

# *the* Behavior Therapist

## Contents

### President's Message

*Dean McKay*

Multiple Disciplines Within the Social Sciences:  
Advancing Cognitive-Behavior Therapy • 29

### From the Editor

*Brett Deacon* • 32

### Clinical Training Update

*Genna Hymowitz, Jessica Salwen, Dina Vivian, Jenna Adamowicz, Aurora Pryor, Catherine Tuppo, Kathryn Cottell, and Heidi Lary Kar*

The Stony Brook University Interdisciplinary Approach  
to the Management of Morbid Obesity • 34

### Research-Practice Links

*Jon Strand and Ricks Warren*

Panic Control Treatment in Private Practice: Effectiveness  
and Clients' Perspectives • 42

### Past Presidents Series

*Alayna Schreier and David J. Hansen*

Perspectives From Past Presidents: Assessment and  
Evidence-Based Practice • 45

### At ABCT

Minutes of the Annual Meeting of Members • 46

\* Preparing to Submit an Abstract • 50

\* Call for Papers • 51

\* Philadelphia Is for Foodies • *back page*

\* ANNUAL CONVENTION IN PHILADELPHIA, NOVEMBER 2014

### *President's Message*

## Multiple Disciplines Within the Social Sciences: Advancing Cognitive-Behavior Therapy

*Dean McKay, Fordham University*



A recent survey (Heatherington et al., 2013) noted that most faculty at research-based doctoral training programs in clinical psychology identify cognitive-behavior therapy (CBT) as their primary theoretical orientation. The dominance of CBT in research-based programs is not surprising given the strong identity of the approach with scientific foundations of behavior. Our approach to treatment has been at the front of the pack in defining the parameters for empirically supported practice, as evidenced by CBT's established efficacy (Hofmann et al., 2012). Heatherington et al. lament the lack of theoretical diversity on the grounds that this will stifle scientific progress in psychosocial interventions. Since we in the CBT movement effectively speak the same language, those of us in programs that primarily emphasize CBT would be essentially operating in an echo chamber, and our approaches might go unchallenged. To this end, a related question that could be asked is, *How informed is CBT by other approaches in the social sciences?*

Heatherington et al. (2013) raise the concerns over limited theoretical diversity within clinical practice. In their survey results, the different theoretical orientations are organized into

[continued on p. 31]

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## Deadline: March 3, 2014

## 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.

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the broad categories of CBT, behavioral,<sup>1</sup> psychodynamic, family systems, and humanistic/existential. They further noted that while the research-oriented programs are largely CBT-oriented, there were more diverse theoretical orientations among free-standing professional schools, counseling doctoral programs, and programs that had a generally lower emphasis on research. There are likely very compelling reasons for this disparity—funding priorities, department hiring practices, productivity of the available scholars within disciplines, internal department politics, just to name a few. Some theoretical approaches, whether fair or not, have become inexorably associated with being something other than scientific. For example, Bornstein (2001, 2002), who is a psychodynamic-oriented researcher, has lamented the antiscience bias (among other challenges) that his same theoretically oriented colleagues need to overcome. Among members of ABCT, the lack of theoretical diversity within clinical psychology is reasonable, and likely has contributed to our ability to focus on specific technique refinements.<sup>2</sup> It has also allowed the diversity of theories within CBT to flourish. And, for me personally as a New York psychologist, the seeming hegemony of CBT may actually be chimeric, since it is still difficult to find suitably trained CBT-oriented psychologists in my community (the tri-state NY area).

To be clear, I am not making a call for more diversity of theories within clinical psychology. However, I do believe we can do better in drawing from other disciplines within the broader social sciences, and integrate these approaches into the science of CBT. To my colleagues in departments that house social psychologists, developmental scientists, basic learning theorists, or basic experimental social scientists (i.e., attention, memory, perception, sensation), consider asking yourself: How much is our work influenced by these disparate areas? These research areas could contribute much to our own work in CBT, in much the way it has in the past when CBT was in its infancy. In this way, the practice of CBT will continue to grow as we draw further upon psy-

chosocial theories that have something to contribute to our practice.

There are some examples we can use to show how the influence of other theoretical traditions and laboratory methods have informed contemporary CBT research. One major development in CBT, attention retraining (cf. Najmi & Amir, 2010), owes much of its development from years of basic psychopathology research on attention allocation processes (Williams, Mathews, & MacLeod, 1996), with roots in general attention allocation theory (i.e., parallel distributed processing: Cohen, Dunbar, & McClelland, 1990). Would this approach exist had clinical scientists ignored the implications of this basic research finding for understanding and potentially ameliorating psychopathology?

Attention retraining has the benefit of being ground in basic science and associated theory. While the roots of virtually all our approaches, and their contemporary modifications, owe a great deal to the basic sciences and laboratory models, it has not been as obvious that we continue to draw on theoretical perspectives from other disciplines. There are some promising potential areas, such as the influence of social psychological processes in clinical practice (Maddux & Tangney, 2010), in particular in health psychology (Klein, Rothman, & Cameron, 2013). There is also the recent inhibitory learning model of exposure (Abramowitz, 2013; Craske et al., 2008), which draws much of its conceptualization from basic laboratory context-learning and memory research (Bouton, 2007).<sup>3</sup> While there are some glimmers of developments where the influence of disciplines outside clinical practice may impact CBT, our colleagues in other disciplines within the social sciences represent great untapped resources for furthering the science of CBT. While many researchers are seeking ways to make their research translational (i.e., between clinical science and neuroscience or medicine) in order to maximize funding opportunities, it may be at the expense of truly innovative translations from the basic science laboratories of colleagues in nearby labs.

Consider this column my informal advertisement for the next ABCT conference,

with a theme that stresses multiple theoretical approaches within the social sciences. Cognitive-behavior therapy has benefited greatly from other scientific disciplines over the years. As noted above, the foundation of CBT is built on basic learning theory (see Kazdin, 1978, for a historical analysis), social psychology (such as attribution theory; Försterling, 1988), and cognitive science (as in the aforementioned attention retraining example). It is my hope that this will serve as an important call for greater translational research within our highly diverse and vibrant discipline.

## References

- Abramowitz, J.S. (2013). The practice of exposure therapy: Relevance of cognitive-behavioral theory and extinction theory. *Behavior Therapy, 44*, 548-558.
- Bornstein, R.F. (2001). The impending death of psychoanalysis. *Psychoanalytic Psychology, 18*, 3-20.
- Bornstein, R.F. (2002). The impending death of psychoanalysis: From destructive obfuscation to constructive dialogue. *Psychoanalytic Psychology, 19*, 580-590.
- Bouton, M.E. (2007). *Learning and behavior: A contemporary synthesis*. Sunderland, MA: Sinauer Associates.
- Cohen, J.D., Dunbar, K., & McClelland, J.L. (1990). On the control of automatic processes: A parallel distributed processing account of the Stroop effect. *Psychological Review, 97*, 332-361.
- Craske, M.G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy, 46*, 5-27.
- Försterling, F. (1988). *Attribution theory in clinical psychology*. Oxford, UK: Wiley.
- Heatherington, L., Messer, S.B., Angus, L., Strauman, T.J., Friedlander, M.L., & Kolden, G.G. (2013). The narrowing of theoretical orientations in clinical psychology doctoral training. *Clinical Psychology: Science and Practice, 19*, 362-374.
- Hofmann, S.G., Asnaani, A., Vonk, I.J., Sawyer, A.T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research, 36*, 427-440.
- Kazdin, A.E. (1978). *History of behavior modification*. Baltimore, MD: University Park Press.
- Klein, W.M.P., Rothman, & A.J., Cameron, L.D. (2013). Theoretical innovations in social and personality psychology and implications for health: Introduction to the special issue. *Health Psychology, 32*, 457-459.
- Maddux, J.E., & Tangney, J.P. (2010). *Social psychological foundations of clinical psychology*. New York: Guilford.

<sup>1</sup> The separate categorization of CBT and behavioral is a product of faculty self-identified orientations. These two categories accounted for 89% of respondents in their survey (Heatherington, et al., 2013, Table 1, p. 366).

<sup>2</sup> The focus solely on theoretical approaches that are within the broader CBT movement has not been hailed by all as a good thing, and there have been some interesting and worthwhile discussions about points of intersection between CBT and other approaches (i.e., Wachtel, 1997).

<sup>3</sup> See also the recent lively discussion about inhibitory learning on ABCT's list serve (from Oct. 10 through Oct. 21, 2013, with last post a summary of the discussion distributed by Kelly Koerner).

- Najmi, S., & Amir, N. (2010). The effect of attention training on a behavioral test of contamination fears in individuals with subclinical obsessive-compulsive symptoms. *Journal of Abnormal Psychology*, 119, 136-142.
- Wachtel, P.L. (1997). *Psychoanalysis, behavior therapy, and the relational world*. Washington, DC: American Psychological Association.
- Williams, J.M.G., Mathews, A., & MacLeod, C. (1996). The emotional stroop task and psychopathology. *Psychological Bulletin*, 120, 3-24.

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I am indebted to Brett Deacon for very helpful comments on a prior draft of this column.

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*At ABCT*

## From the Editor

Brett Deacon, *University of Wyoming*

Allow me to introduce myself. My name is Brett Deacon, and I am honored to serve ABCT as the incoming editor of *the Behavior Therapist* (tBT). ABCT has been my professional home for the past 15 years and has enriched my career and life in innumerable ways. I proudly support the mission of ABCT and am grateful for this opportunity to contribute to the advancement of science-based approaches to understanding and improving the assessment, prevention, and treatment of mental health problems, and to promote health and well-being.

I want to acknowledge Kate Gunthert, the outgoing editor. tBT has flourished under her excellent leadership, and she has worked hard to ease my transition into her former role. Kate assembled a strong group of associate editors, most of whom have graciously agreed to remain on board. With the addition of some new colleagues, we have an editorial team poised to serve tBT well in the years ahead.

tBT occupies a unique niche among CBT publications. As a vehicle for rapid dissemination of news, recent advances, and innovative applications in CBT, tBT serves a critical function not duplicated by any other

ABCT publication. Because tBT is received by all ABCT members, it also has tremendous potential to influence the field. My goal as editor is to maximize tBT's contribution to the mission of ABCT by fostering timely, critical, and productive dialogue on the major contemporary issues facing cognitive-behavioral practitioners and scientists. Despite the extraordinary historical success of CBT, our field is faced with numerous challenges, and emerging issues and technologies pose new opportunities. It is my hope that tBT will play a leading role in addressing these issues.

These are exciting times, and I want tBT to be the source for cutting-edge news, commentary, and science. I invite you, dear colleague, to join me in helping tBT contribute to ABCT's mission by submitting articles, suggesting ideas, describing important developments, and providing feedback. For details about the formal submission process, please review the Instructions for Authors box that appears in every issue of tBT. You may contact me at my email address through the University of Wyoming (bdeacon@uwyo.edu) until July, when I begin a new academic position at the University of Wollongong in Australia. I look forward to working with you! ■

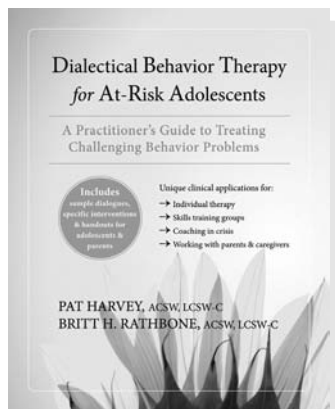
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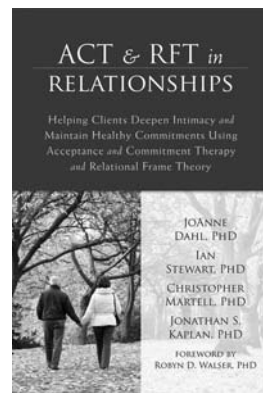


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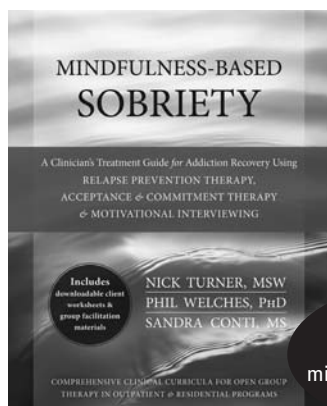


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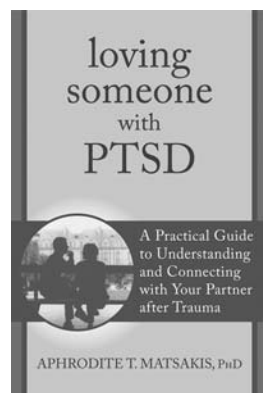
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## The Stony Brook University Interdisciplinary Approach to the Management of Morbid Obesity

Genna Hymowitz, *Stony Brook University and Stony Brook Medicine*

Jessica Salwen, Dina Vivian, Jenna Adamowicz, *Stony Brook University*

Aurora Pryor, Catherine Tupper, Kathryn Cottell, *Stony Brook Medicine*

Heidi Lary Kar, *Stony Brook University*

As the importance of considering biological, psychological, and socioeconomic factors in chronic illnesses becomes increasingly clear, scientists and clinicians can no longer ignore the need to bridge the gaps among disciplines and engage in multidisciplinary and interdisciplinary research and clinical collaborations. With an emphasis on clinical training that integrates science and practice, psychologists are in a unique position to foster such collaborations, and have already begun to do so (e.g., Gatchel & Okifuji, 2006). Additionally, recent research has demonstrated that treatment effectiveness may increase with the use of multidisciplinary approaches. For example, in the management of chronic pain (Gatchell & Okifuji; Scascighini, Toma, Dober-Spielmann, & Sprott, 2008) and migraine and chronic headache (Lemstra, Stewart, & Olszynski, 2002; Magnusson, Reiss, & Becker, 2004), multidisciplinary treatments were significantly more successful than treatment as usual in producing symptom reduction and increases in quality of life. Furthermore, in a sample of chronic pain patients enrolled in a multidisciplinary treatment program, symptom reduction and decreased depression were associated with changes in pain beliefs and coping strategies (Jensen, Turner, & Romano, 1994).

