alyssa Noelle Rowland	Shifali Singh	Masaya Takebe	Taylor Weststrate
Caryn Kseniya Rubanovich	Tharaki Siyaguna	David Talavera	Kendalle Cheyanne Wexler
Kristina Ruggeri	Kelly Elizabeth Slaughter	Mariya Tarshish	Amy Whittermore
Aria Ruggiero	Noel Slesinger	Joseph Glenn Tawney	Dylann Elizabeth Wilkinson
Devon Ruhde	Maud Caroline Berg Smeby	Alicia Makita Taylor	Samantha Wilkinson
Allison Kathleen Ruork	Hillary Smith	Erin Taylor	Wilkinson
Joshua Rutherford	Isaac Smith	Jasmine Taylor	Adam Wilson
Danielle Ryu	Jennifer Smith	Jonathan Teller	Allison Winik
Chelsea Sage-Germain	Steven Smith	Ashlyn Testut	Jennifer D Wong
Hanna Sahlin	Whitney Smith	Kate Theimer	Emma Carolyn Woodward
Nikita Saladi	Suzanna So	Sarah Thomas	Katy Wormley
Rafaella Sale	Kathryn Soltis	Kristen Thompson	Jessica Jo Wright
T. Salem	Elia F Soto	Anders Lillevik Thorsen	Bonnie Yap
Rachel Hannah Salk	Arturo Soto-Nevarez	Lauren Tidwell	Janet Yarboi
Sela Sanberg	Grace Spee	Matthew A. Timmins	Evan Zahniser
William Sanderson	Zachary Speer	Kristen G. Tobias	Samantha Leigh Zaid
Kayla Sargent	Cara Spitalewitz	Hannah Ruth Tomlinson	Nur Hani Binte Zainal
Maureen D. Satyshur	Tara Lee Spitzen	Veronica Torrico	Argero Anne Zerr
Leah Janae Saulter	Catherine Stachniak	Annabelle Torsein	Wanni Zhou
Alyson Savala	Nicole Stadnick	Elise Trim	Xiang Zhou
Caroline Sawyer	Brayden Stanton	Aki Tsuchiyagaito	Yiwen Zhu
Lee Ward Schaefer	Lindsay Staples	Brittany Tusa	Danielle Samantha Zito
Adela Scharff	Aviva Sara Stavsky	Erin G Underbrink	
Jennifer Anne Scheurich	Elizabeth Stein	Chava Zemirah Urecki	
Jenna Lillian Schlein	Steven Steinert	Daniella Vaclavik	
Madison Rae Schmidt	Sarah Steinmetz	Ryan Van Fossen	
Matthew Schooler	Cazzie Es Steinzor	Whitney Van Sant	
Ciera Eden Schoonover	Bradford Lawson Stevens	Sophie Louise van Uijen	
Gabrielle Schreyer	Leah Elizabeth Stevens	Emily Vanderbleek	
Heather Rae Schultz	Melissa Marie Stewart	Lauren VanderBroek	
Paige Schultz	Valerie E Stone	William Michael Vanderlind	
Gregory Schutte	Philip Stoner	Samantha Varon	
Andrew Joel Schwehm	Eivind Rauø Strand	Elizabeth Ann Velkoff	
Susan R. Schwendener	David Strasshofer	Anthony Thomas Vesco	
Meredith Sears	Joanna M Streck	Stephanie Vettorazzi	
Adina Seidenfeld	Brooke Strumbel	Martin Viola	
Stephen Sell	Alexandra Sullivan	Keshia Wagers	
Ambreen Shahabuddin	Timothy Sullivan	Lori A Wagner	
Shahabuddin	Berta J. Summers	Sarah Wahlen	
Christiana Shao	Brittany Sutton	Andrew Warnke	
Rakhel Shapiro	Takakuni Suzuki	Lauren Nicole Weathers	

8th World Congress of Behavioural and Cognitive Therapies, June 22–25, 2016

[www.wcbct2016.com.au](http://www.wcbct2016.com.au)

*advances and innovations in the behavioural and cognitive therapies across the world*



# ABCT ONLINE WEBINARS

www.abct.org



***Learning doesn't need to stop*** at the Convention!

ABCT is proud to provide online webinars for psychologists and other mental health professionals. Our webinars can be attended live or viewed online at your convenience. The webinar series offers opportunities to learn about evidence-based treatments and latest research from the convenience of your home/office.

