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Contents

PRESIDENT'S MESSAGE

Walgreens, Auto Mechanics, and the Arc of a Life

Jonathan S. Abramowitz, *University of North Carolina–Chapel Hill*

ALONG WITH MY (often feeble) attempt to keep up with the psychological literature, I try to read one popular press book each season. Last winter's reading was A *Chance in the World: An Orphan Boy, a Mysterious Past, and How He Found a Place Called Home*, by Steve Pemberton, the Chief Diversity Officer at Walgreens. The book chronicles Pemberton's upbringing in New Bedford, Massachusetts. Removed from an alcoholic mother at age 3, he bounced between foster families, survived dreadful physical abuse and neglect, and ultimately sought out and found his biological kinfolk.

At one point in his journey, Pemberton met a woman who appreciated both his plight and his promise, took him under her wing, and became a fixture in his life. She nurtured him and helped him uncover an inner strength and build self-assurance. Looking back, Pemberton reflected that "small acts of kindness can change the arc of a life."

Those eleven words have been swirling around in my head for several months now. The start of this new academic year, however, makes Pemberton's message especially pertinent for me as I reflect on the late Professor Silas White, who taught the first psychology class I ever attended at Muhlenberg College.

Introduction to Psychology had 40 to 45 students, which made it one of the larger classes at

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➔ **APPLICATION DEADLINE:** October 9, 2015

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.** 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.

'Berg. Yet Dr. White got to know each of us by name. Actually, he seemed to know everyone. He was a fixture on campus, having been teaching there for close to 20 years by the time I arrived in the fall of 1987. Unconventional and distinguished in his own way, he had quite a cheeky sense of humor—which I would later learn made him a rather controversial figure among his faculty peers. I'd often see him outside reading in the crisp fall sunlight or befriending and feeding the many squirrels that inhabit Muhlenberg's grounds in northeastern Pennsylvania. "Good morning, Mr. Abramowitz!" he would abruptly proclaim as I passed by (see Figure 1).

One late afternoon during my first semester I was in the psychology building and happened to comment to a friend that my car, a cast-off of my father's, was growling in misery and hiccupping smoke. Dr. White overheard this and immediately insisted that I trail him to a mechanic around the corner—a guy he knew personally. Once we got to the shop, I listened as he bargained on my behalf, insisting on the "friends and family" rate. Then he gave me a lift back to my dorm in his truck—but not before treating me to a sandwich and soda at his favorite delicatessen. A few days later my car was repaired, my credit card (well, my parents' card) was unscathed, and I had a life-lesson in human kindness.

At the time, that day hardly seemed life-altering. But looking back, it's fair to say that it indeed had an influence on my own "arc." Dr. White's interest in me led to my taking another psychology course with him. Before long, I was part of the psychology department family and I declared it as my major. During my 4 years at Muhlenberg I had my first experiences as a research assistant (I did social psychology and perception research) and as a teaching assistant for psychological statistics. I learned from amazing professors who piqued my interest in graduate school and gave me the nurturance and tools to succeed there and beyond. Thanks in no small part to Dr. White, I was off to the races!

Have small acts of kindness changed the arc of your life? This question, I believe, deserves reflection from all of us. And how do we recognize and appreciate the kind acts that we have been fortunate enough to receive? Sometimes, we get to acknowledge them immediately; in Pemberton's case, he was able to thank his surrogate mother, bringing her into his family and paying tribute to her in print as he shares his story. Often, though, we don't catch the magnitude of such acts in the moment, and it's only in retrospect that we're fully able to appreciate their significance. In my case, the acknowledgment and gratitude comes after Dr. White's death. As recipients of small but essential kindnesses, I believe we can honor the gifts we have received by extending the same to others—as clinicians, as teachers, as mentors, and as human beings. For one never knows when an arc will be changed.

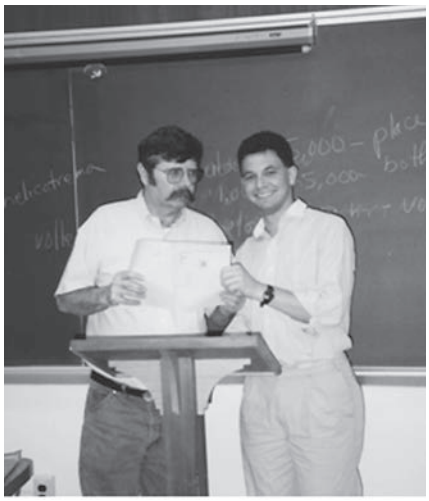

Figure 1. Me with Dr. White sometime between 1987 and 1991.

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The Uncertain Steps on the Certain Path to Progress: Some Guesses About the Future of Cognitive and Behavior Therapies

Todd E. Brown, Michael E. J. Reding, Bruce F. Chorpita,
University of California, Los Angeles

WE WERE RECENTLY INVITED to share our thoughts on emerging issues facing cognitive and behavior therapies for this issue of *the Behavior Therapist*. Ironically, a primary theme in our laboratory research for almost two decades has involved the very notion that many critical issues cannot be known in advance; hence our emphasis on collaborative design, structured flexibility, and real-time (vs. design time) control (e.g., Chorpita & Daleiden, 2014). Furthermore, an honest look back reminds us to be humble—one of us was old enough in the late 1990s to wager guesses about whether and how evidence-based practices would become the new norm. These guesses did not seem farfetched at the time but are now too embarrassingly wrong to revisit here.

That said, we nevertheless feel that there is at least some certainty that more big advances are in store, and even our humbling look backward reassures us of that. It is with that sentiment that we contemplate a few ideas that we feel could become ever more central to our collective conversation as members of ABCT. The following set of topics is not comprehensive, but rather a partial list of the issues our laboratory continues to believe represent the new frontiers we must continue to explore.

Some Developing Ideas

Design

For the past 20 years, an increasingly dominant theme in the field of cognitive and behavior therapies, and of health care practice in general, is that service providers must increasingly adopt and sustain the use of the best-supported interventions. This is particularly true in real-world settings where evidence-based practices (EBPs) are typically underutilized, undersupported, or underpowered even when delivered (e.g., Garland, Bickman, & Chorpita, 2010). Although systemic, organizational, and provider-level factors have been shown to influence the adoption of behavioral therapies (i.e., how to work with the perceptions and practices of providers and organizations to improve uptake of evidence-based approaches), we feel an emphasis on the design side of the equation is due. That is, treatment developers can play a critical role influencing the subsequent dissemination and implementation process through designs that a priori address many of providers' primary concerns and better match the challenging clinical and business contexts in which practice is expected to occur. For example, providers attempting to implement EBP have historically expressed concern that the available innovations are insufficient in meeting the needs of complex cases or diverse communities (e.g., Addis & Krasnow, 2000). To address such concerns, developers may need to increase focus on designing treatment (and training) models whose structure or content can be (a) adapted in real time during a treatment (or training) episode, and (b) updated to incorporate emerging empirical findings without lengthy development cycles.

Design-centered solutions. Design-centered solutions—including, but not limited to, instructional design, protocol design, and service system design—have been increasingly utilized to improve the process of dissemination and implementation. One example of a design-centered strategy in implementation is Weingardt's (2004) instructional design and technology (IDT) approach to training in manual-based therapies, which proposes user-friendly, web-based formats to actively engage providers in the learning process. Relatedly, Just in Time Teaching (JiTT; Novak, Patterson, Gavrin, Christian, & Forinash, 1999) is an instructional design approach that engages learners by allowing them to apply their existing knowledge of a topic just prior to formal instruction, simultaneously providing the instructor with an assessment of learners' incoming understanding of the material so that lessons can be targeted to address knowledge gaps. Such instructional approaches take advantage of recent advances in technology and can potentially enhance the EBP training process through improving the efficiency and utility of teaching as well as bolstering provider engagement during the learning process.

Modular treatment design (e.g., Chorpita, Daleiden, & Weisz, 2005) represents a similar effort to address stakeholder concerns about the flexibility of existing interventions by creating a framework to adjust the flexibility of practice content and sequencing to fit a particular context, with the idea that an intermediate level of flexibility can be identified that balances the application of the structured knowledge base with the reality of clinical uncertainty (e.g., emergent comorbidity; engagement challenges). As has been said elsewhere, these innovations are less about a specific new treatment than about the broader implications of designs that create a collaborative workspace that contains the structured guidance offered by the treatment developer while allowing substantial room for real-time decisions and adaptation in the face of local case-based evidence.

Design approaches can also be used to support the successful adoption and sustainment of existing treatment protocols. For example, Multisystemic therapy (MST; Henggeler & Borduin, 1990) uses a manualized consultation protocol (Schoenwald, 1998) and demonstrated that structured consultation positively impacts both provider adherence and youth treatment outcomes (Schoenwald, Sheidow, & Chapman, 2009). Similar to modular treatment protocols, modular supervision protocols can also be designed based on knowledge distilled from the literature on supervision and offered as resources for addressing provider concerns. For example, a lack of provider engagement in supervision could be addressed with supervisor guides on topics such as motivation and preparation of supervisees.

Treatments informed by feedback. Self-organizing, reflective systems and continuous quality improvement (CQI) infrastructures (e.g., Higa-McMillan, Powell, Daleiden, & Mueller, 2011) represent service system design approaches that promote an increasingly collaborative and self-correcting EBP implementation process. For example, the Contextualized Feedback Intervention and Training (CFIT; Bickman, Riemer, Breda, & Kelley, 2006) program is an evidence-based CQI system that

utilizes ongoing client progress to indicate opportunities for provider learning. Its common practice elements configuration allows the system to suggest individualized evidence-based interventions that are regularly updated to reflect the evolving evidence base. Such infrastructures provide alternatives to more traditional service arrays composed of set EBT menus, which can be costly, redundant, and/or limited in their coverage of client problems and characteristics (Chorpita, Bernstein, & Daleiden, 2011).

In addition to reflective system design, developers of cognitive and behavioral therapies also stand to benefit considerably from utilizing qualitative research to improve the quality of current innovations offered. Consistent with a CQI framework, qualitative research enacts a direct feedback loop between user and developer to identify chief provider concerns regarding EBP implementation and illuminate new pathways to improve existing innovations (e.g., Kazdin, 2008; Southam-Gerow & Dorsey, 2014). The rich, contextually laden data gathered from qualitative approaches allow for a more nuanced understanding of provider experiences, which should be of central concern to us as behavioral treatment developers seeking to maximize the applicability and impact of the interventions we create since their real-world impact is only as great as a provider's willingness to utilize it. The Revised Technology Acceptance Model (Wu & Wang, 2005) suggests that perceived usefulness, perceived ease of use, and compatibility with current practices are principal determinants of new technology adoption. As such, treatment developers must take the necessary steps to ensure that their innovations are optimized in terms of these factors. Simply designing, testing, and disseminating treatments is not enough; we may need to take the significant extra steps of engaging with providers to determine how to best facilitate their use of our treatments, and then redesign our treatments to address their concerns. Better yet, we should engage them initially and throughout the treatment development process rather than at simply its terminal stages. Although promising attempts to facilitate ongoing communication between providers and developers are well under way (e.g., practice research networks; Castonguay et al., 2010), we believe this objective is worthy of increased attention by the ABCT and broader evidence-based therapy communities.

Agility in treatment refinement. Although regular communication between providers and developers seems necessary for improved treatments, it may not be sufficient because we are currently hampered by an arduous development-testing-publishing-retesting cycle as we develop treatments. Although these decade-long cycles have always produced the most reliable knowledge, this pace has threatened the relevance of that knowledge in an era where we have instant access to new research and community practice data that would allow us to refine our treatments at a much faster rate. A shift towards a more rapid development cycle would allow us to reference these manuals as a starting point while allowing possible refinement to reflect the best information available to us. We can harness the strategies used in other fields to implement this approach. For instance, looking to the information technology field, the *agile software development* approach promotes fast turnaround time for the creation of new software products

by utilizing an evolutionary approach that allows for continuous improvement in a rapid and flexible manner. A similar approach could be implemented for the development and refinement of mental health treatments. This shift would undoubtedly be a considerable one, and careful considerations would be necessary to ensure that this process could produce results on par with those found from the traditional development cycle, but the ability to implement rapid refinements could quickly lead to treatments better suited for many. As a comparison, we can look to the shift from the use of encyclopedias to Wikipedia. Although Wikipedia is maligned for not having years of authoritative research behind its entries, its accessibility and ability to be readily modified and refined as new information comes to light has provided greater benefits to more people than encyclopedias ever had.

Technology

Technology continues to evolve and permeate our lives at a breathtaking pace, yet the possibilities enabled by such advances remain largely untapped in the behavioral health field. We owe it to ourselves and the community at large to embrace technology as a means to better the mental health landscape. Although some reluctance or resistance may arise around the use of modern technology as cold, impersonal, or dehumanizing, it can in fact elevate our abilities to explore and interact with others, just as the printed word enabled knowledge dissemination far beyond the reach of oral tradition. Technological tools and strategies are not meant to act as replacements or complements to our approach to behavior therapy; rather, the new technologies and the enduring ones should work synergistically, improving the utility of the technology and improving our abilities to perform. Several approaches towards this goal have begun to take shape, but these efforts must charge past proofs of concept and into full implementations if we are to remain committed to producing the greatest improvements in mental health.

Clinical dashboards. Clinical dashboards, or measurement feedback systems (MFSs), are tools used alongside clinical treatments in order to organize critical information, monitor progress, identify problems, and assist in the selection of treatment strategies (Bickman, 2008; Chorpita, Bernstein, Daleiden, & The Research Network on Youth Mental Health, 2008). Use of dashboards throughout treatment has been found to improve outcomes in both adult (Reese, Norsworthy, & Rowlands, 2009) and youth populations (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011); however, after nearly 15 years of research on these approaches, many of the substantive developments may still lie ahead. For example, although nearly all dashboards provide means to track current treatment progress, few provide context around how that data should be interpreted. Dashboards may need to move towards integrating benchmarks and expected values derived from existing knowledge bases, including client and health-care-population based, as well as the research literature. Including such information alongside observed treatment progress would help contextualize clinical decisions by providing additional information with which to make judgments.

Looking beyond the evidence bases, dashboards have room for ample improvements beyond mere benchmarks. Although simply highlighting "not on track" has been shown to improve outcomes (Lambert, Harmon, Slade, Whipple, & Hawkins, 2005), clinicians given specific feedback might have even greater abilities to better their clients' outcomes. In other words, dashboards could provide suggestions rather than simply providing an alert. Conversely and so as not to remove all sense of agency from a clinician's treatment planning, dashboards could provide more streamlined means for users to explore the data themselves, such as tapping into databases such as the PracticeWise Evidence Based Services database (PWEBS; see Chorpita et al., 2011). However, these features alone will provide only limited benefits unless paired with an increased focus on a critical but largely ignored feature of all dashboards: the user interface and user experience (UI/UX).

The realm of UI/UX has continued to make strides forward via studies in human-computer interaction and design, but dashboard and feedback system development in behavioral health has not placed a heavy focus on these aspects. Dashboards provide many opportunities for the betterment of behavior therapy outcomes and, indeed, real-time measurement. Observation is a core practice of behavioral and cognitive therapies, predating evidence-based manualized treatments by decades, and this technology thus is an opportunity for an efficient manifestation of the core values of CBT practice. However, unwieldy and disparate systems, potentially made even more complicated with the introduction of the previously discussed elements, may have limited uptake until a true dedication to UI/UX is introduced.

Literature mining. The multiple evidence bases discussed by Daleiden and Chorpita (2005) have their own unique challenges around the collection and eventual display of the associated data, but the empirical research evidence is an area of particular interest due to its peer-reviewed and vetted nature. Despite the relatively slow speed at which such evidence is introduced into the field, a vast amount of information is contained across these published manuscripts. However, for all intents and purposes, this information often remains invisible to our membership unless individuals encounter that specific article or discover it by utilizing just the right keyword search, discoveries that are often not temporally aligned with when we might actually need that information to guide a decision.

The process of consolidating and extracting data from published research may need to be improved if we are to increase the impact of cognitive and behavioral research. Meta-analysis and commissioned reviews can be used to chip away at this task, but automated approaches may soon outperform those traditions and may be necessary to make significant headway with an ever-expanding literature. Ontological translation efforts should begin in earnest to map disparate terminologies across studies (e.g., behavioral targets, DSM-5, Research Domain Criteria). These mappings may be obtained via qualitative tools and artificial intelligence strategies that can process full datastores of manuscripts and their associated data, leading to a common metadata structure that can be used to streamline the data exploration required for evidence-based practice and made easier via dashboards. These tools and strategies will require considerable effort to develop, but the undertaking can be made considerably less daunting via the use of interdisciplinary resources and teams, where artificial intelligence and "big data" experts from IT industries can be called upon to offer skills in areas where we have little-to-none. In the perfect world, the publication process would also entail placing a study's results into a central standardized database for all to explore, but absent that (and given the already large number of extant published manuscripts), an automated approach to processing the evidence may be of significant value if we

are to maintain and expand the link between research and practice.

Industries and Workforce

Another consideration involves not what is coming next, but who. Who will be the major parties involved in the collaborative enterprise of research, policy, and practice? For the past 20 years, the dominant practice information management strategy has been served by publishers, accelerated by a 20-year emphasis on manualized treatments. Training in best-supported practices has largely been performed by universities, or more specifically, by those researchers who have developed effective treatment approaches, often through conferences and workshops. More recently, there has been an emphasis on graduate training (Shoham et al., 2014), with an increasing number of graduate programs training in evidence-based approaches (e.g., Bertram, Charnin, Kerns, & Long, 2014)

One wonders whether that is sufficient to keep pace with the way treatment delivery may change as the field continues to industrialize. As a standard of comparison, few of us now purchase food from farmers or clothing from tailors, and yet the research-practice exchange often still necessitates direct encounters between those who produce and those who consume the research evidence base. It may be possible that industries will emerge that coordinate and deliver new discoveries about treatment can make this collaboration more efficient, much as online shopping (e.g., Amazon) has revolutionized retail, search engines (e.g., Google) have revolutionized discrete information retrieval, and digital media services (e.g., Netflix, iTunes) have revolutionized entertainment. Whether those functions are fulfilled by the current institutions adapting (e.g., universities, government) or new institutions emerging is an open question, but a massive increase in efficiency and scalability of knowledge application and management almost certainly will require an industrial leap of some kind.

The concerns around psychological workforce capacity represent one area where this leap seems necessary. The Patient Protection and Affordable Care Act (Patient Protection and Affordable Care Act [ACA], 2010) has significantly expanded insurance coverage to millions with behavioral health concerns but has done less to address the demand for receiving services. Indeed, regardless of the ACA's ultimate political fate, there is a large, unmet demand for additional providers to deliver treatment. This need could be met via the creation of a new training infrastructure built to harness psychology bachelor degree holders, who number 100,000 new graduates per year but who find a psychology-related job less than 7% of the time, partially due to the lack of career paths available to them (Becker, Chorpita, & Daleiden, 2014). By providing these graduates with greater behavioral and cognitive backgrounds along with the opportunities to apply such solutions, the mental health landscape may be better equipped to tackle the demand for its services.