Medical guidelines are also beginning to recognize the role of psychosocial evaluation and intervention in overall patient care and reflect this increased understanding of the need for multidisciplinary approaches in health care. For instance, multiple organizations, including the American Society of Anesthesiologists, National Comprehensive Cancer Network, and U.S. Preventive Services Task Force support the use of psychological evaluations and interventions to identify factors that may predict treatment success and manage overall patient distress

and behavior changes (American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine, 2010; Moyer, 2012; National Comprehensive Cancer Network, 2003). In addition, the recently revised American Heart Association and American College of Cardiology clinical guidelines for obesity treatment indicate that interventions for the treatment of obesity should include behavior therapy in addition to a reduced calorie diet and increased physical activity (Jensen et al., 2013). The American Association of Clinical Endocrinologist, The Obesity Society, and American Society for Metabolic & Bariatric Surgery Clinical Practice Guidelines also recognize the need for multicomponent treatment, indicating that individuals considering bariatric surgery should undergo a psychosocial-behavioral evaluation and advocate the use of multidisciplinary interventions that include assessment for psychological complications and behavioral modification strategies (Mechanick et al., 2013).

However, despite growing acceptance by the medical community of interdisciplinary approaches that address psychological factors, there are few clinical psychology training programs that offer adequate interdisciplinary training opportunities. Thus, future psychologists may be left ill equipped to navigate our increasingly complex health care and research environments. To combat the lack of training opportunities in this area, the Stony Brook University Bariatric and Metabolic Weight Loss Center (BMWLC), Krasner Psychological Center (KPC), and Department of Family Medicine have come together to develop a unique program offering multi- and interdisciplinary training opportunities (from here on denoted as the SBU Obesity Program). The area of obesity provides us

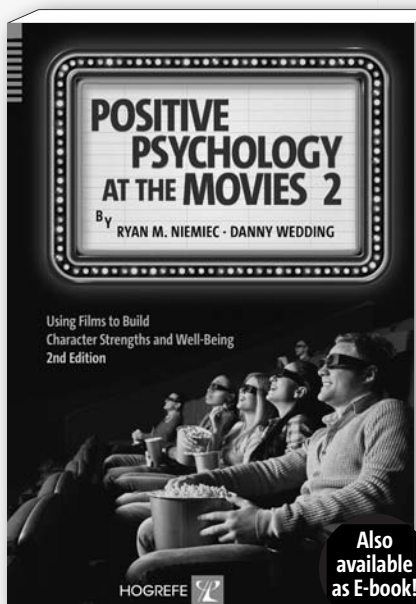
with an excellent example of the need for evidence-based interdisciplinary interventions, research and training opportunities, particularly given the increasing emphasis on a biopsychosocial conceptualization of obesity (National Institutes of Health, 1998). The aim of the current paper is to outline one program's efforts to balance interdisciplinary demands and provide interdisciplinary training for psychologists. Before more thoroughly outlining the current program, it is appropriate to briefly review current research regarding obesity and obesity treatment.

Morbid obesity is a risk factor for a number of life-threatening medical conditions, including heart disease, stroke, diabetes, and cancer, and is associated with mood and anxiety disorders, and increased risk for binge-eating and attempted suicide (Dong, Li, Li, & Price, 2006; Heo et al., 2003; Kolotkin, Meter, & Williams, 2001). Additionally, obesity impacts many areas of daily functioning and can lead to an overall impairment in quality of life (Wang et al., 2008). Despite the significant negative consequences of obesity, the prevalence of morbid obesity has been increasing at an alarming rate over the past two decades (National Center for Chronic Disease Prevention and Health Promotion, 2011). In fact, being overweight is estimated to be the second leading preventable cause of death in the U.S. (Mokdad, Marks, Stroup, & Gerberding, 2004).

Furthermore, although historically obesity was viewed as a simple problem with a simple solution, we now understand that immunological, genetic, neurological, behavioral, environmental, sociopolitical, and endocrinological factors contribute to the development and maintenance of obesity (Agurs-Collins, & Bouchard, 2008; Astrup et al., 1996; Bouchard, 2008; Davis et al., 2011; Fox et al., 2008; Jaworowska & Bazylak, 2011) and that obesity is a chronic disease requiring care throughout the course of a patient's life. The multiple etiological factors leading to obesity, the chronic course of this disease, and the marginal effectiveness or poor maintenance of treatment gains associated with current unimodal treatments (e.g., behavior therapy, dietary changes, physical activity, and/or pharmacotherapy) suggest the need for a comprehensive and interdisciplinary approach to the management of obesity. Research studies evidence this need, suggesting that comprehensive treatments including reduced caloric intake, increased physical activity, and behavior therapy lead to weight loss that is significantly greater



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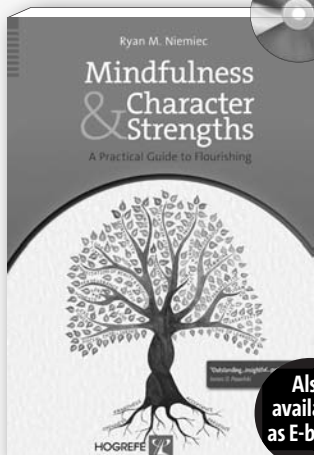
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than that achieved through usual care or limited education and advice (Avenell et al., 2009; Jensen et al., 2013). Furthermore, individuals who undergo a treatment combining dietetic counseling and cognitive therapy or behavior therapy may have better long-term results than individuals who engage in dietary counseling or combined diet and exercise programs (Wadden, & Stunkard, 1986; Werrij et al., 2009). Recent reviews of the literature also indicate that long-term weight loss results can be improved when dietary treatment is combined with either behavior modification, exercise, or pharmacological treatment (Avenell et al., 2004; Jensen et al.).

However, as we are just beginning to understand the complex nature of this disease, there is need for continued investigation into the area of obesity and obesity treatment. The emphasis on interdisciplinary, integrative science and practice is particularly important in a climate where the needs for treatment far outstrip the available resources. Additionally, the available treatments need to be evidence-based and efficacious in order to be supported by third-party payers and government entities. Greater demands for treatment accountability and the factors mentioned thus far have led entities such as the APA, NIH, and NIMH to set as priorities research agendas that seek to promote interdisciplinary collaborations and the integration of science and practice through translational research

paradigms. This integration is particularly applicable when we target outcome research.

We feel that in order to fully achieve this integration, it is necessary to establish cross-disciplinary programs that emphasize research, training and clinical work. Thus, the SBU Obesity Program is designed to (a) provide clients with evidence-based integrated interdisciplinary weight management interventions, (b) provide clinical training opportunities in the area of weight management, and (c) advance our understanding of the etiology and treatment of obesity through basic and outcome research that focuses on the integration of science and practice.

### Program Structure

As stated above, the SBU Obesity Program involves collaborations among the departments of psychology, surgery, and family medicine. The flow chart in Figure 1 depicts the various aspects of this program, including the initial evaluation and treatment process. All new patients who seek treatment at the Stony Brook Medicine BMWLC undergo thorough medical, nutritional, and psychological assessments.

#### Initial Evaluation

The initial *medical assessment* involves a comprehensive review of the patient's medical history and screening for comorbidities

associated with obesity, such as hypertension, diabetes, hyperlipidemia, and sleep apnea. Follow-up medical appointments and additional diagnostic evaluations are then scheduled as medically indicated. The goal of the *nutritional assessment* is to evaluate eating behaviors and patterns, weight history, and environmental issues that may affect weight management. In addition, the nutrition care plan focuses on facilitating development of healthful eating behaviors and lifestyles with the ultimate goals of achievement and maintenance of a healthy weight. Finally, the aim of the *psychological assessment* is to evaluate emotional stability, emotional resilience, motivation and commitment to comply with long-term lifestyle changes, and ability to learn new skills, make wise self-care choices, and set limits. This evaluation includes a comprehensive structured clinical interview and a battery of self-report instruments designed for general assessment of psychological functioning and eating disorders. To ensure effective communication among health care providers, the members of the core treatment team, including surgeons, physical therapists, nurse practitioners, registered dietitians and psychologists, meet on a weekly basis to discuss patient treatment plans.

#### Presurgery Treatment Options

Following the initial evaluations, patients are offered the opportunity to partici-

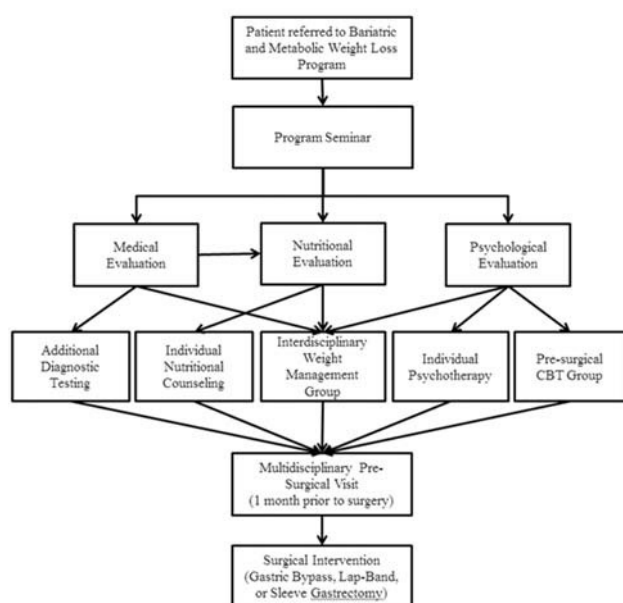


Figure 1. SBU Obesity Program prebariatric surgery

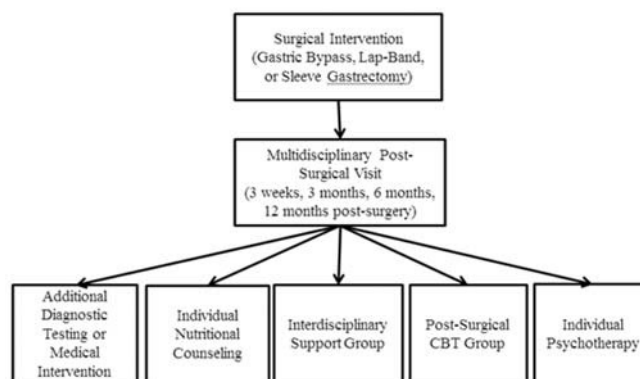


Figure 2. SBU Obesity Program postbariatric surgery



pate in an interdisciplinary 6-month medically supervised weight loss group. This psychoeducational evidence-based group intervention was developed through the collaborative efforts of a team of psychologists, registered dietitians, a physical therapist, and a surgeon and is based upon U.S. Preventive Services Task Force clinical guidelines (Moyer, 2012), the MOVE! Program developed by the Department of Veterans Affairs (Kinsinger et al., 2009; Romanova, Liang, Deng, Li, & Heber, 2013), and the LEARN program for weight management (Brownell, 2004). It is co-led by these various providers, incorporates the elements outlined by Foster, Makris, and Bailer (2005) in their review of behavioral treatments for obesity, and provides patients with information regarding healthful nutrition, planned exercise and lifestyle physical activity, and effective strategies to make cognitive-behavioral changes necessary to lose weight and maintain weight loss. Topics covered include teaching patients the cognitive, emotional, and behavioral factors that lead to dysfunctional eating, the role of exercise and physical activity in maintaining a healthful life style, increasing motivation and eliminating obstacles to physical exercise, how to start an

exercise program, types of exercise, mindfulness-based interventions, food label reading, portion sizes, stress management, self-monitoring of physical activity and nutritional intake, and problem-solving challenging eating situations.