## *Webinars On-Line*

*Abramowitz* | Exposure for OCD  
*Albano* | CBT for Adolescent Anxiety  
*Barnett* | Ethics in Behavioral Telehealth  
*Brown* | CBT for Child Trauma  
*Farchione* | Unified Protocol  
*Fisher* | Ethics  
*Gallagher* | Children with ADHD  
*Gurwitsch* | Parent-Child Interaction Therapy  
*Harvey* | CBT for Insomnia (CBT-I)  
*Hayes* | ACT for Anxiety  
*Herbert* | ACT  
*Keane* | PTSD  
*McCrary* | Substance Abuse  
*McNeil* | Parent-Child Interaction Therapy  
*Miller* | DBT With Adolescents  
*Persons* | Overcoming Treatment Failure  
*Rego* | Utilizing Social Media  
*Resick* | CPT for PTSD  
*Roemer* | Acceptance-Based BT for GAD  
*Segal* | Mindfulness in Clinical Practice  
*Shafran* | OCD/Perfection  
*Shear* | Complicated Grief and Its Treatment  
*Sudak* | Supervision  
*Tirch* | Compassion-Focused Therapy

## *Upcoming Webinars*

April 22, 2016 • 11:00-12:30 EST

*Joe Himle* | What Every Social Worker Needs  
to Know About CBT

May 6, 2016 • 11:00-12:30 EST

*Mary Fristad* | Treatment of Child Bipolar  
Disorder

May 13, 2016 • 11:00-12:30 EST

*Michelle Craske* | Modern Exposure Therapy

June 3, 2016 • 11:30-1:00 EST

*Amy Tischelman* | Working With LGBT  
Adolescents

July 28, 2016 • 11:30-1:00 EST

*Anu Asnaani* | Clinic Issues in Multiculturalism

August 2016 (*day/time TBD*)

*Barbara Kamholz* | Teaching CBT to Residents

September 9, 2016 • 11:00-12:30 EST

*Craig Bryan* | CBT to Prevent Suicidal Behavior

December 19, 2016 • 11:00-12:30 EST

*Muniya Khanna* | Technology and Mental  
Health



# Call for Editor of *the Behavior Therapist*

Candidates are sought for Editor-Elect of *the Behavior Therapist*, Volumes 41–43. The official term for the Editor is January 1, 2018 to December 31, 2020, but the Editor-Elect should be prepared to begin handling manuscripts approximately 1 year prior.

Candidates should send a letter of intent and a copy of their CV to Steve Safren, Ph.D., Publications Coordinator, ABCT, 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008 or via email to [teisler@abct.org](mailto:teisler@abct.org)

Candidates will be asked to prepare a vision letter in support of their candidacy. David Teisler, ABCT's Director of Communications, will provide you with more details on the selection process as well duties and responsibilities of the Editor. Letters of support or recommendation are discouraged. However, candidates should have secured the support of their institution.

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

Letters of intent **MUST BE RECEIVED BY June 1, 2016.**

Vision letters will be required by **June 15, 2016.**

call for

*Golden Moments*

)))

In celebration of ABCT's 50th Anniversary, we are seeking "Golden Moments" from the ABCT membership. Small or large, silly or serious, please send your enduring memories. This can entail:

- your own personal golden moment
- a colleague or friend's golden moment
- a BT/CBT-related golden moment
- an ABCT-specific golden moment

The Golden Moments will be featured in the Oct. issue of *tBT*, on our website, and live at the 50th Annual Convention in NYC (Oct. 27-30).

Please send to ABCT in the form of text, image (jpeg, 300 dpi), or both to: **GoldenMoments@ABCT.org**  
**Deadline:** August 25, 2016

Examples:

"Being in awe every moment of my first ABCT meeting in 1985..." (Michelle Craske)

"Watching Art Freeman and Art Nezu compare ribbons..." (David Teisler)

"In 1979, ABCT, then AABT, offers first award, President's New Researcher, and Dianne Chambless is first recipient!" (M. J. Eimer)

*the Behavior Therapist*

Association for Behavioral  
and Cognitive Therapies

305 Seventh Avenue, 16th floor

New York, NY 10001-6008

212-647-1890 | [www.abct.org](http://www.abct.org)

ADDRESS SERVICE REQUESTED

PRSR STD  
U.S. POSTAGE  
**PAID**  
Hanover, PA  
Permit No. 4

## *What Do You Want?*

It's not completely open-ended, although you could tell us anything, if you really wanted. But we were hoping that you might take a few moments — really, that's all you'll need — to take the *tBT* survey and help us map out the future that you're touching right now. And, yes, I get the irony of sending you to the web to complete a survey about a paper newsletter; if that tickles your funny bone or really annoys you, send me a note at [teisler@abct.org](mailto:teisler@abct.org) (but after you do the survey online at [https://www.surveymonkey.com/r/tBT\\_Survey\\_2016](https://www.surveymonkey.com/r/tBT_Survey_2016)).

—DAVID TEISLER, CAE, *Director of Communications*

### About the *tBT* Survey

We're conducting a survey of members trying to gauge their interest in *tBT*. We'd like your thoughts. As a thank you, we'll enter you into a drawing for one of three webinars/webcasts. PLEASE TAKE THE SURVEY HERE: [https://www.surveymonkey.com/r/tBT\\_Survey\\_2016](https://www.surveymonkey.com/r/tBT_Survey_2016)