Conclusion

It is only fitting that dissemination is this year's ABCT convention theme. Just as ABCT has been coming into its own with a focus shifting away from dysfunction and towards positive behavior, the association will no doubt also come into its own across the many opportunities discussed here. We sit in a golden age of acquisition and application of knowledge, and nothing but opportunity awaits us. Just as we ask "what's next," we can also answer and achieve. The future is what we make it.

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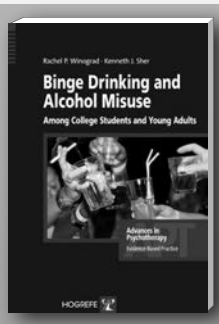

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ACCESS & EQUITY

Using Functional Analytic Psychotherapy to Improve Awareness and Connection in Racially Diverse Client-Therapist Dyads

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AS OF 2010, NON-HISPANIC WHITES comprised 63% of the U.S. population, yet the number of minority psychologists lingers under 25% (American Psychological Association [APA], 2010; U.S. Census Bureau, 2011). The limited data available on psychologist demographics is encouraging insofar as APA membership is shifting to include greater numbers of ethnic and racial minorities in its various membership categories. Even so, the rate at which ethnoracially diverse populations seek mental health services is outpacing the availability of minority psychologists. Ethnic and racial minorities are projected to exceed 57% of the population by 2060 as non-Hispanic White Americans become a minority over the next three decades (U.S. Census Bureau, 2012). As a result, ethnoracially diverse therapy dyads are increasingly common. This growth in diversity accelerates the need for ongoing scholarship, informed attitudes, and clinician competency for multicultural clinical training at parity with other important therapeutic skills.

Discrimination resulting from stigmatized minority status is associated with negative mental health outcomes, such as depression, anxiety, substance use, posttraumatic stress disorder, and overall psychological distress (Banks & Kohn-Wood, 2007; Blume, Lovato, Thyken, & Denny, 2012; Chae, Lincoln, & Jackson, 2011; Pieterse, Todd, Neville, & Carter, 2012). As a result, such experiences and the related psychological sequelae may require focused clinical attention (e.g., Williams, Gooden, & Davis, 2014). Additionally, research indicates that the adaptation of cognitive-behavioral therapies (CBT) for cultural competency may be superior to nonadapted CBT (Kohn, Oden, Munoz, Robinson, & Leavitt, 2002; Miranda et al., 2003). Thus, the mental health community is ethically bound to cultivate multicultural competency and continue investigating empirically supported treatments for diverse populations (Constantine, Miville, & Kindaichi, 2008; Ridley, 1985; Sue, Zane, Hall, & Berger, 2009).

This need is met with a host of challenges as many therapists are unprepared to address cultural issues due to inadequate multicultural education and/or social taboos surrounding racism, discrimination, and White privilege (Neville, Worthington, & Spanierman, 2001; Terwilliger,

Bach, Bryan, & Williams, 2013). There is currently no standardized training model for multicultural competency. Although a handful of scholars have devoted significant energy to measuring multicultural competency, training for therapists to engage clients of diverse racial, ethnic, and cultural backgrounds may remain inadequate (Worthington, Soth-McNett, & Moreno, 2007). One systematic review found that although multicultural training made clinicians feel more knowledgeable, there was poor evidence that patient outcomes were improved; furthermore, the vast majority of programs omitted the concepts of racism, bias, or discrimination from their content (Price et al., 2005).

Matching by racial group has been one approach used to serve ethnoracial minorities seeking mental health services. Proponents of matching point to an elevated perception of multicultural awareness, treatment retention, and client preference (Lee, Sutton, France, & Uhlemann, 1983; Meyer & Zane, 2013). However, matching may oversimplify both the client's and clinician's experience as it assumes a high degree of similarity in backgrounds, values, level of assimilation, religion, and language (Williams, Chasson, & Davis, 2015). It may also remove a critical opportunity for client and clinician to grow and connect as they learn to appreciate differences in cultural values and experiences. Although matching is preferred by most clients, alliance, skill, knowledge of client culture, ethnicity, and race appear to have a greater impact on positive therapeutic outcomes (Cabral & Smith, 2011). Most recently, Ibaraki and Hall (2014) examined ethnic matching, finding it functions as a proxy for shared culture, where common values and closely held beliefs influence the content minority clients discuss in therapy. This suggests therapeutic outcomes are linked to the clinician's ability to understand the client's perspective and cultural background (Flicker, Waldron, Turner, Brody, & Hops, 2008).

One risk in diverse dyads is unintentionally stigmatizing the client. Lack of insight about the client's cultural, racial, or ethnic identity might result in inadvertent microaggressions or other expressions of bias; this may alienate the client, threaten the therapeutic relationship, impede treatment progress, and increase risk of early dropout (Constantine, 2007; Sue, Capodilupo, Torino, & Bucceri, 2007). Additionally, when culturally normative behaviors are not considered in treatment, therapists risk misdiagnosing minority clients (Chapman, DeLapp, & Williams, 2014). Rather than adopting a color blind approach, which discourages the client from expressing their experiences as a racialized minority and exploring protective factors (Terwilliger et al., 2013), therapists can benefit the relationship by bringing this part of the client's experience into therapy. To do this effectively, therapists must first understand their own relationship to diverse groups and acknowledge race as a social power construct (Cardemill & Battle, 2003). By building on this attunement to social power and privilege, therapists can benefit from experiential learning to explore their own feelings, beliefs, and attitudes about race, ethnicity, and culture, to gain greater cross-racial understanding (Devereaux, 1991; Okech & Champe, 2008). In describing the experiential process of growth and change, McKinney (2006) found that "most of the turning

point experiences involved a White person first coming into sustained contact with persons of color." Similarly, cross-racial friendships have been found to enhance cross-racial therapeutic relationships (Okech & Champe). Taken together, this suggests experiential contact and closeness with diverse populations may expand clinical awareness.

Functional Analytic Psychotherapy

Functional analytic psychotherapy (FAP), an approach rooted in the contextual behavioral tradition (Hayes et al., 2012), focuses on the therapeutic relationship as the agent of change to improve the client's outside relationships (Tsai et al., 2009). It is similar to many CBT interventions because it focuses on concrete behavioral change and includes homework assignments, but it differs with respect to the amount of time and attention given to building a strong therapeutic relationship that serves as the primary vehicle for client change. A basic position of FAP is that the therapeutic relationship is a genuine human relationship. This relationship is powerful in promoting learning and change, fostering motivation, and keeping clients engaged in treatment and adherent to treatment plans.

FAP promotes increased awareness both in the client and the therapist. FAP therapists take interpersonal risks by experiencing, processing, and disclosing reactions to the client immediately as they occur in-session in the service of client growth and, in turn, encourage their clients to do the same. When the client engages in courageous self-expression in session, the therapist responds with genuine feedback to increase the connection through the exchange. This vulnerability and immediacy serves as a model to help the client improve connections with others, which is an important transdiagnostic outcome (Wetterneck & Hart, 2012). In this way, FAP provides a complement to peer systems' techniques such as psychoeducation, cognitive restructuring, behavioral experiments, and exposure.

FAP leverages five core principles, or rules, to conceptualize client behaviors, evaluate their functions, and conditionally change or reinforce behaviors through the interpersonal dynamics in the dyadic relationship (Tsai, Callaghan, & Kohlenberg, 2013; Tsai, McKelvie, Kohlenberg, & Kanter, 2014). These client behaviors are identified as clinically relevant behaviors, or CRBs (see Figure 1). Maladaptive CRBs (CRB1s) and adaptive CRBs (CRB2s) are identified collaboratively by both the therapist and client and analyzed for function at both the micro and macro level to broadly understand and effect change in the client (Tsai, Kohlenberg, Kanter, Holman, & Plummer Loudon, 2012). Similarly, therapist-relevant behaviors (TRBs) have a clinically relevant impact in treatment as well.

Recent FAP writings have discussed how the implementation of FAP's five behavioral rules may be supplemented with an understanding of awareness, courage, and therapeutic love towards clients (Tsai et al., 2009; Tsai et al., 2012). The first rule of FAP centers on awareness of how a client's CRBs appear in session and promotes self-awareness as well, including awareness of one's attitudes, biases, and assumptions about the client. The second rule is that clinicians evoke CRBs in therapy, and this may at times involve being courageous and vulnerable with clients. The third rule centers on being therapeutically loving to reinforce positive CRBs while challenging maladaptive CRBs. As behaviors are exhibited in-session, the fourth rule calls for the therapist to be aware of their impact on clients, both as a clinician and as a person. Finally, the fifth rule calls on the therapist to facilitate generalization of in-session client behavior changes to promote sustainable change in the client's life. FAP is particularly well-suited for culturally sensitive CBT and clinician growth because of its focus on the relationship as a primary change mechanism, and FAP is flexible enough to be used for analyzing the functions of behaviors in client-specific content across cultures and ethnicities (Vanderburghe, 2008).

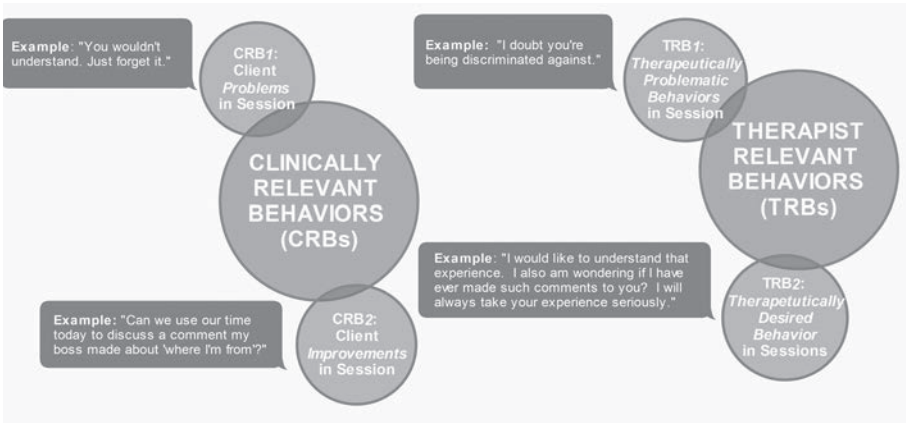

Figure 1. Clinically relevant behaviors

Common Therapist Problem Behaviors

All therapists stand to gain increased competency across treatment approaches, settings, goals, and client backgrounds using an authentic and culturally sensitive approach. Below we describe examples of common challenges therapists experience when working in racially and ethnically diverse therapist-client dyads and how they might be addressed using FAP interventions.

Discomfort Addressing Racial Differences With Clients

Race is one of the first features perceived when encountering a new person, yet despite the obvious differences in an unmatched dyad, many therapists are uncomfortable discussing race (Knox, 2007). FAP emphasizes the unique history of each client, and, for minority clients, ethnic and racial identity are an important part of this history that should be addressed early in treatment. Therapeutic awareness, acceptance, and exploration of discomfort related to racial differences in the service of client growth can be an important shift toward therapist growth that ultimately bolsters trust and connection with the client. Although it may be anxiety-provoking for therapists who have previously avoided such discussions to address racial differences, acknowledging diversity in the therapeutic relationship is likely to result in greater satisfaction and connection with minority clients, as it demonstrates cultural sensitivity (Neville, Tynes, & Utsey, 2009). Working to understand a client's potential struggles with identity, self-concept, and intersectionality may mediate feelings of

invisibility often reported by racial and ethnic minorities, and correspondingly, acknowledging cultural strengths, such as collectivism and racial pride, can promote resilience in the face of challenge (Franklin, 1999; Hays, 2009).

Failure to Understand White Privilege

As a culture, we are socialized not to acknowledge Whiteness and the power and unearned privilege it affords (Neville et al., 2001). As a result, therapists are often confused and uncomfortable with related topics, such as discrimination, racism, and stigmatized minority status. Acknowledging unearned privilege may provoke guilt, shame, and defensiveness. FAP, because it locates the source of this problem in our social context and not in the individual, allows therapists to increase awareness and exploration of White privilege and differential access to important reinforcers (e.g., money, education, promotions) as a result of differences in power and privilege. Deliberate self-disclosure of this status, when used in the service of client growth, may be linked to higher levels of trust and perceived sensitivity in ethnic minority clients and improvements in the quality of the therapeutic relationship (Constantine & Kwan, 2003; Tsai et al., 2009). Indeed, privilege and social group membership are inseparable components of the emergent therapeutic context (Terry, Bolling, Ruiz, & Brown, 2010). For a White therapist, admitting to a stigmatized minority client that the therapist has benefited from race in a way that the client has not, and to exhibit a willingness to change behaviors that maintain power and privilege (e.g., have a sliding fee scale, being open to learning more about indigenous therapies such as soul retrieval for Native Americans) exemplify a commitment to genuineness that can promote authenticity, growth, and connection.

Endorsing Stereotypical Beliefs About Clients

Because of pervasive negative social messages about ethnic and racial minorities, we tend to make automatic and inaccurate judgments about others based on pathological stereotypes, which in turn lead to microaggressions (Blair, Judd, & Fallman, 2004; Williams et al., 2012). Microaggressions committed by therapists have been demonstrated to be a significant predictor of dissatisfaction with the therapeutic experience (Constantine, 2007) and present significant barriers to FAP's fundamental and necessary intimate, trusting, and safe transactions that celebrate the client's expression of his/her full self as an ethnic and cultural being. It is helpful for therapists to acknowledge their own tendency to make unfair judgments and demonstrate a willingness to reject stereotypes. By being courageous enough to admit a lack of accurate knowledge about important cultural, racial, or ethnic topics, therapists can exhibit vulnerability and seek understanding with clients in a manner that will facilitate an open exchange of information. FAP's behavioral and interpersonal techniques allow therapists to admit they are not the authority on all topics, such as the minority experience. In this way, clinicians can begin to understand the client's daily life without relying on stereotypes and subsequently reducing the likelihood of committing harmful microaggressions.

It is not enough, however, just to admit a lack of cultural knowledge. It is important

to remediate these deficits by seeking information from sources other than clients, as ethnic minorities often report feeling weary of bearing the burden of educating others. Furthermore, in order to minimize stereotyping clients, it is important to maintain relentless emphasis on understanding the cultural context of CRBs and the adaptive functions of "problem" behaviors. For example, what may be seen as "dependence" and "enmeshment" by young Asian clients with their families can be understood within a cultural context of emphasis on interdependence and prioritizing family needs over individual needs (Sue & Sue, 2008).

Failure of Therapist to Continually Develop as an Instrument of Change

FAP emphasizes that a therapist's potency as a change agent can be increased by continually cultivating awareness of the impact of one's own history on potential biases. It may be helpful to explore individually or in consultation group questions such as the following:

What were your first experiences with feeling different?

What were you told about others who were ethnoracially different?

What were your earliest memories of race or color?

What stereotypes do you hold of pluralistic populations?

What are your experiences as a person having or not having power in relation to race or class?

What steps can you take to learn more about your clients' cultural backgrounds?

What are your preferred therapeutic methods that may not be culturally attuned or adequate?

How might you be inadvertently repeating negative or oppressive interactions representing the dominant culture with clients?

How can you make use of therapeutic "mistakes" or microaggressions in ways that increase therapeutic alliance?

What is difficult for you to address regarding race, culture, or other differences you have with your clients?

Table 1 lists a few examples of common therapist issues surrounding race, ethnicity, and culture (Daily Life Problems), how the problem might look in a therapeutic relationship (TRB1), and one way that a therapist might overcome the problem from a FAP perspective (TRB2).

Conclusion

As the scholar-clinician community seeks to improve quality of care for everyone, it is imperative that we acknowledge the importance of multicultural knowledge and skills. This includes an appreciation of other psychological perspectives, such as Afrocentric research, which is often viewed critically rather than with respect (Delapp & Williams, 2015). Future scholarship should build on preliminary work to enhance and measure therapist competence in diverse dyads (Constantine, 2008;

Table 1. **Therapist-Relevant Behaviors**

Daily Life Therapist Problem	Problem Behavior (TRB1)	Goal Behavior (TRB2)
White therapist experiences anxiety, agitation, and confusion in response to racially provocative material.	Referring a minority client to another therapist of their same ethnic background.	Expressing the feelings openly with client and also recognizing own potential bias or lack of understanding.
Belief that discussing racial issues beyond a superficial level is a taboo.	Avoiding topics about race or culture and redirecting to a different topic when it is culturally sensitive.	Asking the client if the difference in race is something they would like to discuss, while recognizing that it might be uncomfortable.
White therapist denying benefits experienced from Whiteness because therapist has not previously considered this.	Denying or invalidating client when this topic or problem arises.	Acknowledging the unfair and unearned benefits of being White and validating client if the topic arises.
White therapist ashamed of his/her own ignorance on cultural topics.	Avoiding topics related to race in order to hide own shame.	Expressing feelings openly and asking the client if/how they would like to address the topic. Taking steps to learn more about applicable cultural topics.
Therapist generalizing norms of racial minorities based upon assumptions and research/statistics.	Making assumptions in session about problems and not allowing client to explain problems in his or her own words.	Exploring problems with an open mind and allowing client to express how he or she faces problems associated with race.
Latino male therapist feeling shame about his cultural heritage.	Being too deferential to White clients due to feelings of inferiority.	Acknowledging therapist may have biases due to learning history and being aware and appropriately assertive in session.
Black female therapist with dark skin believes that fairer skinned Black women are arrogant and want to be White.	Hostility toward fair-skinned Black female clients.	Asking client about her experiences as a fair-skinned Black woman, and recognizing her own biases.

Drinane, Owen, Adelson, & Rodolfa, 2014). Such investigations may reveal where cultural competency constructs diverge from general clinician competency, allowing training to better prepare clinicians to work with diverse populations.

Furthermore, many training programs may benefit from a format that is curriculum-integrated and experiential. To answer the need for culturally adapted CBT, we propose FAP for its integrative principles of awareness, courage, and love. Future research should investigate the use of such skills, including clinician self-awareness, immediacy, and connection relative to therapeutic outcomes within mismatched racial dyads. Remembering that training is a lifelong exercise for therapists, FAP provides the additional benefit of ongoing therapist self-discovery and growth (Tsai et al., 2009). In a nation built on fused genealogies and cultures, it is imperative that we advance an understanding and application of skills to enhance treatment utilization, reduce premature dropout, and promote culturally informed change. Every client is a microculture, carrying deeply rooted cultural, social, generational, and reinforcement histories. The building blocks of inclusion, racial equity, social justice and prosocial change can begin within the therapeutic alliance (Vandenberghe et al., 2010).