In addition to the medically supervised weight loss group intervention, if the results of the initial psychological evaluation indicate that a patient would benefit from additional psychological intervention, that patient is invited to participate in a 12-session presurgical cognitive behavioral therapy (CBT) group program. This intervention was adapted from the programs outlined by Apple, Lock, and Peebles (2006), Craighead (2006), and Mitchell and de Zwaan (2005). The goal of this weekly 90-minute CBT-based group is to help surgical candidates prepare for the attitudinal, emotional, physical, and behavioral changes expected after surgery by providing them with the basic skills necessary to manage stress effectively, set clear limits with oneself and with others, maintain clear boundaries, reframe faulty thoughts about food, eating, and oneself, engage in basic self-care behavior, and set realistic expectations for surgery. Topics covered include discussion of the cognitive behavioral model of overeating,

eating and weighing behaviors, mindful eating, stress management, self-care and participation in pleasurable alternative activities, problem-solving and cognitive restructuring, presurgery planning, and relapse prevention. Furthermore, those individuals who require even more intensive psychological treatment, for example, those patients who are experiencing significant symptoms of binge-eating disorder, depression, or anxiety or who require a more thorough stress management training program, are scheduled for individual short-term psychotherapy before bariatric surgery. Patients who are eligible for bariatric surgery then meet with the psychologist, registered dietitian, and surgeon 1 month prior to surgery for additional education and support and to review pre- and postsurgical guidelines.

#### *Postsurgery Treatment Options*

As shown in Figure 2, following surgery, visits with the interdisciplinary team (surgeon, registered dietitian, and psychologist) occur at 3 weeks, 3 months, 6 months, and 1 year. All patients are also invited to participate in the interdisciplinary support group co-led by a psychologist, registered dieti-



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cian, nurse practitioner, and physical therapist. Those patients identified by the treatment team as in need of additional coping skills training or further psychological intervention are invited to participate in a more structured evidence-based postsurgical group. This program was developed based on the work of Apple et al. (2006) and Craighead (2006). Topics covered in this group include the CBT model as it relates to eating, identifying triggers to overeating, identifying hunger and fullness cues, mindful eating, problem solving, review of healthful postsurgical eating and physical activity habits, stress management, body image, interpersonal skills efficacy training, and planning for challenging eating and interpersonal situations. Furthermore, patients in need of a more comprehensive or individualized approach are scheduled for individual short-term CBT.

### Training

Through collaborations with the Departments of Psychology and Family Medicine, the SBU Obesity Program also offers clinical training opportunities (e.g., externships and internships) for dietetic interns, medical students, and psychology doctoral students who are interested in weight management and obesity treatment. Doctoral students who are currently working with the psychological team under the supervision of Drs. Hymowitz and Vivian are trained to conduct behavioral medicine interviews, score a battery of self-report questionnaires, write behavioral medicine reports, provide group and individual treatment, effectively communicate with health care providers from a number of disciplines, and work as part of interdisciplinary treatment and research teams. As part of the training program all students interested in conducting behavioral medicine evaluations are provided with background

readings focusing on the areas of obesity and weight management and are trained to administer and score a battery of self-report questionnaires used in comprehensive weight management and prebariatric surgery behavioral medicine evaluations. Students are also required to learn how to code and enter the data from the battery of self-report questionnaires and the clinical interview administered to each client and write clinical reports. When students are deemed competent enough to conduct evaluations independently, they are permitted to do so under the supervision of the program directors. Supervision is initially in vivo, and then, when deemed appropriate, is based on the student clinician's reports of any challenges. Students are also encouraged to attend weekly interdisciplinary treatment planning meetings and monthly team research meetings, lead interdisciplinary weight management group treatment sessions, treat individual eating disorder and weight management clients, provide inpatient and outpatient case-consultation, and become involved with the various SBU Obesity Program research activities. Furthermore, students are encouraged to communicate regularly with the various members of the treatment team, including the dietician, physical therapist, surgeons, surgical fellows, medical residents, and nurse practitioners at all points in the treatment process. In addition, trainees are also given opportunities to provide psychoeducational workshops to other health care practitioners on topics such as weight bias and patient/clinician communication.

Thus far, three doctoral students have participated or are currently participating in our training program. After completion of her training, one of our former trainees went on to complete an externship program focusing on interdisciplinary research and clinical work with pediatric patients. Another doctoral student and one of the authors of this paper (JS) has continued to par-

ticipate in our program throughout her doctoral training, is planning to attend an internship program that includes an interdisciplinary training component, and has been invited to present research based on the work she has done in this program at national conferences. Further evaluation of our training program will be accomplished through the use of surveys administered to trainees upon completion of their formal clinical training and for up to 2 years postinternship.

### Interdisciplinary Research

In addition to offering a comprehensive treatment program, the SBU Obesity Program is also involved in interdisciplinary research collaborations with the departments of psychology, endocrinology, surgery, and pharmacology. Members of the treatment team are currently developing and implementing research protocols that evaluate biopsychosocial correlates of obesity and predictors of outcome of surgical and behavioral treatments for obesity. Some of this work in the area of treatment outcome research has received grant support and the program itself is undergoing rigorous evaluation to assess and continually improve the services provided to patients.

### Psychological Research

As part of the development of the research component of the SBU Obesity Program, we first applied to the Stony Brook University Human Subjects Institutional Review Board (IRB) for a waiver of consent for retrospective examination of the charts of 282 patients who presented for psychological evaluations between March 2010 and November 2012. This proposal was approved, and thus, we were able to use data from a 75-minute semistructured clinical interview, in addition to numerous self-report measures that were all administered as part of standard clinical care.

One of the initial studies using a subset of 187 participants from the aforementioned data set evaluated psychosocial factors associated with morbid obesity (Salwen, Hymowitz, Vivian, & O'Leary, in press). In particular, we were interested in assessing prevalence rates of childhood abuse (physical neglect, emotional neglect, emotional abuse, physical abuse, and/or sexual abuse) and adult interpersonal abuse (emotional abuse, physical abuse, sexual abuse, and/or receiving threats of death or abandonment) in this population, and evaluating the role that these factors play in de-

**Table 1.** DSM-IV Diagnoses of a Prebariatric Surgery Population

Depressive Disorders		Anxiety Disorders		Other Disorders	
Disorder	%	Disorder	%	Disorder	%
Depressive Disorder NOS	3.8	Anxiety Disorder NOS	3.0	Alcohol Dependence	.4
Major Depressive Disorder	3.1	Panic Disorder	3.0	ADHD	.4
Dysthymic Disorder	2.5	GAD	2.1	Cognitive Disorder	.4
Bipolar Disorder	1.3	Specific Phobia	.4		
		Social Phobia	.4		
		PTSD	.4		

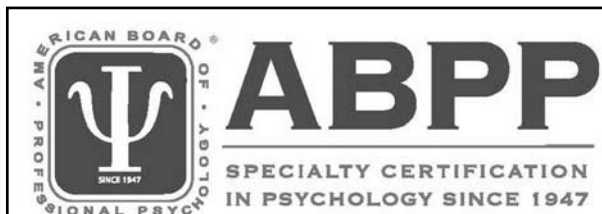
pressive symptoms and morbid obesity. This study provided evidence that patients with morbid obesity seeking bariatric surgery endorse rates of childhood abuse at higher rates than those of other medical populations. Furthermore, the rates of childhood abuse in this population were comparable to those found in populations of individuals with chronic depression or eating disorders. In fact, 61% of the bariatric surgery candidates reported having experienced some form of childhood abuse and 30.5% reported adult interpersonal abuse. Additionally, greater (or more severe) childhood abuse was associated with greater interpersonal abuse in adulthood and current depressive symptoms, and adult interpersonal abuse partially mediated the relationship between childhood abuse and current depressive symptoms. These findings suggest that, while childhood abuse may be related to the initial development of problematic eating patterns and obesity, it may also be related to the development of factors that maintain problematic eating and obesity, such as adult abuse or psychological distress. These results underscore the importance of assessing, and, as needed, psychologically treating, factors related to a

patient's interpersonal history (early and current), in the management of morbid obesity. Relatedly, they highlight the important role that a psychologist plays in a team approach to the medical/surgical treatment of severe obesity.

Using the same data set, we also conducted preliminary analyses to investigate the psychiatric diagnoses of 236 bariatric surgery candidates who underwent a presurgical psychological evaluation at the Krasner Psychological Center. To conduct these analyses, data were abstracted from the DSM-IV Diagnostic Impressions section of patients' presurgical psychological evaluation reports. Patients ranged from 17 to 69 years old ( $M = 42.22$ ,  $SD = 12.837$ ) and were mostly female (64.4%). BMI ranged from 29.95 to 72.80 ( $M = 45.88$ ,  $SD = 7.147$ ); 16.6% of patients fell into the obese range (Class I or II Obesity;  $BMI \geq 30$ ) and 83.1% of patients had a BMI that fell into the extremely obese range (Class III obesity;  $BMI \geq 40$ ). Seventy-six patients were diagnosed with at least one current DSM-IV-TR psychiatric diagnosis (32.2%). The majority of patients received only one diagnosis (28.4%), followed by two and three or more diagnoses (3.4% and

.4%, respectively). More specifically, 10.6% of patients met criteria for a current mood disorder, 8.5% met criteria for a current anxiety disorder, and 23.7% met criteria for a current eating disorder not otherwise specified, namely binge-eating disorder (23.7%). For a breakdown of specific diagnoses, see Table 1.

Additional ongoing psychological research with this population includes the investigation of attentional bias and cognitive control difficulty in response to visual and olfactory food stimuli in individuals diagnosed with obesity. Through a series of experiments involving computerized tasks, we aim to evaluate the impact of motivational states on attention toward food-related cues, between-group differences in ability to inhibit food-related information, and the effects of inhibitory control on eating patterns. Neuroimaging is being used to examine the associated neural mechanisms. Future work will evaluate these relationships longitudinally, exploring the impact of these biopsychosocial variables on factors such as adherence to dietary and surgical guidelines, weight loss, and overall improvement in health and quality of life. These research efforts not only help us to



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provide evidence-based patient care but also provide our students with additional training opportunities in the area of obesity research.

### Benefits of and Barriers to Interdisciplinary Collaboration

Due to its many perceived benefits, interdisciplinary health care has had a long and significant history in the United States (DeWitt & Baldwin, 2007). Clinically, our team has observed that interdisciplinary teamwork allows for improved continuity of care for our patients, and has helped us to prevent potential patient complications and efficiently address the needs of our patients. Research indicates that interdisciplinary treatment leads to better patient outcomes and satisfaction, and is more cost-effective and efficient; it is also associated with reduced health care utilization and better patient adherence (DeWitt & Baldwin; Flor, Fydrich & Turk, 1992; Gatchel & Okifuji, 2006; Hearn & Higginson, 1998; Rogerson, Gatchel, & Bierner, 2009; Scascighini et al., 2008).

Despite the advantages of multidisciplinary and interdisciplinary approaches to patient care, there remain a number of barriers that need to be addressed for truly interdisciplinary programs to be successfully implemented. Our experience has indicated that establishing a comprehensive program requires the investment of a substantial amount of time and energy, and requires significant administrative support, often from multiple departments. Another limitation is the perceived high cost of such programs. Misperceptions regarding the cost of interdisciplinary patient care can also lead to difficulty obtaining third-party payor reimbursement (Gatchel, & Okifuji, 2006). Although research on comprehensive pain management programs suggests that interdisciplinary programs are more cost-effective than conventional medical treatments (Gatchel & Okifuji), future research needs to evaluate the cost-effectiveness of such interdisciplinary programs for obesity. Moreover, the limited funding available to establish interdisciplinary research or clinical collaborations may discourage potential collaborators from engaging in such interdisciplinary endeavors.

In addition, some patients seeking treatment for a medical condition, such as obesity, are reluctant to undergo a psychological evaluation or do not see the need for including a psychological component in their overall care. This may be due to misperceptions regarding the nature of

psychological evaluation and treatment or fears related to the stigma of psychological illness (see Corrigan, 2004). Therefore, our program has found it helpful for all interdisciplinary team members to thoroughly understand and be able to explain the rationale for inclusion of psychological intervention in medical treatment.

Furthermore, multidisciplinary teams, by nature, consist of multiple providers trained to use different disciplinary-specific jargon and to abide by different ethical guidelines; this can lead to misunderstandings and confusion regarding the role of each team member in the treatment decision-making process and the establishment of treatment goals. The SBU Obesity Program aims to prevent and overcome such miscommunication among team members through the use of weekly team meetings and open discussions focusing on delineating the roles of each team member. We have also found it useful to denote a primary treatment leader for patients who require more ongoing or comprehensive care, based on individual patients' needs. For example, for a patient who requires more substantial psychological intervention, the team may decide that the psychologist will be responsible for coordination of care within the team and with outside providers (e.g., social workers, psychiatrists, residential care personnel, etc.). In other cases, nurse practitioners or dietitians may be the most appropriate primary providers.

Additional barriers to interdisciplinary work are well described by the Institute of Medicine Committee on Building Bridges in the Brain, Behavioral, and Clinical Sciences, which indicates that obstacles to interdisciplinary work can be found in a number of areas, including: communication, funding, career development, attitude and institutional structure, and suggests that overcoming these obstacles requires education regarding interdisciplinary work at an early point in training (Pellmar & Eisenberg, 2000). The American Psychological Association's Guidelines for Psychological Practice in Healthcare Delivery Systems (2013) echo many of the concerns outlined by Pellmar and Eisenberg and further discuss ways that psychologists can overcome and prevent such barriers, such as by becoming involved in the development of policies guiding interdisciplinary teamwork at their home institutions, and educating other health care providers regarding the roles and responsibilities of psychologists on multidisciplinary teams.

Thus far the literature suggests the presence of many perceived barriers and benefits

to interdisciplinary care. However, there is need for continued evaluation of interdisciplinary approaches to obesity to further define benefits of such approaches, identify ways to overcome barriers to interdisciplinary care, and justify the use of financial and institutional resources to support interdisciplinary initiatives. The SBU Obesity Program hopes to contribute to this body of research through the use of prospective, longitudinal studies investigating patient outcomes, patient satisfaction, and health care utilization.

### Conclusion

In sum, the SBU Obesity Program aims to meet the needs of our patients and trainees through the development and implementation of an interdisciplinary training, treatment, and research initiative that can serve as a model of other interdisciplinary programs. Although there are a number of barriers to interdisciplinary collaboration, creating a collaborative cross-disciplinary atmosphere will allow us to effectively translate research into practice and prepare the next generation of clinicians to assess and treat patients suffering from obesity using empirically validated interdisciplinary approaches, and, thus, optimize patient outcomes.

### References

- Agurs-Collins, T., & Bouchard, C. (2008). Gene-nutrition and gene-physical activity interactions in the etiology of obesity. *Obesity*, 16, S2-S4.
- American Psychological Association. (2013). Guidelines for psychological practice in healthcare delivery systems. *American Psychologist*, 68, 1-6. doi: 10.1037/a0029890.
- American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine. (2010). Practice guidelines for chronic pain management. *Anesthesiology*, 112, 810-833.
- Apple, R.F., Lock, J., & Peebles, R. (2006). *Preparing for weight loss surgery: Therapist guide*. New York: Oxford University Press.
- Astrup, A., & Buemann, B., Toubro, S., Ranneries, C., & Raben, A. (1996). Low resting metabolic rate in subjects predisposed to obesity: A role for thyroid status. *American Journal of Clinical Nutrition*, 63, 879-83.
- Avenell, A., Brown, T.J., McGee, M.A., Campbell, M.K., Grant, A.M., Broom, J., Jung, R.T., & Smith, W.C.S. (2004). What interventions should we add to weight reducing diets in adults with obesity? A systematic review of randomized controlled trials of adding drug therapy, exercise, behavior therapy or

- combinations of these interventions. *Journal of Human Nutrition and Dietetics*, 17, 293–316.
- Bouchard, C. (2008). Gene-environment interactions in the etiology of obesity: Defining the fundamentals. *Obesity*, 16, S5–S10.
- Brownell, K. (2004). *The LEARN program for weight management: 10th edition*. Eulless, TX: American Health Publishing Company.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59, 614–625. doi: 10.1037/0003-066X.59.7.614.
- Craighead, L.W. (2006). *The appetite awareness workbook: How to listen to your body and overcome bingeing, overeating and obsession with food*. Oakland, CA: New Harbinger.
- Davis, C., Zai, C., Levitan, R.D., Kaplan, A.S., Carter, J.C., Reid-Westoby, C., . . . Kennedy, J.L. (2011). Opiates, overeating and obesity: A psychogenetic analysis. *International Journal of Obesity*, 35, 1347–1354.
- DeWitt, C., & Baldwin, J.R. (2007). Some historical notes on interdisciplinary and interprofessional education and practice in health care in the USA. *Journal of Interprofessional Care*, 21, 23–37.
- Dong, C., Li, W.D., Li, D., & Price, R.A. (2006). Extreme obesity is associated with attempted suicides: Results from a family study. *International Journal of Obesity*, 30, 388–390. doi: 10.1038/sj.ijo.0803119.
- Flor, H., Fydrich, T., & Turk, D.C. (1992). Efficacy of multidisciplinary pain treatment centers: a meta-analytic review. *Pain*, 49, 221–230.
- Foster, G.D., Makris, A.P., & Bailer, B.A. (2005). Behavioral treatment of obesity. *American Journal of Clinical Nutrition*, 82(Suppl.), 230S–5S.
- Fox, C.S., Pencina, M.J., D'Agostino, R.B., Murabito, J.M., Seely, E.W., Pearce, E.N., & Vasan, R.S. (2008). Relations of thyroid function to body weight: Cross-sectional and longitudinal observations in a community-based sample. *Archives of Internal Medicine*, 168, 587–592.
- Gatchel, R. J., & Okifuji, A. (2006). Evidence-based scientific data documenting the treatment and cost effectiveness of comprehensive pain programs for chronic nonmalignant pain. *The Journal of Pain*, 7, 779–793. doi: 10.1016/j.jpain.2006.08.005.
- Hearn, J., & Higgenson, I.J. (1998). Do specialist palliative care teams improve outcomes for cancer patients; a systematic literature review. *Palliative Medicine*, 12, 317–332.
- Heo, M., Allison, D.B., Faith, M.S., Zhu, S., & Fontaine, K.R. (2003). Obesity and quality of life: Mediating effects of pain and comorbidities. *Obesity Research*, 11, 209–16.
- Jaworowska, A., & Bazylak, G. (2011). Chlamydomydia pneumoniae antibodies may be independently associated with increased BMI and percentage of body fat among women. *International Journal of Obesity*, 35, 1225–1232.
- Jensen, M.D., Ryan, D.H., Apovian, C.M., Ard, J.D., Comuzzie, K.A.D., Hu, F.B., . . . Yanovski, S.Z. (2013). *AHA/ACC/TOS Guideline for the management of overweight and obesity in adults: A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society*. Retrieved from <http://circ.ahajournals.org/content/early/2013/11/11/01.cir.000.0437739.71477.ee.citation>.
- Jensen, M. P., Turner, J. A., & Romano, J. M. (1994). Correlates of improvement in multidisciplinary treatment of chronic pain. *Journal of Counseling and Clinical Psychology*, 62, 172–179.
- Kinsinger, L.S., Jones, K.R., Kahwati, L., Harvey, R., Burdick, M., Zele, V. & Yevich, S.J. (2009). Design and dissemination of the MOVE! weight-management program for veterans. *Preventing Chronic Disease*, 6. Retrieved December 18, 2013, from [http://www.cdc.gov/pcd/issues/2009/jul/08\\_0150.htm](http://www.cdc.gov/pcd/issues/2009/jul/08_0150.htm).
- Kolotkin, R. L., Meter, K., & Williams, G. R. (2001). Quality of life and obesity. *Obesity Review*, 2, 219–229. doi: 10.1046/j.1467-789X.2001.00040.x.
- Lemstra, M., Stewart, B., & Olszynski, W. P. (2002). Effectiveness of multidisciplinary intervention in the treatment of migraine: A randomized clinical trial. *Headache: The Journal of Head and Face Pain*, 42, 845–854. doi: 10.1046/j.1526-4610.2002.02202.x
- Magnusson, J. E., Reiss, C. M., & Becker, W. J. (2004). Effectiveness of a multidisciplinary treatment program for chronic daily headache. *Canadian Journal of Neurological Sciences*, 31, 72–79.
- Mechanick, J.I., Youdim, A., Jones, D.B., Garvey, W.T., Hurley, D.L., McMahon, M.M., . . . Brethauer, S. (2013). Clinical practice guidelines for the perioperative nutritional, metabolic and nonsurgical support of the bariatric surgery patient-2013 update: Co-sponsored by American Association of Clinical Endocrinology, The Obesity Society, and American Society for Metabolic & Bariatric Surgery. *Surgery for Obesity and Related Diseases*, 9, 159–191.
- Mitchell, J.E., & de Zwaan, M. (Eds.). (2005). *Bariatric surgery: A guide for mental health professionals*. New York: Routledge.
- Mokdad, A.H., Marks, J.S., Stroup, D.F., & Gerberding, J.L. (2004). Actual causes of death in the United States, 2000. *Journal of the American Medical Association*, 291, 1238–1245.
- Moyer, V.A. (2012). Screening for and management of obesity in adults: U.S. Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine*, 157, I-32. doi:10.7326/0003-4819-157-5-201209040-00482.
- National Center for Chronic Disease Prevention and Health Promotion. (2011). *OBESITY: Halting the epidemic by making health easier*. Atlanta, GA: Centers for Disease Control.
- National Comprehensive Cancer Network. (2003). Distress management. Clinical practice guidelines. *Journal of the National Comprehensive Cancer Network*, 1, 344–374.
- National Institutes of Health (1998). *Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults*. Bethesda, MD: Author.
- Pellmar, T.C., & Eisenberg, L., & Committee on Building Bridges in the Brain, Behavioral, and Clinical Sciences; Division of Neuroscience and Behavioral Health. (Eds.). (2000). *Bridging disciplines in the brain, behavioral, and clinical sciences*. Washington, DC: National Academies Press. Retrieved from <http://www.nap.edu/catalog/9942.html>.
- Rogerson, M.D., Gatchel, R.J., & Bierner, S.M. (2009). A cost utility analysis of interdisciplinary early intervention versus treatment as usual for high-risk acute low back pain patients. *Pain Practice*, 10, 382–395.
- Romanova, M., Liang, L., Deng, M.L., Li, Z., & Heber, D. (2013). Effectiveness of the MOVE! Multidisciplinary Weight Loss Program for Veterans in Los Angeles. *Preventing Chronic Disease*, 10, 120–325. doi: <http://dx.doi.org/10.5888/pcd10.120325>.
- Salwen, J.S., Hymowitz, G., Vivian, D., & O'Leary, K.D. (in press). Childhood abuse, adult interpersonal abuse, and depression in individuals with extreme obesity. *Child Abuse & Neglect*.
- Scascighini, L., Toma, V., Dober-Spielmann, S., & Sprott, H. (2008). Multidisciplinary treatment for chronic pain: A systematic review of interventions and outcomes. *Rheumatology*, 47, 670–678. doi: 10.1093/rheumatology/ken021
- Wadden, T.A., Sternberg, J.A., Letizia, K.A., Stunkard, A.J., & Foster, G.D. (1989). Treatment of obesity by very low calorie diet, behavior therapy, and their combination: A five year perspective. *International Journal of Obesity*, 13, 39–461.
- Wang, Y, Beydoun, M.A., Liang, L., Caballero, B., & Kumanyika, S.K. (2008). Will all Americans become overweight or obese? Estimating the progression and cost of the U.S. obesity epidemic. *Obesity*, 16, 2323–2330. doi:10.1038/oby.2008.351.
- Werrija, M.Q, Jansen, A., Mulkensa, S., Elgersmab, H.J., Amenta, A.J.H.A., & Hospersa, H.J. (2009). Adding cognitive therapy to dietetic treatment is associated with less relapse in obesity. *Journal of Psychosomatic Research*, 67, 315–324.