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Behind the Scenes of Clinical Research: Lessons From a Mindfulness Intervention With Student-Athletes

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INTERVENTION STUDIES ARE IN NO SHORT supply. Researchers are routinely piloting new ideas, applying existing protocols to understudied or unique populations, and working to amass evidence for (or against) a given theoretical orientation. Several frameworks offer guidelines for developing interventions, which include identifying or developing a theoretical framework, determining sample size, creating recruiting strategies, estimating cost, and piloting the intervention (e.g., Craig et al., 2008). But what makes an intervention successful beyond achieving the desired change in human behavior? What details increase participant engagement, reduce attrition, and maximize adherence to a protocol? In this paper, we critically examine a mindfulness intervention study that we conducted with student-athletes. Our hope is that disseminating this information will encourage best practices to maximize intervention implementation.

Study Overview

To orient the reader, we first provide an overview of the study (for full paper, see Goodman, Kashdan, Mallard, & Schumann, 2014). One men's and one women's NCAA Division I athletic team from the same sport participated in a brief mindfulness intervention.[1] The teams separately attended eight 90-minute group sessions over a span of 5 weeks. Two practitioners administered the Mindfulness-Acceptance-Commitment (MAC; Gardner & Moore, 2007), a mindfulness-based program designed for athletes. This intervention is rooted in Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), in which the central aim is to help people observe their thoughts, feelings, sensations, and memories as they exist (without unhelpful attachments), while engaged in value-congruent behavior. Participants are taught foundational principles through lecture, discussion in pairs and larger groups, and experiential exercises. The goal is for athletes to learn how to flexibly attend to, react to, and accept internal and external experiences as they unfold. Athletes are shown how to draw connections between how they respond to stimuli and their athletic performance. Below, we critically examine what worked well and what fell short in our intervention. To improve the design and implementation of interventions, we offer three specific suggestions for researchers and practitioners.

1. Know Your Participants

Before diving into an intervention, get to know the group or groups that will be participating. In our study, the groups were two teams of student-athletes at a large, athletically competitive Division I university. This population was unique in several ways. For one, research suggests that student-athletes tend to be more stressed and at greater risk for emotional and behavioral difficulties than their nonathlete peers (Proctor & Boan-Lenzo, 2010). Student-athletes are typically on tight schedules packed with athletic practice and training, games, schoolwork, romantic relationships, social lives, and, for some, parenting. On top of juggling these obligations, participation in the intervention required an additional 90 minutes twice per week to learn complex material. We were given the task of engaging busy, often exhausted student-athletes with unfamiliar psychological concepts to approach their lives differently. We strategically chose student-athletes for these reasons, as they are an ideal group that could benefit from this type of intervention. It is worth noting that although team coaches and athletic staff did not require student attendance, and the frequency and quality of student participation was kept confidential, most athletes attended every session.

Another unique feature of working with athletes is that they are accustomed to intense physical exercise. Student athletes may prefer to learn through active experiential exercises rather than passive, lecture-based instruction (Groves, Bowd, & Smith, 2010). In our study, the most commonly cited feedback was boredom. For example, one participant suggested, "More hands-on activities for the players to do so we can stay engaged."[2] Concepts introduced in mental health interventions can be difficult to understand, particularly for people with little to no prior familiarity. Ideas need to be broken down concisely, slowly, and in a way that is interesting to the audience. This includes a reliance on storytelling and the intentional collection of examples from their lives to help illustrate points. The student-athletes we worked with wanted more experiential exercises to apply the concepts, especially in relation to their sport. When working with athletes, practitioners should tailor intervention-related stories, metaphors, and exercises to athletes' propensity towards physical movement.

In addition to the qualities of participants, the arrangement of the group can also impact the effects of an intervention. Participating as an entire group (e.g., team, organization, company) will yield a different environment than participating individually or with a subset of others. Teamwork and group cohesiveness can be facilitated by learning, discussing, and practicing new concepts as a team. The MAC intervention protocol we used builds in discussions about individual and team values. These discussions encourage self-disclosure, which can increase feelings of closeness and strengthen teammate relationships. In the written feedback following our intervention, some players wrote the presence of the "team" or "teammates" in their response to what they found most helpful.

In this intervention, we quickly learned that the men's and women's teams had starkly different team dynamics; it would be a mistake to conclude that athletes from the same sport are a homogeneous group that should be treated in a homogeneous manner. The women's team consisted of primarily freshmen and sophomores and had just hired a new coach 2 months prior to the intervention, whereas the men's team consisted of primarily juniors and seniors. Thus, players on the men's team

[1]For confidentiality reasons, we chose to not identify which sport the teams played.

[2]All quotations provided in this paper are direct quotes from intervention participants.

had more time (and more athletic seasons) to connect and get to know one another. These objective differences were indicators of more important subjective differences—the men's team displayed more team chemistry and trust in one another than the women's team. We want to highlight these discoveries about our sample as these characteristics run counter to the "average scores" in prior studies on sex differences (e.g., Haselhuhn et al., 2015) and existing psychological theories (e.g., Cross & Mason, 1997). Unfortunately, our assessment of group characteristics is based on subjective observations that were not measured, which speaks to our next point—measure what matters.

2. Measure What Matters

It was clear to the practitioners at the start of the intervention that the men's and women's teams had different group dynamics, but we (the researchers) did not capture this in our measurements. Our assessment protocol was limited to individual functioning, independent of team dynamics and functioning. To offer anecdotal evidence, the practitioners described the men's team as full of vitality.[3] They said male athletes would arrive at each session talking, laughing, and displaying a lighthearted attitude towards one another. In contrast, the women often came in silent, alone despite proximity to teammates. During group exercises, practitioners said that athletes from the men's team actively engaged in group discussions and seemed more willing to trust one another by sharing personal experiences. Players from the women's team, in contrast, were hesitant to share information and often disengaged during group discussions. These dynamics likely impacted the effectiveness of the intervention, but because we did not measure the constructs being mentioned here, we cannot pronounce this with any degree of certainty. This does offer an opportunity for the next set of researchers and practitioners to test the validity of these research questions.

Following the intervention, players from the men's team reported greater mindfulness, greater goal-directed energy, and less perceived stress following the intervention. Players from the women's team, in contrast, reported no significant increases on any measured areas. We realize that the general response to null findings is to render them noninterpretable. In the past few years there has been a cultural shift in this view, with entire journals dedicated to the potential utility of findings that fail to reach the somewhat arbitrary statistical thresholds of $p < .05$ (e.g., *Journal of Articles in Support of the Null Hypothesis*). In the context of intervention studies, nonsignificant results offer a fine-grained understanding of what worked and did not, what participants understood clearly and less clearly in the assessment battery, and alternative explanations worthy of further consideration and possible exploration be in future studies.

3. Obtain Qualitative Feedback

One strategy to learn what worked during an intervention is to directly ask participants. In our study, participants anonymously responded to two open-ended questions at the conclusion of the program: "What part of this training do you think will help you most with your athletic performance?" and "What feedback, if any, would you like to offer the instructors?" Participants completed these questions in less than 10 minutes and much insight was gained from their responses.

Qualitative feedback is informative for practitioners, researchers, and participants. For practitioners, receiving feedback about what they could do differently (e.g., "More hands-on activities for the players to do so we can stay engaged") can improve their delivery of the intervention. A single dose of feedback can tailor group leaders' communication style and administration of intervention content. For researchers, written feedback offers an often-overlooked glimpse into the participant experience. Sometimes, only a slight modification to the protocol is needed to enhance participant engagement or learning (e.g., "Maybe more videos on particular studies done of different mindfulness practices"). For participants, reflecting on their experience can reinforce concepts they learned during the program. We asked participants in our study to describe how they could apply concepts to enhance their athletic performance. One participant responded with, "I think that the meditation and refocusing will keep improving my performance. A big part of why I may not perform as well as I want to is that I am beating myself up or anxious. Just accepting the anxiety and refocusing to the task at hand and being confident in my abilities." Self-report Likert scale questions cannot capture this valuable information.

Gathering written feedback is one of many strategies for conducting process evaluations, a technique that explores how an intervention is implemented (by the provider) and received (in terms of how participants view the treatment, the provider, and any interpersonal relationships). Other strategies include surveys, focus groups, interviews, and structured field notes (Oakley et al., 2006). Deciding which strategy to use is partly contingent on available resources (e.g., time, money). When resources are sparse, informal written feedback is an efficient, cost-effective option. These types of evaluation methods generate a more detailed understanding of how an intervention worked and what components of the intervention were most effective, not just whether or not participants reported improvement in measured outcomes.

Concluding Thoughts

Applying psychological science means navigating the complexities of bringing science from academic journals to real people. This process can be messy, and the details that improve success are often left out of formal summaries. No intervention is without challenges, mistakes, or flaws. Even strong methodical designs in clinical trials suffer from participant disengagement and/or attrition.

The goal of this paper was to provide a candid assessment of one intervention in hopes of initiating a conversation about how to improve the delivery of interventions. It was inspired by information gleaned from conversations with colleagues about what practices they engage in to maximize attendance, minimize attrition, and maintain high energy levels during sessions. Often we learned of researchers who offered free breakfast at sessions to increase attendance at Sunday-morning sessions, or played uplifting music in the waiting room. To our surprise, when we read the method sections of articles written by these same researchers, none of these useful tactics or strategies could be found. We believe in the value of sharing everything that is helpful and unhelpful to allow for proper replications and, more important, the pursuit of best practices. We echo sentiments of the evidence-based practice movement—"flexibility within fidelity" (e.g., Hamilton, Kendall, Gosch, Furr, & Sood, 2008). That is, researchers and intervention facilitators can adhere to their protocol while flexibly

[3]Each practitioner debriefed with a member of the research team.

attending to the needs of a particular group or individual.

Of course, our study is only one of many interventions, so caution is warranted in drawing firm conclusions from our interpretations. Our hope is that researchers and practitioners will apply lessons learned through this study and critically examine their own programs to maximize their chances of delivering effective interventions.

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CLINICAL TRAINING UPDATE

Creating Publishable Writing Assignments in Clinical Psychology Graduate Courses: A DBT Seminar Reviews the Treatment Outcome Literature

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FACULTY MEMBERS DESIGN clinical psychology graduate courses with multiple goals in mind, including increasing content knowledge, providing structured opportunities for self-reflection, and teaching generalizable skills. Naturally, the balance of these goals varies by course and program model. For the fall semester of 2010, I (DP) was tasked with designing a new psychotherapy course—in dialectical behavior therapy (DBT), a highly evidence-based treatment for borderline personality disorder (BPD) and other emotion-regulation problems—for the clinical psychology doctoral students at Suffolk University, a scientist-practitioner model doctoral (Ph.D.) program in Boston. This seemed like a plum course preparation, as I completed my graduate training at the University of Washington, where I served on Marsha Linehan's DBT treatment team for 2 years. Teaching about DBT was an exciting prospect.

Based on program resources and the elective structure of the curriculum, the course needed to include second- and third-year doctoral students and was solely classroom based, with no clinical practicum component. As the course began, some students were engaging in their first ever clinical experience, while others had moved onto their second; thus, this group of students did not have much clinical experience at all, let alone exposure to DBT. The design of the course fell squarely into the scientist-practitioner tradition: class time and reading assignments focused more strongly on the elements most relevant to the clinical *practice* of DBT (the "how to" and "how come"), and the major writing assignment of the course (the topic of this *tBT* paper) focused on clinical *research* about DBT. In class, students learned about the history, basic principles, biosocial model, modes and functions, and scientific foundations of DBT (Linehan, 1993a; Linehan, 1993b), delving as needed into more general topics in CBT (e.g., Dobson, 2009), such as case conceptualization, functional analysis, and behavioral intervention methods, including traditional CBT skills such as contingency management, exposure, etc. Students practiced mindfulness in class and, outside of class, kept weekly diary cards (as DBT clients do) and engaged in various behavior change experiments throughout the semester, all based on DBT principles and skills. While this was all happening in the classroom, the stu-

dents were working together on group projects primarily outside of class.

It was challenging to select a writing assignment for this course. What was clear from the outset was that the primary goal would be to synthesize knowledge about some aspect of the DBT treatment outcome literature. Through iterations, I developed the eventual assignment after a good deal of literature searching, to determine what kind of original research the students could be asked to complete that would be both helpful to their educations and helpful to the field. In groups, students would perform detailed literature reviews and write systematic review papers (SRPs) that summarized and evaluated the state of the treatment literature on "nonstandard" formulations of DBT. There is no question that "standard DBT" has strong data as an intensive outpatient treatment for individuals who meet criteria for BPD (e.g., Lynch, Trost, Salsman, & Linehan, 2007), as well as those who meet criteria for BPD and comorbid substance dependence (e.g., Dimeff & Linehan, 2008). However, we also know that individual DBT and DBT skills training have been implemented (together and separately) for a variety of clinical populations that do not meet criteria for BPD, and in settings other than the traditional outpatient clinic. I imagined that having students review those parts of the literature would be interesting to them and, frankly, that it would be interesting to me to see the results of their work; there were significant knowledge gaps in the field with direct applicability to nonstandard DBT programs running all over the U.S. I came up with the idea of SRPs because I had co-authored several SRPs and meta-analyses as a graduate student, and found them to be an excellent way to gain deep knowledge about a subject, not only investigating extant findings but also systematically and critically evaluating the research methods that produced those findings.

Assigning an SRP seemed like an ideal way for the class to learn about the forms of DBT that they would be likely to encounter in their training, and to give them a structured opportunity to investigate the empirical basis for those versions of DBT—as well as to gain experience engaging in a collaborative scientific writing process. I thought that would be a novel experience for many of the students—especially those who had not yet engaged in writing projects within their research labs—and that it would provide strong ecological validity to the process of scientific writing postgraduate school. Graduate school research milestones are typically mentored individual work; what was called for in this assignment was working as part of a team, negotiating and delegating roles and tasks, and writing and editing collaboratively. Those latter skills are drawn upon frequently as part of the academic writing process.

The Course Itself

The students were sent the syllabus prior to the start of the semester—with a reading assignment due for the first day, naturally—which included a brief introduction to the assignment (if any readers would like a copy of the syllabus or any course materials, just write and ask: david.pantalone@umb.edu). On the first day of class, we reviewed the SRP assignment in detail. The assignment was divided into four stages, with deadlines interspersed throughout the semester. The 18 enrolled students were randomly assigned to six teams of three (names literally picked out of a hat) and were expected to work together through each stage of the assignment to produce a complete, full-length SRP by the end of the semester. Each team was given time to come to consensus on their rank-ordered list of the six potential SRP topics provided. The universe of possible topics, determined by a thorough literature review conducted by the instructor, included: DBT for mood disorders; DBT for eating disorders; DBT for children/adolescents and their families; DBT for substance use disorders; DBT delivered in inpatient settings; and DBT skills training only.

Each team was required to submit their topic preferences to the instructor at the end of the first class, and the instructor communicated topic assignments before the second class meeting. Randomly grouping students yielded teams diverse in terms of year in the program (second or third), research area (e.g., GAD, self-harm, neuropsychology), population of interest (child vs. adult), publication experience, and clinical experience (some vs. none). Given this diversity, some students and some teams were inevitably more enthusiastic than others about the assignment overall and about their assigned topic specifically.

As an introduction to the goals of the course and the review paper assignment, I provided detailed background information for the students about the process of writing an SRP. We discussed the pros and cons of SRPs, and how they can be useful to a field. In class, I shared relevant articles on the topic (Bem, 1995; Cooper, 2003), as well as example SRPs that I had co-authored. I walked them through two example SRPs on which I had served as a co-author, and highlighted how the amount and type of literature that we encountered led our author teams to make different choices about the aims/scope of the paper, the inclusion/exclusion criteria, and, thus, what to report in tables and figures.

With topics in hand, and equipped with a basic sense of how to complete an SRP, students began working on the first stage of the assignment. Within the first several weeks, each team conducted an initial literature review on their assigned topic. This involved identifying relevant databases, determining and refining their topic-specific search terms, conducting the searches, and compiling a comprehensive list of citations and abstracts of all articles that may be relevant for inclusion. The instructor provided feedback on this document and the potential articles for inclusion. In tandem with feedback from the course instructor, each team engaged in an iterative process of establishing and refining the scope and inclusion/exclusion criteria for their reviews. Once the team finalized the list of articles to be included, they set to work on obtaining the full-text articles and determining column headers for their tables (e.g., setting, sample, intervention, outcome measures, results). After collaboratively deciding on the table contents, team members began extracting relevant data from each of their identified articles and developed coding systems to measure and ensure reliability.

A detailed methods section and all tables were due to the instructor mid-semester, which comprised the second stage of the assignment, and on which the students received detailed written feedback. Stage three of the assignment was when the students turned in their completed papers at the end of the semester. Full-length papers (<4,000 words/body) were required to be formatted correctly in APA style and included all sections: Abstract, Introduction, Methods, Results, Discussion, References, and Tables. The expectation was that final course papers would be, as much as possible given the time constraints, the kind of review papers that could be submitted for peer review at a scientific journal. For the fourth and final stage of the assignment, students shared their findings with their classmates; each team was allotted 20 minutes in the final class meeting to present their SRP findings

and take questions from their classmates. This final presentation allowed teams to learn about the findings of the other SRPs and gave students the chance to reflect on their own projects and process their experiences with the assignment.

What Happened Next?

At the end of the course, each group was offered the option of attempting to pursue publication in a peer-reviewed journal. I oriented the groups to the reality that, despite their high-quality work to date, there would be significantly more work ahead of them to revise their course papers into publishable quality. For example, groups would need to follow the published SRP guidelines (PRISMA; Liberati et al., 2009) and increase their focus on evaluating the methodologic rigor of the reviewed studies, possibly including a table of the methodological elements present in each study. Of the six groups, two groups immediately declined further work on their papers; the DBT for substance abuse group and the DBT for mood disorders groups did not uncover enough studies through their literature reviews to warrant standalone publications at that time. The remaining four groups continued to meet together, both with and without the instructor, to make manuscript revisions over the year following the end of the course. One of the four groups that initially decided to pursue publication later reversed their decision; the group focused on DBT for children/adolescents and their families was scooped by the publication of a highly similar review (Groves, Backer, van den Bosch, & Miller, 2012). This group initially discussed the possibility of turning their work into a meta-analysis, but the data were not well-suited to such a change because of the heterogeneity of disorder groups and outcomes.

Deciding to continue manuscript revisions, the three remaining groups negotiated authorship order and tasks. For many of the students, this was their first experience in collaborative scientific writing. During the authorship order negotiation process, some group members chose not to contribute significantly to the revisions, and the authorship order reflected that their contributions were primarily to the course paper (all authors approved each version submitted to journals, though, of course). Others asked for smaller roles because of time constraints or lack of strong interest in the review paper topic, and thus participated minimally in the publication process. Of note, the submission, revision, and publication process varied greatly across the three groups. All three papers were originally submitted within 8 months of course completion (i.e., by the summer following the fall semester course); two papers initially received revise and resubmit dispositions and one, the DBT for eating disorders paper, was accepted with minimal revisions (Bankoff, Forbes, Karpel, & Pantalone, 2012). The paper on DBT in inpatient settings (Bloom, Woodward, Susmaras, & Pantalone, 2012) was accepted at the first journal, *Psychiatric Services*, after two rounds of editorial review. The paper on DBT skills training initially garnered mixed reviews at a very strong journal and was given a resubmission disposition. However, after the students took an extension and gave the manuscript a major overhaul, it was desk rejected by the editor without additional reviewer input—which was a strong blow to these junior authors. The editor's feedback was that a meta-analysis was needed because of the number of studies reviewed. However, meta-analysis was not feasible for this group, either; the nature of the clinical populations and outcomes across published articles represented such a wide range of populations and outcomes that they could not be meaningfully combined, as would be needed for a quantitative review.

After the rejection, the DBT skills training group again met to renegotiate order of authorship and division of tasks. At this stage, we added an additional author (SMB) who was experienced with DBT and the SRP process (given her role as first author on the already-accepted DBT for eating disorders manuscript) to fully address the extensive feedback from the journal reviewers. In response to the previous reviewer feedback, and in preparation for submitting to a new journal, members of the DBT skills training group were tasked with updating the literature review with articles that had been published since the previous submission since, at this point, the original search had been conducted nearly 2 years earlier. Note that one of the stressful features of SRPs is that they can become outdated quickly. The authors identified several more studies meeting their inclusion criteria and, actually, the findings of this paper changed dramatically with those additions. Also, because there was not uniformity in the way that samples were characterized, treatments were implemented, or that outcomes were measured, the DBT skills training paper authors took the additional step of contacting the first authors of each article to gather additional information. This group also provided an additional framework to organize their findings and evaluate the scientific rigor of each of the reviewed studies (Rounsaville, Carroll, & Onken, 2001), given that most of the articles included were from pilot or other early-stage study designs. Taking all of these steps yielded a significantly revised SRP that was accepted in 2014 and published in 2015 at the *Journal of Clinical Psychology* (Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2015).

Lessons Learned

Research

Through their participation in this assignment, students enrolled in the DBT course reported that they grew a great deal as graduate student researchers. For many students, this was their first experience engaging in a collaborative writing process with the goal of producing a manuscript for review at a peer-reviewed journal. For students with prior publication experience (SMB and SEV), this was a valuable exercise in collaborating with co-authors with different levels of experience and subdisciplinary focus and, in some cases, served as an opportunity to provide peer mentorship to students with less such experience. This was also the first foray for many students into conducting and writing an SRP. In addition to the instructor's primary objective of having students learn how to synthesize the DBT treatment outcome literature, students valued the professional development experiences gained through co-authoring a manuscript, such as negotiating with co-authors and collaborating about authorship, research/writing tasks, and manuscript preparation. For most students, as is evidenced by the fact that 50% of the papers produced in this course were ultimately accepted for publication, the possibility of achieving a publishable product provided strong motivation (both during the semester and beyond) to dedicate the time and effort necessary to produce high-quality papers—that is, a higher degree of time and effort than might be afforded an ordinary course paper, in which publication is not typically an end goal.

Students also learned about the process of writing an SRP and of reviewing treatment outcome research. Though journals varied in the degree to which authors were expected to adhere to these criteria, all three of the articles eventually accepted for

publication were required to follow, to some extent, the PRISMA guidelines (Liberati et al., 2009). Adherence to these guidelines gave students a structure for systematically assessing, presenting, and comparing the methodological rigor of the studies they reviewed in their papers. This project also fostered a deeper understanding of DBT treatment and treatment outcome research more generally, by requiring students to synthesize and compare the treatment protocols reviewed to standard DBT and to each other. Many of the teams found that randomized controlled trials (RCTs) were rare in their topic areas; as such, students were introduced to Rounsaville's (2001) stage model of behavioral therapy research to assist in critically evaluating relevant studies, based on what relevant studies existed and what kinds of studies were still needed. This approach also introduced students to gaps in the current scientific literature pertaining to implementation of evidence-based treatments initially designed to address specific disorders in specific populations, to their broader application in real-world settings.

Clinical

Presentation of these SRPs during the final class session yielded rich discussion of the clinical application of findings. For example, students discussed evidence-based practice, and how pragmatic adaptations to empirically supported treatments may or may not reflect the format of interventions conducted in RCTs. By the end of the semester, all students had completed at least 3 months of clinical practicum, and were able to reflect on the science-practice gap they observed in their clinical training placements. Students described their own adaptations to empirically supported treatments in practice. A few students reflected on their exposure to or use of components of DBT in their clinical practicum work (e.g., DBT-style psychoeducation and skills group, use of skills handouts, use of a behavioral chain analysis to specify problem behaviors). Of note, none of the students yet had exposure to standard DBT in their clinical placements, indicating the clinical importance of several of the SRP topics.

Teaching

From the instructor perspective, this experience was a rich and fulfilling one. Before I taught the course, I consulted with colleagues about the assignment. Many discouraged me from pursuing it (very reasonably, I might add). However, I am glad that I persisted (it could have been disastrous). I learned that it is, indeed, possible to mentor graduate students to produce the seeds of publishable manuscripts during a semester-long course, although it entailed significant effort both before (in terms of planning the topics) and after; the many emails, meetings, and drafts to review took a great deal of time. I had a reduced teaching load the following semester and, thus, had more time than usual to spend mentoring the students through the process. I doubt that this endeavor would have been possible if I had not already had a strong knowledge of DBT and SRPs, and connections to other DBT psychologists from whom we sought consultation. The doctoral students were all talented academically, which was helpful. Finally, the topic was one that held broad appeal for the more clinically oriented as well as the more scientifically oriented students in the course, which I think also contributed to the assignment's success. I have not had the opportunity to teach the seminar again and, frankly, I am not certain what I would do for a writing assignment in a future iteration. If the readers have any ideas, please feel free to send them along!

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How to Establish Yourself as a Burgeoning Psychological Practitioner, Researcher, and Teacher in Today's Political World

Marsha M. Linehan, *University of Washington*

Step 1

Decide you are going to succeed and are going to establish yourself as a psychologist practitioner, educator, researcher, or all three. Deciding to succeed is a lot more important than wanting to succeed. All of us want things at times that we never succeed in getting, primarily because we either never put in the effort or because we did but at some point gave up. So, first decide what you are going to succeed at. This of course is not easy and the road to success is very different for those wanting to be therapists than for those wanting to be researchers and both are different from those wanting to be teachers. Get as much experience as you can in the areas you think you are interested in and be prepared to work hard in making it in the area you finally decide on. Do not force yourself to stay with the career you decided on first if you find that you really don't like it or you find you just don't have the talent for that career. Search for your passion, for work you love, until you find it. Be open to finding the career that fits you to a T.

Step 2

If you are a tulip in a rose garden do not try to be a rose, look for a tulip garden. This problem comes up most often when people think they should be scientists when they really want to be therapists or their heart is in teaching. My typical statement is that no scientist would be a scientist if she or he could be otherwise. That is, science is a LOT of work and there is not that much happiness in it unless you are existentially unable to do otherwise. That is, you love doing science. Troubles can also come up when you think you should be a shockingly fabulous therapist or teacher and you just aren't. As my father always said, do what you are good at and you will be happy. As a psychologist you can see right away why this would be true. The better we are at something the more we are reinforced and the more we are reinforced the happier we tend to be. Remind yourself that you can be good at more than one thing, so look for skill and interest.

The best of all possible worlds, of course, is to love all three and be good at clinical work, research, and teaching. This is a gift at times and a curse at other times. You will get to do most all of the things you love—that is the gift. On the other hand, if this is your garden, you will need to develop an inner toughness, make sure you have validating friends, and be prepared for invalidation. Community clinicians will likely write off your "ivory tower" clinical skills and the so-called "real" scientists who do the hard science may not see you as a real scientist. If you throw yourself into research, politicians, parents, and sometimes your students may think you are putting your own desire to do research, to publish instead of perish, or make a name for yourself above educating the next generation. Woe be you.

Step 3

Be strategic when necessary to get what you want. An example of the need for this is when I was turned down for tenure at the University of Washington by the college council who said I should be in the psychiatry department because I was not a real scientist. So how did I get tenure? First, I went around to faculty and told each faculty member what had happened and asked if they could give me advice on how I should respond. I did not ask faculty to help me but instead did my best to portray the entire problem as a departmental problem, not just my problem. I stayed out of the battle myself since there was really nothing I could do anyway. This worked. For example, at a faculty meeting called to discuss the problem of the college council voting against the department, one faculty member said, "If she is not a real researcher because she is helping people then neither am I because my work helps people too." The rest of the faculty agreed and went to battle.

Step 4

Be prepared to work harder than you ever thought you would, at least at the beginning, and reach out to others whenever you have a chance. If science and/or teaching is your intended career, write at least one comprehensive chapter in the area you want to teach or do research in. The chapter will do a little but not a lot for your career. It will, however, do a lot for your thinking because you will have surveyed all the literature in your area and of necessity organized the information in your chapter. This can be a huge help in organizing your research and teaching over time.

If research is your passion, get to know those who will fund you. If you have a mentor—and let's hope you do—get your mentor to help you figure out who to contact at funding agencies. Practice what to say and how to say it first and then jump in and call the person who will have a say in whether your research ideas fit their objectives or not. If you don't have a mentor, find a friend who has been funded and get advice. If that is not available, come to ABCT meetings and follow my comments below on strategies for getting a lot out of these meetings. Be prepared for failures over and over and if you have a good idea do not give up. If you do get research funding (hurrah!), be sure and get some coaching on how to run a research lab, including how to manage finances. This can be far more complicated than it looks and it is easy to run into trouble. Being a scientist can be a little like being an entrepreneur with, alas, little training in how to succeed.

If therapy is your passion, be sure and get experience not only in providing competent evidence-based treatments but also in training, supervision, and consultation. Get to know the clinical leaders in your area. Look for opportunities to teach or give talks to students. Learn how to manage money, how to bill, and how to be on insurance lists. Get to know the leaders in the field at meetings, go to their talks to keep up with evidence-based interventions. Find out how they bring research into their clinical work. Jackie Persons is my hero here.

If teaching is your passion, get good at it. Talk your mentors into letting you do joint workshops with them when they are teaching on topics you can help with. Get evaluations of your contribution even if you only answer questions at breaks. Do everything you can think of to reduce the

work your mentor has to do for a workshop and you will get more opportunities. When interviewing for a job, be sure to talk about your teaching experience and your high teacher ratings. Lobby to teach what you want but be willing to work up the ladder. When starting, use the teaching notes and slides of your own teachers (assuming they are good) and don't worry, over time you will make a lot of changes and eventually all the notes, handouts, and slides will be yours. Keep up with ABCT's accumulation of on-line teaching resources and use any that meet your needs. Share your own with others and they will share with you. Do public speaking when possible. Don't forget, academia is only one of many avenues for teaching. Write or coauthor a book or publish widely if you want to get lots of invitations to train. Consider working for a company that trains in areas of your expertise. For example, there are quite a few DBT training companies now and just about all of them are desperate for good teachers. Once you have become well known you can look for opportunities to conduct your own workshops. I would suggest starting a training company of your own, but since I made so many, many, many mistakes when I did just that, I am thinking I should tell you how I recovered from all my mistakes before suggesting it . . . That is, unless you are already an entrepreneur.

Step 5

Go to meetings in your area of interest, including ABCT meetings. If you have a mentor there, then you need to follow your mentor around to make sure your mentor introduces you to everyone relevant to any work that you do—that's the first thing. Second, whenever you meet with a senior person, you can comment a little bit on their work but actually they already know everything there is to know about their work and that's the time to talk about your own work and how your own work might be relevant to their work. The other thing to do is try to get yourself on the program, no matter what it is, get on it, so that you can talk about your work in public places. And, because the whole point for a junior person is to come try to meet people, try to make connections and try to have other people hear about what you're doing. Of course, this is the fabulous place to go to see what everybody else is doing also, and you want to remember to pay attention to other young investigators and go to their talks and then you can talk to them about their work, ask questions, things like that. Ultimately your life is going to be controlled by people not too far from your own age, and you are going to need allies throughout your career.

Step 6

Do not start thinking that being intellectually brilliant is the road to all rewards. It is not. As you can see above, psychology is inevitably a community profession and your ability to be effective as a team player and community member is essential.

Step 7

Remember to reference others in your writing and your talks. You can never over-reference but you can definitely under-reference. It doesn't look good to under-reference. Don't speak badly in public about other people's work; it will reflect worse on you than on them. Trashing your mentor, article reviewers, or a grant review committees in public is usually not a good idea either.

Step 8

Learn and use the emotion regulation skills you have taught patients (or if not them, your children). You will need them. I know of no profession that does not have painful ups and downs and psychology is not different. Successes, failures, and rejections are often part of the job. Remember there is usually more to learn from failures than from successes.

Step 9

Keep in mind why you are doing the work you do. Remember that as a teacher, as a researcher, and as a therapist you are in the job to help others. To mentor and help the students you teach. To mentor and help your research assistants and fellows, and need I remind you to love the truth over fame and also your clients no matter how difficult they may sometimes be. (It can be helpful also to remember, even if it is self-interested, that someday some of these very people you mentor and love may be voting on you.)

I have a logo of a profile which I put on my letterhead, my website, my presentation slides, and my books to remind myself who I actually work for in the world … All those with mental disorders.

Step 10

Get a mindfulness practice to stay sane and don't forget to celebrate your successes when they happen.

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With thanks to my fabulous students Andrada Neacsiu, Duke Medical School; Anita Lungu, University of California at San Francisco; and Chelsey Wilks, University of Washington, who reminded me of what I had forgotten.

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ABCT *49th Annual Convention*

ABCT | Chicago | November 12–15, 2015

Improving Dissemination by Promoting Empirically Supported Principles of Psychopathology and Change

PROGRAM CHAIR: Brett Deacon, Ph.D.

ABCT | Hilton Chicago Hotel

Thursday, Nov. 12 – Sunday, Nov. 15

Welcome From the Program Chair | Brett J. Deacon, *University of Wollongong*

I hope to see you in Chicago for ABCT's 49th Annual Convention! The Hilton Chicago is perfectly situated just blocks from Lake Michigan and some of the Windy City's best museums, parks, shopping, restaurants, and nightlife. Our Local Arrangements Committee, co-chaired by Patrick McGrath and Shona Vas, will help you experience the best Chicago has to offer!

The theme of this year's meeting is "Improving Dissemination by Promoting Empirically Supported Principles of Psychopathology and Change." Cognitive and behavioral researchers have identified mechanisms that cause and maintain psychological problems, as well as interventions that target these mechanisms. Although CBT research in recent decades has emphasized treatment manuals for DSM-defined mental disorders, effective disorder-specific protocols remain underutilized. An appealing alternative approach to dissemination is to promote empirically supported principles of psychopathology and change that conceptualize psychological problems not as disorders, but rather as the product of cognitive and behavioral processes. Accordingly, the focus of the 49th ABCT convention includes presentations that highlight principles of psychopathology and change, identify novel and effective strategies for their dissemination, and critically examine the DSM-based paradigm that has come to dominate cognitive and behavioral science and practice.

Journalist Robert Whitaker will kick off our theme this year with his invited address, "Anatomy of an Epidemic: The History and Science of a Failed Paradigm of Care," in which he will review evidence in support of the provocative conclusion that the DSM-based biomedical paradigm has failed. This conclusion, and the possibility of a paradigm shift, will be further explored in a panel discussion where Whitaker will be joined by Steven Hayes, Dean McKay, and Brett Deacon. Next, Carolyn Becker from Trinity University will discuss her groundbreaking efforts to disseminate the Body Project, an empirically supported eating disorders prevention program: "From Bench to Global Impact: Lessons Learned About Translating Research to Reach."

Scott Lilienfeld from Emory University will present "The Brave New World of the Brain: Promises and Perils for Clinical Psychology," exploring the increasing influence of neuroscience on psychology, especially clinical psychology. Next, Art Houts from the University of Memphis (emeritus) will critically examine the history, validity, and future of the DSM diagnostic system in "The Diagnostic and Statistical Manuals of Mental Disorders as Instruments of Cultural Propaganda." Finally, in his presidential address, "Are the Obsessive-Compulsive Related Disorders Related to Obsessive-Compulsive Disorder? A Critical Look at DSM-5's New Category," Jonathan Abramowitz shows us how cognitive-behavioral science can be used to police a contentious conceptual boundary.

In a testament to ABCT's vitality and influence, we received the largest number of submissions to date (more than 2,300!). These were reviewed by a record number of program committee volunteers. This year's convention features a terrific line-up of presentations contributing to this year's theme and covering cutting-edge advances in cognitive-behavioral research and practice.

I am extremely grateful to President Jonathan Abramowitz and the ABCT Board for giving me the opportunity to serve as Program Chair. It has been an honor and privilege to organize this convention alongside many other dedicated individuals who share my love for ABCT and commitment to its principles. First, I would like to thank the members of the 2015 Program Review Committee for their expertise, diligence, and flexibility. Second, the chairs of the Convention and Education Planning Committee did a truly exceptional job—as usual—with this year's program: David Atkins (AMASS), Jeff Goodie (CIT), Barbara Kamholz (Workshops), Sarah Kertz (Master Clinician Seminars), and Lauren Weinstock (Institutes). Jeff, who also served as the Coordinator of Convention and Education Issues, deserves special thanks for his leadership as we navigated several unique challenges this year. Finally, I am extremely thankful for the invaluable assistance of two people in particular. Linda Still, Director of Education and Meeting Services, joined me in a "trial by fire" this year, and I could not have succeeded without her tireless support and guidance. Last but definitely not least, I would like to thank my exceptional Assistant Program Chair and graduate student, Johanna Meyer, who has been a cornerstone throughout this process. I couldn't have asked for a more capable, committed, and flexible partner in this process. Thank you, Linda and Johanna!

Best wishes to you all, and I look forward to seeing you in Chicago!

ABCT's Online Convention Itinerary Planner

Search | Find | Plan

- ▶ ***SEARCH*** *by topic, presenter, session type, day/time*
- ▶ ***BROWSE*** *by day and view the entire program in time/day order*

About the Itinerary Planner

The pages that follow provide an overview of the ticketed sessions and general sessions that will be part of the 2015 convention in Chicago. In order to learn more details about the sessions, including full descriptions and times, skill levels, and learning goals, please utilize the Itinerary Planner.