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## Panic Control Treatment in Private Practice: Effectiveness and Clients' Perspectives

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Marvin Goldfried's (2011) article in this journal, "Generating Research Questions From Clinical Experience: Therapists' Experiences in Using CBT for Panic Disorder," contains important and interesting findings on practicing clinicians' experiences treating panic disorder. Goldfried noted, "The goal of the clinical survey was not only to determine the extent to which CBT works in clinical practice, but also to uncover those mediators and moderators that may create obstacles for effective clinical intervention" (p. 59). The purpose of this article is to contribute to this discussion by presenting the results of a private practice effectiveness study of Panic Control Treatment (PCT). The present study primarily presents clients' perspectives on their treatment and how these reports compare to the findings of Goldfried's survey of clinicians' use of CBT for panic disorder. Fairholme et al. (2014) presents full details of the present study, including benchmark comparisons with other efficacy and effectiveness studies, and discussion of implications for dissemination and transportability.

Goldfried's (2011) survey was advertised internationally to clinicians experienced in using CBT to treat panic disorder. The questionnaire assessed clinicians' perceptions of factors thought to interfere with the effectiveness of treatment. These factors were grouped into the following categories: patients' symptoms related to panic, other patient problems or characteristics, patient expectations, patient beliefs about panic, patient motivation, social systems, problems/limitations associated with the CBT intervention method, and therapy relationship issues (p. 59). A total of 326 clinicians responded to the survey. Some of the main findings were that therapists reported an 80% success rate. Patients' belief that their fears were realistic was perceived by 64% of the therapists as limiting the effectiveness of CBT. As for patient symptoms thought to limit treatment effectiveness, 62% reported

chronicity, and 39% reported severity of symptoms. Approximately 67% of therapists reported that patient motivation contributed to dropout. Compared with less experienced therapists (< 21 years,  $N = 211$ ), more experienced therapists (> 21 years,  $N = 115$ ) more frequently used breathing retraining, relaxation training; assertiveness, communication, and independence training; attempts to resolve stressful conflicts leading to panic; and attempts to help patients understand developmental roots of fears. More experienced therapists were less likely to use simulation of panic symptoms within the session, in-vivo exposure, and cognitive restructuring of feared outcomes associated with panic.

### PCT Effectiveness Study

Participants for the study were 100 consecutive clients with panic disorder with or without agoraphobia who sought treatment at a private practice anxiety disorders clinic in Lake Oswego, Oregon. All clients received PCT following the *Mastery of Your Anxiety and Panic II* (MAP) treatment manual (Barlow & Craske, 1994). Of the 100 patients who began treatment, the mean age was 35.6 years, with ages ranging from 18 to 59. Thirty-one percent were male and 69% were female. Forty-one percent received a primary diagnosis of panic disorder and 59% a primary diagnosis of panic disorder with agoraphobia. The mean duration of panic disorder was 6 years, with a range of 1 month to 31 years. Treatment hours ranged from 4 to 36 hours. There were no exclusions based on medication use, comorbidity, or other factors. Treatment was provided by a multidisciplinary team that included a licensed psychologist (RW) and the other staff trained by RW: a licensed professional counselor, a psychiatric nurse practitioner, and a psychologist resident.

Regarding training in PCT, one of the authors (RW) was trained and certified in PCT by the treatment originators. Training utilized a train-the-trainer model, where

RW received both didactic (training materials, treatment manual, 2-day workshop) and competence-based (supervision on two certification cases, telephone consultation, taped sessions were rated for adherence by treatment originators, all sessions for both certification cases had to achieve 80% adherence) training. RW provided subsequent training to other study therapists (see below), which included didactic (treatment manual, guided review of the treatment manual, role-plays) and competence-based (weekly supervision) training. Study therapists collected patient outcomes on an ongoing basis as part of clinic protocol.

At pretreatment, posttreatment, and follow-up assessment points, participants completed a battery of self-report questionnaires. The measures administered included the Fear Questionnaire (FQ; Marks & Mathews, 1979), the Mobility Inventory (MI; Chambless, Caputo, Jasin, Gracely, & Williams, 1985), the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990), the Body Sensations Questionnaire and the Agoraphobic Cognitions Questionnaire (BSQ and ASQ; both Chambless, Caputo, Bright, & Gallagher, 1984), the State-Trait Anxiety Inventory-Trait subscale (STAI; Spielberger, Gorsuch, & Lushene, 1970), and the Beck Depression Inventory-IA (BDI; Beck & Steer, 1993).

Patients were contacted for follow-up assessment approximately every other year after completion of treatment, allowing the opportunity to complete follow-up batteries on more than one occasion. The follow-up assessment contained the self-report questionnaires previously completed at pre- and posttreatment, along with questions assessing clients' perceptions of various aspects of treatment.

Results indicated that PCT was effective at both posttest and follow-up, with effect sizes comparable to those found in efficacy studies as well as effectiveness studies conducted in a variety of real-world settings (DiMauro et al., 2013; Stewart & Chambless, 2009). The mean of the effect sizes of all the panic-related measures was 1.41 pretreatment to posttreatment and 1.32 pretreatment to follow-up.

Virtually all gains were maintained at two long-term follow-up assessments, which ranged from 1 to over 4 years posttreatment. As far as we know, ours is the first effectiveness study of panic control treatment in a private practice setting.

Clients ranked the specific components of treatment in the order of perceived importance. Education about panic attacks

was rated most important, followed in order by cognitive restructuring, therapeutic relationship, breathing/relaxation, interoceptive exposure, and situational exposure. Clients rated their satisfaction with treatment on a 0- to 8-point scale (0 = none and 8 = *as much as you can imagine*), with 93% reporting satisfaction ratings of 6 or higher.

In response to the question, “Since completing treatment, which of the following statements best describes the quality of your life?” (a = *The same as before ever having panic attacks*; b = *Worse than before having panic attacks*; c = *Better than my life before having panic attacks*), 84% of clients indicated that their quality of life since completing treatment had been as good or superior to their quality of life before the onset of panic. Reasons cited included increased personal growth, self-confidence, and self-acceptance; decreased worry and fear, feeling more in control of their life, doing more new things, being better at solving problems, and having greater compassion for others suffering from emotional problems. The 16% of clients who reported a worse quality of life cited restricted range of activities and loss of independence as primary reasons.

Ninety-one percent of respondents indicated they had used skills learned in CBT to deal with life problems other than panic attacks. Specific examples were managing day-to-day stress, problem-solving and decision-making, overcoming specific fears, managing intense emotions, and improving interpersonal functioning. Table 1 provides some specific examples of clients’ responses to the following question: “Imagine a friend was just beginning PCT for panic disorder and had the following questions. How would you answer them?”

### Goldfried’s Panic Survey

Clinicians who responded to Goldfried’s panic survey indicated that chronicity and severity of symptoms were major factors that undermined treatment effectiveness. Similarly, our study found that longer duration of panic disorder ( $r = .26$ , permutation test exact  $p = .05$ ) and greater agoraphobic avoidance at pretreatment ( $r = .35$ , permutation test exact  $p = .008$ ) predicted lower posttreatment high endstate functioning, though these factors were not associated with long-term follow-up status. Greater agoraphobic avoidance at posttreatment did predict lower high endstate functioning status at follow-up ( $r = .51$ , permutation test exact  $p = .002$ ).

High endstate functioning required a participant to be panic free, have a score of 2

(symptoms rated as slightly disturbing/not really disabling) or less on the FQ-Debilitation scale on the Fear Questionnaire, and achieve normal range scores on four of five measures of agoraphobic avoidance and panic-related anxiety (FQ-Agoraphobia (FQ-AG), MI Accompanied (MI-ACM), MI Alone (MI-ALO), ACQ, and BSQ).

Related to the panic survey findings that patients’ expectations that treatment would result in freedom from all anxiety limited treatment effectiveness, clients in our study, at least when surveyed at follow-up, reported that they did not expect to be panic- and anxiety-free. Further, in contrast to panic survey findings that close to 61% of clinicians found the CBT intervention used “did not provide sufficient guidelines for dealing with patients’ reluctance to eliminate safety behaviors,” the therapists in our private practice study found the guidelines in the MAP manual sufficient to address this issue as well as to provide instructions for successfully evoking panic symptoms in the session, i.e., interoceptive exposure.

The panic survey found that clinicians viewed therapy relationship issues as contributors to clinical difficulties. While we did not measure therapeutic alliance, our clients reported that the therapeutic relationship was more important than the technical components (i.e., breathing/relaxation, and interoceptive and situational exposure). Thus, the therapeutic relationship deserves further attention in CBT for panic disorder in clinical practice.

Another interesting finding in the panic survey was that experienced clinicians were less likely to closely adhere to a CBT protocol. I (RW) am an experienced clinician (>30 years), trained in CBT in graduate school, Board Certified in Cognitive and

Behavioral Psychology, and certified in PCT. The therapists in our practice whom I trained to deliver PCT and I did use the MAP manual flexibly, veering from protocol when the need arose, but returning to it, making sure we covered each of the PCT components. For example, if loss of job or loved one, or acute marital or family problems occurred during treatment, therapists would allow these issues to be the focus of treatment until they no longer seemed to be likely to interfere with following the PCT manual. These detours from protocol might last anywhere from 1 to 5 sessions on average. Such a flexible approach to providing PCT (Huppert et al., 2006) was found to be more effective than greater adherence to the manual in patients who were less motivated in the Multi-Center Collaborative Study of the Treatment of Panic Disorder (Barlow, Gorman, Shear, & Woods, 2000).

### Discussion and Conclusions

The majority of our long-term follow-up sample of clients with panic disorder with or without agoraphobia reported meaningful and durable benefits from PCT. They found the education component of treatment most helpful. They were quite satisfied with the treatment they received, were successful in generalizing PCT skills to deal with other life problems, and most viewed their post PCT lives of as high or higher quality than before the onset of panic disorder. While most clients did not see PCT as having cured their panic disorder, they reported that panic and anxiety no longer interfered significantly in their lives.

Though we did not measure therapeutic alliance or other treatment components as predictors of therapy outcome, interestingly, most clients found the therapeutic re-

**Table 1. “What Would You Tell a Friend Beginning PCT?”**

**Question:** Will I ever get over having panic attacks and the worry about having them?

**Answer:** After treatment, you can expect to have a new outlook on panic attacks and a set of skills to either avert panic attacks or to successfully manage panic symptoms. Panic attacks will be greatly minimized and no longer have a significant effect on your daily life.

**Question:** Will I ever get over my fear of certain activities and places?

**Answer:** Yes, most fear of activities and places will return to normal, but it will take hard work, persistence, patience, and repeated practice of skills learned in treatment.

**Question:** Can I expect a cure or will I mainly learn better ways to live with panic attacks and anxiety?

**Answer:** Treatment doesn’t result in a cure, but you will not perceive panic attacks as dangerous; they will not occur very often and will not be as intense. You will be able to cope with them so that they do not disrupt your life.



## Find a CBT Therapist



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lationship more important than interoceptive and situational exposure. While clients' perceptions of what treatment components are most helpful do not prove these components are in fact related to therapy outcome, it may be fruitful to explore how clients account for their behavior change. These qualitative data may serve as useful information to clients beginning PCT and are wondering what benefits they may achieve. These conclusions should of course be viewed as tentative, given the small sample size, retrospective reports, and other unique characteristics of this private practice effectiveness study.

We applaud the Society of Clinical Psychology's efforts to build a two-way bridge between research and practice. Goldfried's (2011) report on clinicians' experiences in using CBT for panic disorder is informative and hopefully will encourage clinicians to see their work as valuable in exploring effectiveness of CBT in real-world settings and providing researchers avenues for future research (DiMauro et al., 2013; Stewart & Chambless, 2009). We are grateful for the opportunity to share our experiences gained from an effectiveness study in private practice.