The Itinerary Planner is accessible on ABCT's website at www.abct.org/conv2015. To view the entire convention program—including SIG meetings, poster sessions, invited addresses—you can ***search*** by session type, or you can ***browse*** by day. (Keep in mind, the ABCT convention program book will only be mailed to those who pay $10 in advance. All other registrants will receive the book onsite.) After reviewing this special Convention 2015 insert, we hope you will turn to the online Itinerary Planner and begin to build your ultimate ABCT convention experience!

www.abct.org/conv2015

Clinical Intervention Trainings

TICKETED SESSIONS

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

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

CLINICAL INTERVENTION TRAINING 1

Radically Open–Dialectical Behavior Therapy for Disorders of Overcontrol

Thomas R. Lynch, *University of Southampton*

The idea of lacking control over oneself and acting against one's better judgment has long been contemplated as a source of human suffering, dating back as far as Plato (see Plato's Protagoras, 380 BCE). Yet, what are the consequences for a person who habitually engages in self-control—against their better judgment? The problem is not a lack of control—it is an excess! Excessive self-control or overcontrol is associated with social isolation and difficult-to-treat mental health problems such as anorexia nervosa, chronic depression, and obsessive-compulsive personality disorder. The aim of this Clinical Intervention Training is to provide an overview of a transdiagnostic treatment for disorders of overcontrol known as Radically Open–Dialectical Behavior Therapy (RO-DBT; treatment manual in press).

RO-DBT is supported by 20+ years of translational research; including two NIMH-funded randomized controlled trials with refractory depression (RCTs), two open-trials targeting adult anorexia nervosa, one nonrandomized trial targeting treatment-resistant overcontrolled adults, and an ongoing multicenter RCT (http://www.reframed.org.uk). Interventions are informed by a neurobiosocial theory linking current brain-behavioral science to the development of close social bonds and altruistic behaviors. Participants will learn novel strategies designed to assess overcontrolled problems, enhance self-enquiry, relax inhibitory control via activation of differing neural substrates, repair alliance-ruptures, and increase social connectedness using slides, handouts, video clips, and role-plays.

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

CLINICAL INTERVENTION TRAINING 2

Couple Interventions for Adult Psychopathology in the Context of Relationship Distress

Donald H. Baucom, *University of North Carolina at Chapel Hill (assisted by Melanie S. Fischer, University of North Carolina at Chapel Hill)*

Cognitive-behavioral couple therapy (CBCT) is a highly efficacious approach for assisting couples experiencing relationship distress. In many instances, assisting these couples is complicated by one or both partners also experiencing individual psychological difficulties, for example, depression or anxiety disorders. Focusing on how to address both individual psychopathology and relationship distress while working with the couple conjointly, this training will demonstrate how to integrate (a) efficacious intervention principles from individual therapy into a couple treatment format, along with (b) well-established CBCT interventions for treating relationship distress. Participants will learn three different approaches to treating psychopathology in a couple context and how these three approaches can be combined to provide optimal intervention for complex cases. Using anxiety disorders and depression as examples, videotapes and live role-plays will illustrate these techniques. Clear principles for developing treatment plans for specific couples will be presented so that the therapist can develop couple-based interventions for numerous types of psychopathology, in addition to depression and anxiety.

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

CLINICAL INTERVENTION TRAINING 3

Transdiagnostic CBT for Eating Disorders: An Overview and Update

Christopher G. Fairburn, *University of Oxford*

This CIT will describe the "enhanced" CBT approach (CBT-E) to the treatment of the full range of eating disorders seen in clinical practice (including anorexia nervosa, bulimia nervosa, binge eating disorder, and the various forms of atypical eating disorder). Starting with a brief and up-to-date account of the empirical standing of the treatment, the remainder of the session will focus on the implementation of the treatment from assessment through to its completion. Dr. Fairburn will discuss when to use the "focused" and "broad" versions of the treatment, and how the treatment is adapted for young patients and those who are underweight. This training will be suitable for all those who work with people with eating disorders, including those who work with young people. Participants will be provided with a detailed handout.

Institutes

TICKETED SESSIONS

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

— Thursday —

INSTITUTE 1 • 8:30 - 5:30 p.m.

Motivational Interviewing: Integrating CBT

Daniel W. McNeil, *West Virginia University*

INSTITUTE 2 • 8:30 - 5:30 p.m.

Overview of Cognitive Processing Therapy—Cognitive-Only Version

Patricia Resick, *Duke University Medical Center*
Debra Kaysen, *University of Washington*

INSTITUTE 3 • 1:00 - 6:00 p.m.

Inside This Moment: Using Present Moment Interventions to Promote Radical Change in Acceptance and Commitment Therapy

Kirk Strosahl, *Mountainview Consulting Group*
Patricia Robinson, *Mountainview Consulting Group*

INSTITUTE 4 • 1:00 - 6:00 p.m.

Integrating Cognitive Behavioral Insomnia Therapy Into Comorbid Depression, Pain, or Anxiety Treatment

Colleen E. Carney, *Ryerson University*

INSTITUTE 5 • 1:00 - 6:00 p.m.

When the Going Gets Tough in CBT, Get Mindfulness! Individual Mindfulness-Based Cognitive Therapy

Mark A. Lau, *University of British Columbia*

— Thursday —

INSTITUTE 6 • 1:00 - 6:00 p.m.

Brief Cognitive Therapy to Prevent Suicide Attempts

Craig J. Bryan, *National Center for Veterans Studies and University of Utah*

INSTITUTE 7 • 1:00 - 6:00 p.m.

Teaching and Supervising Cognitive Behavioral Therapy: Delivering Effective Multidisciplinary Training

Donna M. Sudak, *Drexel University College of Medicine*
Leslie Sokol, *Academy of Cognitive Therapy*
Marci G. Fox, *Academy of Cognitive Therapy*
Robert Reiser, *Reiser Healthcare Consulting*
R. Trent Codd, III, *CBT Center of WNC, Asheville*
John W. Ludgate, *CBT Center of WNC, Asheville*

INSTITUTE 8 • 1:00 - 6:00 p.m.

Conducting a Marriage Checkup: Preventing Relationship Deterioration and Promoting Long-Term Marital Health

James V. Cordova, *Clark University*

INSTITUTE 9 • 1:00 - 6:00 p.m.

Parent-Child Interaction Therapy

Cheryl B. McNeil, *West Virginia University*

AMASS (Advanced Methodology and Statistics Seminars)

TICKETED SESSIONS

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

— Thursday —

AMASS 1 • 8:30 - 12:30 p.m.

Measuring Emotion in the Voice: Computational Methods for Assessing Vocal Arousal

Brian Baucom, *University of Utah*

— Thursday —

AMASS 2 • 1:00 - 5:00 p.m.

Planning and Designing High-Impact Randomized Behavioral Clinical Trials

Kenneth E. Freedland, *Washington University School of Medicine*
Lynda H. Powell, *Rush University Medical Center*
Peter G. Kaufmann, *National Heart, Lung, and Blood Institute*

Master Clinician Seminars

TICKETED SESSIONS

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

MASTER CLINICIAN SEMINAR 1

The Three-Minute Breathing Space: Steps for Embedding a Brief Mindfulness Practice Into Your Clinical Practice

Zindel V. Segal, *University of Toronto*

MASTER CLINICIAN SEMINAR 2

Comprehensive Cognitive Behavior Therapy for Social Anxiety Disorder to Maximize Gains

Lata K. McGinn, *Ferkauf Graduate School of Psychology, Yeshiva University, Albert Einstein College of Medicine*

MASTER CLINICIAN SEMINAR 3

A Transdiagnostic Approach to Treating Sleep Problems in Clinical Practice

Allison Harvey, *University of California, Berkeley*

MASTER CLINICIAN SEMINAR 4

Handling Treatment Failure Successfully

Jacqueline B. Persons, *Cognitive Behavior Therapy and Science Center, Oakland*

MASTER CLINICIAN SEMINAR 5

Ownership Gone Awry: Understanding and Treating Hoarding Disorder

Gail Steketee, *Boston University*
Randy O. Frost, *Smith College*

MASTER CLINICIAN SEMINAR 6

Cognitive-Behavioral Therapy for Envy

Robert L. Leahy, *American Institute for Cognitive Therapy, NYC*

MASTER CLINICIAN SEMINAR 7

The Unified Protocol for the Treatment of Emotional Disorders in Adolescents

Jill Ehrenreich-May and Jamie A. Mash, *University of Miami*
Master Clinician Seminar 8

MASTER CLINICIAN SEMINAR 8

Cognitive Behavior Therapy for Personality Disorders

Judith S. Beck, *Beck Institute for Cognitive Behavior Therapy and University of Pennsylvania*

Mini Workshops

NO TICKET REQUIRED

Mini Workshops address direct clinical care or training at a broad, introductory level. They are 90 minutes in length and presented throughout the meeting. These useful sessions are included in the conference registration fee.

MINI WORKSHOP 1

The Mindful Way Through Muddy Emotions

Susan M. Orsillo, *Suffolk University*
Lizabeth Roemer, *University of Massachusetts, Boston*

MINI WORKSHOP 2

Supporting Women After Abortion: Exploring Multiple Perspectives on Experiences, Stigma, and Values

Jennifer Katz, *SUNY Genese*

MINI WORKSHOP 3

Affect Regulation Training for Substance Use Disorders: Helping Clients to Engage With Negative Emotions

Paul R. Stasiewicz, *Research Institute on Addictions, University at Buffalo*
Clara M. Bradizza, *Research Institute on Addictions, University at Buffalo*
Kim S. Slosman, *Research Institute on Addictions, University at Buffalo*

MINI WORKSHOP 4

Security and Ethics of Information Technology Use in Psychological Treatment

Jon D. Elhai, *University of Toledo*

MINI WORKSHOP 5

Evidence-Based Treatment of Bipolar Disorder in Youth

Mary A. Fristad, *Ohio State University*

MINI WORKSHOP 6

Mastering the Art of Behavioral Chain Analyses in Dialectical Behavior Therapy

Shireen L. Rizvi, *Rutgers University*
Lorie A. Ritschel, *University of North Carolina School of Medicine*

MINI WORKSHOP 7

Towards the Provision of Culturally Competent Couple Therapy: Clinical Considerations When Working With Same-Sex Couples

Brian Buzzella, *VA San Diego Healthcare System*
Sarah Whitton, *University of Cincinnati*
Shelby Scott, *University of Denver*

MINI WORKSHOP 8

The Business of CBT

Allen R. Miller, *WellSpan Behavioral Health and York Hospital*

MINI WORKSHOP 9

Tips From Elsa, Taylor, and Batman: Metaphors and CBT With Youth

Robert D. Friedberg, *Palo Alto University*

MINI WORKSHOP 10

Taking Exposure and Response Prevention From the Treatment Manual to Your Patients: A Guide to Application for All

Patrick B. McGrath, *Alexian Brothers Center for Anxiety and Obsessive Compulsive Disorders*

MINI WORKSHOP 11

Signaling Matters: How We Survived Without Claws, Horns, or Being Too Thick-Skinned

Thomas R. Lynch, *University of Southampton*

MINI WORKSHOP 12

How and Why to Increase Felt Emotional Safety and Perceived Functionality in Persistent Depression With Trauma History: Rationale, Strategies, and Effectiveness

Jennifer Kim Penberthy, *University of Virginia School of Medicine*
Todd Favorite, *University of Michigan*
Christopher Gioia, *University of Wisconsin-Madison*

MINI WORKSHOP 13

Adolescent DBT Multifamily Skills Training Group: A Live Demonstration

Alec L. Miller, *Cognitive & Behavioral Consultants, LLP*
Jill H. Rathus, *Long Island University–Post*
Linda Spiro, *Cognitive & Behavioral Consultants, LLP*

MINI WORKSHOP 14

Implementing Brief Behavioral Activation Treatment for Depression (BATD) and Technology-Enhanced BATD Through a Mobile Application (Behavioral Apptivation)

Carl W. Lejuez, *University of Maryland, College Park*
Derek Hopko, *University of Tennessee, Knoxville*
Jennifer Dahne, *University of Maryland, College Park*

MINI WORKSHOP 15

Core Competencies in Cognitive-Behavioral Therapy: Becoming an Effective and Competent Cognitive-Behavioral Therapist

Cory F. Newman, *Center for Cognitive Therapy, University of Pennsylvania*

MINI WORKSHOP 16

Training Psychiatry Residents in Cognitive-Behavioral Therapies: Practical Guidance and Strategies for Psychologists

Barbara W. Kamholz, *VA Boston Healthcare System and Boston University School of Medicine*
Gabrielle I. Liverant, *Suffolk University*
Justin M. Hill, *VA Boston Healthcare System and Boston University School of Medicine*

MINI WORKSHOP 17

Promoting Psychological Flexibility in Primary Care: A Dissemination Platform and a Therapeutic Approach

Patricia J. Robinson, *Mountainview Consulting Group*
Jodi Polaha, *East Tennessee State University*
Kirk Strosahl, *University of Washington Family Practice Residency, Community Health of Central Washington*

MINI WORKSHOP 18

Using the New, Second Edition *Mind Over Mood* for Dissemination

Christine A. Padesky, *Center for Cognitive Therapy, Huntington Beach*

Presidential & Invited Addresses

Presidential Address

SATURDAY | 5:15 PM - 6:15 PM | Grand Ballroom

JONATHAN S. ABRAMOWITZ

University of North Carolina–Chapel Hill

Are the Obsessive-Compulsive Related Disorders Related to Obsessive-Compulsive Disorder? A Critical Look at DSM-5's New Category

Invited Addresses

FRIDAY | 12:30 PM - 1:30 PM | Grand Ballroom

CAROLYN BLACK BECKER

Trinity University

From Bench to Global Impact: Lessons Learned About Translating Research to Reach

SATURDAY | 2:00 PM - 3:00 PM | Grand Ballroom

ARTHUR C. HOUTS

Vector Oncology and *University of Memphis*

The Diagnostic and Statistical Manuals of Mental Disorders as Instruments of Cultural Propaganda

SATURDAY | 12:00 PM - 1:00 PM | Grand Ballroom

SCOTT O. LILIENFELD

Emory University

The Brave New World of the Brain: Promises and Perils for Clinical Psychology

FRIDAY | 11:00 AM - 12:00 PM | Grand Ballroom

ROBERT WHITAKER

Harvard University

Anatomy of an Epidemic: The History and Science of a Failed Paradigm of Care

Workshops

TICKETED SESSIONS

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

WORKSHOP 1

Awareness and Connection in Ethnically and Racially Diverse Therapist-Client Dyads

Monnica Williams, *University of Louisville*
Chad T. Wetterneck, *Rogers Memorial Hospital*

WORKSHOP 2

A Manualized CBT Group for Treating Diverse Addictive Behaviors

Bruce S. Liese, *University of Kansas Medical Center*

WORKSHOP 3

Introduction to the Unified Protocol for Transdiagnostic Treatment for Emotional Disorders

Todd J. Farchione, *Center for Anxiety and Related Disorders, Boston University*
Matthew W. Gallagher, *VA Boston Healthcare System*

WORKSHOP 4

Applying Evidence-Based Assessment to Bipolar Disorder: Assessing Quickly and Accurately to Reach Better Outcomes

Eric A. Youngstrom, *University of North Carolina, Chapel Hill*

WORKSHOP 5

Recovery-Oriented Cognitive Therapy: An Evidence-Based Program to Promote |Successful Goal-Achievement and Resilience for Individuals With Schizophrenia, in and out of the Hospital

Paul Grant and Aaron Brinen, *University of Pennsylvania*
Aaron T. Beck, *Perelman School of Medicine*

WORKSHOP 6

CBT for Mental Contamination

Roz Shafran, *UCL Institute of Child Health*
Maureen Whittal, *Vancouver CBT Centre*

WORKSHOP 7

Translating CBT Principles to the Role of a Behavioral Health Consultant in Integrated Primary Care

Risa B. Weisberg, *VA Boston Healthcare System and Brown University*
Cara H. Fuchs, *Brown University*

WORKSHOP 8

Going Digital: Building eHealth and mHealth Interventions

Stephen M. Schueller, *Northwestern University*
Mark Begale, *Northwestern University*
David C. Mohr, *Northwestern University*

WORKSHOP 9

State-of-the-Art Adverse Event Monitoring for Behavioral Health Clinical Trials

John D. Roache, *University of Texas Health Science Center at San Antonio*
Alan L. Peterson, *University of Texas Health Science Center at San Antonio*
Tabatha Blount, *University of Texas Health Science Center at San Antonio*

WORKSHOP 10

When Life Gives You Lemons . . . Use Strengths-Based CBT's Four-Step Model to Build Resilience

Christine A. Padesky, *Center for Cognitive Therapy, Huntington Beach*
Kathleen A. Mooney, *Center for Cognitive Therapy, Huntington Beach*

WORKSHOP 11

Integrated Group CBT for Depression and Substance Abuse

Kimberly Hepner, *RAND Corporation*

WORKSHOP 12

Using Social Skills Training in Clinical Practice With Children and Adolescents

Susan H. Spence, *Griffith University*

WORKSHOP 13

Exposure-Based Interventions for Complex Presentations of Obsessive-Compulsive Symptoms

Dean McKay, *Fordham University*
Fugen Neziroglu, *Bio-Behavioral Institute*

General Sessions

Clinical Roundtables, Panel Discussions, and Symposia are part of the general program: no tickets are required to attend these sessions.