### References

- Barlow, D. H., & Craske, M. G. (1994). *Mastery of your anxiety and panic II*. Albany, NY: Graywind.
- Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2000). Cognitive-behavioral therapy, imipramine, or their combination for panic disorder: A randomized control trial. *Journal of the American Medical Association*, 283, 2529-2536.
- Beck, A. T., & Steer, R. A. (1993). *Manual for the Beck Depression Inventory*. San Antonio, TX: Psychological Corporation.
- Chambless, D. L., Caputo, G. C., Bright, P., & Gallagher, R. (1984). Assessment of fear of fear in agoraphobics: The Body Sensations Questionnaire and the Agoraphobic Cognitions Questionnaire. *Journal of Consulting and Clinical Psychology*, 52, 1090-1097.
- Chambless, D. L., Caputo, G. C., Jasin, S. E., Gracely, E. J., & Williams, C. (1985). The Mobility Inventory for Agoraphobia. *Behaviour Research and Therapy*, 23, 35-44.
- DiMauro, J., Domingues, J., Fernandez, G., & Tolin, D. F. (2013). Long-term effectiveness of CBT for anxiety disorders in an adult outpatient clinic sample: A follow-up study. *Behaviour Research and Therapy*, 51, 82-86.
- Fairholme, C. P., Strand, J., Thomas, J. C., & Warren, R. (2014). *Evaluation of the effectiveness and transportability of panic control treatment in a private practice setting: Acute and long term effects*. Manuscript submitted for publication.
- Goldfried, M. R. (2011). Generating research questions from clinical experience: Therapists' experiences in using CBT for panic disorder. *the Behavior Therapist*, 34, 57-62.
- Huppert, J. D., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods (2006). The interaction of motivation and therapist adherence predicts outcome in cognitive-behavioral therapy for panic disorder: Preliminary findings. *Cognitive and Behavioral Practice*, 13, 198-204.
- Marks, I. M., & Mathews, A. M. (1979). Brief standard self-rating for phobic patients. *Behaviour Research and Therapy*, 17, 263-267.
- Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy*, 28, 487-495.
- Spielberger, C. D., Gorsuch, R. L., & Lushene, R. E. (1970). *Manual for the State-Trait Anxiety Inventory*. Palo Alto, CA: Consulting Psychologists Press.
- Stewart, R. E., & Chambless, D. L. (2009). Cognitive-behavioral therapy for adult anxiety disorders in clinical practice: A meta-analysis of effectiveness studies. *Journal of Consulting and Clinical Psychology*, 77, 595-606.

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We dedicate this article to the memory of Jay C. Thomas, who guided the statistical analysis of this work and who made it possible for numerous graduate students to follow the scientist/practitioner model. Jay was a kind and generous man, esteemed colleague, and good friend.

We also would like to thank Adrienne Young for her expertise and generosity in preparing this manuscript.

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## Perspectives From Past Presidents: Assessment and Evidence-Based Practice

Alayna Schreier and David J. Hansen, *University of Nebraska–Lincoln*

This brief article is the third in a four-part series that provides recommendations on relevant literature and resources from expert researchers and clinicians, past presidents of the Association for Behavioral and Cognitive Therapies (ABCT). Past presidents were surveyed for their perspectives on research articles, theoretical articles, books, websites, and self-help books they would recommend to members of ABCT and readers of *the Behavior Therapist*. The previous articles in this series can be found in the October 2013 and January 2014 issues of *the Behavior Therapist* (Schreier & Hansen, 2013, 2014). The following suggestions are resources and articles related to assessment and evidence-based practice.

Dr. Debra Hope, president from 2010–2011, recommended *The Scientist Practitioner: Research and Accountability in Clinical and Educational Settings* (Barlow, Hayes, & Nelson, 1984). The second edition of this classic text was published in 1999 (Hayes, Barlow, & Nelson-Gray, 1999). Co-authored by three past presidents, this book provides an overview of the use of varying methodologies in everyday clinical practice. Chapters include a focus on treatment evaluation using single-case designs and time-series methodology. This combination of research evidence and treatment is the cornerstone of evidence-based practice.

Dr. Jacqueline Persons, president from 2002–2003, recommended two volumes focused on empirically supported assessment measures. *The Practitioner's Guide to Empirically Based Measures of Depression* (co-authored by past president Dr. Arthur Nezu) provides an overview of depression and a guide to selecting assessment measures in both clinical and research settings (Nezu, Ronan, Meadows, & McClure, 2000). The administration, scoring, interpretation, psychometric properties, and clinical utility of each measure of depression and depression-related constructs are described. Dr. Persons also recommended the *Practitioner's Guide to Empirically Based*

*Measures of Anxiety* (Antony, Orsillo, & Roemer, 2001).

Incorporating assessment results into case conceptualization and treatment planning is a key element of evidence-based practice, as noted in *Cognitive Therapy in Practice: A Case Formulation Approach* (Persons, 1989). Authored by a past president and recommended by Dr. Hope, this book emphasizes the importance of the therapist's hypothesis regarding the underlying psychological mechanisms behind presenting problems, relying on the notion that case conceptualization is at the heart of cognitive therapy. Chapters go on to discuss how that conceptualization guides the selection of treatment. Dr. Persons published an additional volume on the subject in 2008 titled *The Case Formulation Approach to Cognitive-Behavior Therapy*.

Dr. Philip Kendall, president from 1989–1990, recommended a text that covered important research findings in psychotherapy. Dr. Kendall stated that Bergin and Garfield's *Handbook of Psychotherapy and Behavior Change* (Lambert, 2013), now in its sixth edition, is "a classic . . . that introduced the well-known mantra 'what treatment works for what patient problem.'" This text is also valuable for describing the research design most useful for identifying main effects and interactions related to treatment response. Briefly discussed in a previous article in this series, Dr. Thomas Ollendick, president from 1994–1994, recommended *Clinical Behavior Therapy* (Goldfried & Davison, 1976). Co-authored by past president Dr. Gerald Davison, this text includes specific therapeutic techniques for use in clinical behavioral practice.

Dr. Anne Marie Albano, president from 2007–2008, identified three texts relevant to the treatment of childhood disorders. *Child Psychopathology* (Mash & Barkley, 2003) provides comprehensive information on a wide range of child and adolescent disorders. *Assessment of Childhood Disorders* (Mash & Barkley, 2009) includes evidence-based approaches to assessing child and adolescent mental health problems and health risks. *Treatment of Childhood Disorders*

(Mash & Barkley, 2006) provides information on the efficacy and effectiveness of evidence-based treatments for childhood disorders. Dr. Albano also recommended the "Treatments that Work" series, edited by past president Dr. David Barlow and published by Oxford University Press, which includes session-by-session guides for therapists and corresponding workbooks for clients for a variety of presenting problems.

Past presidents also identified valuable examples of evidence-based practice within the literature. Dr. Hope recommended an article examining exposure therapy for the treatment of phobias and anxiety disorders (Craske et al., 2008). This invited essay challenges the reliance on fear levels as an index of learning and presented strategies for enhancing inhibitory learning along with the resulting clinical implications for exposure therapy. Dr. Persons also recommended an article by Lambert, Harmon, Slade, Whipple, and Hawkins (2005) that evaluated a system of measuring and monitoring treatment outcomes. Dr. Persons wrote, "Progress monitoring is a key element of evidence-based practice, and this article provides some nice data to show that when therapists collect data at every session to monitor their patients' progress, patients have better outcome than when therapists do not do this."

Dr. Rosemary Nelson-Gray, president from 1981–1982, recommended an article by Kingdon and Young (2007) that discusses the pros and cons of research into the biological mechanisms of mental disorders for use in clinical psychiatry. Kingdon asserts that this research has not been beneficial for diagnosis, treatment, or destigmatization of mental illness. In contrast, Young states that biological research is just one of the many approaches that can contribute to improved treatment outcomes, citing work surrounding the HPA axis in clinical populations.

These books and articles on assessment and evidence-based practice are relevant for much of the work being conducted within ABCT today. Past presidents have provided their expert recommendations of these texts and articles for the continued education of professionals, educators, students, and readers of *the Behavior Therapist*. The final article in this series will address self-help materials and other resources.

### References

- Antony, M. M., Orsillo, S. M., & Roemer, L. (2001). *Practitioner's guide to empirically based*

- measures of anxiety. New York, NY: Kluwer Academic/Plenum.
- Barlow, D. H., Hayes, S., Nelson, R. O. (1984). *The scientist practitioner: Research and accountability in clinical and educational settings*. New York, NY: Pergamon.
- Craske, M. G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy* 46, 5-27.
- Goldfried, M. R., & Davison, G. C. (1976). *Clinical behavior therapy*. New York, NY: Wiley.
- Kingdon, D. & Young, A.H. (2007). Research into putative biological mechanisms of mental disorders has been of no value in clinical psychiatry. *British Journal of Psychiatry*, 191, 285-290.
- Hayes, S. C., Barlow, D. H., & Nelson-Gray, R. O. (1999). *The scientist practitioner: Research and accountability in the age of managed care* (2nd ed.). Needham Heights, MA: Allyn & Bacon.
- Lambert, M. J. (Ed.). (2013). *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed.). New York: John Wiley.
- Lambert, M. J., Harmon, C., Slade, K., Whipple, J. L., & Hawkins, E. J. (2005). Providing feedback to psychotherapists on their patients' progress: Clinical results and practice suggestions. *Journal of Clinical Psychology*, 61, 165-174.
- Mash, E. J., & Barkley, R. A. (2003). *Child psychopathology* (2nd ed.). New York, NY: The Guilford Press.
- Mash, E. J., & Barkley, R. A. (2006). *Treatment of childhood disorders* (3rd ed.). New York, NY: The Guilford Press.
- Mash, E. J., & Barkley, R. A. (2009). *Assessment of childhood disorders* (4th ed.). New York, NY: The Guilford Press.
- Nezu, A. M., Ronan, G. F., Meadows, E. A., & McClure, K. S. (Eds.). (2000). *Practitioner's guide to empirically based measures of depression*. New York, NY: Kluwer Academic/Plenum.
- Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach*. New York, NY: W. W. Norton.
- Persons, J. B. (2008). *The case formulation approach to cognitive-behavior therapy*. New York, NY: The Guilford Press.
- Schreier, A., & Hansen, D. J. (2013). Perspectives from past presidents: Foundations of behaviorism and studying behavior change. *the Behavior Therapist*, 36, 184-185.
- Schreier, A., & Hansen, D. J. (2014). Perspectives from past presidents: Research design and data analysis. *the Behavior Therapist*, 37, 18-19.

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## At ABCT

# Minutes of the Annual Meeting of Members

Saturday, November 23, 2013, Gaylord Opryland, Nashville

### Call to Order

President Hofmann welcomed members to the 47th Annual Meeting of Members. Notice of the meeting had been sent to all members in September.

### Minutes

Secretary-Treasurer Davis asked for any comments or corrections on the minutes from last year's meeting. M/S/U: The November 17, 2012, minutes were unanimously accepted as distributed.

### Expressions of Gratitude

President Hofmann thanked Robert Klepac for the wonderful job he has done as President; he noted that Lata McGinn is rotating off as representative; and Denise Davis winds up her term as Secretary Treasurer. He thanked Anne Marie Albano for her work as International Associates Committee Chair; Susan White for her work as Public Education and Media Dissemination Chair; Kathleen Gunthert for her service as Editor of *the Behavior Therapist*; Tom Ollendick for his time at the helm of *Behavior Therapy*; Sandy Pimentel

for her service as Continuing Education and Convention Coordinator; Kirsten Haman for her work as Local Arrangements Chair; Muniya Kahn for the superb job she's done as Continuing Education Chair; Risa Weisberg for her service as Institutes Committee Chair; Scott Compton as AMASS Chair; Kevin Chapman as Master Clinician Seminars Chair, and, of course, Justin Weeks as this year's Program Chair and his assistant, Ashley Howell.

A stellar cast of reviewers helped Dr. Weeks put the program together; thanks were extended to: Claire Adams, Abby Adler, Amelia Aldao, Carla Allan, Lauren Alloy, Peggy Andover, Joye Anestis, Michael Anestis, Aleta Angelosante, Karla Anhalt, Chacko Anil, Michael Armeay, David Atkins, Courtney Bagge, Robin Barry, Abbie Beacham, J. Gayle Beck, Kimberly Becker, Rinad Beidas, Kathryn Bell, Courtney Benjamin, Erin Berenz, Jennifer Block-Lerner, Christina Boisseau, Cameo Borntrager, James Boswell, Thomas Bradbury, Scott Braithwaite, Nicole Brandt, Ana Bridges, Ruth Brown, Timothy Brown, Shandra Brown Levey, Steven Bruce, Craig Bryan, Andrew Busch,

Meghan Butryn, Will Canu, Nicole Caporino, Cheryl Carmin, Anil Chacko, Eunice Chen, Mari Clements, Rebecca Cobb, Erika Coles, Daniela Colognori, Dennis Combs, Christine Conelea, Michael Coons, James Cordova, Colleen Cummings, Kristy Dalrymple, Anne Day, Ronda Dearing, Thilo Deckersbach, Patricia DiBartolo, Ida Dickie, David DiLillo, Tiara Dillworth, Linda Dimeff, Brian Doss, Laura Dreer, Jennifer Duncan, Rita Dykstra, Jill Ehrenreich-May, Steven Evans, Todd Farchione, Aaron Fisher, Ellen Flannery-Schroeder, Christopher Flessner, Nicholas Forand, Elisabeth Frazier, Dara Friedman-Wheeler, Patti Fritz, Cara Fuchs, Matthew Gallagher, Richard Gallagher, Frank Gardner, Brandon Gaudiano, Scott Gaynor, Stephanie Godleski, Abigail Goldsmith, Adam Gonzalez, Jeffrey Goodie, Cameron Gordon, Kim Gratz, Paulo Graziano, Rebecca Greif, Amie Grills-Tauchel, Shelby Harris, Katie Hart, Tae Hart, Trevor Hart, Cynthia Hartung, Sarah Hayes-Skelton, Aude Henin, James Herbert, Charmaine Higa-McMillan, Crystal Hill-Chapman, Dina Hirshfeld-Becker, Marjan Holloway, Gareth Holman, Farrah Hughes, Shari Jager-Hyman, Matthew Jarrett, Elissa Jelalian, Amanda Jensen-Doss, Ashley Johnson, Robert Johnson, Adrienne Juarascio, Barbara Kamholz, Kathryn Kanzler, Robert Kern, Jacqueline Kloss, Laura Knouse, Mandy Kumpula, Jennifer Langhinrichsen-Rohling, Robert LaRue,

Robert Leahy, Penny Leisring, Marie LePage, Crystal Lim, Noriel Lim, Gabrielle Liverant, Christopher Lootens, Ilana Luft, Aaron Lyon, Sarah Markowitz, Idalia Massa, Michael McCloskey, Meghan McDevitt-Murphy, Lata McGinn, Kathryn McHugh, Carmen McLean, Daniel McNeil, Elizabeth Meadows, Deborah Melamed, Jennifer Merrill, Terri Messman-Moore, Alicia Meuret, Robert Meyers, Jamie Micco, Alec Miller, Damon Mitchell, John Mitchell, Nathanael Mitchell, Todd Moore, Zella Moore, Jessica Murakami-Brundage, James Murphy, Taryn Myers, Brad Nakamura, Douglas Nangle, Lisa Napolitano, Tara Neavins, Laura Neely, Karl Nelson, Timothy Nelson, Michelle Newman, Janet Ng, Roisin O'Connor, Phyllis Ohr, Bunmi Olatunji, Camilo Ortiz, Julie Owens, John Pachankis, David Pantalone, Yael Perry, Sandra Pimentel, Kristin Pontoski, Katherine Porter, Donna Posluszny, Cynthia Ramirez, Holly Ramsawh, Sheila Rauch, Madhavi Reddy, Simon Rego, John Richey, Lorie Ritschel, Shireen Rizvi, Patricia Robinson, Ronald Rogge, Kelly Rohan, George Ronan, Julie Ryan, Amy Sato, Steven Sayers, Brad Schmidt, Casey Schofield, Edward Selby, Kathy Sexton-Radek, Erin Sheets, Jedidiah Siev, Sandra Sigmon, Monica Skewes, Moria Smoski, Jennifer Snyder, Will Spaulding, Susan Sprich, Sharon Stephan, Diana Stewart, Lindsay Stewart, Catherine Stroud, Gregory Stuart, Sharon Sung, Lance Swenson, Robyn Sysko, Raymond Chip Tafrate, Jeff Temple, Patti Timmons Fritz, Casey Trainor, Kimberli Treadwell, Katherine Tsai, Matthew Tull, Cynthia Turk, Lisa Uebelacker, Angela Utschig, Shona Vas, Andres Viana, Jason Vogler, Michael Walther, Jolie Weingeroff, Lauren Weinstock, Risa Weisberg, Robert Weiss, Adam Weissman, Susan Wenzel, Chad Wetterneck, Bradley White, Kamila White, Susan White, Sarah Whitton, Monnica Williams, Erica Woodin, Matthew Young, Michael Zvolensky, and Rene Zweig.

The Local Arrangements Committee did a great job setting things up and making us feel welcome. The President thanked Chair Kirsten Haman, and members Nina Martin, Laurel Brown, Erin Fowler, Bunmi Olatunji, Eun-ha Kim, Megan Viar, and Brittany Remmert.

### Appointments

The President listed the new appointments to leadership positions: Jeffrey Goodie, 2013-2016 Convention and

Education Issues Coordinator; L. Kevin Chapman, 2014 Program Committee Chair; Brett Deacon, 2014 Associate Program Chair; Deb Drabick and Michael McCloskey, 2014 Local Arrangements Committee Co-Chairs; Lauren Weinstock, 2013-2016 Institutes Committee Chair; David Atkins, 2013-2016 AMASS Committee Chair; Sarah Kertz, 2013-2016 Master Clinician Seminars Committee Chair; John Comer, 2013-2016 Continuing Education Committee Chair; Brett Deacon, *iBT* Editor; Sandra Pimentel, 2013-2016 Public Education and Media Dissemination Committee Chair; Susan White, Editor, Oxford Book Series; and Thomas Ollendick, 2013-2016 International Associates Committee Chair.

### Finance Committee Report

Denise Davis said she has enjoyed her time as Secretary-Treasurer and is happy to report that we have enough funds on hand to now buy some new office chairs for the Central Office conference room. Anyone who has attended a meeting recently will appreciate this investment! She explained the Finance Committee's functions that include protecting the fiscal health of ABCT; tracking income, expenses, and projections; evaluating requests for special projects; reviewing personnel recommendations; monitoring investment portfolio management; ensuring property maintenance of permanent headquarters; and serving as liaison to development activities.

She noted that the committee is comprised of Secretary-Treasurer, Denise Davis, and two hand-selected members, Mike Petronko and Christopher Mosunic, plus the President-Elect, Dean McKay, and ABCT's Executive Director Mary Jane Eimer, as an ex officio member.

She reported that for fiscal 2013, the year just ended, we project a Gross Income of \$1,813,717, with Gross Expenses of \$1,787,476, giving ABCT a Net Income \$26,241. Of this income, 46% came from the Convention, 23% from Publications, 28% from Membership, with another 3% from other sources. These percentages fluctuate year to year, but remain fairly constant. The projected expenses for 2014 are as follows: Convention at \$345,595; Publications at \$307,790; and Membership at \$25,595, totaling \$1,904,962. We are projecting modest surpluses for 2014 and 2015, with a possible deficit in 2016. We tend to focus on our core revenues and benefit from prudent investment management.

Our Capital Expense Fund, which is currently at \$180,000, and our Special Project Funds, currently at \$143,766, provide us with money earmarked for projects outside the normal operating budgets. Within our endowments, we have \$51,548 in Named Awards and \$1,106,132 in Fund the Future, giving us a total of \$1,157,680.

She reported that ABCT is fiscally sound; we pass yearly independent audits; we follow accepted accounting principles; and we are compliant with all state and federal regulations. Our budget is transparent; and staff time and task allocations are congruent with our stated goals. Lots of people have worked hard to get us here—kudos to all!

### Coordinators' Reports

#### *Academic and Professional Issues*

Kamila White, the coordinator of Academic and Professional Issues, thanked Lata McGinn, her Board liaison, and Mary Jane Eimer for their guidance and support, and thanked her committee chairs and members for their outstanding work.

The coordinator reported that the Academic Training Committee, under Gabrielle Liverant, has been extremely productive, and one can look at the website for confirmation as they expand the CBT Teaching Exercises, Demonstrations & Assignments section. They are developing marketing material. The Mentorship Directory is proving to be a very useful resource for students. The committee will maintain and update this section with additional teaching resources, syllabi, demonstrations, and assignments for instructors of CBT courses, as needed.

Shireen Rizvi, Chair of the Committee on Awards and Recognition, hosted the award ceremony for the 2013 award recipients. Congratulations to Thomas H. Ollendick, Career/Lifetime Achievement Award; Michelle G. Craske, Outstanding Contribution by an Individual for Research Activities; Mark S. Bauer, Distinguished Friend to Behavior Therapy; University of Nebraska-Lincoln Clinical Psychology Training Program, David J. Hansen, Director, for being awarded the Outstanding Training Program; Kelly Koerner, Outstanding Service to ABCT; Kaitlin P. Gallo, Virginia A. Roswell Student Dissertation Award; and Sarah Royal, Leonard Krasner Student Dissertation Award. The Committee on Research Facilitation, chaired by Kim Gratz, is examining the procedures to put in place for the new Graduate Student Research Grant

and hosted their first panel discussion at this convention.

The Committee on Affiliations and Specializations, chaired by Ariel Lang, is exploring the need and support for developing a specialty training council.

The Committee on International Associates, chaired by Anne Marie Albano, has developed a new page on the website to link to the Committee on International Associates mission statement, to the World Congress Committee (WCC) in Behavioural and Cognitive Therapies. This link had information on the meeting in Lima, Peru, in 2013 and will include the Call for Papers for the 2016 World Congress to be held in Australia when available.

The Committee on Self-Help Book Recommendations, chaired by R. Trent Codd, presented four books to the Board for approval; their section of the website has been completely revamped and is now linked to the Find a CBT Therapist page.

### *Convention and Continuing Education*

Sandy Pimentel, Coordinator of Convention and Continuing Education, noted we had 3,457 registrants as of Saturday. "Build it and they will come." The coordinator said she can't say enough about Mary Ellen Brown, our Director of Education and Meeting Services, and she praised Managing Editor Stephanie Schwartz, who designed the program book cover and the graphics associated with the convention theme. She praised the committees that work to create the program: Risa Weisberg, Institutes Committee Chair; Scott Compton, AMASS Chair; Kevin Chapman, Master Clinician Seminars Chair; Barbara Kamholz, Workshops Chair; and, of course, Justin Weeks, our Program Chair, and his assistant, Ashley Howell.

The Mini Workshops are a great hit with very positive feedback; they will be back next year.

The CE Committee, headed by Muniya Kahn, has added a total of nine webinars, all of which are also available for viewing now on our website as webcasts. We can't thank Kelly Koerner enough, as it was her expertise that allowed the committee's vision to become reality.

### *Membership Issues*

David DiLillo, Membership Issues Coordinator, thanked Mary Jane Eimer for her constant help: "I have a direct link to her." He also singled out Lisa Yarde, Membership Manager, for her timely access

to any data we need to help us make informed decisions.

He noted that Membership and Student Membership committees continue their priorities of recruitment and retention of members. ABCT has 4,109 members, with 3,922 last year, so we are ahead of where we were last year. The Membership Committee, chaired by Jon Grayson, is contacting lapsed members, and, of those contacted, 300-plus have renewed.

The Student Membership Committee, chaired by Danielle Mack, has been studying the recent trends in undergraduate participation in the convention.

The Clinical Directory and Referral Issues Committee has worked with the Central Office to completely revamp the Find a Therapist directory, which is now renamed Find a CBT Therapist. There is a redesigned splash page and Chair Bob Schachter and his committee have developed a symptom finder to help lay people who might otherwise not know what troubles them. The page is more user friendly with an easy-to-use tool bar. He encouraged all members who take referrals or see clients to participate in this program.

There are 39 Special Interest Groups (SIGs) participating in the SIG expo, and the challenge, which is a good one to have, is how to present all the worthy 293 posters.

The Social Networking and Media Committee, under Josh Magee, has found creative ways to allow the Facebook page to blossom, with tons of friends and lots of likes. There is great symbiosis among FB, Twitter, and the website; a favorite item is Throwback Thursday, when the past is revisited to understand the future. He noted that the List Serve Committee continues to do a good job monitoring the postings, with fabulous interactions among Yoni Schwab, the Chair, Patrick Kerr, the Moderator, and Central Office staff. The list serve continues to receive thought-provoking questions and answers as well as requests for referrals and position offerings.

The Leadership and Elections Committee, under the new leadership of Christopher Martell, is looking for nominations by the February 1 deadline. The 2014 Call for Nominations is on our website, in *iBT*, and on the back page of the addendum. So if you know a colleague you think would be good for governance, or you yourself think you would be good—nominate, nominate, nominate!

### *Publications Committee*

Anne Marie Albano, Publications Coordinator, said that our journals are strong, with both *BT* and *C&BP* rising in their citation ratings and improving their turn-around times. Michelle Newman will be officially taking the helm at *BT* and is already reporting manuscript submissions, so much so that the journal is expanding from *four to six issues a year* and adding another associate editor. Also taking over this year is Brett Deacon at *iBT*, given a two-issue head start by Kate Gunthert. We can all tip our hats to Kate Gunthert and Tom Ollendick, who leave *iBT* and *BT* in excellent shape. Steve Safren, now in his second year at *C&BP*, also saw great increases in manuscript flow while continuing the fast turn-around for which the journal is justifiably acclaimed.