CLINCAL ROUND TABLES

How to Effectively Balance Irreverence and Validation to Reduce Therapy-Interfering Behavior
Moderator: Paul J. Geiger
Panelists: Alexander L. Chapman, Alan E. Fruzzetti, Kim L. Gratz, Lorie A. Ritschel, M. Zachary Rosenthal

Transforming Negative Reactions to Clients: From Frustration to Compassion
Moderator: Robert L. Leahy
Panelists: Marvin Goldfried, Shelley McMain, Dennis Tirch

Provocative Perspectives on Dissemination and Implementation of Evidence-Based Practices
Moderator: Robert D. Friedberg
Panelists: Rinad S. Beidas, Allen Miller, Brad J. Nakamura, Cami Winkelspecht, John Ackerman,

Addressing Real and Imagined Constraints in Utilizing CBT for Autistic Spectrum Disorder: Best Practices Regarding Applicability of CBT to ASD
Moderator: Eric A. Storch
Panelists: Rebecca Sachs, Valerie Gaus, Jonathan H. Hoffman, Connor M. Kerns, Matthew Lerner

Dissemination of Behavioral Therapies in Canada
Moderator: Trevor A. Hart
Panelists: Shannon Wiltsey Stirman, Sanjay Rao, Mark A. Lau

Treating OCD: Perspectives From Five Empirically Supported Approaches
Moderator: Maureen Whittal
Panelists: Roz Shafran, Jon Abramowitz, Michael P. Twohig, Dennis Tirch, Michael Kyrios

Community Reinforcement and Family Training Across Intervention Platforms
Moderator: Carrie Wilkens
Panelists: Katherine R. Pruzan, Nicole Kosanke, Ken Carpenter, Jeff Foote, Cindy Brody

Using an Idiographic Hypothesis-Testing Approach to Clinical Work
Moderator: Jacqueline B. Persons
Panelists: Maureen Whittal, Claudia Zayfert, Janie J. Hong, Polina Eidelman

Optimizing CBT of Anxious Youth: Engaging (or Disengaging!) Parents Across Development
Moderator: Sandra Pimentel
Panelists: James P. Hambrick, Cara A. Settipani, Muniya Khanna, Jonathan S. Comer, Anne Marie Albano

You Know What They Say . . . the Truth About Some Popular Beliefs in Our Field!
Moderator: Simon A. Rego
Panelists: Michelle Craske, Marsha M. Linehan, Thomas Ollendick, Adam Radomsky

Mindfulness-Based Interventions and REBT: Synergistic Possibilities or Fatal Contradictions?
Moderator: Zella E. Moore
Panelists: Frank Gardner, Ray DiGiuseppe, Kristene A. Doyle, Donald R. Marks

From Primary Care to Specialty Psychiatry Practice and Back Again: Barriers and Bridges in the Population-Based Management of Anxiety Disorders
Moderator: Craig N. Sawchuk
Panelists: Katherine M. Moore, Julia Craner, Stephen Whiteside

Theories, Principles, and Examples of Accommodating and Integrating Religion in CBT: Three Approaches
Moderator: Ray DiGiuseppe
Panelists: E. Thomas Dowd, Stevan L. Nielsen, Hank Robb

"It's Just Pot": Best Practices for Conceptualizing and Treating Marijuana Use in a Changing Societal and Clinical Landscape
Moderator: Jonathan H. Hoffman
Panelists: Raymond Chip Tafrate, E. Katia Moritz, F. M. Bishop

Translating Science to Practice: Real-World Applications of Routine Outcome Monitoring
Moderator: Lee D. Cooper
Panelists: Haley Gordon, Corey Fagan, Alexandra P. Peterson, Freda F. Liu

Dissemination and Implementation of Evidence-Based Treatments for Anxiety Disorders
Moderator: Martin E. Franklin
Panelists: Carmen P. McLean, Gerd Kvale, Bjarne Hanson, Jonathan Abramowitz

PANEL DISCUSSIONS

Causal Inference in Clinical Research: Direct Effects and Mediation
Lance M. Rappaport, *Moderator*
Panelists: Ronald Rogge, David Atkins, Nicholas C. Jacobson

Addressing Controversies in Empirically Supported Treatments: New Standards on the Horizon?
Dean McKay, *Moderator*
Panelists: David Tolin, E. David Klonsky, Marvin Goldfried, Bethany A. Teachman, Evan Forman, Steven Hollon

The Rise of the Transdiagnostic Movement for Youth Disorders: Scientific and Dissemination Advantages to Universal Protocols
Andrea Temkin, Kristin L. Toffey, *Moderators*
Panelists: Brian C. Chu, Jill Ehrenreich-May, John E. Lochman, Katharine L. Loeb, Lorie A. Ritschel

Behavior Therapy and Addictive Behaviors: Past, Present, and Future
Barbara S. McCrady, *Moderator*
Panelists: Brian Borsari, Stephen A. Maisto, Jeremiah Weinstock, Carlo DiClemente, Katie Witkiewitz

Negotiating Your First Position and Beyond
RaeAnn Anderson, Laura D. Seligman, *Moderators*
Panelists: Thomas H. Ollendick, Sheila Rauch, Wendy Silverman, Sabine Wilhelm, Douglas Woods

Clinical Implications of Behavioral Economic Theory: Applications Across Addictive Behaviors, Obesity, and Risky Sex
Joanna Buscemi, *Moderator*
Panelists: James Murphy, Mark A. Celio, Christopher J. Correia, Hollie Raynor, Steven R. Lawyer

New Developments in the Use of Technology to Improve CBT Access and Outcomes
Carmen P. McLean, *Moderator*
Panelists: Michael Levin, David C. Mohr, Nick Titov, Kenneth Ruggiero

Clinical Training in Integrated Primary Care: Methods, Challenges, and Recommendations
Scott Fields, *Moderator*
Panelist: Emily M. Selby-Nelson, Risa Weisberg, Abbie Beacham

A Call to Action 10 Years On: Training U.S. Therapists in CBT for Psychosis
Kim T. Mueser, *Moderator*
Panelists: Eric Granholm, Hardy V. Kate, Donna Sudak, Harry J. Sivec, Page Burkholder, Sally E. Riggs

Nothing to Fear but Fear Itself: How Exposure Therapy Trainers Can Effectively Address Anxious Trainees' Reservations About Using the Treatment
Nicholas R. Farrell, *Moderator*
Panelists: Bradley C. Riemann, Dean McKay, Randi E. McCabe, Lori Zoellner, Kristen Benito

Dissemination and Implementation of Child Evidence-Based Practices: Training, Supervision, and Consultation With Professionals From Multiple Disciplines and Settings
Mina Yadegar, Lauren Hoffman, *Moderators*
Panelists: Shannon M. Bennett, Brenna Bry, Daniel M. Cheron, Brian C. Chu, Gerd Kvale

A Critical Look at Four "Pleasing Ideas" in Behavioral Parent Training
Camilo Ortiz, *Moderator*
Panelists: David Reitman, Timothy A. Cavell, Tamara Del Vecchio, Anil Chacko

Innovative Approaches to Collaborative Scientific Writing
Jennifer Block-Lerner, *Moderator*
Panelists: Katherine E. Schaumberg, Julianne C. Flanagan, Lizabeth Roemer, Susan Orsillo, Todd Kashdan, Emma Barrett, Erica Crome, Miriam Forbes

Integrating Innovative Cognitive-Behavioral and Mindfulness Techniques in Treatment for Disordered Eating
Kelly M. Vitousek, *Moderator*
Panelists: Megan M. Hood, Rebecca E. Wilson, Jamal H. Essayli, Mackenzie Kelly, Lindsey B. Hopkins, Jillon S. Vander Wal

Sensory Processing Problems and Mental Health: What Do We Know and What Are We Missing in Behavioral Therapies?
M. Zachary Rosenthal, *Moderator*
Panelists: Dean McKay, Nancy Zucker, Christine A. Conelea, Eric A. Storch

The Healing Power of Web-Based and Mobile Technologies
F. Michler Bishop, *Moderator*
Panelists: Shelly Gable, Reid K. Hester, Mary Larimer

Disseminating and Implementing Evidence-Based Treatments Effectively: Successes, Pitfalls, and Paving the Way to the Future
Anu Asnaani, *Moderator*
Panelists: Michelle Craske, Christopher G. Fairburn, Paul Grant, G. Terence Wilson, David Yusko

How to Do Exposure for Complex OCD
Fugen Neziroglu, *Moderator*
Panelists: Jonathan Abramowitz, Jonathan H. Hoffman, Loren Packer-Hopke, Sony Khemlani-Patel

The Business Side of CBT: A Real-World Discussion About Owning and Operating a CBT Clinical Practice
Regine Galanti, David H. Rosmarin, *Moderators*
Panelists: Thröstur Björgvinsson, R. Trent Codd, Tamar Gordon, Jonathan B. Grayson, Lisa Napolitano

Mindfulness and Acceptance-Based Training in the Health Sciences: Improving Dissemination of Interventions
Jennifer Block-Lerner, *Moderator*
Panelists: Jonathan Hershfield, Agnes Lenda, Michael E. Levin, Michelle Lilly, Donald R. Marks, Noga Zerubavel

The Importance of Cognitive and Behavioral Factors in the Assessment and Treatment of Bariatric Surgery Patients: What Should We Be Doing Better?
Joyce Corsica, *Moderator*
Panelists: Rebecca Wilson, Allison Grupski, Shawn Katterman, Laura K. Campbell

Improving DBT Dissemination and Implementation: Challenges to Implementing Adherent DBT From Clinician Perspectives
Jill H. Rathus, *Moderator*
Panelists: Shannon York, Samuel L. Greenblatt, Lisa Shull Gettings, Lorie A. Ritschel, Laurence Y. Katz

Bridging Basic Science and Treatment Research on Emotional Reactivity in Depression: Theoretical Questions, Methodological Issues, and Pathways for Moving Forward
Rachel Hershenberg, *Moderator*
Panelists: Kari M. Eddington, Daniel Foti, Lauren Bylsma, Jackie K. Gollan, Sona Dimidjian

International Dissemination of ESTs: Lessons and Challenges From the DBT Experience
Andre Ivanoff, *Moderator*
Panelists: Alan E. Fruzzetti, Michaela Swales, Kathryn Korslund, Anthony DuBose, Lars Mehlum, Marsha M. Linehan

Addressing Common Clinical Issues Using ACT
Kate L. Morrison, *Moderator*
Panelists: Lisa Coyne, John P. Forsyth, Steven Hayes, James D. Herbert, Michael P. Twohig

Implementing Exposure-Based CBT Across Health Care Settings: Challenges and Solutions to Training Clinicians
Michael A. Southam-Gerow, *Moderator*
Panelists: C. Alec Pollard, Maria C. Mancebo, Megan L. Smith, Jason Elias, Brock Maxwell, Rita Smith

From the Glass Ceiling to Leaning In: Identifying Today's Challenges for Women Across the Career Spectrum
Christine A. Conelea, *Moderator*
Panelists: Kate McHugh, Risa B. Weisberg, RaeAnn E. Anderson, Sona Dimidjian, Anne Marie Albano

Beyond the Manuals: Using Creativity to Enhance the Exposure Process
Nathaniel Van Kirk, *Moderator*
Panelists: Thröstur Björgvinsson, Bradley Reimann, Jonathan Grayson, C. Alec Pollard

The Future of CBT: Biomarkers, Implementation Science, Scalability, Task Sharing, and Transdiagnostic Cognitive Support Interventions
Simon A. Rego, *Moderator*
Panelists: W. Edward Craighead, Christopher G. Fairburn, Allison Harvey, G. Terence Wilson

Binge-Eating Conceptualization and Considerations
Lisa M. Anderson, *Moderator*
Panelists: Kerri Boutelle, Andrea Goldschmidt, Jason M. Lavender, Helen B. Murray, Cortney S. Warren

Enhancing Therapeutic Outcomes From Both Sides of the Couch: Bridging the Gap Between Client and Practitioner to Enhance Treatment Outcomes
Jason Elias, *Moderator*
Panelists: Elizabeth McIngvale, Nathaniel Van Kirk, Throstur Bjorgvinsson, Richard Baither

The Application of DBT in Forensic Settings and Management of Staff Burnout
Panelists: Sharon B. Robbins, Gordana Eljdupovic, Nicole Kletzka, Ronda Reitz, Jessica Peterson, Jonathan Rhodes

A Critical Discussion of the Implications of Research Domain Criteria for Depression Research and Treatment
Rachel Hershenberg, *Moderator*
Panelists: Greg J. Siegle, W. Edward Craighead, Robert J. DeRubeis, Adele M. Hayes, Michael Kozak, Scott Lilienfeld, Edward Watkins

Addressing Minority Stress in CBT: Considerations for Diverse Populations
Brandon J. Weiss, Brad J. Chapin, *Moderators*
Panelists: John Pachankis, Janie J. Hong, Daniel W. McNeil, Broderick Sawyer, Anu Asnaani

OCD and Related Conditions in Youth: Perspectives on Understanding and Capitalizing on the New Classification System
Meredith E. Coles, *Moderator*
Panelists: Martin E. Franklin, Douglas Woods, Sabine Wilhelm

The Future of Research on Couples and Families in Military and Veteran Populations
Steven Sayers, *Moderator*
Panelists: Shirley Glynn, Richard Heyman, Douglas K. Snyder

Exposure Process: Using CBT Theory to Inform the "Dos and Don'ts" of Conducting Exposure for OCD
Christine A. Conelea, *Moderator*
Panelists: Kristen Benito, Jonathan Abramowitz, Joanna J. Arch, Michael P. Twohig

Anxiety Sensitivity: New Frontiers for a Cross-Cutting Construct
Todd Caze, Debra A. Hope, *Moderators*
Panelists: James Hoezle, Eli Lebowitz, Brad Schmidt, Sherry H. Stewart, Michael Zvolensky

The Biomedical Approach to Psychological Problems: Time for a Paradigm Shift?
Brett Deacon, *Moderator*
Panelists: Dean McKay, Steven Hayes, Robert Whitaker

SYMPOSIA

Due to technical difficulties, we were not able to capture all the Chairs and Discussants for this issue. However, they will be included in the final program book and updated on the on-line Itinerary Planner.

Anxiety and Substance Use Disorder Comorbidity Across the Translational Model: From Laboratory Discoveries to Clinical Outcomes to Treatment Delivery
Kate Wolitzky-Taylor, *Chair*
Joanna J. Arch, *Chair*
Robert deRubeis, *Discussant*

Applying Implicit Theories to the Domain of Psychopathology
David Valentiner, *Chair*
David Yeager, *Discussant*

Approaches to Understanding Anger and Irritability In Youth
Amy Krain Roy, *Chair*
Mary Fristad, *Discussant*

Barriers to Treatment Seeking and Engagement Among Vulnerable Populations
Esteban V. Cardemil, *Chair*
Michael Addis, *Discussant*

Beyond Reaction Time Bias: Neural, Physiological, Ecological, and Clinical Correlates of Information Processing Mechanisms
Rebecca Price, *Chair*
Bethany Teachman, *Discussant*

Beyond Self-Report: Using Couples Interaction Data to Better Understand Couple Aspects of Individual Psychopathology
Steffany J. Fredman, *Chair*
Douglas K. Snyder, *Discussant*

Biases of Emotional Attention: Emerging Perspectives and Their Translational Implications for Intervention Development
Amit Bernstein, *Chair*
TBA, *Discussant*

Bipolar Disorder and Comorbid Anxiety: Clinical Impact, Psychological Interventions, and Innovative Treatments
Martin D. Provencher, *Chair*
Thilo Deckersbach, *Discussant*

BPD Symptoms and the Parent–Child Relationship
Elizabeth J. Kiel, *Chair*
Diana J. Whalen, *Chair*
Alan E. Fruzzetti, *Discussant*

Breaking Down Barriers: How Innovative Dissemination Strategies Can Improve the Adoption and Delivery of Exposure Therapy
Nicholas R. Farrell, *Chair*
Lori Zoellner, *Discussant*

Brief Interventions for Eating Disorders
Jillon S. Vander Wal, *Chair*
Cortney S. Warren, *Discussant*

Changing Minds via Cognitive Bias Modification: Expanding to New Populations and Settings
Courtney Beard, *Chair*
Nader Amir, *Discussant*

Clinical Applications of Economics and Learning Theory in the Context of Social Anxiety, Depression, and Suicidality
Andrew Valdespino, *Chair*
Greg J. Siegel, *Discussant*

Closing the Research-Practice Gap: Advances in the Dissemination and Implementation of Empirically Supported Treatments for Psychological Disorders
Lauren E. Szkodny, *Chair*
Nicholas C. Jacobson, *Chair*
Marvin R. Goldfried, *Discussant*

Cognition and Emotion in Psychopathology: From Mechanisms to Treatment
Michael Vanderlind, *Chair*
Arielle Baskin-Sommers, *Chair*
Christopher Beevers, *Discussant*

Cognitive Style and Emotion Regulation in Bipolar Disorder
Alyson Dodd, *Chair*
Sheri Johnson, *Discussant*

Community-Research Partnerships to Advance the Dissemination and Implementation of Evidence-Based Practices for Youth Mental Health
Sarah Kate Bearman, *Chair*
TBA, *Discussant*

Considering Factors That Underlie Internalizing Conditions: Comprehensive Meta-Analyses of Suicidality, Anxiety, and Tic Disorders
Alessandro S. De Nadai, *Chair*
Evan M. Kleiman, *Chair*
Joseph C. Franklin, *Discussant*

Contextual Considerations in the Assessment and Treatment of Anxiety Disorders Among People of Color
Jennifer H. Martinez, *Chair*
Monnica Williams, *Discussant*

Correlates of Treatment Outcome in Intensive/Residential OCD Treatment: Impact of Underlying Cognitive and Emotional Processes
Nathaniel Van Kirk, *Chair*
Jonathan Abramowitz, *Discussant*

Costs and Benefits of Crowdsourcing Sensitive Data: Methodological and Ethical Considerations
Kathryn M. Bell, *Chair*
Andrew M. Sherrill, *Chair*
Matthew Price, *Discussant*

Disgust and Anxiety-Related Disorders: Issues in Assessment, Process, and Mechanisms
Megan Viar-Paxton, *Chair*
Bunmi Olatunji, *Chair*
Jonathan S. Abramowitz, *Discussant*

Disseminating CBT: Clinical Effectiveness Trials for Patients With Common Mental Illness and Nonsuicidal Self-Injury
Erik Hedman, *Chair*
Brja'nn Ljo'tsson, *Chair*
Matthew T. Tull, *Discussant*

Disseminating Empirically Supported Relationship Interventions for Military Couples
Tatiana Gray, *Chair*
Steffany Fredman, *Discussant*

Disseminating Evidence-Based Psychotherapies and Principles to Diverse Provider Groups Across the Departments of Veterans Affairs and Defense
Jason A. Nieuwsma, *Chair*
Wendy Tenhula, *Discussant*

Dissemination of Couple Therapy and Education: International Perspectives
W. Kim Halford, *Chair*
Thomas N. Bradury, *Discussant*

Does SAD Fit in the Research Domain Criteria?: Opportunities and Challenges Within the NIMH Vision for Translational Research
John A. Richey, *Chair*
Thomas Ollendick, *Discussant*

Doubt in OCD: Exploring Its Scope, Consequences, and Underlying Mechanisms
Reuven Dar, *Chair*
Richard McNally, *Discussant*

Emerging Research in Alcohol-Related Consequences: Implications for Practice and Interventions
Clayton Neighbors, *Chair*
Heather Krieger, *Chair*
Mary Larimer, *Discussant*

Emotion Dysregulation as a Risk Factor for Problem Behaviors and Victimization in Young Adult Women
Holly K. Orcutt, *Chair*
Maria Testa, *Discussant*

Emotion Reactivity and Regulation in PTSD
R. Kathryn McHugh, *Chair*
M. Zachary Rosenthal, *Discussant*

Emotion Regulation as a Transdiagnostic Mechanism: An Examination of the Mediating Role of Difficulties in Emotion Regulation Across Disorders
Michael J. McDermott, *Chair*
Amelia Aldao, *Discussant*

Emotional Development in Children With ADHD
Elizabeth A. Harvey, *Chair*
Andrea Chronis-Tuscano, *Discussant*

Employ or Eliminate? Novel Experimental Investigations of Safety Behavior in CBT
Hannah C. Levy, *Chair*
Adam S. Radomsky, *Chair*
Richard J. McNally, *Discussant*

Etiological Processes in the Incidence of Child Maltreatment and Subsequent Psychiatric Outcomes
Chad Shenk, *Chair*
Terri Messman-Moore, *Discussant*

Evidence-Based Extensions of Couple Therapy to Specific Disorders
Douglas K. Snyder, *Chair*
Jay L. Lebow, *Discussant*

Examining Fears of Evaluation Across Multiple Domains of Psychopathology
Melanie F. Lipton, *Chair*
Andres De Los Reyes, *Chair*
Richard Heimberg, *Discussant*

Examining Stigmas, Help-Seeking Attitudes, and Approaches for Disseminating Empirically Supported Treatments: Evidence Across Cultures
Ashley Harrison, *Chair*
TBA, *Discussant*

Expanding the Horizons of Trauma-Focused CBT for Youth: Barriers and Facilitators of Implementation
Adele M. Hayes, *Chair*
Carly Yasinski, *Discussant*

Extensions of Structural Equation Modeling to Clinical Research
Lance Rappaport, *Chair*
Nicholas C. Jacobson, *Discussant*

Family Matters: Advances in Treatment Approaches for Child and Adolescent Depression
Erin O'Connor, *Chair*
Tessa Mooney, *Chair*
Elizabeth McCauley, *Discussant*

From the Lab to the Real World: How Stress Impacts Emotion Regulation and Subsequent Mental and Physical Health Outcomes
Kirsten E. Gilbert, *Chair*
Meghan E. Quinn, *Chair*
Amelia Aldao, *Discussant*

Getting the Most Out of Emotion Regulation in BPD: Which Strategies and Why
Janice Kuo, *Chair*
Skye Fitzpatrick, *Chair*
Amelia Aldao, *Discussant*

Health Anxiety Across the Life Span: A Renewed Investigation of Associated Psychological Mechanisms
Shannon M. Blakey, *Chair*
Norman B. Schmidt, *Discussant*

How Did You Get There From Here? How Environmental and Person-Level Characteristics Contribute to Nonsuicidal Self-Injury
Sarah E. Victor, *Chair*
Margaret Andover, *Discussant*

Identifying Mechanisms and Moderators of Behavior Change Using Behavioral Activation for Mood Disorders
Jackie Gollan, *Chair*
TBA, *Discussant*

If I Only Had a Brain (Disease): The Effects of Biomedical "Disease" Models of Mental Disorders on Stigma, Prognostic Expectations, and Attitudes Toward CBT
Nicholas R. Farrell, *Chair*
Dean McKay, *Discussant*

Impact of Online Relationship Interventions on Couple and Individual Functioning
Brian D. Doss, *Chair*
Andrew Christensen, *Discussant*

Implementation and Sustainability of DBT in Diverse Community Settings
Melanie S. Harned, *Chair*
Marsha M. Linehan, *Discussant*

Implementation of Evidence-Based Practices and Policy Mandates in Diverse Community Service Settings for Children With Autism Spectrum Disorder
Lauren Brookman-Frazee, *Chair*
Shannon Dorsey, *Discussant*

Improving CBT for Childhood Anxiety Disorders Through a Focus on Mechanisms of Change
Stephen P. H. Whiteside, *Chair*
Eric Storch, *Discussant*

Improving Dissemination and Treatment Outcomes via the Dismantling of Empirically Supported Treatments
Laren R. Conklin, *Chair*
Lisa Onken, *Discussant*

Improving Exposure Outcome in Anxiety Disorders
Ki Eun Shin, *Chair*
Michelle G. Newman, *Chair*
Michelle G. Craske, *Discussant*

Improving Our Understanding of Adaptations to Evidence-Based Treatments
Karen Guan, *Chair*
Alayna L. Park, *Chair*
Shannon Wiltsey Stirman, *Discussant*

Improving Psychological Care for People With Bipolar Disorder: Findings From the NIHR-funded PARADES Program
Steven Jones, *Chair*
TBA, *Discussant*

Innovations in the Treatment of GAD
Martin M. Anthony, *Chair*
Michelle G. Craske, *Discussant*

Innovative Approaches to Measuring Fidelity to Empirically Supported Treatment Elements and Approaches in Community Settings and Across Health Care Systems
Rochelle F. Hanson, *Chair*
Amanda Jensen-Doss, *Discussant*

Innovative Translational Research on Reinforcement Processes: Connecting Basic Lab Research to Inform Clinical Interventions
Victoria Ameral, *Chair*
Kathleen M. Palm Reed, *Discussant*

Integrating Perinatal Health and Mental Health: How Assessment and Intervention Studies Inform Evidence-Based Practice and Dissemination
Rachel P. Kolko, *Chair*
Michele D. Levine, *Chair*
Brian G. Danaher, *Discussant*

Interpersonal Contexts of Emotion Regulation
Kara Christensen, *Chair*
Todd Kashdan, *Discussant*

Interpersonal Mechanisms of Risk for Adolescent Depression
Jessica Hamilton, *Chair*
TBA, *Discussant*

Interpersonal Stress as a "Candidate Environment" for Depression: Neuroendocrine and Genetic Mechanisms
Suzanne Vrshek-Schallhorn, *Chair*
Lisa B. Starr, *Chair*
Kate Harkness, *Discussant*

Interventions for Individuals at Acute Risk for Suicide: Current Research Initiatives
Kate Bentley, *Chair*
Matthew Nock, *Discussant*

Intolerance of Internal Experiences in OCD: Emerging Findings Concerning Novel Psychological Mechanisms
Shannon Blakey, *Chair*
Norman B. Schmidt, *Discussant*

Intolerance of Uncertainty: A Transdiagnostic Perspective Through Different Research Paradigms
Ryan J. Jacoby, *Chair*
Jonathan Grayson, *Discussant*

Intolerance of Uncertainty: New Insights From Longitudinal Investigations
Kathryn A. Sexton, *Chair*
Michel J. Dugas, *Discussant*

Is Being Mindful Always Helpful? Trait Mindfulness and Related Processes as Moderators of Psychological, Health, and Interpersonal Outcomes
Shian-Ling Keng, *Chair*
David Fresco, *Discussant*

Is Being on the Net All Net Gain? Examining Negative Effects of Internet Exposure and Social Media on Youth Internalizing Problems
Tommy Chou, *Chair*
Mitchell J. Prinstein, *Discussant*

Is Hyperarousal a Transdiagnostic Process?
Christopher P. Fairholme, *Chair*
Stewart Shankman, *Discussant*

Living Life to the Fullest: Leveraging Personal Value-Directed Behavior to Enhance Well-Being and Undermine Psychological Distress
Christopher R. Berghoff, *Chair*
Timothy R. Ritzert, *Chair*
Daniel J. Moran, *Discussant*

Looking for Evidence of Evidence-Based Practice in Routine Care: What Practices Have Closed the Gap?
Sarah Kate Bearman, *Chair*
TBA, *Discussant*

Mechanisms of Change and Brain-Based Predictors of Response to CBTs for Anxiety and Depressive Disorders
Heidi Klumpp, *Chair*
Rachel Jacobs, *Chair and Discussant*

Mechanisms of Change for Trauma and Co-Occurring Problems in Urban Youth: Applications for Conceptualization, Intervention, and Dissemination
Liza Suarez, *Chair*
TBA, *Discussant*

Mechanisms of Change in Depression Treatment
Christine A. Padesky, *Chair*
Robert J. DeRubeis, *Discussant*

Mechanisms of Change in Relationship Interventions
Shelby B. Scott, *Chair*
Christina M. Balderrama-Durbin, *Chair*
Scott Stanley, *Discussant*

Mechanisms of Suicide Risk in the Context of Military Service Members and Veterans
Sarah P. Carter, *Chair*
Craig J. Bryan, *Discussant*

Mindful-Based Interventions for Veterans With PTSD: Cognitive, Behavioral, and Neurological Mechanisms of Change
Dana Charmakaya Colgan, *Chair*
Helane Wahbeh, *Chair*
Michael Gawrysiak, *Discussant*

Mindfulness Training Addresses Transdiagnostic Features of Mood Disorders: Implications for Treatment Development and Dissemination
Zindel Segal, *Chair*
Joel Sherrill, *Discussant*

Mobilizing Technology to Enhance Evidence-Based Practice: Assessment, Intervention, and Implications for Implementation
Margaret Anton, *Chair*
Joel Sherrill, *Discussant*

Moderators and Mediators of Impairment Associated With ADHD in Adulthood
Brian T. Wymbs, *Chair*
Andrea Chronis-Tuscano, *Discussant*

Moderators and Mediators of Treatment Response for Adolescent Depression
Eleanor L. McGlinchey, *Chair*
Martha C. Thompson, *Discussant*

Moderators of Cognitive-Behavioral Treatments for PTSD: Implications for Assessment, Intervention, and Dissemination
Erica L. Birkley, *Chair*
Patricia A. Resick, *Discussant*

Motivating Escape and Avoidant Coping: The Impact of Distress Intolerance on Health Behaviors
Kristin L. Szuhany, *Chair*
Michael W. Otto, *Discussant*

Moving Our Work Forward: Using Traditional Methods and Measurement in Novel Ways
Erin E. Reilly, *Chair*
Sasha Dmochowski, *Chair*
James Boswell, *Discussant*

Multimethod Examination of Positive Emotion Dysfunction as a Mechanistic Process Underlying Risky, Self-Destructive, and Health-Compromising Behaviors
Nicole, H. Weiss, *Chair*
Melissa A. Cyders, *Discussant*

Nature and Nurture: The Dynamic Interplay of Physiological Functioning and Family Interactions Across Youth Psychopathology
Christine E. Cooper-Vince, *Chair*
Tommy Chou, *Chair*
Amelia Aldao, *Discussant*

Negative Family Involvement Across Fear-Based Disorders
Lillian Reuman, *Chair*
Don Baucom, *Discussant*

Network Analysis Approach to Psychopathology and Comorbidity
Courtney Beard, *Chair*
Michael Treadway, *Discussant*

Network Analysis: A Symptom Perspective of Psychopathology
Cheri A. Levinson, *Chair*
Julia K. Langer, *Chair*

Neurocognitive Mechanisms in Pediatric Anxiety: Clinical Applications From Cognitive Developmental Neuroscience
Tomer Shechner, *Chair*
Michelle G. Craske, *Discussant*

New Advances and Recent Innovations in the School-Based Implementation of Evidence-Based Practices
Amanda L. Sanchez, *Chair*
Tommy Chou, *Chair*
Elizabeth H. Connors, *Discussant*

New Developments in the Treatment of OCD: Intensive and Concentrated Therapy
Lars-Goran Ost, *Chair*
TBA, *Discussant*

New Developments Toward the Personalized Treatment of Anxiety Disorders
Kate Wolitzky-Taylor, *Chair*
Sherry H. Stewart, *Discussant*

New Measurement Targets and Tools in Pediatric Anxiety and OCD
Robert R. Selles, *Chair*
Dean McKay, *Discussant*

Nonsuicidal Self-Injury and the Self: Exploring the Relationships Among NSSI, Body Factors, and Identity
Stephanie E. Bachtelle, *Chair*
Mary Lear, *Chair*
Margaret S. Andover, *Discussant*

Novel Analytic Methods to Clinical Psychology
Nicholas Jacobson, *Chair*
Lance Rappaport, *Chair*
David Atkins, *Discussant*

Novel Integrated Treatments for PTSD and Co-Occurring Conditions
Julianne C. Flanagan, *Chair*
Denise A. Hien, *Discussant*

Novel Methods in the Prediction of Suicidal and Nonsuicidal Self-Directed Violence
Michael Anestis, *Chair*
Alexander Chapman, *Chair*
Barent Walsh, *Discussant*

Novel Perspectives on Binge Drinking: The Bad, the Worse, and the Ugly
Matthew R. Pearson, *Chair*
Katie Witkiewitz, *Discussant*

Once More, With Feeling: Novel Psychosocial Interventions Informed by Basic Affective Science
Jasmine Mote, *Chair*
Sheri L. Johnson, *Discussant*

Organizational and Mental Health Provider Characteristics Associated With Evidence-Based Practices and Monitoring and Feedback Systems
Amelia Kotte, *Chair*
Kristin Hawley, *Discussant*

Parent Training for Children With Autism Spectrum Disorder and Disruptive Behavior: Results From a Large-Scale Randomized Clinical Trial
Karen Bearss, *Chair*
Susan White, *Discussant*

Partner Accommodation of PTSD Symptoms in Military and Veteran Couples
Steffany J. Fredman, *Chair*
Donald H. Baucom, *Discussant*

Patient Response Profiles: Patient Characteristics Influence Treatment Effects and the Strength of Process-Outcome Relationships in CBT for Depression
Nicholas Forand, *Chair*
Stefan Hofmann, *Discussant*

Personalized Modular Treatment of GAD and Major Depression
Aaron J. Fisher, *Chair*
James F. Boswell, *Discussant*

Policy-Driven Efforts to Implement Multiple Evidence-Based Interventions in Large Child Mental Health Service Systems
Lauren Brookman-Frazee, *Chair*
Bryan Samuels, *Discussant*

Predictors of Outcome and Mechanisms of Change Influencing Response to Exposure-Based CBT for Youth Anxiety and OCDs
Allison Waters, *Chair*
Tom Ollendick, *Discussant*

Preventing and Treating Emotional Disorders by Targeting Repetitive Negative Thinking
Thomas Ehring, *Chair*
Stefan G. Hofmann, *Discussant*

Prevention of Depression in Youth: New Developments, Outcomes, and Mechanisms
Patrick Possel, *Chair*
Judy Garber, *Discussant*

Prospection: An Examination of Future Thinking Across Anxiety, Depression, and Suicide
Jeffrey J. Glenn, *Chair*
Christine B. Cha, *Chair*
Bethany A. Teachman, *Discussant*

Psychologists in Medicine: Applying Core ACT Principles to Meet the Needs of Diverse Medical Populations
Joanna Arch, *Chair*
Steven Hayes, *Discussant*

Psychophysiological Measurement of Transdiagnostic Constructs With Relevance to Eating Disorders
Sarah E. Racine, *Chair*
Eunice Chen, *Discussant*

Psychosocial Considerations in Interventions for Transdiagnostic Risk Factors of Anxiety
Nicholas P. Allan, *Chair*
Jasper A. Smits, *Discussant*

Psychosocial Treatment of Adolescents and Adults With ADHD
Cynthia Hartung, *Chair*
TBA, *Discussant*

Reaching Behavioral Health Smokers With Effective Interventions
Carlo DiClemente, *Chair*
Chad Morris, *Discussant*

Recent Advancements in the Dissemination of Behavioral Activation
Rachel Herschenberg, *Chair*
Christopher Martell, *Discussant*

Repetitive Negative Thinking: Examining Cognitive Correlates and Transdiagnostic Associations With Treatment Outcome
Sarah Kertz, *Chair*
Colette Hirsch, *Discussant*

Results of a Randomized Controlled Trial of the NAVIGATE Recovery After an Initial Schizophrenia Episode-Early Treatment Program for First-Episode Psychosis
Shirley Glynn, *Chair*
TBA, *Discussant*

Reward-Processing Predictors of Depression Treatment Response: Initial Presentation of a Clinical Trial
Erin Walsh, *Chair*
Stacey B. Daughters, *Discussant*

Rumination and Reactivity: Multiple Approaches to Understanding a Transdiagnostic Risk Factor
Catherine B. Stroud, *Chair*
Lori M. Hilt, *Chair*
Lauren B. Alloy, *Discussant*

Same-Sex Couples and Health: Translational Research That Spans Basic Science Discovery to Efficacy Trials of Couples-Based Interventions
Michael E. Newcomb, *Chair*
Brian Mustanski, *Discussant*

Social Support and PTSD: Empirically Based Extensions of Current Knowledge
Jennifer DiMauro, *Chair*
Keith D. Renshaw, *Chair*
Marylene Cloitre, *Discussant*

Strengthening the Relationship Between Practice and Research: Logistics, Challenges, and Benefits From Treatment Effectiveness and Dissemination Studies
Lisa Berghorst, *Chair*
TBA, *Discussant*

Suicidality in Military Personnel and Veterans With PTSD: Risk Factors and Treatment Implications
Laurie J. Zandberg, *Chair*
Alan Peterson, *Discussant*

Supporting Change and Keeping It That Way: Evidence-Based Supervision Models Across Settings
Tara Mehta, *Chair*
Davielle Lakind, *Chair*
Kimberly E. Hoagwood, *Discussant*

Targets of Integrated Treatment Approaches for Comorbid Mental Health and Substance Use Problems in Teens and Adults: Four NIH-Funded Clinical Trials
Carla Kmett Danielson, *Chair*
Lisa Onken, *Discussant*

The Ins, the Outs, and the What-Have-You's of SAD: Intra- and Interpersonal Processes
Joseph K. Carpenter, *Chair*
Stefan G. Hofmann, *Discussant*

The Interplay of Health Behaviors and Substance Use in the Context of HIV
Nicholas S. Perry, *Chair*
David Pantalone, *Discussant*

The Neurocognitive Underpinnings of Anxiety: Implications for Theory and Treatment
Lauren S. Hallion, *Chair*
Shari A. Steinman, *Chair*
David F. Tolin, *Discussant*

The Role of Insomnia and Nightmares in PTSD Treatment: Is Sleep Dysfunction Being Overlooked?
Carmen P. McLean, *Chair*
Philip P. Gehrman, *Discussant*

The Role of Resilience in the Health and Well-Being of Minority Populations
Brian A. Feinstein, *Chair*
Trevor A. Hart, *Chair*
David H. Rosmarin, *Discussant*

Therapist Contributions to Treatment Response in the Pediatric OCD Treatment Studies: Exploring the "Franklin Effect"
Jeffrey Sapyta, *Chair*
TBA, *Discussant*

Therapy Engagement in Community-Based Child Mental Health Services: Evidence-Based Strategies for Engaging Families in Care
Jonathan I. Martinez, *Chair*
Lauren Brookman-Frazee, *Discussant*

Training and Supervision for Evidence-Based Practices: Principles of Change to Support Changes in Therapist Behavior
Robyn Schneiderman, *Chair*
Rinad S. Beidas, *Discussant*

Transdiagnostic and Common Element Interventions: Addressing Multidimensional Barriers to Dissemination and Implementation of Evidence-Based Practices
Amantia Ametaj, *Chair*
TBA, *Discussant*

Traumatic Life Experiences Among Sexual and Gender Minorities: Development and Dissemination of Evidence-Based Assessment and Intervention
Michael S. Boroughs, *Chair*
Conall O'Cleirigh, *Discussant*

Treating Body-Focused Repetitive Behavior Disorders
Robert R. Selles, *Chair*
Michael Himle, *Discussant*

Treatment Engagement in Veteran and Civilian Populations: Predictors, Barriers, and Preferences
C J Fleming, *Chair*
Shannon Kehle-Forbes, *Discussant*

Understanding and Treating Syndemic Health Problems Among Stigmatized Individuals
Brian A. Feinstein, *Chair*
John E. Pachankis, *Chair*
Steven A. Safren, *Discussant*