Carmen McLean and her AEs continue working with David and Leonid, refining the website redesign, with the goal of a January launch. Susan White, who just completed her term as Chair of the Public Education and Media Dissemination Committee, which updates Wiki pages to showcase CBT and ABCT material as well as developing pod casts for our web, has been selected to spearhead our new initiative with Oxford University Press. Sandy Pimentel will take over the duties at PEMDC, and has already begun looking at ways to celebrate our 50th anniversary. Michael Detweiler has been charged with spearheading tweeting efforts, coordinating with Facebook and the web. And Tim Bruce has been doing a phenomenal job shepherding nearly a dozen new fact sheets, which should begin to show up on our pages shortly.

Patti DiBartolo will be spearheading a task force that will examine the direction for our journals when our contract with Elsevier expires. This initiative is important to the Association, both for positioning the journals for maximum exposure as well as for the organization's financial well being. We are looking to have a report before the end of the year.

Finally, Anne Marie thanked David Teisler, our Director of Communications, who keeps the balls aloft and the science disseminating.

### *Executive Director's Report*

Our convention, at which a healthy organization presents great science to a huge, appreciative group of attendees, is the result of a strong relationship between staff and volunteers.

This has been a productive year. ABCT underwent a Board-initiated operations review and came away with both some suggestions for improvements as well as commendations for a well-run organization well positioned to meet future challenges. A fuller explanation can be found in the October *tBT*.

The Executive Director said that she was especially proud of the aggressive approach ABCT is taking to technology as a medium of choice. She listed some examples, including a large number of webinars, all of which are now available as web casts; using QR codes at the convention to link attendees to a number of different destinations on our site; the mobile itinerary planner app as well as the more traditional planner available via the web; and, as Anne Marie mentioned, vital publications and an upcoming redesign launch for the web. In addition, look for new approaches for our Find a CBT Therapist; it's being completely revamped. If you take referrals or see clients, you need to be listed in the ABCT Referral Network.

Membership is on track, in fact a little ahead, and we're making money while producing great products. Mary Jane said she is proud of her staff and gets to work with incredible people. Lisa Yarde is in the midst of implementing a proprietary database to better manage membership and better integrate our many directories; Tonya Childers is running registration in what has been described as the smoothest convention yet; Keith Alger is also downstairs, welcoming new members; Damaris Williams is helping Stephanie Schwartz manage the Central Office back in NYC; and Stephanie, the Managing Editor for all three journals, handles ever more pages ever more quickly. Mary Ellen Brown continues to help our members put on great conventions, smoothly run with an amazing number of sessions crammed into such a short time. Mary Jane and David Teisler were both honored by one of our professional organi-

zations this year. The New York Society of Association Executives honored him as the Outstanding Association Executive and Mary Jane with the Diplomat Award. Mary Jane said that, as at our own ABCT Awards Ceremony, it's great to be recognized by one's peers. 2013 has been a terrific year for ABCT and its staff. Mary Jane encourages members to stop by the ABCT office if visiting New York City.

#### President's Report

President Hofmann thanked the membership for allowing him to serve, and thanked the committees and coordinators for the great work over the past year. He said that it has been rewarding working with the Board of Directors. He also extended special thanks to the Central Office, especially Mary Jane, Mary Ellen, and David.

#### Transition of Officers

Maureen Whittal is joining the Board as Representative at Large and liaison to Academic and Professional Issues; Karen Schmaling is Secretary-Treasurer-Elect; and Jon Abramowitz is this year's President Elect. President Hofmann then introduced the incoming President, Dean McKay.

#### Incoming President's Report

The incoming President thanked those assembled for "the opportunity to increase exposure for his social anxiety," and welcomed the opportunity to serve our members and the CBT community.

#### Adjournment

President Hofmann thanked Mary Jane Eimer for her tireless work and presented her with a gift. The meeting then adjourned.

# now

ABCT

## online

### Our website looks different!

Check out ABCT's newly designed website.

<http://www.abct.org>

## in-press

### Rethinking the Role of Worry in Generalized Anxiety Disorder: Evidence Supporting a Model of Emotional Contrast Avoidance

"Whereas other models of GAD have described worry as an attempt to manage negative emotions through the reduction or avoidance of internal arousal, conversely, we propose that individuals with GAD *embrace* a chronic negative stance as a way to be emotionally prepared for any upcoming negative events..."

Llera & Newman

*Behavior Therapy*

doi: 10.1016/j.beth.2013.12.011

## archive

"... Remember the *t* test, and take heart."

Cohen (1990)

"Things I Have Learned (so far)"  
*American Psychologist*, 45(12)



Feeling disconnected?

Join ABCT's facebook page and interact with those you know (or don't know), receive ABCT-related news, and, in general, enjoy your comrades in mental health.

# Preparing to Submit an Abstract

ABCT will once again be using the ScholarOne abstract submission system. The step-by-step instructions are easily accessed from the ABCT home page. As you prepare your submission, please keep in mind:

- **Presentation type:** Please see the two right-hand columns on this page for descriptions of the various presentation types.
- **Number of presenters/papers:** For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The chair may present a paper, but the discussant may not. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.
- **Title:** Be succinct.
- **Authors/Presenters:** Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their ABCT category. Possibilities are **current member**; **lapsed member** or **nonmember**; **postbaccalaureate**; **student member**; **student nonmember**; **new professional**; **emeritus**.
- **Affiliations:** The system requires that you enter affiliations before entering authors. This allows you to enter an affiliation one time for multiple authors. **DO NOT LIST DEPARTMENTS.** In the following step you will be asked to attach affiliations with appropriate authors.
- **Key Words:** Please read carefully through the pull-down menu of already defined keywords and use one of the already existing keywords, if appropriate. For example, the keyword "military" is already on the list and should be used rather than adding the word "Army." **Do not list behavior therapy, cognitive therapy, or cognitive behavior therapy.**
- **Goals:** For Symposia, Panel Discussions, and Clinical Round Tables, write three statements of no more than 125 characters each, describing the goals of the event. Sample statements are: "Described a variety of dissemination strategies pertaining to the treatment of insomnia"; "Presented data on novel direction in the dissemination of mindfulness-based clinical interventions."
- Overall:** Ask a colleague to proof your abstract for inconsistencies or typos.

## Understanding the ABCT Convention

The ABCT Convention is designed for practitioners, students, scholars, and scientists who come from a broad range of disciplines. The central goal is to provide educational experiences related to behavioral and cognitive therapies that meet the needs of attendees across experience levels, interest areas, and behavioral and cognitive theoretical orientations. Some presentations offer the chance to learn what is new and exciting in behavioral and cognitive assessment and treatment. Other presentations address the clinical-scientific issues of how we develop empirical support for our work. The convention also provides opportunities for professional networking. The ABCT Convention consists of General Sessions and Ticketed Events.

### GENERAL SESSIONS

There are between 150 and 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. General session types include:

**Invited Addresses.** Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge.

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

**Symposia.** Presentations of data, usually investigating the efficacy or effectiveness of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. No more than 6 presenters are allowed.

**Panel Discussions and Clinical Round Tables.** Discussions (or debates) by informed individuals on a current important topic. These are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. No more than 6 presenters are allowed.

**Poster Sessions.** One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,200 and 1,400 posters are presented each year.

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

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

**Special Sessions.** These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training.

**Special Interest Group (SIG) Meetings.** More than 35 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

### TICKETED EVENTS

Ticketed events offer educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment.

**Clinical Intervention Training.** One- and 2-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction.

**Institutes.** Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday, and are generally limited to 40 attendees.

**Workshops.** Covering concerns of the practitioner/educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees.

**Master Clinician Seminars.** The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees.

**Advanced Methodology and Statistics Seminars.** Designed to enhance researchers' abilities, they are 4 hours long and limited to 40 attendees.



# *Call for Papers*

## Enhancing CBT by Drawing Strength From Multiple Disciplines

The road to the current state of scientific support for cognitive-behavioral therapy (CBT) is paved with findings from diverse empirical backgrounds. The areas that have informed contemporary practice of CBT include social psychology, developmental science, behavioral neuroscience, learning theory, and experimental cognitive science, to name a few. The result of drawing together these varied scientific disciplines has been a foundation of CBT procedures and empirically informed practice that has substantially improved the lives of our clients.

As CBT continues to advance, it is timely to revisit the scientific foundations of our specialty. It is anticipated that these disciplines may inform procedures to facilitate treatment delivery and dissemination, as well as improve on the efficacy and efficiency of CBT. Therefore, the theme of this year's conference, "Enhancing CBT by Drawing Strength From Multiple Disciplines Within the Social Sciences" is intended to showcase research that explicitly draws from varied social science areas to build upon the foundation of CBT as currently practiced. Included under this heading are methodologies that draw on modern technological advances and newer theoretical developments in the full corpus of the social and behavioral sciences. Illustrative examples include: how social psychological processes inform efforts at dissemination of CBT approaches to a wider audience of practitioners; what developmental implications result from cognitive-behavioral interventions in youth; how our knowledge of social cognition informs the implementation of CBT in diverse populations; what culturally specific factors influence the delivery of CBT; how human factors play a role in ensuring compliance with behavioral homework using smartphone technology.

We encourage submissions that explore the full range of social and behavioral science influences on the development and implementation of cognitive-behavioral methods. It is hoped that this year's conference will showcase research that illustrates how diverse scientific principles have informed CBT, and how this very same diversity continues to inform future advances in the discipline. Accordingly, areas of social science research that have been underrepresented in past conferences are especially welcome.

Submissions may be in the form of Symposia, Clinical Round Tables, Panel Discussions, and Posters. Information about the conference and for submitting abstracts will be on ABCT's website, [www.abct.org](http://www.abct.org), after January 1, 2014. The online submission portal will open in early February.

48th Annual  
Convention

Philadelphia

November  
20–23, 2014

**Deadline for submission is March 1, 2014**

*the Behavior Therapist*  
Association for Behavioral  
and Cognitive Therapies  
305 Seventh Avenue, 16th floor  
New York, NY 10001-6008  
212-647-1890 | [www.abct.org](http://www.abct.org)

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## 48th Annual Convention

Enhancing CBT by Drawing Strength From Multiple Disciplines



November 20-23, 2014

**PHILADELPHIA *is for* Foodies**

Right across the street from the Philadelphia Marriott Hotel there are dozens of inexpensive food sources in the Redding Terminal Market. Bakeries for you to grab a fresh bagel or croissant, and for lunch lots of picnic possibilities. Here are some to try: **Bassetts Ice Cream**, frozen yogurt, and sorbet • **Flying Monkey Bakery** offers the city's best whoopee pies, cupcakes, truffles, and brownies • **Market Bakery** offers pies, muffins, Danish, brioche, scones, and more. (All LeBus products are certified kosher) • **Metropolitan Bakery** offers breads, foccacia, cookies, tarts, pastries, housemade spreads and tapenades • **Termini Brothers Bakery** offers Italian pastries, cakes, cookies and cannolis • **The Famous 4th Street Cookie Company** offers award winning homemade cookies baked fresh everyday • **Downtown Cheese** — artisanal, domestic and imported cheeses, olives, and crackers • **Fair Food Farmstand** is dedicated to bringing local food to the marketplace and promoting humane sustainable agriculture systems • **Salumeria** offers a full array of international cheeses, Italian deli & groceries, hoagies, salads, and specialty sandwiches • **Lancaster Co. Dairy** offers fresh squeezed juices, homemade lemonade and dairy products • **Miller's Twist** offers hand-rolled soft pretzels baked fresh all day on premises • **Rib Stand** offers baby back ribs, rib sandwiches, and roasted potatoes • **Sweet as Fudge Candy Shoppe** offers homemade fudge and nut brittles, fresh roasted peanuts, dried fruits, and a wide variety of candies • **The Grill at Smucker's** offers breakfast sandwiches, wraps and omelets, Italian sausage sandwiches, French fries, and more • **Dutch Eating Place** offers Pennsylvania Dutch breakfasts and lunches including famous blueberry pancakes, apples dumplings, deli sandwiches and scrapple • **Chocolate by Mueller** is family owned and operated since 1980, and focuses on hand made old fashioned chocolates, made on site.

*Look for listings of additional Redding Market counters.*