Understanding Suicidal and Nonsuicidal Self-Injury Among Adolescents and Emerging Adults: Recent Innovations and Future Directions
Evan M. Kleiman, *Chair*
Adam B. Miller, *Chair*
Mitchell J. Prinstein, *Discussant*

Understanding the Impact of Intimate Partner Communication During Deployment for Military Service Members and Their Partners
Christina Balderrama-Durbin, *Chair*
Douglas K. Snyder, *Discussant*

Understanding Trauma-Related Dissociation: Risk Factors and Outcomes
C J Fleming, *Chair*
Patricia Resick, *Discussant*

Unlocking Adherence: The Key to Improved Treatment Outcomes?
Sarah Markowitz, *Chair*
Louisa Sylvia, *Chair*
Michael Otto, *Discussant*

Using Innovative Technologies to Enhance the Evidence-Based Practice of Psychology
Melanie S. Harned, *Chair*
Linda A. Dimeff, *Discussant*

What's New in Family Interaction and Intervention Research?
Amy Weisman de Mamani, *Chair*
Kim Mueser, *Discussant*

Why Can't I Get Better?: Understanding Complicating Factors in the Course and Treatment of Bipolar Disorder
Emily E. Bernstein, *Chair*
Louisa G. Sylvia, *Chair and Discussant*

Youth Exposed to Violence: Identifying Protective Factors as Targets for Therapeutic Intervention
Noni K. Gaylord-Harden, *Chair*
Scott C. Leon, *Chair*
James Garbarino, *Discussant*

Special Interest Group Meetings

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

Addictive Behaviors
Friday, 1:15 P.M. - 2:15 P.M.,
Conference Room 4D

African Americans in Behavior Therapy
Friday, 3:00 P.M. - 4:00 P.M.,
Conference Room 4F

Anxiety Disorders
Friday, 11:00 A.M. - 12:00 P.M.,
Conference Room 4D

Asian American Issues in Behavior Therapy and Research
Friday, 10:30 A.M. - 11:30 A.M.,
Conference Room 4L

Attention-Deficit / Hyperactivity Disorder
Friday, 12:15 P.M. - 1:15 P.M.,
Conference Room 4D

Autism Spectrum and Development Disorders
Friday, 10:30 A.M. - 11:30 A.M.,
Conference Room 4K

Behavior Analysis
Friday, 2:30 P.M. - 3:30 P.M.,
Conference Room 4D

Behavioral Sleep Medicine
Friday, 10:15 A.M. - 11:45 A.M.,
Conference Room 4F

Bipolar Disorders
Friday, 3:45 P.M. - 4:45 P.M.,
Conference Room 4K

Child and Adolescent Anxiety
Friday, 2:30 P.M. - 3:30 P.M.,
Conference Room 4K

Child and Adolescent Depression
Saturday, 9:00 A.M. - 10:00 A.M.,
Conference Room 4L

Child and School-Related Issues
Friday, 1:15 P.M. - 2:15 P.M.,
Conference Room 4K

Child Maltreatment and Interpersonal Violence
Friday, 4:00 P.M. - 5:00 P.M.,
Conference Room 4F

Clinical Psychology at Liberal Arts Colleges
Friday, 11:00 A.M. - 12:00 P.M.,
Conference Room 4G

Cognitive Therapy
Friday, 3:45 P.M. - 4:45 P.M.,
Conference Room 4L

Couples Research and Treatment
Friday, 10:00 A.M. - 11:00 A.M.,
Conference Room 4D

Dissemination and Implementation Science
Saturday, 3:15 P.M. - 4:15 P.M.,
Conference Room 4D

Forensic Issues and Externalizing Behaviors
Saturday, 11:00 A.M. - 12:00 P.M.,
Conference Room 4D

Functional Analytic Psychotherapy
Friday, 12:30 P.M. - 1:30 P.M.,
Conference Room 4F

Hispanic Issues in Behavior Therapy
Friday, 12:00 P.M. - 1:00 P.M.,
Conference Room 4L

Men's Mental and Physical Health
Saturday, 11:00 A.M. - 12:00 P.M.,
Conference Room 4F

Mindfulness and Acceptance
Saturday, 9:30 A.M. - 10:30 A.M.,
Conference Room 4D

Native American Issues in Behavior Therapy and Research
Friday, 1:15 P.M. - 2:15 P.M.,
Conference Room 4L

Neurocognitive Therapies/ Translational Research
Saturday, 2:00 P.M. - 3:00 P.M.,
Conference Room 4D

Obesity and Eating Disorders
Saturday, 2:00 P.M. - 3:00 P.M.,
Conference Room 4K

Parenting and Families
Saturday, 10:00 A.M. - 11:00 A.M.,
Conference Room 4G

Schizophrenia and Severe Mental Illness
Friday, 12:15 P.M. - 1:15 P.M.,
Conference Room 4G

Spiritual and Religious Issues
Friday, 1:15 P.M. - 2:15 P.M.,
Conference Room 4G

Student
Saturday, 11:00 A.M. - 12:00 P.M.,
Conference Room 4K

Study of Lesbian, Gay, Bisexual, and Transgender
Saturday, 1:30 P.M. - 2:30 P.M.,
Conference Room 4L

Suicide and Self-Injury
Saturday, 10:00 A.M. - 11:00 A.M.,
Conference Room 4K

Technology and Behavior Change
Saturday, 1:30 P.M. - 2:30 P.M.,
Conference Room 4F

TIC and Impulse Control Disorders
Saturday, 3:15 P.M. - 4:15 P.M.,
Conference Room 4K

Trauma and PTSD
Saturday, 2:45 P.M. - 3:45 P.M.,
Conference Room 4L

Women's Issues in Behavior Therapy
Friday, 2:30 P.M. - 3:30 P.M.,
Conference Room 4L

Attendee Orientation to the ABCT Convention

Friday, 8:00 – 9:00 A.M., Salon A4, Lower Level

Bradley Riemann, *Membership Committee Chair*
Danielle Maack, *Student Membership Committee Chair*
David DiLillo, *Membership Issues Coordinator*
Hilary Vidair, *Ambassadors Chair*
Mary Jane Eimer, *Executive Director of ABCT*

Rise and shine! Maximize your ABCT convention experience by joining us first thing Friday morning! Enjoy a cup of coffee and get your personal blueprint to the Chicago Convention. Whether you are a first-time convention attendee or just want to refresh your memory on how to navigate the Convention, all are welcome. Learn how to take full advantage of earning continuing education credits and the documentation required, note networking opportunities, understand how to make the Convention program book your personal road map, how to utilize the online itinerary planner or master the Convention app.

Nursing Mothers Room

We are pleased to announce that for the first time we will be offering a nursing mothers room at the 49th Annual ABCT Convention. It has come to our attention through our Membership Committee and collaboration with the Womens Issues SIG that such a room has the potential to support the full participation of our attendees who have need to nurse or pump during the convention. It is important to ABCT that all attendees have access to resources that will ease their convention experience.

The nursing mothers room will be located on the 4th level of the Hilton Chicago Hotel, PDR 7 Room, and available from 7 a.m. to 7 p.m. Thurs. - Saturday, and 7 a.m. to 1:00 p.m. on Sunday. As this is our first year and we are testing out the room amenities, the room will be a shared space, so please knock before entering. The room will contain electrical outlets, chairs, water bottles, and waste paper baskets. We encourage your feedback on this room through our Convention survey (surveys available in the room), or by emailing Alyssa Ward, Ph.D., former Womens SIG Chair: **DrAlyssaWard@gmail.com**

Saturday Night Improv & Dance

PARTY

The Therapy Players, Chicago's very own Improv troop made up of mental health professionals, will bring their act out of the comedy clubs of Chicago and right to our very own Saturday-night party. Who knew therapists could be so funny?

Then dance away the evening—salsa, rumba, tango, or hip hop. We will have it all. Our DJ will take requests and the photo booth will have plenty of fun props for great pictures that you can take home as a memento of this great party. We hope to see you there!

SATURDAY

9:00 – 11:00 P.M.

Continuing Education
at ABCT's Annual Convention

ABCT is proud to offer you opportunities to learn from proven educators. Here is an efficient and effective way to hone your clinical skills, learn the results of the latest research, and earn continuing education credits as well.

The continuing education fee must be paid (see registration form) for a personalized continuing education credit letter to be distributed.

Psychology

ABCT is approved by the American Psychological Association to sponsor continuing education for psychologists. ABCT maintains responsibility for this program and its content.

Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit.

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

Social Work

ABCT program is approved by the National Association of Social Workers (Aprroval # 886427222) for 25 continuing education contact hours.

Counseling

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

California Board of Behavioral Sciences

ABCT is approved by the California Board of Behavioral Sciences as a continuing education provider for MFTs and LCSWs. ABCT has been granted license number 4600.

Registration & Hotel

Preregister on-line at www.abct.org or, to pay by check, complete the registration form available in PDF format on the ABCT website. Participants are strongly urged to register by the preregistration deadline of October 12, 2015. Between October 13 and October 16 registrations will be accepted at the on-site rates and no registrations will be processed after October 16.

Please note: Convention program books will be distributed on-site. Only those who choose to pay the postage and handling fee of $10 will be mailed a program book in advance.

To receive discounted member registration fees, members must renew for 2015 before completing their registration process.

Preconvention Activities and Registration
The preconvention activities will be held on Wednesday, November 11 and Thursday, November 12 at the Hilton Chicago Hotel. All preconvention activities are designed to be intensive learning experiences. Preregister to ensure participation.

Preregistration for preconvention activities closes October 12. Tickets will be mailed to preregistered attendees.

Any preconvention activities (AMASS, Clinical Intervention Training Sessions, and Institutes) that have open spots will be on sale at the On-site Registration Desk in Salon C on the Lower Level of the Hilton Chicago Hotel on Wednesday, November 11 from 7:30 a.m. to 9:30 a.m., and Thursday, November 12 from 7:30 a.m. to 1:00 p.m.

General Registration
To streamline registration, badges and tickets will be mailed to those who preregister before the deadline of October 12. Upon arrival at the Hilton Chicago Hotel, you can pick up the program book, addendum, additional convention information, and ribbons at the Pre-Registration Desk in Salon C on the Lower Level of the Hotel. PLEASE REMEMBER TO BRING YOUR BADGE, TICKETS, AND CONFIRMATION LETTER WITH YOU TO THE MEETING.

Registration AND materials pickup will be open:

Thursday, November 12: 1:00 p.m.– 8:00 p.m.
Friday, November 13: 7:30 a.m. – 5:00 p.m.
Saturday, November 14: 8:00 a.m. – 5:00 p.m.
Sunday, November 15: 8:00 a.m. – 12:00 p.m.

The general registration fee entitles the registrant to attend all events on November 13–15 except for ticketed sessions. Your canceled check is your receipt. Email confirmation notices will be generated automatically for on-line registrations and will be sent via email the same day you register. Email confirmations will be sent within 1 week for faxed and mailed registrations. If you do not receive an email confirmation in the time specified, please call the ABCT central office, (212) 647-1890, or email Tonya Childers at tchilders@abct.org.

You must wear your badge at all times to be admitted to all official ABCT sessions, events, and the exhibits. If you lose your badge there will be a $15 charge for the replacement.

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

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

Please note: NO PURCHASE ORDERS WILL BE ACCEPTED.

Registering On-Line
The quickest method is to register on-line at www.abct.org. Use this method for immediate feedback on which ticketed sessions you will be attending. To receive members' discounted rates, your ABCT dues must be up to date. If your membership has lapsed, use this opportunity to renew. To get member rates at this conference, your ABCT dues must be paid through October 31, 2016. The ABCT membership year is November 1 – October 31. For those registering on-site, you may renew membership at the ABCT membership booth located in Salon C on the lower level of the hotel.

Registering by Fax
You may fax your completed registration form, along with credit card information and your signature, to (212) 647-1865. If you choose this method please DO NOT send a follow-up hard copy. This will likely cause double payment. For preregistration rates, please register BEFORE the deadline date of October 12.

Registering by Mail
All preregistrations that are paid by check must be mailed to ABCT, 305 Seventh Avenue, 16th Floor, New York, NY 10001. For preregistration rates, forms must be postmarked by the deadline date of Monday, October 12. Forms postmarked between October 13 and October 27 will be processed at on-site rates. Forms postmarked October 28 or later will be processed on-site. There will be no exceptions.

Refund Policy
Refund requests must be in writing. Refunds will be made only until the October 12 deadline, and a $40 handling fee will be deducted. Because of the many costs involved in organizing and producing the Convention, no refunds will be given after October 12.

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

Exhibits, ABCT Information Booth Hours
- Friday & Saturday, 8:30 a.m. – 5:00 p.m.
- Sunday, 9:00 a.m. – 12:00 p.m.

Convention Headquarters Hotel

Hilton Chicago Hotel | 720 South Michigan Avenue
Chicago, IL 60605 U.S.

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

Rooms are available at the ABCT Convention rate until Wednesday, October 14, 2015. After this date, rooms and rates are subject to rate and room availability. Please be sure to book your reservation early! To reserve your room, go to **http://www.abct.org/conv2015**

ABCT Student Buddy Program

Danielle Maack, *Student Membership Committee Chair, University of Mississippi*

IN AN EFFORT TO WELCOME NEW first-time student attendees to the ABCT convention to help promote a positive convention experience, we invite participants in the Student Buddy program at the 49th Annual ABCT Convention in Chicago. This program matches new ABCT student convention attendees ("newbie") with seasoned ABCT student attendees ("buddy") to help familiarize the newbie to the ABCT convention and navigate the meeting. So, you might ask, "What's involved in this Convention Buddy program?" It's quite simple. After the buddy/newbie match has been created (based on information from submitted interest forms), each buddy and newbie will receive each other's contact information. Prior to the convention, the buddy will be asked to connect with the newbie at least once via email or phone to arrange a meeting time and place prior to attending the Friday, November 13, ABCT awards ceremony together. Following the awards ceremony, the buddy will take the newbie to the Welcoming Cocktail Party/SIG Expo, introduce the newbie to a few colleagues, and provide an overview on how to navigate the room. It's as simple as that!

If you and your buddy decide that you want to do more together throughout the convention or end up collaborating on research, that's a bonus! Again, the overall goal is to help newbies feel comfortable and leave after having a professionally rewarding experience. This is a great opportunity to meet new people and begin volunteering with ABCT. Questions? Please contact me, Dani Maack, at djmaack@olemiss.edu. Interested in being a part of this exciting new program? Either fax the mail-in interest form (212-647-1865) or email the requested information to Lisa Yarde at lyarde@abct.org.

Deadline for submissions: October 8, 2015

Newbie Interest Form

NAME:

AFFILIATION:

AREA OF INTEREST:

FACULTY MENTOR:

EXPECTED GRADUATION YEAR AND DEGREE:

QUESTIONS OR EXPECTATIONS OF FIRST ABCT CONVENTION:

Buddy Volunteer Form

NAME:

AFFILIATION:

AREA OF INTEREST:

FACULTY MENTOR:

EXPECTED GRADUATION YEAR AND DEGREE:

OF ABCT CONVENTIONS ATTENDED:

Find a CBT Therapist

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

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

To sign up for the Expanded Find a CBT Therapist, click on the **Renew/Join ABCT** *icon on the right-hand side of the home page; then click on the PDF "2016 Membership Application." You will find the Expanded Find a CBT Therapist form on p. 6.*

ABCT

findCBT.org

CBT Medical Educator Directory

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

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.

2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.

3. Training should take place or be affiliated with an academic training facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

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

To Submit Your Name for Inclusion in the Medical Educator Directory

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

Disclaimer

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

ABCT's Medical Educator Directory

http://www.abct.org
Resources for Professionals
Teaching Resources
CBT Medical Educator Directory

now

ABCT

online

Webinar | October 23
Simon Rego
Promoting Evidence-Based Practice

in-press

Generalization of Contextual Fear in Humans

"...[U]sing VR, it would be possible to build up trauma- or panic-relevant contexts and to expose the patient to such controllable virtual environments to initiate extinction processes. Moreover, VR would allow for manipulating the similarity between the exposure context and the anxiety-related context as well as manipulating features of the exposure context."

Andreatta et al.
Behavior Therapy
doi: 10.1016/j.beth.2014.12.008

archive

"In my view, when we talk about supportive instructional environments, we talk not only about information-rich settings, but also about environmental features that will shape and sustain effective mathemagenic behaviors."

—An Interview With Ernst Rothkopf: Reflections on Educational Psychology (Shaughnessy, *North American Journal of Psychology*, Vol. 7, 2005)

Calls for Editors

Call for Candidates for Editor of *the Behavior Therapist*

Candidates are sought for Editor-Elect of *the Behavior Therapist*, Volumes 40–42. The official term for the Editor is January 1, 2017 to December 31, 2019, 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 Anne Marie Albano, Ph.D., Publications Coordinator, ABCT, 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008 or via email to 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 October 1, 2015.
Vision letters will be required by October 15, 2015.

Call for Candidates for Editor of *Behavior Therapy*

Candidates are sought for Editor-Elect of *Behavior Therapy*, Volumes 49– 52. The official term for the Editor is January 1, 2018 to December 31, 2021, but the Editor-Elect should be prepared to begin handling manuscripts at least 1 year prior.

Candidates should send a letter of intent and a copy of their CV to Anne Marie Albano, Ph.D., Publications Coordinator, ABCT, 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008 or via email to 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 at the appropriate time. 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 October 1, 2015. Vision letters will be required by October 15, 2015. The Editor will be selected at ABCT's Board of Directors meeting in November.

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
ADDRESS SERVICE REQUESTED

AWARDS & RECOGNITION

Congratulations to ABCT's 2015 Award Winners

Career/Lifetime Achievement
- *David M. Clark, Ph.D.*
  University of Oxford

Outstanding Clinician
- *Anne Marie Albano, Ph.D.*
  Columbia University

Outstanding Training Program
- *Charleston Consortium Psychology Training Program*
  Daniel Smith, Ph.D., Co-Director
  Dean G. Kilpatrick, Ph.D., Co-Director

Friend to Behavior Therapy
- *Benedict Carey*
  New York Times

Outstanding Service to ABCT
- *David A. F. Haaga, Ph.D.*
  American University

Virginia A. Roswell Student Dissertation Award
- *Danielle E. MacDonald, M.A.,* Ryerson University

Leonard Krasner Student Dissertation Award
- *Lauren E. Szkodny, M.S.,*
  Pennsylvania State University

President's New Researcher Award
- *Rinad S. Beidas, Ph.D.,* University of Pennsylvania

ADAA Travel Career Award
- *Lindsey Brooke Hopkins, Ph.D.*
- *Brady Nelson, Ph.D.*
- *Carrie Potter, M.A.*

ABCT **Awards & Recognition** **Katherine Baucom, Ph.D., Chair**